healthwatch Swindon

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Bridging the Gap: Substance use, discharge and what comes next

Neighbourhood health and wellbeing insights – May 2026

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Executive summary

This project aims to make hospital discharge safer and more supportive for patients. It focuses on the experiences of adults who use substances and listens to what they say about their care. Their views help show where services can work better together and where support could be stronger when people leave hospital.

The work has been shaped by service users and partner organisations. Their input highlights current challenges and shows where the system could improve, while also recognising the important work done by health and social care staff.

This summary gives an overview of the main points. More detail, including full findings and recommendations, can be found in the main report.

Key findings

People told us that the current discharge process often does not meet the needs of those dealing with substance use, withdrawal, trauma, or difficult social circumstances. Gaps in communication, stigma, and rigid clinical processes can lead to avoidable harm, people leaving hospital early, and repeated crisis admissions. Staff accounts closely matched what service users described.

Discharge as a point of system failure

- Discharge can be rushed, poorly planned, and especially risky at weekends.
- Medication, transport, and follow-up arrangements are often missing.
- Communication between hospital teams, GPs, CGL, and accommodation providers is inconsistent.
- No one is clearly responsible for ensuring a safe transition, meaning people easily "Slipping through the net."

Stigma and erosion of relational care

- People feel judged or dismissed because of their substance use.
- This leads to avoidance of care or leaving hospital before treatment is complete.
- When staff provide trauma-informed, respectful care, it makes a significant positive difference – but this is not consistent.

Medication disruption as a clinical risk

- Frequent interruptions to opioid substitution treatment and alcohol detox cause withdrawal, distress, and self-discharge

- Delays, rigid rules, and poor coordination make these problems worse.
- Flexible, person-centred prescribing improves safety but is not routine.

Advocacy as a protective factor

- Advocates help people feel heard, improve communication, and reduce risk.
- Currently inconsistent and reliant on individual relationships
- When advocacy is missing, people are more likely to return in crisis or be re-admitted.

Summary of key recommendations

Current hospital pathways expose people with substance use and social vulnerabilities to avoidable harm, unsafe discharge, disrupted medication, stigma, and inconsistent advocacy –driving disengagement and repeat admissions.

Standardise safe discharge

- Treat discharge as a coordinated transition of care, not a bed-driven event
- Avoid unsafe timing unless medication, transport, follow-up, and accountability are in place
- Use joint planning, warm handovers, and early follow-up after leaving hospital

Embed trauma-informed, anti-stigma care

- Make reducing stigma a core part of clinical practice
- Prioritise respectful, relational care over surveillance or judgement.
- Set clear expectations for communication and accountability

Make medication continuity a patient safety priority

- Review opioid substitution treatment and alcohol detox prescribing so it consistently follows the standards as set out by the Orange Book government guidelines.
- Medication protocols communicated to patients.
- Hospital teams should coordinate with community services, primary care and public health to support safe consistent prescribing.

Embed advocacy as a core safety function

- Formalise and resource advocacy roles across hospital and community settings
- Ensure advocates are involved early, especially at high-risk points like A&E, admission, and discharge.

- Provide named contacts, clear escalation routes, and proper resourcing.

Substance use care continuity checklist

To help put these recommendations into action, we suggest using a checklist (within the full report). This checklist will help make care safer for patients, improve fairness and fix problems in the current pathway.

Impact

The adoption of an operational checklist and implementation of our recommendations will deliver:

- Fewer unsafe discharges and medication-related harms
- Improved engagement and treatment completion
- Reduced self-discharge, crisis presentations, and re-admissions
- Safer, more equitable care for a high-risk population

The evidence shows that the current system does not reliably provide safe or effective discharge for adults who use substances. Problems such as unsafe discharge, disrupted medication, stigma, and lack of advocacy are not isolated incidents – they are systemic. Both service users and professionals agree that better outcomes are possible when care is coordinated, trauma-informed, and person-centred. Implementing these recommendations would create a safer, more consistent discharge process and improve long-term outcomes for a highly vulnerable population.

I just want care that feels kind.

Statement from our CEO

Bridging the Gap: Listening, learning and acting on what people told us

Too many people who use drugs or alcohol leave hospital feeling unsupported, unheard and unsafe. Our **'Bridging the Gap' report** brings together the voices of people in Swindon with lived experience of hospital discharge, alongside the professionals who support them, to shine a light on what happens in those critical moments when care transitions from hospital back into the community.

Given the stigma that people in this community face, I want to say a huge thank you for coming forward and sharing your experiences. We hope we can influence change for you.

What these people shared with us was honest and, at times, deeply unsettling. Discharge was often described as rushed, confusing and poorly coordinated particularly when it came to medication, follow-up care and basic practical support.

Experiences of stigma, judgement and inconsistent communication were common, leaving many reluctant to seek help again, even when seriously unwell. Yet alongside this, people also told us about moments of compassion, flexibility and kindness. These are reminders that safer, more humane care is not only possible, but already happening in pockets of the system.

This report is not about blaming individuals or services working under immense pressure. Instead, it highlights how systemic gaps in communication, coordination and accountability can create avoidable harm for people with complex needs. It makes clear that discharge is not a single event, but a process – one that requires shared responsibility, trauma-informed practice, continuity of medication and meaningful follow-up.

'Bridging the Gap' is a reflection that things can be done differently and that when compassion is felt, people feel heard and their experiences of services improve. By embedding compassion and coordinated planning into everyday care, we have an opportunity to reduce crisis, prevent harm and rebuild trust.

As we move into an uncertain time within Healthwatch, this report perfectly highlights the need for an independent voice within system change and how removing this approach may leave people, like the ones who came forward to speak with us in this report, less empowered and even more vulnerable to poor quality of care.

- **Kevin Peltonen-Messenger, CEO of TCF (provider of Healthwatch Swindon)**

Glossary

Stigma:

A socially constructed process in which people with substance use disorders are labelled, devalued, and subjected to discriminatory assumptions, leading to exclusion and unequal treatment.

Change Grow Live (CGL):

A health and social care charity providing free, confidential support related to drug and alcohol use, smoking, homelessness, justice and probation, and employment. Read more: www.changegrowlive.org/

Booth House:

Accommodation for adults experiencing homelessness with a connection to Swindon, delivered in partnership with Swindon Borough Council. The service supports people with medium to high needs through its Housing Pathway programme, including access to substance use, debt, health, and wellbeing support. Read more: www.salvationarmy.org.uk/booth-house-swindon

The Nelson Trust:

A specialist charity supporting women and families affected by addiction, trauma, and multiple disadvantage through gender-responsive residential treatment, community support, and trauma-informed women's centres. Read more: www.nelsontrust.com/

Community Services:

Refers to the organisations supporting participants in this project, including CGL, Booth House, and The Nelson Trust.

SBC:

Swindon Borough Council.

Discharge:

The transition from acute or emergency care back into the community, including A&E episodes where individuals are treated and sent home without admission. In this report, the discharge journey begins before hospital entry and continues after leaving, encompassing follow-up care, medication continuity, and re-engagement with community services.

Substance use:

Consumption of psychoactive drugs or alcohol that produces physiological or psychological effects, ranging from occasional use to patterns associated with harm or dependence.

