Social research number:

21/2018

Publication date:

19 April 2018

Review of Working Together to Reduce Harm

APPENDICES

Mae’r ddogfen yma hefyd ar gael yn Gymraeg.

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Review of Working Together to Reduce Harm: Final Report Appendices

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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 Appendices*

Cardiff: Welsh Government

GSR report number 21/2018

Available at: http://gov.wales/statistics-and-research/review-working-together-reduce-harm/?lang=en

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

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Table of contents

Table of contents 1

List of tables 2

1. Appendix A – Stakeholder Consultation 3

2. Appendix B – Comparative Timeline 15

3. Appendix C – Assumed Logic Models 21

4. Appendix D – Alcohol Concern Cymru Reports (Research and Briefing Papers) 34

5. Appendix E – Welsh specific sources of evidence 40

6. Appendix F – Literature Review Summary 48

7. Appendix G – Gaps in Data 97

8. Appendix H – Academic Discourse on Policy Influences 101

List of tables

Table A1.1: Consultation Workshops – by invitation, attendance and notes analysed 4

Table A1.2: Consultation Workshops – analysed themes and consistent messages from stakeholders 7

Table A2.1: Comparative Timeline 15

Figure A3.1: Policy model 22

Table A3.2: Examples of other considerations 23

Figure A3.3: Assumed Core Strategy Logic Model – 2008 25

Figure A3.4: Assumed Action Area 1 (Preventing Harm) Logic Model – 2008 27

Figure A3.5: Assumed Action Area 2 (Support for Substance Misusers) Logic Model – 2008 28

Figure A3.6: Assumed Action Area 3 (Support and Protection for Families) Logic Model – 2008 29

Figure A3.7: Assumed Action Area 4 (Tackling Availability via Enforcement) Logic Model – 2008 30

Figure A3.8: A current (hybrid) logic model representation 32

Figure A3.9: Current Domains of Wellbeing 33

Table A4.1: Summary and commentary on Alcohol Concern Cymru Reports (2010-2016) 34

Table A5.1: Treatment data – Substance Misuse in Wales reports 40

Table A5.2: The Annual Profile of Substance Misuse in Wales 41

Table A5.3: Working Together to Reduce Harm – Substance Misuse Annual Reports 41

Table A5.4: Treatment Frameworks and Guidance 44

Table A5.5: Delivery and Implementation Plans 47

Table A6.1: Categorisation and summary of key literature messages 48

Table A6.2: Summary of key evidence sources – by theme 58

Table A6.3: Summary of Alcohol and Drugs Systematic Reviews 81

1. Appendix A – Stakeholder Consultation

A critical component of the Contribution Analysis methodology required consultation with a broad range of stakeholder groups in order to test out the Theory of Change, as well as capturing a rich layer of qualitative evidence to supplement the performance story. The primary methodology for this consultation was prescribed by Welsh Government as the facilitation of a series of workshops cross Wales. In addition, the review team added a small number of key informant interviews, as well as an online (qualitative) survey to capture additional and comparative evidence streams. The details of these methods, and key themes generated, are presented below.

Stakeholder Workshops

Working in conjunction with the seven Area Planning Boards (APBs) we established nine potential workshops across the country (two for North Wales[1], one each for the other six areas and one on-line Welsh language[2]). A targeted sampling approach was adopted to inviting as broad and inclusive range of voices as possible. The result of which was that 272 invites were dispatched and 117[3] individuals attended.

[1] The APB for North Wales, identified two workshops in either end of the area, rather than one central as that was most likely to be the best attended approach.
[2] Only one individual requested to attend this and as such it became a telephone interview, rather than a workshop.
[3] 118 including the one Welsh language interview.

Table A1.1: Consultation Workshops – by invitation, attendance and notes analysed

APB Area	Location	Invited	Attended	No. of small groups	No. of researcher notes analysed	No. of participant notes analysed
North Wales	Bangor	18	21	3	3	18
North Wales	Wrexham	28	20	3	3	13
Powys	Llandrindod Wells	25	10	2	4	4
Western Bay	Port Talbot	42	12	2	2	7
Dyfed	Camarthen	43	19	3	3	11
Cwm Taf	Mountain Ash	34	18	2	4	8
Gwent	Newport	46	6	1	2	3
Cardiff & Vale	Cardiff	36	11	2	4	4
TOTALS		**272**	**117**	**18**	**25**	**68**

Process and analysis

The process of setting up and analysing the workshop evidence is summarised as follows:

- As can be seen in the table above, 272 invites were dispatched and 117[4] individuals attended (details provided below).
- Each workshop was divided into groups, which were small enough (6-10 individuals), to allow participative contribution, with each group being facilitated by at least one member of the evaluation team who utilised the same structured dialogue (see below).

[4] 118 including the one Welsh language interview.

- The net result of which was that 18 small group conversations were conducted. These were manually recorded by one or two researchers (25 sets of researcher notes in total) and supplemented by additional notes that attendees were encouraged to record during the workshop (68 in total).
- All of these extensive research and attendee notes were than fully transcribed (typed script) and then re-checked for accuracy and clarification.

Structured Dialogue

Each workshop started with a brief overview and presentation from the review team lead. This provided a context and understanding for participants as to the nature of the review and the purpose of the workshops.

Participants were split into small discussion groups with at least one member of the review team facilitating each group. Each participant was provided with a question sheet with space to write their own thoughts, and they were encouraged to help the review by writing things down in their own words where possible. The group facilitator also took notes of the discussions.

The workshop was divided into two sessions, each approximately one hour in length and with each group having three key questions to discuss per session (six in total). At the end of the small group discussions the review team lead led a large group discussion where participants were asked to reflect on the conversation as a whole, and identify the most important messages from the workshop.

The six questions asked of each group were as follows:

1. What changes have you seen or experienced as a direct/indirect result of the strategy?
2. What's been the overall contribution of the strategy at a national level, and local level?
3. How do you know whether the strategy has worked or not?
4. What else would you like to have seen or experienced as a direct/indirect result of the strategy?
5. What external factors have affected delivery/impact of the strategy?

6. What should be the future considerations for where the strategy goes from here?

Analysis

All notes (from both research team facilitators and participants) were typed up following each event. The notes were sent back to each researcher for accuracy checking. The notes were then systematically analysed by one member of the research team for purposes of consistency, with a secondary quality assurance check provided by another member of the review team. Responses were thematised with consistent messages being noted in the table below. Consistent messages were defined as being those which were mentioned in at least five different groups (out of 18) from at least three different workshops (out of seven[5]).

[5] For the purposes of analysis, the responses from the two North Wales APB workshops were combined, so that North Wales did not receive a higher weighting in influencing responses, given that all other APB areas only had one workshop held in them.

Table A1.2: Consultation Workshops – analysed themes and consistent messages from stakeholders

QUESTION 1: What changes have you seen or experienced as a direct/indirect result of the strategy?	
Theme	**Consistent messages[6,7]**
Substance Misuse Sector	• Services are working better as a rule and staff are more focused. [6]
Funding	• Vulnerability of financial viability of services due to climate of austerity. [5]
Substances – trends	• Substances are getting stronger. [5] • Greater focus on alcohol being more harmful than drugs. [5]
Treatment Options	• More tailored/personal approach from services (e.g. moves away from just scripting, more focus on mental health, etc.). [5] • Continued lack of options for those with co-occurring substance misuse and mental health. [6] • Expansion of Harm Reduction options (no longer just about methadone and clean needles). Introduction of naloxone programme a good example, which has led to a really strong focus on preventing drug deaths. [6]
Treatment populations	• Services are NOT well equipped to deal with advent of NPS (particularly in prisons). [5]
Service User Involvement	• There has been an increase in service user involvement activity and appreciation of service user input. [7]
Recovery	• Expansion of recovery agenda/model, including moves towards throughcare and increases in move-on/aftercare (which work well - e.g. peer mentoring). [8]
Families	• Little has changed in relation to support for families.[8] [5]
Partnership /	• Greater emphasis on multi-agency working. Better joint

[6] Numbers in parentheses are the number of times the message was noted across different workshop groups.

[7] In addition to the identified messages listed in the table, a further consistent message relating to 'a significant increase in housing issues' was noted by the research team (across five workshop groups). However, it is not possible to identify this as either a direct or indirect result of the Strategy.

[8] Although some areas/groups did report significant improvements in family support, thus indicating inconsistent developments in support for families across Wales.

multi-agency working	working between statutory and third sector. [7] • Increase in partnership working from the grass-roots up. [5]

QUESTION 2: What's been the overall contribution of the strategy at a national level, and local level?[9]

Theme	Consistent messages
Harm reduction	• There is a real sense that the Strategy has 'done what it said on the tin' – i.e. that it has contributed to reductions in harms associated with substance misuse. [10] • The promotion and development of support and interventions around blood borne viruses is widely seen as one of the big contributions of the Strategy. [8] • Another of the widely acknowledged Strategy contributions (both direct and indirect), has been the introduction of the naloxone programme, which stakeholders felt wouldn't necessarily have existed without the Strategy. [8]
Recovery agenda	• The recovery agenda is recognised to have developed significantly over the life-course of the Strategy (particularly the last few years), and the Strategy is acknowledged by the majority of having been supportive of this. [9] • It is generally felt that the Strategy has supported the significant developments across Wales of the importance of hearing the voice of lived experience at all levels of the treatment and recovery system. Indeed, it was noted that these consultation workshops would not have had the range of lived experience views involved at the start of the Strategy. [6] • There has been a significant increase in the attention paid to service user involvement and promotion of peer mentors across Wales. [5]
Culture change	• Regular conversations within the workshops were noted regarding culture change across the sector, with particular mention being made to a clear mindset

[9] A significant proportion of the conversations on this question focused on what the strategy hasn't been able to do. This element of the feedback has been added to the analysis of Question 4.

	change by the Police. [5] • There is agreement that service provision has evolved positively over the period of the Strategy, mainly epitomised by the appearance that services are no longer just about the handing out of prescriptions. [7] • A key success of the Strategy is noted as being an increase in multi-agency approaches and that it has generally improved confidence levels across providers and commissioners. [8] • The Strategy is noted as being largely responsible for supporting significant improvements in the way individuals/agencies are working, despite the fundamentals of the problem still being the same. [8]
Government influence	• Welsh Government were consistently noted as having been a visible force in the outworking of the Strategy at a local level, which has brought with it a high level of scrutiny. In the main this has been welcomed (mainly as a need to bring 'Health' alongside other partners), although there is a forcible number of voices suggesting the level of scrutiny should now level off. [9]
Data	• Due to improvements/expansion in data collection systems there is improved picture as to the needs of substance misusers across Wales. [5]
Funding	• Ringfencing of funding has made a significant difference across the sector. [6]

QUESTION 3: How do you know whether the strategy has worked or not?

Theme	Consistent messages
Improvements in multi-agency working	• The acknowledged improvements in multi-agency working are viewed as a positive sign that the Strategy is/has been working. [7]
Attendance at recovery groups	• Big increases in people turning up for recovery groups and meeting (all year round) is viewed as another positive sign. [5]
Increase in numbers accessing Hepatitis C treatment	• Big increases in the numbers of individuals accessing Hepatitis C treatment is a positive indication that the Strategy is helping to reduce harm. [7]

User voice	• Individuals who have lived experience are being given a stronger voice as time goes on – which in itself is viewed as a positive contribution of a Strategy that is working. [8]

QUESTION 4: What else would you like to have seen or experienced as a direct/indirect result of the strategy?

Theme	Consistent messages
Much better information sharing	• There is widespread agreement that information sharing across/between partner services/agencies could and should be much better, and that the Strategy has not made any significant dent in this area. [9]
Single point of access	• The development in all areas of a single point of access for substance misuse services and supports. [5]
Improvements for those with mental health and substance misuse issues	• There is a general feeling that the Strategy did not included sufficient focus on this population and therefore, improvements have not been realised. It is recognised that individuals are still (often) bounced between services, as they always have been. [8]
More family and carer support	• There are question marks from a range of stakeholders over whether family and carers have received sufficient attention and services over the lifetime of the Strategy. [6]
A shift to outcomes monitoring	• Measuring 'real' outcomes is viewed as a massive challenge that the current Strategy hasn't made much of a dent in. [8]
Consumption rooms	• Development of consumption rooms is considered by most to be a logical and sensible way to help reduce the harms associated with substance misuse. [7]
More involvement from housing	• Housing is considered to be of such a critical factor that housing representatives need to be much better engaged in substance misuse discussions/decisions. [8]

QUESTION 5: What external factors have affected delivery/impact of the strategy?

Theme	Consistent messages
Lack of mental health service	• Although it is recognised that lack of involvement is often a sign of the significant pressures upon mental

involvement	health services. [6]
Housing issues	• Too many people are homeless or trapped in a negative loop in regards their housing situation and this plays a massive role in preventing individuals from moving on in their recovery. [7]
Output/outcome monitoring	• There is the perception that agencies are often keeping service users for the purpose of ticking boxes rather than realising positive outcomes. [8]
Funding cuts and reliance on European monies	• This is viewed as an obvious external factor that has played the most significant role in directly impacting the ability of the Strategy to reach its goals. [10]
Changing legislation and effects of devolution	• The apparent constant changing landscape in legislation (and particularly the effects of devolution) have (and continue to) play a major role in the ability of the Strategy to fully meet its objectives. [5] • Changes in legislation may prevent the Welsh Government from implementing Minimum Unit Pricing of Alcohol, which is considered to be much needed[10]. [6] • The Licensing Act has not helped with consumption levels, as it's even more widely available than at the start of the Strategy. [5]

QUESTION 6: What should be the future considerations for where the strategy goes from here?

Theme	Consistent messages
Prevention	• The current Strategy focuses more on individuals who are already using, rather than prevention. Widespread support was voiced for changing this balance in any future Strategy. [8]
Integration of Substance Misuse and Mental Services	• The needs of substance misusers with co-occurring mental health issues should be considered as a top priority for future action, given that the perception is of little progress over the course of the current Strategy. [7]

[10] Since the writing of this report significant progress has been made in relation to MUP. Firstly, Public Health Minimum Price for Alcohol (Wales) Bill has been introduced and is currently going through the Assembly scrutiny process; and, secondly, MUP in Scotland has now overcome all legal challenges and the Scottish Government have announced an implementation date of May 1st, 2018.

Further development of Recovery / Peer Support / User Involvement options	• To build upon the experiences of those in North Wales at building residential recovery communities (Recovery Houses) as opposed to historical rehabilitation centres. [5] • Investment is considered important to support the future continuation and capacity of peer support options across Wales. [7]
Evaluation of outcomes	• There was widespread discussion and agreement that any future Strategy should focus on long-term outcomes (and how to measure them). [8]

Key Pan-National Informant Interviews

It was identified early in the process that conducting workshops via APB areas was going to miss a select number of key (pan-national) voices, which wouldn't easily sit within the local area workshops. It was decided to conduct three such telephone interviews (purposefully sampled), with individuals who could provide a singular voice by weight and expertise of role (i.e. they each have a national role rather than an APB level role).

The interviews were conducted with:

- A senior Welsh Government official who was partly responsible for the development of the 2008 Strategy and retains oversight of substance misuse issues within Welsh Government today.
- The Director of Alcohol Concern Cymru[11].
- The Chair of the All Wales Service User Movement (AWSUM)[12].

These individuals were chosen as they are not regular attendees of any one APB, and were therefore not involved in the APB Workshops.

[11] 'Alcohol Concern has been working closely with the Welsh Government since 2009 to help people in Wales to have a healthy relationship with alcohol. They undertake research into how alcohol is marketed, sold and consumed, and make evidence-based proposals for change. They challenge people to think about their own drinking habits, and challenge the alcohol industry about its tactics to get us drinking more. Their aim is a Wales in which alcohol does no harm – in which adults can enjoy alcohol (or choose not to) without causing problems for themselves or others.' (https://www.alcoholconcern.org.uk/Pages/Category/alcohol-concern-cymru).

[12] 'The All Wales Service User Movement (AWSUM) is: a national movement for service users; a direct link between service users and Welsh Government; a group of people that empower service users to help shape substance misuse policy; and an independent voice to create a better Wales for people with substance misuse issues.' (http://awsum.wales/).

Each interview was bespoke in design to focus on the key activities and influence of the interviewee role during the period of the Strategy.

All of the interviews were audio recorded in order to capture complexity of dialogue. They were then fully transcribed and analysed thematically in the same way that the Workshop data was analysed (see above).

The analysis of the interviews has been accounted for and has contributed to the overall performance story contained within the main report.

Online Survey

It was recognised, in setting up the APB Workshops, that quite a number of people who had been invited were unable to attend. It was also recognised, when conducting the workshops, that some individuals had more to say than time allowed within the group discussions. It was therefore decided to design and disseminate an online survey to add a further opportunity for gathering views, and also providing an opportunity to compare the workshop data with a wider set of views for checking accuracy.

A simple, four-question, survey was designed and disseminated (via APB networks) in mid-April 2017 and was available for completion over a four-week period.

The questions designed were structured around the key workshop questions, but amalgamated into four, rather than six questions – to aid ease of access and completion to a wider audience.

The questions were purposely designed as open-ended questions to allow those completing the survey to share views that would add substance to the developing performance story.

Survey questions

The four questions used in the survey were:

1. What changes have you seen or experienced between the beginning of the strategy in 2008 and now?
2. What else would you like to have seen or experienced?
3. What should the Welsh Government take into consideration for any future strategy?

4. How should success be measured (performance or outcomes) in the future?

Analysis

A total of 34 responses were collected, all of which were usable for analysis.

The data was purposely given to a member of the research team who had not been involved in the design or delivery of the APB workshops, to avoid any bias given to the identification of key themes or messages. The aim was to assess whether there were any other significant themes for the performance story that had not been picked up in the workshops.

The analysis did not highlight any other significant themes and there was little consistency to the answers given across the 34 responses.

Although the survey findings are not contradictory to the findings of the workshops, there were no dominant themes identified across the survey responses as a whole – instead there were pockets of cohesive and dominant discourses. The responses appear to be a set of competing, rather than complimentary messages; more personal in nature than consensual. This forms a juxtaposition with the workshop analysis, which is more consistent in nature.

2. Appendix B – Comparative Timeline

To aid the development of the performance story across the duration of the Strategy period, a comparative timeline was produced by the research team, and is presented below.

