MASTERS BY RESEARCH

Exploring Services for Adults on a Methadone Prescription Programme from a Third Sector Perspective

Jones-Blunt, Alice

Award date:
2022

Awarding institution:
Bangor University

Exploring Services for Adults on a Methadone Prescription Programme from a Third Sector Perspective

by

Alice Priscilla Jones-Blunt

Master of Arts by Research (MARes)

Thesis

Submitted to the School of Medical and Health Sciences

Bangor University

Health and Social Care

500350816

December 2021

Abstract

Heroin has been a growing problem in Wales for many years, with referral statistics indicating that heroin has been the most problematic substance since 2014 (Welsh Government 2019d, 24). England and Wales reached their highest levels of drug related deaths since 1993, with heroin and opioids relating to over half of deaths in 2018 (ONS 2020, 3).

Methadone is the initial treatment drug that is offered in Opioid Substitution Therapy (NICE 2020, 8). There has been much debate regarding the effectiveness of methadone (Du Rose 2015), which raises questions to whether an alternative drug may have more socio-economic and personal benefits. Methadone is shown to be effective for reducing drug/heroin use, which is a key harm reduction initiative the Welsh Government are working towards in their most recent Substance Misuse Delivery Plan 2019-22.

This research explores the use of methadone as a treatment option for heroin, opioid and other opiate dependency. It aims to understand the challenges experienced by people referred to substance misuse services from a third sector perspective. The third sector have been both collaborative and competitive with the NHS (Kalk et al 2018, 195), and play an important role in the recovery journey of service users. Three Welsh key policies were analysed to determine best practice guidance and to assess translation into practice: *Integrated Care* (2010), *Community Prescribing* (2011) and *ROISC* (2013).

Six semi-structured interviews were conducted with five service providers from the third sector working with people who use substance use and dependency and one with a Welsh Government affiliation. They were recruited using purposive and snowball sampling. This primary data was analysed following Braun and Clarke's (2006) thematic analysis approach and used some a priori coding following an extensive literature review. The three Welsh policies were analysed using Walt and Gilson's Policy Analysis Triangle Framework (1994) and using a priori coding based on the literature review and interview findings.

The interview findings have shown that Third Sector Organisations (TSOs) interviewed in this present study perceived methadone as ineffective for abstinence. This is likely due to their individual perception of recovery (seemingly abstinence) and problems with community resources and infrastructure. Different understandings of recovery culture and negative attitudes from some mainstream services and the general public can cause barriers for people

accessing services due to associated stigma. Information sharing and the lack of time/money to effectively work with other organisations was a major challenge and could cause services to become insular. The policy analysis found that some areas of the policies were translated into practice (i.e. community prescribing and developing a focus on harm reduction recovery culture), but other areas were not (i.e. a single point of access and integrated care pathways). This may be due to unrealistic policy objectives compared to the resources and means available.

This overall study found issues with access to services, understanding population need and overburdened services. A perception of disempowering hard-to-reach service users, despite policies emphasising a person-centred service delivery. This may be due to service providers and commissioners not having a full understanding of service user needs and differences in recovery journeys. Services should take on board guidance from *Social Services and Wellbeing* (2014) *Act* and focus on the "*What matters?"* conversation. This will help developing an understanding of service user aims and goals for treatment and their personal definition of recovery. As part of these conversations, services could better understand what treatment would be best for a person - methadone, buprenorphine, heroin-assisted treatment or detoxification, rather than habitually focus on methadone which brings additional challenges.

TSOs reported perceptions that they are supporting people who 'fall through the gaps', adding to the potential frustrations between TSOs and the NHS.

Acknowledgements

This has been very challenging in all sense of the word but it has also been the most rewarding and I am very proud of myself to have accomplished writing this thesis. I am very lucky to have had great support, to pick me up and help dust myself off.

Firstly, thank you to the interview participants that took part in this study. Without your participation, this thesis would not be possible. I am ever so grateful and cannot thank you enough.

I want to thank my academic supervisors Dr Anne Krayer and Dr Diane Seddon. Thank you for the inspiration, the support, the kind words when there were tears.
I count my lucky stars I was guided by two very inspirational and intelligent Doctors.

The patience of my family has been wonderful. My husband, Christopher. My parents, Dawn and Richard, I could not have wished for better support and encouragement. Thank you.

Thank you to Freda Smith for proofreading my thesis. I really appreciate the time and effort and the kindness from you to offer.

I would like to thank the company partner and KESS2 for having an interest in this meaningful subject area and contemporary issue and investing many resources into this project and giving me this opportunity. Thank you to Bangor University for supporting this Masters by Research, especially the undergraduate staff from the former School of Social Sciences for getting me to where I am today.

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

I confirm that I am submitting the work with the agreement of my Supervisor(s).

Table of Contents

List of Figures

List of Tables

List of Abbreviations

APB – Area Planning Board

APoSM – Advisory Panel on Substance Misuse

BMA Board of Science – British Medical Association Board of Science

CIW – Care Inspectorate Wales

Community Prescribing – Guidance for Evidence Based Community Prescribing in the Treatment of Substance Misuse

CSPs – Community Safety Partnerships

DNA – Did Not Attend

EBP – Evidence Based Practice

HIW – Health Inspectorate Wales

ICP – Integrated Care Pathways

Integrated Care - Integrated Care and Integrated Care Pathways for Adult Substance Misuse Services in Wales

KESS2 – Knowledge Economic Skills Scholarship 2

MDT – Multi-Disciplinary Team

MDW – Multi-Disciplinary Working

MMT – Methadone Maintenance Treatment

MPP – Methadone Prescription Programme

NHS – National Health Service

NICE – National Institute for Health and Care Excellence

ONS – Office for National Statistics

OST – Opioid Substitution Therapy

ROISC – Recovery Orientated Integrated Systems of Care

SMDP – Substance Misuse Delivery Plan

SMTF – Substance Misuse Treatment Framework

SMS – Substance Misuse Service

SPoA – Single Point of Access

TSOs – Third Sector Organisations

WTtRH – Working Together to Reduce Harm

Introduction

This chapter introduces the thesis and provides a rationale for the study. It outlines the aims and objectives, provides some background and context to the research and an overview of each chapter.

Aims and Objectives

This research explores the use of methadone as a treatment option for heroin, opioid and other opiate dependency.

It explores third sector perceptions of substance misuse services for adults on methadone prescription programmes (MPPs). The objectives are as follows:

- Exploring the challenges that arise when supporting adults (aged 18 and over) who are referred to substance misuse services.
- Exploring third sector professionals' perceptions of treatment and approaches to drug dependence in a region of Wales.
- Analysing three key policies and exploring the challenges associated with their translation into practice, specifically:
  - Integrated Care and Integrated Care Pathways for Adult Substance Misuse Services in Wales (2010a)
  - Substance Misuse Treatment Framework: Guidance for Evidence Based Community Prescribing in the Treatment of substance misuse (2011)
  - Substance Misuse Treatment Framework: Recovery Orientated Integrated Systems of Care (2013)

This research does not directly involve current or former service users, nor does it involve NHS employees such as doctors, pharmacists, or staff from the substance misuse service.

Background

Drug related deaths reached their highest levels (since records began in 1993) in 2018 in England and Wales and have continued to remain high with a 0.8% increase in 2019 (ONS 2020, 3; Turner and Smith 2020, 5; Turner et al 2019, 5). Heroin and other opioids were related to just over half of drug misuse deaths in 2018 (Turner et al 2019, 6), and drug poisonings continue to involve an opiate in 49.2% of registrations in 2019 (ONS 2020, 11). Heroin and

morphine also continued to be the most mentioned opiates in 2019 relating to 1329 drug poisonings (NCA 2020, 8 and cited in ONS 2020, 11). Heroin, opioid and other opiate drug use are a significant problem in Wales.

The Welsh Government's approach to drug dependency is one of reducing drug/heroin use, with initiatives that aim to reduce drug use and improve the life of the individual and minimise the harmful effects on society. The definition of recovery according to the Welsh Government's recovery policy, Recovery Orientated Integrated Systems of Care (ROISC) (2013) and their 2018 annual report from Working Together to Reduce Harm (WTtRH) (2018b, 11) remains a "*process in which the difficulties associated with substance misuse are eliminated or significantly reduced and the resulting personal improvement becomes sustainable*" (Welsh Government 2013, 4). The increase in drug related deaths suggests that there are significant challenges in supporting those who misuse substances. Third Sector Organisations (TSOs) play an important role in providing services to support people who use substances.

Key reports on this topic identified that there is room for improvement within services from service availability and service delivery, as outlined in the Health Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) (2018) review of substance misuse services in Wales. The *Working Together to Reduce Harm* final report (Livingston et al 2018) found there had been improvements over the ten years reviewed in terms of working together, and a key focus on reducing the harms associated with drug use. However, in 2018 HIW and CIW specified that joint-up working, between substance misuse services, secondary care, primary care and mental health services, i.e., communication and information sharing systems (HIW and CIW 2018, 32), needed improving. They identified problems with access to services, particularly for hard-to-reach groups such as people who are homeless, those living in rural communities, older people, and people from minority ethnic groups (HIW and CIW 2018, 7). The Substance Misuse Delivery Plan (SMDP) 2019-22 aims to tackle accessibility of services, including access for hard-to-reach groups; vulnerable groups and furthest away from services (rural communities) (Welsh Government 2019a, 1, 14). The SMDP 2019-22 includes a key element of multiagency working within the plan, whilst also adopting a "*whole person approach*" (Welsh Government 2019a, 10). This thesis explored access to services and multi-disciplinary working (MDW) in the study region to identify:

- potential barriers to MDW
- recommendations for the local area to facilitate joint working.

As well as the above challenges, whether methadone is effective as a treatment is debated in the literature. For example the high likelihood of continuing a MPP for more than four years, and having to follow strict guidelines can be challenging for service users, coupled with a higher risk of mortality (National Treatment Agency for Substance Abuse 2013/PHE 2013 both cited in CSJ 2014, 20; Rosenbaum and Murphy 1987; Boyd 2004; Radcliffe and Stevens 2008, cited in Du Rose 2015, 103, Newcombe 1996, cited in Du Rose 2015, 103), longer and more severe withdrawal compared to heroin (Gossop and Strang 1991, Rosebaum 1981, Stewart 1987 all cited in Du Rose 2015, 103), detoxing (Cohen 2017), and generally being more harmful than heroin (Du Rose 2015, 103). Thus, part of the thesis explores:

- the effectiveness of MPPs and OST as a treatment in general.

This research was conducted in a region of Wales, however, to ensure confidentiality, the specific geographical area is not disclosed. The research was carried out from 1st April 2017 until 18th December 2021. This was a KESS2 scholarship which was funded for 12 months with a write-up period. KESS2 is a Welsh Scholarship scheme which invests into postgraduate students to research a specific topic alongside an associated company partner. As a part of this KESS2 programme, the company partner for this study was a pharmacist, prescribing for MPPs.

Prior to commencing this scholarship, I had graduated with a First-Class BA Honours degree in Health and Social Care (2016), with the aspiration to begin my career in health and social care research. With the company partner's professional expertise on this subject matter, and my professional interest in researching a current significant issue that aspires to improve the lives of others, this Masters by Research was developed.

Current research

Research on the effectiveness of MPPs has been ongoing for decades, with this thesis citing work from Rosenbaum (1981), Gossop and Strang (1991), Newcombe (1996) (all cited in Du Rose 102-103) to more recent research from Drucker et al (2016) Cohen (2017) and Bond and Witton (2017). This highlights the continuous questions around methadone as an effective treatment of heroin dependency.

This is not only a question of methadone, but also the dividing nature of the best approaches to treating drug dependence. There are questions around a focus on abstinence and reducing drug/heroin use, which are likely to be affected by the difficulties of defining

dependency/addiction initially; as a disease (Lorman 2013; Nikmanesh et al 2017) or a choice (Granfield and Cloud 1999; Russell et al 2011; Heyman 2013), a criminal or a health issue (Nutt 2019, The Wallich 2020 and National Assembly for Wales 2017), within medical or psychosocial models. These debates filter down to front-line services and the people at the forefront of dependency needing support but within complex systems, effected by politics, longstanding cultures, and stigmatised attitudes of addiction/dependency.

Recovery capital are the internal resources (e.g., good health or the daily skills to live independently) and external resources (e.g., living in a safe and stable home with drug support/treatment services accessible/available) a person has that supports their recovery (Welsh Government 2013). It is an important concept when talking about recovery. There must be community resources available to support the service user to develop their recovery capital (Hennessey 2017), and societal views on drug dependence can have a detrimental effect on progress (Foley et al 2021; Weiss et al 2006, 283; Woo et al 2017, 5). Building recovery capital is a fundamental objective of *ROISC* (2013), which is one of three policy guidance analysed in this thesis. Another is *Community Prescribing* (2011) to understand the logistics of MPPs, and *Integrated Care* (2010) to explore what is expected and advised for MDW.

WTtRH (2008-2018a) provide an insight over the development of substance misuse services over ten years to then an external review of services from and HIW and CIW (2018) as a whole. These two reports are important contributions to the field as they identify issues that affect the people of Wales and the impact of drug dependence. From these two key reports, the SMDP 2019-22 was devised. The SMDP 2019-22 will be explored in this study to determine whether it is effective for people seeking recovery on a MPPs. Findings from this current study will be compared to the three key reports: WTtRH 2018 (Livingston et al 2018), HIW and CIW 2018 and SMDP 2019-22.

Thesis overview

The thesis begins with a literature review which presents key research, policy, and practice literature with a particular focus on prevention, MDW and person-centred, strengths-based care. Following this, the method and methodology chapter describes the collection of primary data and the policy analysis. It also reflects on the limitations of the study. The interview findings are presented in chapter three, which firstly focuses on recovery approaches, culture, attitudes, and the effectiveness of MPPs, and moves onto exploring recovery capital and its significance, barriers to recovery and role of MDW. The next chapter is the policy analysis,

which uses Walt and Gilson's (1994) Policy Analysis Triangle Framework to analyse the three substance misuse policies. The discussion follows, which explores the perceptions of the third sector along with the literature and research discussing methadone, recovery capital and issues with infrastructure supporting the level of support needed for some cases of heroin dependency, in particular hard-to-reach groups.

The thesis concludes with a summary and recommendations for future research, policy, and practice development.

Chapter One

Literature review

This chapter reviews the policy and research literature exploring drug dependence, focusing on heroin, opioids, and other opiates. It includes discussions on treatment and recovery, the current policy literature supporting this and the culture, stigma, and attitudes to dependency. The literature review is shaped by the three principles associated with service provision in Welsh policy and official reviews of substance misuse services, which were found to be *prevention, integrated working* and *person-centred and strength-based care*.

The impact of heroin on individuals and society

Heroin is the most harmful and problematic illegal drug in the UK for adults who misuse drugs (BMA 2013, 4; Independent Working Group 2017, 12), and the most problematic illegal drug in Wales (Welsh Government 2019d). Social harms associated with drug use include deprivation, family neglect, criminality, effects on employment or driving ability, which can in turn cause problems with loss of earnings, educational attainment, and personal relationships as well as problems within the community (BMA 2013, 3).

According to Public Health Wales, adults aged between 25 and 49 years, accounted for a substantial amount of hospital admissions with opioid use symptoms compared to other illicit substances, and this number had risen 16.7% in five years (from 2011/12 to 2016/17) (Public Health Wales 2018 cited in Watkins 2019; Smith 2017, 9). Opioids continued to represent a large portion of hospital admissions for this age group (47.4%) (Public Health Wales 2020, 10). People who use opiates are at an increased risk (six times more likely) of premature death, particularly soon after leaving treatment (Pierce at al 2015 and Cornish et al 2010, both cited in Independent Working Group 2017, 13). Opiates were recorded in just under half (49.2%) of registered drug poisonings in 2019 (ONS 2020, 11). It was found that heroin and morphine were the most frequently mentioned opiates in 2019 relating to the drug poisoning deaths and similarly and ever so slightly higher in 2018 (ONS 2020, 11). One of the possible factors for this is that the purity of heroin reached a ten year high in the UK in 2019 (National Crime Agency 2020, 8, cited in ONS 2020, 11).

The social and economic costs of drug supply in England and Wales in 2017 is estimated to be £10.7 billion a year with £6 billion linked to drug-related crime (HM Government 2017, 4).

Substance misuse has an impact on Wales' economy and on health, social and justice services as well as the community and the individual (Welsh Government 2019b, 5).

In the UK, 99% of costs linked to drugs are Class A drug use, costing health and social care and effecting criminality (BMA 2013, 3). The National Treatment Outcome Research Study found that for every £1 spent on treatment in the UK, there was a reduction of £3 in public costs found (BMA 2013, 9). Economic costs were also reduced as a result of reduced crime; Opioid Substitution Treatment (OST) has been shown to reduce acquisitive crime (BMA 2013, 9).

Explaining terms

Addiction is a contested term that can be associated with labels such as "*sick, dangerous, disempowered, and unable to exercise agency, choice, and self-determination" (*Madden and Henderson 2020, 9). The International Network of People Who Use Drugs (INPUD) advocate for the term dependency, and the notion that any terminology used to describe drug dependency is person-centred and that the person spoken with is asked their preferred terms. This thesis adopts the term dependency to advocate for destigmatising language. When terms such as *addict, addiction and substance misuse* are used, this is to reflect the wording as used by primary papers, participants, and policy.

Addiction: a disease or a choice?

This thesis embraces the statement that there is no set "*truth*" of addiction (Brown 2000, 282). Addiction is unique to the individual, where they feel powerless. It is treatable and manageable, often with professional help and support.

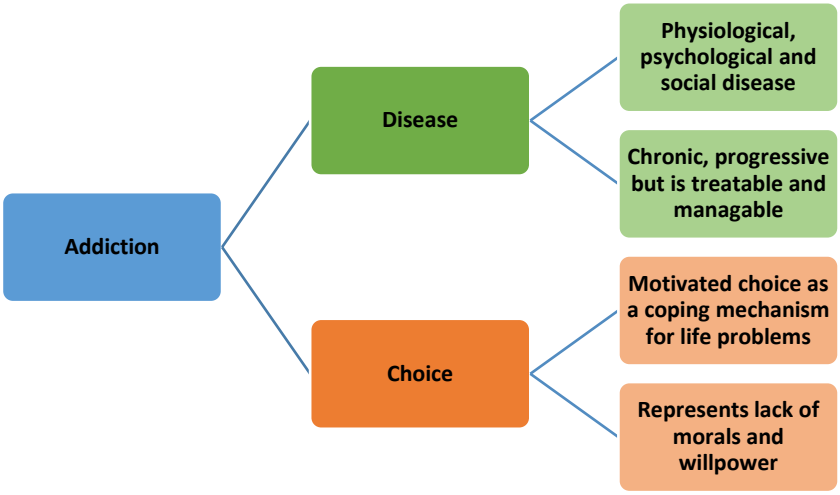


Figure 1.1 Addiction

(based on Nikmanesh et al 2017, 1; Galanter 2006, cited in Nikmanesh et al 2017, 1; Lorman 2013, 437; NIDA 2018a, 1, 3; Russell et al 2011, 151; Schaler 2000, cited in Russell et al 2011, 151; and Peele et al 1991, cited in Russell et al 2011, 151).

Addiction is defined as *"a chronically relapsing disorder, characterized by a compulsive drive to seek drugs and a loss of control over drug intake*" (American Psychiatric Association 2000, cited in Ersche et al 2012, 173). The NHS (2015) refer to addiction as a *"treatable condition",* which acknowledges that it is an illness or a disease that needs treatment, and the NHS also acknowledges the term addiction in general, rather than dependency. The World Health Organisation (n.d.) definition of *"dependence syndrome"* is *"...being a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value."* This definition corresponds strongly to the definition of addiction (Lorman 2013; Nikmanesh et al 2017). WHO (n.d.) replaced the word addiction for dependence in 1964.

Addiction is "*disease-like*", as its detriments outweigh the benefits and is described as a psychiatric disorder with the highest rates of remission (Heyman 2013, 1; Biernacki, 1986; Robins, 1993; Stinson et al 2005; Klingemann et al 2010, cited in Heyman 2013, 1). Addiction is a controversial topic, and disease or choice are two of many debated concepts (see Figure 1.1); illness, disorder and condition are other standpoints of addiction, alongside allergy, sickness, habit, or social construction (Russell et al 2011, 151).

Lorman (2013, 437), states, "*Addiction is a chronic, progressive disease, and if not treated, it is fatal*". Some memoirs of addiction (O'Toole 2005; Jenkins 2017 and Burwell 2015) refer to

addiction similarly, that it needs resources in place, and treatment/support, to manage. Nikmanesh et al (2017, 1) also refer to addiction as a disease, one that is a physiological, psychological and social disease (Galanter 2006, cited in Nikmanesh et al 2017, 1). Nikmanesh and colleagues (2017, 1) state that addiction *"…causes a dependence on the substances, leaving adverse physiological, psychological and social impacts*". NIDA (2018a) demonstrates the issue of addiction, describing it as a chronic disease, and like diabetes, asthma, or heart disease, it is one that does not have a cure but is a condition that is treatable and manageable (NIDA 2018a, 3). Addiction is often interpreted to represent a weakness of a person's morals or that they are making the choice to continue using drugs through a fault of their willpower (NIDA 2018a, 1). This argument is that addiction is a choice, and people have control to overcome it. In terms of the disease model of addiction, the initial first drug use tends to be voluntary, then progresses into a loss of control over the behaviour which develops into a compulsion instead of a choice (Russell et al 2011, 151; and Ochoa 1994; Foulds and Ghodse, 1995, both cited in Russell et al 2011, 151). A more detailed account of biological factors of addiction/dependence is part of the subsection *Trajectories of drug use (page 30-32).* The debated choice model argues that addiction is a "*motivated choice*" (Russell et al 2011, 151). That *every time* a drug is used, it is through a choice (not just the initial drug use) and is usually when there are problems in life; drug use is to avoid addressing problems (Schaler, 2000, cited in Russell et al 2011, 151). In this case, addiction "*resolves*" itself when problems are solved, or people grow out of their addiction when maturing with age (Peele et al, 1991, cited in Russell et al 2011, 151). This argument assumes that people living a possibly problematic lifestyle can change their options and how they "*frame their choices*", and that they have capacity to improve their circumstances (Heyman 2013, 4). However, how "*destructive*" is measured is subjective.

Granfield and Cloud (1999) contributed significantly to the addiction and recovery field and the choice argument. They were some of the first emphasising recovery without treatment and explored how this related to the term "*addiction*". They were less favourable of the disease model of addiction (Brown 2000, 282). They state that more people have overcome addiction without treatment, and their argument is if addiction is a disease then how come people can recover by themselves without treatment (Irvine 2001, 87). Granfield and Cloud (1999) acknowledge that this may be due to their participants having more *social capital* than others, and this may contribute to a "*higher degree of recovery capital*" (Brown 2000, 282). They acknowledge that treatment may be required for people with low recovery capital, including

an assessment of recovery capital to determine the level already attained (Irvine 2001, 87). An issue with the sample from Grandfield and Cloud's study, was that participants did not believe in the disease model (Irvine 2001, 87), which creates possible bias and influence of the data. Recovery capital is discussed on *page 52-54.*

Dependency

The term "*dependence*" is a reference to the physical dependency to a substance, which is associated with the symptoms of tolerance and symptoms experienced during withdrawal and the psychological connection regarding the tolerance, adaption, and withdrawal (O'Brien et al 2006, 764; Madden and Henderson 2020, 9). For example, patients (in an opiate prescription setting for chronic pain) can adjust to the opiate dose, creating an opiate tolerance and dependence, which will happen overtime (Dobbs and Fogger 2018, 58). The increased tolerance to opiates is the dependency, but when it develops into a "*…comorbid psychiatric illness propelling motivation for opioids and emergence of aberrant behaviour*" (George et al 2012; Manhapra et al 2017, cited in Dobbs and Fogger 2018, 58), it can become difficult to differentiate between addiction and dependence (Ballantyne e al 2012 cited in Dobbs and Fogger 2018, 58).

The *Drug misuse and dependence: UK guidelines on clinical management* (2017), purposely avoid the term addiction in their publication unless necessary; dependence is their "*preferred term in these clinical guidelines*" (Independent Working Group 2017, 311). Substance misuse was arguably a "*neutral term*", to include all substances (O'Brien et al 2006, 764). Musalek (2013, 636) and a committee which debated which term to use for the DSM (O'Brien et al 2006, 764), and suggested that it is important to reduce stigma and avoid using stigmatising words such as "'*addict*'", and "'*addiction*'", thereby switching to "'*dependency'*" and "'*dependent*'". The DSM-V refer to it as "'*substance use disorder'*" or "'*dependence syndromes'*" (WHO 1993, American Psychiatric Association 1994 and 2013, all cited in Musalek 2013, 636). However, it is argued that this has not reduced stigma, rather, as Musalek (2013, 636-637) argues it has "*watered down*" addiction, creating addictions such as 'tanning addiction', 'chocoholics' and 'telephone addiction', which he argues has impacted the perceived seriousness of addiction (Musalek 2013, 637). The decision to use the word 'dependence' instead of addiction in the DSM, a result of a single vote, is said to subsequently caused issues with doctors misunderstanding what *addiction* is, and being too cautious prescribing pain medication, assuming patients are addicted, when in fact they are physically dependent (O'Brien et al 2006, 764-765). O'Brien et al (2006, 765) called for a change of the

word back to addiction in the DSM-V, describing the term addiction a "*perfectly acceptable word*" but having negative connotations. However, as explained by Musalek (2013, 636), dependence is still the word chosen for addiction in the DSM-V.

This section acknowledges the complexities and importance of appropriate language on this topic and lays the foundation for comprehensive and complex discussions surrounding the unique issues dependency/addiction brings, and the challenges faced in the study region to achieve a sustainable recovery.

Service user

The term used to describe a person who accesses treatment services, and the relationship between a service organisation and the individual accessing the service, is an important one. Service user is widely referred to as a person who is or has been in touch with services or is entitled to use services. A problem with using this term is that it can give the impression that the person is merely a recipient of a service, one that is passive, and it strips away their identity; character and personal preferences (SCIE 2004). In this sense, it can also identify power dimensions and a hierarchy of control (McLaughlin 2009, 1114). Those who *provide* the services are 'service providers', and those who *use* the service are 'service users' (McLaughlin 2009, 1109). Co-production is a key principle underpinning the Social Services and Wellbeing Act (2014) and it should play a strong role to foster and ensure equal relationships when delivering care and support, between "*practitioners and people"* (Care Council for Wales 2017, 4). Notwithstanding the debates, this thesis adopts the terms, service user and service provider acknowledging the sensitivities associated with them, to align with the policy language and research literature.

Heroin, opioids and other opiates

This thesis focuses on heroin, with reference to opioids and other opiates, and the complexity of this type of drug use and the effectiveness of treatment available for recovery from this specific type of drug. Thus, details on heroin, opioids and other opiates are outlined below.

The Misuse of Drugs Act (1971) categorised drugs from most harmful to least, where cocaine and heroin became Class A (most harmful) (BMA 2013, 91). Heroin (an opiate drug) is an illegal, highly addictive substance which comes from morphine; a natural substance extracted from varieties of poppy plants (the opium poppy plant) (NIDA 2021, 1, 5; Whelan and Remski 2012, 46). Heroin is a physically addictive drug, which creates a physical dependence (cravings

leading to withdrawal symptoms) (UKAT n.d.a). A tolerance is built when somebody becomes adjusted to the dose, therefore requiring an increase of intake to experience the effects of the drug (ibid). This can put people at risk of overdosing, especially if they resume the same dosage after detoxing (ibid). Some research suggests that there is a group of people who are able to control heroin use long-term, without looking for or needing treatment (Shewan and Dalgarno 2010).

There is evidence that people who have experienced ACEs are more likely to use substances and trauma-informed care has become more important in recent years. Trauma-informed practitioners can benefit from an understanding of what the person has experienced and how it may have affected their substance use. It is imperative services implement the 5 principles, being: "*bear witness to the patients experience of trauma… Help patients feel they are in a safe space and recognise their need for physical and emotional safety...Include patients in the healing process… Believe in the patient's strength and resilience… Incorporate processes that are sensitive to a patient's culture, ethnicity, and personal and social identity*" (Purkey et al 2018, 170-171). Treatment for the psychological aspect of heroin addiction usually requires a therapy following a model that is effective for the individual (ibid), such as Cognitive Behavioural Therapy (CBT) (NHS 2020).

Opiates are heroin and diamorphine, which are derived naturally from the opium plant, and opioids (methadone and buprenorphine), are synthetic derivates of said opiates (Whelan and Remski 2012, 46). Opiates are often prescribed by doctors for the management of mild to moderate pain, whereas opioids (and opiates) are prescribed for treating severe or chronic pain (UKAT n.d.b.). UK Addiction Treatment Centre (n.d.b.) elaborate that addiction *can* be from recreational use of opioids as a "*means for escape*", but it can also be unintentional due to their increased tolerance and only when they try to quit the medication that people realise they have a problem. Both types put people at risk of addiction (ibid). Opioids are chemically produced to "*mimic*" endorphins to control the pain and pleasure receptors of the brain, but opioids are made to be much stronger than natural endorphins (ibid). Opioids can be plant-based or synthetic.

Some people can continue to function with a dependency, even within employment, and often reach "*hit bottom*" once their support network (family, friends and colleagues) are no longer supportive, according to Dr. Steven Melemis, a physician in Toronto who specializes in

addiction (Glauser 2014, 19). "*Functioning heroin addicts*" are often still paying their bills and are able to hide their addiction from their families (Ravitz 2018). Some develop an addiction early in life, whereas others experimented with substances later, or took pain medication (Ravitz 2018). People who use heroin typically function in the earlier stages of using heroin, but any challenges in their life such as losing a job or no access to their choice of drug, puts them at risk of overdosing or putting themselves in danger (Ravitz 2018).

This thesis, when referring to heroin, opioids, and other opiate addiction, is referring to all pathways to dependency, with no focus on a particular 'type' of people/person with drug dependence. The next section will discuss the key facts and statistics of heroin dependency and addiction in Wales.

Key facts and statistics

This dataset was collected from 1st April 2018 to 31st March 2019 and is the most recent statistics at the time of writing (Welsh Government 2019d, 2). This evidence is from the Welsh National Database for Substance Misuse in Wales (Welsh Government 2019d, 2).

Table 1.1 Results from the data from referral and assessment data in 2018-19 in Wales

	Heroin	**Methadone***	**Other opiates**	**All substances (drugs and alcohol)**
Age	Median: 37yrs	Median: 38yrs	*NR***	Median: 38yrs
Gender	70.6% male	70% male	67% male	67% male
Ethnicity	*NR***	*NR***	*NR***	87.9% White

*The dataset for methadone stated that it is not clear if the methadone is prescribed or illicit methadone when recorded as main problematic substance (Welsh Government 2019d, 23).

***Not Recorded* (Welsh National Database for Substance Misuse in Wales 2019d)

For *all* substance misuse assessments (not just heroin, opioids, and opiates), the median age for males and females is 38 years (Welsh Government 2019, 29). However, males are more likely to use opiates than females. The statistics show the initial problem drug for people in their early 20s (median of 24) is cannabis, then late 20s (median of 29) is cocaine, mid-thirties is crack (median of 34) and amphetamines (median of 36) then moving onto heroin in their mid-late 30s (median of 37), and methadone (median of 38) (Welsh Government 2019d, 34-36). This shows a problematic pattern that people may move onto more illicit drugs as they age, and their lifestyles change. People of white ethnic origin make up 87.9% (N=16,213) of all assessments

in 2018-19, with very few from other ethnicities recorded (varying from 7-70 people from each origin) (Welsh Government 2019d, 29).

An estimated 238,000 people were registered accessing treatment for drugs in England and Wales in 2017, with just under half of them primary opioid users, mainly heroin (EMCDDA 2019a, 37). OST prescribed figures reached its peak in 2010 and has decreased since then to 150,000 in England and Wales in 2017 (EMCDDA 2019b, 20). Considering that opiate and opioid death increased (they are the main substances responsible for drug poisoning deaths), (ONS 2017, 12; ONS 2020, 11), and that stated OST decreased, this implies there may be an area for further research and practice development relating to access to services or service provision and delivery. Or alternatively, is it possibly due to the purity of the heroin reaching a high level (National Crime Agency 2020, 8) causing more unintentional overdoses.

To compare referrals from 2014-15 to 2018-19, heroin has consistently been the highest problematic substance recorded as a drug (alcohol consistently higher) (Welsh Government 2019d, 24). Heroin referrals have decreased from 20.3% in 2014-15, to 16.6%, decreasing to a lower percentage bracket per year (ibid). From 2014-15 until 2018-19, heroin assessments have decreased showing a steady decline over five years (Welsh Government 2019d, 32). The number of people commencing treatment from 2014-2019 has decreased for heroin users too, which is in line with the referral and assessment rates decreasing (Welsh Government 2019d, 44), because fewer referrals, mean fewer people in treatment. With regards to waiting times for heroin use, 92.6% of people were in treatment within 20 days of referral into treatment in 2018-19, an increase of 2.5% from 2014, but waiting times varied between those years (Welsh Government 2019d, 49).

Overall, this indicates that heroin, opioids, and other opiate problematic use affect men, in their late thirties of white ethnicity as a majority (or they are more likely to access treatment). The following section opens the discussion for key principles in service provision and introduces the SMDP 2019-22.

Drug policy and the impact on services

Alex Stevens (2011a; 2011b) highlighted the impact drug policy and welfare policy can have on individuals and society and therefore on service use and needs. When a drug is classified at a higher level of harm through drug categories and punitive measures associated with the

level of harm it tends not to have the desired effect in practice – sometimes even the opposite. Stevens (2011a) compared drug policies and drug prevalence in Portugal, the USA and England and Wales. He found that the higher punitive outcome of illicit drug use is, the less likely is it to deter people. He also discussed how England and Wales put harm reduction measures (i.e., methadone maintenance) into place before other countries such as America. These measures reduced drug-related harm such as deaths and HIV infection compared to the USA who did not introduce changes until later on. Stevens (2011a; 2011b) also illustrated how the link between social inequality and high drug prevalent areas can be seen through policy makers focusing on the drug related crime as opposed to introducing measures to reduce inequality. Paradoxically, framing of drug use in this way has benefits as it tends to result in an increase drug treatment availability (Stevens 2011b, 107). However, it brings the focus on criminal justice issues with its punitive measures, rather than on addressing inequality (ibid). More recent literature by Wincup and Stevens (2021, 1), discussing "scapegoating and othering", makes reference to Szasz (1975), who writes that drugs and people who use drugs have become "*objects"* for blame and fear. These people are often less likely to be able to deflect these stigmatising labels, which in turn distracts from the wider social harms and "*structural inequalities*" that underpin the problems with drugs (Wincup and Stevens 2021, 2).

Substance Misuse Delivery Plan 2019-22 (SMDP)

The current SMDP 2019-22 based its strategy on current Welsh Government policies, such as (Welsh Government 2019a, 1, 3, 6):

- Taking Wales Forward (2016-2021)
- Prosperity for All: The National Strategy (2017)
- A Healthier Wales (2018c)
- Well-being of Future Generations (Wales) Act (2015)
- Working Together to Reduce Harm (WTRH) ten-year strategy (2008-18)
- Health Inspectorate Wales (HIW) and Care Inspectorate Wales (2018) joint review of substance misuse services in Wales

The SMDP 2019-22 has eight key priorities detailed below:

Figure 1.2 SMDP key priorities

(Information from Welsh Government 2019a, 12-15)

Upon reviewing key policy documents for substance misuse (WTRH, HIW/CIW and SMDP), it is apparent that substance misuse service provision is underpinned by three principles; (1) prevention; (2) multi-disciplinary working; and (3) person-centred, strength- based care.

Principle one: Prevention

The WTtRH (2008-2018a) ten-year strategy aimed to prevent harm related to substance misuse (Welsh Assembly Government 2008a). By prevention, this strategy aimed to educate people on the impacts of drugs and alcohol and inform of the help and support available to people with a substance misuse/dependency issue (Welsh Assembly Government 2008a, 4). The four action areas for WTRH 2008-2018 are preventing harm, support for people who misuse substances to improve their health and aid and maintain recovery, supporting and protecting families,

tackling availability, and protecting individuals and communities via enforcement activity (Welsh Assembly Government 2008a).

Taking Wales Forward (2016-2021) is a government strategy which created Prosperity for All (2017); Taking Wales Forward (2016-2021) focused on improving and making a difference to the lives of people in Wales (Welsh Government 2019a, 3). One of the main elements from Prosperity for All: The National Strategy (2017) is for the health and well-being of people in Wales to be improved by concentrating on prevention instead of treatment (Welsh Government 2019b, 2). A Healthier Wales (2018c) aims to prevent illnesses by detecting problems early, and if prevention is not an option, by supporting people to manage their health and long-term illnesses (Welsh Government 2019c, 3, 13). The aim is to encourage an active and independent lifestyle which will help people stay well (Welsh Government 2019c, 3).

The Well-being of Future Generations (Wales) Act (2015) aims to prevent problems worsening or new problems arising and focuses on tackling areas such as poverty, health inequalities, climate change and jobs losses (Welsh Government 2015c, 4). This "*sustainable development principle*" which should be applied by public bodies, ensures that decisions made for today, consider future generations (Welsh Government 2015c, 7). This is important for tackling drug dependency because poverty, health inequalities and unemployment are just a few factors that influence drug use, as discussed below.

Prevention is a key component of the SMDP 2019-22, as discussed in further detail below with the trajectories of drug use.

Trajectories of drug use

There are recognised factors that increase the risk of drug misuse (Public Health England 2017). There is a pattern between drug misuse and social deprivation, unemployment, housing and homelessness (Independent Working Group 2017, 12; Public Health England 2017; BMA 2013, 5). Homelessness does not directly cause drug use, but increased use of drugs as a means of coping with living without a fixed address is possible (Public Health England 2017). One of the key areas of the SMDP (2019-22) is accommodation and preventing homelessness. Homelessness can lead to a "*downward spiral*" of problematic substance use, which can turn into a "chaotic cycle" (Welsh Government 2019a, 13). Committed and effective partnership working of health and social services, housing, third sector and justice agencies (if required) when working with service users and families is needed (Welsh Government 2019a, 13).

Adolescents are a key group for targeted prevention, as on average first drug use tends to take place in late teenage years (Knopf 2016, 4). One principle in the SMDP (2019-2022) is prevention by tackling problems of Adverse Childhood Experiences (ACEs) as this has been linked to substance misuse. There is some evidence of domino effect whereby children who are exposed to ACEs (childhood maltreatment; physical, sexual, verbal abuse or dysfunctional household; domestic violence, parents separating, substance misuse, mental health problems, criminal behaviour) that involve parental substance misuse, go on to misuse substances themselves (Welsh Government 2019a, 7). Adolescents who have experienced trauma are at a higher risk of illicit drug use (Knopf 2016, 5; BMA 2013, 5), such as physical and sexual abuse young people in care, sex workers are at an increased risk of drug use and peer pressure or poor parental guidance (NIDA 2018a, 3; BMA 2013, 5). Poor mental health and drug misuse can be related (Public Health England 2017). People may use substances to "*self-medicate*" (Independent Working group 2017, 41).

There is also a relationship between victims of Intimate Partner Violence (IPV) having experienced trauma in childhood (also referred to as ACEs) and substance use and drug risk behaviours (Independent Working Group 2017, 43). Trauma is defined as "*an event or events that are experienced by the individual as physically or emotionally harmful, cause significant distress and have enduring effects on their development, functioning and well-being (affecting social, emotional, cognitive, behavioural, physical and/or spiritual functioning)"* (Independent Working group 2017, 41). Knopf (2016, 4-5) agrees that trauma is a risk factor for substance use disorders among adults, and by targeting trauma in adolescence drug use may be prevented by teaching young people how to cope with situations without turning to drugs.

Studies have found that there is an individual neurobiological level of the genetic component linked to drug use, meaning that although there is a genetic predisposition and an increased risk, it does not necessarily mean the person will carry the gene or become dependent on drugs (WHO 2004 cited in BMA 2013, 63; BMA 2013, 63). However, adoption and twin studies have found a 'substantial component' of drug use (BMA 2013, 4). Adoption studies found a strong link between addiction from biological parent's substance use and their child's risk of addiction (BMA 2013, 64). Thus, twin studies have found a genetic contribution to drug use, which can be a factor alongside environmental factors or by chance (Agrawal and Lynskey 2008 cited in BMA 2013, 65; BMA 2013, 65). Certain personality traits (also referred to as personality types by BMA 2013) can also increase the risk of drug use such as impulsiveness,

sensation seeking (strong impulse to seek intense sensations) experiencing negative emotions as a result of drug use causing anxiety or depression (Zuckerman 1994, Tarter et al 2004 and Swendsen et al 2002, all cited in BMA 2013, 68; BMA 2013, 68).

It is important to consider psychological learning theories. *Classical conditioning* is learning by association, for example, a person seeing a syringe or being in the location that drug use occurs, experiences heightened cravings for drug use due to the rewarding properties paired with environmental stimuli, which influence behaviour (Dawe et al 2004 and Drummond et al 1990, cited in BMA 2013, 69-70; BMA 2013, 70). Another theory is *operant conditioning*, which is when drug use is repeated due to the emotional response linked to using drugs (i.e. relieving withdrawal symptoms, euphoria, etc.) (WHO 2004, Wanigaratne 2006, Schulteis and Koob 1996 all cited in BMA 2013, 70). Another useful theory *is social learning*, when a person's role model(s) and peers influence and normalise drug use and thereby any regular positive drug-use outcomes are copied, but any negative outcomes as a result of drug-use are avoided, meaning that observed positive outcomes of drug taking is likely to be copied (Wanigaratne 2006 cited in BMA 2013, 70; BMA 2013, 70).

The genetic connection to drug use and dependence should not be treated in isolation as other contributing factors influence the risk as well (BMA 2013, 65). Family-based studies are uncertain whether the link can be solely based upon genetics, or whether environmental factors are responsible too (i.e. copying behaviours) (Bierut et al 1998, Merikangas et al 1998, Agrawal and Lynskey 2008, all cited in BMA 2013, 64). Genes account for approximately 50% of a risk of addiction (NIDA 2018a, 3). This relates to Social Learning theory discussed above. If somebody is prone genetically, it does not mean that that they will have a compulsion because "*all behaviour has a genetic basis, including voluntary acts*" (Heyman 2013, 4). What Heyman (2013, 4) is saying, is that voluntary actions are carried out by whatever the brain tells the body to do. However, essentially, drugs alter the systems in the brain, which then disrupts underlying self-control (Goldstein and Volkow 2002, and Jentsch and Taylor 1999, both cited in Ersche et al 2012, 193). Biological, psychological, and social factors are all contributing factors which can influence chances of addiction (BMA 2013, 65).

The next section of this chapter introduces the second principle of service provision, *multi-disciplinary working.*

Principle two: Multi-disciplinary working

The SMDP (2019-22) adopts an "*integrated and long-term approach*" to improve outcomes for people who misuse substances (Welsh Government 2019a, 1-2). Multiagency working is a key principle underpinning the SMDP 2019-22. Integrated care is working within a multi-disciplinary team (MDT) to try to meet the needs of a mutual service user and involves professionals across a variety of sectors working collaboratively (SCIE 2018). Collaborative working involves organisations working together towards a shared purpose or goal and involves different levels of cooperation and sharing functions to achieve the shared goal (Boutillier et al 2011, 34).

Integrated care is essential to supporting people with complex needs (SCIE 2018). Often, people with drug dependence have a multitude of problems, which ought to be addressed during their recovery journey, either related to the cause of the initial substance misuse (UKAT n.d.a.). These interlinked issues show the need for integrated working and multidisciplinary teams to work together to address internal barriers to recovery. It is also why the 2010 Welsh Government policy, '*Integrated Care and Integrated Care Pathways for Adult Substance Misuse Services in Wales'* was chosen as a policy to evaluate in this study.

Developing a coordinated and person-centred (SCIC 2018) care plan which connects all relevant services together is essential for recovery. It should be designed to address communication, information sharing, continuity of care and a shared vision for support (SCIE 2018). This coordinated and integrated way of working is important for helping service users integrate into society (EMCDDA 2019b, 20). Partnership working should take place with a range of other services, such as housing and homelessness services and the criminal justice system (Welsh Government 2015a, 4). The Welsh Government state that they are "*firmly committed*" to improving outcomes for people with a dual diagnosis (two or more coexisting diagnosed disorders), by improving collaboration between services such as, health services, social services, third sector services, and justice agencies working with families and carers with the service users to improve outcomes achieved during treatment and interventions (Welsh Government 2015a, 5).

The WTtRH (2008-2018a) strategy focused successfully on a harm reduction agenda (Livingston et al 2018, 7). Over the course of 10 years, it found that partnership, co-ordination

and monitoring arrangements had improved, as well as service delivery and accounting for money spent (Livingston et al 2018, 7). There is also more joined up working with TSOs (Livingston et al 2018, 55). However, a review by HIW and CIW (2018) found that joined up care from Substance Misuse Treatment Services, secondary care, primary care, social services and mental health services is greatly in need of improvement (HIW and CIW 2018, 7). The complexity of peoples' physical and mental health needs is increasing, which puts more strain on services, and there is limited available housing for people and limited help with accessing benefits (ibid).

A number of policies emphasise the need for health and social care services to work together to meet well-being objectives (Welsh Government 2018a, 3; Well-being of Future Generations (Wales) Act 2015; Welsh Government 2015c, 7). The SMDP 2019-22 emphasises that health and social care services need to work together in tackling substance misuse, with all other partners to best support the individual meet their needs and overcome a range of challenges (Welsh Government 2019a, 3, 5-6). This includes collaborative work to take place across other government agencies such as social services, housing, employability, education (to name a few), which may prevent or reduce substance misuse (Welsh Government 2019a, 10). Substance misuse service provision should be based on a "*whole person approach*", where interventions are joined up and individual needs are recognised to go beyond the act of misusing substances (Welsh Government 2019a, 10). A key priority of SMDP 2019-22 is for multi-agency working and care planning to be strengthened to meet individual need (Welsh Government 2019a, 15). This is to ensure people are accessing the right treatment and know all the options for treatment, including for "*co-existing harms*" (Welsh Government 2019a, 15).

Integrated care pathways (ICPs) support service users in transitioning through the four tiers (Welsh Assembly Government 2010a, 3). The four tiers are explained below, based on HIW and CIW (2018, 10):

Tier 1: *information advice, screening, referrals to specialist substance misuse treatment*
Tier 2: *drop in services for information, advice, support, assessment, referrals to structured treatment, brief psychosocial interventions and harm reduction.*
Tier 3: *Specialist community based assessment and structured treatment (substitute prescribing).*
Tier 4: *residential specialised substance misuse treatment (detoxification and rehabilitation)*

MPPs are a Tier 3 service.

Treatment for substance misuse and dependency in Wales

The HIW and CIW (2018) joint report reviewing substance misuse services in Wales found that the quality of treatment is good and effective but waiting times and access to services, especially rural areas, were inconsistent and resources, funding, opening times and housing availability were limited. One of the key priority areas for SMDP 2019-22 is improving access and availability of services, in particular reaching rural communities (Welsh Government 2019a, 14). Area Planning Boards (APBs) need to ensure there are means available for people living in rural areas to access treatment and support (ibid). This can be achieved through outreach, integration with primary care and using digital technology (ibid). Details on the roles and responsibilities of the APB are discussed further in this chapter (*page. 40-41*).

The review also found that services only being available Monday-Friday 9-5 is unhelpful as there is no support during times of crisis (often late at night or during weekends) for relapse or overdose (HIW and CIW 2018, 7). One of the problems identified in the report was the lack of capacity in services and the long waiting times meaning that people were unable to access the treatment for substitute prescribing, detox, rehab, and counselling: also, it was unclear what help was available initially (ibid). There was also an issue across Wales for a lack of suitable housing (HIW and CIW 2018, 31), and the report found that hard-to-reach groups (i.e. homeless, older people and ethnic minorities) need help in accessing treatment, and the design and the planning of services need more work for example, involving service users and the homeless population in service design and development (HIW and CIW 2018, 7, 17, 18). The recommendation is for APBs to understand the needs of their local population better, as much of the monitoring is carried out by people who *have* accessed the service, rather than the people who have not (HIW and CIW 2018, 18). The SMDP 2019-22 state that generally waiting times had decreased, however the "*most vulnerable*" or "*furthest away from services*" need to be targeted to help them access services (Welsh Government 2019a, 1). The provision of drop-in services helped with access for some services, with getting help quickly (HIW and CIW 2018, 7), especially as Tier 3 services such as substitute prescribing can have long waiting lists and for Tier 4 services (rehab) (HIW and CIW 2018, 21). One area of Wales within the report operated walk in services for Tier 3 services to help accessing specialist services quicker which was successful but needed an increase in sessions available (HIW and CIW 2018, 21).

The report stated that although there are high caseloads and limited resources, staff are working hard to provide good care (HIW and CIW 2018, 8). It was reported that there is a lack of suitable premises for services and feeling frustrated about duplicating administration work and

information sharing systems, with some services unwilling to share information (HIW and CIW 2018, 8 and 49). In addition, Key Performance Indicators were reportedly ineffective and 'not meaningful' in monitoring services (HIW and CIW 2018, 8). This does not indicate a "*well managed*" service, despite HIW and CIW (2018, 8) reporting staff felt it was. The expectations of governing bodies such as HIW and CIW may benefit from a collaborative approach to producing effective KPIs, to ensure the realities of providing support/care in this field is achievable and effectively monitored compared to the expectations of reviewing bodies.

Substance misuse services are set up differently in each area in Wales due to different structures and governance across commissioning bodies (HIW and CIW 2018, 8). This effects quality and safety of services because it slows down APBs recognising, monitoring and acting on patterns of problems across Wales in a timely manner (HIW and CIW 2018, 8 and 46). For example, APBs work differently across Wales with the information they gather, reportedly making them seem "*disconnected with what was happening on the ground within services*"; not all review data is gathered by APBs which highlights any incidents, complaints and safeguarding referrals (apart from performance management) (HIW and CIW 2018, 53). Performance monitoring is largely for non-statutory services, as the Health Board have their own Governance arrangements, which mean the APB do not have a full understanding of any issues within the health board services (HIW and CIW 2018, 54).