Scripts:

Prescribed medications –such as opioid substitution treatments or other controlled drugs –issued to support withdrawal management, stabilisation, or dependence treatment.

OST:

Opioid Substitution Treatment, involving prescribed opioid-based medications (e.g., methadone, buprenorphine) to stabilise dependence, reduce withdrawal, and support engagement with treatment.

GWH:

Great Western Hospital.

Introduction

About Healthwatch

Healthwatch is the independent voice of the patient. We listen to peoples' experiences of health and social care services to feedback how to improve them. Healthwatch uses your feedback to better understand the challenges facing the NHS and other care providers and we make sure your experiences improve health and care for everyone – locally and nationally. We can also help you to get the information and advice you need to make the right decisions for you and to get the support you deserve.

Support for this project

Thank you to all the service users and organisations who contributed to this project. Your insights, experiences and support have been essential in shaping our work. Throughout this process, we witnessed the dedication, compassion and commitment shown by those supporting people who use substances.

We are deeply grateful to the following organisations and teams for their involvement: Booth House, The Nelson Trust, CGL, Department for Work and Pensions, Sexual Health, Hepatology, Public Health and the SBC Safeguarding Team.

Although this project highlights opportunities to strengthen support for people who use substances, we want to emphasise that our role has been to amplify the voices of those we spoke with. Whilst we endeavoured to speak to every professional team involved with the discharge of patients, we could only engage with those who elected to participate.

Our aim is to help move towards a system that best meets their needs. We recognise, appreciate and respect the vital work carried out every day across the health and social care system.

Background

The World Health Organization highlights the urgent need to accelerate progress toward Sustainable Development Goal target 3.5, which aims to strengthen the prevention and treatment of substance abuse disorders.

> *"Substance use severely harms individual health, increasing the risk of chronic diseases, mental health conditions, and tragically resulting in millions of preventable deaths every year, while placing a substantial burden on families, communities, and health systems" (WHO, Dr Tedros Adhanom Ghebreyesus).*

In England and Wales, overall substance use has declined from 9.4% in 2020 to 8.7% in 2024, yet drug-related mortality has reached record levels, with 5,565 drug poisoning deaths reported in 2024. This divergence between prevalence and mortality signals persistent weaknesses in the health and social care system, particularly during periods of acute illness and transition between services.

In 2016 the government guidance regarding health matters and preventing drug misuse deaths estimates a cost of £10.7 billion a year to society, 8% of which is on health services. Alongside this, alcohol-related harm was estimated to cost the NHS a further £3.5 billion each year. This was further updated following the Dame Carol Black review in 2020, whereby the overall societal impact of drugs is reported to be £19.3 billion for 2017-18, with drug related deaths accounting for £6.3 billion. Taken together, these figures show not just escalating financial pressure on the NHS but a trajectory of harm that is accelerating faster than policy responses.

Combined with Swindon's Joint Strategic Needs Assessment (JSNA) indicating drug related hospital admissions 2020-21 to be 83 per 100,000 compared to England's average of 50.22 per 100,000. And a much higher rate for alcohol specific admissions with 644 hospital admission per 100,000 population. Support and improved access for people identified as using substances has never been more critical.

Hospitals represent a critical point of contact for people who use drugs and alcohol, who experience disproportionately high rates of emergency admission for chronic conditions, injuries, and infections. Frequent attenders often accumulate substantially longer inpatient stays and present with complex medical, psychological, and social needs that acute care services alone are not equipped to address. Despite the importance of this juncture, hospital experiences are frequently shaped by undertreated withdrawal, inadequate pain management, behavioural restrictions, stigma, and premature self-discharge, all of which contribute to disrupted care and repeated admissions.

Continuity of care is further undermined by fragmented pathways between hospitals and community services. Barriers to information-sharing, limited awareness of available support, and barriers to accessing specialist substance use services are repeatedly identified as structural weaknesses. These gaps are particularly dangerous for people who use illicit opioids. The risk of fatal overdose increases four-fold in the 48 hours following hospital discharge, and one in fourteen opioid-related deaths occur within two weeks of leaving an acute ward. Hospital policies and practices –such as delays in initiating opioid agonist therapy, poor management of pain and withdrawal, and stigmatising attitudes – contribute to what has been described as the "hospital risk environment," driving patient-directed discharge and impeding treatment completion. Loss of opioid or alcohol tolerance during admission, combined with inadequate substitution therapy and barriers to community services further heighten overdose risk after discharge.

Beyond the hospital setting, many individuals face substantial challenges that impede sustained recovery. Unmet basic needs –including secure housing, employment, and financial stability –are consistently identified as major barriers to maintaining abstinence. Social isolation, limited access to continuing care,

and poor coordination between inpatient and outpatient services further undermine treatment retention and increase relapse risk. These difficulties are often compounded by ongoing mental health problems, psychological distress, and the broader consequences of relationship breakdowns or financial strain during the transition back into the community.

This sentiment is echoed in our previous report, looking into how health outcomes for women with multiple unmet needs could be improved. With a need for clear, consistent provision and the gap between need and support to be reduced. These key factors are required to help solidify a relationship of trust with health and care providers so that individuals feel heard and outcomes are improved. With a reported 95% of respondents feeling early help services had failed them. And of the 65% reporting they had sought help for their substance use, but only 38% felt they received adequate support. With reports of being told "They said they didn't know what to do with me". Whilst this report focussed on the experiences of women, it highlights the need for clear and consistent information across the system. In particular, at critical points throughout the patient journey.

A person-centred, holistic, multi-agency approach is therefore essential. Evidence highlights the importance of predictable care, empowerment, and strong social support networks in reducing relapse risk and sustaining engagement. Although recent policy initiatives, such as the *From Harm to Hope* strategy, aim to strengthen the drug and alcohol treatment workforce and improve continuity of care, there remains limited evidence on how discharge planning and follow-up interventions are implemented in practice, particularly within hospital settings.

Infographic from OHID Health Matters: Call to action

Taken together, these findings suggest there is more to understand about how hospital discharge processes can best support people who use drugs and alcohol. To build on this, we aim to explore how post-discharge support systems can be strengthened to promote continuity of care and long-term recovery.

Our hope is to better understand the gaps that can emerge between inpatient care and community reintegration, and to use these insights to develop actionable recommendations for patients while also advocating for broader systemic improvements. By continuing to listen to people's experiences and the challenges they face, we can work towards more coordinated, person-centred approaches that reduce harm and support sustained recovery.

What we did

To build a detailed understanding of peoples lived experiences, we used a qualitative approach designed to capture in-depth accounts of what individuals had encountered. Although the primary focus was on people who use substances, we also recognised the crucial contribution of wider support services. Their insights and perspectives were essential for developing a comprehensive view of the system and shaping meaningful recommendations.

Eligible participants included individuals with lived experience of being discharged from hospital while using substances, whether currently or in the past. We also conducted professional interviews with anyone working in roles that support people who use substances.

Interviews with service users were carried out during engagement events at Booth House, The Nelson Trust, and CGL. Alongside this, we interviewed professionals who support this population and circulated an online survey to services experiencing winter pressures, ensuring they could still share their views. Both sets of interviews followed semi-structured guides developed in advance, drawing on commonly reported outcomes and issues identified in academic literature. All interviews were audio-recorded or documented in writing, then transcribed verbatim and anonymised for analysis.