Table A2.1: Comparative Timeline

Date	Devolution, Elections and External Events[13]	Alcohol and Drug Law, Policy and Strategy Documents Wales (England, Scotland and UK)[14][15]	Key Policy Activity (Wales only)[16]	Commentary
Prior to 2000	1979 1st Welsh devolution referendum; rejected. 1997 2nd Welsh devolution referendum; successful	1973 Misuse of Drugs Act 1996 **Forward Together: A strategy to combat drug and alcohol**	1999 The 'Welsh Advisory Committee on Drug and Alcohol Use' (WACDAM) is abolished and a temporary 'Substance Misuse Advisory Panel' (SMAP) established	The current framework for 'illegal drugs' is now 44 years old. It has been subject to minor rather than wholesale review, and is consistently criticised for not accurately reflecting the

[13] National Assembly for Wales (2017) *History of Welsh Devolution* http://www.assembly.wales/en/abthome/role-of-assembly-how-it-works/Pages/history-welsh-devolution.aspx
[14] Transform (2017) http://www.tdpf.org.uk/resources/drug-policy-timeline
[15] Dropwise (2016) What are the UK Drug Laws http://www.drugwise.org.uk/wp-content/uploads/druglinktimeline-1.pdf
[16] Welsh Assembly Government (2004) *Substance Misuse: Key Structural and Policy Developments SJR-12-04(p.1) ANNEX 1* http://www.assembly.wales/Committee%20Documents/SJR%2012-04%20(p.1)%20Policy%20Review%20Substance%20Misuse%20-%20Annex%201-23092004-15301/n0000000000000000000000000023650-English.pdf

	1997 UK Elections – Labour (Tony Blair) succeed ending 18 previous years of Conservative rule. 1998 Government of Wales Act; National Assembly into being 1999 1st Assembly elections; minority Labour government returned -coalition with Liberal Democrats	**use in Wales** 1998 Tackling drugs to build a better Britain (Home Office) 1998 Crime and Disorder Act (Introduction of Drug Testing Orders)		harms caused between legal and illegal drugs[17]. (Various drugs have been added or had their classification changed in the in-between years). Wales has had a joined-up strategy approach for alcohol and drugs since 1996; this is distinct from separate approaches in England and Scotland. 1998 Westminster drug strategy refers to Britain, yet policy devolving.
2000-2008	2001 UK Elections; Labour and Tony Blair returned to power 2002 Term Welsh Assembly Government adopted 2003 2nd Assembly Elections; Labour wins 50% of seats and	2000 **Tackling substance misuse in Wales: A partnership approach** 2003 Hidden Harm: Responding to the needs of the children of problem	2001 Advisory Panel on Substance Misuse' (APoSM) established 2003 DAATs and LATs are abolished and replaced by SMATs (Substance Misuse Action Teams) (22 -utilising co-terminus nature of Community Safety Partnership, Local Authority and Local Health Boards) 2003 Substance Misuse Advisory	Health and social welfare becoming devolved matters, as strategy is being formulated. 2000 - Wales consolidates it's approach to dealing with all drugs within one policy document

[17] Nutt, D.J; King, L.A and Phillips, L.D. (2010) Drug harms in the UK: a multicriteria decision analysis *Lancet* 376 (9752):1558–1565, 6

	forms government 2005 UK Elections; Labour and Tony Blair returned for third time 2006 2nd Government of Wales Act- formal separation of powers between Legislature (National Assembly) and Executive (Welsh Government). (Powers to make Laws -in defined areas) 2007 3rd Assembly elections; Labour and Plaid Coalition for 'One Wales' formed.	drug users (ACMD) 2004 The Alcohol harm reduction strategy for England 2007 Safe, Sensible, Social: The next steps in the national alcohol strategy (England)	Regional Teams (SMARTs) - established 2003 - Wales Substance Misuse Services Review 2002/03, Final Report 2004-5 Substance Misuse Treatment Frameworks (SMTF's) established (Additional frameworks added at later dates)	
2008-2013	2009 -Restructure of NHS in Wales (Establishment of 7 LHB and 3 NHS Trusts) 2009 Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) established	2008 **Working together to reduce harm: The substance misuse strategy for Wales 2008-2018** 2008 The road to recovery: A new approach to tackling	Responsibility in WG rests with Local Government and Communities portfolio 2008 Substance Misuse Strategy Three-year Implementation Plan 2008-11 2008 the Substance Misuse Action Fund (SMAF) = £25m 2008 National Substance Misuse	2008 marks an increase in the differences between policy and strategy across the four UK nations. Wales continues to be only UK government with a combined substance policy. This said policies all still have some similar larger target areas; Prevention, Harm

	2010 UK Elections; Conservatives form coalition with Liberal Democrats under David Cameron 2010 Home Office cuts DIP Funding by 8% 2011 -3rd referendum; increased powers 2011 4th Assembly Election; Labour again achieves 50% of the seats 2012 Police and Crime Commissioners (PCCs) are introduced	Scotland's drug problem. 2009 Alcohol Framework for Action (Scotland) issued 2010 Drug Strategy 2010, reducing demand, restricting supply, building recovery: supporting people to live a drug free life (England) 2012 The Government's Alcohol Strategy 2012 The Alcohol (Minimum Pricing) (Scotland) Act 2012	Strategy Implementation Board was established 2009 -Guidance issued to move from 22 SMATs to 7 Area Planning Boards (APB) 2009 £1m ring fence for Tier 4 services 2009 New guidance for Welsh National Database for Substance Misuse (WNDSM) 2009 Treatment Outcome Profile (TOPS) introduced 2009 1st Welsh Service User Conference 2010 APBs established 2010 SMAF budget increased by £5.9m to £34.5m. 2010 Integrated Family Support Team (IFST) -pioneer areas begin 2011 new Harm Reduction Database was introduced for use 2011 Welsh Government support Recovery Cymru 2011 All-Wales Late Night Economy Group is founded 2012 Responsibility in WG moves to	Reduction, Treatment and Availability, are common themes. Emergency of 'recovery' elements within policies; most notable in Scotland Funding -has combined streams; SMAF, Health (Local Health Boards), Criminal Justice (Home Office; Police and Probation), plus other contributing elements. Local Health Boards monies ring fenced. Scotland, signals a continued (activity) push to see alcohol as one of its top three policy priorities. This is not matched elsewhere; indeed, a dilution of alcohol and drug policy begins to appear in England in particular. Budget consolidation; within Wales through new ministerial portfolio and through PCC for combined Police and DIP

			Health and Social Services	monies
2013-2016	2013 Drug Intervention Programme funding from the Home Office is ended 2014 Wales Act 2015 UK Elections; Conservatives with David Cameron secure majority 2016 5th Assembly Elections; Labour gain 29 seats, and short of majority 2016 'Brexit' Referendum 2016 Revised recommended consumption of alcohol guidelines are issued jointly by the CMOs of the UK	2016 Psychoactive substances ACT	2013 The SMAF budget 2013/14 is £32.547 million, with £22.663m of this allocated to APB (£2.75m ring-fenced for children and young people's projects and £17.134m is ring-fenced within LHB) 2013 Recovery Oriented Systems of Care Framework introduced 2013 WEDINOS (Welsh Network of Emerging Drugs and Identification of Novel Substances) is launched 2014 Substance Misuse Service User Involvement Framework issued 2014 Data Information and Analysis Board (DIAB) established 2015 Health and Social Care Committee published a report on its inquiry into alcohol and substance misuse 2016 Responsibility in WG sits with Minister for Social Services and Public Health following election 2016 (Sept) 2016-18 Delivery Plan issued.	Assembly elections now move to a fixed 5-year cycle. Welsh government policy and location of responsibility continues to (reflect developed responsibility and direction of travel) sit with health and social services remits.
2017 -	2017 UK Elections			2017 Act determines those

beyond	2017 Wales Act; amends 2006 and 2014 Acts			powers that are conferred and those reserved. (In a sense making clear what Welsh Government cannot do). This could have the potential to remove any chance of Welsh Government introducing any Minimum Unit Price Law separate to England[18].

[18] Since the writing of this report significant progress has been made in relation to MUP. Firstly, Public Health Minimum Price for Alcohol (Wales) Bill has been introduced and is currently going through the Assembly scrutiny process; and, secondly, MUP in Scotland has now overcome all legal challenges and the Scottish Government have announced an implementation date of May 1st, 2018.

3. Appendix C – Assumed Logic Models

This review was commissioned with the prescribed methodology of Contribution Analysis. At the heart of this process, is the identification of logic models. The review process established that there we no formal, explicit logic models in place from the start of the Strategy. However, through testing, it became evident to the review team that there was an implicit theory of change during the Strategy development. This Appendix summarises these considerations, and in doing so, it offers (1) an assumed theory of change, (2) a set of assumed 'starting point' (2008) logic models, and (3) a suggested visualisation of possible next steps.

3.1 Context

The assumed Theory of Change considerations (see **Section 5** of the main report) identify activity or impact across a number of domains (which become the assumed 'starting point' logic models. What the Strategy did not do, and therefore this Appendix has not done, is to suggest the weighting of these domains, i.e. whether it is assumed that one area or some activities are likely to contribute more heavily than others (and whether resources and/or activities follow such weighting).

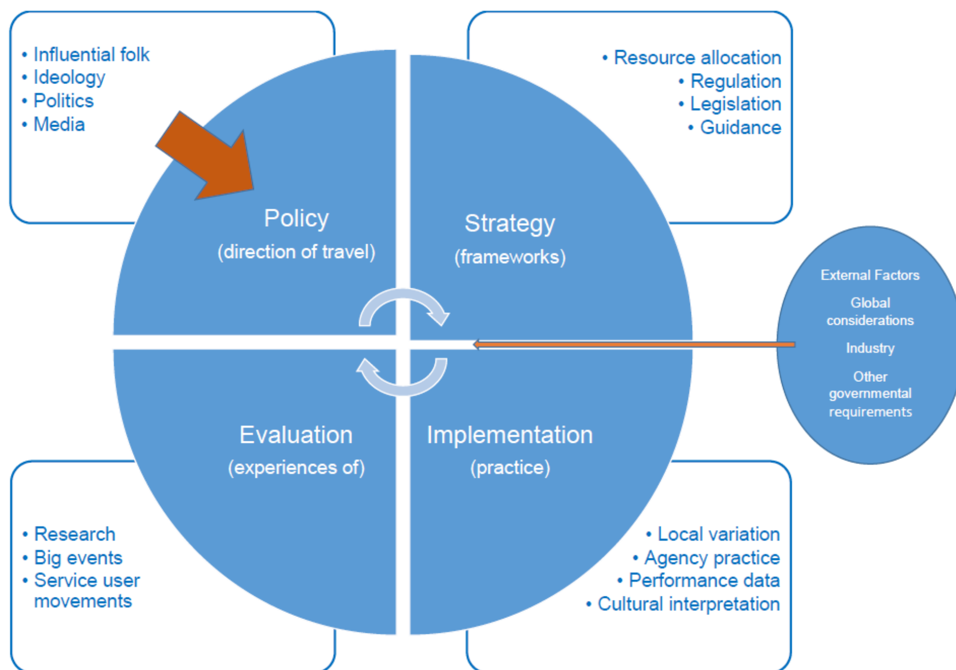
Strategies are reflections of policy. To make sense of them it is important to understand the policy context. However, alcohol and other drug use cuts across a vast swathe of agendas, so it is inherent to whole societies.

Alcohol and other drug strategies primarily concern themselves with addressing the negative consequences of use. Therefore, to capture the wider contextual story, it is important to:

- understand the complex factors that contribute to policy development and evolution (see **Figure A3.1** below).

- place what is being evaluated (i.e. Welsh Government Substance Misuse Strategy related activity) within a range of other considerations that are equally as likely to contribute to any change in use/behaviour/consequences of alcohol and drug use[19] (see **Table A3.2** below).

Figure A3.1: Policy model



[19] This is of course the whole raison d'etre of the Contribution Analysis approach.

Table A3.2: Examples of other considerations

Sphere of influence	Examples of consideration
Other WG Activity	• Notably: health, social care, education, criminal, housing, homelessness, domestic abuse and mental health
Other priorities/pressures for key actors/agencies	• Austerity • Risk management
UK Government Activity	• Benefit system • Criminal law • Border activity
Industry Activity	• Alcohol • Tobacco • Pharma • Illegal
International alcohol and drug policy/activity	• Afghanistan war on opium • Migration (different criminal populations)
Individual well-being	• Love • Spirituality

3.2 Assumed (implicit) overall starting point of the Strategy

It is worth noting that the *Working Together to Reduce Harm* strategy is a fixed document, but it does have its own journey which is better understood by (1) preceding documents and events (see **Appendix B**), (2) its starting points (2008), and (3) the current reporting and monitoring framework alongside recent policy and legal developments.

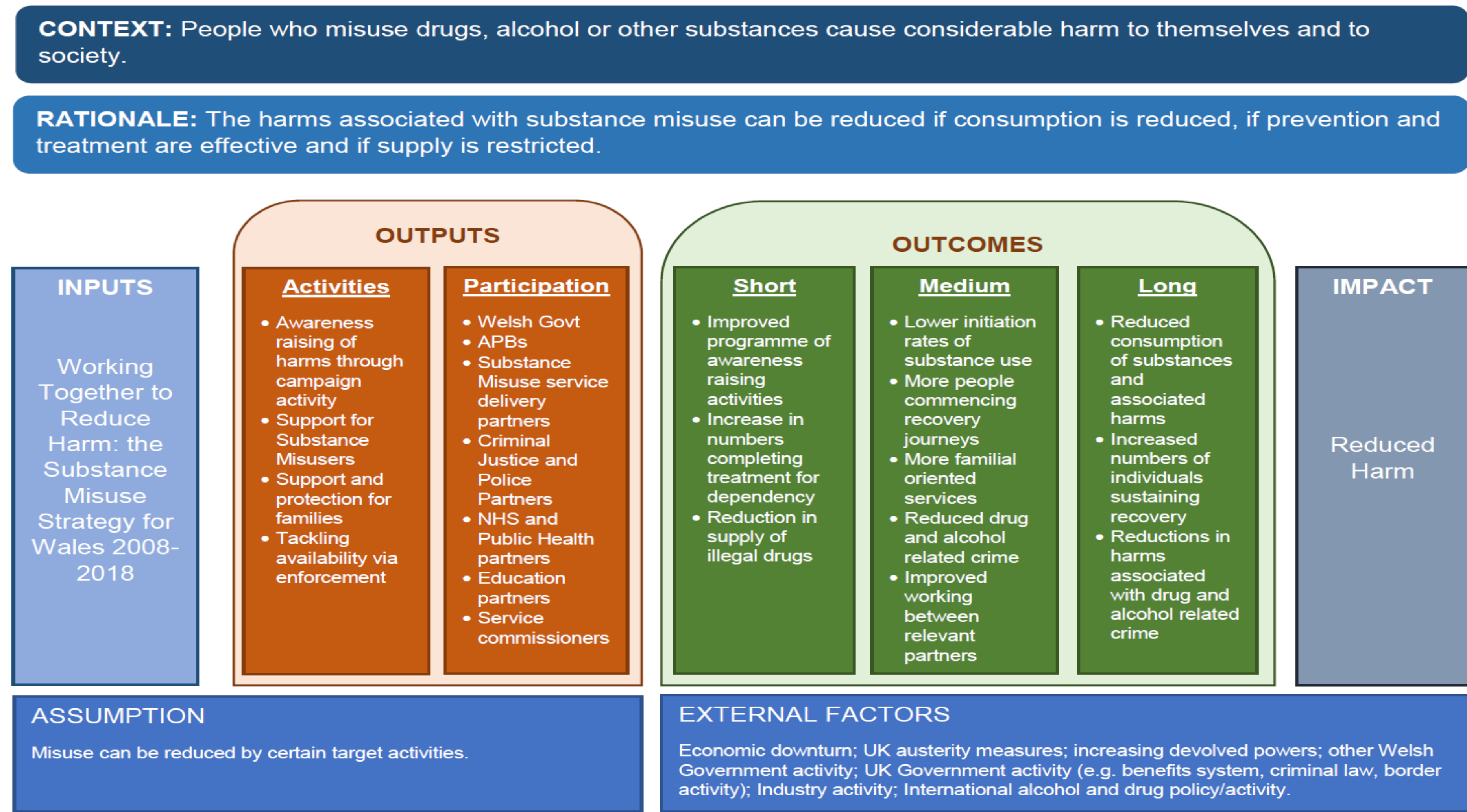
In this context, the current description of the framework, landscape, problems and solutions in the 2016 report[20] is not exactly that of the 2008 position. More recently, the Welsh Government have framed health and social care policy within the *Social Services and Wellbeing [Wales] Act 2014* and the *Future Generations [Wales] Act 2015*.

The overarching starting assumption for the Strategy was that people who misuse drugs, alcohol or other substances cause considerable harm to themselves and to society[21]. The implied assumption therefore was that 'some' people 'misuse'; hence why this Strategy was called a 'misuse' strategy (see **Section 4** of the main report), despite the Welsh Government also being concerned with whole population consumption, which is a 'use' agenda.

So, the core logic model for the 2008 starting point was clearly based on the assumption that 'misuse equals harm'.

[20] Welsh Government (2016). Working Together to Reduce Harm: Substance Misuse Annual Report and Forward Look 2016. Available at: http://gov.wales/docs/dhss/publications/161220ar-sm-en.pdf
[21] A critical consideration for the review team was that the use of alcohol and some other drugs is also desirable, creates economic activity and has a range of positive benefits.

Figure A3.3: Assumed Core Strategy Logic Model – 2008



3.3 Assumed (implicit) strands of the Strategy

The Strategy explicitly identifies four areas: (1) preventing harm, (2) support for users, (3) families and (4) tackling availability via enforcement. The following diagrams (**Figures A3.4-A3.7**) translate these strands into implicit logic models.