SMS offer a range of services for all four tiers, (HIW and CIW 2018, 10). APBs (and their partner agencies) are responsible for planning, commissioning, and overseeing service delivery in Wales (ibid). All services should be person-centred, with consideration of their physical, social, and psychosocial needs (HIW and CIW 2018, 28). The Social Services and Well-being Act (2014) introduced the "*what matters?*" conversation through creating "*equal, reciprocal and caring relationships*" and an "*asset-based approach*" (Social Care Wales 2019, no page number). Following an asset-based approach and following a "*what matters*?" conversation in substance misuse treatment is vital to ensuring person-centred care, and personalised recovery.

The third sector play an important role in the recovery journey of dependency, therefore it is important to understand their role and purpose, as well as funding and their relationship with public services. TSOs were previously full, or part funded by grants through public bodies, and service provision was more likely "*co-constructed*" with the local government. However, with less grant funding available, TSO contracts for "*diverse services and projects on behalf of*

public agencies" have increased which has made unequal power relationships due to TSO working under "*regulatory controls and risk management*", rather than a "*co-delivery*" (Milbourne and Cushman 2013, 490). This is because historically, the NHS provided pharmacological treatment, such as in-patient detoxification and supposedly OST, through commissioners funding statutory NHS services and advice, psychosocial interventions and residential rehabilitation was provided by TSOs (Turner 2005, cited in Kalk et al 2018, 195). However, from the mid-2000s onwards, TSOs began to successfully bid for funding for treatment services which were already provided by statutory NHS services, instead of taking a collaborative approach (Kalk et al 2018, 195). Reasons for this were that the NHS were not listening to needs of the local communities and they were hesitant in reacting to a performance driven framework for service provision in England, and TSOs were reportedly experienced as "*more responsive*" to local commissioner needs (Kalk et al 2018, 195).

NHS clinicians were surprised at this transition from a collaborative relationship with TSO to a competitive one (Kalk et al 2018, 195). Although waiting lists times were reduced for treatment and a better response to local need achieved, this change of relationship caused some issues; as Turner (2005, cited in Kalk et al 2018, 196) states, the initial differences between the NHS and TSOs is that the latter sector were innovative and "*locally responsive*". However due to bidding for the same as NHS, they had to change their methods to comply with clinical governance structures and bidding requirements (Turner 2005 cited in Kalk et al 2018, 196) and friction between both sectors becomes apparent (Kalk et al 2018, 196). Moreover, Kalk et al (2018, 196) highlight the issue of a lack specialised NHS services, i.e., a lack of addiction specialist doctors and allied healthcare professionals, and in some places, and NHS addiction provision is no more in parts of England such as Birmingham (Drummond 2015, cited in Kalk et al 2018, 196). The SMDP 2019-22 have a forward look for GPs to receive more training (Welsh Government 2019a, 18). Regulating healthcare has been minimal from a commissioning standpoint, meaning less qualified TSO staff are granted bids (as they cost less but offer a needed service) and they argue that TSOs do not have NHS level insurance minimising opportunities for research (Kalk et al 2018, 196). This approach to shifting services to TSOs can influence funding cuts to NHS addiction treatment contracts, often 30%, which then requires TSOs (a "*collective voice*"), and the NHS to work together to raise awareness of funding cuts.

There is limited research on TSO delivering Evidence Based Practice (EBP) services, which is "*worrisome*", that TSO may not have "*implementation ability*" to deliver interventions that

could be harmful to service users (McCord 2003., Dishion et al 1999., Petrosino et al 2013, all cited in Bach-Mortensen et al 2018, 2; Bach-Mortensen et al 2018, 2). TSO often support vulnerable groups which makes the use of EBP more essential to follow in particular mentioning that TSOs deliver EBP for addiction (Amodeo et al 2011, cited in Bach-Mortensen et al 2018, 2), but with little research on EBP and TSO (Bach-Mortensen et al 2018, 2). Barriers include that TSOs may not always adhere to EBP and a lack of resources to perform effectively (Amodeo et al 2011, Kimber et al 2012, and Ramanadhan et al 2012, all cited in Bach-Mortensen et al 2018, 3). However, benefits include having skilled staff and affiliations to research institutions (Lundgren et al 2011, Ramanadham et al 2012, both cited in Bach-Mortensen et al 2018, 3), which is beneficial because research aims to improve services and facilitates innovation.

Voluntary Sector Organisations (VSOs) can play an important role by working with health and social care providers and working across "*institutional barriers*" (Holder 2013, Grant et al 2000, both cited in Croft and Currie 2020, 549). VSOs are a type of TSO as TSO is an umbrella term for a range of non-public or private sector organisations (NAO, n.d.). There needs to be a policy focus for healthcare commissioners to work more closely with VSO in particular during times of pressure on statutory services and during austerity (Baird et al 2018, Evers and Laville 2004, and Baggott and Jones 2014, all cited in Croft and Currie 2020, 549). Implementing policy which sets out to include VSOs during integrated care is challenging in practice because of different goals, priorities and values of the NHS compared to TSO (Baird et al 2018; Hutchinson et al 2018, both cited in Croft and Currie 2020, 549). All VSO are at risk of being "*exploited*" by statutory services by offering the service as a replacement to health and social care services, rather than an additional supporting service (Croft and Currie 2020, 553). VSOs are known to provide services that address gaps in statutory service provision, which can benefit health and social care services by easing pressure and more effective joint working (Croft and Currie 2020, 553). However, there is also a risk of tension between statutory services and TSO, if open communication and partnership approach is not carried out. VSOs are able to be more flexible with their service provision, whereas statutory services are not (Croft and Currie 2020, 553). This is likely due to TSO being independent from governing bodies and are usually only restricted by funding requirements.

TSOs are able to develop different visions for their services; statutory services often have different rules and functions. Each TSO have their own values and perspectives on treatment

and approaches, i.e., Narcotics Anonymous UK are strictly committed to abstinence and community (NAUK n.d.), whereas The Wallich (2020) are less restrictive with an approach to reducing drug use. They believe substance misuse should be treated as a health issue (The Wallich 2020). The Welsh Government support this approach to substance misuse (Welsh Government 2019b, 1) and the Senedd voted in favour of substance misuse being treated as a health issue in 2017 (National Assembly for Wales 2017). TSOs play a major role in service provision and due to their different approaches can often develop a closer relationship to the public compared to the public sector who may not (NAO n.d.) and the third sector can access people with "*human development issues*" (socio-economic issues) that the government cannot or chooses not to (Cornelius and Wallace 2013, 237). The TSOs are often driven by different values, with aspirations to support social goals such as public welfare and economic well-being, as opposed to profit led (NAO n.d.). TSO profits are reinvested back into the organisation (NAO n.d.; Thomas 2017, 6) and they are mostly independent from the government (NAO n.d.), although they may work closely as seen with the SMDP 2019-22 (Welsh Government 2019a, 1, 12). Further advantages are the sensitivity they have towards the community and can be flexible to the diverse needs of their community (Thomas 2017, 6). This would be advantageous with people with substance misuse issues and their need for out-of-hours support, in terms of services opening during evenings and weekends, which HIW and CIW (2018) found was a much-needed resource for this client group.

HM Government (2010) released a strategy that made a commitment to ensure charities and other TSOs had a greater role in public services (National Audit Office n.d.). This benefits the commissioners (NAO n.d.). There has been a competition culture between charities that apply for the same funding, especially in the UK where core funding of 30 to 40 years has been declining and government cuts were being made meant that they were competing for the same funding, according to the Children's Society, Joe Jenkins (director of supporter impact and income (Radojev 2018).

The Welsh Government work with TSO who are "*key in delivering the front-line support to individuals*" (Welsh Government 2019a, 12). The Welsh Government's (2021, 25) *White Paper* on improving social care arrangements and strengthening partnership working to better support people's well-being, emphasises the role of TSOs. The paper states that TSOs have greatly focused on preventative measures for service delivery and helped towards the Regional Partnership Board agenda to strengthen integration to improve people's well-being (Welsh Government 2021, 25). The Integrated Care fund (which was put into place to drive integration

of services forward) seems to enable TSOs and statutory services to work together to ensure sustainable services are developed (Welsh Government 2021, 23).

Voluntary and Community Sectors (VCS) (also under TSO) and GPs can have opposing working cultures (Southby and Gamsu 2018, 366). For example, GPs' work is grounded in a medical model whereas VCS work is underpinned by community development principles (Southby and Gamsu 2018, 366). Their differing norms, values and approaches to the community and their healthcare needs, can vary considerably. This needs to be addressed prior to integrated working (Aveling and Jovchelovitch 2014; White et al 2017; Bryson et al 2006, all cited in Southby and Gamsu 2018, 367) as otherwise working together can be challenging, in particular with reference to different professional roles and responsibilities when supporting this patient/client group. Other barriers of a collaboration between both sectors, being that the often-limited funding, staff turnover (in VCS and GP surgeries), and lack of time to build relationships from GPs may make it difficult for effective integrated working (Southby and Gamsu 2018, 366), but this is not unique to VCS. The Welsh Government (2015a, 17) suggests a culture change led by a senior clinician and educating and supporting NHS staff to change the culture through supervisions, appraisals, and personal development.

TSOs tend to have more freedom to offer services that the NHS may be restricted to provide unless grants come with conditions that TSOs have to follow. The competitiveness between NHS and TSOs for bids, as well as between TSOs themselves for the same funding, can cause friction between services, impacting on integrated working. The liberty of service provision and delivery as well as better access to hard-to-reach groups can help with engagement, as the service is often less clinical.

Area Planning Boards and Community Safety Partnerships

APBs were introduced within WTtRH's (2008-2018a) ten-year strategy. They are responsible for planning and commissioning substance misuse services that meet the needs of individuals, families, and the community (Welsh Government 2013, 9). They are also responsible for implementing the policy Recovery Orientated Systems of Care (*ROISC*) (Welsh Government, 2013) and ensuring *Community Prescribing* guidance is being followed (Welsh Government 2011, 2).

APBs work closely with CSPs to deliver services using available resources and statutory responsibilities to deliver the Welsh Government's Substance Misuse Strategy (Welsh Assembly Government 2010a, 4). CSPs were developed to protect communities from crime and to feel safer, through a partnership of representatives of the police, local authorities, fire and rescue, health and probation services (NHS 2019). The Crime and Disorder Act 1998 created CSPs in Wales to prevent crime in the local area (NHS 2019; Home Office 1998, cited in Rogers and Thomas 2017, 8).

APBs and CSPs are responsible for ensuring National Core Standards are met, particularly when developing ICPs, and they also evaluate service provision (waiting times, staff training, resources, etc.), and ensure Service Level Agreements and contracts are in place between commissioners and organisations (Welsh Assembly Government 2010a, 4 and 10).

National Core Standards for Substance Misuse Services in Wales 2010

The National Core Standards, published a decade ago, are the most current guidance for all service providers of Substance Misuse Treatment Services in Wales (Welsh Assembly Government 2010b, 2). The Core Standards are applicable to the responsible authorities of the CSPs, the APBs as well as everyone who provides a service for substance misuse in Wales (Welsh Assembly Government 2010b, 2 and 4). There are 25 Core Standards that encompass the needs of service users, service providers and governance (Welsh Assembly Government 2010b).

The Core Standards aim to (Welsh Assembly Government 2010b, 3):

- "*Strengthen the governance and accountability of substance misuse service planning and delivery,*
- *Ensure that a citizen focussed approach is integrated into all key activities related to service planning, review and delivery; and ultimately,*
- *Ensure that the full range of services are delivered effectively, safely and consistently across Wales*."

They are important overall to ensure all substance misuse services are operating on the same standards and values across Wales.

Opioid Substitution Therapy

OST is a Tier 3 (community) service, with two medication either methadone or buprenorphine. In Wales, methadone accounted for 67% of OST and 33% for buprenorphine (EMADDA

2019b, 21). The aim of opioid substitution treatment is to allow the service user to gain control of their life by alleviating symptoms of withdrawal from heroin, which prevents seeking and using (BMA 2013, 9; NHS Foundation Trust 2015).

NICE guidance recommends that service users are informed of abstinence-based treatment, maintenance-based treatment, and reducing drug use (NICE 2020, 4). When managing opioid dependence, oral formulations of methadone and buprenorphine are both recommended for maintenance therapy "*using flexible dosing regimens*" (NICE 2020, 8). Which drug depends on the individual case, but if both are suitable then methadone should be prescribed first (NICE 2020, 8). This is likely because methadone is cheaper to prescribe than buprenorphine (NHSBSA 2016 and BNF 2016, both cited in Kenworthy et al 2017, 743). Whichever drug is prescribed this should be provided alongside "supportive care" (NICE 2020, 8).

Substitution programmes

Methadone is a *"synthetic* opioid agonist" (NIDA 2018b, 3). MPP dosages vary depending on the tolerance and many methadone patients are known to use heroin on top of their prescription also, questioning whether the dosages influence the decision to continue using illicit drugs (Public Health England 2013, cited in CSJ 2014, 20). The BMA (2013, 9) argue that the higher the dose of methadone, the more effective the treatment is due to the gradual increased tolerance of opioids, making heroin "*less reinforcing and cessation of use more likely*" (BMA 2013, 9).

Buprenorphine is the alternative medication to methadone for opioid substitution treatment (if both drugs would be suitable) (NICE 2020, 8). Buprenorphine differs from methadone because it has a 'partial opioid agonist *and* opioid antagonist activity', which creates a "*milder, less euphoric and less sedating effect than full opioid agonists such as diamorphine or methadone*" (NICE 2007a, 10). Buprenorphine has a high affinity for opioid receptors, meaning that "*duration of action*" is prolonged at higher doses, allowing for regimes that allow alternate-day dosing (NICE 2007a, 10-11). Buprenorphine (which is the active ingredient in Subutex) causes less analgesia and euphoria but is better for preventing withdrawal symptoms (Whelan and Remski 2012, 46). Alternatively, Suboxone (buprenorphine with naloxone) which works like Subutex, is better for take-home medication because of the added ingredient, Naloxone (Itzoe and Guarnieri 2017, 1430; EMCDDA n.d.). Naloxone is the added ingredient in buprenorphine to prevent abuse of medication so a 'high' cannot be achieved (CRC Health n.d.

cited in Itzoe and Guarnieri 2017, 1432). Unless the medication is abused, there is no difference between Subutex and Suboxone, only it allows for the individual to take the prescription home rather than daily doses of supervised consumption (CRC Health n.d.).

Effectiveness of Opioid Substitution Therapy and Methadone Prescription Programmes

Maintenance programmes can reduce the risk of blood-borne virus, including HIV infection by sharing used needles (Gowing et al 2011, Veilleux et al 2010, both cited in Uchtenhagen 2013, 284). It also improves health and reduces involvement in criminal activity and heroin use (Uchtenhagen 2013, 284; Fernandez and Libby, 2011; Lind et al, 2005; Mattick et al, 2009, cited in Du Rose 2015, 102, and Du Rose 2015, 102). Although crimes may still be committed whilst on methadone maintenance (Bloor et al 2008, cited in Du Rose 2015, 102).

The routine of daily supervision of OST can help reconstruct complex daily routines and in a safe, non-punitive and non-judgemental way (BMA 2013, 9). However, service users have stated the inflexible, strict rules and regulations are seen as counterproductive and create a barrier to living a "'normal' life" (Rosenbaum 1981, Rosenbaum and Murphy 1987, Boyd 2004, Radcliffe and Stevens 2008, all cited in Du Rose 2015, 103). Methadone maintenance is claimed to be for social control rather than harm reduction for the service user (Rosenbaum 1981; Boyd 2004, cited in Du Rose 2015, 102). As the punitive consequences of methadone maintenance such as termination of prescription, is not a practice carried out in other healthcare treatments, which reflects the perception of people/a person with illegal drug dependence as "*immoral, criminal, sick individuals, and moralistic approaches entrenched drug policy*" (Du Rose 2015, 104). Methadone maintenance allows governments to regulate, monitor and control heroin dependents (Rosenbaum 1981, Rosenbaum and Murphy 1987, Boyd 2004, Radcliffe and Stevens 2008 all cited in Du Rose 2015, 103). This is agreed by Harris and McElrath (2012), who associate the social control of methadone maintenance to stigma and the additional control that being subject to being stigmatised can have. This is discussed further on *page 55-57.*

The National Treatment Agency for Substance Abuse (2013) and PHE (2013, both cited in CSJ 2014, 20), found that 48,510 methadone patients are still on prescriptions for four or more years, an increase from 39,725 from 2012-2013, and the year previous (2010-2011) there had been an increase of a quarter of patients (National Treatment Agency for Substance Abuse 2013 and PHE 2013, both cited in CSJ 2014, 20). Service users can feel trapped in a "*state-*

sponsored dependency" that CJS refer to as a failing of a drug treatment system (CJS 2014, 27). Difficulties gaining flexible employment that works around daily supervision for prescription within the pharmacy (Du Rose 2015, 104) were highlighted.

Funding for drugs and alcohol treatment is being misspent on interventions that have "*very poor long-term outcome*", "*of these the most widely used is methadone*", although it isn't clear how "*long-term*" is measured (CSJ 2014, 28). Methadone has also been reported to be more harmful than heroin (Du Rose 2015, 103) because there is a reportedly higher risk of mortality associated with methadone (Newcombe 1996, cited in Rose 2015, 103) and withdrawal is more severe and longer lasting compared to heroin (Gossop and Strang, 1991; Rosenbaum, 1981; Stewart, 1987, cited in Du Rose 2015, 103).

Sometimes, methadone and buprenorphine medications that are prescribed in opioid substitution treatments are misused illicitly (UK Focal Point on Drugs 2016, 9). However, supervised consumption, whereby the need is determined by clinical guidelines (Department of Health England and the devolved administrations 2007, cited in UK Focal Point on Drugs 2016, 9), came into practice in the late 1990s which is effective in reducing misuse (Strang 2010, cited in UK Focal Point on Drugs 2016, 9). Mattick et al (2014) report that buprenorphine is less effective compared to methadone in keeping people in treatment; buprenorphine is not as potent as methadone. Nielsen et al (2016), however states that there is no or minimal difference between methadone and buprenorphine to keep people in treatment, reduce opioid use or reduce side effects when compared to detox or psychological treatment independently. MPPs can reduce heroin use in heroin dependent people and keep them in treatment programmes (Mattick et al 2009, 2).

Methadone Maintenance Treatment (MMT) and prescription of heroin and other drugs are harm reduction strategies (Drucker et al 2016) and Smye et al 2011). Substitution opiate treatment (using methadone and buprenorphine), is described as the "*preeminent harm-reduction approach to opiate addiction*" (Ruiz et al 2011, cited in Drucker et al 2016, 242), and the research paper argues the positive outcomes include a decrease in heroin use and injecting and thus reduction in HIV transmission, reduction in crime, and increasing employment and improved access and use of health and social services (Drucker et al 2016, 242). However, Smye et al (2011) argue that harm reduction does not always address the initial reasons of substance misuse and the negative social conditions such as limited quality housing,

unemployment, no social support or education (Pauly 2008, 8 cited in Smye et al 2011, 1). In a study of 82 patients, only 28 of them had successfully reduced their methadone dose to zero ml (detoxed) (Cohen 2017). Either through short treatment of approximately one year (stabilising and then a detox), or longer-term treatment where the patients reduce their doses for detox over time (ibid). This mirrors Calsyn et al (2006, cited in Cohen 2017) who found that none of the 30 trial patients on agonist treatment (such as methadone) successfully reduced. Abstinence may not be the outcome sought by everyone.

Older research from the US and the Netherlands, suggests that prescribed heroin may have a role to play in treatment. Drucker et al (2016) described that in 1997 the National Institute of Health Consensus Conference focused on more effective medical treatment of opiate dependency, by improving medical training, better access to methadone, and reducing restrictions of regulations that prevent availability and quality of methadone treatment (National Institutes of Health 1997, cited in Drucker et al 2016, 242). They also discussed the notion of heroin-assisted treatment for opiate dependency, arguing that medical heroin prescription can be a positive way forward for "*treatment-resistant heroin addicts who did not profit sufficiently from existing treatments*" (Drucker et al 2016, 243). The Central Committee on the Treatment of Heroin Addicts (CCBH) in the Netherlands is reflected upon by Blanken et al (2010), who states that a combination of methadone and heroin was more effective medically and socially than using methadone alone (assessed over 12 months treatment) (Cited in Drucker et al 2016, 243). Drucker et al (2016, 244) argue that political objections overcome medical or public health considerations to heroin-based treatment. They continue, discussing the need for practitioners to actively engage in "*provision of evidence-based clinical care and in the active social role of experts who engage in professional and public advocacy*" (Drucker et al 2016, 246).

Alternatives to methadone and buprenorphine treatment drugs are heroin-assisted treatment, slow-release oral morphine, tincture of opium and opioid antagonist naltrexone (Bond and Witton 2017). Opioid dependence is divided into psychological dependence (seeking pleasurable effect), and physical dependence (withdrawal symptoms if without the drug) (Bond and Witton 2017, 1). Methadone and buprenorphine are the only two options for OST in the UK (National Institute for Health and Care Excellence 2007, cited in Bond and Witton 2017, 3), although Scotland has recently implemented the use of heroin-assisted treatment (Burns 2019). This paper discusses that the UK promised results from the first trial of pharmaceutical

heroin, but it is no longer supported by the then current government policy (Bond and Witton 2017, 3). There are two options to treat heroin addiction, either detoxification or substitution (Bond and Witton 2017, 4). For detox, the most common method is replacing heroin for methadone then gradually reducing the dose of methadone over 3-4 weeks, usually in a hospital then followed by relapse prevention strategies (ibid). If the person has a long history of dependency, they may be at a higher risk of returning to use of drugs and re-entering treatment, thus this method of treatment is not cost-effective unless people are motivated to change and are already living a stable life (Bond and Witton 2017, 4).

Heroin-assisted treatment has been found to be an effective option for people who are not successful with the standard maintenance treatments (Bond and Witton 2017, 6-7). There can be long waiting lists for treatment and a "*high threshold for starting treatment*", which can increase the length of heroin use, and lead to the development of an intolerance or other drug use. However, access has improved in the UK because the treatment is free, and of the focus on harm reduction which was adopted in the late 80s (Marlatt 1996, cited in Bond and Witton 2017, 7; Bond and Witton 2017, 7). Despite harm reduction initiatives, there is still a need for more person-centred approaches to ensure individuals are involved in the treatment aims and treatment process (Bond and Witton 2017, 7). Medication alone is not enough for treatment of heroin dependency, and guidelines are clear about the need for regular counselling, psychosocial therapy, and social interventions (WHO 2009 and NTA 2012, cited in Bond and Witton 2017, 8). Bond and Witton (2017, 8) recommend further research to determine what treatment is best for different people and the different treatment strategies.

Current research confirms that methadone may not be as effective in all cases, and alternatives such as buprenorphine or heroin-assisted treatment may be more beneficial for some individuals. It also emphasises that it is important to treat the psychological dependence and the root cause of the dependency when prescribed OST to support sustainable recovery.

Alternatives to current opioid treatment

NICE (2019) in February 2019 recommended a Buprenorphine prolonged-release injection (Buvidal, Camurus) which is an opioid partial agonist/antagonist that is administered by a health professional weekly or monthly. It is administered instead of methadone or oral buprenorphine, and its first administration is during clear signs of withdrawal (Camurus AB 2020, 4). It is used to treat people with an opioid dependence who are also receiving medical, social and psychological support (Camurus AB 2020, 1). It is an option for service users where

"*there is a risk of diversion of opioid substitution medicines*", or if there is a concern over the safe storage of medicines at home (NICE 2019, 1). Also, it is used if people are not able to attend the daily supervision for their opioid substitution medication (i.e., working, in education or within "*custodial settings*" such as a prison) (NICE 2019, 1-2).

The Welsh Government enabled this injection to be given once a month to former heroin users to prevent daily visits to the pharmacy for daily oral medication during the coronavirus pandemic (Welsh Government 2020). They have also provided £10 million to help with homelessness, as Julie James, Housing and Local Government Minister, states that substance misuse and homelessness "*often go hand in hand*" (Welsh Government 2020). This new funding along with the new measures aim to assist with self-isolation, social distancing and overall coronavirus guidance and regulations for this cohort of people (Welsh Government 2020). This aims to support former heroin users as their immune systems are often poorer and are therefore at a higher risk of contracting the virus, and consequently putting NHS at risk of coronavirus spreading in the process during daily supervision (Welsh Government 2020). In addition, the extra funding and new measures will help prevent people who are homeless and people who use heroin at higher risk as they suffer with "*respiratory conditions and other underlying health conditions*" (Welsh Government 2020). This can be a positive step in that service users do not have to travel daily for supervision, if difficult to do so, although this may jeopardise opportunities for monitoring and mentoring the service user.

Heroin-assisted treatment involves the prescription of heroin in a medical setting as an alternative to methadone or buprenorphine. Heroin prescription reduces heroin use, criminal activity, mental health and social functioning, and retention in treatment is better (Hartnoll et al 1980; McCusker and Davies, 1996; Perneger et al, 1998 cited in Du Rose 2015, 102). In a trial in Britain called the Randomised Injectable Opiate Treatment Trial (RIOTT) reported that heroin-assisted treatment was more cost effective than oral methadone (Byford et al 2013, cited in Schechter 2015, 2), and injecting [methadone] instead of oral methadone was also more cost effective (Byford et al 2013, 341). This is in line with evidence which suggests that heroin-assisted treatment is cheaper, more cost effective and preferred by service users to other treatment options (Schechter 2015, 1; Du Rose 2015, 103; and Byford et al 2013 cited in Schechter 2015, 2). However, negative societal and political views based on negative perception of heroin are a barrier (Schechter 2015; Du Rose 2015, 103). Methadone maintenance should still be offered as a "*conventional therapy*" only for those that methadone

or other conventional treatment has not worked heroin-assisted therapy within a specialised clinic should be offered (Schechter 2015, 2).

So far, this chapter has focused on *prevention* and *multi-disciplinary working* and raised questions as to whether TSOs are involved members of the MDT. The following section discusses *person-centred and strength-based car*e, by introducing the treatments and services available for service users and where areas of MDW would be beneficial.

Principle three: person-centred and strength-based care

The SMDP (2019-22) states that substance misuse services in Wales need to be "*citizen centred*", taking on a strength based public health approach, which focuses on reducing drug/heroin use, prevention and treatment (Welsh Government 2019a, 3). One of the key priorities for the SMDP 2019-22 is strengthening multi-disciplinary care to meet people's needs, which includes a reducing drug/heroin use with less expectation of abstinence (unless if preferred), and to ensure that residential treatment is available with minimal waiting times and in suitable locations (Welsh Government 2019a, 15). Residential treatment or treatment within the community are two options somebody should be able to choose (ibid). The SMDP (2019-2022) clearly stated that harm reduction will be at the core of substance misuse delivery (Welsh Government 2019a, 7), with over 10% additional funding having been put into substance misuse, with a greater focus on harm reduction (Gething 2019).

Recovery is an important part of person-centred and strength-based care. The Welsh Government (2013, 4) definition of recovery is as follows:

> "*Recovery from problematic drug or alcohol use is defined as a process in which the difficulties associated with substance misuse are eliminated or significantly reduced, and the resulting personal improvement becomes sustainable".*
>
> (Recovery Orientated Integrated Systems of Care 2013, 4)

The Welsh Government adopted the above definition during the development of Substance Misuse Treatment Framework (SMTF). An important extract from this policy illustrates the flexibility of the recovery model: "*The model does not assume that people will have to be abstinent to achieve recovery and recognises that 'you are in recovery if you say you are'*". (Welsh Government 2013, 18). Recovery is a process and has many levels of progression;

services should support personal journeys in recovery as lived by service users (Independent Working Group 2017, 39).

Recovery

Initiatives for reducing drug/heroin use are primarily addressed within the community such as needle and syringe programmes, maintenance and Suboxone programmes (Collins 2019), and take-home naloxone (temporarily prevents overdosing) (Welsh Government 2019a, 11):

> *"Harm reduction [is] a set of compassionate and pragmatic approaches for reducing harm associated with high-risk behaviours and improving quality of life*"
>
> (Collins et al 2012, 5).

Harm reduction is flexible for service users because it accommodates any goal; it can be "*broadly construed*", which can reduce "*substance related harm*" and improve quality of life (Collins, Grazioli et al 2015, cited in Collins et al 2019, 27; Collins et al 2019, 27), and includes abstinence. Harm reduction "*re-humanizes addiction*" in that addictive behaviours are adaptations of suffering as a coping mechanism (Tatarsky 2019). By reducing drug/heroin use there should not be a push for abstinence, likewise a professional does not impose their personal "*values, agendas and projections*" onto the person (Tatarsky 2019) Thus, there is an opportunity for the service user to become empowered and take responsibility for their own journey to positive change (Tatarsky 2019). The Welsh Government (2013, 5) support this view, stating that there must not be a "*hierarchy of recovery*" relating to abstinence/non-abstinence.

Harm reduction aims to promote positive change for somebody who uses drugs (Harm Reduction International n.d.). The approach encompasses public health goals (improving health, social well-being, and quality of life, and improves the lives of drug users, without a *"…narrow focus on abstinence from drugs"* (Stancliff et al 2015, 206). As a result, there is a reduction and prevention in blood-borne illnesses such as HIV, viral hepatitis and tuberculosis and other injection related harms (Stancliff et al 2015, 206; Harm Reduction International n.d.), alongside a prevention in fatal overdoses, especially for those on methadone or buprenorphine (Clausen et al 2008, cited in Stancliff et al 2015, 212; Stancliff et al 2015, 206).

Service users can be in recovery by abstaining from substances or reducing the harm of using substances/drugs (Collins 2019). Abstinence can be refraining from all intake of substances

(drugs and alcohol), *or* not using the problem substance only (Dale-Perera 2017, 5). Some believe that where physical and psychological dependence is present, then abstinence is "*undoubtedly the primary treatment objective*" (Musalek 2013, 639).

Abstinence on its own does not constitute recovery, as recovery involves *"…a process of both voluntary control of substance use plus working towards positive outcomes in a range of other recovery capital domains*." (Dale-Perera 2017, 6). This relates to the concept of sobriety. Sobriety is fundamental to overcoming drug dependence (Helm 2019, 29), and includes emotional and mental aspects of recovery (Helm 2019, 34). Abstinence on its own may work for a physical dependency issue, but sobriety identifies the psychological hold that the individual will need to learn new ways of coping with. Abstinence alongside a stable lifestyle (stable job, house, relationships, etc.) is one way of describing recovery, but this is deemed "*too simplistic*", and it "…*marginalizes and generalizes the mental and emotional background of the compulsive disorder*" (Helm 2019, 30).

There are several options for abstinence-based recovery such as detoxification either within the community or within residential rehabilitation programmes, and through 12-step programmes. Residential rehabilitation is the most effective abstinence-based treatment; with two thirds of patients in effective abstinence-based rehabilitation centres overcoming their addiction (National Treatment Agency 2012, cited in CSJ 2014, 20; CSJ 2014, 20). The "*longer-term*" data gathered to understand successfully overcoming dependence through residential rehab rates was recorded from 2010 to March 2012 (National Treatment Agency 2012, 6). This found the majority of the sample who were termed "*successful*" (n=2008); overcame their *dependency* with no further structured treatment after exiting rehab (n=1110), (National Treatment Agency 2012, 6). Despite this evidence of successful treatment, residential rehabilitation has faced continuous decommission (CSJ 2014, 20). Abstinence based treatment is the goal of some people who use drugs, but it is not for everyone and should not be offered as the only option (Harm Reduction International n.d.).

Treatment services have constantly failed to support abstinence-based recovery, which the Centre for Social Justice (2014) state was a 'recovery revolution' promised by the UK government in the 2010 Drug Strategy (Centre for Social Justice 2014, 20). Britain spent approximately £1 billion on drug and alcohol treatment (NAO 2010, cited in CSJ 2014, 28), however the number of people with a heroin dependence and alcohol dependence had not fallen substantially, which indicates *"that this money is not well spent*" (UK Focal Point on Drugs

2013, cited in CSJ 2014, 28). The push for abstinence in the UK between 2012 and 2015 (at the expense of substitution programmes) and the increase of opioid related deaths may be related (Middleton 2016, cited in Godlee 2016, 1). However, the redirection onto reducing drug/heroin use understands the personal choice of abstinence, and states that they will ensure abstinence is available (Welsh Government 2019a, 15), which is where the "*person-centred*" approach is evidently important, ensuring the aspirations of the service user is always leading the journey. This is where A Healthier Wales (2018c) and Social Services and Well-being Act (2014) are significant to substance dependence. A Healthier Wales (2018c) aims for a "*person-centred approach*" by helping people access health and social care services and working with the person and their family to explore and agree a plan to deliver what is best for them (Welsh Government 2018a, 2). Similarly, the Social Services and Well-being Act (2014) emphasises the importance of supporting people to achieve their personal well-being outcomes (Welsh Government 2015b).

Methadone Prescription Programmes and recovery

Adopting a reducing drug/heroin use agenda to methadone prescription can help people engage with services regularly, which is a positive step; depending on how success is measured (Scottish Recovery Consortium n.d., 12-13).

There is a debate whether MPPs (and all Opioid Substitution Treatments) meet one of the definitions of abstinence (Betty Ford Institute Consensus Panel 2007, cited in Dale-Perera 2017, 5). Many authors and policy bodies suggest those on MPPs (or OST) are abstinent from heroin (ibid), therefore meeting the second definition of abstinence, and are utilising 'assisted abstinence' (UKDPC 2008 and White and Mojer-Torres 2010, both cited in Dale-Perera 2017, 5). However, the Centre for Social Justice (2014, 20) disagree, stating that approximately 150,000 heroin users are still prescribed 'addictive opiate substitutes' (usually methadone), *"...replacing one addiction for another*". Clinicians are advised not to influence the service user's decision when deciding on OST maintenance or other treatments but are to provide the service user with all the information to make an informed choice that is most suitable to them (Independent Working Group 2017, 38 Welsh Government 2019a, 5, 15). Rose (2015, 103) also refers to methadone maintenance as a "*state-sponsored addiction*", which the UK media sources have also previously reported this as state sponsored (Reilly 2010; Gyngell 2012, both cited in Du Rose 2015, 103), which can influence public attitudes towards MPPs.

Substitution therapy initially aimed for an abstinence-based recovery as the treatment goal and was offered to reduce risks of infections and to access the people who refused an abstinence-based treatment (Musalek 2013, 636). The expectation was that service users would then progress to a "*treatment facility*" where their dose would be reduced and eventually lead to abstinence whilst working on their motivation (Dolan et al 2007, cited in Musalek 2013, 636). Nowadays, abstinence is not a desired treatment goal by experts (Musalek 2013, 636), and substitution therapy has evolved into a "*counselling and treatment program*", now called harm reduction (Egli et al 2009 and British Columbia Minister of Health 2005, both cited in Musalek 2013, 636).

Recovery capital (strength-based approach)

Recovery capital is prominent *in ROISC* (2013) and is important because it can help to improve quality of life, through either an abstinence or by reducing harm. The concept of recovery capital evolved from by Granfield and Cloud (1999; 2001, cited in, Dale-Perera 2017, 6), and is even practiced in social work through 'strengths-based approaches', which focuses on an individual's strengths including their personal strengths and their social and community networks (SCIE n.d.). White and Cloud (2008) continued to redefine recovery capital by including the role of the community. *ROISC* (2013) defines recovery capital; "*Recovery capital refers to the internal and external resources an individual has to achieve and sustain behavioural change and recovery*" (Welsh Government 2013, 6). In this thesis, recovery capital is defined adopting Welsh Government guidance/policy (2013):

- *"Social networks*
- *Physical - money, somewhere to live*
- *Human – skills, health, employment*
- *Cultural – values and beliefs*
- *Community issues – availability/quality of services*" (Welsh Government 2013, 6).

This is based on Granfield and Cloud (2001) and White and Cloud (2008), shown in table 1.2 situated in appendix G.

There are various ways to categorise recovery capital, with some closely related, but with the fundamental principles remaining consistent.

White and Cloud (2008, cited in Best and Laudet 2010, 3) devised a model relating recovery capital to problem severity, arguing that the level of intervention for recovery will vary dependent on the severity and complexity of problems surrounding their substance dependency. They created a "*quadrant model*", which Best and Laudet (2010, 3) re-produced:

Table 1.3 Quadrant Model: Recovery capital and Problem severity.

Table 1: Recovery Capital / Problem Severity Matrix
(re-produced with permission from **White and Cloud**, 2008)[8]

(Best and Laudet 2010, 3)

The above model represents good practice for interventions depending on the individual case. For example (White and Cloud 2008, cited in Best and Laudet 2010, 3):

- High recovery capital + low problem severity = brief interventions of various types
- High recovery capital + high problem severity = out-patient detoxification with intense community support
- Low recovery capital + low problem severity = residential rehabilitation with appropriate follow-up
- Low recovery capital + high problem severity = combination of intense interventions

ROISC (Welsh Government 2013, 6) does refer to problem severity, and states that it should determine the level of care provided in treatment and post-treatment. The problem severity against recovery capital is an important indicator to the type of treatment an individual would benefit from. There is an Assessment of Recovery Capital (ARC) to determine someone's level of recovery capital (Welsh Government 2013). However, an issue with ARC is that it does not

account for the community capital (services available and accessible), which influences the pathways available for the service user. An ARC also provides limited direction to identifying the next steps in the service user's recovery (Best and Laudet 2010, cited in Cano et al 2017, 180-181 and Cano et al 2017, 180-181). In relation to the quadrant model above - where a person with low recovery capital and high problem severity needs a combination of intense treatments - if there are little resources in their geographical area then the 'combination' may be limited. Also, these may be the population group who require the most resources to help build themselves up to achieve recovery. Thus, the concept of recovery capital can be disempowering for people with no internal or external resources as they will need the initial support which will be determined by what is available and accessible in their area, rather than a personalised, intense combination of support.

Welsh Policy stipulates that treatment services should support the service user to become aware of their recovery capital and support them to build and sustain it (Welsh Government 2013, 6).

Recovery community

This is a part of social and community capital. A recovery community is a group of people who share similar experiences of substance dependency and are in recovery. Mutual aid groups and peer mentors are recovery community examples that can bring people together.

Mutual aid groups are based on voluntary relationships between people who share life experiences (Welsh Government 2013, 8), e.g., experience of substance dependency. Being within a mutual aid group can increase elements of social capital and help re-integration into society (Calcaterra and Raineri 2019, 2). It is important service users have a supportive social network around them because a negative network or a low social support network increases the chances of substance abuse (MacDonald et al 2004; Lemos et al 2012; Martin-Storey et al 2011, all cited in Nikmanesh et al 2017, 5).

A staff member or volunteer who has personal experience with substance dependency can provide *peer support* by developing a supportive relationship with the service user (Welsh Government 2013, 8). This relationship may reduce rates of returning to substance dependency, increase treatment retention, and improve the relationships between service providers and social support (Reif et al 2014, 860). Service users have also reported a better experience of treatment (Reif et al 2014, 860), reduced substance misuse, improvement in treatment engagement, a reduction of risky behaviour related to HIV and Hepatitis C Virus and

improvement of "*substance related outcomes*" as a result of being part of a recovery community (Tracy and Wallace 2016, 152). However, boundaries need to be in place between the service user and the peer support worker to always remain professional (Mendoza et al 2016, 145). The benefit of having mutual aid groups is the level of understanding from engaging with somebody who has similar experiences, leading to feelings of acceptance and the building of supportive relationships (Calcaterra and Raineri 2019, 8). This companionship and empathy can reduce the effects of stress service users experience (Nikmanesh et al 2017, 5).

Livingston and colleagues (2018, 55) found that third sector partnership with Welsh Government was one area success of the strategy. They recommend that future policies should have '*harm reduction*' and '*useful accountability of activity*' as fundamental foundations (Livingston et al 2018, 8).

Stigma and attitudes of drug (heroin) dependency

As Goffman (1963, 12) states, a stigma is a "*failing, a shortcoming, a handicap*", and the stigmatised person is not "*whole and usual*" but rather "*tainted, discredited*". This is from "*processing an attribute that makes him different from others*", and "*less of a desirable kind*" (Goffman 1963, 12). People with a heroin dependence are profoundly stigmatised, which has an impact on their chances of recovery. Best et al (2015) found that transitioning from the identity of a person with a drug dependence or '*addict'* (as the literature terms) to a new identity in the recovery journey is important in the recovery of a person with a heroin dependence (Biernacki 1986, 141 and McIntosh and McKeganey 2000, 2002, all cited in Best et al 2015, 113).

People with a heroin dependency are likely to experience stigma from healthcare services and from the general public/society, which can be challenging for recovery (UKDPC 2010, 2-3, 13). Perceived stigma and negative staff attitudes may complicate the medical management of heroin dependence (BMA 2013, 9). Perceived stigma of drug misuse can lead to unsafe drug taking and can create a barrier between healthcare services and service users (Csete et al 2016, cited in Godlee 2016, 1). This stigma can prevent people seeking help, and causing escalating effects such as losing employment, family, housing, etc. (HIW 2012, 5-6).

Stigma can be experienced at a micro level (internalized stigma) and a macro level (institutionalised stigma), which can affect the individual if they "*accept the social meaning*" of the stigma experienced (Lloyd 2010, 43 cited in Harris and McElrath 2012, 811; Harris and McElrath 2012, 811). To explain further, the understanding of institutionalised stigma is the *"...rules, policies and procedures of private and public entities in positions of power that restrict the rights and opportunities of people with mental illness*" (Livingston and Boyd 2010, 2151, cited by Harris and McElrath 2012, 811), whereby people experiencing the stigma may feel "devalued members of society" (Livingston and Boyd 2010, 2151, cited by Harris and McElrath 2012, 811). Methadone can be associated with social control and institutionalised stigma which is shown to create challenges to reintegration (Harris and McElrath 2012, 818). Harris and McElrath (2012, 820) suggest that these facets of stigma can lead to poor outcomes for MMT. They suggest that service users of MMT should have more of a voice to improve service delivery and in the process become consumers/customers of MMT (Fraser and Valentine 2008 and Reisinger et al 2009 both cited in Harris and McElrath 2012, 820), rather than "*suspects*" in terms of being treated from a criminal perspective, and not as a patient (Vigilant, 2001 cited in Harris and McElrath 2012, 820; and Harris and McElrath 2012, 820). There are several measures that can be taken to address stigma and following are some examples. It is important to ensure that use of language is destigmatising, for example, MMT clinics adjusting their name to "*addiction recovery centres*" as this may avoid institutionalised identities that are associated with MMT clinics (White 2010, 46 cited in Harris and McElrath 2012, 820). These centres should "*actively involve"* people who have experienced heroin dependence and have since made positive life changes (Harris and McElrath 2012, 820). Pharmacies should also concentrate on reducing the impact they have on creating institutionalised stigma by offering "*anti-stigma training*" to pharmacists and staff and welcoming feedback from services users with regular meetings with pharmacists (ibid).

HIW and CIW (2018) found that in Wales, staff were generally helpful and listened to the person's needs and showed compassion and genuine aspiration to help and support this client group (HIW and CIW 2018, 7). However, stigma is still an issue and little progress has been made to reduce it, and the report concluded that there is a need to raise awareness and understanding among the public as well as some health and social care professionals (hospitals, GPs and pharmacies) (ibid). HIW and CIW (2018, 29) found that substance misuse service (SMS) staff have provided positive support to service users, which is imperative for continuing engagement (HIW and CIW 2018, 29; Welsh Government 2019a, 12).

Multiple studies have found a strong correlation between methadone maintenance therapy (MMT) and stigma (Des Jarlais et al 1995; Smith 2010 and Tempalski et al 2007, cited in Earnshaw et al 2013, 111). Studies show that stigma affects MMT's retention and success (Anstice et al 2009; Brener and von Hippel 2008; Brener et al 2007; 2010; von Hippel et al 2008, all cited in Earnshaw et al 2013, 111). Stigmatising behaviour and attitudes from healthcare workers as well as family, friends, co-workers, and employers can all have a detrimental impact on the recovery success of MMT (Earnshaw et al 2013, 112). Woo et al (2017, 4) found that of the service users on MMT participating in their study, 78% felt stigmatised at least once, and a breakdown of sources of stigmatising were from friends (56%), healthcare workers (44%), family (33%) and the community (33%).

Evidence suggests that GPs have not always empathised with patients with a substance misuse problem and have not understood the factors, (biological, psychological, or social), contributing to their misuse (HIW 2012, 6). People have experienced problems registering at a GP surgery once they became aware of their substance dependency, and there are many prejudices people experience prior to accessing treatment (HIW 2012, 6). Even during appointments regarding other health issues, the healthcare professionals have attributed health problems to substance dependence, and not referred them for further screening or testing (HIW 2012, 7). This research suggests that some healthcare professionals and doctors may adopt a 'self-inflicted' attitude towards people who use drugs, and thus treat them with suspicion, which Independent Working Group (2017, 248) highlighted too. Consequently, interactions may be less supportive and empathic. This includes "*specialist addiction services*" who may treat people who use drugs with lower standards and exclude people from services for "*tenuous reasons*", although specific reasons are not discussed (Independent Working Group 2017, 248). This issue of stigma when attending a GP appointment, and the training GPs receive on substance dependency as well as ensuring care pathways are in place between primary care and substance misuse services are all areas reflected in the SMDP strategy (Gething 2019). The SMDP 2019-22 aims to ensure services are accessible to everyone regardless of "*background or circumstances*" (Welsh Government 2019a, 7). The Welsh Government are committed to ensuring the dignity and rights and that everybody can access *all* services regardless of their circumstances (Welsh Government 2019a, 12).

Chapter conclusion

Drug related deaths were at their highest levels in 2018, and heroin and other opioids were related to over half of the deaths (Turner et al 2019, 5-6; Turner and Smith 2020, 5), despite treatment using OST being available and service users referred for heroin use in 2018-19 were seen within 20 days of referral (92.6%) (Welsh Government 2019, 49). This raises the question whether current practices are effective as there is not an equal focus on abstinence, and the use of MPPs to achieve abstinence. Reducing drug/heroin use is prominent in current strategies (SMDP 2019-22), and although this is suitable for some service users, a higher focus on abstinence might better suit others. There have been research findings which suggest methadone is ineffective for abstinence (CSJ 2014, 20). However, Musalek (2013, 636) argues that substitution therapy aimed to reduce drug/heroin use, from its initial goal of achieving abstinence.

The following chapter will explain the *research methodology and methods* adopted to address the research gaps identified in this literature review.

Chapter Two

Methodology and Methods

Overview: Introduction, aim and objectives

This study draws on primary and secondary data sources. The primary data was collected before the secondary data and is presented first within this chapter and thesis to represent this timeline. The methodology for the primary data was semi-structured qualitative interviews and recruited five third-sector professionals and one member of the Welsh Government. The sampling adopted snowball and purposeful sampling techniques to reach the target population. Secondary data was identified from an analysis of three Welsh policies relating to substance misuse; *Integrated Care and Integrated Care Pathways* (2010), *SMTF; Guidance for Evidence Based Community Prescribing in the Treatment of Substance Misuse* (2011) *Recovery Orientated Integrated Systems of Care* (2013). The methodology for this data analysis was applying Walt and Gilson's Policy Analysis Triangle Framework (1994) to the policies. An overview of the research process (audit trail) can be found in table 2.1 in appendix H.

The aim was to establish whether areas of divergence exist between policy aims and service outcomes and to explore third sector perceptions of SMS for adults in methadone substitution treatment within the study area. The three objectives for this research are as follows:

- Exploring the challenges that arise when supporting adults (aged 18 and over) who are referred to substance misuse services.
- Exploring third sector professionals' perceptions of treatment and approaches to drug dependence in a region of Wales.
- Analysing three key policies and exploring the challenges associated with their translation into practice

Qualitative design

Qualitative research seeks to understand the lives of others by talking about their experiences, beliefs, attitudes, interactions, and behaviours (Pathak et al 2013, 2). As this study examined the experiences, beliefs, attitudes, interactions, and behaviours of the third sector relating to supporting people who misuse substances, a qualitative approach was judged to be appropriate.

Ontology and epistemology

This study's ontology adopts a relativist approach, meaning truths are found by interacting with experiences and meanings, told by different people, which is done by adopting an emic epistemology, inductive approach to truth, by exploring what meanings people attach to their experiences subjectively. A relativist approach was adopted by asking people about their views on methadone and substance misuse services, due to an interest to explore different experiences and meanings attached to this research topic. Ontology seeks to understand reality by distinguishing what we believe exists (Berryman 2019, 272).

Social constructivism is a part of epistemology, which O'Leary (2010, 7) defines as "*theories of knowledge that emphasize that the world is constructed by human beings as they interact and engage in interpretation*". In other words, how the world is perceived by others. One person will construct meaning different to someone else's, even towards the same phenomenon (Crotty 1998, 9).

Symbolic interactionism is a part of constructivism and is focused on how others make sense of the world and assign meanings when interacting (Sarantakos 1998, 48). Symbolic interactionism is relevant to this study because participants make meaning of their experiences in different ways. For example, with regards to policy development, the Welsh Government policies analysed in this thesis were written from a perspective based on statistics of crime, drug related death or harm, drug use, etc., economic impact on drug-related harm, financial availability to fund treatment/services and other governing factors which shape the policy agenda. In contrast, frontline workers who work with the service users experience and observe first-hand the impact which can result from these policy decisions (positive and negative), which will shape "their meanings when interacting", as referred to above. Not only this, but when third sector professionals or governing bodies are working within/reviewing substance misuse, they will have their own experiences of the world which will influence their decisions and their interpretation of experiences. This is important when considering adherence to policy guidance, when there are differing perceptions, experiences and feelings towards a subject that is sensitive and affects peoples' lives.