Insights from these conversations informed the development of a semi-structured workshop guide, which was used to facilitate a series of workshops with service users. This step ensured that the emerging findings and recommendations were grounded in the voices of people with lived experience. During the workshops, participants were invited to:

- Identify what matters most for a good hospital discharge.
- Visualise the discharge experience and identify points that stood out as positive or negative.
- Co-create solutions and ideas for resources.

Data collection	Number of participants
Interviews with service users	9
Interviews with professionals	8
Online questionnaire with professionals	7
Workshop with service users	18 (plus 2 professionals who joined)

Drawing on all the data gathered, Thematic analysis was employed to examine the interview transcripts to uncover underlying ideas, assumptions, and ideologies shaping the data's content. We analysed the key insights and organised them into the themes presented below. We are grateful to the Healthwatch Swindon volunteers and a Healthwatch placement student for their support with data analysis and for offering additional perspectives to ensure our findings remained grounded in the evidence.

What we heard

Analysis of interviews with both service users and professionals revealed three overarching themes:

(1) Communication, coordination and ownership at discharge

(2) Stigma, Labelling and erosion of relational care

(3) Medication continuity, flexibility and risk

These shed light on the systemic, relational, and clinical factors shaping hospital experiences for people who use substances. Service users described in detail how structural gaps and interpersonal dynamics can combine to create avoidable harm, disengagement, and repeated cycles of crisis care. Professionals largely echoed these accounts, offering additional insight into organisational pressures and system-level fragmentation.

While all participants shared a broader range of experiences than those highlighted here, the primary aim of this project was to develop recommendations for improving care in Swindon. We therefore focused on the issues most frequently reported. Contact us to access the full data set.

Quotes indicate whether they were provided by a professional or a service user. No further identifying details are included, as neither service use nor professional role offers additional meaningful context and withholding this information helps protect confidentiality.

Communication, coordination and ownership at discharge

Across interviews and workshops, service users and professionals suggested discharge was a critical point in a patients care journey but shared how it commonly breaks down. Experiences were characterised by abrupt decision-making, limited planning, and an absence of coordination. These patterns created transitions that felt unsafe, poorly communicated, and disconnected from the realities of substance use, withdrawal, and social vulnerability.

Fragmented pathways:

Service users consistently described discharge as a moment where care "falls off a cliff," with many reporting that they were released "*with nothing*," "*no plan, support or ongoing care*," and little understanding of what would happen next.

"I just wanted someone to check on me and ask if I'm ok." (Service user)

These experiences were not limited to the point of discharge; several participants emphasised that gaps in care began from admission, noting an absence of continuity across the entire hospital pathway.

"No one asks what I need; I just wanted someone to check on me and ask if I'm ok." (Service user)

"No one's ever asked what you need… there has to be discussion and action." (Service user)

These accounts point to a systemic pattern of fragmented transitions rather than isolated incidents. Experiences of abrupt or unsafe discharge were common, with some individuals feeling as though they were being "*pushed out the door*" without consideration of their wellbeing.

"I didn't even get up to a ward… they just sent me on my merry way." (Service user)

Both service users and professionals highlighted the speed and unpredictability of discharge decisions. Ward rounds could result in individuals being told with minimal notice that they would be leaving – *"you'll be going home in an hour"* – leaving insufficient time to arrange medication, transport, or community follow up.

Poor timing further compounded these risks. Participants described being discharged late at night without safe transport, experiencing withdrawal, unclear about their treatment plan, still managing their original health issues.

"They just sent me on my merry way, and I've just been in a massive car crash with pleurisy." (Service user)

Such experiences illustrate how discharge decisions often fail to consider the cognitive and physical wellbeing of individuals, and environmental challenges associated with substance use. These accounts reveal how operational

pressures and institutional routines can inadvertently create unsafe discharge environments for people who use substances.

"You can't just look at the health needs – you have to look at the addiction side." (Service user)

Notably, participants did describe occasional positive experiences, such as being provided with clear information and funded transport. These examples demonstrate that safe and coordinated discharge is possible when communication and planning are prioritised.

"My discharge was great; they told me everything and paid for my taxi back to Booth House; I sent a thank-you card." (Service user)

Absent aftercare:

Concerns about discharge processes were closely linked to wider issues of poor coordination across the system. A recurring theme was the absence of meaningful follow-up.

'When they've discharged you, was there ever a plan?' – "Nothing. Never." "No Never" (Service user)

"there has to be discussion and action – you can't just talk to me about it." (Service user)

The most frequently cited gap related to mental health support. Despite the well-established vicious cycle between mental health and substance use, participants described being discharged without any follow-up for their psychological needs. Several service users explained that the lack of timely mental health support pushed them toward self-medication, as "it feels too late" to seek help. As one person put it.

"More trauma… vicious circle… can't deal with what goes on in your head… go to your only coping mechanism." (Professional)

"It's exhausting going from one service to another." (Service user)

Unclear responsibility for discharge planning further compounded these challenges. Service users described significant gaps in support around wider social determinants of health, particularly housing and basic social needs. Several people reported being discharged "back out onto the streets" without any practical support, reinforcing the perception that "they don't care if you've got no housing."

"They just discharge you back onto the streets… they don't help with housing." (Service user)

"Discharged in the middle of the night… got lost due to withdrawal." (Service user)

These experiences create additional complications for individuals already presenting with complex needs, leaving them to navigate unsafe or unstable circumstances immediately after discharge. The absence of coordinated planning not only undermines recovery but also increases the likelihood of further crises and re-admission.

"He was homeless and still sent him out on the street and within a month he was back in and had to have a drain put in and a rib removed. That's how bad he was, he literally had pneumonia." (Service user)

Although there were examples of effective follow-up, these were described as difficult to access and often dependent on individual advocates –such as community services, trauma-informed nurses, or family members –rather than the system itself. Outside of these cases, the most consistently positive follow-up experiences came from hepatology, sexual health, and maternity services.

"When it does happen it's great… everything goes amazingly well but too often it doesn't happen and it just causes chaos for the service users." (Professional)

Across accounts, both service users and professionals identified the lack of follow-up as a critical systemic gap. Service users repeatedly shared that *"no one ever checks back in"* while professionals acknowledged that people *"slip through the net"* when discharge planning is inconsistent or absent.

Breakdowns in communication extended beyond hospital teams and frequently involved gaps in communication with community services. When community teams were notified about a person's admission, discharge transitions tended to be more positive because preparations and support could be put in place.

"If everyone's communicating well… they feel quite nurtured when they leave" (Professional)

"When it comes to this person's being discharged today. Oh, they're going to need their prescription picking up" (Professional)

However, participants consistently reported that when community services were not informed –or were unaware that someone had been admitted –discharge experiences were worse. While both, we and participants recognise the pressure and workload faced by hospital teams, the inconsistency of communication was seen to directly contribute to negative outcomes. Professionals described fragmented communication links and delays while waiting for essential information before they could offer support.