Figure A3.4: Assumed Action Area 1 (Preventing Harm) Logic Model – 2008

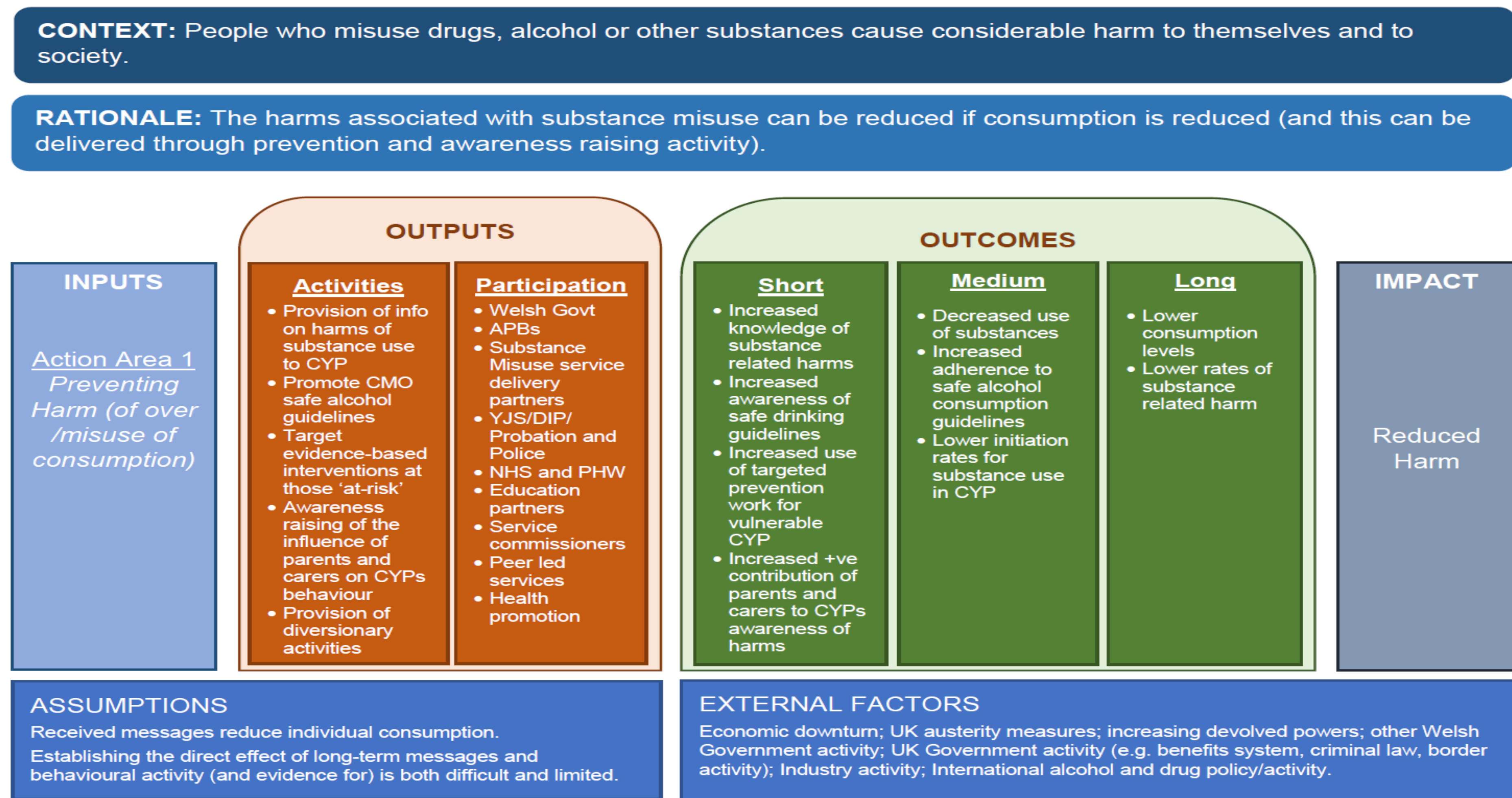
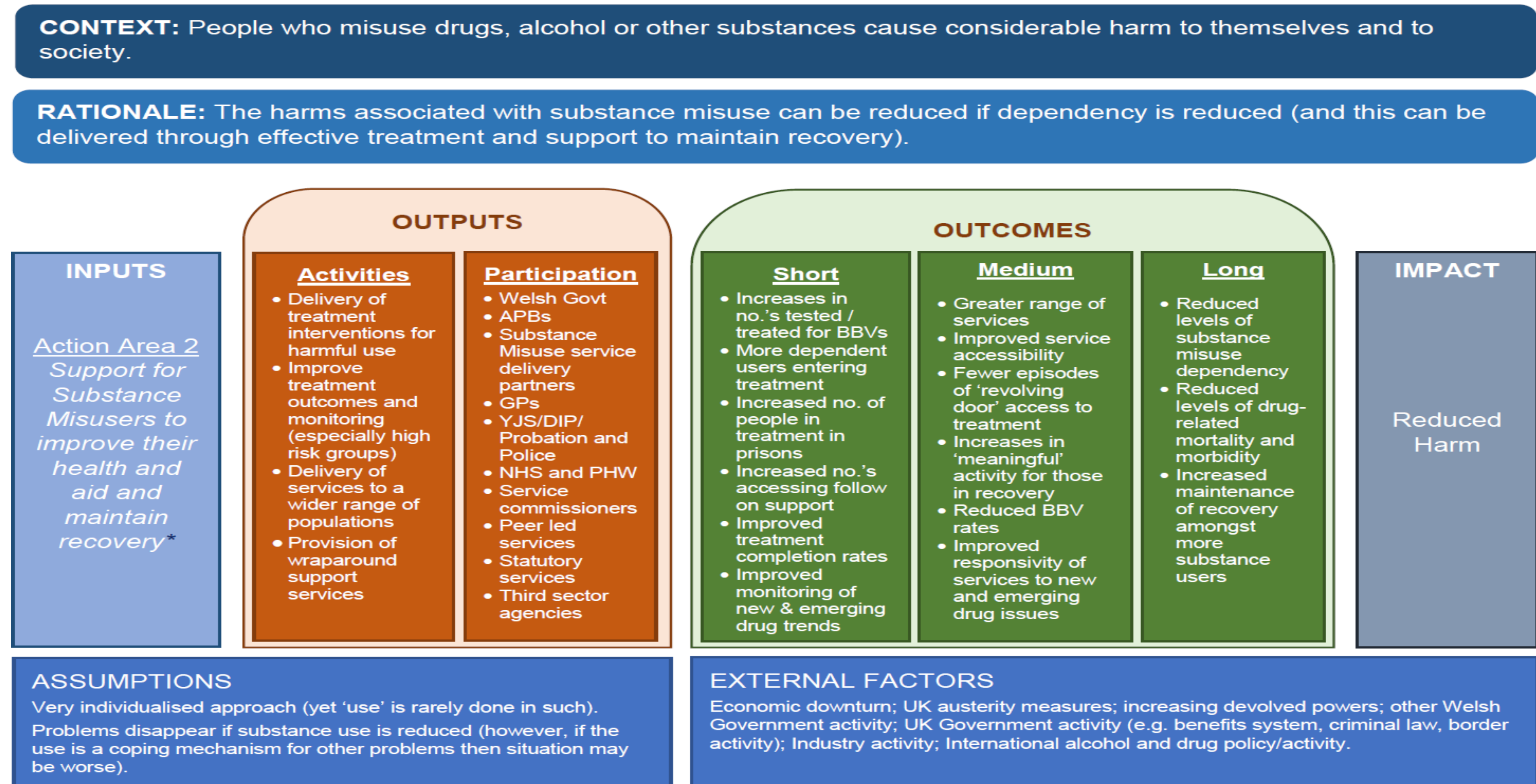
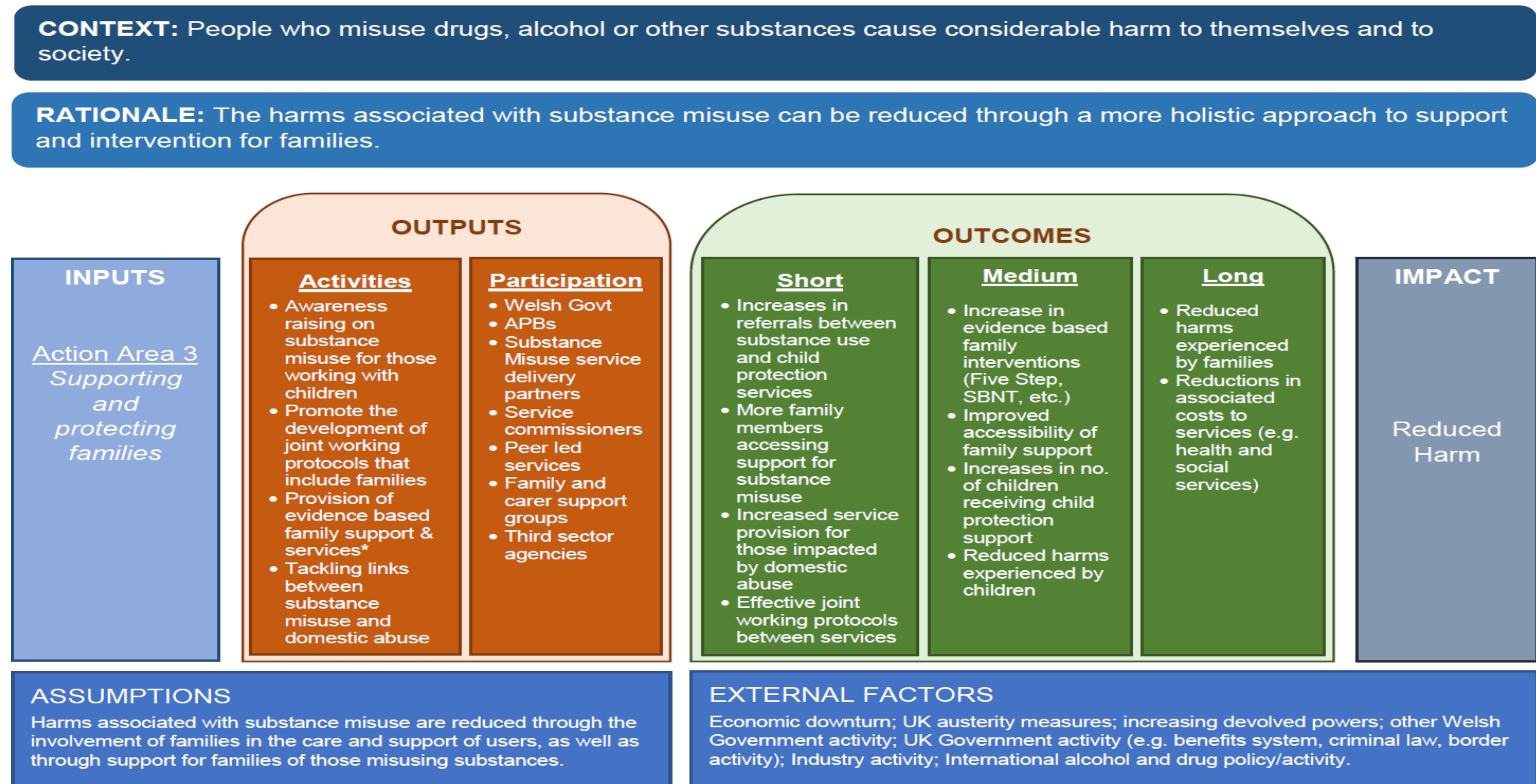


Figure A3.5: Assumed Action Area 2 (Support for Substance Misusers) Logic Model – 2008



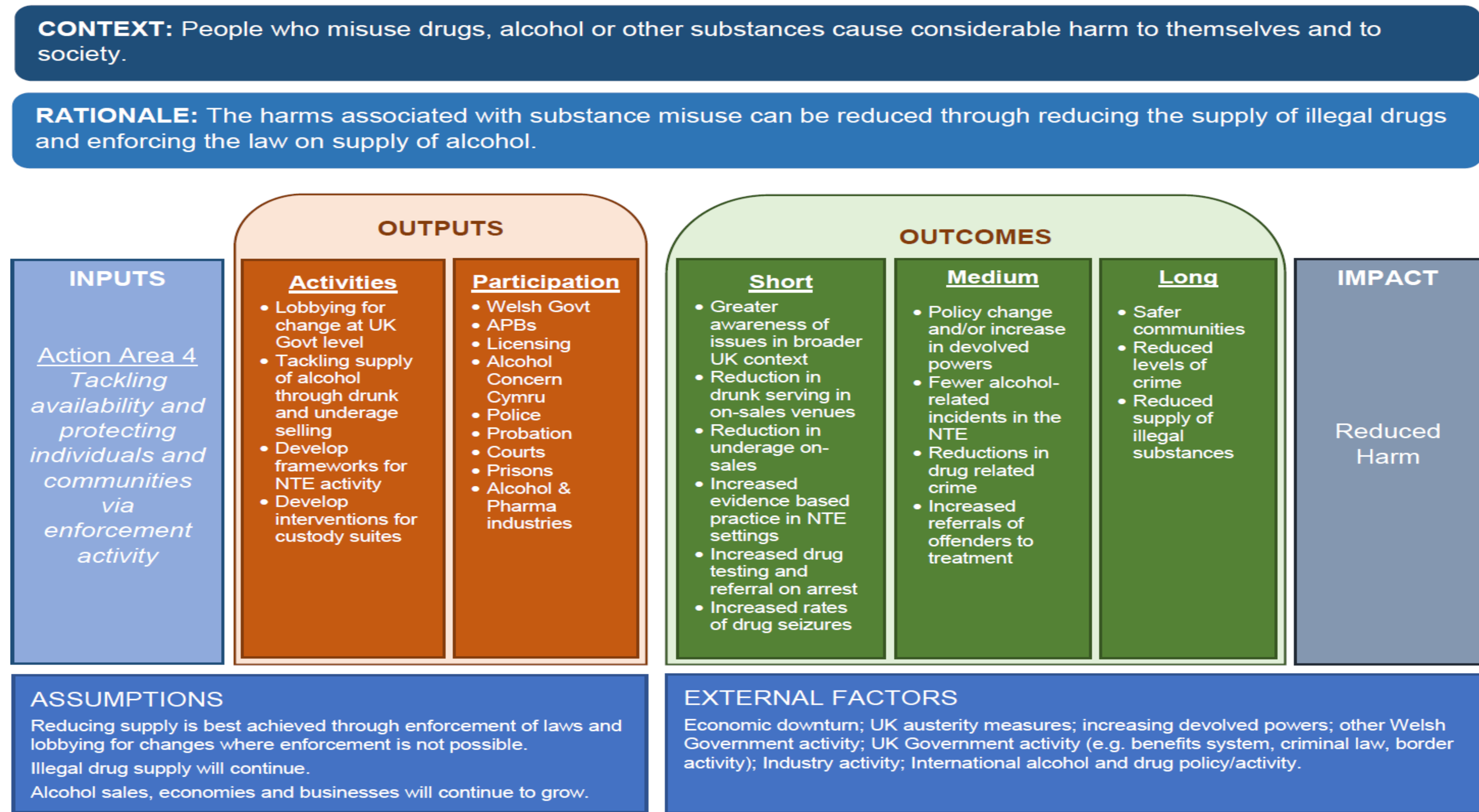
* The Working Together to Reduce Harm strategy refers to 'substance misusers'. This language is highly discordant with post-Social Services and Wellbeing Act understanding, which would now refer to 'support for individuals'.

Figure A3.6: Assumed Action Area 3 (Support and Protection for Families) Logic Model – 2008



* Evidence suggests three types of family intervention: (1) family therapy intervention, (2) work with families only to affect user, and (3) work with families only to meet their needs and not the user's needs.

Figure A3.7: Assumed Action Area 4 (Tackling Availability via Enforcement) Logic Model – 2008



3.4 Current (end of Strategy) considerations

The above logic models are presented in a traditional linear construct. The review team suggest that the current position can be better understood in a hybrid logic model. The following visualisation (**Figure A3.8**) is a suggestion how to demonstrate the dynamic and fluid nature of the diversity of contributions to strategy impact. It takes current policy preoccupations and service provision orientations through a lens based on a preferred scenario of ‘better wellbeing for all’, rather than a focus on ‘impact of reduced harm’ (as reflected in the assumed starting point logic models, as above). This is suggesting alignment and integration of substance use (not ‘misuse’) policy with the now-dominant *Social Services and Wellbeing [Wales] Act 2014* and the *Future Generations [Wales] Act 2015*.

Figure A3.8: A current (hybrid) logic model representation

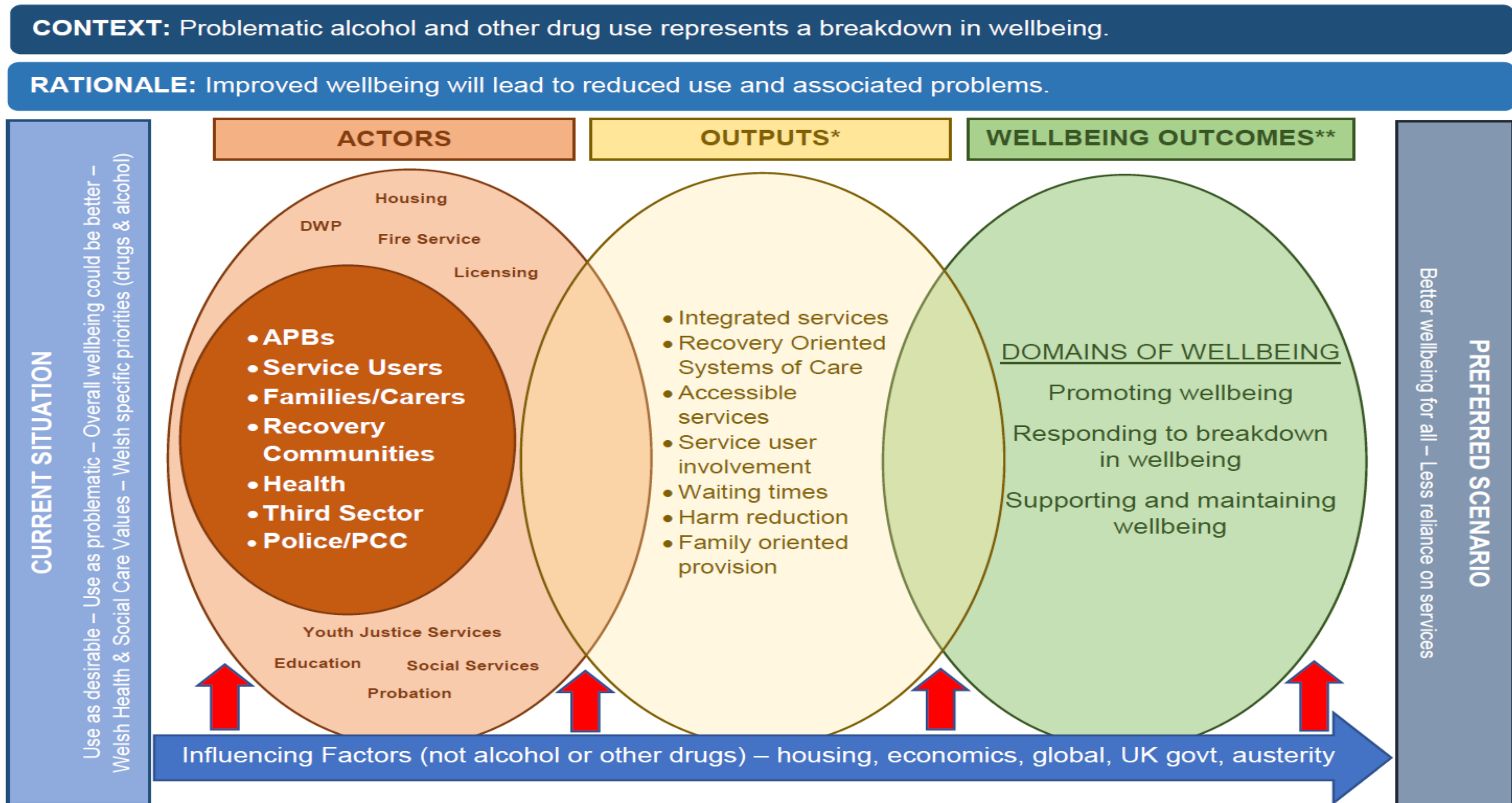


Figure A3.9: Current Domains of Wellbeing

Promoting well-being	Health Promotion Harm Reduction (individual and community) Diversion Advocacy
Intervening during breakdown in well-being	In-Patient/community Detoxification Residential Rehabilitation Homelessness Criminal Justice Mental Health Domestic Abuse
Maintaining and supporting well-being	Treatment Counselling Groups Peer Self Help Recovery

4. Appendix D – Alcohol Concern Cymru Reports (Research and Briefing Papers)

The main review report makes a number of references to a body of work completed over the period 2011-2016 by Alcohol Concern Cymru. These policy and research reflections are considered to be of value because of their specific focus on the Welsh context. This Appendix provides a list of the key documents and key messages that have been incorporated into the Strategy review.

Table A4.1: Summary and commentary on Alcohol Concern Cymru Reports (2010-2016)

Year	Title	Summary and commentary
2016	Cheap booze on our streets	*Availability* • Survey of six locations across North Wales identifying numerous examples of alcohol available at less than 25p per unit (Cider and Perry), plus a range of others at less than 50 per unit (Lager, Beer, Wine, Fortified wine and Spirits). • Evidence to support the call for a Welsh Minimum Unit Price for alcohol.
	Alcohol and suicide	*Harm Reduction/Treatment* • Brief guide drawing across some research that highlights the likely connections between suicide/self/harm and alcohol use – as both a concern for those who are vulnerable through other life factors (and not in alcohol treatment) and those who may also be in treatment. Recommendations for the role of Brief Intervention and more professional awareness.
2015	Drink responsibly (but please keep drinking)	*Availability* • Analysis of 18 issues in total of 5 leading supermarket lifestyle magazines between - July and December 2014. Identified high volumes of alcohol adverts with some messages (48%) containing messages about responsible drinking. • .. but couched within a bigger picture of selling and wanting consumers to buy and promoting a lifestyle.

		• Recommendation for bigger print messages, that are based on factual – health and alcohol content.
	The relationship between alcohol and gambling behaviours	*Treatment/Distinct Populations* • Extensive international literature review – highlighting the correlation between two behaviours that can have significant adverse consequences. Notes evidence for alcohol use leading to less control of gambling behaviour. • Identifies the overlap potential of treatment interventions. (cf this with the excellent work of the Living Room in Cardiff).
2014	Creating customers: Finding new ways and places to sell alcohol, and new people to buy it	*Prevention/Availability* • Detailed exploration of some of the marketing approaches of the alcohol industry. • Concludes with recommendations about need for more independent regulation and factual promotion/advertisements.
	Alcohol and the workplace	*Prevention/Harm Reduction* • Brief guide to role that workplaces can play in delivering interventions to help address the associated cost (time and performance) of alcohol use and impact on workplace.
	Brand stretch: How alcohol brands are pushing marketing boundaries	*Prevention* • Brief exploration of how alcohol brands are stretched into non-alcohol products.
	Take care: An Alcohol Concern Cymru project in partnership with NewLink Wales to support unpaid carers to avoid problems with alcohol	*Families* • Detailed survey and focus group research with carers across Wales. • Confirmation that alcohol is used as a coping mechanism by carers to deal with the stresses of their role. • Recommendations to raise awareness of the issue, information to carers and information, advice, training and support for those working with and supporting carers.
2013	A losing bet? Alcohol and	*Prevention/Treatment*

	gambling: investigating parallels and shared solutions	• Detailed report highlighting the links and overlaps between the two behaviours. • A number of recommendations are offered across policy, prevention, assessment and treatment domains.
	On the road: Alcohol and driving	*Harm Reduction* • Review of literature and policy that looks in particular at the issue of driving under the influence of alcohol, but also more broadly at the place of alcohol on our roads. • It makes a number of recommendations about legal limits, industry practices and cultural awareness/attitude (much of which is not in the devolved domain of the Welsh Government).
	All in the mind: Meeting the challenge of alcohol-related brain damage	*Treatment* • Detailed paper, summarising issues, research and conversations with a few experts. • Identifies the extent of ARBD and the potential cost to individuals and society. • It makes a number of key recommendations (two of which are picked up in the 2016-2018 Delivery Plan).
	On your doorstep: Underage access to alcohol via home delivery services	*Availability* • Survey of nearly 1,000 young people in Wales combined with South Wales police report that identifies the relative ease with which young people (under age of 18) can buy alcohol online and through grocery delivery services. • Recommendations about proof of age and industry behaviour (also not all within Welsh Government remit).
2012	On the front line: Alcohol and the armed forces	*Treatment – distinct populations* • Discursive piece collating strands that highlights the significant role of alcohol amongst this population.
	Everyone's problem: The role of local alcohol	*Strategic Overview* • A detailed summary review of the overall landscape, that identifies three years into the

	services in tackling Wales' unhealthy relationship with alcohol	strategy that Alcohol remains a significant and whole population concern. • Four recommendations; interesting benchmarks? • Spending on alcohol remaining a priority. • Role of APBs increased – for more consistency across Wales and ensuring national priorities met. • Ensuring accurate recording; notably of dependent drinkers. • Change in public health discourse – not seeing alcohol as a neutral issue.
	Making an impression: Recognition of alcohol brands by primary school children	*Prevention* • Small study with 10-11-year-olds in Wales identifying that they have significant levels of brand recognition (and therefore exposure to) alcohol and brands of alcohol.
	Under pressure: supporting unpaid carers in Wales	*Families* • Survey identifying 1 in 5 carers use alcohol to cope with the pressures of their caring role.
	Minimum pricing and the pub	
	Full to the brim? Outlet density and alcohol-related harm	*Availability* • Brief literature review and case study (Cardiff) of issues and impacts of high density outlet clustering. • Recommendations and implications for licensing activities.
2011	Out of the way? Alcohol displays in supermarkets	*Availability* • Brief paper highlighting prominent displays and selling points of alcohol in supermarkets.
	Hidden harm? Alcohol and older people in Wales	*Treatment – Distinct Populations* • Brief summary piece supporting the increase of concern, use and presentation of this group.