Literature search strategy for the background chapter

During the literature search process, terms such as "*methadone*", "*effectiveness*", "*methadone prescription programmes*", "*harm reduction*", "*addiction*", "*heroin addiction*", "*heroin users*", "*opioid substitution treatment*", "*recovery*", "*recovery outcomes*", "*abstinence*", were

searched, primarily within the timeframe of 2015-2021. Also, "*Third Sector Organisations AND addiction*". There were limited literature relating to OST and MPP within this timeframe, therefore the time frame was increased to 2011-2021, which also is close to the timeframe of the Welsh policy chosen (2010-2013). Search relating to the effectiveness of MDW also included terms such as "*multi-disciplinary teams", "integrated working"*, "*substance misuse services", "Single Point of Access", and "health services".* Journal databases utilised were JSTOR, Springer, PubMed, Science Direct, ProQuest, Wiley Online Library, Cochrane library and Bangor University online library and I also used Google scholar.

Primary data collection

Selection criteria,

Third Sector Organisations

TSOs working with drug dependence were the main focus of the study because they have been known to address issues that other sectors and government have failed to do so or have chosen not to (Cornelius and Wallace 2013, 237; e.g. Church and Frost 1995, Hart 2003, Lawless et al 1998 and Sesnan 2001, cited by examples provided by Cornelius and Wallace 2013, 237). Such as the asylum seeker system which is heavily supported by TSO (Mayblin and James 2017). TSOs can also work closely with the Welsh Government and can be key to delivering front line services (Welsh Government 2019a, 12), and are often involved as key stakeholders in policy making (Welsh Government 2013).

Description of the interview sample

Below is a table of participant characteristics.

Table 2.2 Participant population

Participant name*	**Gender**	**Role**	**Organisation type**	**Interview duration**
Daniel	Male	Project lead	Substance misuse	00:49:05
Polly	Female	Officer	Welsh Government	00:23:03
Nigel	Male	Support worker	Substance misuse	00:31:18
Samuel	Male	Project worker	Substance misuse	00:15:28
William	Male	Co-ordinator	Substance misuse	00:48:58
Gary	Male	Co-ordinator	Substance misuse	00:57:31

***Names changed to adhere to confidentiality and protect anonymity**

Due to the limited 12-months timeframe of this study, a sample size of 6 professionals was aimed for which was successfully achieved. The budget (provided by the KESS2 studentship) included the costs of travel, materials, and transcription.

Table 2.3 Participant sample information

Table 1: Population Sample type	Third sector, relating to substance misuse and dependency
Sample size	• 6
Sample	• 5 third sector and 1 affiliated to the Welsh Government. 4 of third sector participants had personal experiences of substance misuse and/or dependency*
Setting	• Third sector sample were operational staff • Welsh Government

*****Some participants had personal experience of dependency and were in recovery themselves. However, they were interviewed in a professional capacity only. Their personal experiences *are not* reported in this thesis.

Sampling and recruitment

Identification of interview sample

A combination of purposive and snowball sampling was used. Three participants were recruited through purposive sampling, and three were recruited through snowball sampling.

Purposive and Snowball Sampling

Purposive sampling recruits participants that are likely to provide "*appropriate and useful*" information (Kelly 2010, 317, cited in Campbell et al 2020, 3). As Campbell et al (2020, 3) explains, using purposing sampling helps access a specific type or group of people that have different views about ideas and issues being presented, and would therefore need to be included in the sample (Mason 2002; Robinson 2014; Trost 1986, all cited in Campbell et al 2020, 3). This study required the perceptions specifically of the third sector, and therefore it was important a purposive sampling technique was used.

Snowball sampling was carried out by asking the participants that were interviewed to share the details of the project with their colleagues and other organisations working within substance misuse and dependency with a focus on MPPs. A limitation of using this sampling method is that the participant population is at risk of influencing the results of the study, although, it helps with the recruitment process (Emerson 2015, 166).

Semi-structured interviews

Semi-structured interviews allowed for gaining subjective insights from third sector professionals who had experience working with individuals who misused substances. The areas of substantive interest addressed during the interviews included: views on MPPs; experiences of delivering services and the associated challenges such as MDW. The interview schedule was developed in collaboration with one of the project supervisors and was informed by an understanding of the existing evidence base and the evidence gaps. The interview schedule guided the interviews and provided an aide memoir to ensure that all the key topics were covered (Holloway and Wheeler 2010 and Gill et al 2008, both cited in Kallio et al 2016, 2955).

Recording and secure storage of interview data

The university provided an encrypted, password protected MP3 recording device and a password protected laptop to support data collection and the write-up of the thesis. Interview data (transcriptions) were saved in a secure folder on the University drive which was only accessible by myself and the project supervisors. The consent forms and anonymised transcriptions were secured in a locked filing cabinet at the university in a locked office.

This project followed the Data Protection Act 1998/2018 and revised GDPR (2018). The participants' data was not used in any other way, only for the purpose they consented to.

Transcriptions

The interviews were transcribed by a reputable company. They anonymised all identifiers relating to participants and study location.

Thematic analysis.

Analysis of interview data

Interview data was coded following an initial review of the literature, including policy documents such as WTtRH (2008-2018a) and the Welsh Government SMFTs, and discussions

with the company partner regarding service delivery and MDW. This provided an understanding of the broad policy context which shaped the coding of interviews.

Thematic analysis of primary data

Thematic analysis was the chosen approach for analysis because it allows identifying, analysing, and reporting patterns (themes) within a qualitative data set. This primary data analysis followed Braun and Clarke's (2006) six steps of thematic analysis because it supports the development of themes from codes and is based on interpretive and analytical work by the researcher. Importantly, it recognises that the researcher brings their own values, skills and experiences to the analysis (Braun and Clarke 2021). The six steps being: becoming familiar with the data by reading over the transcripts multiple times, as well as listening to the recorded interviews; coding the data through recognising important areas from an extensive literature review (a priori coding), that relate to the research question and objectives; then searching for themes from those codes to identify any similarity to construct themes; the themes were then reviewed individually and their relationship with each other; these themes were then defined and named by analysing them separately to distinguish what each theme brings to this research. Lastly, the themes were written up and presented in the findings chapter (See appendix I for coding structure table 2.4).

Reflections on the research process

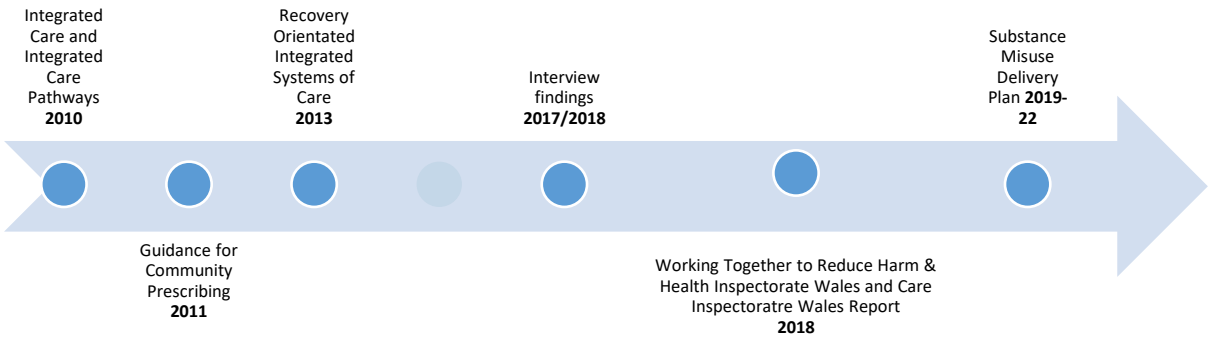


Figure 2.3 Timeline of data and key reports

The above timeline demonstrates the chronology of this research study. The three policies were published from 2010-2013, which gave sufficient time for them to be implemented (four years). In 2017/2018, the primary data was gathered (qualitative semi-structured interviews with third sector professionals). Within this time-period, WTtRH (2008-2018a) was implemented, and a

final report published, as well as the HIW and CIW Joint Thematic Report, in 2018. The most recent SMDP was released in 2019, covering the period 2019 -22.

When networking during the recruitment phase, it was important participants identity remained confidential and the researcher did not show recognition when a participant's name was recommended, e.g. did not acknowledge the contact was known and revealed that they had participated already. This happened on several occasions, where the researcher was sensitive to this information. For example, when returning to the same location where an interview had already taken place, and whilst waiting for the participant, the researcher engaged in polite encounters and was sensitive to information provided, to avoid the risk of others realising the participation of the previous interviewee within the organisation.

Frequent debriefing sessions and "*peer scrutiny of the research project"* (Shenton 2004, 67) also enhanced credibility through supervision meetings where the researcher was able to discuss and develop ideas and interpretations. This helped to reflect on any potential biases and preferences (Shenton 2004, 67). The research was also presented at the Society for the Study of Addiction conference 2017 in a poster presentation which included critical discussions and thinking from academics and professionals in the field.

Trustworthiness of the research findings

The concept of trustworthiness of a study is very significant to qualitative research. Lincoln and Guba (1985, cited in Korstjens and Moser 2018, 121) introduced trustworthiness and its four main elements: credibility, transferability, dependability, and confirmability.

Ensuring the research is credible is an important part of ensuring trustworthiness (Lincoln and Guba 1985, cited in Shenton 2004, 64). Credibility refers to having confidence in the data and what was found. According to Hiles and Čermák (2007, 2), "*the credibility of any qualitative study lies in the transparency of its specific paradigm assumptions*". They also state that its important researchers are explicit in their choices, decisions and justifications involved in the whole research process, constantly examining research strategies, selection of the participants and the decisions of collecting/interpreting data (Hiles and Čermák 2007, 2). The methodology of the thesis is transparent and justified and the researcher thoroughly engaged in regular discussions regarding the direction of the project (with my supervisors and company representatives), ensuring the research aims and objectives were directly at the forefront of decisions made.

This research made sure that participants were aware they could withdraw at any time, without reason, and their participation will not be included in the project. They were also reassured that their participation will be kept confidential and anonymous. This increases credibility because it helps "*ensure honesty in informants when contributing data*" (Shenton 2004, 66).

Transferability refers to the degree to which findings can be transferred to other settings or context (Lincoln and Guba 1985, cited in Korstjens and Moser 2017, 121).

Korstjens and Moser (2018, 122) relate to the researcher giving a 'thick description' of the participants and research process. Contextual issues such as demographic, socio-economic and clinical characteristics, sample size, sample, setting, etc., should be outlined in detail. This enables the reader to form a judgement about transferability and details are presented later on. The details of sample characteristics are provided above, which provides sample information without breaching confidentiality. Details of the policies analysed, and the reasons for specific policies are also included earlier in this chapter.

Dependability refers to how dependable the research is by demonstrating how 'logical, traceable and clearly documented' the process is (Tobin and Begley 2004, cited in Nowell et al 2017, 3), also known as auditing the research process (Koch 1994, cited in Nowell et al 2017, 3).

The processes within the study were noted in detail, from recruitment to arranging interviews and the setting the interview took place in. This means that another researcher could repeat the work, "*if not necessarily to gain the same results*" (Shenton 2004, 71). An audit trail of the data collection process was also kept.

Establishing credibility, transferability and dependability shows confirmability (Guba and Lincoln 1989, cited in Nowell et al 2017, 3). Confirmability is the validation that the interpretations and findings of the research study is from the data obtained, and not previous conceptions from the researcher (Tobin & Begley, 2004, cited in Nowell et al 2017, 3). Thus, details of why a particular sample was chosen, certain policies were analysed, key conclusions have been made are explained for example, or as Koch (1994) says *"…reasons for theoretical, methodological, and analytical choices throughout the entire study*" (cited in Nowell et al 2017, 3).

Conduct of the interviews

Short memos of the interviews were written to reflect on participants' experiences and their perspectives. The researcher also had meetings with the academic supervisors to reflect on the conduct of the interviews and interpretation of the data. The researcher's peers and work colleagues were also beneficial in reflecting on the research process by discussing findings and interpretations with them.

Ethical considerations

Prior to recruiting individuals to the study, ethical approval was obtained. The information sheet and invitation to participate, consent forms (Welsh and English) and the interview schedule are included in appendices A-E.

The participant information sheet included details of the purpose of study, made it clear that there was no obligation to take part and that people could withdraw at any time without reason. Information and details of the University the study was taking place at and the names/contact details of the academic supervisors were also available if the participant wished to make contact with the supervisors/University (i.e. any clarification regarding the project, complaints, etc.)

Informed consent

The researcher ensured the participants provided informed consent i.e., were of (adult) age to participate, had mental capacity and were fully aware of what they were consenting to by providing a detailed information leaflet and discussing participation and any questions before interviews.

The researcher also ensured two consent forms were signed prior to the interview commencing and the recording being made. These consent forms included consent to interview, and consent to record the interview.

Anonymity and confidentiality

It was made clear in the information sheet and prior to the interview commencing, that the identity of the participants would be anonymised, and strict confidentiality procedures would be followed at all times. This included the need to breach confidentiality if the participant or someone else was judged to be at risk of serious harm.

Confidentiality and anonymity of the participant and any identifiable information (such as their place of work) was respected and abiding by confidentiality was explained in the information

sheet. Privacy was always respected, for example the researcher gave the participant the opportunity to choose the location the interview took place (either at their place of work or a suitable location, or the researcher organised a room at the University which was confidential.) This research also adhered to Data Protection Act (1998) and GDPR (2018).

Sensitivity

Some topics on the interview schedule (see appendix E) were sensitive, and due to this, the researcher was prepared to move onto the following question or stop the interview at any time if this was necessary. It was made known from the beginning that the participant had the right to withdraw at any time during the interview or not answer a specific question. All participants continued with the interviews and no one withdrew from the interviews/study.

Description of the policy analysis

Policy data

Three substance misuse policies were analysed:

- Integrated Care and Integrated Care Pathways for Adult Substance Misuse Services in Wales (2010)
- Substance Misuse Treatment Framework: Guidance for Evidence Based Community Prescribing in the Treatment of substance misuse (2011)
- Substance Misuse Treatment Framework: Recovery Orientated Integrated Systems of Care (2013)

The policies are within a timescale of 2010-13 and are the most recent guidance. The eldest policy, *Integrated Care* (2010) has been discontinued, and the most recent policy *ROISC* (2013) has replaced this earlier policy. However, the 2010 Welsh Government policy includes elements that are not covered in as much detail in the 2013 ROISC policy; even though the findings from the literature would suggest that these aspects are essential. For example, a single record of care, single point of access (SPoA) and the appointment of a co-ordinator of care.

Table 2.4 Overview of Welsh Policy

Policy	Date	Purpose
Integrated Care and Integrated Care Pathways	2010	All services involved in the care of the mutual service user to work together using an integrated care pathway and for ease of access using SPOA.
Guidance for Community Prescribing for Substance Misuse	2011	Procedures how to prescribe in the community abiding to legal and contractual obligations. Advise for maintenance, detoxing and supervised consumption
Recovery Orientated Integrated Systems of Care	2013	Evolving the recovery culture, service user led care plans, use of ICPs. Introducing the role of recovery capital, and the responsibilities of the APB.

The reason Welsh policy was chosen, as opposed to United Kingdom Parliament policy, was to reflect on the primary data collected in Wales and to explore connect and potential disconnect between policy and practice. In addition, this was a KESS2 project: KESS aims to create a sustainable future for Wales through investment in research and knowledge advancement.

Health policy analysis

Walt and Gilson's health policy analysis triangle (1994) was used to analyse the three policies. It focuses on the actors, context, content, and process. This is a well-known framework which has been employed in other studies, such as Eckhardt et al (2019), who state that this framework incorporates the historical context as well as the actors involved and the process of reform (Eckhardt et al 2019, 3).

This framework for analysing health policy has also been used by El-Jardali et al (2014), who conducted an in-depth analysis and adapted Walt and Gilson (1994) initial framework, using a "*simplified approach to a complex set of interrelationships*" (El-Jardali et al 2014, 46-47). This simplified approach was not used in this study, only the original framework.

The Policy Analysis Triangle incorporates more than just the content of a policy. It includes the social, economic, political, cultural, other environmental and international context, as well as how policy was initiated, developed, negotiated, implemented and evaluated (Buse et al 2012, cited in O'Brien et al 2020, 2). It also looks at the influential people, groups, and organisations that were involved in development of the policy (El-Jardali et al 2014, 47; O'Brien et al 2020, 2).

Policy analysis can help policymakers and researchers to better understand health policy reform and to help plan for 'more effective implementation' (Walt and Gilson 1994, 354). O'Brien et al (2020) argues that health policy decision making is often premised on the dominant value judgements of a society, which can sometimes hinder the achievement of policy aims and implementation targets (May et al 2014 and McHugh et al 2014, both cited in O'Brien 2020, 1). This is especially important in this research project as drug dependency is strongly stigmatised by the public and some health and social professionals, particularly with heroin, opiate and opioid use is involved (UKDP 2010, 2 and 5-6).

A limitation of the Policy Analysis Triangle is that it does not go into detail about the specific time the policy was developed, compared to Kingdon's Multiple Streams Theory (1984) (Kingdon 1984, cited in El Jardali et al 2014, 47). This entails a "*policy window*", looking at the problem at the time, current policy and influencing politics (El-Jardali et al 2014, 47). However, the policy analysis triangle still explores the policy in depth, whilst including contributing factors surrounding the policymaking.

The Policy Analysis Triangle (1994) goes beyond looking at the content of a policy, and by analysing actors, context, and process of the policy, acknowledges that they are inter-related (Buse et al 2012, 9). This framework is therefore appropriate for this study because the individual policies and their relationship with each other need to be addressed to understand the entire policy and its influence in the drug dependence and treatment field.

The figure below shows an example of the policy analysis triangle.

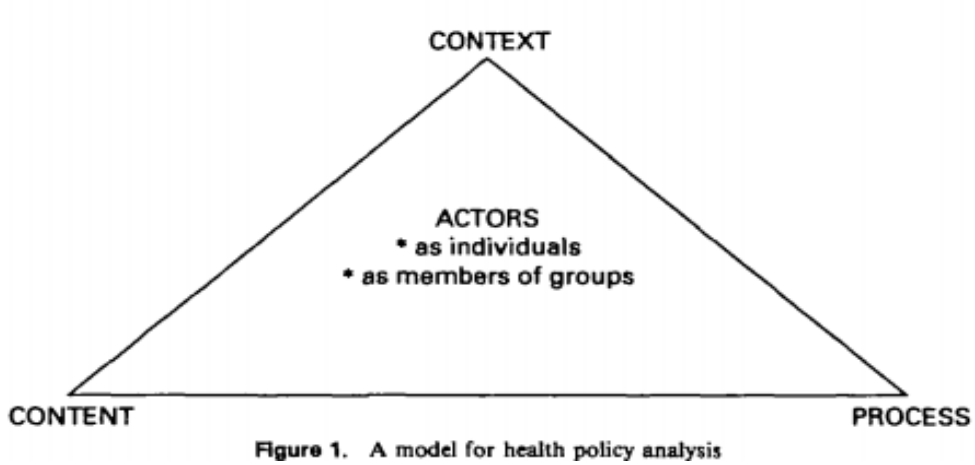


Figure 1. A model for health policy analysis

(Walt and Gilson 1994, 354)

Figure 2.1 Walt and Gilson's (1994) Policy Analysis Triangle

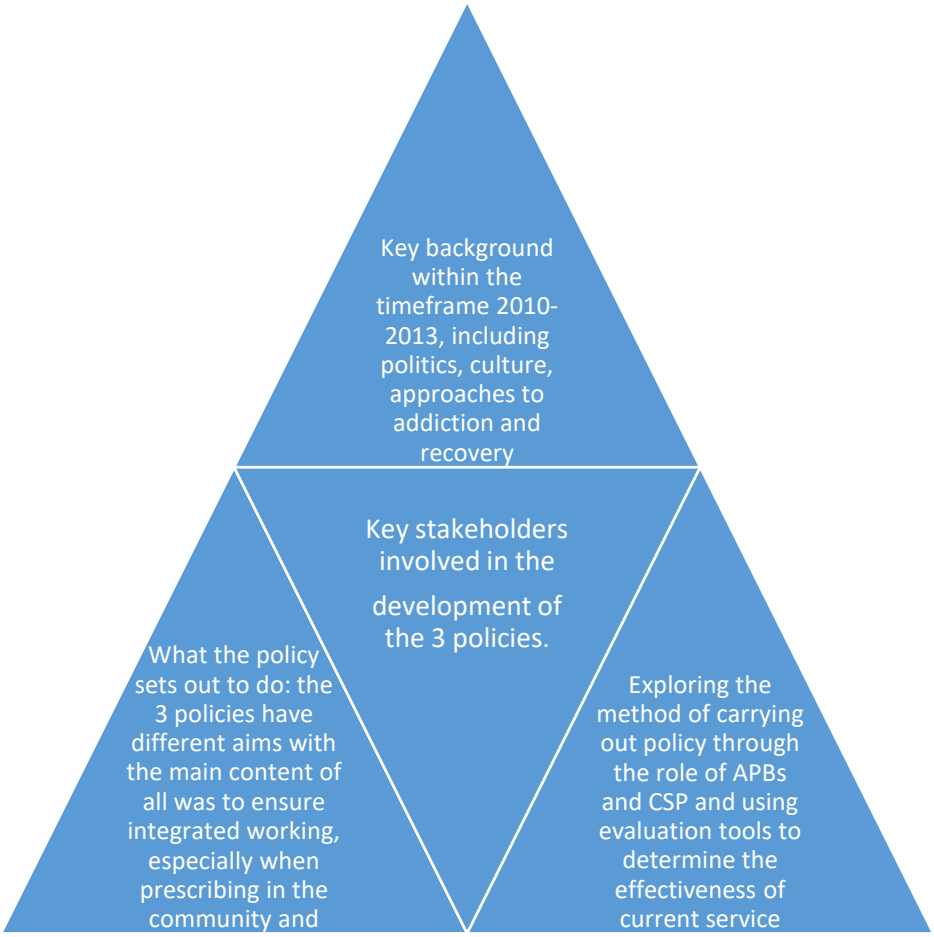


Figure 2.2 Present study policy dataset applied to Policy Analysis Triangle

The figure above provides an overview of how the three policies fit into the policy analysis Model.

Reflexivity

Reflexivity is an integral part of qualitative research and credibility (Dodgson 2019). This is self-awareness and reflexive thinking during the research journey, from conducting the literature review, collecting to analysing data, to writing up the thesis, with a focus on the researcher's pre-conceived assumptions (Mauthner and Doucet 2003, cited in Korstjens and Moser 2018, 123). Korstjens and Moser (2018, 123) refer to 'reflexive notes', where the interviewer makes notes on each interview, and the analyses of the data. This helps to understand how interpretations are arrived at. The interview setting was also noted, e.g., interruptions, etc.

The project's research question, and the aims and objectives (to understand the effectiveness of MPPs) were co-formulated with the company partner (this is a requirement of KESS2), and

the academic supervisors guided and advised the researcher with the study design. The researcher was not familiar with the topic to start with but was interested in it because of her desire to research an important topic which affected people in Wales and had societal and economic impact, with the opportunity to possibly improve service delivery by understanding potential issues and barriers.

To tackle the potential of bias and pre-conceived ideas, interview transcripts, analysis and interpretation was discussed with the supervisors and initial findings presented at a Society for the Study of Addiction conference to get feedback. Key reports that informed the discussion in the final chapter (Working Together to Reduce Harm 2018, HIW and CIW 2018) were published after the interviews had taken place and after coding/interpreting. Findings from this research tie in with the key reports.

The researcher read memoirs of people who had experienced dependency issues and their journey into treatment and recovery. The language used in these publications favoured the terms "*addiction*" and "*addict*" and "*clean*". As discussed previously, language has negative connotations and can create hierarchies of MMP service users (Harris and McElrath 2012, 821). Although the researcher reflected upon the use of language all along, it is not always easy to follow the various debates around the use of certain terms. There is an effort throughout to use language that is non-stigmatising terms in this thesis to avoid potential stigma and prejudice.

Any personal perceptions of substance/drug use from the researcher may have come from supporting people whose family members experience issues with substances, awareness of drug use in adolescence, visiting a homeless drop-in where drug use was prevalent, the representation of drug use through the media and *influencers* on social media who describe themselves as in recovery and share their story. However, the researcher was largely unfamiliar with heroin use and MPPs, and reading peer-reviewed journals expanded the researchers understanding and awareness. Engaging in discussions with the researcher's supervisors was helpful and supported academic learning on the subject.

Using the policy analysis triangle framework was advantageous because it provided a clear understanding of what is expected from services when comparing to the primary data. The comparison of what should happen (policy) with what does happen (interviews) enabled the reader to see what is expected of service providers, and what is experienced by the service user and the TSOs. Conducting the interviews first and using Braun and Clarke's (2006) thematic analysis of the interview data prior to carrying out the policy analysis was also advantageous

to the study as there was no policy-informed bias to influence the primary data analysis (i.e., the researcher had limited knowledge of the guidance set out by the Welsh Government). Once the policy analysis was completed and the researcher had both complete datasets, the discussion chapter enabled the opportunity to explore issues in a critical and detailed manner.

A challenge following this approach was that the researcher did not create the interview schedule based on findings from the policy analysis, which could have made for a more direct comparison of key policy themes.

Data Coding and Analysis

A priori codes

A priori codes are predetermined codes based on an understanding of existing evidence and prior insights into policy implementation and practice. A priori coding is an established approach to coding data.

My understanding of the research, policy and practice literature informed the a priori codes used in the interview data analysis and additional a priori codes from the interview data to inform the policy analysis. The most recent SMDP 2019-22 was published during the conduct of the policy analysis. See appendix I where the coding structure is presented.

Limitations

Initially, it was hoped to complete narrative interviews with service users to explore their personal experiences and understand the issues around recovery and substance use from their perspective. The researcher also hoped to lead focus groups with service users and another with professionals (NHS and third sector staff). However, with issues with access, IRAS and NHS ethical approval this was unrealistic. This would have gone beyond the remit of a Masters by Research project. However, the researcher overcame this limitation by emphasising the policies relating to this study and comparing the interview findings to said policy.

Timeframe

This was a funded project with a timeframe of 12 months funded and a writing up period. As Research and Development approval from the Heath Board was impracticable to obtain within the time frame, subsequently NHS employees or patients could not be included in this study.

To overcome this, it was decided to focus on third sector professionals, as they generally work for organisations with different approaches/values and have different knowledge and experiences to medical professionals.

Resources

This project was funded through a studentship, which had a budget for different areas of the research, i.e. transcribing, travel, conferences, student bursary, etc. This came with minor challenges such as specific timeframes to use the budget within the set 12-month period, and to follow necessary procedures to ensure value for money, which often required multiple quotes from different approved sources. This was overcome by incorporating the time it took to receive approval for budget spending into the planning and organising. For example, the conference poster was completed in time for budget approval and printing, plus quotes were asked for during the development of the poster.

Access to participants

Accessing potential research participants was difficult due to ensuring they were not NHS staff, challenges making contact and lack of responses. These challenges were addressed by ensuring the people that were contacted met ethical guidelines (were not NHS employees) before contact was made, i.e., the organisation was not funded by the NHS, nor ran by them either. Additionally, the researcher checked if any employers were NHS staff that worked within the TSO. The lack of responses was dealt with by a follow up e-mail/phone call at a different time of day to check their interest in participating. Respondents who showed an interest but then failed to follow through (unanswered e-mails/phone calls), would be considered as disinterested after appropriate follow up measures took place such as another e-mail or telephone call. There were suggestions that people are very busy, and organisations understaffed which made it harder for them to participate.

The barrier of non-response was dealt with differently on a case-by-case basis; if the organisation was considered a key service that would benefit the study (i.e., a local service that service users are likely to access or if their service has been mentioned previously), they were contacted via telephone after at least two weeks of waiting for a response. If a service replied, but then was unreachable, depending on the extent to which their interest in participating was expressed, another e-mail and/or follow-up with a telephone call was carried out.

Chapter Conclusion

This chapter has described the methods and methodology of data collection and analysis used in this study. It has highlighted key aspects of the research process, including securing ethical approval, participant recruitment and the analysis of policy documents and has reflected on the research, including its original aims and its limitations. Presented next, the Primary data: *interview findings.*

Chapter Three

Primary Data: *Interview findings*

This chapter presents the primary data from the interviews in two parts. Part one discusses the perceptions of participants in relation to approaches to recovery, whether abstinence can be achieved using MMPs, the recovery culture and attitudes in the study region and overall effectiveness of methadone for treating heroin dependency. Part two brings into focus the challenges that are present when referring somebody to substance misuse services and recovery capital and its relation to current issues in the study region and with MDW and integrated care. The table below summarises the main findings of the primary data.

Table 3.1 Main primary findings

Approaches to recovery	**Reducing drug/heroin use and abstinence**
	•The effectiveness of methadone depends on the needs of each individual, what their recovery aspirations are and their motivation for treatment. •Recovery for third sector professionals is mostly abstinence-based.
Building recovery capital	**Important for both approaches to recovery**
	•Recovery capital includes addressing the biopsychosocial aspects of addiction/dependence. •A barrier to building recovery capital is unsuitable accomodation. •Problems within services cause further challenges to building recovery captial and therefore recovery.
Issue with access to services and integrated working	**Current service delivery/provison is not accessible for hard-to-reach groups** **Services should be more integrated**
	•Current services are not accessible for the population in need of OST due to the level of functioning required to arrange and attend appointments. •Issue with lack of time to effectively work together, difference in recovery culture and lack of understanding causing difficulties for integrated working.

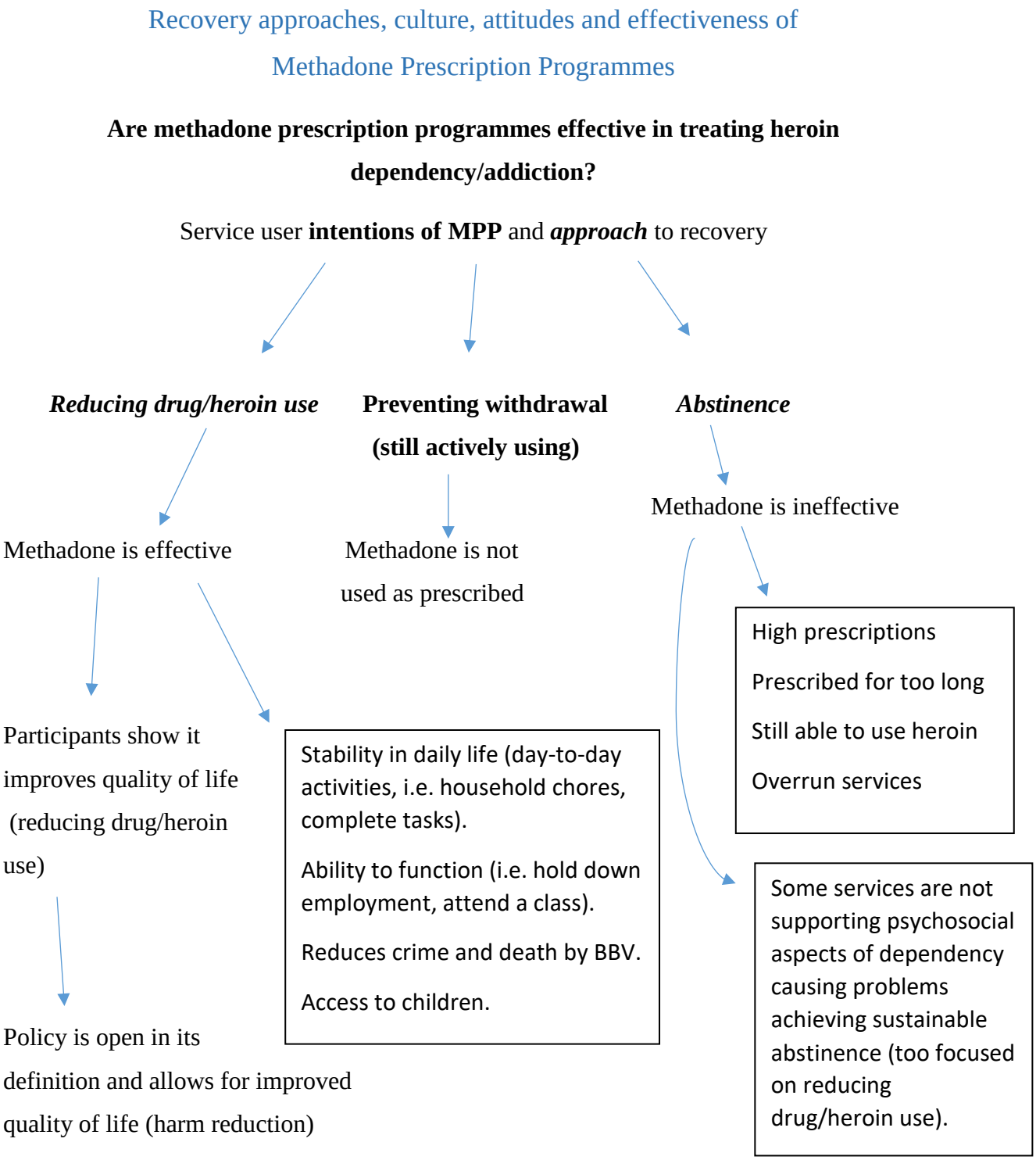


Figure 3.1 Primary data findings

Figure 3.1 (above) shows in **bold** the three reasons why somebody would go on a MPP based on interview findings; to reduce drug/heroin use, to prevent withdrawal (still actively using), or to achieve abstinence. Reducing the use of heroin/drug use or becoming abstinent are two approaches to recovery that are a part of the debate of what constitutes recovery. Harm reduction was described by participants as a state where consumption of drugs is reduced to

enable a service user to live a stable and functional life which is a basis on which to build their recovery capital (i.e. an income, somewhere to live, a social network, etc.). For some, this constitutes recovery despite still being on a methadone prescription, whereas for others, only abstinence, where the service user is clean from heroin and other opiates means recovery. Whether an abstinent or reducing harm-based recovery, both require a commitment to recovery and high recovery capital.

Approaches to recovery

During analysis of the interviews, it became evident that recovery to most third sector workers (in this study) constitutes abstinence.

Below, are quotes from each interviewee to portray the language used to discuss recovery, to show how this conclusion was made:

> *"Basically, you get recovery by spending time with people that are clean and sober, in the same way as you get addiction by spending your time with people that drink and take drugs."*
>
> (Excerpt from interview with Daniel)

> *"Putting down a substance is just the start really, that's the first step in, in recovery."*
>
> (Excerpt from interview with Nigel)

> *"But for me, a philosophy of an addict, an addict in the true sense will never regain control of any type of substances.*
>
> (Excerpt from interview with William)

> *"It's, it's like recovery's got levels and when you stop using it's the very beginning because you still have to learn to be honest, with other people and yourself."*
>
> (Excerpt from interview with Gary)

Polly is affiliated with the Welsh Government and uses the same language as the third sector participants when talking about recovery.

> *"…they're not in recovery are they but they can function, and they do function really well, umm, and it works for them."*
>
> (Excerpt from interview with Polly)

However, Gary makes the point that abstaining from drugs does not mean that they are in recovery:

> *"Umm, they're chaotic, don't turn up to appointments, blame everyone else for everything ever - abdicate personal responsibility for anything that's happened in their lives and it's like, they're not using drugs but that's not recovery."*
>
> (Excerpt from interview with Gary)

Samuel, a third sector service provider, came across quite neutral in his view of recovery, indicating that it is up to the individual person, and what's right for them:

> *"It has to be service user led, all of it, because we all have our own opinions on other people's lives, however, what's right for me isn't right for say you or probably [name], let alone somebody who's in recovery, they need to be able to find their own path and they need to have the right amount of time to do that.*"
>
> (Excerpt from interview with Samuel)

The above quotes show how the participants describe recovery. It shows that recovery is not just about abstaining from substances but goes further. As participants such as Gary and Nigel state, stopping drug use is just the beginning, and Daniel argues that people with a *"heroin addiction*" must work harder than people on other substances to achieve recovery (abstinence and overcoming psychosocial challenges).

Methadone prescription programmes are effective for reducing harm.

Figure 3.1 shows that somebody focusing on *reducing drug/heroin use* can be successful in doing so. MPPs can provide stability, increase the ability to function, reduce engagement in criminal activities and prevent death by blood borne virus. It can help people to rebuild their life, such as having access from agencies to see their children. Somebody may be on a methadone prescription, but they may be in employment, see their children and live in a suitable home. The findings suggest that MPPs can be effective in reducing drug/heroin use but that it requires a strong commitment and support to build recovery capital.

Functioning, stability, crime reduction and reduction in BBV deaths

Participants emphasised that in their professional experience the ability to function and lead a stable lifestyle is linked to harm reduction and preventing withdrawal symptoms. MPPs can enable somebody to function, but the reason for functioning can vary amongst service users. When asked if MPPs are successful, Gary stated, *"…professionally yes, it's fantastic; it brings stability and all the rest of it",* and Polly agrees stating that with methadone service users

"…*can function and they do function really well*". When people are in recovery, they can begin to get positive outcomes from OST:

> *"When you see people starting to get well and getting their lives back together, getting their driving licences back, getting, you know, access to their children and getting their credit cards back, getting jobs, getting nice places to live, you know, looking well, and then you see them helping others, it's fantastic. It really is, it's fantastic, there's no other word for it. So that's, that's a bonus."*
>
> (Excerpt from interview with Nigel)

On the other hand, Nigel states: "*Unfortunately there will be some cases where, umm, addicts see it as a bit of a, as a bit of a free fix really, you know."*, and Daniel stated that; *"… methadone is a state-sponsored addiction*". William speaks of the motive of the service user, giving an example that completing an NVQ2 course can give somebody the grounding to ensure they do not use illicit drugs, and this could heighten their chances of realising their goals. Thus, sticking solely to methadone when the motive is to gain the qualification. This example shows that MPPs *can* work, but the service user's intention is important in determining its success. Gary says; *"personally, while somebody is still chaotically using, absolutely it saves lives, it saves people from really terrible consequences, because if someone's poorly, physically poorly due to withdrawal, it forces them to make really stupid decisions in order to get the money or they can be really poorly and that's unpleasant*." This motive is to prevent withdrawal, whilst still actively using illicit drugs.

On the other hand, Gary also gave an example discussing a service user he was supporting, explaining how a MPP helped the person to avoid becoming physically poorly from withdrawal and helped *prevent* him committing crime:

> *"Umm, when he was still chaotically using, it helped him just in that he's got no money and can't buy heroin, so the opiate will help him not be really poorly. So, it's just the stability of not being physically ill. So then on days where he couldn't get heroin top ups he didn't have to steal as much to get - because he didn't have money, so he didn't have to go and commit petty crime. So yes it, it did help him, absolutely."*
>
> (Excerpt from interview with Gary)

This is where methadone can help prevent crime. Daniel provides an example stating:

> *"…it's like it's a penny a ml, by all accounts, so if you've got somebody that's on a hundred mils of heroin a day, which equates to six bags of heroin a day, umm, which is six or seven small crimes, you can manage that for a pound."*
>
> (Excerpt from interview with Daniel)

Daniel also states how "…*like I say it does bring down the numbers of drug-related deaths and the numbers of blood born viruses"* which also highlights the benefits of MPPs from a professional perspective.

Reducing harm to live a functional and stable life is possible using MPPs, as Gary shows:

> *"And he's still on a methadone prescription, but that's okay, because he's got structure and order in his life. And I think he's still looking at reducing, but he's in no rush for a detox, he's in no rush to come off it completely, he's just - he's quite happy being stable. It's the first time he's been stable in 35 years."*
>
> (Excerpt from interview with Gary)

This shows that MPPs can be successful for the recovery of heroin or other opiate dependency by reducing harm. However, if wishing to adopt an abstinent approach to MPP, then this example does not constitute recovery, but from a perspective of reducing drug/heroin use then the service user has built a recovery capital for themselves and is able to live a seemingly 'normal' life.

Abstinence requires great commitment, and the main motivation of the service user needs to be to detox from heroin/drug use. Nigel's next quote illustrates that the motive of the service user determines whether methadone prescription can be successful in recovery, especially for abstinence:

> *"If an individual with a heroin problem wants to stop using heroin, and wants to stop, get out of that life, the dealers, the crime, you know, they want to get out of that environment, I think methadone is - it serves its purpose well for someone who's serious, who's, who's actually serious about getting clean."*
>
> (Excerpt from interview with Nigel)

The example above illustrates a motivation for treatment being to live a crime free life.

MPPs serve three key purposes. One is for somebody to have a substitute for illicit heroin so they can move forward from heroin use and the lifestyle they may have lived. Secondly, if somebody committed crime to fund their heroin dependency, then MPPs prevent withdrawal symptoms if they want to move away from criminal activity. Thirdly, if they still want to continue their criminal and heroin induced lifestyle, then MPPs still prevents withdrawal symptoms that can enable somebody to commit crime to fund their further heroin use. Therefore, if somebody is aiming to move away from heroin, and the criminal activity to fund it then MPPs are successful. However, due to the stability and ability to function that MPP provides, this can also assist somebody to continue their criminal activity if they are not ready

to prevent illicit heroin use, and this is when MPPs are problematic. Nevertheless, this is down to the individual and their motivations.

Methadone prescription programmes are not effective for abstinence

The right side of the diagram shows the abstinence aspect to recovery, and illustrates that methadone is not *always* effective in aiding this part of recovery. It does work for the minority - participants agreed that most of the time methadone does not work unless the person misusing substances is 100% committed. This may be because prescriptions are prescribed at too high a dose, are prescribed for too long and service users are still physically able to use heroin or other opiates alongside their prescription due to the full agonist within the medication.

High prescriptions and staying on too long

To exemplify these claims, the following are quotes from Samuel and Daniel:

> *"I think that there is a lot of people who are put on high methadone scripts and it's not reduced very quickly."*
>
> (Excerpt from interview with Samuel)

Daniel talks about people topping up their methadone prescription with heroin, and the way services approached the topic of dosages:

> *"Umm, I can remember it used to be - it used to be the standard first question from the prescribing consultant do you need your methadone to go up, to the extent where – and he - now his question is, are you stable so can we look to reduce it down, because even he's realised that, you know, that this isn't working for people, because it was this idea that, umm, if you're using – it's sub therapeutic, but for it to become therapeutic you need to stop using but all that had happened was they'd up it ten mils; people are still using gear on the top because gear isn't methadone, methadone isn't gear."*
>
> (Excerpt from interview with Daniel)

He demonstrates this by stating that one individual was on "*like two hundred and fifty mils, per day; do you know what I mean, that's a massive, massive amount."* and stating that "*I mean it wasn't uncommon once upon a time in this area for people to be on a hundred mils plus, you know, which is a whacking dose, a therapeutic dose is about thirty, forty mils; the vast majority have come down now again."*

Another observation made was that service users are on methadone for too long a period:

> *"...people just get parked on it and, you know, umm, we've had examples of guys who might only have used heroin for sort of three or four years but have still been sat on a prescribing script for sort of five or ten years afterwards, umm, and that's quite*

common, sort of not just in this area but sort of throughout the UK and, err, throughout Europe as well."

(Excerpt from interview with Daniel)

"Umm, so you can get a lot of people who go on methadone for like six weeks, end up on methadone for 40 years. It's - it doesn't tend to be a short-term solution; it tends to be mid-term at best. I don't think I know anybody that's gone on methadone for short-term."

(Excerpt from interview with Gary)

Samuel agrees here, stating that he has been working in this industry for ten years and "*I honestly can't think of anybody in that time who I've seen come off methadone. And all I know is that they'll reduce by two milligrams every now and again and it's just kind of okay."*

These are the perceptions of third sector service providers (seemingly with an abstinent focus), but if the service user perceives themselves to be in recovery by reducing their drug/heroin use and their motive *is not* to become abstinent, this could then be interpreted that MPPs *are* working in preventing criminal activity and illicit drug use, but they are not successful for people who want to become abstinent.

Methadone is harder to detox from than heroin

Gary continues, stating that methadone is harder to detox from than heroin:

"Umm, and the way most people come off of a methadone prescription, if they're not detoxed in a proper detox unit or through like a community detox programme, if they just decide that they don't want to take methadone anymore, they'll often cold turkey off the methadone, go back on heroin for a little bit and wean off. It's something that happens. But you, you won't hear that much in services because you'll hear that at peer support meetings."

(Excerpt from interview with Gary)

Samuel states that "*methadone is so addictive",* with further quotes from Daniel, William and Gary exemplifying the issue that methadone takes longer to withdraw from:

"…the simple fact of the matter is you can do a heroin detox in sort of four or five days; you can do a methadone detox it takes four or five weeks."

(Excerpt from interview with Daniel)

"…umm, in terms of methadone, it's really hard to get off. Heroin, you can fully withdraw from heroin in five to six days, be out of your system. Very intense, you're going to go through it. Methadone's three to four weeks. That's the challenge, you know."

(Excerpt from interview with William)

"Because the side effects of coming off methadone is actually much more difficult. You've got to; you've got to come off it much, much, much slower. It takes a longer time to come off methadone than it does off heroin, which [laughs]."

(Excerpt from interview with Gary)

Gary believes that if somebody is already functioning well and their life is relatively stable, then they should not be prescribed methadone straight away:

"…they seem to be really quick at prescribing methadone. So say if somebody's got a heroin addiction but they're working, they're doing okay, they're reasonably stable anyway, even with using street drugs, instead of putting them on methadone which is actually more difficult to come off than just street heroin is, where the advice could be given, use a little bit less each day until you're no longer ill, that could be given and then they're not stuck with a methadone habit which is harder to quit than heroin."

(Excerpt from interview with Gary)

Participants reported that service users can still use illicit heroin or other opioids to top up their methadone prescription, as Daniel stated: "*One we know chooses to stay on methadone, umm, because it leaves the door open to him for using in the sort of future should he decide to.".* This is where Subutex/buprenorphine is seen as preferable to methadone by participants. They felt that due to the partial agonist, either sickness is experienced, or no 'high' affect is caused if illicit heroin or opiates are used, therefore it is believed by the participants to be more beneficial for somebody who is seeking abstinence.

Daniel, William, and Samuel all agree that Subutex is more effective than methadone. William is quoted in both extracts below:

"*I'm not a great supporter of it [methadone] to be honest with you. I, umm, I think I, I think Subutex is better."*

(Excerpt from interview with William)

"Umm, from what I see, from what I hear, from what people tell me, from what I experience, is that, umm, Subutex is more beneficial than methadone."

(Excerpt from interview with William)

In terms of methadone or Subutex, Daniel agreed with the preference of prescribing Subutex, stating:

"…basically, all it [methadone] is, is it's a safety net for people. It doesn't – all it does is it meets a physical opiate dependency, but it doesn't give them the same buzz that heroin gives them; it's not the same effect. Umm, it's a slow release, slow acted opiate, so it's completely different, umm, whereas with sort of Subutex, umm, or Suboxone specifically, you get that opiate blocker in there. Umm, so it's always a good indicator

> *for us really if people are coming to us if they're on methadone or they're on Subutex, if they're on Subutex we know that there's a much better chance of them staying clean and maintaining, err, maintaining abstinence from heroin and also as well it's a much easier drug to detox from, err, than sort of methadone."*
>
> (Excerpt from interview with Daniel)

Daniel believes there should be a change towards prescribing Subutex instead of methadone due to the opiate blocker as it shows commitment to abstinence if service users are on Subutex. Samuel agrees with the benefits of the opiate blocker, stating, "*I would say yeah, with a blocker. Umm, just because there's no need to top up as such",* as methadone does not block the euphoric "*high*" effect of additional illicit heroin use, whereas Subutex does, and has been more successful in his experience, although he states "….*but then again it goes down to the service user actually, using their medication and actually wanting to move forward as well."* William also pointed out that he believes; "*I think, umm, I think abstinence is the best way to deal with heroin*". On the other hand, Nigel believes; "*I doubt whether she could - she or a lot of other heroin addicts could come off heroin without the use of methadone*". William says that "*government wanted most people off methadone and put onto Suboxone because Suboxone at the time or Subutex it was called, umm, had an antagonist in it where if you'd used heroin you'd become poorly, or the heroin wouldn't work".* Gary also expressed how Subutex can be used illicitly by "*...you can break the time delay on it is not always fantastic. So, I hear quite a lot about Subutex being bought and sold and because when you crush them up you wreck the time delay".*

Services were also reported to be overburdened and facing funding problems.

Part one summary

In summary, findings suggest that sustainable abstinence using a methadone prescription is possible after building recovery capital and with a commitment to change. They need to be committed to change and sustainable recovery, because somebody who is only on a methadone prescription to prevent withdrawal symptoms does not have the motivation for recovery and is not using methadone as intended.

MPPs *can* be successful in recovery from heroin dependence to reduce harm and abstinence, but it depends on the perception of recovery, the commitment to that approach and the level of recovery capital.

The impact of recovery capital, barriers to recovery and role of integrated care

Figure 3.2 Challenges to current treatment

The above image are key terms from interviews which relate to common challenges when supporting adults aged 18 and over, who are referred to substance misuse services. Engagement was a key theme and as a result is more prominent in the image, other sizing is not specific, nor the colour has no specific indication:

> *"…and that recovery capital is there as well in terms of, you know, family support, friends and integration into the community; I think that's all important and you know, it does happen but, umm, it is difficult as well."*
>
> (Excerpt from interview with Polly)

Engagement is the most common challenge when contacting service users, arranging and attending appointments. This relates to recovery capital. It is important to highlight that good relationships with staff and professionals are essential. The importance of staff and professionals developing and maintaining trust and rapport with service users cannot be overstated when aiming to support service users on their journey to recovery. Building trust is fundamental and applies to all aspects of recovery.

Interview findings suggests that treatment for heroin or other opiate dependency is intended for service users who have some measure of recovery capital, i.e. an address (physical capital), a telephone/mobile phone (physical capital), and organisation and communication skills to make and attend appointments (human capital), and the ability to then *engage* with the services (human capital), and the availability of services in the area (community and cultural capital).

People that are experiencing problems engaging as a direct result of their dependency (such as homelessness, or who are living complex lives due to heroin use, where they lack the skills needed to function in everyday life), are likely not successful in their recovery because communication between service providers and service users is limited or non-existent and this is a barrier to recovery. Assessment of Recovery Capital (ARC) was not directly referred to in the interviews, however Polly did acknowledge the term, recovery capital, as illustrated in the excerpt above (*page 86*).