"If they don't contact me by e-mail to let me know this person is in and leaving, then it falls down immediately. There's no other way of doing it." (Professional)

"There's no link there… I am now still waiting for that e-mail to come back… It's disjointed." (Professional)

Some community professionals also shared that even when communication pathways exist, their expertise is not always respected. They reported feeling stigmatised or dismissed, despite their longstanding relationships with service users and their role in providing ongoing support.

"Staff [Community service] need to be treated as professionals with the same courtesies as a qualified professional. Whilst not providing medical care, they know their clients well and can provide insight and knowledge to help aid individuals' treatment and recovery… Judgements are dismissed as not a qualified carer or a loved one." (Professional)

Inconsistent and Inaccessible Communication:

Across accounts, service users described a persistent lack of clear, timely, and accessible communication from hospital teams. Many said that "no one tells us what's going on," leaving them unsure about their treatment, capacity assessments, medication plans, and the reasons behind discharge decisions.

"No one explains what happens after treatment or how heroin addiction links to dialysis." (Service User)

Participants described information being delivered abruptly –sometimes during rushed ward rounds or at the moment of discharge –leaving little space for questions, clarification, or shared decision-making. For people experiencing withdrawal, cognitive impairment, or distress, this made it even harder to engage with their care. Other examples included being awaken from sleep and presented with medical information, leaving them feeling "blind-sided" and "confused."

Professionals echoed these concerns, noting that discharge plans, detox decisions, and medication changes were often not communicated in ways that service users could understand or act on.

This lack of explanation created confusion not only for people in hospital but also for the community teams expected to support them afterwards. Some service users described compassionate, trauma-informed interactions, while others felt dismissed, judged, or spoken to in ways that reinforced stigma. These inconsistencies shaped whether people felt safe to disclose substance use, seek help, or return to hospital in future crises.

"My chest, my breathing… I feel like I'm dying but I still won't go up there." (Service user)

Taken together, the findings depict a communication environment that is fragmented, unpredictable, and often poorly aligned with the needs of people with complex health and social circumstances. Without clear explanations, collaborative planning, or consistent points of contact, service users experience care as disjointed and disempowering –further eroding trust and contributing to avoidable risks during and after discharge.

Stigma, labelling and erosion of relational care

Stigma functioned as a widespread, built-in force shaping how people who use substances were perceived, assessed, and treated within hospital settings. Across accounts, substance use became the dominant interpretive frame through which needs were understood, often eclipsing co-existing physical or mental health concerns. The following sub-themes illustrate how stigma operated interpersonally, clinically, and structurally to undermine safety, trust, and engagement.

Stigma as a barrier to equitable care:

Service users consistently described being judged or devalued because of their substance use. Participants reported being "looked down on," treated as "stupid," or labelled "difficult" without staff attempting to understand their behaviour or context.

"They call people 'difficult' without asking how to work with them properly." (Service user)

"In the hospital, they feel, you know, belittled or not, talk. Talk down to or, you know, staff and were a little bit critical of their life choices of drugs." (Professional)

Several recounted being placed near security or nurses' desks "so they can watch you," signalling that they were perceived as inherently risky or untrustworthy.

"Addicts get stuck right by the nurse's desk so they can watch you." (Service user)

"They make a point of sticking you in a room right by security so they can watch you." (Service user)

These practices were not confined to emergency care; they were described across wards and clinical teams. Although stigma was pervasive, participants also described isolated but powerful examples of care that felt humane, respectful, and free from judgement. These moments often stood out precisely because they contrasted so sharply with routine experiences.

"I put in a great comment for her (Nurse) in PALS because she was so amazing… she got it straight away." (Service user)

Professionals corroborated these accounts, noting that some colleagues attributed all presenting problems to "the alcohol or the drugs," or framed substance use as an "unwise decision" rather than a health condition. This diagnostic overshadowing contributed to differential treatment, as presented in theme 1 where service users were "patched up and discharged" more quickly and did not have clinical needs met.

"They just say, oh, it's the alcohol or it's the drugs. Well, actually it's something bigger than that." (Professional)

Such patterns reflect a moralising logic in which substance use diminishes perceived legitimacy as a patient. Service users described feelings of having no other option than to engage in risky behaviours in order to be taken seriously.

"You have to be ill enough to be taken seriously" (Service user)

"I've just downed a whole bottle [Vodka] because it's the only way they see me" (Service user)

Erosion of trust:

The relational consequences of stigma were profound. Service users described avoiding hospital even when acutely unwell – "I feel like I'm dying but I still won't

go up there" – and leaving prematurely because they felt judged, ignored, or left to withdraw without adequate support.

Others internalised these experiences, expressing resignation or describing long-term disengagement from healthcare.

"I've accepted I might die" (Service user)

"After years of no one supporting me, I don't trust them" (Service User)

Participants also described feeling alone during treatment, lacking any meaningful connection with staff, and enduring repeated, impersonal conversations that felt more like scripts than genuine engagement. Being pushed to engage, spoken to dismissively, or confronted with staff who appeared uninterested in their perspectives triggered distress, anger, or withdrawal from care.

I don't like hospitals; I've got no connection with the staff even though I go a couple of times a week for hours. (Service user)

"Many do not approach staff because they feel judged or afraid." (Professional)

These relational ruptures were not incidental; they shaped whether people stayed in hospital, accepted treatment, or returned in future crises. These structural dynamics intersected with unmet social needs – homelessness, poverty, trauma, and social isolation – compounding the barriers to safe and equitable care. In this context, isolated examples of relationally attuned practice stood out as exceptional: clinicians who listened, adjusted medication based on withdrawal, or arranged safe transport were described as rare but deeply meaningful. Their rarity underscores the extent to which service users feel that stigma has become normalised within the system.

"It is always the case of as soon as you mentioned a substance-based usage, they're actually completely changes. It's like there's, you know, done something horrifically wrong." (Professional)

"I hate having the same talks over and over; it makes it hard for me to accept support." (Service user)

Across these sub-themes, stigma emerges not simply as an attitudinal problem but as a structural determinant of health. It shapes how needs are interpreted, how decisions are made, and how care is delivered. By eroding trust, undermining relational safety, and constraining clinical judgement, stigma contributes to a predictable cycle of disengagement and risk. The accounts presented here highlight the urgent need for trauma-informed, relationally grounded practice that recognises substance use as part of – rather than a barrier to – legitimate healthcare.

Medication continuity, flexibility and risk

Medication continuity – particularly around methadone, Subutex, and alcohol detox regimes – emerged as a critical point of vulnerability within the hospital pathway. Across service-user and professional accounts, disruptions to opioid substitution treatment (OST) and alcohol detoxification were not occasional anomalies but routine features of care. These disruptions were experienced as clinically unsafe, emotionally distressing, and structurally embedded within hospital processes.

Preventable withdrawal and its consequences:

Service users described frequent interruptions to their OST, often beginning at the point of admission. Scripts were stopped because individuals were "technically admitted," or withheld if they had used other substances, regardless of clinical need.

"AAU can't take people on methadone… had stopped my script because I'm technically admitted" (Service user)

Participants reported long delays before doses were administered, with some waiting hours in highly triggering environments while withdrawing. These delays were not benign: they led to early self-discharge, unmanaged withdrawal, and in some cases, complete disengagement from care.