	Mixed messages: Alcohol and energy drinks	*Harm Reduction/Treatment* • Brief paper highlighting potential relationship between the two, and possibility of interactions when both are taken at same time. • Recommendation for further research and harm reduction messages.
	New media, new problem? Alcohol, young people and the internet	*Prevention* • Extensive literature review report considering the increasingly prominent role that the internet plays as a means of promoting alcohol use. • Area of activity beyond realms of Welsh Government activity.
	An unhealthy mix? Alcohol industry sponsorship of sport and cultural events in Wales	*Prevention* • Detailed report highlighting the extent and implied consequences of the role of sponsorship and alcohol advertising at sporting events.
	Achieving positive change in the drinking culture of Wales	*Strategic considerations* • Extensive research review and synthesis of existing literature, together with a broad-based consultation process. Suggests that Welsh approaches to drinking can be influenced in four strands; control, harm reduction, attitudes and young people.
	Counting the Cost: Irresponsible alcohol promotions in the night-time economy in Wales	*Availability (and limits of devolution)* • Snapshot survey of 43 venues in three locations across Wales, evidence significant levels of promotion of very cheap alcohol. • Call for public health to be an objective of licensing. • Codes of practice here are non-mandatory and between industry and Home Office/Department of Health not Welsh Government.
	What's the damage? Negative health consequences of alcohol misuse in Wales	*Prevention* • Telephone survey of 1,000 drinkers found low levels of awareness about consequences of heavy drinking.

	• Issues around nature and type of labelling on alcohol drinks is not a devolved issue.
It's only a game? Domestic abuse, sporting events and alcohol	*Harm Reduction/Treatment* • Brief paper highlighting the concerns about links and evidence for increased instances of domestic abuse during high profile sporting events (where there is increased consumption of alcohol).
A drinking nation? Wales and alcohol	*Strategic Considerations* • Detailed document outlines overall (substantive) relationship (historical to present) of Wales (as a nation) and alcohol. • Concludes with a number of very broad recommendations across a range of strategic policy domains.
Alcohol and calories	*Prevention/Harm Reduction* • Brief paper highlighting awareness about levels of calories within alcoholic drinks.
Fuelling the problem? The sale of alcohol at petrol stations in Wales	*Availability* • Brief paper highlighting the role that fuelling stations play as an outlet for sale of alcohol (some literature and small Welsh telephone survey data).
Off the rails? Alcohol and public transport in Wales	*Availability* • Brief paper looking at sale and use of alcohol on the rails.

All the reports above are available at: https://www.alcoholconcern.org.uk/publications

Appendix E – Welsh specific sources of evidence

This review acknowledges the significant progress and volume of Welsh specific data and evaluations. The review team have deliberately not set out to replicate in full the detail of these evidence sources, because they are readily available, annually updated and voluminous. Key findings and messages have been incorporated into the review analysis. This Appendix provides a logical ordering of this material and comprehensive referencing.

Specifically, the range of Welsh specific sources of evidence (and references) of documents accessed by the review team are as follows:

Performance data capture documents

Table A5.1: Treatment data – Substance Misuse in Wales reports

2015-2016	http://gov.wales/docs/dhss/publications/161025datawalessubmisuseen.pdf
2014-2015	http://gov.wales/docs/dhss/publications/151029annual-reporten.pdf
2013-2014	http://gov.wales/docs/dhss/report/141029substancemisuseinwales1314en.pdf
2012-2013	http://gov.wales/docs/dhss/publications/131031profilesmtreatmenten.pdf
2011-2012	http://gov.wales/docs/phhs/publications/121227substanceen.pdf
2010-2011	http://gov.wales/docs/dsjlg/publications/commsafety/111027submisusereportv2en.pdf

Table A5.2: The Annual Profile of Substance Misuse in Wales

2015-2016	http://www.wales.nhs.uk/sitesplus/documents/888/Piecing%20the%20Puzzle%20FINAL%202016%2C%20v2%2C%2025%20Oct%202016.pdf
2014-2015	http://gov.wales/docs/dhss/publications/160104substanceannualen.pdf
2013-2014	http://gov.wales/docs/dhss/report/141029submisuseprofilewalesen.pdf
2012-2013	http://gov.wales/docs/dhss/publications/131031profilesmtreatmenten.pdf

Reports and reviews

Table A5.3: Working Together to Reduce Harm – Substance Misuse Annual Reports[22]

2016	http://gov.wales/docs/dhss/publications/161220ar-sm-en.pdf
2015	http://gov.wales/docs/dhss/publications/151111reporten.pdf
2014	http://gov.wales/docs/dhss/report/141029substancemisusear14en.pdf
2013	http://gov.wales/docs/dhss/publications/131030submisuseprogressreporten.pdf
2012	http://gov.wales/docs/dhss/publications/121211substanceannualreporten.pdf
2011	http://gov.wales/docs/dsjlg/publications/commsafety/111027smannreporten.doc
2010	http://gov.wales/docs/dsjlg/publications/commsafety/101118smannreporten.doc
2009	http://gov.wales/docs/dsjlg/publications/commsafety/100128ap2009v1en.doc

[22] Since the draft version of this report was submitted an update has been published, which is available at: http://gov.wales/docs/dhss/publications/171031substance-reporten.pdf

Specific Reports

Substance misuse focused

Advisory Panel on Substance Misuse (APoSM) (2017) A Report on: Substance Misuse in an **Ageing Population** Cardiff, Welsh Government. Available at: http://gov.wales/docs/dhss/publications/170302ageing-population-reporten.pdf

Advisory Panel on Substance Misuse (APoSM) (2015) Reducing the harms associated with **prescription-only analgesics**: Tramadol. Cardiff, Welsh Government. Available at: http://gov.wales/docs/dhss/publications/151112tramadolreporten.pdf

Advisory Panel on Substance Misuse (2014) **Minimum unit pricing**: a review of its potential in a Welsh context. Cardiff, Welsh Government. Available at: http://gov.wales/docs/dhss/publications/140725uniten.pdf

Alwyn, T and Thomas, E (2014a) **Children & Young People**; Compendium of Good Practice Guidance on Integrated Care for Children & Young People aged up to 18 years of age who Misuse Substances, Cardiff, Welsh Government. Available at: http://gov.wales/docs/dsjlg/publications/commsafety/120206compendiumen.pdf

Alwyn, T and Thomas, E (2014b) Review of two **peer led recovery** interventions in Wales. Cardiff, Welsh Government. Available at: http://gov.wales/docs/caecd/research/2014/141127-review-two-peer-led-recovery-interventions-en.pdf

Bennet T and Holloway K (2011) Evaluation of the Take Home **Naloxone** Demonstration Project Merthy Tydfil, Welsh Assembly Government. Available at: http://gov.wales/statistics-and-research/evaluation-take-home-naloxone-demonstration-project/?lang=en

Health Inspectorate Wales (2012) Substance Misuse Services in Wales Are they **meeting the needs** of service users and their families? Caerphilly, Health Inspectorate Wales. Available at: http://hiw.org.uk/docs/hiw/reports/120327substancemisuse1112en.pdf[23]

Health Inspectorate Wales (2009) Substance Misuse Services: All Wales Review of Substitute **Prescribing Services** Caerphilly, Health Inspectorate Wales. Available at: http://www.hiw.org.uk/docopen.cfm?orgid=477&id=125383

Jordan, P and Sheppard, J (2013) Tackling Alcohol Misuse Through **Screening and Brief Interventions** A Knowledge Transfer Partnership Final Report. Available at:

[23] This critically evaluative report identified a number of significant recommendations for the Welsh Government to consider in relation to meeting the needs of service users and their families. Whilst there is no formal, specific response to these recommendations, there is evidence to suggest that the period 2012-2016 has seen substantive progress against a range of the recommendations. Indeed, these responses have been incorporated into the body of the main report. Future strategic direction should be cognisant of ensuring these recommendations have been responded to.

http://www.ias.org.uk/uploads/pdf/HSR/Implementation%20of%20brief%20advice%20in%20Wales_knowledge%20transfer%20report.pdf
Maguire, M. Holloway, K and Bennett, G (2014) Evaluation of ESF Peer Mentoring Wales. Cardiff, Welsh Government. Available at: http://gov.wales/docs/caecd/research/2014/140207-evaluation-european-social-fund-peer-mentoring-report-en.pdf
Sagar, T and Symons, K (2015) **Sex Work, Drug and Alcohol Use**: Bringing the Voices of Sex Workers into the Policy and Service Development Framework in Wales. Swansea, Swansea University. Available at: http://gov.wales/docs/dhss/publications/160927reporten.pdf
Smith, J and Lyons, M (2010) Influencing factors and implications of **unplanned drop out from substance misuse services** in Wales: Guidance for reducing unplanned drop out from and promoting reengagement with substance misuse services. Public Health Wales. Available at: http://www2.nphs.wales.nhs.uk:8080/BloodBorneVirusesDocs.nsf/3dc04669c9e1eaa880257062003b246b/bee22a0587b6a00d802576f0003ccd13/$FILE/Influences%20and%20implications%20%20of%20unplanned%20drop%20out.pdf
Stead, J. Lloyd, G. Baird, A. Brown, J. Riddell, S. Weedon, E and Laugharne, J. (2011). **All Wales School Liaison Core Programme** (AWSLCP) Evaluation Report. Merthyr Tydfil, Welsh Government. Available at: http://dera.ioe.ac.uk/13168/1/110314allwalesschoolliaisoncoreprogrammeen.doc
Thom, G; Delahunty, L; Harvey, P and Ardil, J. (2014) Evaluation of the Integrated Family Support Service Final Year 3 Report, Cardiff, Welsh Government. http://gov.wales/docs/caecd/research/2014/140328-evaluation-integrated-family-support-service-year-3-en.pdf
Welsh Police Forces (2015) **All Wales School Liaison Core Programme Review** 2015: Supporting the Well-being of Future Generations. Unpublished.
Wright, S. Gray, P. Watts, E. McAteer, L. Hazel, N. Liddle M and Haines, K. (2010) Evaluation of Early Parental Intervention Pilot Projects. Swansea, Swansea University. Available at: http://gov.wales/docs/caecd/research/100809-early-parental-intervention-pilot-projects-en.pdf

Related

Hill, A et al. (2011) Evaluation of the Welsh **school-based counselling** strategy. Cardiff, Welsh Government. Available at: http://gov.wales/statistics-and-research/evaluation-welsh-school-based-counselling-strategy/?lang=en

Sinclair, A and Ledermaier, S.(2013) Evaluation of the Outcomes for **Employers** Participating in the Corporate Health Standard and Small Workplace Health Award. Cardiff Welsh Government. Available at: http://gov.wales/statistics-and-research/evaluation-outcomes-employers-participating-corporate-health-standard-small-workplace-health-award/?lang=en

Substance Misuse Treatment Framework (SMTF) and other guidance

The following list is not exhaustive – there are other documents and publications available via the Welsh Government on substance misuse. These include advice and information leaflets, conference reviews etc. We have tried to extract all those documents that are pertinent to the purpose of this review - and those wishing to explore the context for our deliberations further, rather than a complete extraction of all documents.

Table A5.4: Treatment Frameworks and Guidance

2017	Welsh Government Working Together to Reduce Harm **Revised Guidance for Substance Misuse Area Planning Boards** 2017. Cardiff, Welsh Government. http://gov.wales/docs/dhss/publications/170306guidance2017en.pdf
2015	Welsh Government **A Guide to Inpatient Detoxification and Residential Rehabilitation Centres** in Wales, Cardiff, Welsh Government. http://gov.wales/docs/dhss/publications/151002guideen.pdf
2015	Service Framework for the Treatment of People with a **Co-occurring Mental Health** and Substance Misuse Problem http://gov.wales/docs/dhss/publications/150909reporten.pdf
2015	Welsh Government **Revised Guidance for Commissioning** Substance Misuse Services Cardiff, Welsh Government. http://gov.wales/docs/dhss/publications/151014commisioningen.pdf

2014	Substance Misuse Treatment Framework (SMTF) **Service User Involvement** http://gov.wales/docs/dhss/publications/141003substanceen.pdf
2014	Substance Misuse Treatment Framework (SMTF) Improving Access to Substance Misuse Treatment for **Veterans** http://gov.wales/docs/dhss/publications/140220veteransen.pdf
2014	Welsh Government Guidance for undertaking **fatal and non-fatal drug poisoning reviews** in Wales. Cardiff, Welsh Government. http://gov.wales/docs/dhss/publications/140701substanceen.pdf
2014	Substance Misuse Treatment Framework (SMTF) Improving Access to Substance Misuse Treatment for **Older People** http://gov.wales/docs/dhss/publications/141113substanceen.pdf
2013	Substance Misuse Treatment Framework (SMTF) **Recovery Oriented Integrated Systems of Care** http://gov.wales/docs/dhss/publications/131023substanceframeworken.pdf
2013	Substance Misuse Treatment Framework **Health and Wellbeing** Compendium http://gov.wales/docs/dhss/publications/130705substanceen.pdf
2012	Children & Young People: Compendium of Good Practice Guidance on Integrated Care for **Children & Young People** aged up to 18 years of age who Misuse Substances http://gov.wales/docs/dsjlg/publications/commsafety/120206compendiumen.pdf
2011	Substance Misuse Treatment Framework (SMTF) Prevention and Education of **Volatile Substance Abuse** (VSA) http://gov.wales/docs/dsjlg/publications/commsafety/110518vsaen.pdf
2011	Substance Misuse Treatment Framework (SMTF) Guidance for Evidence Based **Community Prescribing** in the Treatment of Substance Misuse http://gov.wales/docs/dsjlg/publications/commsafety/110628prescribingen.pdf
2011	Substance Misuse Treatment Framework (SMTF) Guidance for Evidence Based **Psychosocial Interventions** in the Treatment of Substance Misuse http://gov.wales/docs/dsjlg/publications/commsafety/110628pyschosocialen.pdf
2011	Substance Misuse Treatment Framework (SMTF) Guidance for the Provision of Evidence Based **Tier 4 Services** in

	the Treatment of Substance Misuse http://gov.wales/docs/dsjlg/publications/commsafety/110628tier4servicesen.pdf
2011	Substance Misuse Treatment Framework (SMTF) for Alcohol **Prevention and Education in Higher & Further Education** Establishments http://gov.wales/docs/dsjlg/publications/commsafety/110728alcoholhefeen.pdf
2011	Integrated Care for **Children and Young People** aged up to 18 years of age who Misuse Substances http://gov.wales/docs/dsjlg/publications/commsafety/110331cypen.pdf
2010	**Integrated Care and Integrated Care Pathways for Adult** Substance Misuse Services in Wales http://gov.wales/docs/dsjlg/publications/commsafety/101013pathwaysen.pdf
2010	**National Core Standards** for Substance Misuse Services in Wales http://gov.wales/docs/dsjlg/publications/commsafety/101310misuseservicesen.pdf
2009	Good Practice Guidance on Managing **Alcohol Misuse in the Workplace** http://gov.wales/docs/dsjlg/publications/commsafety/091127treaten.pdf
2009	Guidance for the Planning and Provision of Substance Misuse Services to Children and **Young People in the Care of Youth Offending Services** http://gov.wales/docs/dsjlg/publications/commsafety/100311treatyoten.pdf
Undated	Substance Misuse Treatment Framework **Carers and Families** of Substance Misusers A Framework for the Provision of Support and Involvement http://gov.wales/docs/dhss/publications/141114carersen.pdf
Undated	Guidance **Domestic Abuse** Joint Working http://gov.wales/docs/dsjlg/publications/commsafety/090430smtfdomesticabusee.pdf
Undated	Substance Misuse Treatment Framework **Information and Advisory Services** http://gov.wales/docs/dhss/publications/141114informationen.pdf
Undated	Good Practice Framework for the Provision of Substance Misuse Services to **Homeless** People and those with Accommodation Problems

	http://gov.wales/docs/dhss/publications/141114homelessen.pdf
Host site	http://gov.wales/topics/people-and-communities/communities/safety/substancemisuse/policy/treatmentframework/?lang=en
Foreword	http://gov.wales/docs/dhss/publications/141113foreworden.pdf

Table A5.5: Delivery and Implementation Plans

2016-2018	Three-year delivery plan http://gov.wales/docs/dhss/publications/160906substance-missuse-2016-2018en.pdf
2013-2015	Three-year delivery plan http://gov.wales/docs/substancemisuse/publications/130219StrategyDeliveryPlan13-15en.pdf
2011-2012	One-year implementation Plan http://gov.wales/docs/dsjlg/publications/commsafety/120125implan1112.pdf
2008-2010	Three-year implementation plan http://gov.wales/dsjlg/publications/commmunitysafety/strategy/plane.pdf?lang=en

5. Appendix F – Literature Review Summary

In early stages of the review process the review team set out to explore the wider academic national and international evidence base. This was a structured search, rather than a systematic review; the result of which was a volume of material that helped contextualise the analysis. This Appendix provides reference, details and commentary on the accessed sources.

5.1 Overview of key literature messages and summary

The following table summarises extracts from this process against the Strategy structure ('primary category').