Excerpts from the interviews with Polly and Gary portray the unique complexities of heroin dependency and the vulnerabilities of service users:

> *"Umm, but with, umm, heroin you see more, umm, vulnerable people really, umm, that have experienced difficult times or, umm, adverse experiences in their childhood or, umm, adult life so that you'd see them more vulnerable and maybe see that it's more difficult for them to recover, umm, you know."*
>
> (Excerpt from interview with Polly)

> "*And also, the people who are in that very vulnerable client group specifically, they just feel like the worlds against them, it doesn't matter, they don't matter and it's difficult for them to get - take an active part in their own treatment, to engage properly, because they already feel disempowered."*
>
> (Excerpt from interview with Gary)

Participants illustrate that recovery capital is significant in achieving and sustaining recovery from heroin dependency. If someone has gone through professional treatment, then it is the role of substance misuse services and the key worker to help build recovery capital for people who issue substances, as Daniel states:

> *"A lot of these guys are sort of – it kind of almost feels they've missed the boat a little bit really and, and sort of aren't equipped physically or, or sort of mentally or emotionally to, to go through the recovery process, even though recovery is in theory something that everybody is capable of."*
>
> (Excerpt from interview with Daniel)

The development of recovery capital should be service user led. Gary states how involving the service user in their recovery treatment plan helps them feel empowered and valued:

> *"It can change them and how they think about their own treatment. And once you've got somebody taking an active interest in their own treatment then they'll care, and they'll apply themselves to it more effectively. And it's not their fault that they're disempowered. But as soon as you empower them you start seeing a real difference."*
>
> (Excerpt from interview with Gary)

It is a joint process between the service user and their keyworker.

The following ROISCs (2013) five fundamental principles of recovery capital, will be applied to the interview findings to these categories to determine the challenges to recovery.

- Social networks (peer support)
- Physical (money and somewhere to live)
- Human (skills, health, employment)
- Cultural (values and beliefs)
- Community issues (availability / quality of services)

Social networks

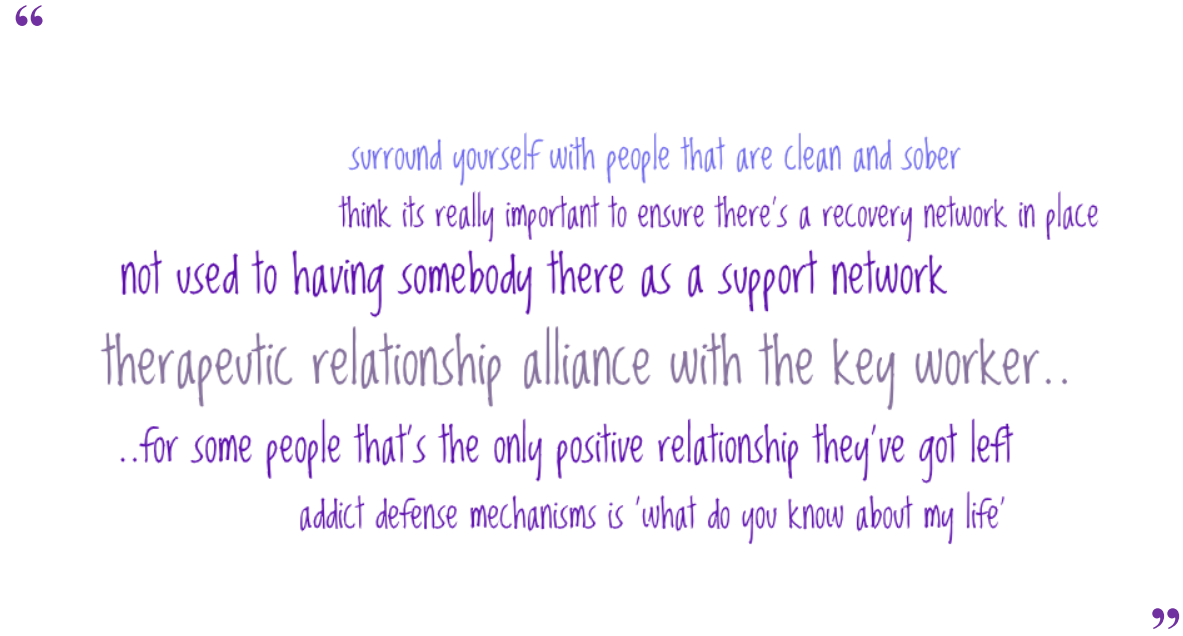


Figure 3.3 Social network interview quotations

(Excerpts from interviews with Daniel, Polly and Samuel)

A positive support network (depending on the nature of the relationship) is important in developing and maintaining social recovery capital, and typically includes keyworkers and peers also in recovery.

Daniel demonstrates the study region has key workers that develop relationships with service users. However, William puts forward that often the key workers do not have the level of understanding needed for supporting those with heroin or other opiate dependencies. Daniel's quotation illustrates the positive aspect of having a good relationship with the keyworker:

> *"…they have that sort of therapeutic relationship alliance with the key worker that they see maybe once a fortnight or something like that; for some people that's the only positive relationship they've got left."*
>
> (Excerpt from interview with Daniel)

Gary's quote below demonstrates the importance of having supportive people around service users, as some have been feeling alone for some time and it is difficult to adapt to support:

> *"And not used to having somebody there as a support network."*
>
> (Excerpt from interview with Gary)

Polly highlights the importance of a support network in place, stating *"I think it's really important to ensure there's a recovery network in place and that recovery capital is there as well in terms of, you know, family support, friends and integration into the community; I think that's all important and you know, it does happen but, umm, it is difficult as well."*

The experiences previously shared by Daniel and Nigel are also relevant here as Daniel describes recovery as being achieved through being around people who are "*clean and sober*", surrounding themselves with likeminded people.

Nigel and Gary discuss adapting social groups to support recovery, as Gary elaborates regarding a service user he was supporting, "*he used to hang round in a cohort of like 26 people and he's one person who's doing all right – in fact, he's doing wonderful."* Daniel continues to say that a recovery setting is much more comfortable in comparison to 'normal' friends and family, because people in recovery cope differently and talk about different things, and people outside of recovery do not understand their experiences in the same way.

Peer support is related to social capital but also community capital because of the available opportunities within the community:

> *"you've got to have something that they can connect to and refer to, because otherwise like I say it just, umm, err, it's an easy cop out for an addict, what do you know about my life, and that's – I think it's one of the sort of things that happens like when people come in here, they think that nobody knows how they feel, they think that nobody's experienced what they've experienced."*
>
> (Excerpt from interview with Daniel)

Peer support helps the service user to engage with a relatable role model, and converse with someone who has experienced similar difficulties. Daniel explains that people who are in recovery themselves have "*a whole skill set"* needed for recovery that "*individuals who aren't*

in recovery don't have." Daniel states that people in recovery themselves have awareness, compassion and empathy that is important: "…*addict defence mechanisms is what do you know about my life. You don't know what I'm experiencing; you don't know what I've been through".*

Nigel reports that offering peer support can help individuals stay in recovery themselves by feeling they have something to offer which is invaluable, "*And for somebody who's spent most of his life either drunk or drugged up, to suddenly feel like they've got something to offer, is quite - it's quite huge, you know. It's a big thing you know.*" Nigel emphasizes that it can offer hope for the service user, as well as embracing the feeling of having something to offer for the service provider:

> *"…they're being dealt with by somebody who's been where they are, you know, I think that's, that's a huge incentive, and, umm, I think it's a huge incentive. It can work. There is, there is hope. Because at the end of the day a lot of addicts, they've lost hope, you know. They've just lost it, you know, so I think to be able to offer some hope is just absolutely lifesaving."*
>
> (Excerpt from interview with Nigel)

Physical Capital

There is an issue with travelling to essential services such as the pharmacy or chemist, and to see the key worker, travel can present challenges in rural areas alongside the expense of traveling:

> *"I see it's very difficult because of the rurality, so for example, umm, an individual wanting supervision, various supervision, they'd have to travel, umm, to a local, umm, you know, GP surgery chemist or, umm, to see the key worker and, you know, one, the travelling is appalling anyway, you know, there's no good bus service, umm, there might be just one bus in the day, umm, and to travel to and from the, umm, you know, from appointments is a nightmare, as well as the cost as well if they want to do daily supervision, you know, they'd have to travel daily."*
>
> (Excerpt from interview with Polly)

If an individual is able to seek treatment and support, they may face additional barriers of access through limited public transport in rural communities. Samuel, believes that living in rural areas makes it more difficult to attend aftercare services, which prevents achievable and sustainable recovery, and that more intervention and support is needed in these rural areas.

In terms of cost, financial support towards bus tickets can be applied for, but not all bus services offer this option, according to Polly. She continues to say that rural communities still have the issue of cost because bus services are run by smaller companies that do not provide this bus

ticket support service, so the cost would have to be covered by the service user. Polly suggests that this can create dependency issues when the cost and skills needed to access a bus ticket are taken care of for them, because it creates a reliance on the service to get the bus ticket, instead of developing independence. However, as Polly says, it does help service users at the beginning to improve service engagement and to build a relationship.

Human Capital

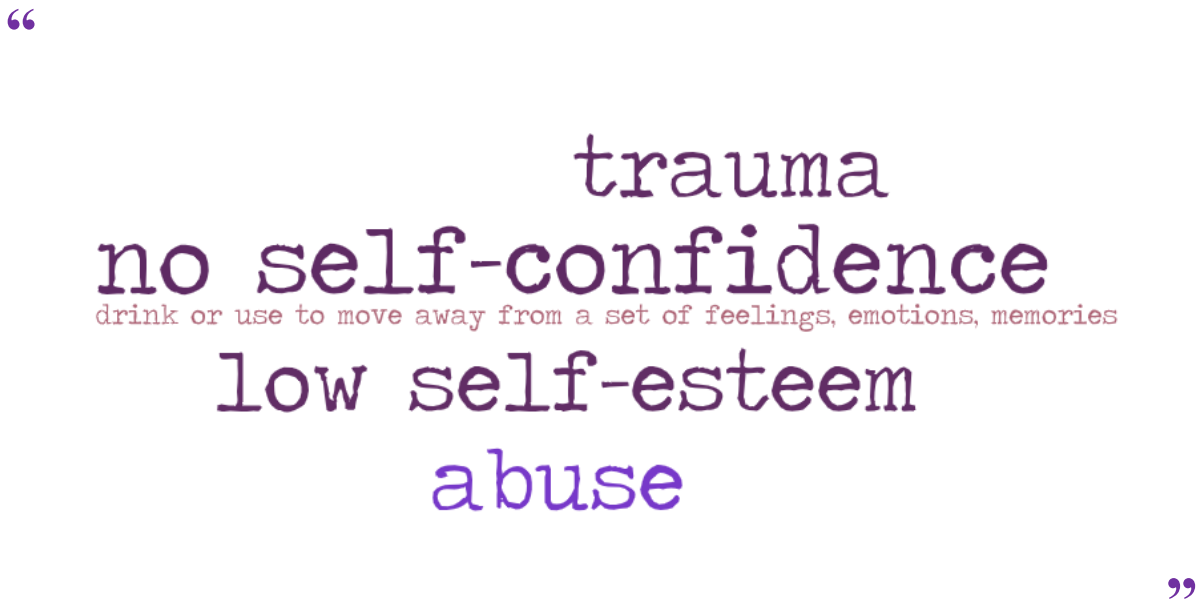


Figure 3.4 Human capital quotations

(Excerpts from interviews with Daniel and Nigel)

The above are quotes Daniel and Nigel, who state that often service users have negative feelings and beliefs about themselves that should be addressed to restore and build confidence. Negative personal experiences need to be addressed to learn to deal with emotions and feelings, as Daniel says; *"...whether it be abuse, trauma, low self-esteem, no self-confidence"* there are similarities to others:

> *"You know, they tend to have low self-esteem. Even when they're in recovery they can, they can have low self-esteem."*
>
> (Excerpt from interview with Nigel)

Eliciting service users' experiences and perception is important and requires active listening and empathy:

> *"…they very often have this feeling that, I don't matter, the views I have don't matter, why are you speaking to me anyway. And they've got such a low opinion of themselves and their opinions that it can actually be quite difficult to get the information out of them. Umm, and the way around that is just supporting them and making sure that they feel valued."*
>
> (Excerpt from interview with Gary)

Gary continued to say that attitudes from some staff members also disempower service users and negatively reinforce the way the service user feels about themselves. However, he states that it is becoming rarer to come across staff that believe "*it doesn't matter what they [service user] say*". The power being listened to has on a service user is invaluable, as Nigel states *"…I mean a great, a great organisation, just because they're listening."* Listening is also a tool that Gary refers to, when bad practice is reported, it is important to listen to what is being said. This simple act contributes towards the development of trusting relationship which are the basis for working together towards building service users' recovery capital and addressing barriers to recovery.

Psychosocial interventions are also very important to help achieve human recovery capital, to help build self-esteem and confidence, and talking therapies to understand and deal with experiences leading up to substance misuse are an example of those interventions. However, as discussed earlier in this chapter, some services are not addressing the psychological causes of heroin and other opiate dependencies, which makes the chances of returning to heroin/drug use higher if they have not addressed the root cause. As Daniel states below, service users are just "*white knuckle sober"* unless feelings, emotions and past experiences are dealt with, and alternative coping mechanisms are developed:

> *"Umm, I think for a lot of the, a lot of the opiate users it's such, umm, it's such an effort to abstain from heroin use that when they do that they think they've cracked it, and they think that, that's enough, but we know that nine times out of ten, and that's to super generalise it, for the majority of people we drink or we use to move away from a set of feelings, emotions, memories, umm, things like that, and without developing those, err, alternative coping mechanisms, quite often, umm, you're just sort of white-knuckle sober and waiting for a disaster to happen and if that doesn't, if the only thing you've changed is that you've stopped using, then nine times out of then you're going to pick up again, and you're going to use."*
>
> (Excerpt from interview with Daniel)

Service users need to develop coping mechanisms that will replace drug taking and a support network. Nigel highlighted the need for psychological causes of substance misuse to be addressed, and how appropriate social networks are essential to building and maintaining social capital. Examples of challenges are boredom, filling a void, feeling physically uncomfortable working through habits, and facing the fear of change. Positive coping mechanisms need to be developed and changes to social life being made. This is echoed by Daniel who states:

> "*You need to develop a positive social network; you need to develop coping mechanisms…"*
>
> (Excerpt from interview with Daniel)

Daniel clarifies that building a social group that is not substance misuse focused and includes individuals that support people to deal with their emotions and thoughts without drink or drugs is essential. A social group can encourage recovery and support decisions for positive well-being.

Daniel delved deeper discussing coping mechanisms directly, saying that it is important to learn to cope with life through dealing with feelings and understanding yourself better, rather than masking the feelings with substances. This adds another layer of negative feelings such as guilt and shame. He compared illicit drug misuse to the general population turning to alcohol to deal with emotions.

Community capital

Community capital are the structural resources available, and issues experienced by a service user in their local area such as housing, transport and also issues experiencing stigma. Granfield and Cloud (2001) and The Welsh Government (2013) define community capital as availability and quality of services.

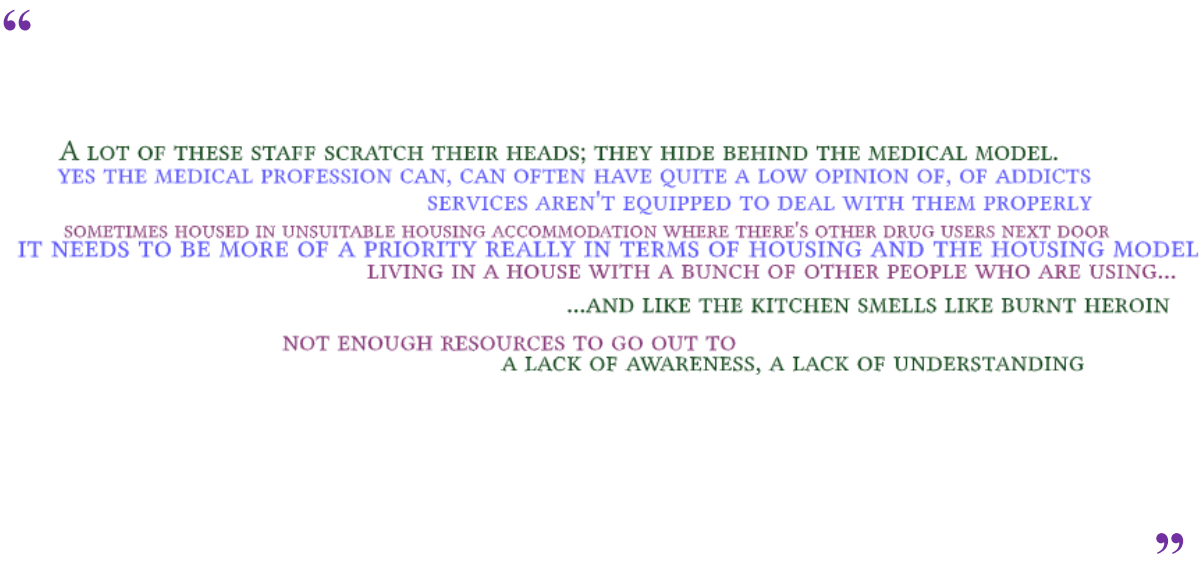


Figure 3.5 Community capital interview quotations

(Excerpt from William, Nigel, Samuel, Polly, Gary and Daniel)

A lack of resources (housing, transportation, and staff numbers) and funding affect the substance misuse services, which ultimately affects the service user's experience. It makes working difficult because of understaffing, funding cuts and overstretched services. Samuel states that services being under resourced is a problem in this specific region; "*However, I understand that lots of services are overrun and struggling, so it's trying to actually get perceptions that their needs are there, however, services aren't equipped to deal with them properly, if that makes sense".* He continues, stating that services are dealing with a high caseload, which detracts from successfully addressing the underlying causes of the substance misuse:

> *"Umm, for instance I know substance misuse would see a client for like five or ten minutes, where I don't think personally, I don't think that's enough because the substance misuse might be their lead kind of need, and they'll get a prescription and then just go because that's what they need. However, I think they need more of an intervention than that, but I understand that services for substance misuse are struggling because they've got such a high caseload."*

(Excerpt from interview with Samuel)

William discusses the time pressures facing the service, stating:

> *"It's a heavily overpopulated, under resourced with staff and the service less and less. You're on a conveyor belt. You see them once a month, you're in the waiting room,*

you go in, you see the scrip, you piss in a bottle for, for the drug test and you walk out with your script and you see them next month.

(Excerpt from interview with William)

Gary talked about his own service suffering from funding cuts, but also the difficulties the third sector and substance misuse services face when cuts need to be made:

"I think we had a 15% cut in three years and a lot of services got cut, because there's some places you can't make a cut in, so the third sector got hit quite hard, substance misuse got hit quite hard. And it forced a lot of companies, organisations, to think differently about what they're going to do and how they're going to do it."

(Excerpt from interview with Gary)

Gary continued to state that: "*the health service ones they find it very difficult because they're stretched. That's a problem. They're just really, really stretched.*

Daniel disclosed that long waiting lists are an issue in the study region:

"A lot of the referrals that come through that clogs up the waiting list, you can have maybe sort of two hundred people waiting to be assigned a key worker and it's like a one in, one out basis at the moment; sixty or seventy of them people might not need – you know, they haven't got dependency issues so, you know, all they need is access to stuff like AA, NA, peer support from here and all the psychosocial groups that we do; that can be enough for, for a lot of people…"

(Excerpt from interview with Daniel)

Gary gives an example of current practice "*...you come off heroin and go on methadone and then you come off methadone either through a detox or through a rehab*". However, for people who use heroin who find it difficult to engage with current service models, it may be more beneficial to withdraw from heroin through Tier 4 residential or inpatient rehab rather than Tier 3 within the community.

Rehabilitation centres are also encouraged by William, but he points to challenges in terms of access down the line due to privatisation:

"Oh, I encourage people to get rehab now if they want rehab. Because it is being privatised. The only people getting into rehab in ten or fifteen years will be people who've got a rich mum. People on council estates will not be able to get rehab."

(Excerpt from interview with William)

Polly highlights challenges with location:

> *"…those wanting to, you know, go to detox and rehab, umm, it can be really difficult because there's one in [place] which is too close to a lot of individuals because they're still in their community where they can access, umm, individuals through use or whatever, umm, but others, umm, other rehabs are too far and I think that's a barrier because, you know, they still want contact with their families, umm, contact on weekends or they want to be closer to home, not travelling, you know, as far as [place] or, umm, you know, travelling four to five hours; it's really too far, umm, and really difficult for individuals to think of, umm, and they feel so vulnerable anyway, so that's a barrier definitely*."

(Excerpt from interview with Polly)

Accessing services: arranging and attending appointments

The following section is linked with human capital and physical capital, however presented under community capital as accessing services reflects the lack of availability and varying quality of services in the area, whilst also illustrating that human capital is needed to begin the recovery journey.

The sometimes challenging lives of service users can make the arrangements of appointments, *and the whole concept of an appointment*, difficult for some to adhere to. Polly gives an example that if you've been referred to a service, a letter will be sent out, asking you to contact the service to make an appointment. However, this isn't sometimes possible because of complex lifestyles such as having no fixed address or struggling to organise yourself:

> *"…with health, you know, they're starting to send letters out, umm, that you've, umm, self-referred or you've been referred onto a service and if you need an appointment to contact and you know, sometimes you're not in a place or a position to make arrangements to keep those appointments and to turn up, so getting, you know, to a point that you can get better and recover can be very difficult if you're in a chaotic place in your life."*

(Excerpt from interview with Polly)

These issues are echoed by Gary, William and Polly.

Being "*street homeless"*, as some clients of the interviewees are, means that they often have no concept of time. This increases difficulties when using this system of sending letters, Gary gives an example of this:

> *"…the really vulnerable groups, they don't have work, they set their calendar by when the giro goes in. So, they've got one important moment of any week, it's when the money hits the bank. The rest of the time it can be any day, any time. So, if you ask them to come for structured support and you say right, every Tuesday at half past nine, turn up.*

They probably won't, because they don't know what day it is, they've been sleeping rough, they get trapped up in whatever chaos they're trapped up in."

(Excerpt from interview with Gary)

William discussed the problem of drug use to keep warm when sleeping in doorways (which can also take away the concept of time, apart from when it is sunrise), arguing that; *"They don't know what day it is but we are expecting them to meet appointments".*

Service users are often described as uncontactable due to losing or selling their mobile phones, by Polly, William and Gary:

"Some of them don't have phones or any way of contacting and it's just very, very difficult on this level of unstructured chaos to access anything at all. They've got a lot of challenges, from everywhere."

(Excerpt from interview with Gary)

This makes sending reminder messages and phone calls to the service users difficult due to not having a mobile or changing numbers. Polly also stated that resources are tight and not enough staff available, "*not enough capacity with staff either",* and also:

"there's no – not enough resources to go out to, umm, to individuals all the time, so you have to, umm, you know, get them to come to an appointment as well, so it can be very difficult, as you can imagine"

(Excerpt from interview with Polly)

Polly shared that "*It could be easier for service users to get the information and get the support but how; I don't know",* but as Gary suggested, structured support is not realistic.

Experiencing low confidence and feeling disempowered (as mentioned earlier) has a negative impact on engagement:

"Well as I've said right there, I think a lot of it is, you know, being in a position where you can be confident and organised enough to attend the appointments and feel that you can, you know, it's so difficult to engage with new people you don't know and built a relationship…"

(Excerpt from interview with Polly)

"And also, the people who are in that very vulnerable client group specifically, they just feel like the worlds against them, it doesn't matter, they don't matter and it's difficult for them to get - take an active part in their own treatment, to engage properly, because they already feel disempowered."

(Excerpt from interview with Gary)

Stigma

Stigma is experienced by people who misuse substances whatever level of capital held, and can be experienced from accessing substance misuse services, and judgements made of the 'type' of people that are using the service:

> *"…a lot, a lot of people don't want to go to services in the first place because of stigma attached to them and they're the people who are so vulnerable, who don't want to go to these areas because they have an idea of what the client group going there will be. So, it stops their access to services and getting the help that they need."*
>
> (Excerpt from interview with Gary)

All participants agreed that substance misuse and dependency can happen to *any* type of person. Whilst Gary outlined that certain characteristics, behaviours and appearances are often associated with addiction, the majority are 'normal' people:

> *"All kinds. Umm, before - a few years ago I had this very definitive idea of what an addict looked like, or what somebody with mental health problems looked like and I was wrong. It's anyone."*
>
> (Excerpt from interview with Gary)

Daniel and Gary have seen high powered businesspeople misuse substances, and Daniel specifically mentioned middle-class housewives and well-paid professionals. However, most are from working-class backgrounds and as Gary and William stated, homeless people.

Culture and attitudes within mainstream services

Participants discuss a lack of understanding amongst services providers of what "*addicts*" need. William discussed how services have the best intentions but there is a severe lack of understanding of the different type of "*addicts*". It is assumed that people with dependency issues are vulnerable and struggling to function day-to-day, consumed by the dependency.

Gary and Nigel state how people in the medical profession can have a negative opinion of people with an "*addiction"*. Gary exemplifies how patients with a substance misuse problem can be ignored during treatments with GPs for believed to be unrelated issues stating "*It's very difficult for them to get the GP to take their health condition seriously because the GP will automatically go, well you use drugs*." Nigel believes that services need to be more understanding:

> *"Umm, and yes the medical profession can, can often have quite a low opinion of, of addicts because when - especially using addicts because people who, who are still*

actively in addiction, they don't, they don't make for, for the best, umm, examples of human behaviour, you know."

(Excerpt from interview with Nigel)

Negative attitudes towards service users and recovery have also been identified by Gary and Daniel. Gary specifically is discussing attitudes within management:

***"**When you find a patch of bad attitude it's usually - often, often it's a management issue. Umm, so even if frontline workers don't believe that, they've worked in the culture for long enough that that is, is a truth. And just by questioning it you're, you're getting around the barrier, umm, by just chipping away and doing a bit here and a bit there, they start seeing the real value of what you're doing. And it's just through time, perseverance, assistance and stubborn determination, three-quarters of the time [laughs]."*

(Excerpt from interview with Gary)

Daniel discussed management also, stating the effect a change in management can have on a service:

"…when we've had those managers move on, the people that have come in after them, umm, have sort of – have lacked the courage or the conviction or lacked the awareness and recovery orientation because, because like I say because health is focused so much around the actual physical act of drinking or using, recovery is a psychosocial process; they don't have an understanding of that so there's a lack of ignorance – there's an ignorance, a lack of awareness, a lack of understanding, a lack of knowledge, so they just focus upon the bits that, that they're sort of good at and, and rather than sort of trying to incorporate and embrace it."

(Excerpt from interview with Daniel)

The above quotations indicate that there is limited awareness or differences in perception amongst some managers of the complexities of heroin dependency and recovery. William and Daniel felt strongly that the recovery agenda is overlooked in treatment, and many professionals are focusing too much on reducing drug/heroin use and not on equally on abstinence and the overall well-being of service users.

Participants agreed that recovery is considered differently by different professional groups. As Daniel says, "…*Yeah there will be things that will be unique within your addiction, in the same way as there will be within your recovery…"* There is no set milestone that is agreed upon by medical professionals, third sector, society or service users themselves as opinions differ across the board. Service users would even differ in their personal recovery.

Daniel, who equates recovery with abstinence, states that treatments are geared up towards reducing harm, stating that:

> *"…service delivery is all geared up towards people that are actively using. Umm, the focus is all very much still around harm reduction, umm, even though we should have been moving more towards a recovery model, err, and a recovery agenda. It's still very much geared up towards harm reduction, especially for those that are on, umm, opi – you know, opiate prescribing."*
>
> (Excerpt from interview with Daniel)

Daniel is stating that for people who want to be abstinent, this approach is not working because the services are too focused on reducing harm, rather than abstinence.

Another example of Daniel's understanding of the recovery model is the quote below:

> *"I also think as well that we're at a point where because the recovery agenda is becoming more, err, more prevalent, umm, there's a push now or there's the desire to look at detoxing sort of – and getting people clean, umm, but I actually think that we're detoxing the wrong sort of type of people; I think that for some guys that have been on, umm, heroin or methadone for fifteen, twenty years, the chances of them being able to detox, err, achieve abstinence and maintain abstinence, err, is very slim."*
>
> (Excerpt from interview with Daniel)

William argues that health services tend to focus on the medical model and lack the recognition of wider social issues:

> *"So, in terms of service delivery, umm, I think there's still a lack of understanding why people, umm - we're dealing with a - the UK utilises the medical model of harm reduction. It's great at stopping people from getting worse, there's not much scope in it to get people better. A lot of these staff scratch their heads; they hide behind the medical model."*
>
> (Excerpt from interview with William)

William discusses the psychosocial and emotional aspects of using heroin and believes that the current system does not pay much attention to that but focuses on the physicality of using drugs. This also ties in with other comments about people are being pushed into detoxing. Overall, consensus is that when a push for abstinence is made, without treating the emotional and mental aspects of the dependency/addiction, then return to drug use is more likely. Daniel and William elaborate how recovery is not understood in services, stating that:

> *"They look at me like I've got two heads when I'm talking about recovery. Recovery is still a blasphemous word in some parts of drug services. Sadly."*
>
> (Excerpt from interview with William)

> *"And I think there's also been a feeling amongst, umm, certain treatment services that this was just another fad; it was another phase and that things would go and that we'd be back to doing what we've always done within a sort of period of time really."*
>
> (Excerpt from interview with Daniel)

Daniel thinks that because there has been limited aftercare after detoxing people have "*got stuck on treatment for so long*", and because the psychosocial aspects have not been dealt with, that is when people are more at risk of relapse and overdose:

> *"It's ironic but when you're clean that's when you're at your greatest risk of sort of going home and dying."*
>
> (Excerpt from interview with Daniel)

Daniel shares that he thinks services are focused on harm reduction intentionally to ensure funding because substance misuse and recovery is an industry, "*…because it's all – you know, let's be honest, it's an industry, there's money, err, at play, commissioning and jobs and everything that goes behind, and quite often it can be a bit of a pissing competition between agencies".*

> *"umm, it's – there's no money in recovery, umm, it's all sort of, it's all sort of, it's all top loaded, umm, towards treatment and towards, umm, individuals who're still actively drinking and still actively using, umm, and that's one of the, umm, I think the big issues".*
>
> (Excerpt from interview with Daniel)

Services focus on a reducing drug/heroin use, and do not approach abstinence effectively. When they do, they are encouraging detox to service users who are not psychosocially equipped, which increases the risk of returning to drug use and overdose (as Daniel describes above with detoxing the "*wrong people"* and being at a higher risk of dying from overdose). Subsequently they are not addressing the root cause(s) of the dependency through psychosocial interventions and focusing too much on the physical dependency to heroin or other opiates.

Methadone is found to be effective in reducing harm, but Subutex is effective in pursuing abstinence. Like methadone, Subutex on its own will not work, as psychosocial causes also need to be addressed. In the study region, methadone is rarely successful in achieving abstinence due to possible continuation of illicit heroin or other opiate use, long withdrawal process, service funding cuts, lack of staff and a lack of understanding within services of the individuals they support and of recovery itself.

Accommodation

Similar to above, this section has been presented under community capital even though it is strongly related to physical capital. Having somewhere to live is a main component of physical capital. However, the lack of availability in the study area was one of the main issues.

Access to suitable housing was reported to be a challenging issue in the study area. This includes allocated accommodation where drug use is prevalent in the neighbourhood, or within the same house:

> *"It's very difficult for somebody to be in long term committed recovery when they're living in a house with a bunch of other people who are using, chaotic and like the kitchen smells like burnt heroin."*
>
> (Excerpt from interview with Gary)

> *"…cause I think one of the other issues is housing, you know, once you've been in a detox and they have, umm, they're sometimes housed in unsuitable housing accommodation where there's other drug users next door or, umm, you know, that are not in recovery so that means that they relapse quite easily because it's just around them, you know."*
>
> (Excerpt from interview with Polly)

One participant illustrated the importance of suitable accommodation, and the improvements in one person's recovery because of their surroundings:

> *"…he moved from a living condition which was very poor, he got a little one-bedroom flat, much better. So, he wasn't living in a shared house with a bunch of other people who were all chaotic, he had his own little private one-bedroom flat, so he wasn't immersed in it."*
>
> (Excerpt from interview with Gary)

He continued to explain the changes in this service user:

> *"And then because he had this one-bedroom flat and he wasn't immersed in it, he then started volunteering at some of the services that he'd been accessing because he was a success story and he wanted to give back to the people that helped him, and it was quite a long process, but he had it in him, and he was ready, and he did it."*
>
> (Excerpt from interview with Gary)

Gary shows here that a starting point such as being placed in suitable housing, means that the service user can build their recovery capital and find a purpose for himself where he volunteered for a service he had once used. 'Giving something back' helps in developing

human capital in feeling empowered, valuable and needed, increases confidence and self-esteem, and therefore increasing human recovery capital as well as community capital.

It is important to look at options to prevent relapse through the provision of suitable accommodation:

> *"So, it's really important to look at the options and how we can, you know, make sure that, that doesn't happen really. But it is difficult because, you know, you can't always ensure that happens, but I think it needs to be more of a priority really in terms of housing and the housing model."*

(Excerpt from interview with Polly)

Abstinent-based housing helps people in recovery being with likeminded people; there is housing in this region of Wales where this support can be offered, which has helped several people.

> *"… a place where they can live where it's clean and it's sober, umm, because again like I sort of said that if you surround yourself with people that are clean and sober, you're much more likely to sort of stay that way yourself so that was, err, that was why we sort of took the step into the housing."*

(Excerpt from interview with Daniel)

Repeating information during assessments

Interview findings indicates that there are issues with having to repeat information during assessments. This can cause additional distress. As discussed, people with drug dependency often have difficult pasts, or they may have negative memories and experiences from when they have been using. Repeatedly discussing these is difficult:

> *"…I think sometimes as well, you know, you are referred to other services and you have to say the same old stories, the same old stuff again and again; it's just it would be, you know, useful if there'd be, umm, one, you know, access point that all information can, you know, be shared and you don't have to repeat yourself and, you know, the information will be there and there's more, you know, help in terms of housing support and, umm, you know, benefit support and everything else."*

(Excerpt from interview with Polly)

Daniel identified similar problems:

> *"…you might have one individual that might be accessing four or five different services and they have to do four or five different assessments, they have to sit there four or five times and tell their story; some of the stuff can be very, very painful as well. If you've got underlying trauma or anything like that, that underpins your addiction, you've got to go through that four or five times because the agencies aren't joined up enough to do one common assessment, even though it's been something that's been recommended for donkey's years, one common assessment for everybody that is then shared out.*"
>
> (Excerpt from interview with Daniel)

This highlights the benefits of a SPoA for substance misuse services. According to Daniel, it had been trialled one time "*where you would have one, one individual who would do all the assessments, err, one agency, and then basically the rest of the treatment package was worked out like on a pie chart".* However, Daniel says that "*it's a fantastic idea in theory, but in principle it's not really worked, and we've not seen anything like that up in, in this neck of the woods".* Daniel explains reasons why this has not worked being "*…Umm, so it's always difficult to sort of say, you know, if it would work, but like I said the current system, it's, it's more geared up towards the benefit of the services than it is towards the benefit of the service user."*

Participants suggested ways to increase engagement during assessments. Gary emphasised that excellent communication skills are essential for helping with engagement. Being professional includes being empathic and non-judgemental. This is vital at the first point of call and throughout service provision to encourage continuous engagement of service users with services; William suggested a "*customer service outlet in every reception*", and Gary stated that the person who answers the phone and deals with enquiries should be pleasant, well informed, and offer assessments for a service straight away. Professionals should support people who misuse substances during that first phone call, because a person-centred approach, *"makes the world of difference to the person needing help",* and they are more likely to continue that service. He describes the first time somebody reaches out for advice and help with their substance misuse or dependency as "*harrowing, it's really scary".*

A SPoA would have a lot of benefits as Gary states; "*if they can have a single point of access and then that single point of access person is polite [laughs] then it can save people [laughs]."* He also highlights problems when the first port of call is attending their GP surgery:

> *"Umm, and then the doctor doesn't know what to do, because he's your general practitioner, it's not really his job to be a specialist. So, all your doctor does really is*

give you a list of phone numbers. So, when you phone that - or give you a phone number, and when you phone that phone number if the person on the other end of that one phone call is nice and polite and invites you and even if that service isn't right for you but can signpost you to where you need to be, it makes the universe of difference."

(Excerpt from interview with Gary)

MDW and effective information sharing could help reduce the need to repeat sensitive information during assessments. There are a number of examples where multi-agency is working well (e.g. drop-in centres) and a number of examples where it is not working so well (e.g. information sharing), for example; a drop-in event where all services are represented was suggested as good practice by William:

"…we take away all the appointments and just on a Friday all services in the room, we can achieve on a Friday what it can take months to achieve. We get all the appointments dealt with all in one. It's really effective. And that is a mark of the partnership working we've got round here."

(Excerpt from interview with William)

William explains that during the drop-in sessions there are various important services and organisations, such as substance misuse services, housing, GP, etc. present and able to offer support to an individual with multiple issues due to their drug use. It has been very effective, as William discussed:

"We've got about eighty, ninety people, service users in today. The reason that it's so effective is a lot of this cohort are street homeless; they haven't got what we take for granted as a means to tell the time, they don't know what day it is either. If you're sleeping in a box all night in a doorway, you've got no concept of time. And some of the drugs you might be using to keep warm, definitely takes away your concern for time. But they do know when the sun comes up to make your way to this place."

(Excerpt from interview with William)

Gary exemplified a case where a drop in was successful in helping a service user access support:

"…he really engaged, he attended loads of stuff and he forced some structure into his life. So, on times when he wasn't in a structure appointment he'd go to a drop in and he just accessed everything and then bit by bit he got better and he told his workers at the drop in, like when his appointments were going to be and then they reminded him, and he just - he got all this support, all this help in order to manage himself, in order to get better. But we can't force that for anyone."

(Excerpt from interview with Gary)

Role of multi-disciplinary working in aiding recovery capital

Several participants spoke of the importance for effective MDW, where all professionals and service organisations involved in the care of a service user (housing, benefits, keyworkers, GPs, pharmacists, psychosocial services, etc.), work together to support service users in their recovery journey:

> *"…it needs to be driven by the individual, umm, and what we need to work out is that we only – any one of us only play a certain part in that puzzle."*
>
> (Excerpt from interview with Daniel)

MDTs support the service user in various aspects of life which they may find challenging, for example staying in recovery, applying or keeping benefits and housing support; by working together professionals and service organisations are more effective. They all have a role to play in supporting the service user, as Gary illustrates:

> *"…if you give somebody an amazing house but their benefits don't work, they'll lose it. If you give somebody an amazing house and they can't get their using under control and they end up in a situation in the house, they'll lose the house. So, no matter what you give somebody, if you don't give them the support to keep it then you're just setting them up to fail."*
>
> (Excerpt from interview with Gary)

Gary discusses how getting professionals in one room is difficult; it is expensive and time consuming. However, communication is key, either face-to-face or through e-mails and telephone calls to discuss the mutual service user and support them to build their recovery capital. Daniel continues by saying it is good practice for services to work together to ensure the appropriate referral is made as this can help to prevent long waiting lists. Gary states how MDW working has improved, and is now working *"certainly it works better than it has*", he agrees it could improve by services communicating better. He continues describing the idyllic MDT being: "…*the idea is that everybody comes and sits round the table and supports the individual in the middle in all of the aspects that they need support with. While also empowering them to make their own decisions".* He continues to discuss the difficulties to this (time consuming and costly), however alternatively; "…*they can send each other notes, they can send each other emails, they can communicate and work better together for the person."*

Nigel also discussed information sharing being important as a part of MDW; *"You know, because that's a big thing, information sharing. Obviously it's essential, err, in any, in any walk of life really, err, where there's more than one, you know, there's multi-agencies involved,*

information sharing is essential", Samuel agrees stating that services (SMS and third sector) are not openly communicating between each other: *"and I think we've become so insular on that I think just sharing information across the board should be three way meetings - not constantly but at least once a month to find out where we're all at, umm, to move forward that way."*. However, it is problematic organising meetings with other partners regarding a mutual service user, with finding a time that is suitable for all:

> *"Every now and again it's just trying to find time, trying to get the right people at the right time, in the right place."*
>
> (Excerpt from interview with Samuel)

Gary expresses that in the health service inter-professional working is challenging due to high caseloads and limited resources:

> "*So their joined up working is horrendous even though it's the same organisation".*
>
> (Excerpt from interview with Gary)

Daniel illustrates that it can be challenging for TSOs to secure continued funding and that working together can help to overcome some of these challenges. Ensuring service users are referred and are engaging within services is significant in evidencing the need for the service to commissioners. Gary agrees, stating:

> *"There's now more partnership working than before which is breaking down a lot of the silo kind of walls and instead of people going, these are my, these are my individuals and we need them on our books in order to get funding, which happened there's now more - they can see the benefits for the individual because they're forced to partnership work, they now see the benefits of partnership working. And overall, it's actually moving forward in a positive direction."*
>
> (Excerpt from interview with Gary)

William discussed negative media attention towards certain areas of the region regarding substance misuse has improved partnership working, stating: "*what negative media attention has done is made them stronger as an allied, umm, partnership to combat some of these issues. So, we've forever round the table."*

> *"Whether it works well at the moment, it does not work as well as it could, or maybe as well as it should, but that's conjecture anyway."*
>
> (Excerpt from interview with Gary)

Participants' perceptions may differ, which is not unusual as they will probably work in different geographical areas.

Chapter Conclusion

This chapter has identified some of the key challenges facing organisations seeking to support people who misuse substances, in particular, the challenge of providing person-centred care to vulnerable individuals who may find it difficult to engage with services on a regular basis and in a timely way. Lack of staff time, high caseloads and funding pressures are mentioned. The need for effective MDW is established.

The primary data concludes that for recovery based on reducing drug/heroin use based or abstinence to work, strong recovery capital is needed. Recovery capital is the basis for recovery. Thus, services should work together to ensure the service user is receiving the right support to meet all their needs to live a stable and functional life, as well as drug-free *if* suitable for the service user. Establishing a positive way of life, such as living in suitable accommodation, building a social network, and having a purpose such as employment, education or volunteering all support the development of recovery capital. Service users may also need suitable psychosocial (counselling/social groups) and physical support (opiate prescribing). A SPoA approach is likely to be beneficial here, so a key worker can personalise service user recovery plans to ensure they are successful in their goals.

Differences in approaches to recovery culture, particularly in relation to reducing drug/heroin use and abstinence, are highlighted as are longstanding issues that relate to the stigmatisation of people who misuse substances. There are problems with available resources within services, the attitudes of some staff from statutory treatment services and the challenges when working with professionals from different backgrounds.

Other challenges are problems with engagement, due to the way services are provided and delivered, such as the method of communication not meeting some needs for service users, and the service users who are able to attend appointments struggling with repetitive assessments. Also, the focus on reducing harm caused by drug use and not promoting abstinence as much may cause service users to feel "*stuck*" in treatment and unable to move off their MPP. This is the responsibility of commissioners and service delivery managers to ensure services have the resources available and staff to appropriately carry them out.

The following chapter provides the *policy analysis*.

Chapter Four

Secondary data: *Policy Analysis*

In this chapter, the following policies are analysed using the Policy Analysis Triangle framework (Walt and Gilson 1994): *Integrated Care and Integrated Care Pathways* (2010a), *Guidance for Evidence Based Community Prescribing in the Treatment of Substance Misuse* (2011) and *Recovery Orientated Integrated Systems of Care* (2013) The chapter begins by setting the policy context in Wales at the time the policies were published.

Setting the Welsh policy context 2010-2013.

The three key policies, named above, were published during a coalition government in the UK and a Labour Government in Wales, following the referendum for the devolution of Wales.

Devolution of Wales

During this time of the coalition government in 2010, the devolution of Wales meant that although Wales could make their own laws (measures), they had to go through parliament to get any measures passed. In 2006, Wales was granted the ability to pass primary legislation (Civil Service n.d., 4). This was under the Government of Wales Act 2006 and the Welsh Devolution Referendum in 2011 passed for Wales to have further ability to make laws in areas of devolved power, which included health, social care and housing (Cabinet Office and Office of the Secretary of State for Wales 2018). To relate this to substance misuse during this time, the WTtRH (2008-2018a) strategy for Wales explained that non-devolved public bodies such as police, probation and prison services should shape their approach based on UK *or* England and Wales' strategy and targets. This is because Welsh Police forces are not devolved, which can create challenges. This means that a Welsh police service could follow UK Government strategies e.g., *Drugs: protecting families and communities* (HM Government 2008), which may have impacted on the implementation of WTtRH (2008-2018a), because they are non-devolved and therefore can be more flexible in their approach to how they deliver this agenda (WTtRH 2008-2018a, 19). For example, other areas could combine Welsh substance misuse strategy and UK Government strategies and targets which support the delivery of the WAG substance misuse strategy (Welsh Assembly Government 2008a, 19). This is relevant to this thesis and more so, this chapter, because it is important to understand the relationship between the UK Government and Welsh Government, and how some public bodies have their own national strategies they must follow.

Austerity

Policy changes during this time (of coalition UK government) reportedly affected people who use drugs, with funding cuts to local authority services and benefits for working aged adults (Bulman 2017). In 2016, drug-related deaths were at the highest in England and Wales since records began in 1993 (Bulman 2017) and has continued to remain the highest in 2019 (ONS 2020, 2-3). In 2012, the coalition government decided to remove funding set aside for drug and alcohol treatment. This made it difficult for local authorities to continue their effort with tackling substance misuse and supporting/offering treatment to people who use drugs (Bulman 2017). These cuts put more pressure on the NHS (Bulman 2017). This had a long-term impact on the increase of substance misuse rates because of a lack of resources to fund appropriate treatment, and consequently a low recovery rate due to the limited availability of treatment and support.

The development and implementation of the three policies discussed in this thesis were during the 2008 economic recession in the UK. The impact of the 18-month recession lasted five years. In 2008, the UK government reported it expected social problems because of the recession including: homelessness, family breakdowns, increased drug and alcohol misuse, and a rise in the number of children in care (Carvel 2008). Austerity measures affecting employment, welfare measures and social integration often influence substance misuse (Sexauer 2014). Important allied support services that help people affected by substance misuse, by underpinning their recovery capital such as housing and employment facing funding cuts, consequently affecting substance misuse services (Sexauer 2014). A centre co-ordinator for Recovery Cymru stated that substance misuse increased in these times of social deprivation (Sexauer 2014). Even in 2019, the UK faced funding cuts for treatment services which caused an '*addiction crisis'* (Gabbatiss 2019). This suggests that factors believed to contribute to rises in substance dependency, such as economic and financial factors, have not improved, and substance misuse services lack resources to implement policy into practice.

Political influence on drug policy

Kaleidoscope's (rehabilitation services and supports health-based drug policy in Wales) Regional Manager, James Varty argues that drug policies are ineffective because of the focus on the illegality of drugs, and this illegal status of drugs make them "*unsafe and dangerous*" (Sexauer 2014). With Bunt (a drug strategy manager in Avon and Somerset) stating that crimes such as burglary and anti-social behaviour are a result of the bigger issue of drug dependency (ibid). Framing drug taking as a poverty and inequality issue (which is heightened during

austerity as found above) would be more beneficial (ibid). Various groups (including social workers and TSOs) argue that drug policy should be health-based (ibid).

The example of Professor David Nutt in 2009 illustrates there were conflicting opinions on drug laws when these policies were published. Nutt's views on legalising cannabis did not fit with the Home Offices' "*clear messages about the dangers of drugs*" and he was subsequently released from his role as Senior Drugs Advisor at the Home Office (Travis 2009; Nutt 2020). This created a debate about whether drug policy was truly based on scientific evidence, or politically motivated (Travis 2009: Nutt 2019), or whether policies were representative of scientific evidence. Professor Nutt stated that nothing had changed ten years on, and that drug use was still perceived as a criminal problem in the Home Office (Nutt 2019). Nutt (2020, 5) recommends for the Department of Health and Social Services to take over drug policy from a public health approach, rather than the Home Office which focus' on banning and prosecuting.

Welsh Policy

Table 4.1 Policy main findings

Integrated Care and Integrated Care Pathways (2010a)

- Using SPoA for substance misuse to prevent repetative assesments
- Co-ordinator of care to support service users to build their recovery capital
- Staff training to ensure all know how to conduct and use an integrated care pathway

Guidance for Evidence Based Comunity Prescribing in the Treatment of Substance Misuse (2011)

- Problems with access for the rural comunity is acknowledged and supported
- Daily supervision is required to ensure compliance to community prescribing until trust/stablity is built
- Effective OST relies on successful integrated working to help develop recovery capital and determine underlying issues for misusing substances
- Training should be provided to ensure competent staff

Recovery Orientated Integrated Systems of Care (2013)

- Treatment is based around the Assessment of Recovery Capital (ARC) and the support treatment provides to help build this.
- Recovery culture required a change, and this policy guidance helped to bring forward a recovery movement for subsance misuse services.
- Services should be integrated to ensure service users are effectively building their recovery capital. This should be carried out using integrated care pathways
- Staff should receive training on the recovery movement and culture.

Integrated Care and Integrated Care Pathways (2010a)

Integrated Care and Integrated Care Pathways (2010a) is the first policy analysed in this chapter.

Actors and Context

The *Integrated Care and Integrated Care Pathways* (2010a) is part of the Welsh Government's *'Substance Misuse Services and System Improvement'*. It is one of three guidance documents in 2010, the other two being *'Guidance for Establishing Substance Misuse Area Planning Boards* 2010' and '*National Core Standards for Substance Misuse Services in Wales* 2010', and they both helped inform *Integrated Care* 2010 (Welsh Assembly Government 2010a, 2).