"If you've got a drug problem, they don't want to work with you; I had no methadone for four days and missed my meds for two; I left because I couldn't cope" (Service user)

Professionals corroborated these accounts, noting sometimes hospital teams did not always contact community services or pharmacies to confirm doses given in hospital, leaving individuals without their usual medication.

"They're getting better, but they're not always contacting us or the pharmacy to find out what dose someone's supposed to be on." (Professional)

"Quite often, individuals will walk out of A&E because they're not getting their OST, so if they've gone there before pharmacy opens up before they pick up, that need isn't always being noted." (Professional)

Service users shared accounts where they would leave hospital to use substance, or some cases in hospital to manage withdrawal due to lack of support. Leading to them being kicked out of hospital and being presented as morally wrong, despite a lack of understanding of what they were experiencing.

"For me to then have to sit in A&E for 12, 14 hours with nothing and you can't use up there because one time I've used up there and they've thrown me out." (Service user)

These patterns reflect a system in which withdrawal is implicitly tolerated – or rendered invisible – rather than treated as a preventable clinical harm. As some described, how it was easier to "contact a dealer" than receive OST while waiting.

Medication timing and preventable harm:

Timing emerged as a structural determinant of medication safety. Hospital regimes which operated on a 24-hour cycle that pushed doses later each day, meant that people often received medication hours after they needed it.

Service users described waiting up to six hours for methadone in environments that exacerbated cravings and distress. Others reported that doses drifted later and later each day, leaving them in prolonged withdrawal.

"They do it on a 24-hour running period… doses get later and later… I'm not getting my morning dose until 11 o'clock." (Service user)

Linking into theme 1, when community services are not notified a patient is being discharged it often leads to individuals wating as prescriptions are restricted to 2pm. Moreover, the town centre was described as a "triggering place" for some, adding negative psychological consequences in addition to withdrawal.

"Town centre is a massive trigger… they make me wait six hours while withdrawing." (Service user)

Professionals and service users did share positive examples where individuals were discharged with scripts or could collect them from the hospital pharmacy. However, this was rare and required community services to "push for them". This highlights a key gap, where if OST is not supported, service users are more susceptible to choosing substance instead.

"For someone who's just been discharged from hospital, that's a tricky scenario… Drug dealers will quite happily deliver to your door. Unfortunately, pharmacies don't." (Professional)

Weekend discharges were described as particularly dangerous. Participants spoke of being discharged on Fridays or Sundays without scripts, leaving them with no safe way to manage withdrawal until Monday.

"By the time they've gone through all the hospital system, it's going to be easily 6:00… They're then off the prescription for the weekend." (Professional)

Professionals echoed this concern, describing weekend discharges as "a nightmare" and highlighting the lack of seven-day pharmacy access. These timing issues were not incidental; they were built into the system, producing predictable and avoidable risk.

"They've asked the hospital so many times to keep me in, to not discharge me over the weekend because there's no script." (Service user)

Lack of standardisation:

Alcohol detoxification practices were similarly inconsistent. Service users described being given inappropriate medications – such as codeine for withdrawal – or being placed on holding regimes that prevented acute withdrawal but did not constitute a detox.

"I've gone up there withdrawing so badly one time and they thought giving me codeine would help." (Service user)

"Sometimes stabilise them and hold them, which is a bit frustrating. You've had them for so long you could have detoxed them." (Professional)

Professionals noted that some teams relied heavily on lorazepam, despite it not being the recommended first-line option, while others delayed recognising withdrawal symptoms for days.

"It's the [Ward] who used lorazepam a lot and it's like that really isn't your first choice when it comes to alcohol detox or even just maintaining someone in the knowledge they're going to return to drinking when they discharge." (Professional)

These inconsistencies created a landscape in which the quality of detox depended heavily on which team was involved, which ward a person was admitted to, and how well staff understood alcohol dependence. While some participants described "beautiful" examples of detox that enabled psychological work and onward referral to rehab, these were framed as exceptions rather than standard practice.

The lack of "professional curiosity" can lead to "missed opportunities" to support someone, unfortunately cases we shared where a cycle of detox and admission lead to fatalities.

"Alcohol dependent… detoxed numerous times… then discharged, we start the process again… at least two of them have died." (Professional)

Good Practice as the exception, not the norm:

Despite the systemic challenges, both service users and professionals identified examples of flexible, person-centred prescribing that mitigated risk and supported engagement.

"One doctor gave me 30ml and said if you're still withdrawing in an hour, I'll give you another 30ml… it kept me in hospital." (Service user)

Professionals similarly highlighted cases where collaborative prescribing, early communication with community services, and attention to usual medication regimes enabled safe care.

"I feel safe at Community service; apart from a few people there no one has ever supported me." (Service user)

These examples demonstrate that continuity and safety are achievable when professionals work relationally, trust service-user expertise, and prioritise harm reduction over rigid adherence to protocol. However, such practice was consistently described as the exception rather than the norm.

Across accounts, medication continuity functioned as a litmus test for system integration – and it frequently failed. Disrupted scripts, delayed doses, inconsistent detox regimes, and unsafe weekend discharges created predictable patterns of withdrawal, self-discharge, and avoidable harm. While isolated examples of flexible, person-centred practice illustrate what safe care can look like, the dominant narrative was one of inflexibility, fragmentation, and structural barriers that undermined both clinical safety and patient trust.

Overarching theme - The contingency of advocacy

Across all themes, advocacy emerged as a critical mechanism that mitigates risk and supports engagement. Service users frequently relied on Booth House staff, specific CGL workers, or individual clinicians who "understand" and "keep people safe." These advocates translated complex systems, challenged unsafe decisions, and provided relational continuity in an otherwise fragmented landscape.

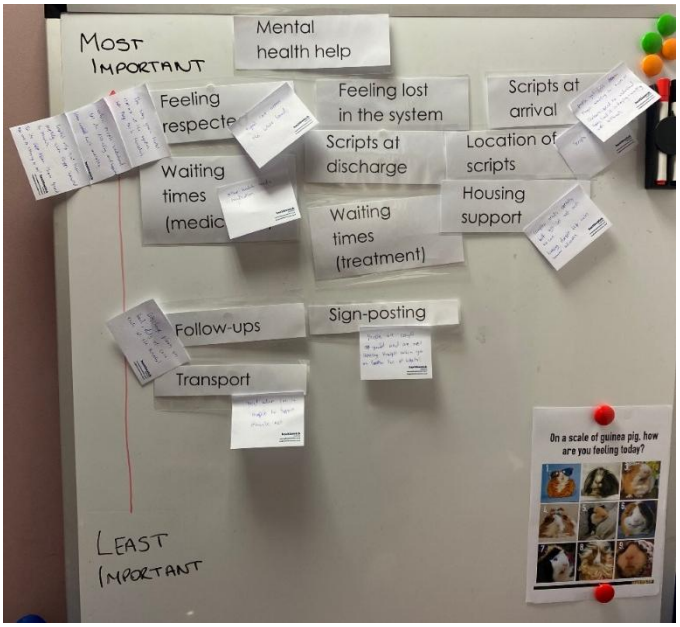
"If they don't listen to Community service staff, they miss chances to help us properly." (Service user)