Table A6.1: Categorisation and summary of key literature messages

Primary-category	Sub-category	Key Commentary	Key Sources
OVERVIEW	Policy	• There are increasing and marked differences between the four nations approach to alcohol (and other drugs) related policy. It is worth noting that other nations within the UK have separate drugs policies, and alcohol is treated as distinct to illegal drugs. • "Working Together to Reduce Harm…" deliberately argues for a collective substance misuse approach (i.e. a singular drug policy). • Many argue that alcohol is different to other illicit and illegal drugs use; because of a) its complex social	• Alcohol and Public Policy Group. (2010) Alcohol: No ordinary commodity – a summary of the second edition. Addiction 105(5): 769–779. • Fitzgerald, N. and Angus, C. (2015). Four nations: How evidence-based are alcohol policies and programmes across the UK? London, Alliance for Useful Evidence/Alcohol Health Alliance. • Nutt, D.J; King, L.A and Phillips, L.D. (2010) Drug harms in the UK:

	context, b) legality supports such a larger population consumption, c) it is a significant if not dominant cause of health and crime concerns d) the role of legalised industry to promote and sell and e) its role in the economy. However, when compared with other drugs it can be argued the very significant harm that alcohol causes, especially in comparison to some illegal drugs, means it should be treated more akin to some illegal drugs.	a multicriteria decision analysis. Lancet 376 (9752):1558–1565. • UK Government. (2012) The Government's Alcohol Strategy. London, Home Office.
Overall patterns of use	• Welsh prevalence trends essentially mirror those of UK. • Alcohol as primary drug of use and presentation (followed by cannabis related drugs). Overall general population alcohol use has seen small levels of decline. • Significant alcohol use - increasingly identifiable in distinct patterns with elements of populations (e.g. leaving care, child protection, criminal justice, older people etc) • Ageing group of dependent opiate users.	• See **Appendix G** – 'Welsh specific sources of evidence'

		• Increases in New Psychoactive Substance use.	
	External factors	• Significant number of external factors on availability, consumption, legislation, policy and treatment approaches identifiable in the literature. These include; ○ International; legal and illegal drug supply markets ○ Other government Activity ○ Economic austerity and prosperity (social injustice) ○ Moral and Political discourse	• Ahmad, M and Richardson, A (2016) Impact of the reduction in heroin supply between 2010 and 2011, Research Report 91. London, Home Office. • Chief Medical Officer for Wales. (2016) Annual Report 2015-16 Rebalancing healthcare Working in partnership to reduce social inequity. Cardiff.
EVIDENCE BASE	Data Quality Country specific	• Availability of Wales specific research data findings within international literature is very limited. • Extensive range of Welsh Government and other related data – although some note concerns about quality expressed.	• See search methodology information in **Section 6.5** below. • See **Appendix G** – 'Welsh specific sources of evidence' • NHS Wales Informatics Service. (2015) Treatment data substance misuse services in Wales 2013-2014. Cardiff, Welsh Government.
	Strategy-specific evaluation data	• Limited availability. A consequence of identifying Contribution Analysis as the preferred model of evaluation part-way through the life of the Strategy. De facto	• n/a

		evidence of continuing evaluation exists in the publication of successive substance misuse delivery plans. These updated and built on initial implementation of the Strategy providing a framework for continuing evaluation.	
ACTION AREA 1: Prevention	Young people	• Evidence of some reduction in overall young people's consumption, possible generational trends. Within this some groups using hazardously and harmfully. • Strong evidence for impact of familial environment on learning and as a situation in which pressure to use can occur. • Limited/mixed evidence about effectiveness of peer group and or school education programmes. • There are expressed issues of effectiveness & cost effectiveness of adopting whole population public health alcohol family intervention.	• See **Appendix G** – 'Welsh specific sources of evidence' • Valentine, G; Jayne, M; Gould. M and Keenan, J. (2010) Family life alcohol and consumption: a study of the transmission of drinking practices. York, Joseph Rowntree Foundation. • Obuna B, Hayes, C and Fulton, J. (2016) Factors influencing levels of alcohol misuse in UK adolescents; a systematic literature review. International Journal of Current Research; Vol 8, Issue 10, pp. 39611-39617. • Segrott, J; Gillespie, D; Holliday, J; Humphreys, I; Murphy, S; Phillips, C; Reed, H; Rothwell, H; Foxcroft, D; Hood, K; Roberts, Z; Scourfield, J; Thomas, C and Moore, L. (2014)

			Preventing substance misuse; study protocol for a randomised control trial of the Strengthening Families Programme 10-14 UK (SFP10-14UK). BMC Public Health; 14:49 http://www.biomedcentral.com/1471-2458
	Harm reduction	• Appears to be strong evidence for a range of interventions with alcohol, heroin and other drugs.	• Cochrane Database material (see **Section 6.4** below) • See **Appendix G** – 'Welsh specific sources of evidence'
ACTION AREA 2: Treatment	Alcohol	• There is extensive traditional research and systematic reviews indicating evidence as strong for a range of interventions. • Notably are brief, prescribing and stepped care model of service delivery.	• Department of Health. (2006) Models of Care for Alcohol Misusers https://www.alcohollearningcentre.org.uk/_assets/BACKUP/DH_docs/ALC_Resource_MOCAM.pdf • Cochrane Database material (see **Section 6.4** below)
	Drugs	• There is extensive traditional research and systematic reviews indicating evidence as strong for a range of interventions. • Notably detoxification, substitute prescribing and stepped models of care. There are numerous comprehensive	• Department of Health. (2006) Models of Care for Alcohol Misusers https://www.alcohollearningcentre.org.uk/_assets/BACKUP/DH_docs/ALC_Resource_MOCAM.pdf • National Institute for Clinical Excellence. (2017) Drug misuse:

		suites of treatment guidance and technology appraisals.	Guidance various. https://www.nice.org.uk/resources/health-protection/drug-misuse • Cochrane Database material (see **Section 6.4** below)
ACTION AREA 3: Families	Prevention Education	• Evidence points to positive influence or negative impact of early years experiences and family environment. The evidence supporting effectiveness for preventative interventions is mixed.	• Chief Medical Officer for Wales. (2016) Annual Report 2015-16 Rebalancing healthcare working in partnership to reduce social inequity. Cardiff. • Valentine, G; Jayne, M; Gould, M and Keenan, J. (2010) Family life alcohol and consumption: a study of the transmission of drinking practices. York, Joseph Rowntree Foundation. • Obuna B., Hayes, C and Fulton, J.. (2016). Factors influencing levels of alcohol misuse in UK adolescents; a systematic literature review. International Journal of Current Research. 8(10): 39611-39617.
	Family Interventions	• Extensive Evaluation of IFSS – suggested value and impact, but some mixed findings. • Extensive evidence exists to show effectiveness of a range of other familial interventions.	• Copello, A; Orford, J; Hodgson, R and Tober, G. (2009) Social behaviour and network therapy for alcohol problems. London, Routledge. • Forrester, D; Holland, S; Williams A and Copello, A. (2016) Helping

			families where parents misuse drugs or alcohol? A mixed methods comparative evaluation of an intensive family preservation service. Child and Family Social Work 21(1): 65–75. • Forrester, D; Copello, A; Waissbein, C and Pokhrel, S. (2008) Evaluation of an intensive family preservation service for families affected by parental substance misuse. Child Abuse Review 17(6): 410-26. • Forrester, D (2012) Motivational Interviewing for Working with Parental Substance Misuse: A Guide to Support the IFS Teams Luton, University of Bedfordshire • Thom, G; Delahunty, L; Harvey, P and Ardil, J. (2014) Evaluation of the Integrated Family Support Service Final Year 3 Report, Cardiff, Welsh Government. http://gov.wales/docs/caecd/research/2014/140328-evaluation-integrated-family-support-service-year-3-en.pdf
ACTION AREA 4: Availability and	Availability	• Global trends indicate illegal drugs readily available, with some occasional	• National Institute for Health and Care Excellence (NICE). (2010) Alcohol-use

Enforcement		market pressures and trend changes. • There are plenty of evidence based (population level) recommendations on Price, Availability & Marketing. This includes specific evidence in support of Minimum Unit Pricing for alcohol.	disorders prevention: Public health Guideline (PH24). London: NICE. • Holmes, J; Meng, Y; Meier, P.S; Brenan, A; Angus, C; Guo, Y; Hill-Mcmanus, D and Purshouse, R, C.. (2014) February 10). Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study. Lancet 383: 1655-64. • Meng, Y; Sadler, S; Gell, L; Holmes, J and Brennan A. (2014) Model-based appraisal of minimum unit pricing for alcohol in Wales. Cardiff, Welsh Government.
	Enforcement	• There are available recommendations for best practice on licensing.	• National Institute for Health and Care Excellence (NICE). (2010) Alcohol-use disorders prevention: Public health Guideline (PH24). London: NICE.
Implied Action Area: Partnerships	Commissioning	• Extensive guidance exists about what is recommended best commissioning practice, use of resources and effective interventions.	• Welsh Government Substance Misuse (commissioning and Treatment Frameworks) – see **Appendix G** - 'Welsh specific sources of evidence'). • National Institute for Health and Care Excellence (NICE). (2010) Alcohol-use disorders prevention: Public health

			Guideline (PH24). London: NICE. • Raistrick, D; Heather, N and Godfrey, C (2006) Review of the effectiveness of treatment for alcohol problems London. National Treatment Agency for Substance Misuse.
OTHER	Wider impact on families	• There is extensive evidence of the impact on wider family of problematic alcohol and other drug use and benefits and contribution of wider family to support and recovery processes.	• Copello, A; Orford, J; Hodgson, R and Tober, G. (2009) Social behaviour and network therapy for alcohol problems. London, Routledge. • Copello, A; Templeton, L and Powell, J. (2009) Adult family members and carers of dependent drug users: prevalence, social cost, resource savings and treatment responses. London, UK Drug Policy Commission.
	Wider benefits of treatment	• Economic analyses demonstrate value of alcohol & other drug treatment to wider society (costs/benefits not typically included in cost effectiveness calculations).	• Godfrey, C; Stewart, D and Gossop, M. (2004). Economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from the National Treatment Outcome Research Study (NTORS). Addiction, 99: 697–707.Cartwright, W. (2008). Economic costs of drug abuse: financial, cost of illness, and services. Journal of Substance Abuse

			Treatment, 34: 224–233.
FUTURE CONSIDERATIONS	Wales specific research & data generation	• Develop research & evaluation partnerships. This could be facilitated by: 1. Negotiate proper differentiation between English and Welsh data in existing / longitudinal research protocols & programmes (ONS etc.). 2. Commission / co-commission research with comparable countries e.g. UK to contrast & compare impacts of increasing devolution on strategy, policy and outcomes. 3. Develop & promote international partnerships with & between partner organisations to research & evaluate policy & strategy interventions ideally including countries beyond UK.	
	Strategy-specific evaluation design	• Selection of the preferred evaluation methodology / methodologies when a new strategy is being developed will inform & enhance data collection from the outset. Conceptualise Strategy as an action research programme and employ best practice in research	

	• design. May include evaluation beyond duration of strategy. • Active consideration of how to integrate current understandings within Wellbeing and Future Generations Frameworks.	

5.2 Full bibliographic details of key sources and additional source material and further commentary

The following table provides full referencing and additional commentary within a critical thematic framework.

Table A6.2: Summary of key evidence sources – by theme

Theme	Source details	Further Commentary
Policy	• Fitzgerald, N. and Angus, C. (2015) Four Nations: How evidence-based are alcohol policies and programmes across the UK? London, Alliance for Useful Evidence/Alcohol Health Alliance. • Alcohol and Public Policy Group. (2010) Alcohol: No ordinary commodity – a summary of the second edition. Addiction 105(5): 769–779. • Nutt, D.J; King, L.A and Phillips, L.D. (2010) Drug harms in the UK: a multicriteria decision analysis. Lancet 376 (9752):1558–1565. • UK Government. (2012) The government's alcohol strategy. London, Home Office. • Lloyd, C and McKeganey, N. (2010) Drugs research: An overview of evidence and questions	• Fitzgerald and Angus (2015) argue that Wales has some elements of alcohol policy that adopt a good evidence base and others that do not. They suggest that Wales falls behind Scotland but is ahead of England in this regard. • Alcohol Public Policy Group (2010) explores extent to which alcohol can be seen as a drug or distinct through cultural, legal and social positioning. • Nutt et al's (2010) is a critical paper - identifying alcohol as significantly more harmful than many illegal drugs. Implications of findings for review of alcohol and drugs law rejected by UK government. • UK Alcohol Strategy - Marked difference between English (UK) Government) and Welsh (or Scottish) approaches.

	for policy. York, Joseph Rowntree Foundation. • Babor, T; Caetano, R; Casswell, S; Edwards, G; Giesbrecht, N; Graham, K; Grube, J; Hill, N; Holder, H; Homel, R. Livingston, M; Österberg, E; Rehm, J; Room R and Rossow I. (2010)Alcohol: No ordinary commodity. Research and public policy. 2nd edition. Oxford: Oxford Medical Publications, Oxford University Press. • Erikson, C; Geidne, S; Larsson, M and Pettersson, C. (2011) A Research strategy case study of alcohol and drug prevention by non-governmental organizations in Sweden 2003-2009. Substance Abuse Treatment, Prevention, and Policy 2011 6:8 http://www.substanceabusepolicy.com/content/6/1/8	• The first decade of the 21st century saw a trebling of the government led investment into drug treatment (Lloyd and McKeganey, 2010). *Working Together to Reduce Harm* was written on the back of this explosion. • *Working Together to Reduce Harm* has a policy structure that reflects some of the elements in one of the key reviews of evidence for alcohol policy interventions by Babor et al (2010). This review suggests five areas of evidence for policy intervention; regulatory action on pricing, marketing and availability of alcohol, early intervention and treatment; and approaches to reduce drink driving, safer drinking environments and treatment. From which it can be seen *Working Together to Reduce Harm* two strands on treatment and availability are direct correlates, and harm reductions closely related. It can also be noted however that interventions on pricing and marketing are significantly absent. • A significant study of provision in Sweden concluded that often it was programme rather than evidence driven (Erikson, 2011). They suggest the need for greater effective relationships between researchers and the practice community.
Patterns of use	• Centre for Social Justice. (2013) No quick fix - Exposing the depth of Britain's drug and alcohol problem. London, Centre for Social Justice.	• The volumes, patterns and changes of use of alcohol and other drugs within the general population are well established (Davies et al, 2012;

	- Davies, C; English, L; Stewart, C; Edginton, M; McVeigh, J and Bellis, M,A (eds). (2012) United Kingdom drug situation: Annual report to the European Monitoring Centre for Drugs and Drug Addiction. London, Department of Health. - Lader, D. (2016) Drug Misuse: Findings from the 2015/16 Crime Survey for England and Wales Second edition. London, Home Office. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564760/drug-misuse-1516.pdf - Niblett, P. (2015) Statistics on alcohol. London, Health and Social Care Information Centre. http://content.digital.nhs.uk/catalogue/PUB17712/alc-eng-2015-rep.pdf - Robinson, S and Harris, H. (2011) Smoking and drinking among adults 2009: A Report on the 2009 General Lifestyle Survey. London, Office for National Statistics. - Wadd, S and Galvani, S. (2014) Working with older people with alcohol problems: Insight from specialist substance misuse professionals and their service users. Social Work Education: The International Journal, 33(5):656-69. - Fitzgerald, N. and Angus, C. (2015). Four nations: How evidence-based are alcohol policies and programmes across the UK? London, Alliance for Useful Evidence/Alcohol Health	Robinson and Harris, 2011). These show some overall (small percentage) decreases in general population use, but continued sections of hazardous and harmful use (Niblett, 2015). - Recent drug use data identifies that in the general population 35% of people aged between 16- and 59-years-old reported taking an illicit substance at some point, with 8% reporting use within the past year (Lader, 2016). - Some populations within this have shown some increase; notably older people (Wadd and Galvani, 2014). - Irrespective of the changing demographics and patterns of use some argue that the costs associated with use are rising (Centre for Social Justice, 2013). Within this it is those who are most vulnerable who bear the greater burden or cost. - While it is important to develop a range or strains of activity, evidence also points towards whole population approaches and reductions in overall population consumption as impacting on harm (Fitzgerald and Angus, 2015). - Welsh referrals for specialist treatment, indicate alcohol use (54%) higher than drug use (Heroin 9.4% other drugs 20.8%). Of 30,039 referrals made 8,453 complete successfully, 5280 remain in treatment more than half of all referrals are lost to services. Concern noted about increased use of

	Alliance. • NHS Wales Informatics Service. (2015) Treatment Data Substance Misuse Services in Wales 2013-2014. Cardiff, Welsh Government.	NPS & IPEDs (NHS Wales Informatics Service, 2015).[24]
External factors	• Chief Medical Officer for Wales. (2016) Annual report 2015-16: Rebalancing healthcare working in partnership to reduce social inequity. Cardiff. • Harhay, M.O; Bor, J.; Basu, S; McKee, M; Mindell, J.S; Shelton, N,.J and Stuckler, D. (2014) Differential impact of the economic recession on alcohol use among white British adults, 2004–2010. European Journal of Public Health 24 (3): 410-415. • Lloyd, C and McKeganey, N. (2010) Drugs research: An overview of evidence and questions for policy. York, Joseph Rowntree Foundation. • Nutt, D.J; King, L.A and Phillips, L.D. (2010) Drug harms in the UK: a multicriteria decision analysis. Lancet 376 (9752):1558–1565. • Public Health Wales. (2016) Making a difference: Investing in sustainable health and well-being for the people of Wales [Internet]. Public Health Wales NHS Trust; 2016 p.12. Available from: http://www.wales.nhs.uk/sitesplus/documents/888/Making%20A%20Difference_Evidence%28E_w	• Chief Medical Office for Wales (2016) reports that inequalities in population health outcomes in Wales are associated with the socioeconomic status of individuals. Some suggestion that poverty (increased proportionate cost as % of income) can reduce consumption. • Illegal or Illicit drug use is an emotive subject, which engenders a range of often value based interpretations. As a consequence of this, policy, and especially those elements of drug policy that appear most controversial are often strongly shaped by the moral and political arguments rather than necessarily science or research (Lloyd and McKeganey, 2010; Nutt et al, 2010). • The recently published Public Health Wales report Making a Difference, describes 10 key evidence-based ways to make a difference to levels of ill health and inequalities. 1. Ensuring a good start in life for all. 2. Promoting mental wellbeing and preventing mental ill health.

[24] Subsequent to the submission of the draft version of this report, an updated report has been published, which (as per the main report) shows patterns of use have been broadly consistent over the last few years of reporting – with alcohol use higher than heroin and other drug use. This updated report is available at: http://gov.wales/docs/dhss/publications/171025misuseen.pdf

eb%29.pdf

- Ross-Houle, K; Venturas, C; Bradbury, A and Porcellato, I. (2017) An exploration of the role of alcohol in relation to living situation and significant life events for the homeless population in Merseyside, UK. London, Alcohol Research UK.
- Edwards, C and Jeffray, C. (2014) On Tap - Organised crime and the illicit trade in tobacco, alcohol and pharmaceuticals in the UK. London The Royal United Services Institute for Defence and Security Studies.
- UK Drugs Policy Commission. (2012). Charting New Waters: Delivering drug policy at a time of radical reform and financial austerity. London: UK Drugs Policy Commission.
- UK Drugs Policy Commission. (2012). Domino Effects: The impact of localism and austerity on services for young people and on drug problems. London: UK Drugs Policy Commission.

3. Preventing violence and abuse.
4. Reducing prevalence of smoking.
5. Reducing prevalence of alcohol misuse.
6. Promoting physical activity.
7. Promoting healthy diet and preventing obesity.
8. Protection from disease and early identification.
9. Reducing economic and social inequalities and mitigating austerity.
10. Ensuring a safe and health-promoting natural and built environment.

- Significant use is both a cause and effect of homelessness and consequently is considered to be a major health risk and social determinant amongst the homeless (Ross-Houle et al, 2017). Often these experiences reflect where individuals have perhaps lacked social capital during significant life events, and will then need support in establishing this and/or recovery capital to escape cyclical patterns of substance use and homelessness.
- One of the difficult areas for Welsh Government to have responsibility for and influence, is the increasing influence or organised crime organisations on the illicit trade of legal drugs and the illegal markets of other drugs. There is good evidence to suggest that this influence is increasing and significant, shaped by a mixture of forces like migration, economics, opportunity etc (Edwards and Jeffray, 2014). This said it is clear that Welsh

		Government can encourage its police forces and local government licencing/trading standards to be more cognisant of these activities and engage in cross agency and border activity, including the sharing of intelligence. (see additional commentary below)
Data Evaluation	• NHS Wales Informatics Service. (2015) Treatment data substance misuse services in Wales 2013-2014. Cardiff, Welsh Government. • Rychetnik L; Frommer, M; Hawe, P and Shiell, L (2002). Criteria for evaluation evidence in public health interventions. Journal of Epidemiological Community Health ;56(2): 119-127. • Sanson-Fisher, R. W; Bonevski, B; Green, L. W., and D'Este, C. (2007) Limitations of the randomized controlled trial in evaluating population-based health interventions. American Journal of Preventive Medicine. 33(2): 155-61.	• NHS Wales Informatics Service identify concerns which include: o quality of recording and coding; only primary substance used recorded as priority; o methadone data: not clear whether prescribed or illegally obtained; o of the 30,039 referrals made 8,453 complete successful and 5280 remain with services – not known why over half referrals lost to services (p.5); and o additionally, 13 children aged less than 10 years were referred for alcohol and cannabis use: unclear on appropriateness / nature of such referral. • The processes for establishing appraisal and validity of public health interventions and certainty in evaluation evidence is complex (Rychetnik et al, 2002). Judgements must be made on whether interventions are sufficiently well evidenced to implement, if they are transferable to individuals and populations, and if so will results be replicated. Although Randomised Controlled Trials (RCTs)

		provide the least biased results, they are often impractical to conduct for reasons of time, 'contamination' of sample, cost, and ethical considerations (Sanson-Fischer et al, 2007).
Prevention: Young people	• Chief Medical Officer for Wales. (2016) Annual Report 2015-16 Rebalancing healthcare working in partnership to reduce social inequity. Cardiff. • Alcohol and Public Policy Group. (2010) Alcohol: No ordinary commodity – a summary of the second edition. Addiction 105(5): 769–779. • Lloyd, C and McKeganey, N. (2010) Drugs research: An overview of evidence and questions for policy. York, Joseph Rowntree Foundation. • Valentine, G; Jayne, M; Gould, M and Keenan, J. (2010) Family life alcohol and consumption: a study of the transmission of drinking practices. York, Joseph Rowntree Foundation. • Obuna B., Hayes, C and Fulton, J. (2016). Factors influencing levels of alcohol misuse in UK adolescents; a systematic literature review. International Journal of Current Research. 8(10): 39611-39617. • Bennett, T and Holloway, K. (2014) Drug misuse among university students in the UK; implications for prevention. Journal of Substance Use and Misuse; 49(4): 448-455. • Segrott, J; Gillespie, D; Holliday, J; Humphreys, I; Murphy, S; Phillips, C; Reed, H; Rothwell, H;	• The importance of early intervention services for expectant mothers/families and newly born children (the first 1,000 days) in influencing long term and lifelong outcomes is increasingly well evidenced. Parental and other familial drinking, other drug use and related behaviour are known to be a significant factor in adverse childhood experiences (CMO for Wales 2016). • Alcohol and Public Policy Group (2010) suggest the evidence for prevention programme effectiveness with regards to impact on long term sustained changes in drinking behaviour is limited, and perhaps most effective when targeted at high-risk groups rather than say all young people. There is strong evidence to suggest that targeted prevention rather than whole population prevention methods is likely to be the most effective use of resources. For example; young people with troubled pasts likely to heavily use cannabis and this compound experiences (Lloyd and McKeganey, 2010). • Specific study of drug use in South Wales university students found high levels of consumption and reported harm (Bennet and Holloway, 2014).