Integrated working and ICPs in substance misuse needed to improve because of multiple problems individuals who misuse substances can experience, and the complexity of substance misuse (Welsh Assembly Government 2010a, 3). This means that care and interventions are often required by a range of services (ibid). At times, care is undertaken by two or more organisations, therefore collaborations between agencies and disciplines are beneficial to all involved; service users, families, and carers (not specified whether paid or unpaid carers), of the service user, as well as the substance misuse workforce and other relevant services (ibid). Primary care and substance misuse treatment collaborations have shown to have improved dependency outcomes and severity of dependency decreases (Laine et al 2001 and Weisner et al 2001 both cited in Samet et al 2003, 513; Samet et al 2003).

Suggested indicators, deadlines or outcomes are not proposed in the policy framework. Such as no KPI or measurement tools to indicate progress, nor a timeframe where this policy would be implemented or reviewed.

The policy is no longer available as an online resource on the Welsh Government website where all policy publications for drug misuse and dependency are accessible. Guidance for integrated care for drug treatment services is now directed to *SMTF Recovery Oriented Integrated Systems of Care (ROISC)* 2013. However, whether *Integrated Care* (2010a) has been replaced by *ROISC* (2013) is not clearly stated in either policy.

The policy document does not specify who was involved in drawing it up, but it does refer to key publications that informed the policy. Key stakeholders responsible for the following documents are Welsh Government, NICE, HIW, Department of Health, NHS and National Treatment Agency. The publications are (Welsh Assembly Government 2010a, 2):

- Welsh Assembly Government - *WTtRH: The Substance Misuse Strategy for Wales* (2008a), *WTtRH: The Substance Misuse Strategy, Three-year Implementation Plan 2008-11* (2008b), *SMTF for Wales* (2004b) and *Framework guidance for Community Safety Partnerships to Commission Substance Misuse Services* (2005).
- NICE guidelines (not specific which publication was reviewed).
- HIW – *Substance Misuse Services: All Wales Review of Substitute Prescribing* (2009)
- Drug Misuse and Dependence: UK Guidelines on Clinical Management (Department of Health -England- and the devolved administrations 2007, cited in Welsh Assembly Government 2010a, 2)
- NLIAH - Integrated Care Pathways: A Guide to Good Practice (2005)
- NTA – Models of Care for Treatment for Adult Drug Misusers: Update (2006)
- HM Government – *Safe. Sensible. Social: The next steps in the National Alcohol Strategy* (2007)

An additional resource this policy refers to is the Welsh Assembly Government's (2006) *"Key Performance Indicators for substance misuse treatment services in Wales*" when referring to the key elements of SPoA, in particularly ensuring the first appointment should be offered within 10 working days (Welsh Assembly Government 2010a, 9). Also, the 'General Principles' to follow when developing an integrated care pathway in the policy framework includes a 'preparation for integrated working' which is based upon a publication by Maslin-Prothero and Bennion (2010, cited in Welsh Assembly Government 2010a, 11), a literature review of integrated team working. A reference list is provided in the policy.

The policy is for a "*full range of partners*" that plan and deliver substance misuse services to deliver integrated care and support in Wales (Welsh Assembly Government 2010a, 2). A list of the "*full range of partners*" is not provided, but it does broadly define partners as those that are "*in contact with individuals who misuse substances*" (ibid). The policy aims to guide these partners to develop and implement IPCs pathways by working together (ibid). In terms of implementing the policy framework, CSPs and APBs have the responsibility of ensuring integrated services are delivered for individuals who misuse substances.

The policy states that the APB or CSP are responsible for monitoring and for "*governance arrangements*" (Welsh Assembly Government 2010a, 10). It does not suggest specific evaluation tools like other guidance such as *Community Prescribing* (2011) or *ROISC* (2013)

but it does state the need for protocols to delegate responsibility and accountability and clarify expectations of service providers (bid).

Content and Process

The policy defines an integrated care pathway as:

> *"…a multi-disciplinary and multi-agency outline of the service user journey mapping what will happen, where, when and by whom."*
>
> (Welsh Assembly Government 2010a, 3)

Integrated Care (2010a) aims for consistency in its approach for integrated working, and for ICPs to be developed in substance misuse services in Wales (Welsh Assembly Government 2010a, 2). The aim is for a seamless transition between services to prevent non-engagement or the need for multiple assessments to be carried out (Welsh Assembly Government 2008a, cited in Welsh Assembly Government 2010a, 2). This is to be achieved by using SPoA for substance misuse and a single record of care to accompany the service user on their journey. The list of areas where the use of ICPs should be created covers many populations of service users (pregnant women, parents, co-occurring problems), but important to note that "*stabilisation on substitute medication*" and detoxification in the community are two areas ICPs are recommended for use (Welsh Assembly Government 2010a, 16).

There are four key principles which are prominent in the policy framework. These are *training:* Staff performance and development, *Assessment:* single record of care, SPoA and co-ordinator of care, *Integrated Care*: Integrated care pathways; and the *Map of medicine*. These key principles indicate what the policy is planning to deliver (content) and how it plans it deliver it (process).

The policy acknowledges that delivering integrated support can be challenging because it requires resources, effective communication, competent management, effective education and training of staff, and an understanding of expectations of the key stakeholders. The policy did not provide any guidance on the resources required, but they did mention that staff is one resource they required and "*other resources*" (Welsh Assembly Government 2010a, 9), presumably money and time. The policy aims to tackle scarce resources and expertise to support Welsh Assembly Government 2008-2018 (2008a), by the APBs and CSPs developing integrated care service specifications, information sharing protocols, performance management systems, workforce development (joint training initiatives) and protocols for accountability and responsibility of each agency and organisation and of colleagues (Welsh Assembly

Government 2010a, 4-5). To ensure effective joint working, management need to ensure workforces are appropriately supported and individuals should be represented at a "*strategic level*" (Welsh Assembly Government 2010a, 5). Integrated care pathway should be based on local need (Welsh Assembly Government 2010a, 2).

Training: Staff performance and development

Key to the implementation of the policy is staff performance and development. Staff should be qualified and competent to deliver care and support within the integrated care pathway, which requires resources; training, education and supervision which needs funding and time. Staff performance and development requires supportive management to be able to offer regular supervision meetings, and training and education to staff at the beginning of the implementation period and throughout to ensure staff are competent in delivering ICPs (Welsh Assembly Government 2010a, 15). Service Level Agreements (SLAs) can be used to ensure core standards (see bibliography for full list of Core Standards), are being adhered to and the use of performance indicators to ensure quality (Welsh Assembly Government 2010a, 16). No extra funding or the status of funding is mentioned in the policy, nor whether additional staff would be employed to ensure staff are not overstretched by having a high workload.

Furthermore, joint education and training is strongly recommended for several reasons; it can be beneficial for the staff within the integrated care pathway to promote team building, keeping all staff informed of the development of the ICP and allow an opportunity to agree on the aims and objectives of the ICPs (Welsh Assembly Government 2010a, 5), for each individual service user. Also, it is helpful to discuss access and referral procedures, treatments, and interventions available and protocols for information sharing and for staff to be prepared for implementing the pathway (ibid). This presents an opportunity for staff from different workforces and services to network and build rapport with each other. However, there needs to be sufficient resources (financial, availability, staff) to enable joint training days to go ahead.

The policy also recommends staff and services to share an office or building to support the shared vision of care, but if this is unrealistic then to consider how resources, skills and information can be shared effectively (Welsh Assembly Government 2010a, 9). The success of sharing office space/buildings requires professionalism if differences in service and work ethos produces conflict. It is the role of the ICP co-ordinator to ensure mechanisms are in place to

address any conflict between organisations or agencies (Welsh Assembly Government 2010a, 13).

Turning to their section on "*sharing information and resources*" is states that there should be excellent communication, information sharing and exchanging skills and knowledge across organisations and agencies (Welsh Assembly Government 2010a, 4-5). The policy does not define "*excellent communication*", but it does state that information technology systems could be used to share information (Welsh Assembly Government 2010a, 4). To implement this policy, all organisations and staff need to be able to participate, meaning making additional time for integrated care (Welsh Assembly Government 2010a, 15). There should be a mechanism in place to ensure feedback and concerns on the ICP from staff are taken into consideration and responded to, ensuring staff can feel heard and any issues are addressed (ibid). A review of the ICP should take place regularly with feedback from service users and staff (service providers) to ensure the pathway is updated with current need and the views of service delivery and MDW (Welsh Assembly Government 2010a, 15/16).

Assessment: single record of care, single point of access and co-ordinator of care

Assessments are to be carried out over time to avoid overwhelming the service user (Welsh Assembly Government 2010a, 6). They are to be conducted collaboratively between service users and staff (ibid). Staff need to be knowledgeable, skilful and competent with professional judgement to identify individual needs to develop care plans and any urgent issues needing action, and any appropriate referrals, harm reduction advice and brief interventions (ibid). Safeguarding policies and protocols need to be in place when assessing the service user, to determine the risk to vulnerable adults and children, if applicable, during the planning of the ICP between agencies and organisations (Welsh Assembly Government 2010a, 9).

A single record of care aims to enhance communication and information sharing between services, avoids duplication of obtaining service user information and accompanies the service user throughout their journey (Welsh Assembly Government 2010a, 5). The service user should have their own version developed from the one on record, for them to have access to their available referral pathways (Welsh Assembly Government 2010a, 16). It states times, when and by whom things will happen, to have alongside their own version of the single record of care which can be created (Welsh Assembly Government 2010a, 16; 5). All staff and organisations involved should receive the ICP, relevant documents and protocols so that they are able to contribute and monitor a service user's progress (Welsh Assembly Government

2010a, 15). By implementing a single record of care, service providers will save time having the initial assessment and will already know the details and background of the service user.

The person who carried out the initial assessment at the SPoA is to be the service user's Co-ordinator of Care (Welsh Assembly Government 2010a, 6). They will be up to date with progress and needs which will be reviewed regularly to check goals status and ensure appropriate specialist pathways are being referred to (ibid). SPoA should have information and referral pathways and a mechanism for self-referral in place (Welsh Assembly Government 2010a, .7). During a specialist referral, the service user is still working with the original care co-ordinator, and the care co-ordinator will liaise with the specialist staff who provide care specific to their speciality only (Welsh Assembly Government, 2010a, 6). For example, housing organisations should only support the mutual service user for housing needs because it is specific to their service speciality, and not for support outside of their remit. Care plans will be reviewed, and the service user will be referred to the care co-ordinator after completion of their service (ibid).

Partner agencies need to ensure their own pathway links with the main pathway to reconnect to the "*assessment coordination of care and periodic review care plan*" (Welsh Assembly Government 2010a, 7). The co-ordinator of care is responsible for ensuring the care plan is reviewed at each "*reconnection*" (ibid).

Integrated Care: Integrated care pathways

The integrated care pathway should be developed across the 4 Tiers (see Chapter One, *page 34*) (Welsh Assembly Government 2010a, 12). The "*majority*" of service users to have an initial SOPA and single record of care prior to the development of more specialised and complex pathways (ibid).

An integrated care pathway development co-ordinator should be identified, and the roles and responsibilities of all members should be clarified; additional training and joint management/joint co-ordination may be preferred to manage the development of ICPs (Welsh Assembly Government 2010a, 12). The pathway should be built from a shared vision of the service user's journey and from this, form the basis of the pathway and model of care (Welsh Assembly Government 2010a, 13). Operational staff from all organisations and agencies that

provide care need to be involved in the process of developing the implementation pathway (Welsh Assembly Government 2010a, 12). This includes all other services that are involved with them from primary and secondary care, housing services and other related services such as domestic violence services and mental health services (Welsh Assembly Government 2010a, 13, 16).

There should be an agreement between stakeholders to determine which areas ICPs are required (Welsh Assembly Government 2010a, 12). Organisations and agencies are responsible for identifying gaps in care and support provision when developing the ICP (Welsh Assembly Government 2010a, 13). When developing the ICP, there should be staff that are responsible for developing the pathway, whilst others will contribute their expert opinion (Welsh Assembly Government 2010a, 12). Service users and carers are involved in developing the pathway and provide their opinion from personal experience (ibid).

Responsibility for implementing Integrated Care Pathways

To ensure successful implementation of ICPs, all partner agencies require effective joint working (Welsh Assembly Government 2010a, 4). APBs should help the CSPs and other partners (ibid). The pathways need to be agreed upon between local providers and built in to service specifications and SLAs (APBs and CSPs need to approve them prior to implementation). Pathways should be sufficiently comprehensive and include all relevant elements of care and support required (see appendix F for example from the policy) (Welsh Assembly Government 2010a, 11). ICPs should also manage the expectations of service users by explaining the roles and responsibilities of staff and detailing the interventions, treatments and outcomes they should expect (ibid).

Draft pathways

The model for ICPs and principles for joint working should be consistent across board, with the details being unique to the individual service user. Therefore, a draft pathway with relevant feedback from each stage of the ICP on the service user journey will determine the success of the ICP. The policy states that the draft pathway should be piloted prior to the final version being implemented and feedback from key stakeholders including service users, at each stage of the process, on the outcome of the pathway and any improvements (Welsh Assembly Government 2010a, 15). This pilot is to be carried out over a period of time or with a certain number of service users (ibid). Data to monitor the key indicators should be collected and tested

during this pilot period, and all feedback collated, analysed and reported to be CSP and/or the APB to sanction changes (ibid). ICPs need to be regularly reviewed and modified when appropriate (ibid) Any feedback from service users and staff needs to be analysed and followed through; any reasons and circumstances why this is not followed, need to be reviewed to keep the pathway dynamic (Welsh Assembly Government 2010a 15-16). Despite a pilot being advised prior to the finalised version of an integrated care pathway, it does not indicate how long specifically the pilot will assess its effectiveness, or who would report findings from the pilot. There is a question how much this policy was implemented and where findings from monitoring and key indicators can be found.

CSPs and service providers need to 'map and identify' local needs to develop appropriate ICPs and commission any gaps in local service provision (Welsh Assembly Government 2010a, 12). They propose to do this by reviewing current "*local practice and processes of care*" as well as "*feedback from key stakeholders*", who are defined as service users/carers, commissioners/planners, substance misuse workers and all other services (related and generic services, as defined in the policy) (ibid).

Map of medicine

A map of medicine "p*rovides evidence-based, practice informed care maps that are adaptable locally for clinically-led service improvement programmes*." (NHS Networks 2010, no page number), and it also defined by Brennan et al (2011, 94) as "…*evidence-based online clinical knowledge resource*". This tool has been discontinued since 2018 (Cegedim Heathcare Solutions 2019), although the policy still refers to it, likely because this policy appears to have been replaced by *ROISC* (2013).

The policy recommends updating and using the Map of Medicine accordingly with local need (Welsh Assembly Government 2010a, 12). Review of current local practice and processes of care is important as is feedback from key stakeholders, including service users, carers, commissioners/planners, members of the substance misuse workforce and all related services (ibid). This aims to help identify gaps in commissioning and highlight resource needs and gaining feedback from key stakeholders and organisations on ICPs (as mentioned earlier), will help commissioners identify where funding is required (ibid). A review of the Map of Medicine found that referral systems for secondary care improved, decrease in waiting times and cost effectiveness, however the evidence available evaluating its effectiveness was minimal and the existing evidence varied in quality (Brennan et al 2011, 93).

Substance Misuse Treatment Framework (SMTF)

The SMTF for Wales which *Community Prescribing* (2011) and *ROISC* (2013) is a part of, was first published in 2004. The foreword for this original document states the *SMTF* reflects the vision from the previous publication '*Wales: A Better Country*. *The Strategic Agenda of the Welsh Assembly Government'* (2003) (Welsh Assembly Government 2004b, 1). This strategy aims for "*a sustainable future for Wales where action for social, economic and environmental improvement work together to create positive change*" (Welsh Assembly Government 2004b, 1). A key aim was also to increase the engagement of "*problem substance misuse strategy"* to improve their health and social inclusion (ibid).

The overall framework began its policy development in 2003 with members of the Welsh Government, an Advisory Panel on Substance Misuse (APoSM), and a representative from the National Public Health Service for Wales Vulnerable Adults Team, who developed the basis of the framework (Welsh Assembly Government 2004b, 1). The APoSM, established in 2001, consisted of a range of experts such as health, GP, pharmacists, voluntary sector, criminal justice, education, local authorities and WAG (Welsh Assembly Government 2004b, 76). Additional funding was allocated to increase the capacity of treatment services across Wales, by Edwina Hart (Welsh Assembly Government 2004b, 1) to support those affected by substance misuse issues. However, no details of the year the funding was allocated in provided. The component documents of *SMTF* included 'specialist subgroups', which represented the Substance Misuse Treatment community in Wales (ibid), which is specified in *ROISC* (2013), but not *Community Prescribing* (2011). Indicating that ROISC (2013) utilised specialist subgroups in the development of the policy, whereas community prescribing (2011) did not.

In the development of *SMTF*, the *Models of Care for the treatment of drug misusers*, by the National Treatment Agency for Substance Misuse in England was used to inform its development (Welsh Assembly Government 2004b, 1). The framework sets out to assist CSPs in the coordination of delivering the Welsh substance misuse strategy and to support "*Responsible Authorities*" and other partners who develop needs-based services (Welsh Assembly Government 2004b, 2).

SMTF: Guidance for Evidence Based Community Prescribing in the Treatment of Substance Misuse (2011)

This policy is closely related to *ROISC* (2013) and *Integrated Care* (2010a). The policy emphasises that prescribing cannot be a standalone treatment but needs to go hand in hand with

psychosocial interventions and integrated working practices. It references SPoA recovery capital and recovery support.

Actors and Context

This policy does not stipulate who was involved in drawing it up. It does, however, include evidence of which this framework is analysed in its development (Welsh Government 2011, 3):

- NICE Guidance (2007b, 2008, 2010, 2011).
- National Treatment Agency (NTA) guidance – Substance Misuse Guidance (Raistrick et al 2006)
- Drug Misuse and Dependence (2007)
- Cochrane database reviews (Amato et al 2010 and Rösner et al 2010).
- Peer reviewed papers – key addiction and substance misuse journals
- Substance misuse workforce planning and development publications
- National substance misuse strategies (i.e., Welsh Assembly Government 2008a).

This policy supersedes the *SMTF Service Framework for Community Prescribing* (2004a).

This policy also refers to *WTtRH* (2008-2018a), and its aim to manage resources effectively, which is also supported by *Integrated Care* (2010a) and the *National Core Standards for Substance Misuse Services in Wales* (2010b) (Welsh Government 2011, 2). Two of the aims of *Community Prescribing* (2011) are to "*inform and develop integrated care pathways*" and to "*promote interagency and multidisciplinary care*" which is in line with the two other policies reviewed.

Community Prescribing (2011) policy based its evidence on NICE guidance to decide on the drug medication used and the treatments available for community prescribing (Welsh Government 2011, 14). The NICE guidance was published in 2008; *Drug Misuse: Opioid Detoxification. National Clinical Practice Guideline Number 52.* Community prescribing draws on NICE (2011:2010) for alcohol misuse treatment as well as work by Raistrick et al (2006), who looked at the available evidence to determine the effectiveness of different interventions to treat alcohol misuse and dependence, which found that treatment type is unique to the individual and their reasons behind alcohol misuse or dependence, but receiving the correct treatment is vital for "*improvements made*" (Raistrick et al 2006, 14 and 174).

The policy referred to other resources within the policy framework such as Ghodse (2010) for drug specific literature (in addition to key publications stated earlier), HIW (2009) for the review of substitute prescribing and the Stationary Office (2001) for the *Misuse of Drugs Regulations* (Welsh Government 2013, 20-21). Alcohol misuse specific literature was also referenced. To develop the guidance, National Assembly for Wales (NAW) (2001) and Welsh Government publications were taken into consideration (Welsh Government 2011, 20-21).

This policy is for partners in contact with people who misuse substances (Welsh Government 2011, 2). The partners are not explicitly stated, but it does state that members of the APB, commissioners, planners and "*those who deliver substance misuse services*" are responsible for ensuring any treatments and interventions are commissioned and implemented using "*evidence of effectiveness outlined in this framework*" (ibid). The policy framework refers to individuals who misuse substances as either clients, patients, or service users.

It does not state clearly who is responsible for policy implementation. However, Specialist Substance Misuse Teams or GP-led prescribing and shared care are tasked with delivering community prescribing (Welsh Government 2011, 5). Also, APBs and LHBs are responsible for ensuring community prescribing is accessible and available (ibid). Overall, community prescribing is carried out under NHS Clinical Governance arrangements in Wales (Welsh Government 2011, 4). It would be these selected subgroups who presumably are responsible for implementing this policy guidance into practice.

To measure progress and compliance of this policy guidance, Treatment Outcomes Profiles (TOP) are used for evaluation as well as data received from the Welsh National Database of Substance Misuse (WNDSM) (Welsh Government 2011, 12). *Community Prescribing* (2011) and *ROISC* (2013) both allow other evaluation tools to be used as well as TOP if preferred locally (Welsh Government 2011, 12 and Welsh Government 2013, 14).

Content and Process

The policy sets out guidance for community prescribing for detoxification, maintenance programmes and supervised consumption. It includes legal regulations and contractual obligations that must be adhered to when prescribing medication for substance misuse in the community. It includes an explanation of how to access community prescribing, how it is delivered, the assessment process and the aftercare and support that should be available.

With regards to accessing community prescribing, this policy framework recommends a SPoA for Substance Misuse services, which was also recommended in *Integrated Care* (2010a) (Welsh Government 2011, 5). It also acknowledges the need for flexible opening times (evenings and weekends) (Welsh Government 2011, 6). This policy framework specifically looks at prison and criminal justice settings, pregnant women who misuse substances, co-morbid diagnoses and complex poly-drug (more than one drug) use (Welsh Government 2011, 11).

Integrated working

The policy framework is very similar in its process to *Integrated Care* (2010a) and *ROISC* (2013), in that it relies on integrated working through MDTs and ICPs (Welsh Government 2011, 3). *Community Prescribing* (2011) should work as one part of a care plan (ibid), as *ROISC* (2013) covers. In addition, however, this policy advises for a joint three-monthly review of the treatment and care plans with the integrated team (Welsh Government 2011, 6).

Staff training and competence

Like *Integrated Care* (2010a) and *ROISC* (2013), *Community Prescribing* (2011) has a considerable focus on training and ensuring the staff carrying out community prescribing are competent (Welsh Government 2011, 13). This policy is more specific about ensuring all staff involved (GPs, Pharmacists, keyworkers) are up to date on their knowledge and skills for community prescribing, including all staff under lead GPs involved in community prescribing (ibid). Noted skills required for specialised keyworkers who are involved in substance misuse prescribing are; to recognise withdrawal symptoms and possible need for psychosocial interventions, also for any need for harm reduction interventions such as overdose risk and advise as required; ensure correct use of medication as prescribed, review and revise the care plans and treatment goals a minimum of every three months and refer onto other services where required such as housing, employment (ibid). GPs and pharmacists need to be adequately trained through continuing their professional development (ibid).

Assessment

Assessment details are like *Integrated Care* (2010a) and *ROISC* (2013) in that they should prevent overwhelming the service user with requests for information (Welsh Government 2011, 11) and focus on service user needs. However, *Community Prescribing* (2011) includes a more detailed account of what a comprehensive assessment should entail. Key workers should initiate the assessment process and conduct the assessment with the service user (ibid).

Its aim is to determine the physical, psychological, and social functioning of the individual, and the keyworker makes arrangements for relevant interventions (ibid). The assessment specifically covers (ibid):

1. Nature and severity of substance misuse
2. Reasons for substance misuse
3. Impact of substance misuse to their physical, psychological, and social functioning
4. Level of cognitive ability
5. Personal resources the client has that will help through treatment such as family/friends support.

This account of what an assessment involves is important to cover in the overall policy framework and is not provided in *Integrated Care* (2010a) or *ROISC* (2013).

Community prescribing

This policy refers to NICE (2008) guidance when determining whether methadone or buprenorphine is prescribed for OST. It states that methadone or buprenorphine should be offered to people for detoxification, unless one of the two are already used for maintenance therapy (Welsh Government 2011, 14). There is no criteria or evidence for determining which OST drug is prescribed for maintenance in this policy.

Maintenance and detoxification programmes aim to *"…reduce cravings, prevent withdrawal symptoms, reduce harm and eliminate the reinforcing properties to drug taking*" (Welsh Government 2011, 14).

Maintenance programmes

Maintenance programmes are carried out under a rigid dispensing regime (including dispensing following appropriate procedures to prevent abuse of medication), which is monitored through random routine testing (Welsh Government 2011, 8). This is very frequent to begin with, with daily monitoring until the client is stable, which is measured through clinical assessment and toxicology results (ibid). Assessment and managing the clinical, social and environmental risk are also advised to increase successful outcomes from maintenance programmes, as well as ongoing assessments generally to assess needs and ensure the care plan is up to date and referrals for psychosocial interventions made where appropriate (Welsh Government 2011, 9).

There is no timescale for the length maintenance programmes in this policy guidance. Presumably, it is to continue until the criteria for detoxification is met, and the client is ready to reduce their dose to detox, and this is agreed amongst the specialist team.

Detoxification at home and in the community for opioid dependency

"*Opiates and other drugs*" detox treatment use substitute medication or slow reduction programmes (Welsh Government 2011, 6). The duration and dosage of detoxification depends on how severe the dependence is, their physical and psychological health and any other medication that may be prescribed (Welsh Government 2011, 7). An opiate detoxification is prescribed for over 5-7 days which is taken through administration of a long-acting drug such as Methadone, which is reduced gradually until finished (Welsh Government 2011, 8). The alternative option for some service users is a slow reduction programme if deemed more appropriate, which can take up to 12 weeks (ibid). The policy does not explain why this option may be more suitable. Close monitoring of the service users' condition through detox is carried out to ensure risk of relapse and overdose is reduced and hopefully prevented (Welsh Government 2011, 8).

There are criteria (from NICE guidelines 2008), for community opiate detoxification that must be met before it is prescribed (Welsh Government 2011, 8). These are a physical dependency to opioids, capacity to comply, and motivation to change some drug use and a supportive network and a stable accommodation (ibid). These relate to Best et al (2009, cited in Welsh Government 2013, 5) and their *key conclusions* discussed in the next subsection (*page 127*). In addition, there needs to be specialist or primary care practitioners providing coordinated care in place for daily visits to monitor withdrawal, and finally psychosocial interventions if needed. Also, as stated above, there needs to be a protocol with dosage of medication and duration details of the detox which will vary case-by-case (dependent on the person's physical and psychological health and if other medication is prescribed) (Welsh Government 2011, 7). It is the responsibility of the keyworker to ensure medication is taken as prescribed, as well as ensuring external resources are in place such as housing, employment, social support (Welsh Government 2011, 13).

Supervised consumption for maintenance and slow reduction programmes (detox)

As well as the above guidance for specific community prescribing programmes, there are other factors that are advised within this guidance. These are that *all* patients are supervised daily for the first 3 months (Welsh Government 2011, 9). The policy acknowledges the difficulties for

rural communities where this obligation will be a challenge, and it aims to overcome this by making "*balanced decisions*" in the care plan and "*other user-friendly approaches to supervision*", however no further detail is provided about what alternative approaches to supervision might be considered appropriate (ibid). Confidentiality and privacy should be respected with discrete areas or rooms to ensure dispensing arrangements are person-centred to meet the requirements of the service user (ibid).

The service user and pharmacist who is dispensing the medication should be in "*personal contact*" to encourage "*team working*" and there should also be an agreement between the client, specialist team and pharmacist (also called shared care) prior to a written or dispensed prescription (Welsh Government 2011, 9). The type of "*agreements*" is not specified, apart from one which is for an agreement for regular feedback from the pharmacist to the specialist team before any remuneration (ibid). In addition, there is a restricted number of patients allowed per pharmacy for dispensed supervised prescription which is determined by a local needs assessment (ibid).

Aftercare

After detoxification, continued support, treatment and monitoring should be offered such as structured day care, supported housing, residential rehabilitation, vocational support, psychosocial interventions and community-based relapse prevention (Welsh Government 2011, 12). Recovery support groups and supportive networks through peer mentoring are also included within the guidance as well as "*ongoing maintenance prescribing programmes*" (ibid).

The policy framework states that relapse rates are high, hence the above support should be offered for at least 6 months, as advised by NICE (2008 and 2011, cited in Welsh Government 2011, 12; Welsh Government 2011, 12). If relapse does occur, then clients should be reassessed to determine the reasons and discuss treatment and intervention options (Welsh Government 2011, 12).

SMTF: Recovery Orientated Integrated Systems of Care (2013)

Actors

Recovery Orientated Integrated Systems of Care (2013) was drawn up through an "*extensive collaborative and consultative approach*" (Welsh Government 2013, 3) by a specialist subgroup of the Advisory Panel on Substance Misuse (APoSM).

The involvement of a range of people from different backgrounds helps to ensure that the component policies within this Framework is diverse and relevant to a range of people, especially views of service providers and service users (Welsh Government 2013, 3).

The evidence base for *ROISC* (2013) is primarily literature from Best et al (2009). This includes *key conclusions* by Best et al (2009) to support recovery-based approaches. For example, (Welsh Government, 2013, 5) emphasises that recovery is a personal process, and therefore the policy adopted an open definition to allow for *all* recovery approaches to be considered as recovery. The policy recognises that service users' motivation and circumstances impact on recovery stabilisation and that stabilisation takes time. The likelihood of recovery being sustainable is dependent on the extent of recovery capital: personal and psychological resources, social support and basic 'foundations of quality of life'; however, the service user defines this (e.g., "safe place to live, meaningful activities and a role in their community"), however barriers to recovery can be psychological, significant physical health problems (e.g., blood borne viruses) and social isolation. The policy also references "*on-going chaotic substance misuse*" (Welsh Government 2013, 5) as a barrier to recovery. Structured treatment has a "*key role to play in an individual's recovery*" but also highlights the importance of on-going community support to maintain and continue the recovery journey (ibid). Recovery of a parent from substance misuse can have a considerable impact on families, in particular children and young people, and professionals and communities need a fundamental change in their culture and attitudes to enable a recovery model, although the "*fundamental*" change is not explicitly defined (ibid).

ROISC (2013) is heavily based upon research from David Best and his colleagues over four publications from 2009-2012. His work on recovery capital and understanding recovery from addiction is widely referred to in *ROISC* (2013).

The aim of *ROISC* (2013) is to provide guidance to APB commissioners, planners, service providers and service users to establish recovery orientated integrated systems (Welsh Government 2013, 3). Two of the objectives for *ROISC* (2013) are to create an across-the-board definition of recovery and create a recovery culture within treatment provision, on across all of Wales (ibid). However, whether this is realistically attainable, is discussed in *Chapter Five: Discussion and Conclusion.*

It is not clear who is responsible for delivering this guidance, but the policy language indicates that SMS providers are responsible for delivering the policy framework, and APBs are responsible for implementing it (Welsh Government 2013, 3 and 10). APBs will monitor the outcomes of *ROISC* (2013), to ensure the guidance is being followed (Welsh Government 2013, 10). This is carried out through performance management and audits (Welsh Government 2013, 13-14).

To recognise how success is measured, commissioners are required to ensure service specifications and performance monitoring have recovery orientated outcomes and activity indicators included within them (Welsh Government 2013, 14). The intended outcomes of the service users must be realistic and developed in partnership with their keyworker (ibid). *ROISC* (2013) make it clear that "*organisations need to be clear about recovery, the ultimate outcome sought and the method of measuring whether they have been successful*" (Welsh Government 2013, 13). This requires a delivery plan and partnership working between staff and service users (ibid).

The examples for "*actual meaningful outcomes for individual service users*" are:

"

Meaningful relationships
Appropriate and settled accommodation
Access to education and employment
Financial stability
Engagement in meaningful activity
Good physical health
Mental well-being

"

(Welsh Government 2013, 14)

This policy uses the same evaluation tool as *Community Prescribing* (2011) to monitor the activity and measures effectiveness of substance misuse services through National Key Performance Indicators which the Welsh Government use Treatment Outcome Profile (TOP) (Welsh Government 2013, 14). TOP measures success through a core set of outcome measures of physical health and mental well-being (ibid).

More specifically to measure the success of *ROISC* (2013), an audit checklist was recommended to follow as a "*tool to facilitate cultural and operational change*" (Welsh Government 2013, 14). Service users and the recovery community were valued for their feedback and viewpoints on how well their service is running, in which commissioners and service providers were to communicate how they have taken service user feedback and measuring success by identifying issues and improving practice (ibid). In other words, through service delivery.

Context

Mark Drakeford AM was the Minister for Health and Social Services when *Recovery Orientated Integrated Systems of Care* (2013) was developed. He recommended the time for a "*fundamental shift in the culture of substance misuse services in Wales*" (Welsh Government 2013, 1). He believed that *ROISC* (2013) provided a choice and ensured the most suitable "*package of support*" was provided to increase the chances of change and recovery (ibid). There has been a "lack of shared vision, and meaningful communication between stakeholders" (Welsh Government 2013, 4). It was prior to the policy development of *ROISC* (2013) that recovery had become a well-discussed topic in the UK "*substance misuse treatment systems*" (ibid). With inconsistencies and confusion, including a lack of understanding about recovery, and what recovery means for service users, providers, and commissioners, it has caused distractions from the opportunities recovery presents (ibid); *"…to engage in appropriate support and treatment, thereby enabling them to make changes in their behaviour to improve their overall chances of recovery*" (Welsh Government 2013, 1). Difficulties agreeing on the recovery approach and definition made it harder, for example, discussions about abstinence or making "*positive changes"* such as reducing drug/heroin use (Welsh Government 2013, 4). As noted, recovery is defined as: "*Recovery from problematic drug or alcohol use is defined as a process in which the difficulties associated with substance misuse are eliminated or significantly reduced, and the resulting personal improvement becomes sustainable*." (Welsh Government 2013, 4). The suggested outcome for this policy is for service providers to deliver a service in agreement of the recovery principles that is in the best interests of the service user. Recovery principles are not defined within the policy, which can cause issues with its inclusion in delivery.

The context in which the policy is written in terms of the culture and philosophy at this time, was grounded in "*hope, encouragement and empowerment",* and believing that people will recover from substance misuse issues in Wales. Services are to be recovery focused, adaptable

and transparent (Welsh Government 2013, 4). As stated earlier in the literature review, it also aims for personal beliefs and ideologies with regards to abstinence or non-abstinence (reducing harm) recovery approaches were to be put aside, and a pragmatic, meaningful and service user orientated approach adopted (Welsh Government 2013, 5). Overall, the context in which recovery was perceived was for a focus on building strengths and assets for individual journeys and changing the system (in terms of recovery culture) to facilitate this (Welsh Government 2013, 4).

Content and Process

The aim of *Recovery Orientated Integrated Systems of Care* (2013) was to establish integrated systems of recovery (Welsh Government 2013, 3) by reducing barriers to accessing and completing treatment. The framework relies on front line staff, organisational learning and assisting in the recovery-based treatment for its successful implementation (Welsh Government 2013, 9).

Integrated care pathways

ROISC (2013) and *Integrated Care* (2010a) are very similar in their content. This is because they both aim for an integrated process for recovery, as does *Community Prescribing* (2011). As stated, it would suggest that *ROISC* (2013) replaced *Integrated Care* (2010a), with *ROISC* (2013) including "*integrated care pathways*" in their policy. *ROISC* (2013) suggests using ICPs to support service users to access "*recovery support*"; policy examples being access to housing, employment and education (Welsh Government 2013, 12). Through their APB, it is the role of commissioners and service providers to ensure integrated working is taking place to maximise recovery capital (ibid).

ROISC (2013) does not continue the recommendation for single record of care, SPoA for substance misuse or for a co-ordinator of care from *Integrated Care* (2010a). These three concepts are not mentioned in the updated policy. *ROSIC* (2013) does not acknowledge the 2010 policy, apart from adopting "*integrated care pathways*" into its policy framework as an element for integrated care.

The policy does highlight that education, training and employment should have a 'written pathway' by commissioners to increase service user access (Welsh Government 2013, 12). As mentioned in *Integrated Care* (2010a) when developing an integrated care pathway, there should also be an integrated system which provides access to recovery support such as employment and accommodation, in addition *ROISC* (2013) states that services should work

together to help 'harness' these "*key building blocks to maximise recovery*" (Welsh Assembly Government 2010a, 16, and Welsh Government 2013, 12). However, these different services will have their own priorities and funding budgets and effective joint working requires participation across many disciplines.

This policy also recommended joint protocols across all key partners which include shared definitions, objectives and outcomes (Welsh Government 2013, 12). Organisations need to be clear about recovery; ultimate outcomes sought and their method of measuring success and communicate how to effectively deliver that vision (ibid). The *Integrated Care* (2010a) policy does not stipulate their means for assessing success of their policy or ICPs.

Care planning

As well as an integrated care pathway, which defines the details of working together for the service user, there is also a care plan which defines service user goals and identifies main issues that have been recognised during the assessment (Welsh Government 2013, 13). This care plan is collaborative with the service user and their "*practitioner*" and should meet audit requirements (carried out by service managers and commissioners), it should also be service user led and an ongoing working document (ibid). Having to meet audit requirements could create tensions as service users may not feel as flexible in their plan as having to meet requirements.

ROISC (2013) provides more detail on how the care plans should be drawn up, implemented and reviewed. Regular reviews of the care planning arrangements should take place to check that the recovery principles are fully adopted and to identify whether the process has been truly service user-led, and to review their aspirations and opportunities (Welsh Government 2013, 12-13).

Training

In line *with Integrated Care* (2010a) and *Community Prescribing* (2011), *ROISC* (2013) incorporates staff training and development into the policy framework, but with an additional focus on embedding recovery culture and attitudes into services. To ensure this, APBs are responsible for making sure that new staff are "*fully trained*" on the principles of recovery from induction to supervision and personal development plans (PDPs) (Welsh Government 2013, 11). Existing staff were to receive training on the "*recovery movement for Wales*" and the recovery community were to be involved in training and briefings to professionals, care plans should be reviewed, self-audits to be carried out and for professionals to educate themselves

on local (community) resources and ensure service users are aware how to access (Welsh Government 2013, 12). Community resources are defined and some examples within the policy by Best and Laudet (2010), being "*houses and job opportunities to enable and sustain recovery pathways*" (Welsh Government 2013, 7). The policy does not stipulate clearly what the recovery movement for Wales is, nor the recovery principle, but it does draw upon *key conclusions* discussed above (*page 127*). It introduces a broad definition about recovery being a personal journey where abstinence should be a choice (Welsh Government 2013, 4-5.)

The policy also outlines the need for "*competent staff, good systems of clinical governance and value for money within substance misuse treatment systems*" (Welsh Government 2013, 9), to implement and determine this. The policy recognises the importance of staff training, reviews and supervision. The policy acknowledges that this requires sufficient resources and time, but does not state where this may come from, or what resources they entail (Welsh Government 2013, 11). The workforce needs to be diverse, and organisations should have strategies in place which ensure this (Welsh Government 2013, 12), however "*diverse*" isn't defined apart from "*…unique benefits and risks different types of workers bring to the table…*" (Welsh Government 2013, 12). However, to support this diverse workforce, appropriate training, supervision and support should be undertaken (ibid). The role of the wider workforce for implementing recovery-oriented principles into the substance misuse sector must not be disregarded and should include volunteers, mentors, health professionals, criminal justice agencies and other partners (Welsh Government 2013, 11). The recovery philosophy and culture should be embedded in the recruitment, supervision and performance management process, and "*psychosocial tools*" should be provided to practitioners to work with (ibid), however no definition or further information of psychosocial tools.

Recovery capital

Recovery capital, discussed in chapter one, is assessed and developed to determine people's level of support and care needs and any treatment and post-treatment support required. Chapter one discussed that there are various ways to categorise recovery capital, such as social, physical, human, cultural and community capital. The fundamental principles are mirrored within ROISC (2013).

These components can, "*support or jeopardise recovery*" (Welsh Government 2013, 6). It is these categories that are worked on during substance misuse treatment, where services use an

"*asset-based approach*" to help people identify what existing resources they have and what new recovery capital needs to be built (ibid).

APBs are responsible for ensuring Assessment of Recovery Capital (ARC) is applied (Welsh Government 2013, 7). Recovery capital should be assessed by substance misuse providers using ARC to "*enhance each area of recovery capital*", where this tool will calculate a person's well-being score; the higher the score the "*better levels of overall functioning*" (Welsh Government 2013, 7, 21). This can then be used to measure an increase in recovery capital (Best 2009; Best et al 2010, cited in Welsh Government 2013, 7). This is based on Granfield and Cloud's (1999) Recovery Capital. The Recovery Star is a similar tool used to measure recovery in mental health fields, focusing upon "…*managing mental health, physical health and self-care, living skills, social networks, work, relationships, addictive behaviour, responsibilities, identify and self-esteem, trust and hope*" (Dickens et al 2012, 46). ROSIC (2013) references Best and Laudet (2010, cited in Welsh Government 2013, 7) categorisation of recovery capital; personal, social and community capital. This is similar to the work of White and Cloud (2008) and Granfield and Cloud (1999; 2001) (as mentioned in chapter one, *page 52-53* and appendix G).

The policy states that commissioners should base funding on population need, and APBs are responsible for this (Welsh Government 2013, 12). A whole system approach with variety of treatments and aftercare treatments is necessary; abstinent based, traditional residential rehabilitation and parallel integrated support that is aimed towards reintegration and recovery, towards individuals that do not feel ready for full abstinence (ibid).

Recovery champions

ROISC (2013) discuss the effectiveness of mutual aid and peer support of people who have personal experience of substance misuse themselves (Welsh Government 2013, 8). The policy states that people with experience of treatment and recovery can encourage others in their journey; service providers should consider how they could best utilise the opportunity to encourage opportunities for peer support (ibid).

The policy aims for local partnerships to promote mutual aid and peer-led community support by APBs establishing links with mutual aid groups and ensuring pathways are in place for services (Welsh Government 2013, 8). Mutual aid groups should be encouraged during the

treatment journey and be discussed with all service users; commissioners and planners should support the growth of mutual aid groups when areas lack the resources, e.g. "*all services have the relevant pathways in place*" to form them (ibid). No specific resources are mentioned which aim to encourage mutual-aid groups, although it would seem that it is the opportunities service users have to build mutual aid relationships. Peer-based, mutual aid and recovery community services (and other support networks), need to be created and utilised (ibid), and there needs to be an effective reporting mechanism to ensure any issues are dealt with meaningfully and relevant for monitoring and assessment (Welsh Government 2013, 14).

Chapter Conclusion

Key themes underpinning the three policies

All three policies share the theme of integrated working/MDW, and the principle that treating the service user requires a whole person approach. Each policy has their own focus for integrated working, OST or recovery from substance misuse and dependency, and the roles of the frontline staff and APBs by ensuring services are person-centred focused to ensure best quality of services. Two policies acknowledge the need to improve access to services for rural communities (Welsh Government 2011) and avoiding repetitive assessments through using SPoA for substance misuse service provision (Welsh Assembly Government 2010a). This would prevent overwhelming the service user, a common aim (Welsh Assembly Government 2010a and Welsh Government 2011). There should also be a Co-ordinator of Care to support the service user throughout their journey of developing recovery capital (Welsh Assembly Government 2010a and Welsh Government 2013). Recovery culture was due a fundamental "*shift"* which was embedded into ROISC (2013) (Welsh Government 2013, 1). Staff training is paramount in all three policies to ensure all frontline professionals are aware of the policies in place and their content (Welsh Assembly Government 2010a; 2011; 2013). The main areas to take note with regards to this policy analysis are set-out a table found in Appendix J.

Integrated care, staff training and assessments are present in each policy, while exiting treatment and aftercare are more prominent in *Community Prescribing* (2011) and *ROISC* (2013), although it is mentioned in *Integrated Care* (2010a), as an example of an integrated care pathway. Therefore, integrated care, staff training and assessments should be common practice for service providers as all three policies advise. Table 4.2 showing this is found in appendix J.

The policies have strong links to each other whilst still holding individual values and objectives. They complement each other, in particularly Community Prescribing (2011) as this makes references to integrated working and the recovery aspect of opiate prescribing, and *Integrated Care* (2010a) and *ROISC* (2013) both acknowledge that it is an integrated system to support service users. The objectives of each policy (integrated working, opioid substitution and recovery) make the policies stronger together because being on an opioid substitute treats the physical dependency, recovery capital supports the psychosocial aspect of the dependency and integrated working across services helps to address biopsychosocial elements through different services depending on the individual and their needs. Thus, each policy makes an important contribution to treatment for service users.

The differences between the policies are the individual factors each bring such as Map of Medicine (Welsh Assembly Government 2010a), OST and aftercare (Welsh Government 2011) and Recovery capital and recovery champions (Welsh Government 2013). The *Community Prescribing* (2011) policy is more health/medical focused compared to the other two. However, it still includes recovery values such as ensuring service delivery is person-centred and working together to help support the service user through treatment.

Integrated Care (2010a) and *ROISC* (2013) are similar in context with regards to integrated working, but as *ROISC* (2013) has seemingly replaced *Integrated Care* (2010a), it has removed SPoA and Single Record of Care from its policy, but it does not acknowledge this or explain why. *ROISC* (2013) has carried forward ICPs but has a stronger focus on recovery in terms of understanding individual recovery, assessments, recovery culture and building recovery communities.

This chapter presented the policy analysis and what is expected in practice for substance misuse treatment. The following chapter presents the *Discussion and Conclusion*, considering both datasets along with the existing research literature.

Chapter Five
Discussion and Conclusion

The aim of this research was to explore third sector professionals' views on the effectiveness of substance misuse services for adults on MPPs and how they work in practice. Interview findings were considered alongside three relevant Welsh policies, to build a comprehensive understanding of the subject matter and identify areas where the translation of policy intentions into practice is challenging. This thesis has highlighted some of the challenges for treatment and recovery from the perspective of those working in the third sector and those reported in the academic and policy literature.

Perceptions and Challenges of Methadone Prescription Programmes

Research participants had strong feelings *against* methadone and believed Subutex, detoxing or heroin itself is more beneficial than methadone. Their perspectives can be summarised as follows:

- Methadone is unlikely to be effective for abstinence-based recovery
- There is a lack of resources (e.g., funding, staff, community resources such as housing and transportation in the study area, causing problems for developing recovery capital (community)
- Recovery, in terms of the psychosocial model of recovery, should be considered more in treatment.

MPPs have been shown to reduce harm by reducing the risk of blood borne viruses, reducing criminal activity, help building stability and support the ability to function on a day-to-day basis (Gowing et al 2011 and Veilleux et al 2010, both cited in Uchtenhagen 2013, 284; Uchtenhagen 2013, 284; Fernandez and Libby 2011, Lind et al 2005, Mattick et al 2009 cited in Rose 2015, 102; BMA 2013, 9, and evidenced in the interview findings). The empirical evidence gathered in the present study suggests that MPPs can be beneficial, but service users could become 'stuck' on prescriptions if psychosocial and practical support is limited. This could be due to overburdened services - and a possible lack of understanding or awareness of such needs within statutory services or a problem with infrastructure. This is supported by CJS (2014, 27), Du Rose (2015, 103) and this present studies interview findings which suggests that service users can get trapped in a "*state sponsored addiction*" as referred to within the

literature and interview findings. HIW and CIW (2018) also found similar results in their joint review, and the SMDP 2019-22 aims to highlight issues relating to access to services and combating stigma from the public and some health services.

Challenges identified by those participating in the empirical element of the research interview findings, as well as key reports such as HIW and CIW (2018), SMDP 2019-22 and WTtRH 2018 (Livingston et al 2018) are:

- Access to services: such as location of services; transportation issues for the rural community;
- Lack of understanding of *population need*, with regards to service users who are described as "*hard-to-reach*" or "*chaotic*";
- Overburdened services, leading to capacity issues in service delivery;
- Stigma experienced by people with substance misuse issues;
- Multi-disciplinary working.

This present study concluded that MPPs are effective depending on individual interpretations of recovery and the goal and motivation of service users. As the literature review argues, opioid substitution was initially seen as an abstinence-based approach (Musalek 2013, 636), however it has evolved to a focus more on reducing harm (Egli et al 2009 and British Columbia ministry of Health both cited in Musalek 2013, 636). The aim of detoxification and maintenance programmes (OST), is harm reduction (Welsh Government 2011, 14). According to the interview findings in this present study, services are encouraging detox to the "*wrong people"*, increasing the risk of returning to drug use and overdose because they do not have the psychosocial resources in place. It is important to recognise that not everyone is the same, and not one approach will be best for everyone. OST is one initiative of harm reduction (Collins 2019), and Cohen (2017) found that reducing methadone dosages to zero for abstinence was ineffective. *Community prescribing* (2011, 5) emphasises the need that the service users should be fully informed of their treatment options and an integrated approach must be incorporated into care to prevent relapse after stabilisation or detox, and support should be offered to help with emotional and practical problems. Interview evidence from the present study suggests that reducing harm is the main focus for treatment in the study area. However, interviewees believe it is not an effective approach to heroin dependency due to the challenges that often arise with this population group and the lack of translating recovery policy agendas into service delivery practice - as seen with previous reports from HIW and CIW (2018). The more recent SMDP

2019-22 is focused on harm reduction, which is reflected by practices in the study area (according to the interviewees). However, interviewees do not agree that this is the best way forward, based on their experiences working with service users. SMDP 2019-22 aims for a harm reduction approach that should include all goals of recovery, however in doing so, interviewees feel that there was a lack of focus for abstinence.

The amount of funding and resources provided by the Welsh Government for dependency in an area, influences the opportunities to support recovery. Funding and resources are provided by the Welsh Government who are made aware of the population need through APBs, who are each responsible for an area in Wales. One possible explanation of minimal community resources, based on the literature, is the perception of addiction (dependency) as criminal, rather than a focus on health and wider social and economic factors. This can affect how people perceive dependency, and influences the stigma and judgements made towards the specific population (as a criminal, rather than unwell). This may also influence staff culture and attitudes, and which services take the lead on support. The policies provide important guidance but the wider context of resources, funding, approaches to treatment not meeting all needs, is not reflected in the policy, possibly the standard of what is expected is set too high given the means of what services have. This is discussed in this chapter.