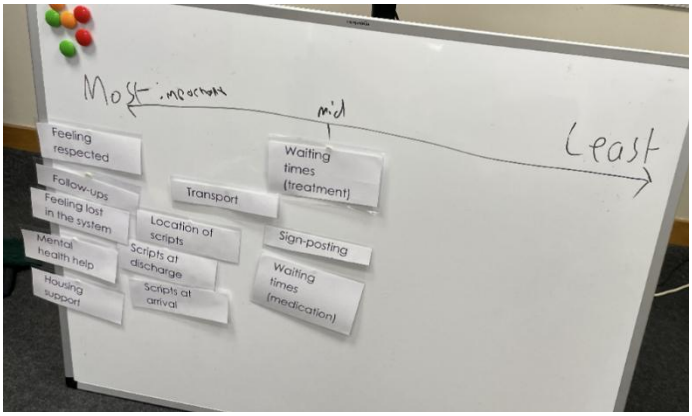
Professionals also recognised the importance of advocacy, noting that people with substance use needs often require someone to "fight their corner" and ensure their needs are not overlooked. However, advocacy was described as inconsistent, dependent on individual relationships, and rarely embedded within formal pathways.

Where advocacy was absent, the combined effects of poor communication, stigma, and medication disruption created predictable cycles of crisis, disengagement, and re-admission.

Workshop results

The workshops enabled us to explore several insights from the interviews in greater depth. Whereby the following priority areas were identified with 'feeling respected', 'feeling lost in the system' and 'mental health help' scoring highest across both sessions.





From here we looked at both solutions and resources to help improve the current process and experience. With a notable need for respect, inclusion and compassion. The resources and solutions required stemmed from basic necessities of care and kindness.

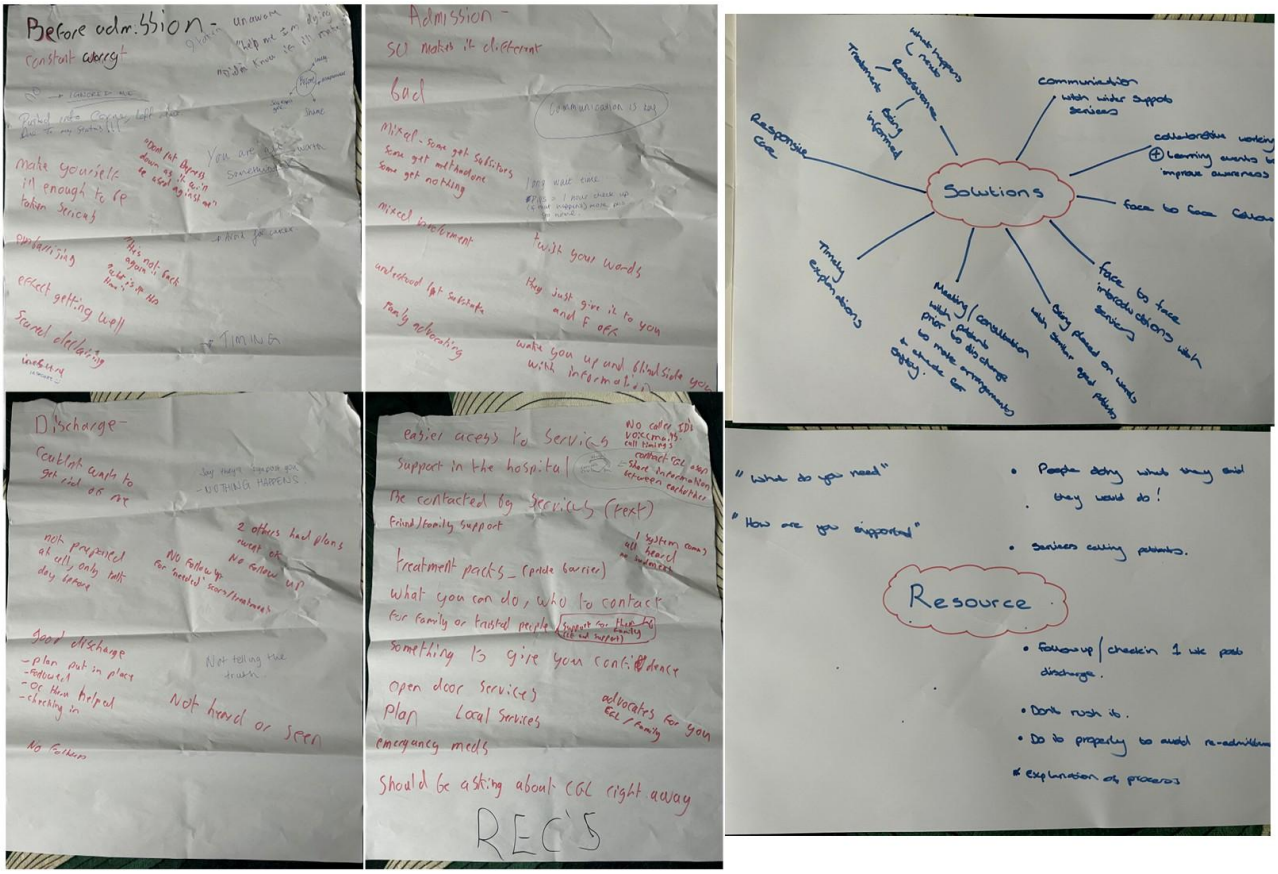
- Clear communication and understanding of substance use and its effects.
- Face to face interactions with agreed next steps to help facilitate an achievable discharge plan.
- Medication available at point of discharge to avoid costly delays in recovery.

Whilst a physical resource of leaflets etc was widely rejected due to mistrust and previous experiences where nothing came from reaching out to services. However, introductions to mental health and substance support services were welcomed if made prior to discharge and followed up a week later. Anything later was considered a missed opportunity for them to know who they are speaking to and establish a level of trust to engage with that service. And only 2 participants would initiate contact with services after being signposted with a leaflet.

Everyone felt the limited communication not only to them but between services hindered the level of care received. Only 1 person reported a positive experience of interagency communication, with their hospital discharge being reported to CGL. But often the waiting time for follow up and empty promises of referrals left people finding the experience quite traumatic and further deepening the feelings of distrust.

All but 2 participants reported issues with medication. This varied from being left for over 12 hours with no access to their script, to being discharged and made to wait several hours in town before being able to collect vital medications. Often causing people to self-discharge or self-medicate. Every participant raised concerns of the lack of training and understanding hospital staff have of substance use and its effects, with reports of being 'treated like an animal'. Another reporting 'it's a lottery, you might get someone who understands, or you might have to lie about your substance use to get any medical support with the fear of judgement'.

The results of what we heard from the workshop can be found in the appendix below.



Co-produced recommendations

The following recommendations have been developed based on the feedback and ideas received from contributors to this report

Implement a standardised, patient centred discharge pathway for people with substance use and social vulnerabilities, with explicit safeguards for timing, communication, and follow-up.