	Foxcroft, D; Hood, K; Roberts, Z; Scourfield, J; Thomas, C and Moore, L. (2014) Preventing substance Misuse; study protocol for a randomised control trial of the Strengthening Families Programme 10-14 UK (SFP10-14UK). BMC Public Health; 14:49 http://www.biomedcentral.com/1471-2458	
Harm reduction	• Aspinall E.J; Nambiar, D; Goldberg, D.J; Hickman, M; Weir A, Van Velzen, E; Palmateer, N; Doyle, J.S; Hellard, M.E and Hutchinson, S.J. (2014) Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: a systematic review and meta-analysis. International Journal of Epidemiology (2014) 43 (1): 235-248 • Bennett, T and Holloway, K. (2011) Evaluation of the take home naloxone demonstration project. Merthyr Tydfil, Welsh Assembly Government. • Public Health England. (2016) Understanding and preventing drug-related deaths: The report of a national expert working group to investigate drug-related deaths in England. London, Public Health England. • Parker H;Bury, C and Eggington, R. (1998) New heroin outbreaks amongst young people in England and Wales: Crime Detection and Prevention Series, Paper 92. London: Home Office Police Research Group.	• Needle and syringe exchange programmes help reduce the transmission of HIV among injecting drug users (Aspinall et al 2014). • 30% of all drug related deaths mention alcohol or the impact of long term alcohol use e.g. liver cirrhosis (p.8). Public Health England (PHE) analysis of these rates found that although a direct relationship could not be established between the policy focus on recovery, 'poorly-oriented practice' created an increased risk with an apparent 'correlation between economic and health inequalities, deprivation and drug-related deaths (Public Health England, 2016). Such an effect is particularly prevalent in locations of the original heroin 'outbreaks' of the 1980's i.e. in North and North- East England (Parker et al, 1998). Public Health England recommends aligned commissioning and whole system approaches to the complex needs of people who use drugs.

	• Degenhardt,L: Charlson, F; Stanaway, J; Larney, S; Alexander, L.T; Hickman, M; Cowie, B; Hall, W.D; Strang, J; Whiteford, H and Vos, T (2016). Estimating the burden of disease attributable to injecting drug use as a risk factor for HIV, hepatitis C and hepatitis B: findings from the Global Burden of Disease Study 2013. Lancet Infectious Diseases16(2): 1385-98.	
Treatment General	• Raistrick, D; Heather, N and Godfrey, C. (2006) Review of the effectiveness of treatment for alcohol problems. London, National Treatment Agency for Substance Misuse. • Orford, J. (2008) Asking the right questions in the right way: the need for a shift in research on psychological treatments for addiction. Addiction 103(6):875-85. • Lundahl, B. W; Kunz, C; Brownell, C; Tollefson, D and Burke, B. L. (2010) A meta-analysis of motivational interviewing: twenty-five years of empirical studies Research on Social Work Practice, 20(2):137-60 • Smedslund G, Berg, R.C; Hammerstrøm, K.T; Steiro, A; Leiknes, K.A; Dahl, H.M and Karlsen, K (2011). Motivational interviewing for substance abuse. Oxford: Cochrane Collection Wiley. • Sweetman, J; Raistrick, D; Mdege, N.D and Crosby, H. (2013) A systematic review of substance misuse assessment packages. Drugs	• The evidence base for treatment interventions (especially Tier 3 and Tier 4) is well established. This evidence has traditionally been hierarchised in favour of experimental and randomised control trial research methodologies; and cognitive and medical interventions (Raistrick et al, 2006). Frequently when subject to much larger trials, whilst interventions make a difference, there is no evidence of one intervention being particularly stronger than another – i.e. Project MATCH, UKATT (Orford, 2008). The Welsh Government has based many of its key treatment considerations around the integrated use of motivational interviewing (MI), for example brief interventions and IFSS. The evidence base for the use of MI is substantive and well proven (Lundahl et al, 2010; Smedslund et al, 2011).

	and Alcohol Review: 32(4). 347-355.	
Treatment Alcohol	• Schmidt, C. S; Schulte, B; Seo, H.-N, Kuhn, S, O'Donnell, A; Kriston, L; Verthein, U and Reimer, J. (2016) Meta-analysis on the effectiveness of alcohol screening with brief interventions for patients in emergency care settings. Addiction, 111: 783–794. doi: 10.1111/add.13263. http://onlinelibrary.wiley.com/doi/10.1111/add.13263/full • Newbury-Birch, D; McGovern, R; Birch, J; O'Neill, G; Kaner, H; Sondhi, A and Lynch K. (2016)," A rapid systematic review of what we know about alcohol use disorders and brief interventions in the criminal justice system ", International Journal of Prisoner Health, Vol. 12 Issue 1 pp. 57 - 70 • Models of Care for treatment of adult drug misusers – update (DH HO 2006) http://www.nta.nhs.uk/uploads/nta_modelsofcare_update_2006_moc3.pdf • Williams, R; Ashton, K; Aspinall, R; Bellis, M.A; Bosanquet, J; Cramp, M.E; Day, N; Dhawan, A; Dillon, J; Dyson, J; Ferguson, J; Foster, G; Gilmore, I; Glynn, M; Guthrie; J.A; Hudson, M; Kelly, D; Langford, A; Newsome, P; O'Grady, J; Pryke, R; Ryder, S; Samyn, M; Sheron, N and Verne, J. (2015). Implementation of the Lancet	• The evidence for brief interventions – in some settings is strong; so primary and secondary health care, (Schmidt et al, 2015) and questioned for Criminal Justice (Newbury-Birch et al, 2016). • Prescribing interventions: as well as for facilitating detoxification medications are indicated to support abstinence post detoxification and to reduce alcohol intake (N.B. wholly consistent & congruent with NICE Clinical Guidance 115). • The failure of UK health policy to adequately address the needs of those with liver disease as the third most common cause of death after ischaemic heart disease and self-harm in the UK is demonstrated by the 400% increase in mortality rates since 1970. Particularly noteworthy is the prevalence in those aged under 65, demonstrated in both hospital admission rates and mortality. This parallels the national rise in alcohol consumption in that time-period, and changes in social patterns for stronger, cheaper alcohol more frequently consumed at home. The first annual report on implementing the Lancet Standing Commission on Liver Disease indicated that NHS Wales had introduced 'Together for Health the Liver Disease Delivery Plan' and that the Welsh Government was

	Standing Commission on Liver Disease in the UK. Lancet :386, pp. 2098-111. • Williams, R; Aspinall, R; Bellis, M; Camps-Walsh, G; Cramp, M; Dhawan, A; Ferguson, J; Forton, D; Foster, G; Gilmore I; Hickman, M; Hudson, M; Kelly, D; Langford, A; Lombard, M; Longworth, L; Martin, N; Moriarty, K; Newsome, P; O'Grady, J; Pryke' R; Rutter, H;, Ryder, S Sheron, N and Smith, T. (2014). Addressing liver disease in the UK: a blueprint for attaining excellence in health care and reducing premature mortality from lifestyle issues of excess consumption of alcohol, obesity and viral hepatitis. Lancet:384: 1953-1997. • National Institute for Health and Care Excellence. (2016). Alcohol use disorders overview. Manchester, NICE.	considering proposals through national consultation in 2015 for a minimum unit price of £0.50[25]. This is projected to reduce annual liver disease deaths (by 21) and hospital admissions (by 119) in addition to a systems model introduced by Public Health Wales. (Williams 2014, 2015).
Treatment Drugs	• Department of Health (2006) Models of Care for Alcohol Misusers London, Department of Health. https://www.alcohollearningcentre.org.uk/_assets/BACKUP/DH_docs/ALC_Resource_MOCAM.pdf • Werba, D; Kamarulzamanc, A; Meachamb, M.C; Raffulb, C; Fischerd, B; Strathdeeb, S.A and Wood C. (2015) The effectiveness of compulsory drug treatment: A systematic review International	• There is limited scientific literature evaluating compulsory drug treatment. Evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms. (Werba et al, 2015)

[25] Since the writing of this report significant progress has been made in relation to MUP. Firstly, Public Health Minimum Price for Alcohol (Wales) Bill has been introduced and is currently going through the Assembly scrutiny process; and, secondly, MUP in Scotland has now overcome all legal challenges and the Scottish Government have announced an implementation date of May 1st, 2018.

	Journal of Drug Policy 28 Pages 1–9	
Treatment Specific Populations	• Wadd, S. (2014) The Forgotten people: Drug problems in later life. Luton, University of Bedfordshire. • Advisory Panel on Substance Misuse (APOSM). (2017) Substance misuse in an aging population. Cardiff, Welsh Government. • Holley-Moore G and Beech, B. (2016) Drink Wise Age Well: Alcohol use and the over 50s in the UK. London, International Longevity Centre. • Debell, F., Fear, N.T., Head, M.; Batt-Rawden, S; Greenberg, N; Wessely, S and Goodwin, L. (2014) A systematic review of the comorbidity between PTSD and alcohol misuse, Social Psychiatry and Pyschiatric Epidemiology 49 (9): 1401-1425.	• There is a strong correlation between PTSD and significant alcohol problems (Debell et al, 2014)
Treatment Recovery (Mutual Aid)	• Best, D. (2016) Developing strengths based recovery systems through community connections Addiction (On Line access - DOI: 10.1111/add.13588) • Humphreys, K. (2004) Circles of recovery: Self-help organizations for addictions. Cambridge, Cambridge University Press. • Best, D; Rome, A; Kirstie A; Hanning, K.A; White, W; Gossop, M; Taylor, A and Perkins, A. (2010) A review of international evidence to support Scotland's national drugs strategy, The Road to Recovery. Edinburgh: Scottish Government	• Over the passage of the strategy period, recovery and concepts, interventions and models have become increasingly established in alcohol and drug considerations in the UK (Roth and Best, 2012). A range of articles in recent 2016 editions of Addiction explore and summarise current conceptualisations (for example Best, 2016; Lancaster, 2016; McKay, 2016). These recovery interventions utilise the recognition of people's strengths and ability to change, (McCormack, 2007). Many of the community support and recovery model approaches are based around the effectiveness of peer support

Social Research.

- Fischer, J; Jenkins, N. Bloor, M, Neale J and Berney, L (2007) Drug user involvement in treatment decisions. York, Joseph Rowntree Foundation https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/2012-drug-user-treatment.pdf
- Lancaster, K. (2016) Rethinking recovery. Addiction (On line access DOI: 10.1111/add.13552).
- Livingston, W; Baker, M; Atkins, B and Jobber, S. (2011) A tale of the spontaneous emergence of a recovery group and the characteristics that are making it thrive: exploring the politics and knowledge of recovery. The Journal of Groups in Addiction & Recovery, 6(1-2):176-96.
- McCormack, J. (2007) Recovery and strengths based practice: Scottish Recovery Network Discussion Paper Series Paper 6. Glasgow, Scottish Recovery Network.
- McKay, J.R. (2016) Making the hard work of recovery more attractive for those with substance use disorders. Addiction (On line access 10.1111/add.13502).
- Roth, J and Best, D (editors) (2012) Addiction and recovery in the UK. London, Routledge.
- Roth, J; White, W and Kelly, J. (2013) Broadening the base of addiction mutual support

(Humphreys, 2004; Livingston et al, 2011; Roth et al, 2013).

- The active engagement of drug service recipients in treatment decisions, is likely to improve their retention within and satisfaction of treatment (Fischer et al 2007).

	groups: Bringing theory and science to contemporary trends London, Routledge.	
Family Interventions	• Copello, A; Orford, J; Hodgson, R and Tober, G. (2009a) Social Behaviour and Network Therapy for alcohol problems. London, Routledge. • Copello, A; Templeton, L and Powell, J. (2009b) Adult family members and carers of dependent drug users: Prevalence, social cost, resource savings and treatment responses. London, UK Drug Policy Commission. • Forrester, D; Holland, S; Williams A and Copello, A (2016) Helping families where parents misuse drugs or alcohol? A mixed methods comparative evaluation of an intensive family preservation service. Child and Family Social Work 21(1): 65–75. • Forrester, D; Copello, A; Waissbein, C and Pokhrel, S. (2008) Evaluation of an intensive family preservation service for families affected by parental substance misuse Child Abuse Review, 17(6):410-26. • Forrester, D. (2012) Motivational interviewing for working with parental substance misuse: A Guide to support the IFS teams. Luton, University of Bedfordshire • Holland, S; Forrester, D; Williams, A and Copello, A. (2014) Parenting and substance misuse: Understanding accounts and realities in child	• Evidence exists for support for families in three contexts 1. Family interventions – focus on change is systemic and to address alcohol and drug use. 2. Significant other interventions – services to family members that seek to impact on another's alcohol and drug use. 3. Support to families – interventions that do not direct activity towards alcohol and drug use, but rather meet family members' other needs. • Familial interventions enable alcohol and drug work to be done in wider holistic practice settings and not just specialist substance misuse agencies – for example social work (Copello et al, 2009a, 2009b; Forrester et al, 2008 Forrester et al 2016, Holland et al 2014). This is obviously consistent with some of the journeys implied with the Social Services and Well-being [Wales] Act (2014). • The incorporation of motivational interviewing into a model for intensive family support associated with child protection and alcohol or drug use is now well established (Forrester, 2012; Forrester et al, 2008, 2016), and evidenced through the establishment of the Integrated Family Support Services (IFSS), a mainstream Welsh Government priority and provision (Social Services and Well-being [Wales]

protection contexts. British Journal of Social Work 44(6): 1491-1507. • Templeton, L; Ford, A; McKell, J; Valentine, C; Walter, T; Velleman, R; Bauld, L; Hay, G. and Hollywood, J. (2016). Bereavement through substance use: findings from an interview study with adults in England and Scotland. Addiction Research and Theory, doi: 10.3109/16066359.2016.1153632 • Thom, G; Delahunty, L; Harvey, P and Ardil, J. (2014) Evaluation of the Integrated Family Support Service Final Year 3 Report, Cardiff, Welsh Government. http://gov.wales/docs/caecd/research/2014/140328-evaluation-integrated-family-support-service-year-3-en.pdf • Valentine, C. and Walter, T. (2015) Creative responses to a drug- or alcohol-related death: A sociocultural analysis. Illness, Crisis and Loss 23(4):310–322. • Welsh Government (2012) The Integrated Family Support Teams (family support functions) (Wales) regulations 2012. Cardiff, Welsh Government. • Welsh Assembly Government. (2008) Stronger families: Supporting vulnerable children and families through a new approach to Integrated Family Support Services (consultation). Cardiff,	Act (2014); Thom et al, 2014; Welsh Assembly Government, 2008; Welsh Government, 2012). • The evidence base for specific family interventions with alcohol and drug users, like social behaviour network therapy or the Five Step model, is now strongly recognised. These familial interventions frequently adopt the core elements of recognised and evidenced approaches (that is, family and network therapy) that focus on the involvement, needs and support of family members. • One of the key support issues for families is dealing with Death - Templeton et al. (2016) argue that deaths associated with alcohol and/or drugs belong to a category of “special” deaths. They suggest this is the case for three distinct reasons. Firstly, those deaths are usually of a traumatic nature; secondly, they frequently see stigma directed to both the bereaved and the deceased; and, finally, the grief experienced by the bereaved can be considered as disenfranchised (Valentine and Walter, 2015).

	Welsh Assembly Government. • Wright S; Gray P; McAteer L; Watts E; Haines K; Liddle M. (2011) Evaluation of the CRAFT pilot project. Cardiff, Welsh Government.	
Availability Enforcement	• Leyshon, M and Misell, A. (2010) Counting the cost: Irresponsible alcohol promotions in the night-time economy in Wales. London, Alcohol Concern. • Public Health Wales (2016) Making a Difference: Investing in Sustainable Health and Well-being for the people of Wales. Available at: http://www.wales.nhs.uk/sitesplus/documents/888/Making%20A%20Difference_Evidence%28E_web%29.pdf • Thompson, K; Stockwell, T; Wettlaufer, A; Geisbrecht, N and Thomas, G. (2017) Minimum alcohol pricing policies in practice: A critical examination of implementation in Canada Journal of Public Health Policy 38(1): 39–57. • Anderson, Z; Whelan, G; Hughes, K and Bellis, M. A. (2009) Evaluation of the Lancashire polycarbonate glass pilot project. Liverpool, Centre for Public Health. http://www.cph.org.uk/wp-content/uploads/2012/08/evaluation-of-the-lancashire-polycarbonate-glass-pilot-project.pdf • Brands, J; van Alast, I and Schwanen, T. (2015) Safety, surveillance and policing in the night-time	• Calls for MUP in Wales have been articulated (Leyshon and Misell, 2010; Public Health Wales, 2016). The evaluation of Canada's minimum pricing (rather than full minimum unit pricing) policies has demonstrated that increased prices can be suggested to have significantly reduced alcohol consumption. However, the Canadian approach has also led to the identity of three key concerns; (1) the exclusion of minimum prices for several beverage categories, (2) minimum prices below the recommended minimum and (3) prices are not regularly adjusted for inflation or alcohol content. (Thompson et al, 2017). • The promotion of night time economies is sought for the economic (employment and revenue) advantage bought to Welsh urban communities, and is considered an integral part of tourism led provision. However, this comes at a cost. While there has been a lot of research that suggest that activities are associated with harm reduction within successful management of night time economies (Anderson et al, 2009; Brandt et al, 2015), many authors articulate that the alcohol industry has an undue influence over these and other such policy developments

economy: (Re)turning to numbers. Geoforum 62: 24-27. http://www.sciencedirect.com/science/article/pii/S001671851500072X

- Fitzgerald, N. and Angus, C. (2015). Four nations: How evidence-based are alcohol policies and programmes across the UK? London, Alliance for Useful Evidence/Alcohol Health Alliance.
- McCambridge J, Hawkins B, and Holden C. (2014) Vested interests in addiction research and policy: The challenge corporate lobbying poses to reducing society's alcohol problems: Insights from UK evidence on minimum unit pricing. Addiction.109(2):199-205.
- Livingston, W. (2017) Death, grief and bereavement; relationships with alcohol and other drug use, in Thompson, N. and Cox, G. R. (eds) (2017) Handbook of the sociology of death, grief and bereavement. New York, Routledge.
- Deacon, T. (2017) Huge amount of alcohol seized from underage people. Wales Online [Accessed 24/03/2017] http://www.walesonline.co.uk/news/wales-news/huge-amount-alcohol-seized-underage-12775373
- National Institute for Health and Care Excellence (NICE) (2010) Alcohol-use disorders prevention:

(Fitzgerald and Angus, 2015; Thompson et al, 2017). Governments often rely on voluntary self-regulation of the alcohol industry; the efficacy of such arrangements have been consistently questioned (McCambridge et al 2014). It is argued that the alcohol industry continues to promote, and potentially irresponsibly and with negative health impact, alcohol within night-time economy drinking venues (Leyshon and Misell 2010, Public Health Wales 2016).