Access to services

Service users need to have the internal and external resources to begin and sustain their recovery journey. This is where *ROISC* (2013) is relevant with recovery capital, based on Best et al (2009). Policy guidance recognises the challenges when attending appointments because of rurality (*Community Prescribing* 2011, and primary data). Nevertheless, challenges to accessing treatment is an ongoing issue, even though help with travel is given. The infrastructure may be lacking (e.g., not enough buses), and also there may be not be enough staff to supervise appointments. This indicates an inability to translate *Community Prescribing* (2011) and *ROISC* (2013) into practice.

Difficulties may arise when accessing or trying to access support because of living "*chaotically*" (complex lifestyles) or experiencing repetitive assessments, as evidenced by interview findings. *Integrated Care* (2010a) and *Community Prescribing* (2011) recommend support to prevent overwhelming and disengaging, but this does not seem to be carried out in practice, as evidenced by the interview findings. This is in line with the literature (Godersky et al 2019).

HIW and CIW (2018) and SMDP 2019-22 also emphasise that hard-to-reach groups need help accessing services. However, if *ROISC's* (2013) focus on person-centred approaches to treatment were implemented this would help to address these. It would also be helpful to follow advice that hard-to-reach groups should be involved in service design and development (HIW and CIW, 2018). Service users and the recovery community were included in the development of *ROISC* (2013, 3). Structured treatment has a "*key role to play in an individual's recovery*" as well as on-going community support to maintain and continue the recovery journey (Welsh Government 2013, 5). Although it is understandable that there is a need for structure, the interview findings from the present study suggest when somebody is experiencing "*ongoing chaotic substance misuse*", it is helpful to address the physical and psychological hold of the dependency in a way that empowers the individual, rather than creates barriers for them (i.e. arranging an appointment at a set time/date when this is a challenge for someone; in this case, a drop-in centre may be more beneficial for the service user). Recovery may be interpreted by services differently, including statutory, TSOs and service users themselves. Thus, this present study identified that if a recovery approach is used, problem severity and existing recovery capital, as outlined by White and Cloud (2008, cited in Best and Laudet 2010, 3), should be used to inform approaches. This means that it is not only about the person that is supported, but about wider social structures that need to be in place, such as availability of counselling or other psychosocial interventions, suitable housing not only to prevent homelessness but to avoid drug prevalent areas, support with income and/or benefits, flexible working arrangements if people need to attend an appointment or collect their methadone prescription, for example. This is always a challenge. It is also imperative that the service user's vision for recovery is at the forefront of recovery care plans because this is very important to sustain recovery (Welsh Government 2013, 13). Thus, treatment services should give service users an informed choice of their options (Independent Working Group 2017, 38 Welsh Government 2019a, 5, 15).

Understanding of population need

Interview findings suggest that the challenges faced by service users include a lack of community capital, which indicates a need for re-evaluating *population need* by the APB (as one part of their role is to determine what each area in Wales requires to sustain individuals' recovery), and for additional funding to help provide the resources needed for helping with access to services. Psychological and physical health problems because of dependency, social isolation and "*on-going chaotic substance misuse*" are seen as barriers to recovery (Best et al 2009, cited in Welsh Government 2013, 5). Current service delivery in the study area does not

seem to address these barriers sufficiently as evidenced in the interview findings. The issue of unsuitable housing is a key theme found in the interview findings, which is in line with the HIW and CIW (2018, 28 and 31) review findings for service users across Wales. It is the responsibility of the APB to assess need, through the SMS reporting engagement statistics using KPI (Welsh Government 2011, 6), and the Welsh Government can then provide the resources to overcome challenges. However, HIW and CIW (2018, 51) found that monitoring systems using KPIs are not effective due to differing interpretations of engagement and issues with service users engaging in structured administrative work such as form filling. This may explain why Welsh Government may not address certain barriers (i.e. lack of engagement) despite the WTtRH final report suggesting monitoring had improved over the ten-year review (Livingston et al 2018). The HIW and CIW (2018, 54) also noted that the APB performance monitoring is largely for non-statutory services. Thus, may not have full access to the Health Board's performance monitoring, implicating access to data for understanding the potential barriers and facilitators, stating "…*this means they [APB] may not have a full picture of what is happening across all services and opportunities to share learning could be missed*." (HIW and CIW 2018, 54).

In addition to this, some of the criticism of OST expressed by the interviewees in the present study is the withdrawal guidance by *Community Prescribing* (2011), such as the length of time withdrawal through detoxing takes. Despite there being two options, it seems the slower 12-week reduction programme is offered more often. However, the risk of returning to drug use and overdose needs to be considered, if the service user is withdrawn without adequate support, offering the longer withdrawal may be safer. Interviewees also argued that daily supervision is difficult when the person with an addiction/dependency has a "*chaotic*" lifestyle, meaning the guidance *community prescribing* (2011) offers may not be person-centred, because the service delivered is sometimes not suitable, i.e., unable to organise oneself to attend an appointment. OST can create barriers to achieving abstinence, due to how long service users are on the prescriptions (National Treatment Agency for Substance Abuse 2013 and PHE 2013, both cited in CSJ 2014, 20), as well as the difficulty withdrawing from methadone (more severe and lasting longer compared to heroin withdrawal) (Gossop and Strang 1991; Rosenbaum 1981; Steward 1987, cited in Rose 2015, 103). This may lead to little recovery progress being made. However, the same problems will arise if heroin-assisted treatment is used as an alternative in terms of daily supervision. Buprenorphine can be offered as a monthly injection, which was in

place during the Covid-19 pandemic, indicating this is possible to carry out (Welsh Government 2020).

Consequently, some service users are being prescribed MPP although they do not have high recovery capital (according to the interview findings, such as skills or confidence to attend appointments or inability to pay for transport or no transport available). This suggests that parts of *community prescribing* (2011) guidance are not followed in the study area and highlights Hennessey's (2017) key point that the resources to help build recovery capital need to be in place. An appropriate alternative treatment pathway for low recovery capital and high problem severity would be a "*combination of intense interventions*" (White and Cloud 2008, cited in Best and Laudet 2010, 3). However, in addition to assessing need, applying recovery capital to service provision needs to be in line with health and social policy to ensure resources and funding is in place to support the SMS and SMDP 2019-22.

Interview findings indicate that people with heroin dependency are likely to have low recovery capital and high problem severity, thus Tier 3 community treatment is unsuitable. An Assessment using a Recovery Capital scale could be advantageous for planning the recovery treatment pathway. Research suggests that measuring recovery capital at baseline and over time is essential and can inform service delivery (Cleveland et al 2021). Empirical evidence from the present study suggests that measurement is not routinely used in the study area (this is based on a small sample size), or that the resources are not in place for successful use of this assessment pathway. Measurements like ARC could indicate what level of support service users require (including what tier). For example, based on the interview findings of the present study and of the literature, adopting White and Cloud's (2008) model (discussed in Chapter One, *page 53-54*) would benefit service users' engagement if it was applied to the Welsh Government's substance misuse treatment tier system. If a person had high recovery capital + low problem severity, brief interventions of various types might be fine (Tier 1). Whereas someone with high recovery capital + high problem severity is more likely to benefit from an out-patient detoxification treatment with intense community support. This is supported by more recent literature which suggests that ARC predicts substance abuse treatment completion and improved response to treatment (Sánchez et al, 2020; Witbrodt et al 2019).

This lack of awareness of service user needs may be a result of "*managerialism",* which is minimising community engagement by focusing on office-based working (rather than home

visits). Roy and Buchanan (2016, 401) describe this as further isolating "*health and social welfare staff from the local communities they serve"*. If service providers carried out home visits or met within the community in which the service user lives, it will bring a greater understanding of the social context in which they live, including the wider context of the substance misuse/dependency, which increases empathy and true understanding of need and potential barriers to access (Roy et al 2013, cited in Roy and Buchanan 2016, 402; Roy and Buchanan 2016, 404). Home visits have also been shown to help with engagement in mainstream health services (Priebe et al 2005, cited in Roy and Buchanan 2016, 401), and could be very beneficial in the study area. However, funding needs to be in place to support repeated home visits. This is discussed further on *page 150-151*. An additional challenge to implementing community engagement from service providers over the last 18 months are Covid-19 safety and regulations. Frontline substance misuse workers who would complete recovery measures such as ARC with service users have to have experience and understanding of the social and environmental barriers faced by service users (Roy and Buchanan 2016). *Integrated Care* (2010a, 12) advises that ICPs are developed across the four tiers, using SPoA for substance misuse and single record of care to begin with. As much as this is a great idea in theory, this may be too aspiring with the means available. As discussed earlier and based on the interview findings, SPoA is not used in the study because of an unsuccessful pilot, and the difficulties with information sharing and MDW.

Overburdened services

These barriers to providing effective treatment options such as a high volume of caseloads and limited community resources (such as suitable housing, regular transport, flexible appointment arrangements) (according to the interview findings), causes complications when services aim to work with the service user to offer personalised recovery (ROISC 2013) and ensure their recovery capital is improved. Using a harm reduction approach to treatment puts the responsibility on the service user but without practical and social resources in place to support them reduce the harm, i.e., arranging appointments via the telephone and/or letters, when lost mobile phones and no fixed abode is a common difficulty for hard-to-reach, as the interview findings suggest. Focusing on individual behaviours without taking wider social, environmental, and economic factors into account will set people up to fail (Richardson et al 2013; Spooner and Hetherington 2004).

Community Prescribing (2011, 5) states that maintenance programmes should be offered alongside psychosocial interventions. Interviewees in the present study, policy (*Community Prescribing* 2011), and the research literature agreed that person-centred care is important alongside OST, especially the availability of psychosocial interventions (Bond and Witton 2017, 7 and WHO 2009 and NTA 2012, cited in Bond and Witton 2017, 8). The service users' motivation and circumstances impact on recovery stabilisation and stabilisation takes time (Welsh Government 2013, 5). This can be addressed through timely assessments which determine recovery capital and problem severity, and the resources needed to help address personal barriers. This will help overcome long waiting lists for example as the interview findings says there can be a significant amount on the waiting list who do not require a key worker, and just signposting to Tier 1 or 2 services.

Social policy and treating drug dependency

The findings from the present study indicate that there is a misalignment of substance misuse/dependency and social policies and the infrastructure in place to support people with substance use problems. As Hennessy (2017) states, there is a lack of attention towards community-level factors and what is actually available for people in the community, which requires additional funding and understanding the local *population need*. Research suggests that poverty and income inequality is linked to substance misuse, and these are the areas social policy requires a clearer focus on substance misuse (Independent Working Group 2017, 12; Public Health England 2017; BMA 2013, 5). Social policy should be supportive of people with substance misuse/dependency problems rather than create barriers. For example, the "*Help for Work*" programme created barriers for people with drug and alcohol problems, with a *Mandatory Intensive Regime* to prevent regular claimants, continuing stigmatisation (Bauman 2000 and Watson 2013, both cited in Roy and Buchanan 2016, 400; Roy and Buchanan 2016, 400). This is particularly disappointing as research has found that working can support the development of recovery capital, better mental and physical health, and lower dependence (Lowe et al 2018).

The Social Services and Well-being Act (2014) emphasises the importance of supporting people to achieve their personal well-being outcomes (Welsh Government 2017). The Well-being of Future Generations (Wales) Act (2015) focuses on tackling areas such as poverty, health inequalities and jobs losses (Welsh Government 2015c, 4) and A Healthier Wales (2018c) aims to encourage an active and independent lifestyle which will help people stay well

(Welsh Government 2018a, 3). This demonstrates three key Welsh social policies which are proving difficult adhering to in relation to supporting substance misuse services users, particularly to poverty and tackling health inequalities (Welsh Government 2015c) and encouraging an active and independent lifestyle (Welsh Government 2018a, 3). Although a healthy lifestyle may be encouraged, the inability to fully support this through provisions such as out of hours appointments for substance misuse (HIW and CIW 2018) or attending home visits to encourage engagement (Roy and Buchanan 2016) is often met with further challenges, such as staffing availability or lone-working procedures.

There are key social policies in place, but with little emphasis on substance misuse/dependency and its individual challenges. A reason why this may be an issue carried forward by the recent SMDP 2019-22 is that; harm reduction does not always address initial factors for substance misuse in the first instance, such as negative social conditions including the social and community context of the dependency (Smye et al 2011, 1).

The recovery concept

MPPs are more effective for reducing harm associated with heroin dependency. There is a greater focus on reducing drug/heroin use, although abstinence is still a treatment option, which correlates with the aim to reduce harm in *ROISC* (2013) and SMDP 2019-22. Based on the interviews, the third sector's recovery focus seemed to be on abstinence, which contrasts with the NHS/Welsh Government approach of the wider perspective to reduce harm. This may cause friction between statutory services and TSOs. TSOs experience more of the challenges and barriers to recovery at first hand. Therefore, TSOs may see a person as "*stuck*" on MPP whereas the NHS may see the person in recovery. The NHS will likely be more restricted to how they operate their services as their funding is provided through the Health Board/Welsh Government, whereas TSOs tend to have more freedom to deliver their service through their own service visions and strategies. Although there is often competition for funding between charities (interview findings and Radojev 2018) and they may have to adhere to funding requirements (Turner 2005 cited in Kalk et al 2018, 196). Yet, there is also no agreed approach between TSOs either; for example, the Wallich (2020) lean towards reducing drug/heroin use,, Recovery Cymru lean towards abstinence but accept that it is not everybody's goal (Recovery Cymru n.d.), whereas Narcotics Anonymous, are strictly abstinence based (NAUK n.d.). This illustrates that there is no set approach between TSOs either. Although abstinence seems more

favoured amongst TSOs in the study regions recovery communities; their values are similar, focusing on building a community, inclusion and control over substances.

Even defining abstinence as a recovery approach can be challenging (Dale-Perer 2017, 5), particularly the argument of "*assisted abstinence*" meaning being abstinent from heroin but supported through OST (UKDPC 2008 and White and Mojer-Torres 2010, both cited in Dale-Perera 2017, 5; Betty Ford Institute Consensus Panel 2007, cited in Dale-Perera 2017, 5), which could also be interpreted as reducing harm, however some perceive this as "*replacing one addiction for another"* (CSJ 2014, 20). This highlights the continuing challenge to defining dependency and recovery, even if one sector was in agreement.

ROISC (2013) has a very open approach to recovery and emphasises that there is no "*hierarchy of recovery*". From the third sector interviews, the difficulties faced when discussing the recovery model with services and councils, seem to focus on an understanding of recovery based on the medical model. The medical model focus' on the health perspective such as the physicality of drug use, whereas interviewees see abstinence as a psycho-social recovery model incorporating the biopsychosocial model. This challenge is reflected in the literature by Southby and Gamsu (2018, 366) who stated that GPs work from a medical model, whereas voluntary and third sector come from a community development perspective with different attitudes and culture differences. Working from different models will bring additional challenges to integrated working and multi-disciplinary (Aveling and Jovchelovitch 2014, White et al 2017 and Bryson et al 2006, all cited in Southby and Gamsu 2018, 367). It was clear from the interview findings from this present study that it is felt that the recovery agenda is overlooked in treatment, focusing too much on reducing drug/heroin use and also the "*medical model*", rather than the internal and external factors of their recovery (recovery capital) (Welsh Government 2013, 6). Based on the literature review and the interview findings from the present study, a culture and attitude change of recovery and dependency is needed to reduce stigma and widen understanding within services aware that abstinence or reducing the harm associated with drug use may mean recovery to individuals. The interview findings from the present study concurs with policy that recovery is individual and should be defined by the person. Recovery is personal and a strict definition of recovery is not advised (Best et al 2009, cited in Welsh Government 2013, 5). There are differing views on what recovery entails and how to define it.

Roy and Buchanan (2016, 399-400) discuss the issue of who has ownership and decides on the meaning of recovery; they argue that the recovery agenda has become a policy objective and is promoted and led by the government (Home Office 2012, cited in Roy and Buchanan 2016, 399). However, it is influenced by austerity, and adapted and shaped to be suitable of costs and resources available. For example, during times of austerity, the governments concept of recovery focused upon abstinence and cost-cutting, as opposed to rehabilitation, reintegrating, and "*full citizenship*" (Monaghan and Wincup 2013, Roy 2013, Watson 2013 all cited in Roy and Buchanan 2016, 400). This would suggest that the current agenda to reduce drug/heroin use and related harm in the SMDP 2019-22 may be a means to focus on a reduction of drug related deaths, as deaths were at their highest level in 2019 (ONS 2020, 2-3). Particularly as Middleton (2016, cited in Godlee 2016, 1) states that the push for abstinence between 2012 and 2015 may be related to increased opioid related deaths. The more people that are on an OST, the more there is a reduction in drug related harm. In addition, Roy and Buchanan (2016, 400) state that "*payment by results*" influences service providers to concentrate on outcome measures, rather than what could be delivered. There is also competition between other health and social care needs (Roy and Buchanan 2016, 400), particularly if substance misuse is interpreted as a health, rather than a criminal issue. The NHS is already under pressure and faces additional pressures due to Covid-19, which may make funding substance misuse services more challenging. A low amount of funding may lead to an increase in "*hurried*" abstinence (Roy and Buchanan 2016, 400), which may in part be responsible for a high volume of heroin and opiate related deaths (ONS 2017, 12).

Recovery culture and stigmatisation in treatment

The TSO interviewees explain a need for a change in recovery culture and attitudes. *ROISC* (2013) emphasises the need for a fundamental change (detail of the reason for the change not stated) in service culture and attitudes to the recovery model and a recognition of the importance of recovery capital (Welsh Government 2013, 5). This need for a culture change was put forward by *ROISC* (2013) eight years ago, however the current interview findings indicates that recovery culture still needs to be further developed; for example, reducing stigma from some staff within statutory services, and accepting and supporting personal journeys of recovery (interview findings and Welsh Government 2013, 4). The literature review found similar results, with HIW and CIW (2018) recognising the barriers to accessing treatment, and the SMDP 2019-22 emphasising the need to help hard-to-reach groups accessing treatment, regardless of their background (Welsh Government 2019a, 7). Societal attitudes towards

substance misuse/dependency are a significant barrier in building recovery capital (Foley et al 2021, 1). One major drawback of this is that the substance misuse policies do not align with the SMDP 2019-22 objective to support hard-to-reach groups. For example, there are no specific plans for supporting rural communities, nor is there alternative Tier 3 support for hard-to-reach or people experiencing homelessness and misusing substances. SMDP 2019-22 focus on reducing harm but does state that abstinence should be an option and particularly to make residential treatment more readily available for "*those with complex problems"* (Welsh Government 2019a, 15), by developing referral pathways into residential treatments such as through homelessness support (Welsh Government 2019a, 30). They promise to ensure this is still available with minimal waiting times and suitable locations (Welsh Government 2019a, 15).

Heroin-assisted treatment is recommended as an alternative treatment to methadone or buprenorphine where MPPs are not effective for people (Bond and Witton 2017, Drucker et al 2016, 243; Blanken et al 2010, cited in Drucker et al 2016, 243). Buprenorphine is advised by NICE (2008) within *Community Prescribing* (2011, 14) to be used as an alternative to methadone, but from the interview findings in this present study and EMADDA (2019b, 21), methadone is more prominent in treatment in Wales, despite not reportedly effective. Scotland recently began heroin-assisted treatment where the standard forms of treatment are not successful (i.e. MPP) (which Bond and Witton 2017, 6-7 and Schechter 2015, 2 also recommended) and alongside addiction/dependency counselling and welfare support such as housing and benefits (Burns 2019). Scotland has a high rate of drug-related deaths, almost three times higher compared to the UK as a whole (Burns 2019), and as a result changed their treatment approach. Supervision takes place twice a day every day, and service users administer the drug themselves (Burns 2019).

This is unlikely to be supported as a wider UK treatment option due to stigma towards heroin use. The UK Government decided not to continue a pharmaceutical heroin trial (RIOTT), despite RIOTT reporting better cost effectiveness for heroin-assisted treatment compared to oral methadone (Bond and Witton 2017, 3; and Byford et al 2013, cited in Schechter 2015, 2). This is despite the knowledge that it is harder to withdraw from methadone than from heroin (Gossop and Strang 1991, Rosenbaum 1981, Stewart 1987 cited in Du Rose 2015, 103, and interview findings). Interviewees in the present study agreed that buprenorphine is more effective compared to methadone, and that ideally heroin should be reduced each day until

abstinence can be achieved. Both these options were seen by the interviewees as more positive rather than prescribing methadone. Du Rose (2015, 3) and Schechter (2015) argued that government resistance to heroin as a treatment option is due to negative societal and political views. Drucker et al (2016, 246) and the interview findings of the present study argue that experts need to advocate for change.

Stigma and negative attitudes towards the drug user population are still apparent, as discussed in the interviews and the literature, despite efforts to change this within recovery culture (ROISC, 2013, HIW and CIW, 2018, 7; Welsh Government, 2019a, 12; Gething 2019). Particularly issues with referral for screening for issues outside of the substance misuse and dependency, and a general "*self-inflicted*" attitude towards people who use drugs (HIW 2012, 7, Independent Working Group 2017, 248 and interview findings). Stigma may be experienced in primary care, and then develops into a barrier to accessing further treatment, Experiences like this means that people are more likely to turn to TSOs for peer support aspect of recovery, where they may feel less stigmatised (Welsh Government 2013, 8). It is evident that stigma continues to be an issue (Welsh Government report 2019b) and minimal progress has been made to address this. The Welsh Government (2015a, 17) emphasises that a culture change needs to be supported by training, support, and education, pushed by senior clinicians and management throughout each organisation to be effective. Stigma associated with drug problems not only creates barriers to people accessing treatment (Hamilton 2021). It has been argued that a negative attitude of "personal choice" and the criminal issue of drug use, influenced the funding cuts towards treatment, which are likely related to the record high number of drug-related deaths in England and Wales (Hamilton 2021). The UK need to invest into effective treatment for people struggling with drug use, and work on changing the negative attitudes (ibid).

Livingston et al (2011, 45) researched the effectiveness of interventions which aimed to reduce stigma related to substance misuse disorders from the person themselves, social stigma from the general public and structural stigma from medical students. Their systematic review found that interventions mostly improved stigma outcomes (Livingston et al 2011, 45). Thus, interventions should be integrated into services to help reduce the barriers stigma can bring. Health conditions that are prone to stigma such as HIV/AIDs and tuberculosis, where the risk can be increased with intravenous drug use (Gowing et al 2011, Veilleux et al 2010, both cited in Uchtenhagen 2013, 284; Stancliff et al 2015, 206; Harm Reduction International n.d.) and

mental health issues, can increase stigma and have an emotional impact (Weiss et al 2006, 283-284). Counselling and group therapy can help build resilience towards stigma often experienced (Weiss et al 2006, 283). The general public and health care workers would also benefit from awareness raising campaigns, focusing on correcting misinformation which can fuel fear and judgement towards people who misuse drugs (Weiss et al 2006, 283; Woo et al 2017, 5). Harris and McElrath (2012) contributed to strategies that could help reduce institutionalised and internalised stigma through equal power relationships. Examples are the renaming of clinics to reflect a less stigmatising and labelling association and including former heroin dependents in taking a greater role in services and anti-stigma training.

Perceptions of dependency can influence policy making, service provision and multi-disciplinary working

Part of being a recovery-oriented service would be being welcoming at first contact and having person-centred care and *what matters?* approach (HIW and CIW 2018, 28; Social Care Wales 2019; and interview findings), and with professionals who understand the issues involved and have good communication skills (HIW 2012, 6-7, Independent Working Group 2017, 248, Gething 2019 and the interview findings). These are areas the SMDP 2019-22 are targeting, for example, ensuring GPs receive training on substance misuse/dependency (Gething 2019). Integrated working should be an integral part of treatment according to all three policies (Welsh Assembly Government 2010a; Welsh Government 2011, 5; Welsh Government 2013, 10), but ICPs were not explicitly discussed by participants. Reference was made to a number of practical issues associated with joint working including information sharing, SPoAs, repetitive assessments, and the need for drop-ins. HIW and CIW (2018) and the interviews all suggest that OST drop-in centres have been effective for service users previously. However, whether this is for a "*free fix*" (as mentioned in the interviews), or whether it is assisting the service users who struggle to engage with structured appointments, is unknown. The primary data suggests that there is evidence of integrated and MDW, but it could be improved in various ways, e.g. better information sharing through regular meetings, as also advised (three monthly) by *Community Prescribing* (2011). This is also a common finding in the HIW and CIW Joint Thematic Report (2018). The importance of information sharing, and the issue of repetitive assessments becoming a barrier to recovery, could be improved by having a SPoA for Substance Misuse (Welsh Assembly Government, 2010a). *Integrated Care* (2010a) includes excellent communication in their policy, however the lack of suitable premises for services, frustrations about duplicating work and information sharing systems and some services

unwilling to share information (HIW and CIW 2018, 8 and 49), does not indicate successful in practice. Improving multi-agency working is a key aim of the SMDP 2019-22 (Welsh Government 2019a, 15).

The current research suggests that guidance given in *Integrated Care* (2010a) is not followed. Interestingly, this policy has been discontinued but nonetheless, *ROISC* (2013) still refers to ICPs, and integrated working as a key component as does *Community Prescribing* (2011). It seems from the primary data that although the idea of a one-off assessment is valued and perceived as important, it is difficult to translate into practice. Possibly reasons mentioned in the interviews include of a lack of agreed information sharing, different IT systems, a high demand on services and lack of funding. The discontinued *Integrated Care* (2010a) policy and no reference to a SPoA in *ROISC* (2013) suggests a change in focus from substance misuse policies. There is a lack of existing research literature, evaluating SPoAs generally and what makes them work well. Literature from Rimmer (2017) highlighted the benefits of a SPoA, ensuring a more sufficient overall service, where people do not fall through the gaps due to waiting lists or a referral ineligibility. From the discussion above, it is evident that the *key conclusions* of recovery from *ROISC* (2013) are still important, eight years on (detailed in chapter four, *page 127*).

A debate posing a challenge in treatment is whether dependency is considered a health-based or a criminal issue. Welsh Government believe it should be considered a health issue, judging by a vote which decided on a health-focused approach (The Wallich 2020 and National Assembly for Wales 2017). However, Professor Nutt (2019) emphasised that the Home Office considers drug use a criminal problem. He argues that drug policies are politically motivated rather than scientifically based (Travis 2009; Nutt 2019). This is still a complex and ongoing debate, which overall influences policy, provision and working practices. The Wallich (2020) argues the Well-being of Future Generations Act (2015) cannot fulfil its aims with the current approach to illegal drugs, arguing the drug related deaths have been at their highest in four years, with Wales having the worst death rate in the UK on average. A review of the misuse of drugs in England by Dame Carol Black, indicated that people with drug problems should be treated the same as a diabetic or other chronic health patients, with "*skilled health workers"* as opposed to volunteers who are sometimes untrained (Hamilton 2021), which Amodeo et al (2011), Kimber et al (2012), and Ramanadhan et al (2012) (all cited in Bach-Mortensen et al 2018, 3),

also share as a concern, and which ties in with discussion above regarding home working, professional backgrounds and education.

The relationship between TSOs and statutory services

It has been suggested that TSOs and the NHS' relationship can be open to increased pressure as TSOs are becoming a more prominent organisation (but this does not necessarily mean problematic) to deliver support for substance misuse and dependency, although the worry of how qualified the TSOs are to deliver this standard of care has been highlighted (McCord 2003; Dishion et al 1999; Petrosino et al 2013, all cited in Bach-Mortensen et al 2018, 2; Bach-Mortensen et al 2018, 2; Kalk et al 2018, 196). On the other hand, some TSOs may have direct experience themselves which is instrumental in peer support (Welsh Government 2013, 8). TSOs might be able to bridge a gap in statutory service provision and often work better with hard-to-reach groups, as they can be more flexible in their service provision (Croft and Currie 2020, 553). TSOs can also support statutory services during times of high pressure and austerity by utilising volunteers for the stepping back of state provision (Baird et al 2018, Evers and Laville 2004 and Baggott and Jones 2014, all cited in Croft and Currie 2020, 549; Baggott and Jones 2014, 202). The literature search for this study showed that there is little TSO research and there is hardly any research on evidence-based practice (McCord 2003, Dishion et al 1999 and Petrosino et al 1999 all cited in Bach-Mortensen et al 2018, 2). They offer a service where the Government may struggle to reach certain groups, and have been seen to acknowledge local need, where it has been previously ignored (Kalk et al 2018, 195, Turner 2005, cited in Kalk et al 2018, 196). TSO interviewees felt their opinions have not been heard previously where they have tried to express issues or areas for change. This can cause tensions between TSOs and Government/statutory services. In terms of this research, and from the language and context in which the interviewees discussed substance misuse services, TSOs have a negative perception of current statutory service delivery.

Findings from the present study suggest that TSOs have unique experiences and skills for treatment for heroin, opioid and other opiate dependency and substance misuse generally, which should be considered more during policy making.

Looking forward

On a general note, there are parts of the policies which have been implemented in practice. *Integrated Care* (2010a) seems to have been implemented partly, but there are practical issues

to resolve. ICPs do not seem to be implemented in this study region at all, although this is based on a small sample of TSOs. *Community Prescribing* (2011) has implemented substitute prescribing with regards to methadone being offered first (compared to buprenorphine), and the 12-week slow reduction programme (even though this approach is not seen as beneficial by interviewees in the current study). On another note, keyworkers are to ensure the medications are taken as prescribed (Welsh Government 2011, 13) but the misuse of heroin on top of MPP is reported from the interview findings in this present study and in the literature (Public Health England 2013, cited in CSJ 2014, 20). It is also a role of the key worker to ensure recovery capital is assessed and developed (Welsh Government 2011, 13 and Welsh Government 2013, 14), which this discussion has shown is challenging without the infrastructure in place. *ROISC* (2013) has partly been implemented as it set out to. For example, there has been a change in culture to some extent with the focus on implementing reducing drug/heroin use and related harm in practice as set-out in the policy. However, the TSO interviewees in this present study do not agree this is successful for abstinence. *ROISC* (2013) also strived for the concept of recovery capital to be implemented and building of recovery capital to be supported. However, according to TSO interviewees, this has not happened. This may indicate challenges to assessments and recovery. For example, the Recovery Star assessment is effective for measuring the improvements of mental health for service users, but it does not measure the recovery culture from service providers (Lloyd et al 2016, 62). Other measures or combination of measures may be helpful (O'Connell et al 2005, cited in Lloyd et al 2016, 62). *ROSIC* (2013) has been referred to in a recent publication by Welsh Government (2018b, 11), which suggests the policy is still one of the main policy guidance and training within substance misuse.

The policies were based on best evidence at the time but objectives were too ambitious and no clear consensus between groups on the way forward. For example, there is the debate of what recovery means, how it should be defined, measured, and supported. These issues are likely to be common amongst many conditions and disabilities. Having resources in place, working with service users, and other services to help implement individual recovery aims is what would be beneficial for service users in the long term – be it reducing the drug related harm or abstinence. The funding needs to be available, and the service-user focus needs to be at the forefront of treatment; what is needed for that individual person to recover needs to be available, e.g. housing. The political nature of drug use and differing opinions in terms of a health versus a criminal approach make this a challenging area to work in. The Welsh Government focused initially on abstinence, and there was an increase in deaths, so they moved towards promoting

initiatives to reduce drug use and related harm, which reduces the availability of rehabs and abstinent-based support for people who wish to attain abstinence rather than reduce drug/heroin use.

Limitations and strengths of the study

This study focused on the perspectives of TSOs and their relationship with the NHS and Welsh Government in supporting and delivering services for service users of MPPs. A limitation, but opportunity for future research, was that a multitude of stakeholder's perspectives such as NHS staff directly involved in MPP service user treatment from GPs, SMS key workers, substance misuse nurses and pharmacists, inpatient rehabilitation staff and indirect staff such as healthcare receptionists, A&E staff and dentists could not be explored. Also, talking to Welsh Government representatives involved in substance misuse policymaking would be useful in future studies. The absence of voices from OST/MPP patients (former and current) is a limitation of this study and future research should include this stakeholder group. This level of inclusion was beyond the means of a Masters by Research study.

One other limitation of this research study was the small sample interviewed for the TSO interviews due to resource limitations. A larger sample may have allowed to capture a wider perspective. Nonetheless, a key strength of this study was the focus on the third sector. From the literature review, it was clear that there is limited research focusing on the third sector, especially in relation to substance misuse/dependency, and this research study identified and filled a gap in evidence in relation to the perceptions of TSO. Fundamentally, TSOs play a key role in the recovery journey of service users, often becoming key in building a recovery community and supporting the learning of skills.

Further research

In addition to future research exploring the effectiveness of MPPs through encompassing the three key stakeholder groups; TSO, statutory services and patients, it would also be useful to conduct a longitudinal research study on this topic. Particularly, exploring recovery capital over long term to determine whether funding is allocated to valuable areas lacking in resources, to explore whether drug-related harm and deaths influence drug policy in terms of their approach to service provision and delivery, and to document if and how service users recovery capital changes over time. Additionally, applying a mixed-methods study methodology would provide a bigger picture of data to analyse through qualitative and quantitative methods. In particular, qualitative research with people using drugs would be helpful to better understand key issues

and experiences. For example, Maher (2002) conducted longitudinal ethnographic research exploring injecting drug use. She proposed that ethnographic fieldwork is an important methodology contributing to the understanding of injecting drug use and ways of overcoming vulnerability (Maher 2002).

Recommendations

TSOs may have different perceptions of what recovery is from each other, and from NHS/statutory services: for example, organisations may work with an abstinence service vision or to reduce drug/heroin use, and medical models or psychosocial models to dependency. This can add to difficulties for MDW. Neale et al (2016) highlights that different stakeholders use different "*indicators*" to measure recovery from "*addiction*" in the British Isles. Statutory services should support the service user based on the service users' definition of recovery, and the service user can then decide which TSOs they wish to receive additional support from, depending which approach suits them. This relates to Bradshaw's taxonomy of need, stating that people's needs in a certain location may be similar based on socio-economic status, and the more awareness people have of availability of services, the more empowered people will be to ask for the relevant service (Bradshaw 1972, cited in Asadi-Lari et al 2003). The definition of recovery followed by services supporting a service user, should be the one they believe in, so that support can be put in place as required. There is a need to:

- Address physical *and* psychological dependency without disempowering the service user: understand their strengths and resources during the initial assessment using something like the Recovery Capital Scale and Recovery Capital/Problem severity model and use results to inform treatment and service delivery. Providing a 'one size fits all' in terms of service delivery and provision is not effective.
- Have a "*what matters?"* conversation to develop the best approach and treatment for the service user.
- Understand the circumstances a service user is experiencing through home visits/circumstantial visits. Service providers can then gain insight into the life and challenges the service user experiences, which could be causing barriers to their treatment engagement and recovery. Service providers need to work closely with policymakers and commissioners to inform a better understanding of population need. This can also support the development of better monitoring systems.
- Consider using a single point of access for substance misuse. This will avoid repetitive assessments and is likely to improve engagement and provide a more coherent service.

However, more learning is needed to understand what the challenges are to offering such a service.

- Welsh Government to make additional funding available for abstinence, as opposed to focusing mainly on reducing drug/heroin use.
- Put in place outreach support and drop-in centres for hard-to-reach groups, where structured community support is not effective. This could also help with information sharing and better communication between agencies. Availability of residential rehabilitation to support those with low recovery capital and high problem severity is also needed.
- Consider using buprenorphine prolonged-release injection and heroin-assisted treatment on a case-by-case basis. This would be for service users who are committed to treatment and developing their recovery capital, but struggle to attend daily supervision due to a lack of community resources or employment flexibility, for example.

Bibliography

Agrawal A and Lynskey MT (2008), Are there genetic influences on addiction: evidence from family, adoption and twin studies. *Addiction* **103**: 1069-81. Cited in BMA 2013, p.64-65.

Amato L, Minozzi S, Vecchi S, Davoli M. Benzodiazepines for alcohol withdrawal. Cochrane Database of Systematic Reviews 2010, Issue 3. Art. No.: CD005063. DOI: 10.1002/14651858.CD005063.pub3. Cited in Welsh Government 2013, p. 16.

American Psychiatric Association (1994), DSM-IV-TR: Diagnostic and Statistical Manual of Mental Disorders (4th Edition). *American Psychiatric Press*, DC, USA (1994). Cited in Musalek 2013, pg.636.

American Psychiatric Association (2000), Diagnostic and Statistical Manual of Mental Disorders. 4th ed, Text Revision. Washington, DC: *American Psychiatric Association*; 2000. Cited in Ersche et al 2012, p.173.

American Psychiatric Association (2013), DSM-V: Diagnostic and Statistical Manual of Mental Disorders (5th Edition). *American Psychiatric Press*, DC, USA (2013). Cited in Musalek 2013, pg.636

Amodeo M, Lundgren L, Cohen A, Rose D, Chassler D, Beltrame C, et al (2011), Barriers to implementing evidence-based practices in addiction treatment programs: comparing staff reports on motivational interviewing, adolescent community reinforcement approach, assertive community treatment, and cognitive-behavioral therapy. *Eval Program Plann*. 2011; 34:382–9. https://doi. org/10.1016/j.evalprogplan.2011.02.005. Cited in Bach-Mortensen et al 2018, p.2-3.

Anstice S, Strike CJ, Brands B (2009), Supervised methadone consumption: client issues and stigma. *Substance Use & Misuse*. 2009; **44**:794–808.10.1080/10826080802483936 [PubMed: 19444722]. Cited in Earnshaw et al 2013, p.111.

Asadi-Lari, M., Packham, C. and Gray, D. Need for redefining needs. *Health Qual Life Outcomes* **1,** 34 (2003). https://doi.org/10.1186/1477-7525-1-34.

Aveling, EL., and Jovchelovitch, S. (2014), Partnerships as knowledge encounters: A psychosocial theory of partnerships for health and community development. *Journal of Health*

Psychology, 19(1), 34–45. https://doi.org/10.1177/1359105313509733. Cited in Southby and Gamsu 2018, p.367.

Bach-Mortensen, A., Lange, BCL., and Montgomery, P. (2018), Barriers and facilitators to implementing evidence-based interventions among third sector organisations: A systematic review. *Implementation Science*, 13 doi:http://dx.doi.org/10.1186/s13012-018-0789-7. (Accessed 17th April, 2021).

Baggott, R., and Jones, K. (2014), The voluntary sector and health policy: the role of national level health consumer and patients' organisations in the UK. *Social Science & Medicine* 123:202-9. Also cited in Croft and Currie 2020, p.549.

Baird, B., Cream J., Weaks, I, (2018*), Commissioner Perspectives on working with the voluntary, community and social enterprise sector*. London: The Kings Fund. Cited in Croft and Currie 2020, p.549.

Ballantyne, JC., Sullivan, MD., and Kolodny, A. (2012), Opioid dependence vs addiction: A distinction without a difference? *Archives of Internal Medicine*, 172(17), 1342Y1343. doi:10.1001/archinternmed.2012.3212. Cited in Dobbs and Fogger 2018, p.58.

Bauman, Z. (2000), Am I my brother's keeper? *European Journal of Social Work*, 3, 1: 5–11. Cited in Roy and Buchanan 2016, p.400.

Berryman, DR. (2019), Ontology, Epistemology, Methodology, and Methods: Information for Librarian Researchers. *Medical Reference Services Quarterly* 2019, VOL. 38, NO. 3, 271-279 https://doi.org/10.1080/02763869.2019.1623614

Best, D., Beckwith, M., Haslam, C., Haslam, A., Jetten, J., Mawson, E., and Lubman, D. I. (2015), Overcoming alcohol and other drug addiction as a process of social identity transition: the social identity model of recovery (SIMOR). *Addiction Research & Theory* 24:2, 111-123, DOI: 10.3109/16066359.2015.1075980 (Accessed 26th July 2019).

Best, D., Day, E., Morgan, B., Oza, T., Copello, A., Gossop, M. (2009), What treatment means in practice: An analysis of the delivery of evidence-based interventions in criminal justice drug treatment services in Birmingham, England. *Addiction Research & Theory* Vol 17, 2009 – issue 6. https://doi.org/10.3109/16066350802447090 Accessed 24th March 2021. (Cited in Welsh Government 2013).

Best, D, and Laudet, AB. (2010), The Potential of Recovery Capital. *RSA Projects*. Citizen Power Peterborough. https://www.thersa.org/globalassets/pdfs/reports/a4-recovery-capital-230710-v5.pdf. Accessed 24th March 2021. Also cited in ROISC 2013, Welsh Government 2013, p.7. and Cano et al 2017, pp.180-181.

Best, D., Rome, A., Hanning, KA., White, W., Gossop, M., Taylor, A., and Perkins, A. (2010), Research for Recovery: A Review of the Drugs Evidence Base. *Scottish Government Social Research*. ISSN 0950 2254 ISBN 978 0 7559 9505 9 (Accessed 24th March 2021). https://www.drugsandalcohol.ie/13872/1/Recovery_Scotland.pdf. Cited in *ROISC* 2013, Welsh Government 2013, p.7.

Betty Ford Institute Consensus Panel (2007), 'What is recovery? A working definition from the Betty Ford Institute', *Journal of Substance Abuse Treatment* 33, pp. 221-228. Cited in Dale-Perera 2017, p.5.

Biernacki, P. (1986), *Pathways from heroin addiction: Recovery without treatment*. Philadelphia: Temple University Press. Cited in Best et al 2015, p.113 and cited in Heyman 2013, p.1.

Bierut LJ, Dinwiddie SH, Begleiter H, Crowe RR, Hesselbrock V, Nurnberger JI Jr, Porjesz B, Schuckit MA, and Reich T. (1998), Familial transmission of substance dependence: alcohol, marijuana, cocaine, and habitual smoking: a report from the Collaborative Study on the Genetics of Alcoholism. *Archives of General Psychiatry* 55: 982-8. Cited in BMA 2013, p.64.

Blanken P, van den Brink W, Hendriks VM, Huijsman IA, Klous MG, Rook EJ, Wakelin JS, Barendrecht C, Beijnen JH, and van Ree JM. (2010), Heroin-assisted treatment in the Netherlands: History, findings, and international context. *European Neuropsychopharmacology* 20 (Suppl 2): S105–S158. Cited in Drucker et al 2016, p.243.

Bloor, M.J., McIntosh, J., McKeganey, N.P. and Robertson, M. (2008), '"Topping up" methadone: an analysis of patterns of heroin use among a treatment sample of Scottish drug-users', *International Journal of Drug Policy*, vol 19, no 3, pp 248-54. Cited in Du Rose 2015, p.102.

Board of Science (BMA) (2013), Drugs of Dependence: The role of medical professionals. January 2013. *Board of Science*. London: British Medical Association.

Bond, A. J., and Witton, J., (2017), Perspectives on the Pharmacological Treatment of Heroin Addiction. *Clinical Medicine Insights: Psychiatry* Volume 8: 1–10. DOI: //doi.org/10.1177/1179557317737322 Accessed 17th April 2021.

Boutillier, M., O'Connor, P., Zyzis, T., Roberts, J., and Banasiak, K. (2011), Does Collaborative Service Delivery Improve Client and Organization Outcomes? A Review of the Evidence on NPO Collaboration in Health and Social Services. WELLESLEY INSTITUTE | ADVANCING URBAN HEALTH.

Boyd, S. (2004), *From witches to crack moms: Women, drug law and policy*. Durham, NC: Carolina Academic Press. Cited in Du Rose 2015, p. 102-103.

Bradshaw J (1972), A taxonomy of social need. Problems and progress in medical care: essays on current research (Edited by: Mclachlan G). Oxford, Nuffield Provincial Hospital Trust 1972., 7th series. Cited in Asadi-Lari et al 2003.

Braun, V., and Clarke, V., (2006), Using thematic analysis in psychology. *Qualitative Research in Psychology*. Volume 3, 2006. Issue 2

Braun, V., and Clake, V. (2021), Can I use TA? Should I use TA? Should I *not* use TA? Comparing Reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Couns Psychother Res. 2021:21:37-47.*

Brener, L, and von Hippel, W. (2008), Measuring attitudes toward injecting drug users and people with Hepatitis C. *Substance Use & Misuse*. 2008; 43:295–302.10.1080/10826080701202627 [PubMed: 18365932]. Cited in Earnshaw et al 2013, p.111.

Brener, L, von Hippel, W, Kippax, S. (2007), Prejudice among health care workers toward injecting drug users with hepatitis C: does greater contact lead to less prejudice? *International Journal of Drug Policy*. 2007; 18:381–387.10.1016/j.drugpo.2007.01.006 [PubMed: 17854726]. Cited in Earnshaw et al 2013, p.111.

Brener, L., von Hippel., W, Kippax, S., Preacher, K.J. (2010), The role of physician and nurse attitudes in the health care of injecting drug users. *Substance Use & Misuse*. 2010; 45:1007–1018.10.3109/10826081003659543 [PubMed: 20441447]. Cited in Earnshaw et al 2013, p.111

Brennan, N., Mattick, K., and Ellis, T (2011), The Map of Medicine: a review of evidence for its impact on healthcare. Review Article. *Health Information and Libraries Journal*. **28**, pp.93–100. DOI: 10.1111/j.1471-1842.2011.00940.*x*

British Columbia ministry of Health (2005), Harm Reduction: British Columbia Community Guide. www.health.gov.bc.ca/library/publications/ year/2005/hrcommunityguide.pdf. Cited in Musalek 2013, 636).

British Medical Association, Royal Pharmaceutical Society. British National Formulary (BNF) (2016), 67. June. London*: BMJ Group and Pharmaceutical Press*; 2016. Cited in Kenworthy et al 2017, 743.

Brown, N. (2000), Coming Clean: Overcoming Addiction Without Treatment. Peer reviewed journal of *Robert Granfield., and William Cloud, New York, New York University Press 1999. Health and Social Work* Vol 25: No4 pp. 281-282.

Bryson, J. M., Crosby, B. C., and Stone, M. M. (2006), The design and implementation of cross- sector collaborations: Propositions from the literature. *Public Administration Review,* 66, 44–55. https://doi.org/10.1111/j.1540-6210.2006.00665.x cited in Southby and Gamsu 2018, p.367.

Bulman, M. (2017), Drug and alcohol treatment funding slashed across England by 16% in four years. *The Independent.* https://www.independent.co.uk/news/uk/home-news/spending-on-drug-and-alcohol-treatment-slashed-by-105m-in-four-years-a7912531.html. (Accessed 5th July 2019).

Burns, C. (2019), Scotland's first heroin-assisted treatment service launched in Glasgow. *The Pharmaceutical Journal*, PJ, December 2019, Vol 303, No 7932;303(7932): DOI:10.1211/PJ.2019.20207404. Article last updated 12 February 2021 19:00. Accessed 18th July 2021.

Burwell, D'A. (2015), *Saving Jake: When Addiction Hits Home*. FocusUp Books: Los Atlos, California

Buse, K., Mays, N., and Walt, G. (2012), Making Health Policy: *Understanding public health.* Second edition. Open University Press: McGraw-Hill Education (UK): Maidenhead. ISBN 0335246354, 9780335246359. Also cited in O'Brien et al 2020, p.2.

Byford, S., Barrett, B., Metrebian, N., Groshkova, T., Cary, M., Charles, V., Lintzeris, N. and Strang, J. (2013), "Cost-effectiveness of injectable opioid treatment v. oral methadone for chronic heroin addiction," *British Journal of Psychiatry*. Cambridge University Press, 203(5), pp. 341–349. doi: 10.1192/bjp.bp.112.111583. Also cited in Schechter 2015, p.2.

Cabinet Office and Office of the Secretary of State for Wales. Guidance (2018), Devolution settlement: Wales. Published 20 February 2013. Last updated 10 September 2018. Devolution settlement: Wales - GOV.UK (www.gov.uk) (Accessed 29th August 2021).

Calcaterra, V., and Raineri, M. L. (2019), Helping each other: a peer supervision group with facilitators of mutual aid groups. *Social Work with Groups*, DOI:10.1080/01609513.2019.1642829 (Accessed 10th March 2020).

Calsyn DA, Malcy JA, and Saxon AJ. (2006), Slow tapering from methadone maintenance. *JSAT* 2006; 30:19-63. Cited in Cohen 2017.

Campbell, S., Greenwood, M., Prior, S., Shearer T., Walkem, K., Young, S., Bywaters, D., and Walker, K. (2020), Purposive sampling: complex or simple? Research case examples. *Journal of Research in Nursing* Vol 25, issue 8:652-661.

Camurus AB (2020), *Package leaflet: Information for the user. Buvidal 8 mg prolonged-release solution for injection; Buvidal 16 mg prolonged-release solution for injection; Buvidal 24 mg prolonged-release solution for injection; Buvidal 32 mg prolonged-release solution for injection; Buvidal 64 mg prolonged-release solution for injection; Buvidal 96 mg prolonged-release solution for injection; Buvidal 128 mg prolonged-release solution for injection buprenorphine*. Ideon Science Park:Sweden.

Cano, I., Best, D., Edwards, M., Lehma, John (2017), Recovery capital pathways: Modelling the components of recovery wellbeing. *Drug and Alcohol Dependence* 181:11-19.

Care Council for Wales (2017), Planning, Commissioning and Co-Production. Social Services and Wellbeing Act (2014). Care Council for Wales: Cardiff.

Carvel, J. (2008), Councils expect social problems from recession. *The Guardian.* https://www.theguardian.com/society/2008/dec/19/local-government-recession (Accessed 5th July 2020)

Cegedim Healthcare Solutions (2019), What Can Replace Map of Medicine? 30 January 2019. https://www.cegedimrx.co.uk/blog/what-can-replace-map-of-medicine (Accessed 20th August 2021.)

Centre for Social Justice (CSJ) (2014), *Ambitious for Recovery: Tackling drug and alcohol addiction in the UK. Breakthrough Britain II.* Centre for Social Justice: London.

Church, A. and Frost, M. (1995), "The Thames Gateway – an analysis of the emergence of a sub-regional regeneration initiative", The Geographical Journal, Vol. 161 No. 2, pp. 199-209. Cited in Cornelius and Wallace 2013, p.237.

Civil Service (n.d.), Introduction to Devolution. Devolution and You.