- End unsafe discharge timing: Avoid Friday, late-day, and weekend discharges unless continuity of medication, transport, and community support is fully guaranteed. If discharge cannot be delayed, a named service must take responsibility for bridging care to ensure this continuity regardless of the day.
- Embed joint discharge planning: Require early, shared discharge planning involving hospital teams, CGL, GPs, and relevant accommodation providers (e.g. Booth House), with clear ownership and real-time information sharing rather than reliance on informal or individual contacts.
- Guarantee continuity of medication and transport: Ensure access to methadone and other essential medication at the point of discharge, alongside safe transport arrangements, particularly for people experiencing withdrawal or instability.
- Introduce proactive follow-up: Establish a routine post discharge check-in (e.g. within 24–72 hours), so responsibility for transition does not fall solely on the service user and individuals do not "slip through the net."
- Replace passive signposting with proactive, relationship-based introductions to support services before discharge, followed by early post discharge follow-up.

We need to shift the perception of discharge being a transactional, bed driven decision to a coordinated transition of care, designed with service users and grounded in the realities of substance use, withdrawal, and social vulnerability.

Embed trauma informed, anti-stigma practice as a core component of hospital care for people who use substances, with accountability at both individual and organisational levels.

- Make stigma reduction a priority and not optional: Implement ongoing training for all frontline and clinical staff that reframes substance use as a health condition rather than a moral or behavioural failure. Training should

focus on reflective practice, language use, power dynamics, and the cumulative harm of dismissive or surveillance-oriented care.

- Shift from surveillance to relational care: Review practices such as placing patients near security or nurses' stations "to be watched," and replace them with relationship-focused approaches that prioritise trust, dignity, and psychological safety unless there is a clear, documented clinical rationale.
- Embed trauma informed communication standards: Establish clear expectations for how staff engage with patients, including listening without assumptions, avoiding scripted or dismissive interactions, and recognising how tone, pacing, and pressure can trigger distress and disengagement.
- Introduce accountability and feedback mechanisms: Create safe routes for service users to report stigmatizing experiences, and ensure these are reviewed systematically rather than treated as isolated incidents. Use this feedback to inform supervision, service improvement, and leadership oversight.
- Model and scale relationally attuned practice: Identify and amplify examples of good practice already occurring – such as clinicians who adapt care, listen, or arrange practical support – so these behaviours become the norm rather than exceptional.

We need to recognise stigma as a structural determinant of health, not merely an interpersonal issue. Addressing it requires changes to culture, training, supervision, and accountability – without which people will continue to avoid care, disengage prematurely, and experience worse outcomes despite clinical need.

Review current pathways to promote flexible medication continuity for people receiving OST or alcohol detox, helping to ensure timely prescribing, continuity across settings and person-centred clinical judgement.

- Safe and reassuring transitions through the adoption of iHOST interventions so not to trigger suspension of methadone or Subutex. Hospital policies around prescribing to be reviewed against current clinical guidance as outlined in the Orange Book, to ensure best practice is being adhered to.
- Hospital teams should work with community services, primary care and public health to ensure safe and effective prescribing to meet patient's needs, particularly for weekends discharges where patients will not have access to community prescribers or when establishing patients current prescribing patterns at admission and ownership of medication continuity after discharge.
- Adoption of flexible, harm-reduction approaches to support engagement and reduce the risk of withdrawal or leaving medical treatment early.
- Reduce variation of knowledge by GWH adopting iHOST training to staff members.

- Identify and support clinical champions to model safe, responsive prescribing.
- On call arrangements should support alcohol detox and OST prescribing outside standard hours to prevent avoidable harm.
- Reduce reliance on ad hoc phone calls by embedding shared processes and documentation.
- Hospital staff should clearly communicate with patients about any potential delays in their methadone prescriptions whether these occur on arrival or throughout their stay in hospital. This helps patients understand the reasons for delays and prevents them from feeling dismissed or overlooked.

By treating medication continuity as a safety issue and addressing these areas to improve current prescribing systems we can avoid people withdrawing on wards, leaving hospital early or experiencing preventable harm. By using a best practice approach to offer flexibility, clinical judgement can be supported, engagement improved and risk decreased.

Embed advocacy as a standard component of hospital and community care for people with substance use needs, with clear roles, accountability, and continuity across settings.

Formalise advocacy roles within care pathways

- Advocacy should not depend on individual goodwill or personal relationships.
- Clearly defined advocacy roles (e.g. named key worker, liaison worker, or peer advocate) should be embedded into admission, treatment, and discharge processes for people with substance use needs.

Ensure early and consistent involvement of advocates

- Advocates should be involved at key transition points (A&E attendance, admission, ward transfer, discharge), where risks related to communication, medication, and stigma are highest.
- Automatic referral to advocacy support should be triggered for individuals with known substance use or social vulnerability.

Strengthen cross-service recognition of advocacy

- Hospital teams should recognise advocates (e.g. Booth House staff, CGL workers) as legitimate partners in care planning, not peripheral or external voices.
- Clear protocols should support advocates' involvement in decision making, information sharing, and escalation of concerns.

Provide continuity through named contacts

- Assign a named advocate or key worker who remains involved across settings, reducing the need for service users to repeatedly explain their history or navigate complex systems alone.
- This continuity should bridge hospital, community services, and accommodation providers.

Support advocates to challenge unsafe decisions

- Systems should explicitly enable advocates to raise concerns about unsafe discharge, medication disruption, or dismissive care without fear of being ignored or penalised.
- Clear escalation routes should be established and communicated to both staff and advocates.

Resource and protect advocacy capacity

- Advocacy should be recognised as essential safety work and resourced accordingly, rather than added informally to already stretched roles.
- This includes protected time, training, and access to clinical teams and information.

Monitor outcomes where advocacy is present or absent

- Services should track outcomes such as self-discharge, medication continuity, re-attendance, and engagement, comparing pathways with and without advocacy involvement.
- This data can support continuous improvement and justify sustained investment.

Advocacy needs to be treated as a core safety mechanism, not an optional enhancement. The evidence shows that where advocacy is present, risks are mitigated and engagement improves; where it is absent, predictable cycles of crisis, disengagement, and re-admission follow. Embedding advocacy within formal pathways would reduce reliance on individual relationships and create more equitable, safer care.

Substance use care continuity checklist

To support the afore mentioned recommendations into practice, we propose using the below 'operational checklist' to improve patient safety, equity interventions and to address failure points in the current pathways.

The impact will be tangible: fewer self-discharges and re-attendances, safer weekend discharges, improved engagement with community services, reduced medication-related incidents, and better patient experience –especially for people with high social vulnerabilities. Clear roles, time-critical prescribing, and routine 24–72-hour follow-up create accountability and close the "gaps" where people currently slip through the net, improving outcomes while reducing operational churn and cost.