- Fitzgerald and Angus (2015) suggest three elements to an approach in this area; pricing, availability [licensing and sales] and marketing [promotion, product and packaging]. Welsh government appears stronger on availability than the other two areas. There are those who argue that such contingency management approaches are alternatively just an appeasement cost to a culture of excessive drink related behaviour (including death) that has become the acceptable price for industries and local authorities to make money (Livingston, 2017).
- Cwm Taf Youth Engagement Project seized over a 12-week period ‘huge’ amounts of alcohol from underage drinkers, especially vodka, and mostly bought by adults and given to younger people (Deacon, 2017).

	Public Health Guideline (PH24) London: NICE. • Holmes J., Meng, Y; Meier, P.S; Brenan, A; Angus, C; Guo, Y; Hill-Mcmanus, D and Purshouse, R, C. (2014). Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study. Lancet 383:1655-64. • Jones I. (2014). Public attitudes to minimum unit pricing of alcohol. Cardiff; Welsh Government. • Meng, Y;,Sadler, S; Gell, L; Holmes J and Brennan A. (2014) Model-based appraisal of minimum unit pricing for alcohol in Wales. Cardiff, Welsh Government.	
Commissioning	• Drugscope. (2013) State of the Sector 2013 London, Drugscope. • Gosling, H. (2016) Payment by results: Challenges and conflicts for the therapeutic community. Criminology and Criminal Justice 16(5) 519– 533. • The Recovery Oriented Drug Treatment Expert Group. (2013) Medications in recovery: Best practice in reviewing treatment: Supplementary Advice. London, Public Health England.	• Frequent cycles (3-5 years or less) of recommissioning and retendering can be seen as negative activity, which adversely impacts on service provision. Service providers found that developing relationships between and within new structures is not always consistent (Drugscope, 2013). There is evidence that in recent years traditional ‘substance misuse’ services are developing new and stronger partnerships beyond their immediate confines, notably: housing and housing support; clients with complex needs or multiple exclusions, and employment and employment support (Drugscope, 2013). • Gosling (2016) argues that payment by results does little more for enhancing the quality of provision and

		instead just provides additional strains and stresses; "transforming individual progression into a financially driven bureaucratic process" (p519). • The development of truly recovery orientated provision remains a commissioning challenge (Drugscope, 2013).
Wider impact on families	• Copello, A; Templeton, L and Powell, J. (2009) Adult family members and carers of dependent drug users: prevalence, social cost, resource savings and treatment responses. London, UK Drug Policy Commission. • Cyfle. (2017) Newsletter -February 2017. Llandudno, Cyfle/CAIS.	• 47% of the 844 individuals registered with Cyfle (Out of Work Service for Wales; targeting alcohol and drug users) in a six-month period (August 2016- January 2017) were reported as "in recovery from a combination of substance misuse and mental health issues" (Cyfle 2017).
Wider benefits of treatment	• Cartwright, W. (2008) Economic costs of drug abuse: financial, cost of illness, and services. Journal of Substance Abuse Treatment, 34: 224–233. • Godfrey, C; Stewart, D., Gossop, M. (2004) Economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from the National Treatment Outcome Research Study (NTORS). Addiction 99: 697–707.	
Wales specific research & data generation	• Orford, J. (2008) Asking the right questions in the right way: the need for a shift in research on psychological treatments for addiction. Addiction 103(6):875-85.	• Over the period of the strategy there has been an increased recognition of the need to embrace different research questions and methodologies. With particular regard played to understanding the intra-personal nature of a) helping relationships and

		b) the recovery process. (Orford 2008)
Future Strategy-specific evaluation design	• Chief Medical Officer for Wales. (2016) Annual Report 2015-16 Rebalancing healthcare working in partnership to reduce social inequity. Cardiff.	• Lots of questions about how to integrate well-being into policy. Evidence of more holistic Welsh Government approaches – so whole and systemic' i.e. Chief Medical Officer for Wales (2016) approach.

Additional Commentary

This passage provides additional context to the preceding tables.

Understanding Contribution

The European Monitoring Centre for Drugs and Drug Addiction[26] evaluates three components of national drugs strategies:

- Monitoring via routine data collection of the local drug-scape, responses, and interventions;
- Evaluation of the drug policy intervention, benefits from associated initiatives and resource allocations;
- Assessment of effectiveness or impact evaluation in which the 'outcomes' (short -term effects), and the impacts (long-term effects), on the drugs phenomenon are brought about (at least in part) because of the national drugs strategy (p.75). The central components considered include financial and political commitment, leadership, accountability, and financial autonomy with feasible indicators (p.80).

Market Trends and Proximity – The Scale of the Problem

Some global events have overtaken all UK policy impacts. Key among these are:

- The reported heroin scarcity of 2010-2011[27]. At the peak in November 2011, the wholesale prices rose but street prices remained stable. Police seizures found a heroin purity of 4% with other substances reported as added to regular usage, most commonly alcohol and benzodiazepines. Reassertion of the market led to increased purity of 36% by 2014[28], and a 67% rise in Drug Related Death (DRD) from 579 in 2012, to 952 by 2014[29].
- Increased availability over the past five years. In part, this has been due to the globalisation of transport, particularly maritime routes, which have taken

[26] European Monitoring Centre for Drugs and Drug Addiction (2015) Perspective on Drugs: Opioid trafficking routes from Asia to Europe, Lisbon, EMCDDA.
[27] Ahmad, M and Richardson, A (2016) Impact of the reduction in heroin supply between 2010 and 2011, Research Report 91. London, Home Office.
[28] https://visual.ons.gov.uk/deaths-involving-heroin-up-by-two-thirds-in-two-years/
[29] ONS (2015) Deaths involving heroin up by two thirds in two years: Deaths related to Drug Poisoning in England and Wales 2014 London ONS Digital.

over from the traditional Balkan route for heroin as there is lack of law enforcement capacity[30].

- Increased production of 14 synthetic opioids has been reported to the EU early warning system since 2005, including pharmaceutical preparations of morphine, buprenorphine, fentanyl, methadone, and tramadol (European Monitoring Centre for Drugs and Drug Addiction, 2015).
- The World Drugs Report (UNODC, 2016) notes that global cannabis use and trafficking has remained relatively stable, with an increase in cocaine and Amphetamine-Type Substances (ATS) production. The report also notes:
    - In 2014, 234 substances were under control, rising to 244 by January 2016, with key routes to European markets established through the Balkans for heroin and Africa for cocaine and stimulants.
    - An increase in polydrug use and non-medical use of opioid drugs and a new surge in heroin markets in Europe.
    - Drug trafficking of 66 New Psychoactive Substances (NPS) was recorded in 2014, and a further 75 were reported to UNODC in 2015 of a wide range that did not belong to any previously classified groups.

Minimum Unit Pricing (MUP) of Alcohol

The Glasgow and Edinburgh study on alcohol pricing and purchase which commenced in 2011/12, showed links between higher levels of deprivation and increased harms[31]. For instance, participant coping strategies for lack of funds to purchase alcohol were trading down to cheaper white cider at £0.17 per unit. The death rate in participants of the study was 16.4% (n=105) with a mean age of 45.6 years.

These findings reflected other study outcomes with evidence for ‘The Glasgow effect’ such as those focused on smoking, which show a direct association

[30] UNODC (2015) Global Maritime Crime Programme: Annual Report 2015 Vienna UNODC.
[31] Chick, J and Gill, J (2015) Alcohol pricing and purchasing among heavy drinkers in Edinburgh and Glasgow: current trends and implications for pricing policies. London Alcohol Research UK.

between poverty and the need for national policy to address social patterning pertaining to this harmful behaviour[32].

Chick and Gill (2015)[33] concluded that introducing a minimum unit price of £0.45 would be associated with health gains, but that they would be unevenly distributed between groups. The introduction would be of most benefit to harmful drinkers in terms of morbidity and mortality owing to volume of purchase and consumption of alcohol below £0.45/unit currently.

Cochrane Collection Alcohol and Drugs Systematic Reviews

As part of the initial literature review, a specific search of the Cochrane database was performed. The following table provides a summary of those sources.

The search method used for the Cochrane database was to select initially all reviews published in the Cochrane Drugs and Alcohol Group. This is a separate collection of reviews relating to interventions concerning substance misuse.

[32] Gray L and Leyland AH (2009) Is the "Glasgow Effect" of cigarette smoking explained by socio-economic status? A multilevel analysis. BMC Open Access July.
[33] Chick, J and Gill, J (2015) Alcohol pricing and purchasing among heavy drinkers in Edinburgh and Glasgow: current trends and implications for pricing policies. London Alcohol Research UK.

Table A6.3: Summary of Alcohol and Drugs Systematic Reviews

Review Title	Number of studies reviewed	Number of Participants	Indication of benefit/effectiveness
Amato, L; Minozzi, S; Vecchi, S and Davoli, M (2010) Benzodiazepines for acute alcohol withdrawal syndrome. Rome: Cochrane Collaboration Wiley. 17;(3):CD005063. doi: 10.1002/14651858.CD005063.pub3	64	4309	Yes – when compared with placebo for seizure control in alcohol withdrawal syndrome, however many outcomes compare to other drugs e.g. Chlordiazepoxide which in some cases performed better. Safety data is sparse.
Amato, L; Minozzi, S. Davoli, M and Vecchi, S (2011) Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence. Oxford: Cochrane Collection Wiley. 5;(10):CD004147. doi: 10.1002/14651858.CD004147.pub4.	34	3777	No – not found beneficial as the studies were not sufficiently sensitive to measure psychosocial outcomes on well-being or long enough to measure impact on mortality.
Amato, L; Minozzi, S; Davoli,M; Vecchi, S; Ferri M.M and Mayet, S (2011) Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification. Oxford: Cochrane Collection Wiley. 16;(3):CD005031. doi: 10.1002/14651858.CD005031.pub2	11	1592	Yes – effects found on completion of treatment. However limited evidence as small numbers of participants, lack of detailed outcomes and not possible to undertake a cumulative analysis.

Amato, L; Minozzi, S and Davoli, M (2011) Safety and efficacy of medicines for the treatment of alcohol withdrawal syndrome. Oxford: Cochrane Collection Wiley. Issue 6. Art. No.: CD008537. DOI: 10.1002/14651858.CD008537.pub2.	5 reviews 114 studies	7333	No - Only statistically significant finding was benzodiazepines perform better than placebo for control of seizure (3 studies/324 patients, moderate quality evidence) and benzodiazepines are also better than anti-psychotics (4 studies/ 633 patients, high quality evidence).
Amato, L; Davoli, M; Minozzi, S; Ferroni, E; Ali, R and Ferri, M (2013) Methadone at tapered doses for the management of opioid withdrawal. Oxford: Cochrane Collection Wiley. Issue 2. Art. No.: CD003409. DOI: 10.1002/14651858.CD003409.pub4.	23	2467	Yes – studies confirmed that slow tapering of temporary substitution of long-acting opioids could reduce withdrawal severity however the majority of heroin patients experience relapse. Differences in medication and regime adopted resulted in different symptoms in participants. 15-34 years old at increased risk of death.
Carney, T; Myers, B.J; Louw, J and Okwundu, C.I (2016) Brief school-based interventions and behavioural outcomes for substance-using adolescents. Oxford: Cochrane Collection Wiley. Issue 1. Art. No.: CD008969. DOI: 10.1002/14651858.CD008969.pub3.	6	1176	Low or very low-quality evidence that interventions reduced cannabis and alcohol use, rather than substance use and delinquent behaviour in general. These effects were sustained in long term follow-up. Further studies needed.
Castells, X; Cunill, R; Pérez-Mañá, C; Vidal, and Capellà, D (2016) Efficacy of psychostimulant drugs for cocaine dependence. Oxford: Cochrane Collection	26	2366	Efficacy is not entirely clear but appears promising and warrants further investigation.

Wiley. Issue 9. Art. No.: CD007380. DOI: 10.1002/14651858.CD007380.pub4.			
Darker, C. D; Sweeney, B.P; Barry, J.M; Farrell, M.F and Donnelly-Swift. E (2015) Psychosocial interventions for benzodiazepine harmful use, abuse or dependence. Oxford: Cochrane Collection Wiley. Issue 5. Art. No.: CD009652. DOI: 10.1002/14651858.CD009652.pub2.	25	1666	No – Insufficient at present - there is evidence for short term effect up to 3 months but not sustained at 6 months.
Faggiano, F; Minozzi, S; Versino,E and Buscemi, D (2014) Universal school-based prevention for illicit drug use. Oxford: Cochrane Collection Wiley. Issue 12. Art. No.: CD003020. DOI: 10.1002/14651858.CD003020.pub3.	51	127,146	Yes – small but significant effects based on social competence and social influence interventions for drug use prevention strategies, should be incorporated into comprehensive drugs strategies in order to achieve population level impact.
Ferri, M; Minozzi, S; Bo, A and Amato, L (2013) Slow -release oral morphine as maintenance therapy for opioid dependence. Oxford: Cochrane Collection Wiley. Issue 6. Art. No.: CD009879. DOI: 10.1002/14651858.CD009879.pub2.	3	195	No – insufficient studies, 2 suggest possible reduction in opioid use, one suggests slow release oral morphine reduces depressive symptoms.
Ferri, M; Allara, E; Bo, A; Gasparrini, A and	23	188,934	No – not able to draw conclusions on whether

Faggiano, F (2013) Media campaigns for the prevention of illicit drug use in young people. Oxford: Cochrane Collection Wiley. Issue 6. Art. No.: CD009287. DOI: 10.1002/14651858.CD009287.pub2.			media campaigns impact drug use prevention for young people.
Ferri, M; Davoli, M and Perucci, C.A (2014) Heroin maintenance for chronic heroin-dependent individuals. Oxford: Cochrane Collection Wiley. Issue 12. Art. No.: CD003410. DOI: 10.1002/14651858.CD003410.pub4.	8	2007	Yes – for those with history of maintenance therapy fails, injectable heroin provided at premises 2-3 times daily. Reduced illicit drug use, criminality, incarceration, and it supposes by association reduction in mortality and retention in treatment.
Foxcroft,D.R and Tsertsvadze, A (2011) Universal family-based prevention programs for alcohol misuse in young people. Oxford: Cochrane Collaboration Wiley. Issue 9. Art. No.: CD009308. DOI: 10.1002/14651858.CD009308.	12 RCTs	Unspecified students 18 years or younger	Yes – Small but generally consistent and persistent effect on studies involving enhancing parental skills, social and peer resistance skills.
Foxcroft, D.R and, Tsertsvadze, A (2011) Universal school-based prevention programs for alcohol misuse in young people. Oxford: Cochrane Collaboration Wiley. Issue 5. Art. No.: CD009113. DOI: 10.1002/14651858.CD009113.	53	Unspecified students aged 18 years or younger	Yes – Most common effect was on binge drinking and drunkenness. Certain generic psycho social and developmental programmes are effective and should be considered in policy ‘Lifeskills, Unplugged and Good Behaviour Game’.

Foxcroft, D.R and, Tsertsvadze, A (2011) Universal multi-component prevention programs for alcohol misuse in young people. Oxford: Cochrane Collaboration Wiley. Issue 9. Art. No.: CD009307. DOI: 10.1002/14651858.CD009307.	20	Unspecified	No – 12 out of 20 programs evidenced some effect for multiple component interventions however there is little evidence that these are more beneficial than single interventions.
Foxcroft, D. R; Moreira, M.T; Almeida Santimano, N.M.L and Smith, L.A (2015) Social norms information for alcohol mis-use in university and college students. Oxford: Cochrane Collaboration Wiley. Issue 12. Art. No.: CD006748. DOI: 10.1002/14651858.CD006748.pub4.	70	44,958	No – Low to moderate effect of intervention as no sustained benefits obtained from social norms interventions at 4-5 months.
Foxcroft D.R; Coombes L; Wood S; Allen D; Almeida Santimano N.M.L andMoreira M.T (2016) Motivational interviewing for the prevention of alcohol misuse in young adults. Cochrane Database of Systematic Reviews Issue 7. Art. No.: CD007025. DOI: 10.1002/14651858.CD007025.pub4.	84	22,872	No – Small or borderline effects that motivational interviewing reduced alcohol consumption, frequency, or related offences at 4 month and 12-month follow-up in study population aged 15-24.
Gates, P.J; Sabioni, P; Copeland, J; Le Foll,B and Gowing, L (2016) Psychosocial interventions for cannabis use disorder. Oxford:	23	4045	No – results unclear with little generalisability. Rates of abstinence low or unstable although psychosocial interventions do reduce frequency

Cochrane Collaboration Wiley. Issue 5. Art. No.: CD005336. DOI: 10.1002/14651858.CD005336.pub4.			and severity of use in short term. Intensive Motivational Enhancement Therapy and Cognitive Enhancement Therapy (4) with abstinence based incentives most supported.
Gates, S; Smith, L.A and Foxcroft, D (2008) Auricular acupuncture for cocaine dependence. Oxford: Cochrane Collection Wiley. Issue 1. Art. No.: CD005192. DOI: 10.1002/14651858.CD005192.pub2.	7	1433	No evidence as poor-quality studies using 3,4 or 5 of the recommended acupuncture points. Requires further research.
Gowing, L; Ali,R and White, J.M (2010) Opioid antagonists under heavy sedation of anaesthesia for opioid withdrawal. Oxford: Cochrane Collection Wiley. Issue 1. Art. No.: CD002022. DOI: 10.1002/14651858.CD002022.pub3.	9	1109	No – the risk of adverse effects with heavy sedation, high monetary cost, lack of intensive care beds and lack of benefit mean the value of antagonist induced withdrawal is not supported.
Gowing, L; Farrell, M.F; Bornemann, R; Sullivan, L.E and Ali,R (2011) Oral substitution treatment of injecting opioid users for prevention of HIV infection. Oxford: Cochrane Collection Wiley. Issue 8. Art. No.: CD004145. DOI: 10.1002/14651858.CD004145.pub4.	38	12,400	Yes – reduces HIV transmission as significantly reduces injecting drug use, sharing of injecting equipment, multiple sex partners, sex for drugs or money has little impact on condom use. However, the studies were poorly controlled for bias.
Indave, B.I; Minozzi; S; Pani, P.P and Amato, L (2016) Antipsychotic medications for cocaine	14	719	Major limitation of data is the numbers of people who withdrew from the studies and reporting.

dependence. Oxford: Cochrane Collection. Issue 3. Art. No.: CD006306. DOI: 10.1002/14651858.CD006306.pub3.			
Klimas, J; Tobin, H; Field, C.A; O'Gorman, C.S.M; Glynn, L,G; Keenan, E; Saunders, J; Bury, G; Dunne, C and Cullen, W (2014) Psychosocial interventions to reduce alcohol consumption in concurrent problem alcohol users and illicit drug users. Oxford: Cochrane Collaboration Wiley. Issue 12. Art. No.: CD009269. DOI: 10.1002/14651858.CD009269.pub3.	4	594	No – Could not answer question as could not combine study results owing to low quality evidence. Of interest because increases risk of Hepatitis C Virus progression and opiate over dose. Uncertain if talking therapies impact people primarily drinking or using drugs. More research needed.
Leone, M.A; Vigna-Taglianti, F; Avanzi, G; Brambilla, R and Faggiano, F (2010) Gamma-hydroybutyrate (GHB) for the treatment of alcohol withdrawal and prevetion of relapse. Turin: Cochrane Collaboration Wiley. Issue 2. Art. No.: CD006266. DOI: 10.1002/14651858.CD006266.pub2.	13	648	No – Not enough evidence to determine whether GHB is more effective than placebo or other medication. Most commonly reported side effects in higher doses, dizziness, and vertigo. Potential for addiction requires careful medical supervision.
Liu, L and Wang L.N (2015) Baclofen for alcohol withdrawal syndrome. Beijing: Cochrane Collaboration. Issue 4. Art. No.: CD008502. DOI:	2	81	No – Insufficient, low quality evidence on usefulness of Baclofen for alcohol withdrawal syndrome although one study reported on safety data and found no side effects with either

10.1002/14651858.CD008502.pub4.			Baclofen or Diazepam. Requires further research.
Marshall, K; Gowing, L; Ali, R and Le Foll, B (2014) Pharmacotherapies for cannabis dependence. Oxford: Cochrane Collaboration. Issue 12. Art. No.: CD008940. DOI: 10.1002/14651858.CD008940.pub2.	14	958	No – Evidence quality was downgraded as weak. Current treatment with antidepressants, atypical antidepressants, anxiolytics and norepinephrine reuptake inhibitors of little value. Tetrahydrocannabinol (THC) should be considered but little evidence currently.
McQueen; J; Howe, T,E; Allan, L; Mains, D and Hardy, V (2011).Brief interventions for heavy alcohol users admitted to hospital wards. Oxford: Cochrane Collaboration Wiley. Issue 8. Art. No.: CD005191. DOI: 10.1002/14651858.CD005191.pub3.	14	4041	Yes – benefits in relation to reductions in alcohol use and death rates. Mostly male and further research needed.
Minozzi, S; Amato, L; Vecchi, S and Davoli, M (2010) Anticonvulsants for alcohol withdrawal. Rome: Department of Epidemiology Rome. Cochrane Collaboration Wiley.	56	4076	No – Insufficient evidence that anticonvulsants are beneficial for alcohol withdrawal syndrome however in 3 studies (262 participants) carbemazipine may be more beneficial than benzodiazepines. Needs more research and larger scale studies.
Minozzi, S; Amato, L; Vecchi, S; Davoli, M; Kirchmayer, U and Verster, A (2011) Oral naltrexone as maintenance treatment to prevent relapse in opioid addicts who have	13	1158	No – Oral naltrexone not superior to placebo or other agents e.g. benzodiazepines and buprenorphine in preventing re-incarceration. Poor retention rates in studies of 28%.

undergone detoxification.			
Minozzi, S; Amato, L; Bellisario, C; Ferri, M and Davoli, M (2013) Maintenance treatments for opiate-dependent pregnant women. Oxford: Cochrane Collection Wiley.	4	271	Few differences found comparing buprenorphine, methadone or slow release morphine given from 23 weeks gestation until delivery. Methadone appears to increase treatment retention whilst buprenorphine causes less neonatal abstinence syndrome. Body of evidence too small.
Minozzi, S; Amato, L; Bellisario, C and Davoli, M (2014) Detoxification treatments for heroin dependent adolescents. Oxford: Cochrane Collection Wiley.	2	190	No – Increasing numbers of 13-18 years old using heroin. Results limited by the small number of studies. One trial suggested trends favouring buprenorphine over clonidine for reducing dropout but no difference in duration and severity of withdrawal symptoms.
Minozzi, S; Amato, L; Bellisario, C and Davoli, M (2014) Maintenance treatment for opioid dependent adolescents. Oxford: Cochrane Collection Wiley.	2	187	No – as difficult to compare with 2 trials alone, and the ethical issues of young people. Studies comparing maintenance with detox or psychosocial interventions required to be undertaken prior to any on pharmaceutical interventions. Plus, longitudinal studies considering outcomes are urgently needed.
Minozzi S; Cinquini, M; Amato, L; Davoli, M; Farrell, M.F; Pani, P.P and Vecchi, S (2015) Anticonvulsants for cocaine dependence.	20	2068	No evidence in moderate quality data owing to poor reporting and selection bias, needs further research.