Clausen T, Anchersen K, Waal H (2008), Mortality prior to, during and after opioid maintenance treatment (OMT): a national prospective cross-registry study. *Drug Alcohol Depend* 2008; 94(1):151–7. Cited in Stancliff et al 2015, p.212.

Cleveland, HH., Brick, TR., Knapp, KS., and Croff, JM. (2021), Recovery and Recovery Capital: Aligning Measurement with Theory and Practice. In Julie M. Croff and Jason Beaman (eds.) *Family Resilience and Recovery from Opioids and Other Addictions*, pp109-128. Springer.

Cloud, W. and Granfield, W. (2009) Conceptualising recovery capital: Expansion of a theoretical construct, *Substance Use and Misuse,* 42, 12/13, 1971-1986. Cited in Best and Laudet 2010, 4.

Cohen, R. (2017), Successful discharges from opiate substitution therapy – dose reduction to zero. Luton Drug Service. NHS Cambridgeshire Community Services NHS Trust. Poster for SSA conference Nov 2017.

Collins, SE. (2019), *Sobriety is just one pathway to recovery. Harm reduction is another*. First Opinion. April 11, 2019 https://www.statnews.com/2019/04/11/harm-reduction-substance-use-disorder/ (Accessed 14th June 2021).

Collins, SE., Clifasefi, SL., Logan, DE., Samples, LS., Somers, JM., and Marlatt, GA. (2012), *Current Status, Historical Highlights, and Basic Principles of Harm Reduction. Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors,* Second Edition. Edited by G. Alan Marlatt, Mary E. Larimer, and Katie Witkiewitz.

Collins SE, Clifasefi SL, Nelson LA, Stanton J, Goldstein SC, Taylor EM, Hoffmann G, King VL, Hatsukami AS, Cunningham ZL, Taylor E, Mayberry N, Malone DK, Jackson TR (2019), Randomized controlled trial of harm reduction treatment for alcohol (HaRT-A) for people experiencing homelessness and alcohol use disorder. *Int J Drug Policy*. 2019 May; 67:24-33. doi: 10.1016/j.drugpo.2019.01.002. Epub 2019 Mar 6. PMID: 30851620; PMCID: PMC6488431.

Cornelius, N., and Wallace, J. (2013), Capabilities, urban unrest and social enterprise Limits of the actions of third sector organisations. *The International Journal of Public Sector Management*; Bradford Vol. 26, Iss. 3, (2013): 232-249. DOI:10.1108/IJPSM-11-2008-0043

Cornish, R., Macleod, J., Strang, J., Vickerman, P., and Hickman, M. (2010), Risk of death during and after opiate substitution treatment in primary care: prospective observational study in UK General Practice Research Database. *BMJ* 341:bmj.c5475. Cited in Independent Working Group 2017, p.13.

CRC Health (n.d.), *Suboxone Vs. Subutex: What's The Difference? (And Which One Is Right For You?* Website. Also cited in Itzoe and Guarnieri 2017, p.1432.

Croft, C., and Currie, G. (2020), Realizing policy aspirations of voluntary sector involvement in integrated care provision: Insights from the English National Health Service. *Health Policy* 124 (2020) 549–555.

Crotty, M. (1998), *The Foundations of Social Research. Meaning and perspective in the research process.* Allen and Unwin: Australia.

Csete J, Kamarulzaman A, Kazatchkine M, Altice F, Balicki M, Buxton J, Cepeda J, Comfort M, Goosby E, Goulão J, Hart C, Kerr T, Lajous AM, Lewis S, Martin N, Mejía D, Camacho A, Mathieson D, Obot I, Ogunrombi A, Sherman S, Stone J, Vallath N, Vickerman P, Zábranský T, Beyrer C. (2016), Public health and international drug policy [The Lancet-Johns Hopkins Commission]. *Lancet* 2016;387:1427-80. doi:10.1016/ S0140-6736(16)00619-Xpmid:27021149. Cited in Godlee 2016, p.1

Dale-Perera, A (2017), Recovery, reintegration, abstinence, harm reduction: the role of different goals within drug treatment in the European context. Background paper commissioned by the EMCDDA for Health and social responses to drug problems: a European *guide European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)*. October 2017.

Dawe S., Gullo MJ., and Loxton NJ. (2004), Reward drive and rash impulsiveness as dimensions of impulsivity: implications for substance misuse. *Addictive Behaviors* 29: 1389-405. Cited in BMA 2013, p.69.

Department of Health (England) and the devolved administrations (2007). *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. Retrieved from http://www.nta.nhs.uk/ uploads/clinical_guidelines_2007.pdf. Cited in UK Focal Point on Drugs 2016, p.9. and

original document also cited in Welsh Assembly Government 2010a and Welsh Government 2011 (the Scottish Government, Welsh Assembly Government and Northern Ireland Executive http://www.nta.nhs.uk/publications/documents/clinical_guidelines_2007.pdf)

Des Jarlais DC, Paone D, Friedman SR, Peyser N, Newman RG. (1995), Regulating controversial programs for unpopular people: methadone maintenance and syringe exchange programs. *American Journal of Public Health*. 1995; 85(11):1577–1584. [PubMed: 7485676]. Cited in Earnshaw et al 2013, p.111

Dickens, G., Weleminsky, J., Onifade, Y., and Sugarman, P. (2012), Recovery Star: validating user recovery. *The Psychiatrist* (2012), 36, 45-50, doi: 10.1192/pb.bp.111.034264.

Dishion, TJ., Mccord, J., Poulin, F. (1999), When interventions harm: peer groups and problem behavior. *Am Psychol*. 1999; 54:755–64. https://doi.org/10.1037/ 0003-066X.54.9.755. Cited in Bach-Mortensen et al 2018, p.2.

Dobbs, GC., and Fogger, SA. (2018), Opiate Dependence or Addiction? A Review of the Centers for Disease Control and Prevention Guidelines for Management of Chronic Pain. *Journal of Addictions Nursing.* Volume 29: Number 1, 57-61, doi: 10.1097/JAN.0000000000000212. PMID: 29505462. (Accessed 2nd August 2021).

Dodgson, JE. (2019), Reflexivity in Qualitative Research. *Journal of Human Lactation* 2019, Vol. 35(2) 220–222.

Dolan K., Larney S., and Wodak A (2007), The integration of harm reduction into abstinence-based therapeutic communities: a case study of we help ourselves. Asian J. *Couns*. 14(1–2), 1–19 (2007). Cited in Musalek 2013, 636.

Drucker, E., Anderson, K., Haemmig, R., Heimer, R., Small, D., Walley, A., Wood, E., van Beek, I. (2016), Treating Addictions: Harm Reduction in Clinical Care and Prevention. *Bioethical Inquiry* DOI 10.1007/s11673-016-9720-6. SYMPOSIUM: STRUCTURAL COMPETENCY.

Drummond, C (2015), The Future of Addiction Psychiatry in 2015. Royal College of Psychiatrists. http://www. rcpsych.ac.uk/pdf/Drummond%20Colin%20-%20Future%20of%20Addiction%20May%202015.pdf. Cited in Kalk et al 2018, p.196.

Drummond, DC., Cooper, T., and Glautier, SP. (1990) Conditioned learning in alcohol dependence: implications for cue exposure treatment. *British Journal of Addiction* 85: 725-43. Cited in BMA 2013, p.70.

Du Rose, N. (2015), *The Governance of Female Drug Users: Women's Experiences of Drug Policy*. Policy Press: Bristol.

Earnshaw, V., Smith, L., and Copenhaver, M. (2013), Drug Addiction Stigma in the Context of Methadone Maintenance Therapy: An Investigation into Understudied Sources of Stigma. *International journal of mental health and addiction*, *11*(1), 110–122. https://doi.org/10.1007/s11469-012-9402-5.

Eckhardt, M., Carlfjord, S., Faresjö, T., Crespo-Burgos, A., Forsberg, BC., Falk, M. (2019), Universal Health Coverage in Marginalized Populations: A Qualitative Evaluation of a Health Reform Implementation in Rural Ecuador. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*. Volume 56: 1–10. DOI: 10.1177/0046958019880699

Egli N, Pina M, Christensen PS., Aebi, M., and Killias, M. (2009), Effects of drug substitution programs on offending among drug-addicts. *Campbell Syst. Rev*. 3 (2009). Cited in Musalek 2013, pg.636.

El-Jardali, F., Karroum, LB., Ataya, N., El-Ghali, HA., and Hammoud, R. (2014), A retrospective health policy analysis of the development and implementation of the voluntary health insurance system in Lebanon: Learning from failure. *Social Science and Medicine* 123, 45-54.

Emerson, RW. (2015), Convenience Sampling, Random Sampling, and Snowball Sampling: How Does Sampling Affect the Validity of Research. *Journal of Visual Impairment & Blindness*. 2015;109(2):164-168. doi:10.1177/0145482X1510900215 (accessed 8th November 2020)

Ersche, KD., Turton, AJ., Croudace, I., and Stochl, J. (2012), Who Do You Think Is in Control in Addiction? A Pilot Study on Drug-related Locus of Control Beliefs. *Addictive Disorders & Their Treatment*. Volume 11, Number 4 December 2012 pp.173–223.DOI: 10.1097/ADT.0b013e31823da151 (Accessed 19th April 2021).

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (n.d.), *Take-Home Naloxone*. Website. https://www.emcdda.europa.eu/publications/topic-overviews/take-home-

naloxone_en#:~:text=Programmes%20that%20combine%20training%20on,places%20where%20overdoses%20might%20occur. (Accessed 4th August 2021).

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2019a), *European Drug Report Trends and Developments 2019*. EMCDDA.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2019b), *United-Kingdom United Kingdom Country Drug Report 2019*. EMCDDA.

Evers, A., and Laville J-I. (2004), *The third sector in Europe*. Edward Elgar Publishing. Cited in Croft and Currie 2020, p.549.

Fernandez, H. and Libby, T.A. (2011), *Heroin: it's history, pharmacology, and treatment* (2nd edn), Center City, MN: Hazelden. Cited in Du Rose 2015, p.102.

Foley, M., Reidy, M., and Wells, J.S.G. (2021), Recovery capital: stakeholder's experiences and expectations for enabling sustainable recovery from substance use in the South East Region of Ireland. *Journal of Substance Use.* DOI: 10.1080/14659891.2021.1941342

Foulds J., and Ghodse A.H., (1995), The role of nicotine in tobacco smoking: Implications for tobacco control policy. *Journal of the Royal Society of Health*. 1995; 115: 225-230. Cited in Russell et al 2011, p.151.

Fraser, S., and Valentine, K. (2008), Substance and substitution: Methadone subjects in liberal societies. New York: Palgrave Macmillan. Cited in Harris and McElrath 2012, p.820.

Gabbatiss, J. (2019), UK facing 'addiction crisis' as councils cut funding for treatment while alcohol-related deaths soar. *The Independent* Monday 11 February 2019 01:04. https://www.independent.co.uk/news/health/alcohol-deaths-council-funding-cuts-drug-addiction-services-austerity-jonathan-ashworth-a8772301.html (Accessed 14th August 2021).

Galanter, M. (2006), Innovations: alcohol & drug abuse: spirituality in Alcoholics Anonymous: a valuable adjunct to psychiatric services. *Psychiatr Serv*. 2006;57(3):307–9. doi: 10.1176/appi.ps.57.3.307. [PubMed: 16524986]. Cited in Nikmanesh et al 2017, p.1.

George, O., Le Moal, M., and Koob, GF. (2012), Allostasis and addiction: Role of the dopamine and corticotropin-releasing factor systems. *Physiology and Behavior*, 106(1), 58-64. doi:10.1016/j.physbeh.2011.11.004. Cited in Dobbs and Fogger 2018, p.58).

Gething, V. AM. (2019), *Written Statement: Substance Misuse Delivery Plan 2019-2022*. CABINET STATEMENT. 23 October 2019.

Ghodse, H. (2010), *Drugs and Addictive Behaviour: A guide to treatment.* Cambridge: Cambridge University Press. Cited in Welsh Government 2011, pg.5.

Gill, P., Stewart, K., Treasure, E. and Chadwick, B. (2008), Methods of data collection in qualitative research: interviews and focus groups. *British Dental Journal* 204(6), 291–295. doi:10.1038/bdj.2008.192. Cited in Kallio et al 2016, p.2955.

Glauser, W. (2014), "High-functioning addicts": intervening before trouble hits. *CMAJ*, January 7, 2014, 186(1) 1. CMAJ 2014. DOI:10.1503/cmaj.109-4667.

Godersky, ME., Saxon, AJ., Merrill, JO., Samet, JH., Simoni, JM., and Tsui, JI. (2019), Provider and patient perspectives on barriers to buprenorphine adherence and the acceptability of video directly observed therapy to enhance adherence. *Addict Sci Clin Pract* 14, 11 (2019). https://doi-org.ezproxy.bangor.ac.uk/10.1186/s13722-019-0139-3

Godlee, F. (2016), The war on drugs has failed: doctors should lead calls for drug policy reform. *BMJ* 2016; 355:i6067 doi: 10.1136/bmj.i6067 (Accessed 29th June 2021).

Goffman, E. (1963), *Stigma: Notes on the Management of Spoiled Identity.* London: Penguin

Goldstein, RZ., and Volkow., ND. (2002), Drug addiction and its underlying neurobiological basis: neuroimaging evidence for the involvement of the frontal cortex. *Am J Psychiatry*. 2002; 159:1642–1652. 3. Cited in Ersche et al 2012, pg.193.

Gossop, M. and Strang, J. (1991), 'A comparison of the withdrawal responses of heroin and methadone addicts during detoxification', *The British Journal of Psychiatry*, vol 158, pp 697-9. Cited in Du Rose 2015, p.103.

Gowing, L., Farrell, MF., Bornemann, R., Sullivan, LE., and Ali, R. (2011), Substitution treatment of injecting opioid users for prevention of HIV infection. *Cochrane Database System Rev* 2011; issue 8:CD004145. Cited in Uchtenhagen 2013, p.284.

Granfield, R., and Cloud, W. (1999), *Coming Clean: Overcoming Addiction without Treatment.* New York: New York University Press. Cited in Brown 2000, p. 282 and Irvine 2001, p.87.

Granfield, R., Cloud, W. (2001), Social context and "natural recovery": the role of social capital in the resolution of drug-associated problems', *Substance Use and Misuse* 36, pp. 1543-1570. Cited in Dale-Perera 2017, p.6.

Grant, C., Goodenough T., Harvey I., and Hine C. (2000), A randomised controlled trial and economic evaluation of a referrals facilitator between primary care and the voluntary sector. *BMJ* 2000, 320 (7232):419-23. Cited in Croft and Currie 2020, p.549.

Guba, E. G., and Lincoln, Y. (1989), *Fourth generation evaluation*. Newbury Park, CA: Sage. Cited in Nowell et al 2017, p.3.

Gyngell, K. (2012), '*Will the coalition get to grips with the state sponsored addiction it inherited from Labour?*', Mail Online, Blog, 13 January (http://gyngellblog.dailymail.co.uk/2012/01/willthe-coalition-get-to-grips-with-the-state-sponsored-addiction-itinherited-from-labour.html). Cited in Du Rose 2015, p.103.

Hamilton, I. (2021), Treat illegal drug uses as health issue, says UK government review – here's why. *The Conversation.* July 8, 2021 3.59pm BST. https://theconversation.com/treat-illegal-drug-use-as-health-issue-says-uk-government-review-heres-why-163953 (Accessed 30th August 2021).

Harm Reduction International (n.d.), *What is harm reduction?* Website. https://www.hri.global/what-is-harm-reduction Accessed 15th August 2021.

Harris, J., and McElrath, K. (2012), Methadone as Social Control: Institutionalized Stigma and the Prospect of Recovery. *Qualitative Health Research* 22(6) 810-824. DOI: 10.1177/1049732311432718.

Hart, A. (2003), "A neighbourhood renewal project in Dalston, Hackney: towards a new form of partnership for inner city regeneration", Journal of Retail and Leisure Property, Vol. 3 No. 3, pp. 237-249. Cited in Cornelius and Wallace 2013, p.237.

Hartnoll, R., Mitcheson, M., Battersby, A., Brown, G., Ellis, M., Fleming, P. and Hedley, M. (1980), 'Evaluation of heroin maintenance in controlled trial', *Archives of General Psychiatry*, vol 37, pp 877-84. Cited in Du Rose 2015, p.102.

Health Inspectorate Wales (HIW) (2009), Substance Misuse Services: All Wales Review of Substitute Prescribing Services. *Health Inspectorate Wales*.

http://www.hiw.org.uk/Documents/477/SMSR%20Year%201%20Report%20FINAL%2025%2008%2009-e.pdf. Cited in Welsh Assembly Government 2010a.

Health Inspectorate Wales (HIW) (2012), Substance Misuse Services in Wales Are they meeting the needs of service users and their families? *Healthcare Inspectorate Wales*. March 2012.

Health Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) (2018), Review of Substance Misuse Services in Wales Joint Thematic Report. *Healthcare Inspectorate Wales*.

Helm, P. (2019), Sobriety versus abstinence. How 12-stepper negotiate long-term recovery across groups. *Addiction research & theory*, VOL. 27, NO. 1, 29–36. https://doi.org/10.1080/16066359.2018.1530348. (Accessed 22nd January 2020).

Hennessy, EA. (2017), Recovery capital: a systematic review of the literature, *Addiction Research & Theory*, 25:5, 349-360, DOI: 10.1080/16066359.2017.1297990.

Heyman, G. (2013), Addiction and Choice: theory and new data. May 2013, Volume 4, article 31. doi: 10.3389/fpsyt.2013.00031 (Accessed 25 May 2021).

Hiles, D., and ČermáK, I. (2007), *Qualitative Research: Transparency and Narrative Oriented Inquiry.* Paper presented at 10th ECP, Prague, CZ, July 3- 6, 2007.

HM Government (2007), *Safe. Sensible. Social: The next steps in the National Alcohol Strategy*. London: The Home Office. Cited in Welsh Assembly Government 2010a.

HM Government (2008), *Drugs: protecting families and communities. The 2008 drug strategy*. First Edition.

HM Government (2010), *Building a Stronger Civil Society'*. October 2010. Cited in National Audit Office (2010).

HM Government (2017*), 2017 Drug Strategy*. July 2017.

Holder, H. (2013), *Role of the voluntary sector in providing commissioning support*. London: Nuffield Trust. Cited in Croft and Currie 2020, p.549.

Holloway I., and Wheeler, S. (2010), *Qualitative Research in Nursing and Health Care*, 3rd edn. Wiley-Blackwell, Chichester, Ames,Iowa. Cited Kallio et al 2016, p.2955.

Home Office (1998), *Crime and Disorder Act 1998.* London: The Stationary Office. Cited in Rogers and Thomas 2017, p.8.

Home Office (2012), Putting Full Recovery First: The Recovery Roadmap, https://www.gov.uk/government/publications/putting-full-recovery-first-the-recovery-roadmap (accessed 18 February 2014). Cited in Roy and Buchanan 2016, p.399.

Hutchinson, E., Nayiga, S., Nabirye, C., Taaka, L, and Staedke, SG. (2018), Data value and care value in the practice of health systems: A case study in Uganda. *Social Science & Medicine* 211: 123-130. Cited in Croft and Currie, p.549.

Independent [Expert] Working Group (2017), *Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working* Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health.

Irvine, L. (2001), Reviewed Work: *Coming Clean: Overcoming Addiction without Treatment* by Robert Granfield, William Cloud. *Contemporary Sociology*, vol. 30, no. 1, 2001, pp. 86–87. *JSTOR*, www.jstor.org/stable/2654369. Accessed 24 Mar. 2021.

Itzoe, ML, and Guarnieri, M. (2017), New developments in managing opioid addiction: impact of a subdermal buprenorphine implant. *Drug Design, Development and Therapy* 2017:11 1429–1437.

Jenkins, T. (2017), *High Achiever: The Incredible True Story of One Addicts Double Life.* Harmony Books: New York.

Jentsch, JD., and Taylor, JR. (1999), Impulsivity resulting from frontostriatal dysfunction in drug abuse: implications for the control of behavior by reward- related stimuli. *Psychopharmacology.* 1999;146:373–390. Cited in Ersche et al 2012, p.193.

Kalk, NJ., Robertson, J R., Kidd, B., Day, E., Kelleher, MJ., Gilvarry, E., and Strang, J. (2018), Treatment and Intervention for Opiate Dependence in the United Kingdom: Lessons from Triumph and Failure. *Eur J Crim Policy Res* (2018) 24:183–200. https://doi.org/10.1007/s10610-017-9364-z (Accessed 17th April 2021).

Kallio, H., Pietila, A-M., Johnson, M., and Kangasniemi, M. (2016), Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. Review paper. *Leading Global Nursing Research* **https://doi.org/10.1111/jan.13031** (Accessed 8th November 2020).

Kelly, S. (2010), Qualitative interviewing techniques and styles. In: Bourgeault I, Dingwall R and de Vries R (eds) *The Sage Handbook of Qualitative Methods in Health Research.* Thousand Oaks: Sage Publications. Cited in Campbell et al 2020, p.3.

Kimber, M., Barwick, M., Fearing, G. (2012), Becoming an evidence-based service provider: staff perceptions and experiences of organizational change. *J Behav Health Serv Res*. 2012;39:314–32. https://doi.org/10.1007/s11414-012-9276-0. Cited in Bach-Mortensen et al 2018, p.3.

Kingdon, JW. (1984), *Agendas, Alternatives and Public Policies*. Little, Brown and Company, Boston and Toronto. Cited in El-Jardali et al 2014, p.47.

Klingemann, H. K., Sobell, M. B., and Sobell, L. C. (2010), Continuities and changes in self-change research. *Addiction* 105, 1510–1518. Cited in Heyman 2013, p.1.

Knopf, A. (2016), Childhood trauma heightens risk for teen drug misuse. *The Brown University Child and Adolescent Behavior Letter 32*:9.

Koch, T. (1994), Establishing rigour in qualitative research: The decision trail. *Journal of Advanced Nursing*, 19, 976–986. doi:10.1111/ j.1365-2648.1994.tb01177.x. Cited in Nowell et al 2017, p.3.

Korstjens, I., and Moser, A. (2018), Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing, *European Journal of General Practice*, DOI: 10.1080/13814788.2017.1375092.

Laine, CW., Hauck, WW., Gourevitch, MN., Rothman, J., Cohen, A., and Turner, BJ. (2001), Regular out-patient medical and drug abuse care and subsequent hospitalization of people who use illicit drugs. *Journal of the American Medical Association*, 285, 2355–2362. Cited in Samet et al 2003, p.513.

Lawless, P., Else, P., Farnell, R., Furbey, R., Lund, S. and Wishart, B. (1998), "Community based initiative and state urban policy: the Church Urban Fund", Regional Studies, Vol. 32 No. 2, pp. 161-174. Cited in Cornelius and Wallace 2013, p.237.

Lemos, Vde A, Antunes, HK., Baptista, MN., Tufik, S., Mello, MT., Formigoni, ML. (2012), Low family support perception: a 'social marker' of substance dependence? *Rev Bras Psiquiatr*. 2012;34(1):52–9. [PubMed: 22392389]. Cited in Nikmanesh et al 2017, p.5.

Lincoln, Y.S, and Guba, E.G. (1985), *Naturalistic inquiry*, Beverly Hills: Sage, 1985. Cited in Shenton 2004, p.64 and Korstjens and Moser 2018, p.121.

Lind, B., Chen, S., Weatherburn, D. and Mattick, R. (2005), 'The effectiveness of methadone maintenance treatment in controlling crime: an Australian aggregate-level analysis', *Journal of Criminology*, vol 45, no 2, pp 201-11. Cited in Du Rose 2015, p.102.

Livingston, J. D., and Boyd, J. E. (2010), Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. Social Science and Medicine, 71, 2150-2161. doi:10.1016/j. socscimed.2010.09.030. Cited in Harris and McElrath 2012, p.811.

Livingston, JD., Milne, T., Fang, ML., and Amari, E. (2011), The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addiction*, 107, 39–50.

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

Lloyd, C. (2010), Sinning and sinned against: The stigmatisation of problem drug users. London: UK Drug Policy Commission. Retrieved from www.ukdpc.org.uk/resources/ Stigma_Expert_Commentary_final.pdf. Cited in Harris and McElrath 2012, p.811.

Lloyd, C., Williams, PL., Machingura, T., and Tse, S. (2016), A focus on recovery: using the Mental Health Recovery Star as an outcome measure, *Advances in Mental Health*, 14:1, 57-64, DOI: 10.1080/18387357.2015.1064341.

Lorman, WJ. (2013), Maintaining Sobriety and Recovery. *Nursing Clinics of North America* Volume 48, Issue 3, September 2013, Pages 437-444.

Lowe, E., Akhtar, S., Emmerson, O., Parkman, T., and Day, E. (2018), The impact of employment on perceived recovery from opiate dependence. *Drugs and Alcohol Today* Vol 18, issue 4. pp. 206-216. https://doi.org/10.1108/DAT-12-2017-0062. (Accessed 15th July 2021).

Lundgren, L., Krull I, Zerden L de S., Mccarty D. (2011), Community-based addiction treatment staff attitudes about the usefulness of evidence-based addiction treatment and CBO

organizational linkages to research institutions. *Eval Program Plann*. 2011;34:356–65. https://doi.org/10.1016/j.evalprogplan.2011.02.002. Cited in Bach-Mortensen et al 2018, p.3.

MacDonald, EM., Luxmoore, M., Pica, S., Tanti, C., Blackman, JM., Catford, N., and Stockton, P. (2004), Social networks of people with dual diagnosis: the quantity and quality of relationships at different stages of substance use treatment. *Community Ment Health J*. 2004;40(5):451–64. [PubMed: 15529478]. Cited in Nikmanesh et al 2017, p.5.

Madden, A., and Henderson, C. (2020), Words Matter! Language Statement and Reference Guide. INPUD: London.

Maher, L. (2002), Don't leave us this way: ethnography and injecting drug use in the age of AIDS, *International Journal of Drug Policy*, Volume 13, Issue 4, 2002, Pages 311-325, ISSN 0955-3959,https://doi.org/10.1016/S0955-3959(02)00118-4. (https://www.sciencedirect.com/science/article/pii/S0955395902001184)

Manhapra, A., Arias, AJ., and Ballantyne, J. C. (2017), The conundrum of opioid tapering in long-term opioid therapy for chronic pain: A commentary. *Substance Abuse*, vol. 0, 1-10. doi:10.1080/08897077.2017. 1381663. Cited in Dobbs and Fogger 2018, p.58).

Marlatt, GA. (1996), Harm reduction: come as you are. *Addict Behav*. 1996;21:779–788. Cited in Bond and Witton 2017, p.7.

Martin-Storey, A., Serbin, LA., Stack, DM., Ledingham, JE., and Schwartzman, AE. (2011), Self and peer perceptions of childhood aggression, social withdrawal and likeability predict adult substance abuse and dependence in men and women: a 30-year prospective longitudinal study. *Addict Behav*. 2011;36(12):1267–74. doi: 10.1016/j.addbeh.2011.07.043. [PubMed: 21889853]. Cited in Nikmanesh et al 2017, p.5.

Maslin-Prothero. SE., and Bennion, AE. (2010) Integrated team working: a literature review. *International Journal of Integrated Care*. Vol 10. p1-10. Cited in Welsh Assembly Government 2010a, p.11.

Mason, J. (2002), *Qualitative Researching*. 2nd edition. SAGE Publications: London. Cited in Campbell et al 2020, p.3.

Mattick, RP., Breen, C., Kimber, J., and Davoli, M. (2009), Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews* 2009, Issue 3, Wiley and Sons. Art. No.: CD002209.DOI:

10.1002/14651858.CD002209.pub2. (Accessed 6th August 2019). Also cited in Du Rose 2015, p.102.

Mattick, RP., Breen, C., Kimber, J., and Davoli, M. (2014), Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database of Systematic Reviews* 2014, Issue 2. Art. No.: CD002207. DOI: 10.1002/14651858.CD002207.pub4. (Accessed 7th August 2019).

Mauthner NS, and Doucet, A. (2003), Reflexive accounts and accounts of reflexivity in qualitative data. *Soc* 2003; 37:413–431. Cited in Korstjens and Moser 2018, p.123.

May, P.,Hynes, G., McCallion, P., Payne, S., Larkin, P., and McCarron, M. (2014), Policy analysis: palliative care in Ireland. Health Policy, 115 (2014), pp. 68-74. Cited in O'Brien 2020, p.1.

Mayblin, L., and James, P. (2017), Asylum and refugee support: civil society filling the gaps? The University of Warwick: Coventry.

McCord, J. (2003), Cures that harm: unanticipated outcomes of crime prevention programs. *Ann Am Acad Pol Soc Sci*. 2003;587:16–30. Cited in Bach-Mortensen et al 2018, p.2.

McCusker, C. and Davies, M. (1996), 'Prescribing drug of choice to illicit heroin users: the experience of a UK community drug team', *Journal of Substance Abuse Treatment*, vol 13, pp 521-31. Cited in Du Rose 2015, p.102.

McHugh, SM., Perry, IJ. Bradley, C., and Brugha, R. (2014), Developing recommendations to improve the quality of diabetes care in Ireland: a policy analysis. *Health Res Policy Syst*, 12 (2014), p. 53. Cited by O'Brien 2020, 1.

McIntosh, J., and McKeganey, N. (2000), Addicts' narratives of recovery from drug use: Constructing a non-addict identity. *Social Science & Medicine*, 50, 1501–1510. Cited in Best et al 2015, p.113.

McIntosh, J., and McKeganey, N. (2002), *Beating the Dragon: The Recovery from Dependent Drug Use.* London: Prentice Hall. Cited in Best et al 2015, p.113.

McLaughlin, H. (2009), What's in a Name: 'Client', 'Patient', 'Customer', 'Consumer', 'Expert by Experience', 'Service User' – What's Next? *British Journal of Social Work* 39:1101-1117.

Mendoza, NS., Resko, S., Wohlert, B., and Baldwin, A. (2016), "We have to help each other heal": The path to recovery and becoming a professional peer support. *Journal of Human Behavior in the Social Environment* Volume 26, 2016 - Issue 2. DOI: 10.1080/10911359.2015.1052912. (Accessed 10th March 2020).

Merikangas, KR., Stolar, M., Stevens, DE., Goulet, J., Preisig, MA., Fenton, B., Zhang, H., O'Malley, SS., Rounsaville, BJ. (1998), Familial transmission of substance use disorders. *Archives of General Psychiatry* 55: 973-9. Cited in BMA 2013, p.64.

Middleton, J., McGrail S., and Stringer, K. (2016), *Drug related deaths in England and Wales. BMJ* 2016;355:i5259. doi:10.1136/bmj.i5259pmid:27754839. Cited in Godlee 2016, pg.1.

Milbourne, L., and Cushman, M. (2013), From the Third Sector to the Big Society: How Changing UK Government Policies Have Eroded Third Sector Trust. *Voluntas* (2013) 24:485–508 DOI 10.1007/s11266-012-9302-0 (cited April 17, 2021).

Misuse of Drugs Act (1971), https://www.legislation.gov.uk/ukpga/1971/38/contents. Website. Accessed 12th August 2021.

Musalek, M. (2013), Reduction of harmful consumption versus total abstinence in addiction. Treatment. *Neuropsychiatry* (2013) 3(6), 635–644.

Narcotics Anonymous United Kingdom (NAUK) (n.d.), What is NA. Website. https://ukna.org/content/what-na (Accessed 13th April 2021).

National Assembly for Wales (NAW) (2001), Clinical Governance: Developing A Strategic Approach. Cited in Welsh Government 2011.

National Assembly for Wales (2017), Votes and Proceedings – Plenary. Y Senedd, Tuesday 21 November 2017, 13:30. https://business.senedd.wales/documents/g4636/Printable%20minutes%20Tuesday%2021-Nov-2017%2013.30%20Plenary.pdf?T=1 (Accessed 14th June 2021)

National Audit Office (NAO) (n.d.), What are third sector organisations and their benefits for commissioners? NAO. Website. https://www.nao.org.uk/successful-commissioning/introduction/what-are-civil-society-organisations-and-their-benefits-for-commissioners/ (Accessed 24th July 2019).

National Audit Office (NAO) (2010), *Tackling Problem Use*, London: The Stationary Office, 2010 [accessed via: www.nao.org.uk/wp-content/ uploads/2010/03/0910297.pdf (08/08/13)]. Cited in CSJ 2014 p.28

National Crime Agency (NCA) (2020), National Strategic Assessment of Serious and Organised Crime. Also cited in ONS 2020, pg.11.

National Health Service Business Services Authority (NHSBSA) (2016), *NHS Prescription Services.* 2016. http://www.nhsbsa.nhs.uk/Prescription Services.aspx. Accessed 7th March 2017. Cited in Kenworthy et al 2017, 743.

National Health Service (NHS) (2015), *Addiction: What is it? Health body*. 18 April 2015. Website. https://www.nhs.uk/live-well/healthy-body/addiction-what-is-it/ (Accessed 6th August 2019 and accessed 9th February 2021).

National Health Service (NHS) (2019), *Community Safety Partnerships*. Website. https://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/community_safety_partnership_de.asp?shownav=1 (Accessed 10th March 2020).

National Health Service (NHS) (2020), *Drug addiction: getting help -Healthy body.* Website. https://www.nhs.uk/live-well/healthy-body/drug-addiction-getting-help/ (Accessed 21 May 2021).

National Health Service (NHS) Networks (2010), *Map of Medicine*. Website. 21:20 - Sun 28 Feb 2010. https://www.networks.nhs.uk/nhs-networks/map-of-medicine (Accessed 14th August 2021).

National Institutes of Health (1997), Effective medical treatment of opiate addiction. *NIH Consensus Statement* 15(6): 1–38. Cited in Drucker et al 2016, p.242.

National Institute for Health and Care Excellence (NICE) (2007a), *Methadone and Buprenorphine for the Management of Opioid Dependence.* London: National Institute for Health and Care Excellence Technology appraisal guidance (TA114); 2007. Last reviewed February 2016 with no new effects. Also cited in Bond and Witton 2017, p.3.

National Institute for Health and Care Excellence (NICE) (2007b), Naltrexone for the management of opioid dependence. *NICE technology appraisal guidance* 115. National Institute for Health and Clinical Excellence.

http://www.nice.org.uk/nicemedia/live/11604/33812/33812.pdf. Cited in Welsh Government 2011.

National Institute of Health and Care Excellence (NICE) (2008), Drug Misuse: Opioid detoxification. National Clinical Practice Guideline Number 52. *National Institute for Health & Clinical Excellence.* http://www.nice.org.uk/nicemedia/live/11813/35999/35999.pdf. Cited in Welsh Government 2011.

National Institute of Health and Care Excellence (NICE) (2010), Alcohol use disorders: Diagnosis and clinical management of alcohol related physical complications. Clinical Guideline 100. *National Institute for Health & Clinical Excellence*. http://www.nice.org.uk/nicemedia/live/12995/48989/48989.pdf. Cited in Welsh Government 2011.

National Institute of Health and Care Excellence (NICE) (2011), Alcohol use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence. *National Institute for Health & Clinical Excellence.* http://www.nice.org.uk/nicemedia/live/11875/51786/51786.pdf. Cited in Welsh Government 2011.

National Institute for Health and Care Excellence (NICE) (2019), *Opioid dependence: buprenorphine prolonged release injection (Buvidal). Evidence summary*. Published: 14 February 2019. nice.org.uk/guidance/es19. Accessed April 17, 2021.

National Institute for Health and Care Excellence (NICE) (2020), *Drug misuse management in over 16s overview.* NICE Pathway last updated: 23 November 2020.

National Institute on Drug Abuse (NIDA) (2018a), Drug Facts: Understanding Drug Use and Addiction. June 2018. *National Institute on Drug Abuse*; National Institutes of Health; U.S. Department of Health and Human Services.

National Institute on Drug Abuse (NIDA) (2018b), *Medications to Treat Opioid Use Disorder Research Report.* NIDA.

National Institute on Drug Abuse (NIDA) (2021), *Heroin. Drug Facts*. https://www.drugabuse.gov/publications/drugfacts/heroin

National Treatment Agency (2012), The Role of Residential Rehab, 2012, [accessed via: www.nta.nhs.uk/uploads/roleofresi-rehab.pdf (07.07.14)]. Also cited in CSJ 2014, 20)

National Treatment Agency for Substance Abuse (2013), *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2010/11* [accessed via:

www.nta.nhs.uk/uploads/prevalence_estimates_201011bylocalauthority[0].xlsm (07.08.14)]; Cited in CSJ 2014, p.20.

National Treatment Agency (NTA) for Substance Misuse (2006) *Models of Care for Treatment of Adult Drug Misusers: Update. London: National Treatment Agency for Substance Misuse*. Cited in Welsh Assembly Government 2010a.

National Treatment Agency (NTA) for Substance Misuse (2012), *Medications in Recovery: Reorientating Drug Dependence Treatment.* London: National Treatment Agency; 2012. Cited in Bond and Witton 2017, p.8.

Neale, J., Panebianco, D., Finch, E., Marsden, J, Mitcheson, L., Rose, D., Strang, J., and Wykes, T. (2016), Emerging consensus on measuring addiction recovery: Findings from a multi-stakeholder consultation exercise, Drugs: Education, Prevention and Policy, 23:1, 31-40, DOI: 10.3109/09687637.2015.1100587

Newcombe, R. (1996), 'Live and let die: is methadone more likely to kill you than heroin?', *Druglink*, vol 11, no 1, pp 9-12. Cited in Du Rose 2015, p.103.

Nielsen, S., Larance, B., Degenhardt, L., Gowing, L., Kehler, C., and Lintzeris, N. (2016), Opioid agonist treatment for pharmaceutical opioid dependent people. *Cochrane Database Syst Rev.* 2016 May 9;(5):CD011117. doi: 10.1002/14651858.CD011117.pub2. PMID: 27157143.

Nikmanesh, Z., Baluchi, MH., and Motlagh, AAP. (2017), The Role of Self-Efficacy Beliefs and Social Support on Prediction of Addiction Relapse. *Int J High Risk Behav Addict*. 2017 March; 6(1):e21209. doi: 10.5812/ijhrba.21209 (Accessed 6th August 2019 and also accessed 23rd January 2020).

NLIAH (2005) *Integrated Care Pathways: A Guide to Good Practice.* Llanharan: National Leadership and Innovation Agency for Healthcare. Cited in Welsh Assembly Government 2010a.

Nowell, LS., Norris, JM., White, DE., and Moules, NJ. (2017), Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods* Vol 16:1-13. DOI: 10.1177/1609406917733847 (Accessed 21st January 2021).

Nutt, D. (2019), Nothing has changed since I was sacked. Drugs policy still doesn't work. *The Guardian* Thursday 10 Oct 2019 16.04 BST. Website.

https://www.theguardian.com/commentisfree/2019/oct/10/drugs-policy-advisory-council-expert-david-nutt (Accessed 14th August 2021).

Nutt, DJ (2020), "Groundhog decade not brave new world". Drug Science, *Policy and Law* Volume 6: 1–6.

O'Brien, CP., Volkow, N., and Li, T-K. (2006), What's in a Word? Addiction Versus Dependence in DSM-V. Editorial. *Am J Psychiatry* 163:5, May 2006.

O'Brien, G., Sinnott, S-J., Walshie, V., Mulcahy, M., and Byrne, S. (2020), Health policy triangle framework: Narrative review of the recent literature. *Health Policy* OPEN Volume 1, December 2020, 100016.

Ochoa, E.L.M. (1994), Nicotine-related brain disorders: The neurobiological basis of nicotine dependence. *Cellular and Molecular Neurobiology*. 1994; 14: 195-225. Cited in Russell et al 2011, p.151.

O'Connell, M., Tondora, J., Croog, G., Evans, A. L., and Davidson, L. (2005), From rhetoric to routine: Assessing perceptions of recovery-oriented practices in a state mental health and addiction system. *Psychiatric Rehabilitation Journal*, 28, 378–386. Cited in Lloyd et al 2016, p.62.

O'Leary, Z. (2010), *Doing Your Research Project.* 3rd edition. Sage Publications Limited: London.

Office for National Statistics (ONS) (2017), *Deaths related to drug poisoning in England and Wales*: 2016 registrations. ONS.

Office for National Statistics (ONS) (2020), *Deaths related to drug poisoning in England and Wales: 2019 registrations.* Statistical bulletin. 14 October 2020.

O'Toole, J. (2005), *Heroin.* Maverick House Publishers: Ireland.

Pathak, V., Jena, B., Kalra., S. (2013), Qualitative research. *Perspect Clin Res.* 2013 Jul;4(3):192. doi: 10.4103/2229-3485.115389. PMID: 24010063; PMCID: PMC3757586.

Pauly, B. (2008), Harm reduction through a social justice lens. *Int J Drug Policy* 2008, 19:4-10. Cited in Smye et al 2011, p.1.

Peele S., Brodsky A., and Arnold M. (1991), *The truth about addiction and recovery: The life process program for outgrowing destructive habits.* Simon & Schuster, New York 1991. Cited in Russell et al 2011, p.151.

Perneger, T.V., Giner, F., del Rio, M. and Mino, A. (1998) 'Randomised trial of heroin maintenance programme for addicts who fail in conventional drug treatments', *British Medical Journal*, vol 317, no 7150, pp 13-18. Cited in Du Rose 2015, p.102.

Petrosino, A., Turpin-Petrosino, C., Hollis-Peel, ME., Lavenberg, JG. (2013), 'Scared Straight' and other juvenile awareness programs for preventing juvenile delinquency. *Cochrane Database Syst Rev*. 2013;(4):CD002796. https://doi. org/10.1002/14651858.CD002796.pub2. Cited in Bach-Mortensen et al 2018, p.2.

Pierce, M., Bird, SM., Hickman, M., and Millar, T. (2015), National record linkage study of mortality for a large cohort of opioid users ascertained by drug treatment or criminal justice sources in England, 2005–2009. *Drug and Alcohol Dependence* 146: 17-23. Independent Working Group 2017, p.13.

Priebe, S., Watts, J., Chase, M. and Matanov, A. (2005), Processes of disengagement and engagement in assertive outreach patients: a qualitative study, *British Journal of Psychiatry*, 11, 187: 438–43. Cited in Roy and Buchanan 2016, p.401.

Public Health England (PHE) (2013), *Drug Statistics from the National Drug Treatment Monitoring System*, 2013 [accessed via: www.nta.nhs.uk/ uploads/annualdrugstatistics2012-13-statisticalreport.pdf 06.08.14)]. Cited in CSJ 2014, p.20

Public Health England (2017), *Health matters: preventing drug misuse deaths*. Guidance. Updated 15 September 2017. Website. https://www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths (Accessed 29th January 2020).

Public Health Wales (2018), *Data mining Wales: The annual profile for substance misuse 2017-18.* Cited in Watkins 2019.

Public Health Wales (2020), *Data mining Wales: The annual profile for substance misuse 2019-20.*

Purkey, E., Patel, E., and Phillips, S.P. (2018), Truama-informed Care. *Canadian Family Physician* Vol 64, March 2018.

Radcliffe, P. and Stevens, A. (2008) 'Are drug treatment services only for "thieving junkie scumbags"? Drug users and the management of stigmatised identities', *Social Science & Medicine*, October, vol 67, no 7, pp 1065-73. Cited in Du Rose 2015, p.103.

Radojev, H. (2018), *Charities 'taking chunks out of each other' to raise funds*. 18th October 2018. Civil Society News. Website. https://www.civilsociety.co.uk/news/charities-are-taking-chunks-out-of-each-other-because-of-increased-competition.html#sthash.bkRLg0vy.dpuf (accessed 29th April 2020).

Raistrick, D., Heather, N., and Godfrey, C. (2006), *Review of the effectiveness of treatment for alcohol problems*. London: National Treatment Agency. Cited in Welsh Government 2011, pg.5.

Ramanadhan, S., Crisostomo, J., Alexander-Molloy, J., Gandelman, E., Grullon, M., Lora, V., Reeves, C., Savage, C.; PLANET MassCONECT C-PAC, Viswanath, K. (2012), Perceptions of evidence-based programs among community based organizations tackling health disparities: a qualitative study. *Health Educ Res*. 2012;27:717–28. https://doi.org/10.1093/her/cyr088. Cited in Bach-Mortensen et al 2018, p.3.

Ravitz, Jessica (2018), *Inside the secret lives of functioning heroin addicts. CNN Health*. Website Article. Accessed 4th August 2021. https://edition.cnn.com/2018/02/27/health/functioning-heroin-addicts/index.htmlfile:///C:/Users/sopa62/Downloads/ProQuestDocuments-2020-02-18.pdf

Recovery Cymru (n.d.), *About us*. Website. http://www.recoverycymru.org.uk/recovery-vision/. (Accessed 15th August 2021).

Reilly, J. (2010), 'State-sponsored heroin addicts costing us €20m', *Irish News*, 29 August (http://m.independent.ie/irish-news/ statesponsored-heroin-addicts-costing-us-20m-26675936.html). Cited in Du Rose 2015, p.103.

Reisinger, H. S., Schwartz, R. P., Mitchell, S. G., Peterson, J. A., Kelly, S. M., O'Grady, K. E., Marrari, E. A., Brown, B. B., and Agar, M. H. (2009), Premature discharge from methadone treatment: Patient perspectives. Journal of Psychoactive Drugs, 41, 285-296. Retrieved from http://www.tandfonline.com/doi/abs/10.1080/0279107 2.2009.10400539. Cited in Harris and McElrath 2012, p.820.

Richardson, L., Wood, E., and Kerr, T. (2013), The impact of social, structural and physical environmental factors on transitions into employment among people who inject drugs. *Social science & medicine* (1982), 76(1), 126–133. https://doi.org/10.1016/j.socscimed.2012.10.015

Rimmer, A. (2017), Children need single point of access to talking therapies, says children's commissioner. *British Medical Journal* Vol. 359 (20 Nov 2017 - 26 Nov 2017) (1 page).

Robins, L. N. (1993), Vietnam veterans' rapid recovery from heroin addiction: a fluke or normal expectation? *Addiction* 188, 1041–1054. Cited in Heyman 2013, p.1.

Robinson, OC. (2014), Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology* 11(1): 25–41. Cited in Campbell et al 2020, p.3.

Rogers, C., and Thomas, G. (2017), *The Welsh Government Working Together for Safer Communities Oversight Group.* Working Together for Safer Communities Project. Working Together for Safer Communities (Community Safety Partnerships) Review 2017. University of South Wales.

Rosenbaum, M. (1981), *Women on heroin*, New Brunswick, NJ: Rutgers University Press. Cited in Du Rose 2015, p.102-103.

Rosenbaum, M., and Murphy, S. (1987), 'Not the picture of health: women on methadone', *Journal of Psychoactive Drugs*, vol 19, no 2, pp 217-26. Cited in Du Rose, p.103.

Rösner, S, Hackl-Herrwerth, A., Leucht, S., Lehert, P., Vecchi, S., and Soyka, M. (2010), Acamprosate for alcohol dependence. *Cochrane Database of Systematic Reviews* 2010, Issue 9. Art. No.: CD004332. DOI: 10.1002/14651858. CD004332.pub2. Cited in Welsh Government 2011, p.17.

Roy, A., Willocks, K. and Buffin, J. (2013), *An Evaluation of Inspire's Outreach Activity in East Lancashire*, Preston: University of Central Lancashire. Cited in Roy and Buchanan 2016, p.402.

Roy, A., and Buchanan, J. (2016), The Paradoxes of Recovery Policy: Exploring the Impact of Austerity and Responsibilisation for the Citizenship Claims of People with Drug Problems. *Social Policy and Administration* ISSN 0144–5596 DOI: 10.1111/spol.12139 © 2015 VOL. 50, NO. 3, May 2016, PP. 398–413

Ruiz, P., Strain, E.C., and Lowinson. J.H. (2011), *Lowinson and Ruiz's substance abuse: A comprehensive textbook*, 5th ed. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins. Cited in Drucker et al 2016, p.242.

Russell, C., Davies, JB., and Hunter, SC. (2011), Predictors of addiction treatment providers' beliefs in the disease and choice models of addiction. *Journal of Substance Abuse Treatment* 40:150-164.

Samet, JH., Larson, MJ., Horton, NJ., Doyle, K., Winter, M., and Saitz, R. (2003), Linking alcohol- and drug-dependent adults to primary medical care: a randomized controlled trial of a multi-disciplinary health intervention in a detoxification unit. Research Report. *Society for the Study of Addiction to Alcohol and Other Drugs. Addiction*, 98, 509–516.

Sánchez, J., Sahker, E., and Arndt, S. (2020), The Assessment of Recovery Capital (ARC) predicts substance abuse treatment completion. *Addictive Behaviors* Volume 102, March 2020, 106189

Sarantakos S. (1998) *Varieties of social research. In: Social Research*. Palgrave, London. https://doi.org/10.1007/978-1-349-14884-4_2

Schaler, J.A. (2000), *Addiction is a choice*. Open Court, Chicago, IL2000. Cited in Russell et al 2011, p.151.

Schechter, MT. (2015), Drug users should be able to get heroin from the health system. Personal View. *BMJ* 2015;350:h1753 doi: 10.1136/bmj.h1753 (Published 14 April 2015) (Accessed 28th June 2021).

Schulteis, G., and Koob, G. (1996), Reinforcement processes in opiate addiction: a homeostatic model. *Neurochemical Research* 21: 1437-54. Cited in BMA 2013 p.34.

SCIE (n.d.), *Strength-based approaches.* Website. https://www.scie.org.uk/strengths-based-approaches. Accessed 15th August 2021.

SCIE (2004), *Involving service users and carers in social work education: Defining service users and carers.* Website. https://www.scie.org.uk/publications/guides/guide04/gs/10-3.asp (Accessed 29th April 2020).

SCIE (2018), *Integrated care research and practice; Multidisciplinary teams.* Website, including video. Social Care Institute for Excellence. https://www.scie.org.uk/integrated-care/research-practice/activities/multidisciplinary-teams (Accessed 23rd January 2020).