Oxford: Cochrane Collection Wiley.			
Amato, L; Minozzi, S; Pani, P.P; Solimini, R; Vecchi, S; Zuccaro, P and Davoli, M (2015) Dopamine agonists for the treatment of people who misuse cocaine. Oxford: Cochrane Collection.	24	2147	Unsupported so permits consideration of possible beneficial and possible adverse effects or perhaps in combination with psycho social intervention.
Minozzi S; Saulle, R; De Crescenzo, F and Amato, L (2016) Psychosocial interventions for psychostimulant misuse. Oxford: Cochrane Collection WIley.	52	6923	Moderate evidence that improves adherence to end of intervention, reducing dropout and longest period of abstinence but not overall in terms of relapse.
Muckle W; Muckle J; Welch, V and Tugwell, P (2012) Managed alcohol as a harm reduction intervention for alcohol addiction in populations at high risk of substance abuse. Ottawa: University of Ottawa, Cochrane Library Wiley.	0 (22 articles relevant but excluded)	0	No – Insufficient evidence. Difficult to develop measures of success, establishing long term efficacy and causal relationships. Lack of reviews needs further work yet to be evidenced by systematic or other review.
Nielsen S; Larance, B; Degenhardt, L; Gowing, L; Kehler, C and Lintzeris N (2016) Opioid agonist treatment for pharmaceutical opioid dependent people. Cochrane Collection Wiley.	6	607	Low to moderate quality evidence. Methadone and buprenorphine both equally effective. Maintenance with buprenorphine appears more effective than detoxification or psychological treatments.
Pani, P.P; Trogu, E; Vacca, R; Amato, L; Vecchi, S and Davoli M (2010). Disulfiram for the treatment of cocaine dependence. Oxford:	7	492	Trends for fewer dropouts from treatment but not statistically significant.

Cochrane Collection.			
Pani, P.P; Trogu, E; Vacca, R; Amato, L; Vecchi, S and Davoli M Antidepressants for cocaine abuse and dependence. Oxford: Cochrane Collection Wiley.	37	3551	No evidence for primary outcomes or use as a mainstay for treatment, although do have expected results on mood and associated secondary outcomes e.g. depression.
Pani, P.P; Trogu, E; Pacini, M and Maremmani, I (2014) Anticonvulsants for alcohol dependence. Pisa: University of Pisa, Cochrane Collection Wiley.	25	2641	No – Insufficient evidence for use due to low numbers. 17 placebo trials showed anti-convulsant treatment was more effective in relation to number of drinks and heavy drinking. However not clear if enhances abstinence and lack of evidence on known and reported side-effects.
Perez-Mana, C; Castells, X; Torrens, M; Capella, D and Farre, M (2013) Efficacy of psychostimulant drugs for amphetamine abuse or dependency. Oxford: Cochrane Collaboration Wiley.	11	791	No – 4 psychostimulants used in addition to psychosocial intervention were not found to either reduce cravings or increase abstinence compared to placebo. Further trials needed, longer than 8-20 weeks duration.
Perry, A.E; Neilson, M; Martyn-St James, M; Glanville, JM; Woodhouse, R; Godfrey, C and Hewitt C (2015) Interventions for drug-using offenders with co-occurring mental illness. Oxford: Cochrane Collection Wiley.	8	2058	No – Lack of clear reporting and too much variation, although 2 studies showed some benefit for therapeutic communities and aftercare. Needs further study.
Perry, A.E; Neilson, M; Martyn-St. James, M;	9	1792	3 out of 9 studies showed positive trends in

Glanville, J.M; McCool, R and Duffy, S (2015) Interventions for female drug-using offenders. Oxford: Cochrane Collection Wiley.			reducing reincarceration but not drug use or arrest rates. Need studies with better description of treatment modalities and to identify important aspects for female offenders who use drugs.
Perry, A.E; Neilson M, Martyn-St James, M; Glanville, J.M; Woodhouse, R; Godfrey, C and Hewitt, C (2015) Pharmacological interventions for drug-using offenders. Oxford: Cochrane Collection Wiley.	14	2647	Small number of studies with high levels of bias. Mixed results in not reducing drug use but showing an effect on criminal activity with no significant difference between methadone, buprenorphine, diamorphine, or naltrexone.
Rosner, S; Hackl-Herrwerth, A; Leucht, S; Lehert, P; Vecchi, S and Soyka, M (2010) Acamprosate for alcohol dependent patients. Munich: University of Munich Cochrane Library Wiley.	24	6915	Yes – in 3 studies no difference when compared with Naltrexone for return to any/ heavy drinking or cumulative abstinence duration. Safe and effective for supporting abstinence from alcohol after detoxification. Benefit increases when used with psychosocial intervention, reduces risk of returning to drinking.
Rosner, S; Hackl-Herrwerth, A; Leucht, S; Lehert, P; Vecchi, S; Srisurapanont, M and Soyka, M (2010). Opioid antagonists for alcohol dependence. Oxford: Cochrane Collaboration Wiley.	50	7793	Yes – Naltrexone taken over a three-month period assisted in reduction of alcohol intake. Nalmefene data too sparse for commentary.
Sarai, M; Tejani, A.M; Chan, A.H; Kuo, I.F and Li, J (2013) Magnesium for alcohol	4	317	No – Insufficient data/detail/information on benefits or harms of using magnesium

withdrawal. Vancouver: University of British Columbia Cochrane Collection Wiley.			supplementation. Low levels of magnesium occur in many with alcohol withdrawal syndrome leading to suggestion that this causes ‘hyperexcitability’ and many of the symptoms of alcohol withdrawal syndrome.
Siegfried, N; Pienaar, D.C; Ataguba, J.E; Volmink, J; Kredo, T; Jere, M and Parry C.D.H (2014). Restricting or banning the advertising of alcohol to reduce alcohol consumption in adults and adolescents. Oxford: Cochrane Collection Wiley.	4	80	No clear effect, low quality of evidence 3 interrupted time series studies conducted in Canada 1970’s/80’s. Randomised control trial in Netherlands.
Smedslund, G; Berg, R.C; Hammerstrøm, K.T; Steiro, A; Leiknes, K.A; Dahl, H.M and Karlsen, K (2011) Motivational interviewing for substance abuse. Oxford: Cochrane Collection Wiley.	59	13,342	Yes – people who received motivational interviewing reduced substance use more than those who did not. However, motivational interviewing seems to be as effective as active treatment, treatment as usual or feedback. Not enough data on MI to report on.
Terplan, M; Ramanadhan, S; Locke, A; Longinaker, N and Lui S (2015) Psychosocial interventions for pregnant women in outpatient illicit drug treatment programs compared to other interventions. Oxford: Cochrane Collection Wiley.	14	1298	No difference when motivational interviewing undertaken within comprehensive care. However, no studies evaluated obstetric or neonatal outcomes making it difficult to assess the outcomes of psychosocial interventions. Needs further detailed study.

Thomas RE, Thomas, R.E; Lorenzetti, D and Spragins, W (2011) Mentoring adolescents to prevent drug and alcohol use. Oxford: Cochrane Collection Wiley.	4	1194	Deprived and minority people including a cohort whose parents are people living with HIV. In 2 studies mentoring reduce alcohol initiation and in one it reduced drug use initiation. The authors note that the studies looked at formal programmes whereas most mentoring is informal and therefore unreported.

Structured literature search methodology

This passage provides a brief summary of the processes followed to support this Appendix.

The literature search began with a structured database analysis. The following eleven databases were identified as most likely sources of information for specific studies, Randomised Controlled Trials (RCTs) or systematic reviews of interventions: Campbell Collaboration, CRD (York) Reviews, Cochrane Collection Systematic Review Database, DARE, Drug and Alcohol Findings Effectiveness Bank, European monitoring Centre for Drugs and Drug Addition (EMCDDA), Health Technology Assessment (HTA), NHS Economic Evaluation Database (NHS-EED), National Institute for Health and Care Excellence (NICE), Prospero and Public Library of Science (PLoS).

Initial searching was undertaken using key reference terms Wales or Welsh in addition to substance use related ones. But yields were non- specific. Unfortunately, very little documentation was returned referring exclusively to Wales. The most frequently cited were Home Office related UK documents; studies pertaining to New South Wales in Australia; or the surname Welsh. This led to the search strategy being again modified to look for well evidenced systematic reviews.

For this database review, searching was confined to 2010-2016, to overlap that from the previous evaluation, and to capture activity for the decade 2010-2020.

The search terms used were: 'Wales, Welsh-Government, alcohol, substance-use, substance-misuse, illicit-drugs, illegal-drugs, heroin, cocaine, cannabis, tobacco, NPS, overdose, harm/s, injecting, risk, ethanol, mental health, children, community/communities, safety, blood-borne viruses, drug-education, health-improvement, drug-sentencing, drug-crime, drug-prisoners'. When consistent poor yield was apparent, the search was simplified to the following to find exclusively Welsh studies: 'Wales+ Welsh+ substance +misuse+ strategy+ policy'. Resultant yield was again non-specific. And then repeated without reference to Wales or Welsh.

The process was then added to with a more journalistic approach of either specific tailored searches across academic and internet sources and/or the use of material already known to the team by dint of relevant prior experience.

In summary, the literature element of the data evidence acquisition can be described as comprehensive or structured but not systematic, which is consistent with the overall methodology and limitations of the commissioned size of the review.

6. Appendix G – Gaps in Data

Contribution analysis requires that logic models are then tested against data, and where there are gaps in available evidence these are highlighted. The following are suggested as the principle areas in which it was hard to find firm evidence.

6.1 Research from within Wales finding its way into international 'substance use' journals'

We have highlighted in **Appendix F** how there was very little evidence of this in our search of systematic trial related data. Another example of this is that in a search of Addiction Journal for the term Wales in the abstract for all articles between 2007-2017 found 33 relevant articles; 17 referred to New South Wales in Australia, 14 were of wider UK research and database sets and only 2 were Welsh specific. These two were of night time economy and smoking cessation rather than of the harmful using treatment seeking population that is the focus of the strategy. While there are many ways to ensure that research has an impact, and indeed in can be argued that busy practitioners struggle to stay up to date with current academic journal material, it nonetheless feels important that much of the treatment research activity within Wales ought to be additionally validated by the peer review process related to such publications. This suggests a need for those in Wales responsible for supporting the research agenda to more actively encourage this activity.

6.2 Outcome rather than output data for prevention activity

The lack of provision for measuring outcomes within the strategy was noted in the Bennet et al (2013)[34] evaluation and by Roberts (2016).[35]

[34] Bennett, T. et al. (2013) Evaluation of the Implementation of the Substance Misuse Strategy for Wales. Welsh Government. Available at: http://gov.wales/docs/caecd/research/130610-evaluation-implementation-substance-misuse-strategy-en.pdf.

[35] Roberts, H. (2016) Misuse of prescription and over-the-counter medications. Cardiff, National Assembly for Wales. http://www.assembly.wales/research%20documents/16-

This was especially scarce for the Welsh schools related projects. Much of the data set and evaluation reports is activity experience or end of intervention data, rather than that which demonstrates an impact on subsequent consumption behaviour. It is imperative that such monitoring and evaluations include long term follow up data to be able to establish any changes in future use patterns. We have already highlighted in **Appendix F**, especially with regards to Foxcroft and Tsertsvadze (2012)[36], that Cochrane review some of the ambivalent and inconclusive evidence for these approaches. Champion et al (2013)[37] and Midford (2010)[38] highlight the limitations of these whole young peoples' population social influence approaches, suggesting they have varying degrees of success. These studies suggest that energies would be more usefully spent on targeted and harm reduction activities, including the use of computer or internet based approaches.

6.3 Individual rather than agency orientated outcome data

We have already applauded the progress in output and agency activity related data. The adoption of Treatment Outcome Profile System (TOPS) and other outcome data is an additional step in the right direction. Further changes to Welsh National Database for Substance Misuse (WNDSM) that allow individual pathways (of unique individual user id) through multiple treatment interventions, from multiple providers, are to be welcomed. However, none of this yet fully matches with the newer, longer term policy and strategic directions of recovery and well-being, which are much more emerging and embryonic dialogues, as reflected in the recent (2016) special edition (7:3) of the Canadian Journal of Addiction.[39]

039%2016-039%20-%20addication%20to%20over%20the%20counter%20prescriptions/16-039-web-english.pdf

[36] Foxcroft, D. R. and Tsertsvadze, A. (2012), Cochrane Review: Universal school-based prevention programs for alcohol misuse in young people. Evidenced. -Based Child Health, 7: 450–575.

[37] Champion K, E, Newton N,C, Barrett E, L, and Teesson M. (2013) A systematic review of school-based alcohol and other drug prevention programs facilitated by computers or the Internet. Drug Alcohol Review 32:115-123

[38] Midford, R. (2010), Drug prevention programmes for young people: where have we been and where should we be going?. Addiction, 105: 1688–1695.

[39] http://www.csam-smca.org/canadian-journal-of-addiction/

Treatment outcome effectiveness, right back to the US originator of the 1969 Drugs Abuse Reporting Program (DARP)[40], and its successors of Treatment Outcome Prospective Study and Drug Abuse Treatment Outcomes Studies, clearly demonstrates treatment (intensive and repeated interventions) to make a difference. The preoccupation here is with the effectiveness of treatment or agency activity against key substance use (and crime) related measures. There should be no surprise of the demonstration of this effectiveness for these outcomes – this has already been proven through the peer review research and trials that led to such treatment formulation, and is the whole raison d'etre of evidenced based practice. Indeed, Franey and Ashton (2002)[41] neatly summarise what is known to work and Orford (2008)[42] has signalled the extent and limitations of these paradigms. Simply put we know treatment works.

Thus, it can be argued that the current use of outcomes measures has become more of an exercise in accountability and monitoring than it is really contributing to what is really making a long term (outcome) difference to individuals lives. The measures in TOPS while capturing some health and social functioning, still do so with this older narrow treatment interpretation in mind rather than all the concerns of the individual. Further they only suggest an improvement in functioning and offer no exploration of why, so therefore assume a correlation with treatment, even if brought about by some other life event. Indeed, no real participant led research has yet taken place to establish what users might determine as long term meaningful recovery outcomes and how these might best be measured.

Sustained lifestyle or recovery outcomes are only truly measurable over the long term and after treatment has ended. So, say, at a minimum of twelve months, if not two or five years, down the line (indeed DARP had a twelve year follow up) and would suggest the need to compliment outcomes designed to measure agency effectiveness with those that result in individual sustained lifestyle changes. So, the adoption of more routine follow-up data,

[40] Simpson, D. D. & Sells, S. B. (Eds.). (1990). Opioid addiction and treatment: A 12-year follow-up. Malabar, FL: Krieger
[41] Franey, C and Aston, M. (2002) The grand design lessons from DATOS. Findings Issue 7. http://www.datos.org/DATOS-FINDINGS.pdf
[42] Orford, J. (2008) (op cit)

something much more like NTORS. More typically current guidance mandates the use of processes like TOPS at treatment start, review and exit, but any suggestions of follow up use are only advisory rather than compulsory.

Intrinsic to this conversation then, and implied in the adoption of contribution analysis, is the difficultly that the more we use the recovery (say return of senses) or well-being (say feeling valued member of society) outcomes, the harder it is to correlate them with any substance use intervention activity or distinguish the contribution of this from say culture or economic change, (and or other government policy). Despite this obvious limitation it seems important moves are made to capture more comprehensive and nuanced set of longitudinal data which looks at individual sustained lifestyle in addition to demonstrating intervention effectiveness, and ask of users what they perceive as having made a difference.

6.4 Other potential gaps

The above three gaps relate to the two key areas of harm reduction and treatment, where overall there is substantive activity, output and outcome data. It is much harder to provide comprehensive comment, within a substance misuse specific review, on broader economic, health and social outcome measurements.

In this context, the challenge of establishing effective outcome measures for whole population wellbeing is not the sole preserve of substance misuse policy makers and service providers. This implies the need for the development of new, longitudinal data measurement tools rather than gaps in the existing data collection sphere.

7. Appendix H – Academic Discourse on Policy Influences

As highlighted in **section 8.4** of the main report, there are considered to be a significant number of external influences that shape policy responses. The review has also identified that a comprehensive analysis of influences is beyond its scope, and has given indicative examples. Many of these considerations have also been subject to academic discourse, of which the following list is a representation of some of that debate:

- Alcohol and Public Policy Group. (2010) Alcohol: No Ordinary Commodity – a summary of the second edition, Addiction 105(5): 769-779.
- Babor T,F and Robaina K. (2103) Public health, academic medicine, and the alcohol industry's corporate social responsibility activities. American Journal of Public Health. 103(2):206-214.
- Bakke O, and Endal D. (2010) Vested interests in addiction research and policy alcohol policies out of context: Drinks industry supplanting government role in alcohol policies in sub-Saharan Africa. Addiction. 105(1):22-28.
- Jernigan D, H. (2012) Global alcohol producers, science, and policy: The case of the international center for alcohol policies. American Journal of Public Health. 102(1):80-89.
- Hawkins B, Holden C, and McCambridge J. (2012) Alcohol industry influence on UK alcohol policy: A new research agenda for public health. Critical Public Health. 22(3):297-305.
- Hawkins B, and Holden C. (2013) Framing the alcohol policy debate: Industry actors and the regulation of the UK beverage alcohol market. Critical Policy Studies. 7(1):53-71.
- McCambridge J, Hawkins B, and Holden C. (2014) Vested interests in addiction research and policy: The challenge corporate lobbying poses to reducing society's alcohol problems: Insights from UK evidence on minimum unit pricing. Addiction.109(2):199-205.
- Stenius K, and Babor T, F. (2010) The alcohol industry and public interest science. Addiction. 105(2):191-198.