Scottish Recovery Consortium (n.d.), *Methadone Matters.*

Sesnan, M. (2001), "Greenwich Leisure Limited – The 'third way': from cuts and closures to expansion and success", Journal of Leisure Property, Vol. 1 No. 3, pp. 220-226. Cited in Cornelius and Wallace 2013, p.237.

Sexauer, C. (2014), Drug Use & Austerity: How Could UK Gov't Cuts Affect Substance Misuse? *Talking Drugs.* Article. 26 November 2014. www.talkingdrugs.org/drug-use-austerity-how-are-uk-government-cuts-affecting-substance-misuse (accessed 19th July 2021).

Shenton, AK. (2004), Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information* 22 (2004) 63–75.

Shewan, D., and Dalgarno (2010), Evidence for controlled heroin use? Low levels of negative health and social outcomes among non-treatment heroin users in Glasgow (Scotland). *The British Psychological Society* Volume 10, Issue 1:33-48.

Smith, CBR. (2010), Socio-spatial stigmatization and the contested space of addiction treatment: remapping strategies of opposition to the disorder of drugs. *Social Science & Medicine*. 2010; 70:859– 866.10.1016/j.socscimed.2009.10.033 [PubMed: 19944509]. Cited in Earnshaw et al 2013, p.111.

Smith, J. (2017), *Data mining Wales: The annual profile for substance misuse 2016-17*. Public Health Wales, Cardiff. UK. October 2017.

Smye, V., Browne, AJ., Varcoe, C., and Josewski, V. (2011), Harm reduction, methadone maintenance treatment and the root causes of health and social inequities: An intersectional lens in the Canadian context. *Harm Reduction Journal* 2011, 8:17

Social Care Wales (2019), *What matters conversations and assessment*. 10 October 2019. Website. https://socialcare.wales/service-improvement/what-matters-conversations-and-assessment (accessed 15th August 2021).

Southby, K., and Gamsu, M. (2018), Factors affecting general practice collaboration with voluntary and community sector organisations. *Health and Social Care in the Community*. Volume26, Issue3. May 2018, pp.e360-e369. https://doi.org/10.1111/hsc.12538 (Accessed 11th May 2021).

Spooner, C., and Hetherington, K. (2004), *Social Detriments of Drug Use.* Technical Report Number 228. ISBN: 0 7334 2244 6 (accessed 15th July 2021). National Drug and Alcohol Research Centre; University of New South Wales: Sydney.

Stancliff, S., Phillips., BW., Maghsoudi, N., and Joseph, H. (2015) Harm Reduction: Front Line Public Health, *Journal of Addictive Diseases*, 34:2-3, 206-219, DOI: 10.1080/10550887.2015.1059651.

Stevens, A. (2011a), Alex Stevens: Does drug policy matter? *YouTube Video.* Jan 10, 2011. https://www.youtube.com/watch?v=fEc3_-NCzjw (accessed 17th December 2021).

Stevens, A. (2011b), *Drugs, Crime and Public Health: The political economy of drug policy*. Routledge: Taylor and Francis Group: Oxon.

Stewart, T. (1987), *The heroin users*, London: Pandora. Cited in Du Rose 2015, p.103.

Stinson, F. S., Grant, B. F., Dawson, D., Ruan, W. J., Huang, B., and Saha, T. (2005), Comorbidity between DSMIV alcohol and specific drug use disorders in the United States: results from the National epidemiological survey on alcohol and related conditions. *Drug Alcohol Depend*. 80, 105–116. Cited in Heyman 2013, p.1.

Strang, J. (2010). Impact of supervision of methadone consumption on deaths related to methadone overdose (1993-2008): analyses using OD4 index in England and Scotland. *British Medical Journal*, 341, c4851. doi:http://dx.doi.org/10.1136/bmj.c4851. Cited in UK Focal Point on Drugs 2016, p.9.

Swendsen, JD., Conway, KP., Rounsaville, BJ., Merikangas, KR. (2002), Are personality traits familial risk factors for substance use disorders? Results of a controlled family study. *American Journal of Pschiatry* 159: 1760-6. Cited in BMA 2013, p.68.

Szasz, T. (1975), Ceremonial Chemistry: the ritual persecution of drugs, addicts and pushers. Old Woking: Unwin Brothers Limited. Cited in Wincup and Stevens 2021, p.1.

Tarter, RE., Kirisci, L., Habeych, M., Reynolds, M., and Vanyukov, M. (2004), Neurobehaviour disinhibition in childhood predisposes boys to substance use disorder by

young adulthood: direct and mediated etiologic pathways. *Drug and Alcohol Dependence* 73: 121-32. Cited in BMA 2013, p.68.

Tatarsky, A. (2019), The Challenge of Harm Reduction. *Psychotherapy Networker*. Washington Vol. 43, Iss. 5, (Sep/Oct 2019): 29-35,52. (Accessed 17th February 2020).

Tempalski, B., Friedman, R., Keem, M., Cooper, H., Friedman, SR. (2007), NIMBY localism and national inequitable exclusion alliances: the case of syringe exchange programs in the United States. *Geoforum*. 2007; 38:1250–1263.10.1016/j.geoforum.2007.03.012 [PubMed: 18978931]. Cited in Earnshaw et al 2013, p.111

The Wallich (2020), *Call for Drug Consumption Rooms in Wales Increases*. The Wallich Response. 08 Jan 2020. https://thewallich.com/news/call-drug-consumption-rooms-wales-increases/ (Accessed 13th April 2021).

Thomas, HV. (2017), Local Authority Funding of Third Sector Services. Wales Audit Office: Cardiff.

Tobin, GA., and Begley, CM. (2004), Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, 48, 388–396. doi:10.1111/j.1365-2648.2004.03207.x. Cited in Nowell et al 2017, p.3.

Tracy, K., and Wallace, SP. (2016), Benefits of peer support groups in the treatment of addiction. *Subst Abuse Rehabil*. 2016 Sep 29;7:143-154. eCollection 2016. (https://www.ncbi.nlm.nih.gov/pubmed/27729825) cited 29th April 2020.

Travis, A. (2009), Chief drug adviser David Nutt sacked over cannabis stance. *The Guardian* Friday 30 Oct 2009 19.41 GMT. https://www.theguardian.com/politics/2009/oct/30/david-nutt-drugs-adviser-sacked (Accessed 14th August 2021).

Trost, JA. (1986) Statistically non-representative stratified sampling: A sampling technique for qualitative studies. *Qualitative Sociology* 9(1): 54–57. Cited in Campbell et al 2020, p.3.

Turner, D. (2005). The development of the voluntary sector: No further need for pioneers? In Strang, J. and Gossop, M. (Ed.), *Heroin addiction and the British system*. I. Oxford: Routledge. Cited Kalk et al 2017, pp.195-196.

Turner, D. and Smith, J. (2020), Harm Reduction Database Wales: Drug related mortality. Annual Report 2019-20. Public Health Wales. *Substance Misuse Programme, Health Protection Division, Public Health Wales 2020.*

https://phw.nhs.wales/publications/publications1/harm-reduction-database-wales-drug-related-mortality-report-2019-20/ (Accessed 18th January 2021).

Turner, D., Morgan, G., and Smith, J. (2019), Harm Reduction Database Wales: Drug related mortality Annual Report 2018-19. *Substance Misuse Programme.* Health Protection Division, Public Health Wales: Cardiff.

Uchtenhagen, A. (2013), Abstinence versus Agonist Maintenance Treatment: An Outdated Debate? Editorial. *Eur Addict Res* 2013;19:283–286 (Accessed 23rd May 2021). DOI: 10.1159/000350373

UK Addiction Treatment Centres (UKAT) (n.d.a), *Heroin Addiction and Abuse*. Website. https://www.ukat.co.uk/drugs/heroin/ (Accessed 21 May 2021).

UK Addiction treatment Centres (UKAT) (n.d.b), *Opiate/Opioid Addiction and Abuse*. Website. https://www.ukat.co.uk/opiates/ (Accessed 21 May 2021).

UK Drug Policy Commission (UKDPC) (2008), '*The UK Drug Policy Commission Recovery Consensus Group: a vision of recovery'*, UKDPC Policy Report, July 2008, UKDPC, London. Cited in Dale-Perera 2017, p.5.

UK Drug Policy Commission (UCDPC) (2010), *Getting Serious About Stigma: the problem with stigmatising drug users: an overview*. UKSPC

UK Focal Point on Drugs (2013), *UK Drug Situation 2013* [accessed via: www.nta.nhs.uk/uploads/24780focalpointreport2013.pdf (06.08.14)]. Cited in CSJ 2014, 28.

UK Focal Point on Drugs (2016), *United Kingdom Drug Situation: Focal Point Annual Report 2016*. Edited by Catherine Crawford, Rhia Gohel, Miranda Heneghan, Fay Thomson and Craig Wright. United Kingdom Focal Point at Public Health England: London.

United Nations Office on Drugs and Crime (2012), *World drug report 2012*. New York: United Nations Publications. Cited Drucker et al 2016, p.241.

Veilleux, JC., Colvin, PJ., Anderson, J., York, C., Heinz, AJ. (2010), A review of opiate dependence treatment: pharmacological and psychological interventions to treat opioid addiction. *Clin Psychol Rev* 2010; 30: 155–166. Cited in Uchtenhagen 2013, p.284.

Vigilant, L. G. (2001), "Liquid handcuffs": The phenomenology of recovery on methadone maintenance. (Doctoral dissertation, Boston College). Retrieved from WorldCat database (OCLC: 48134549). Cited in Harris and McElrath 2012, p.820.

Von Hippel, W., Brener, L., and von Hippel, C. (2008), Implicit prejudice toward injecting drug users predicts intentions to change jobs among drug and alcohol nurses. *Psychological Science*. 2008; 19:7– 11.10.1111/j.1467-9280.2008.02037.x [PubMed: 18181783]. Cited in Earnshaw et al 2013, p.111.

Walt, G., and Gilson, L. (1994), Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy Plan*. 1994 Dec;9(4):353-70. doi: 10.1093/heapol/9.4.353. PMID: 10139469. (Accessed 18th January 2021). https://pubmed.ncbi.nlm.nih.gov/10139469/

Wanigaratne, S. (2006) Psychology of addiction. *Psychiatry* 5: 455-60. Cited in BMA 2013, p.70.

Watkins, P. (2019), *Substance Misuse in Wales. National Assembly for Wales Research Service.* February 2019.

Watson, J. (2013), The good, the bad and the vague: assessing emerging Conservative drug policy, *Critical Social Policy*, 33, 2: 285–304. Cited in Roy and Buchanan 2016, p.400.

Weisner, C., Mertens, J., Parthasarathy, S., Moore, C., and Lu, Y. (2001), Integrating primary medical care with addiction treatment: a randomized controlled trial. *Journal of the American Medical Association*, 286, 1715–1723. Cited in Samet et al 2003, p.513.

Weiss, MG., Ramakrishna, J., and Somma, D. (2006), "Health-related Stigma: Rethinking Concepts and Interventions." *Psychol Health Med* 11 (2006): 277–87. Print.

Wellbeing of Future Generations (Wales) Act 2015. 2015 anaw 2. The Stationary Office: United Kingdom.

Welsh Assembly Government (2003), *Wales: a better country: the strategic agenda of the Welsh Assembly Government.* Welsh Assembly Government: Wales. Cited in Welsh Assembly Government 2004b.

Welsh Assembly Government (2004a), *Substance Misuse Treatment Framework Service Framework for Community Prescribing*. Cited in Welsh Government 2011.

Welsh Assembly Government (2004b), *Substance Misuse Treatment Framework for Wales.* Cardiff: Welsh Assembly Government: Wales. Also cited in Welsh Assembly Government 2010a.

Welsh Assembly Government (2005) *Framework Guidance for Community Safety Partnerships to Commission Substance Misuse Services. Cardiff: Welsh Assembly Government.* Cited in Welsh Assembly Government 2010a.

Welsh Assembly Government (2006) *Key Performance Indicators for substance misuse treatment services in Wales.* Cardiff: Welsh Assembly Government. Cited in Welsh Assembly Government 2010a.

Welsh Assembly Government (2008a), *Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018.* Cardiff: Welsh Assembly Government. Also cited in Welsh Assembly Government 2010a, Welsh Government 2011; 2013, 2019a).

Welsh Assembly Government (2008b) *Working Together to Reduce Harm: The Substance Misuse Strategy. Three-year Implementation Plan 2008-11*. Cardiff: Welsh Assembly Government. Cited in Welsh Government 2008a.

Welsh Assembly Government (2010a), Integrated Care and Integrated Care Pathways for Adult Substance Misuse Services in Wales. *Substance Misuse Service and System Improvement*. June 2010.

Welsh Assembly Government (2010b), National Core Standards for Substance Misuse Services in Wales. *Substance Misuse Service and System Improvement.* May 2010. Welsh Assembly Government.

Welsh Government (2011), Substance Misuse Treatment Framework (SMTF) Guidance for Evidence Based Community Prescribing in the Treatment of Substance Misuse. *WG-12567* F9161011. ISBN 978 0 7504 6271 6.

Welsh Government (2013), Substance Misuse Treatment Framework (SMTF) Recovery Oriented Integrated Systems of Care. *WG19800*. Digital ISBN 978 1 4734 0258 4.

Welsh Government (2014), *Social Services and Well-being (Wales) Act 2014*. Welsh Government.

Welsh Government (2015a), *Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem*. Welsh Government.

Welsh Government (2015b), Social Services and Well-being (Wales) Act 2014. Code of practice in relation to measuring social services performance. *WG25383* Digital ISBN 978 1 4734 4193-4.

Welsh Government (2015c), Well-being of Future Generations (Wales) Act 2015. *The Essentials.* 2nd edition May 2015. Welsh Government.

Welsh Government (2016), Taking Wales Forward 2016-2021. Welsh Government *WG29234*. Cited in Welsh Government 2019a, p.3.

Welsh Government (2017), Prosperity for All: the national strategy Taking Wales Forward. *WG32422* Digital ISBN: 978 1 4734 9922 5. Cited in Welsh Government 2019a, p.3.

Welsh Government (2018a), In Brief – A Healthier Wales: our Plan for Health and Social Care. *WG34928*. Digital ISBN: 978-1-78937-298-4. Cited in Welsh Government 2019a.

Welsh Government (2018b*), Working Together to Reduce Harm: Substance Misuse Annual Report and Forward Look 2018*. https://gov.wales/sites/default/files/publications/2019-03/working-together-to-reduce-harm-substance-misuse-annual-report-and-forward-look-2018.pdf (accessed 9th July 2019)

Welsh Government (2019a), *Substance Misuse Delivery Plan.* October 2019. 2019-2022.

Welsh Government (2019b), Substance Misuse Delivery Plan 2019-2022. Consultation Document. Number: *WG38273*. https://gov.wales/sites/default/files/consultations/2019-06/consultation-document.pdf (Accessed 2nd August 2021).

Welsh Government (2019c), A Healthier Wales (2018): our Plan for Health and Social Care. *WG39129*. Digital ISBN 978-1-83933-278-4 Print ISBN 978-1-83933-277-7.

Welsh Government (2019d), *Treatment Data - Substance Misuse in Wales 2018-19*. NHS Wales Informatics Service. Welsh Government.

Welsh Government (2020), *Wales to roll out once-a-month injection for recovering heroin addicts to help protect NHS staff.* Press Release 21st April 2020.

Welsh Government (2021), Rebalancing Care and Support. White Paper. Number: *WG41756*. Welsh Government.

Whelan, PJ., and Remski, K. (2012), Buprenorphine vs methadone treatment: A review of evidence in both developed and developing worlds. *J Neurosci Rural Pract*. 2012;3(1):45–50. doi:10.4103/0976-3147.91934 (Accessed 7th August 2019).

White, J., Cornish, F., and Kerr, S. (2017), Front- line perspectives on 'joined- up' working relationships: A qualitative study of social prescribing in the west of Scotland. *Health and Social Care in the Community.* https://doi.org/10.1111/hsc.12290. Cited in Southby and Gamsu 2018, p.367.

White, W. L. (2010), Long-term strategies to reduce the stigma attached to addiction, treatment, and recovery within the City of Philadelphia (with particular reference to medication-assisted treatment/recovery). Retrieved from http://www.comproviders.com/files/stigma-williamwhite-101309.pdf. Cited in Harris and McElrath 2012, p.820.

White, WL., and Cloud, W. (2008), Recovery Capital: A Primer for Addictions Professionals. *Counselor*, 9(5), 22-27. file:///C:/Users/sopa62/Downloads/2008RecoveryCapitalPrimer.pdf accessed 24th March 2021. Cited in Best and Laudet 2010, 3.

White, W. L. and Mojer-Torries, L. (2010), *Recovery-oriented methadone maintenance.* Great Lakes Addiction Technology Transfer Center, Chicago. Cited in Dale-Perera 2017, p.5

Wincup, E. and Stevens, A. (2021), Scapegoating and othering in drug policy: A special themed section. *Int J Drug Policy*. 2021 Jan;87:103093. doi: 10.1016/j.drugpo.2020.103093. PMID: 33678397.

Witbrodt, J., Polcin, D., Korcha, R., and Li, L. (2019), Beneficial effects of motivational interviewing case management: A latent class analysis of recovery capital among sober living residents with criminal justice involvement. *Drug and Alcohol Dependence*, 200, 124-132. doi: 10.1016/j.drugalcdep.2019.03.017.

Woo, J., Bhalerao, A., Bawor, M., Bhatt, M., Dennis, B., Mouravska, N., Zielinski, L., and Samaa, Z. (2017), "Don't Judge a Book by Its Cover": A Qualitative Study of Methadone Patients' Experiences of Stigma". *Substance Abuse: Research and Treatment* pp.1–12. DOI: 10.1177/1178221816685087 (accessed 19th July 2021).

World Health Organisation (n.d.), *Management of substance abuse. Dependence syndrome.* Website. https://www.who.int/substance_abuse/terminology/definition1/en/ (Accessed 22nd January 2020).

Word Health Organisation (WHO) (1993), ICD-10: *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. WHO, Geneva, Switzerland (1993). Cited in Musalek 2013, pg.636.

World Health Organisation (WHO) (2004), *Neuroscience of psychoactive substance use and dependence.* Geneva: World Health Organisation. Cited in BMA 2013, p.63 and p.70.

World Health Organisation (WHO) (2009), *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*. Geneva, Switzerland: World Health Organisation; 2009. Cited in Bond and Witton 2017, p.8.

Zuckerman, M. (1994), *Behavioural expressions and biosocial bases of sensation seeking*. Cambridge: Cambridge University Press. Cited in BMA 2013, p.68.

Appendix A: Information sheet and invitation to participate

INFORMATION SHEET &

INVITATION TO PARTICIPATE FOR PROFESSIONALS AND PRACTITIONERS

Study: Rewriting Scripts: Promoting multi-disciplinary services for users on a methadone prescription programme.

Introduction:

You are being invited to take part in a project looking at whether areas of divergence exist between policy aims and service outcomes for adults in methadone substitution treatment within the [Local Health Board] operational area. Before you decide whether or not to participate, it is important for you to understand why the project is being done and what it will involve. Please take the time to read the following information and discuss it with relatives and/or friends if you wish.

What is the purpose of the study?

To establish whether areas of divergence exist between policy aims and service outcomes for adults in methadone substitution treatment within [Name of Health Board].

This study seeks to identify:

1. Professional roles and responsibilities towards this client, including knowledge base and values;
2. Barriers and facilitators to providing integrated pathways of care underpinned by collaborative relationships;
3. Perceptions of challenges facing this client group;
4. Working to current policy and practice guidelines and meeting the requirements of National Service Frameworks;
5. Strengths and weaknesses of services and models of service organisation and delivery;
6. Examples of good practice which are transferable across service settings.

Why have I been chosen?

This information has been passed on to you through [company partner details]

Do I have to take part?

It is up to you to decide whether or not to take part. Your decision will not affect any services or support that you receive.

If you decide to take part you should contact Alice Jones by e-mail on sopa62@bangor.ac.uk, who will send you a consent form to return via e-mail. Please remember to keep this information sheet.

What will happen if I decide to take part?

You will be invited to interview to talk about your experiences and views on methadone prescription programmes. We would be interested to hear about your role in the journey of recovery for addicts on methadone substitution programmes, your involvement, what your motivations for getting involved were, and whether there are any challenges you might or have faced, and how you manage these. Are there any rewarding aspects? What are your responsibilities working in a multi-disciplinary team, do you think they are an important part of recovery? Such questions will be included in the interview to determine your outlook on certain topics concerning recovery. The interview will take approximately 60 minutes.

There are no right or wrong answers and the interviews will be completed in English. The interview may be recorded, with your consent, and the interviewer will take some written notes.

Will my taking part in this study be kept confidential?

Yes. Your contact details will be stored on a confidential database. The information you share will be treated in confidence. You will not be identified in any reports or publications.

However, if you share information that is suggestive of risk to yourself or others, this will be passed on to a designated individual within your Local Authority.

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time without giving a reason. If you decide to withdraw, your decision will not affect any services or support that you receive.

What will happen to the results of the study?

The findings from this study will be used to form a dissertation as part of a Masters by Research degree. The information gathered will also be given to [company partner name] at [company partner address and Local Health Board] to assist them with improving recovery programmes and multi-disciplinary services.

Who is organising and funding the research?

The project is being organised by the School of Medical and Health Sciences at Bangor University in collaboration with the KESS 2 programme and [company partner details. The project is funded by KESS 2 and [company partner details].

Contact for further information:

If you would like more information, please contact Alice Jones on [insert researcher contact number] or by email at sopa62@bangor.ac.uk . If you feel you would like to make a complaint, please contact the academic supervisor(s) (contact details at the end of this participant information sheet).

Next steps:

If you decide that you would like to take part, please contact Alice Jones by e-mail sopa62@bangor.ac.uk, who will send you a consent form to complete and return via e-mail.

Thank you for kindly taking the time to read this information.

ACADEMIC SUPERVISOR CONTACT – Dr Paul Carré, School of Social Sciences.
Dr Anne Krayer, School of Social Sciences

PRIFYSGOL BANGOR
NEUADD OGWEN,
BANGOR, LL57 2DG
FFÔN: +44 (0) 1248 382222

EBOST:
p.carre@bangor.ac.uk
a.krayer@bangor.ac.uk

BANGOR UNIVERSITY
BANGOR, GWYNEDD, LL57 2DG
TEL: +44 (0) 1248 382222

EMAIL:
p.carre@bangor.ac.uk
a.krayer@bangor.ac.uk

Appendix B: Consent to interview form (English)

CONSENT TO INTERVIEW FORM

Study: Rewriting Scripts: Promoting multi-disciplinary services for users on a methadone prescription programme.

Please tick the boxes that apply to you.

I confirm that I have read and understand the information sheet for this study ☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason ☐

I understand that my contact details will be stored on a confidential database ☐

Name:

_____

Address:

_____

_____

_____

_____

Post code:

_____

Telephone number:

_____

Signature:

_____

Date:

_____

Please return this form by e-mail to sopa62@bangor.ac.uk

Thank you

Appendix C: Consent to Interview Form (Welsh)

FFURFLEN GYDSYNIO AR GYFER CYFWELIAD

Study: Rewriting Scripts: Promoting multi-disciplinary services for users on a methadone prescription programme.

Rhowch □ yn y blychau sy'n berthnasol i chi.

Cadarnhaf fy mod wedi darllen a deall y daflen wybodaeth yng nghyswllt yr astudiaeth uchod. ☐

Deallaf fy mod yn cyfranogi o'm gwirfodd, a bod gennyf hawl i dynnu'n ôl ar unrhyw adeg, heb roi rheswm. ☐

Deallaf y cedwir fy manylion cyswllt ar gronfa ddata gyfrinachol. ☐

Enw:

_____

Cyfeiriad:

_____

_____

_____

Cod Post:

_____

Rhif ffôn:

_____

Llofnod:

_____

Dyddiad:

_____

Anfonwch y ffurflen hon yn ôl yn yr amlen radbost sydd wedi'i darparu. Diolch

Appendix D: Consent to record research interview

CONSENT TO RECORD RESEARCH INTERVIEW

CANIATÂD CYFRANOGWR I RECORDIO CYFWELIAD YMCHWIL

Study: Rewriting Scripts: Promoting multi-disciplinary services for users on a methadone prescription programme.

To be completed prior to interview.

I gael ei lenwi cyn dechrau'r cyfweliad.

Please tick the boxes that apply to you.

Ticiwch y blychau sy'n berthnasol i chi.

I agree for this research interview to be recorded and for the recording to be used for the purposes that have been explained to me. ☐

Cytunaf i'r cyfweliad ymchwil yma gael ei recordio, ac i'r recordiad gael ei ddefnyddio ar gyfer rhesymau sydd wedi eu hegluro i mi ☐

I understand that all the information I provide will be treated as strictly confidential. ☐

Deallaf y bydd yr holl wybodaeth rwy'n ei roi yn cael ei drin yn hollol gyfrinachol. ☐

Name: _____

Enw: _____

Signature: _____

Llofnod: _____

Date: _____

Dyddiad: _____

Interviewer signature

_____

Llofnod y Cyfwelydd:

_____

Appendix E: Interview schedule

Individual Interview Schedule: Professionals and Practitioners.

Introduction

My name is Alice Jones, and this project is being organised by the School of Medical and Health Sciences at Bangor University, alongside [company partner details], looking at whether areas of divergence exist between policy aims and service outcomes for adults on methadone substitution treatment. Firstly, I would like to thank you for sparing your time to participate in this research project. There are no right or wrong opinions, I would like you to feel comfortable saying what you really think and how you really feel. And all information provided will be strictly confidential.

Preceding the question section:

- Participants will be asked **Do you have any questions or concerns.** A copy of the information leaflet will be made available prior and during this stage.
- Participant will be reminded that **the interview will be recorded**, and consent will be given before recording begins. Consent to record forms will be made available for participant to sign before the interview session begins.
- The participants will be reassured that **information provided will remain confidential. Any information you share would be treated as strictly confidential – you would not be identified in any reports or outputs arising from this work.**
- The interviewer will also emphasise **that if for any reason, the interview can be terminated and the recorder can be stopped at any time**.

The individual interviews will begin with discussing multi-disciplinary teams then onto more profession focused questions.

Views relating to methadone substitution programmes and experiences delivering services.

1. **Can you tell me your job title, your role and your specific responsibilities towards an addict on the methadone prescription programme? (**Or opioid addiction if relevant).
2. **In your experience, what type of people use your services?** (Age, gender, demographic).
3. **Can you give me examples of challenges you face with service delivery in your experience?** Or the challenges other services have that you have seen?

2. How do you manage challenges?

4. **What are your perceptions of the challenges that face this client group?**
5. **How do you work with other organisations/services in supporting this population?**
6. **Can you give examples of good practice which ought to be addressed in all other services?**

Supplementary questions

4. What are your responsibilities working in a multi-disciplinary team, do you think they are an important part of recovery?

1. What were your motivations for getting involved?

3. Are there any rewarding aspects?

5. How long are your services offered to patients after they have finished the methadone substitution programme, and do you think this is enough/too much?

6. In your experience, have you found methadone substitution programmes successful in the short and long term recovery of drug addicts?

7. Is prescription drug addiction considered/prevented/treated when prescribing methadone?

Supplementary topics:

Thoughts on multi-disciplinary services, Importance of communication, Barriers/facilitators, Strengths/weaknesses, organisation. Recovery- Physical dependence/ psychological or social cause

ACADEMIC SUPERVISOR CONTACT – Dr Paul Carré, School of Social Sciences.
Dr Anne Krayer, School of Social Sciences

PRIFYSGOL BANGOR
NEUADD OGWEN,
BANGOR, LL57 2DG
FFÔN: +44 (0) 1248 382222

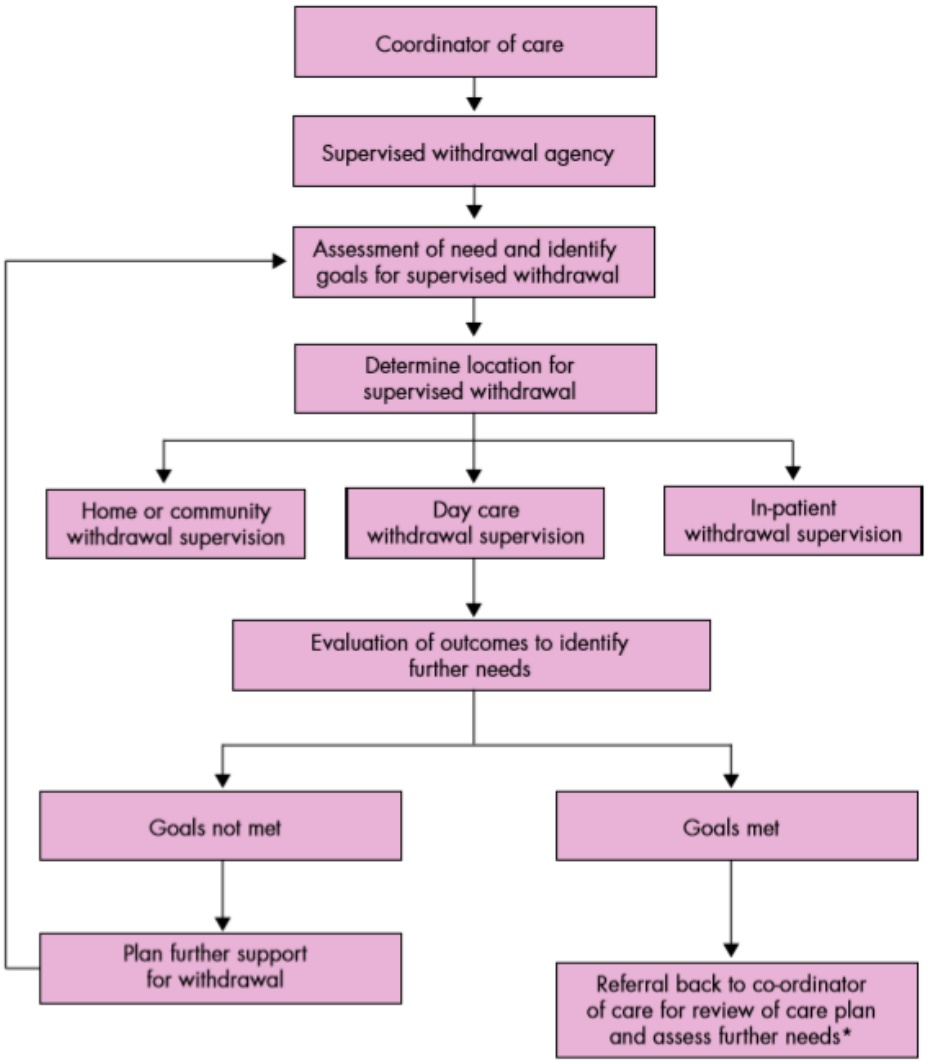
EBOST:
p.carre@bangor.ac.uk
a.krayer@bangor.ac.uk

BANGOR UNIVERSITY
BANGOR, GWYNEDD, LL57 2DG
TEL: +44 (0) 1248 382222

EMAIL:
p.carre@bangor.ac.uk
a.krayer@bangor.ac.uk

Appendix F: Example of an Integrated Care Pathway

Diagram 2: An example of a specialist integrated care pathway flowchart



* Examples of the next step may involve referral for:

- Aftercare support
- Relapse prevention
- Psychosocial interventions
- Assistance with housing

(Welsh Assembly Government 2010a, 8).

Appendix G: Defining recovery capital

Table 1.2 Definitions of Recovery Capital

Name	Definition
Granfield and Cloud (2001, cited in Dale-Perera 2017, 6).	Social (relationships), human (health and well-being, aspirations, achievements), physical (housing and money) and cultural (values, beliefs, attitudes, meets social behaviours).
White and Cloud (2008, 23-24)	Personal recovery capital: defined as physical capital (physical health, financial assets, "*safe and recovery-conductive shelter*", clothing, food, transportation access and health insurance), and human capital (values, knowledge, skills, problem solving, self-awareness, self-esteem and self-efficacy). Family/social recovery capital: close relationships and recovery supportive relationships. Partaking in "*sobriety based*" leisure and "*rational connections to conventional institutions*" such as places in the mainstream community such as schools, churches, workplaces. Community recovery capital: attitudes, policies, addiction/recovery related resources Cultural capital: this is a part of community capital and relates to availability of specific culture-based recovery pathways
Cloud and Granfield (2009, cited in Best and Laudet 2010, 4)	Social, Physical, Human and Cultural, (although social, human and cultural capital are said to be closely related).
Best et al (2010, cited in Welsh Government 2011, 7)	Substance misuse and sobriety, Psychological health and Physical health, Community involvement and Social support, Meaningful activities, Risk taking, Housing and safety and Recovery experience
Best and Laudet (2010) (these definitions are referred to in *ROISC 2013* Welsh Government 2013, 7) and also correlate to White and Cloud (2008, 23-24)	Personal recovery capital, social recovery capital and community recovery capital

The Welsh Government (2013)	Social networks, physical (money and accommodation), human (skills, health and employment), cultural (values and beliefs) and community issues (availability and quality of services) (Welsh Government 2013, 6)

Appendix H: Overview of the research process (audit trail).

Table 2.1 Overview of research process (audit trail)

Action	**Year**	**Further details**
Developing the project	Summer/Autumn 2016	• Protocol development • KESS 2 scholarship development with LHB as a partner • Submission for funding
Approval of the project	December 2016	• KESS2 funding was approved.
Start date for Project	1st May 2017	• Official start for KESS2 project.
Writing interview schedules, information sheets, consent forms.	2017	• Preparation of ethics application and supporting documentation.
Ethical approval	July 2017	• Approval granted for professionals • Exclusion of service users due to limited resource and time

Recruiting participants	September 2017 – January 2018	• Via email and phone contact (purposive and snowball sampling), sending ethics approved information sheet and consent forms. • Challenges recruiting participants
Conference presentation	November 2017	• Attended Society for the Study of Addiction 2017 conference, which included a poster presentation.
Interviewing participants	November 2017 – January 2018	• Interviews.
Interview transcription	February 2018 – April 2018	• Interview recordings transcribed by an approved transcriber
Quarterly review meetings	At regular intervals	• Reviews of project progress and direction with company partner and supervisors.
Coding and analysing interview data	April – May 2018	• Reading and listening to interviews and coding.
Writing up/funding period finished.	May 2018 – October 2018	• Working on drafts of literature review, methods, interview findings
Introducing a policy dataset	November 2018	• Policy analysis completed.
Short break	December 2018	• Personal reasons.

Writing-up and editing of thesis	2019-2021	• Reviewing multiple draft chapters and engaging in regular meetings with supervisors.

Appendix I: Coding structure

Table 2.4 Coding structure

Category	Codes	Description of Codes	Examples of codes from interviews	Examples of codes from policy documents
Approaches to recovery	The different ways of perceiving and defining recovery. E.g., as abstinence or reducing drug/heroin use.			
	Recovery capital-personal enablers	The personal skills and resources that are available, examples are coping skills, self-esteem, self-efficacy, positive identity and competencies (Welsh Government 2013, 7).	- Being listened to - Develop coping mechanisms to deal with feelings, emotions, memories	- A person's internal resources needed to achieve and sustain change in behaviour and in recovery. - It is the role of the substance misuse treatment services to help educate and support people to recognise recovery capital acquired and what needs to develop. -

	Recovery capital- personal, barriers	Codes relating to barriers to achieving personal recovery capital	- Don't feel mentally or emotionally equipped - experience of trauma - low confidence/self-esteem	
	Recovery capital - Social enablers	Social network and their engagement with their network, and a commitment to normative values (Welsh Government 2013, 7).	- Therapeutic relationship alliance with the key worker sometimes only one left - Positive support networks - Feeling more comfortable amongst recovery community compared to "*normal friends and family*".	- A persons internal and external resources required to achieve and sustain behavioural change and recovery. - It is the role of the substance misuse treatment services to help educate and support people to recognise recovery capital acquired and what needs to be developed. - Recovery champions/mutual aid groups

	Recovery capital – Social, barriers	Codes relating to barriers to achieving social recovery capital	- Not used to having a support network - Difficulty to trust and engage with…. - Building this does happen but it is difficult as well.	
	Recovery capital – Community, enablers	Recovery champions, recovery support from treatment and community resources such as housing, employment opportunities, to enable and sustain recovery pathways (Welsh Government 2013, 7).	- Professional support by people who have *been through it themselves, "what do you know about my life?*!", huge incentive seeing someone else's progress - Peer support in place - Suitable housing - Volunteering opportunities - Finding a purpose - Giving something back - Housing model needs to be higher priority	- A person's external resources already developed and what is needed to achieve and sustain behavioural change and recovery - It is the role of the substance misuse treatment services including the APB to help educate and support service users to recognise recovery capital acquired and what is needed to be worked on/needed in the community.

	Recovery capital – Community, barriers	Codes relating to barriers to achieving community recovery capital	- Defence mechanisms, feeling alone in the journey - Lost hope - Being housed in an area with drug use is prevalent or in the same house as users – increase risk of relapse	
	Physical recovery enablers	Any positive mention of physical effects addiction and recovery has on the body	-	- Slow-release programmes, maintenance programmes, detoxification programmes.
	Physical recovery barriers	Any negative mention of physical effects addiction and recovery has on the body	- Withdrawal from heroin/opiates/opioids.	
	Process of recovery	This includes any mention of changes and a journey, being ready to move on, etc.	- Supportive surrounding - Changing self - Learning new coping mechanisms - Journey - Challenges - Opportunities	- Recovery is personal to each individual

Abstinence vs reducing drug/heroin use	Discussions about what the best approach is and why; strengths and weaknesses of the different approaches			
	Positive role of MPPs	Any mention of positive role of MPP such as prevention of criminality and supporting ability to function	- Gives ability to function - Enables stability - Reduces crime and BBV deaths - Requires commitment - Prevents consequences of drug taking	- Reduces cravings - Prevents withdrawal - Reduces harm - "*eliminates the reinforcing properties of drug taking*" (Welsh Government 2011, 14). - Withdrawal is 5-7 days or 12 weeks if more appropriate. - Daily supervision for first 3 months with adjustments for rural community. - Supportive aftercare programmes for at least 6 months and recovery groups to prevent relapse.

	Negative role of MPPs	Any mention of negative role of MPPs such as difficulty of coming off Methadone, needing additional support to……	- Prescribed for too long - High dosage of prescriptions - Services are overrun - Not happy or a great supporter of methadone prescription system - Still using - Small percentage find successful - Relapse - Harder to withdraw than heroin - Long term treatment - Requires commitment - Criminality - Rurality - Separation from society - Subutex (buprenorphine) is more beneficial	- Rigid dispensing regime - Random routine testing – daily at first until stable determined through clinical assessments and toxicology results - Community detox requires stable accommodation, supportive network, and motivation to change, capacity and physical dependence. - Discrete areas or rooms to ensure confidentiality - Requires strong integrated working - Relapse rates are high

Culture and attitudes within services	Issues around stigma, service culture in terms of practical issues within services (reluctant to change) and service ethos (how addiction and recovery is perceived).			
	Stigma	Services stigmatise clients in different ways and/or clients may feel reluctant to engage because of stigma	- There is a huge amount of stigma by wider community and treatment professionals of 'once an addict always an addict' - Bad patch of attitude is often a management issue - Medical profession has a low opinion - Staff members thinking it doesn't matter what the addict says, impacting how the service user feels about themselves. - Being laughed at the prospect of someone (an addict) changing their life. - People feeling reluctant to attend SMS due to stigma	- Training on substance misuse and the recovery agenda for all staff is recommended within the policy documents. - No codes from policies directly relating to stigma.

			attached to them, so not getting the help they need.	
	Service culture	Any positive or negative mention of issues such as flexibility (in terms of delivery, appointments,), access, approachable (understand addicts may have different concept of time and have chaotic lives)	- Travel – the requirement to travel for daily supervision, especially from rural areas with poor bus services and the issue of cost - Support for the cost of bus tickets for rural but not for all bus companies, also an issue with developing dependency - The distance/location of services - Unable to arrange appointments due to loss of or sold their phone - They (service users) don't know what day it is yet they are expected to meet appointments.	- Ready for a change in the culture of substance misuse services (*ROISC* 2013).
	Service ethos	Any approaches and thoughts towards addiction and recovery	- Lack of ethnic minorities accessing services	- Importance of not developing

		(e.g. addicts are always criminals); willingness to change; 0affordability; inclusiveness (different ethnicities)	- No money in recovery - Still massive amount of work to do, dependent on handful of practitioners supporting recovery - Recovery oriented systems reduce staff sickness, staff stress - Recovery agenda is believed to be "*just a phase*" by treatment services - Recovery still blasphemous word in parts of drug services - Stuck in a failed system - Substance misuse shouldn't be a prescription service, it should be therapeutic interventions - Dysfunctional system, never worked - New managers lacking courage, conviction or awareness due to health	hierarchies of recovery, i.e. abstinence or reducing drug/heroin use (*ROISC* 2013, 5) - Personal beliefs need to be put aside (*ROISC* 2013, 5). - Recovery and substance misuse training should be provided to understand need.

			focus of substance misuse/ also lack understanding and knowledge of the psychosocial process of recovery - More recovering addicts working in recovery field will drive an internal culture shift - Current system geared up to benefit services, not service user.	
Integrated and multidisciplinary working	The benefits and challenges multi-disciplinary working			
	Benefits	Includes practical issues such as providing timely services, and consistent support, effective communication between organisations and with the service user	- Forever round the table - Works better than it ever has - SPoA is needed	- Single record of care – informed service users of treatment plan, also enhances communication and information sharing between services, avoids duplication

				and stays with the service user. - SPoA for substance misuse – reduce repetition - Services required to work together for effective community prescribing -
	challenges	Issues such as information sharing	- Health services find it difficult because they are very stretched - Trying to get the right people at the right time - Become insular. Should have monthly three-way meetings - Information sharing is important - SPoA was trailed but not successful - Repetitive assessments	

			- Services are overrun	

Appendix J Similarities and differences between the policies

Table 4.2 Similarities and differences between the policies

Integrated Care and Integrated care pathways (2010a)	**Community Prescribing (2011)**	**Recovery Orientated Integrated Systems of Care (2013)**		***Thematic codes of all 3 policies***
Integrated Care Pathways	Integrated working	Integrated care pathways		Integrated care [pathways]
Training: Staff performance and development	Staff training and competence	Training		Staff Training
Assessment: Single record of care, SPoA and co-ordinator of care	Assessment	Care planning		Assessments/SPoA
Map of Medicine (no longer functional)	OST	Recovery capital		No similar codes
No other codes from *Integrated Care* (2010a)	Aftercare	Recovery champions		Exiting treatment/aftercare

Appendix K: Main findings from both datasets

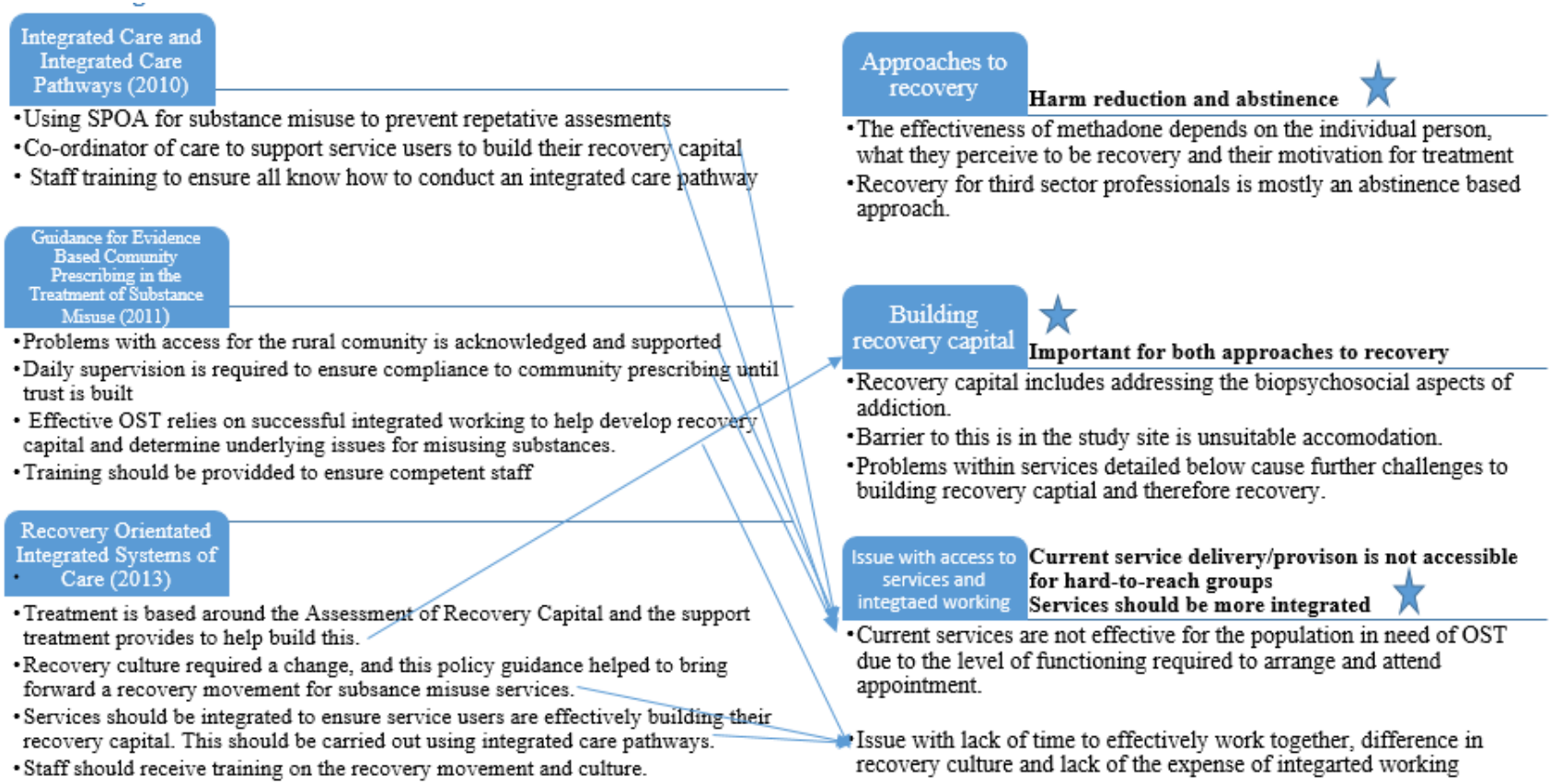


Figure 5.1: Main findings from both datasets

To the left are the key areas from the policy analysis and the interview findings to the left. The arrows highlight which key areas from the policies relate to the interview findings. The blue stars indicate key finding.

Appendix L: Main themes from both datasets

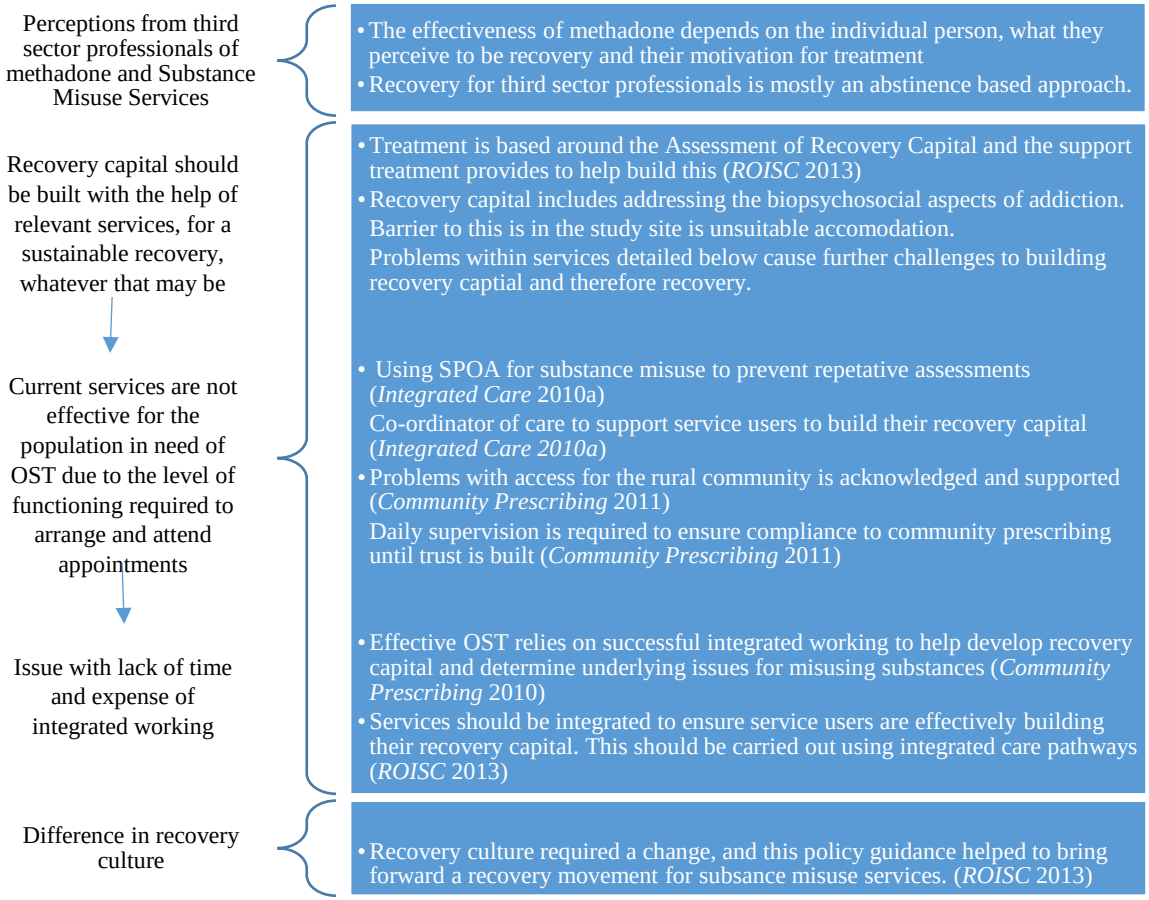


Figure 5.2: Policy and primary data

The figure above illustrates on the right the key points from the interview findings/policy analysis and to the left the theme associated to the findings.