Admission & Early Planning (Day 0–1)

☐ Screen for substance use, OST, alcohol dependence, and social vulnerability
☐ Verify OST / detox medication same day with CGL / pharmacy
☐ Establish a plan for medication continuity (use interim dosing if verification delayed)
☐ Assign named advocate / key worker
☐ Initiate joint discharge planning at admission
☐ Notify and involve: CGL, GP, accommodation provider (if relevant)
☐ Document shared ownership for medication and discharge planning

Medication Safety & Continuity (Throughout Admission)

☐ Have prescribing decisions been informed as per Orange Book guidelines
☐ Medication process has been communicated with the patient
☐ Where possible align dosing times to patient need
☐ Where current alcohol detox medication regime is changed, it has been communicated to the patient.
☐ Ensure weekend / out of hours prescribing cover is in place
☐ Maintain routine communication with CGL and pharmacy

Trauma-Informed & Anti-Stigma Practice (Every Contact)

☐ Use non-judgemental, trauma informed and person-centred language
☐ Listen without assumptions or pressure
☐ Harm reduction practices communicated to patient
☐ Have dignity, privacy, and psychological safety standards been met
☐ Offer opportunities for feedback or concerns to be raised safely

☐ Ensure access to gender-responsive support

Advocacy & Support (Throughout Admission & Discharge)

☐ Advocate notified of key transitions (A&E, ward moves, discharge)
☐ Care planning communicated with advocate / key worker
☐ Advocate given opportunity to raise concerns about unsafe care or discharge

Discharge Readiness (Before Discharge Decision)

☐ Discharge planned with, not for, the patient
☐ Joint discharge plan agreed and documented
☐ Medication arranged and communicated to patient
☐ Safe transport arranged
☐ Accommodation confirmed (where applicable)
☐ Community services introduced before discharge

Post-Discharge Follow-Up (24–72 Hours)

☐ Follow-up contact completed within 24–72 hours
☐ Medication continuity confirmed
☐ Attendance with community services checked
☐ Risks or gaps escalated promptly

Oversight & Quality Monitoring

☐ Track outcomes:

- ☐ Self-discharge
- ☐ Medication continuity
- ☐ Re-attendance
- ☐ Engagement post-discharge

☐ Review stigma-related feedback regularly
☐ Use data to inform supervision, training, and service improvement
☐ Share and scale examples of good relational practice
☐ Involve lived experience in staff training and development

Conclusion

Together, these findings demonstrate that poor outcomes for people with substance use and social vulnerabilities are not the result of individual behaviour or clinical complexity, but of systemic failures in discharge, medication continuity, stigma, coordination, and advocacy. Current hospital pathways are often fragmented, protocol-driven, and insufficiently attuned to the realities of substance use, withdrawal, and social instability, resulting in avoidable harm, disengagement from care, and repeated crisis and re-admission.

The evidence shows that safer, more effective care is achievable when systems are designed around people rather than processes. Where discharge is planned collaboratively, medication continuity is treated as a safety priority, stigma is actively challenged, and advocacy is embedded, service users are more likely to remain engaged, complete treatment, and transition safely into community care.

Meaningful improvement therefore requires a whole-system shift: from transactional, bed-driven decision making to coordinated transitions of care; from surveillance and stigma to trauma-informed, relational practice; from rigid protocols to flexible, clinically led judgement; and from reliance on individual goodwill to formally embedded advocacy and accountability. Without these changes, people will continue to fall through gaps that are predictable, preventable, and structurally produced. With them, hospitals have the opportunity to become places of safety, continuity, and trust for some of the most vulnerable people they serve.

Next steps

In addition to sharing this report with all the providers we engaged with during this project, we will also be sharing these actionable recommendations and inviting the trial of the operational checklist with the following key stakeholders:

Swindon Borough Council - Adult Social Care Leadership Team: Key audience for trauma-informed recommendations and support for vulnerable adults.

Health and Wellbeing Board / JSNA Team - Overseeing Swindon's Joint Strategic Needs Assessment and Health and Wellbeing Strategy. Key for integrating findings into strategic planning.

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board – Designing and commissioning NHS services locally.

Great Western Hospital Trust – Main provider of secondary care for Swindon residents. Key for redevelopment of current pathways.

Avon and Wiltshire Mental Health Partnership – Provider for adult clinical mental health services in Swindon.

Stakeholder response

The Nelson Trust

Additional improvements to your recommendations could include strengthening the consistency and accountability of cross-service communication, particularly by creating shared digital tools or standardised documentation to reduce reliance on individual contacts or ad hoc processes.

It may also be beneficial to formalise rapid-response mechanisms—such as a complex transitions huddle or agreed escalation routes—to better manage high-risk discharges and prevent individuals from falling through system gaps.

Embedding whole-system trauma-informed practice could be enhanced by extending training and reflective supervision to all staff groups, including non-clinical teams, and by incorporating routine monitoring of culture-change indicators.

Medication continuity could be further improved through clearer protocols for verifying community prescriptions, restarting OST after missed doses, and strengthening weekend or out-of-hours arrangements.

Finally, advocacy could be reinforced by defining clear role boundaries, ensuring adequate resources to maintain capacity, and integrating advocates into routine safety and quality monitoring so insights from lived experience feed directly into service improvement.

These additions would help create a more consistent, reliable, and person-centred system across the full care pathway.

The Substance Use Care Continuity Checklist strongly reflects the kind of practical, compassionate, and joined-up approach we know makes a real difference to the women we support.

From our perspective, this checklist captures many of the essential safeguards that prevent women from being discharged into risk, instability, or isolation, and it provides a level of structure that is often missing in current pathways.

We particularly welcome the focus on early identification of substance use and social vulnerability, as well as the commitment to same-day medication verification — both of which are critical in preventing withdrawal, distress, or unplanned self-discharge.

The emphasis on trauma-informed and anti-stigma practice resonates deeply with our work, recognising that how women are spoken to and treated is as important as the clinical care they receive.

We also value the explicit inclusion of advocacy throughout the hospital journey, as we see every day how vital it is for women to have a trusted, consistent voice alongside them, especially during moments of crisis or transition.

The structured approach to discharge readiness and the expectation of 24–72 hour follow-up reflect an understanding that safety does not end at the hospital door.

Finally, the commitment to oversight and monitoring — including lived experience involvement — shows a meaningful shift towards accountability, learning, and culture change.

Overall, this checklist aligns closely with what we at the Nelson Trust know supports safety, dignity, and continuity for women experiencing multiple vulnerabilities, and we believe it has the potential to significantly reduce avoidable harm while improving engagement and outcomes.

The report and its recommendations stand out as thoughtful, grounded, and genuinely responsive to the realities experienced by people with substance use and multiple vulnerabilities.

What we particularly appreciate is the shift away from transactional processes towards relational, coordinated care rooted in compassion, dignity, and evidence.

The report clearly recognises the systemic nature of the issues — stigma, fragmented pathways, inconsistent prescribing — and proposes changes that are both practical and transformational.

One further observation is that the report could emphasise even more strongly the importance of co-production and lived experience at every stage of implementation; this will not only build trust but ensure the changes remain relevant, trauma-informed, and sustainable.

We also see an opportunity to highlight how these recommendations align with wider national priorities around reducing health inequalities, improving continuity of care, and strengthening community partnership working.

Overall, the report provides a strong platform for meaningful change, and with the right commitment, it has real potential to improve safety, engagement, and outcomes for those who are too often left without a voice in traditional health systems.

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Appendices

Appendix 1: Professional participants

Appendix 2: Workshop data

Appendix 3: Interview and workshop guides

To view or download appendices 1-3, please go to:
https://www.healthwatchswindon.org.uk/bridging-gap-substance-use-discharge-and-what-comes-next

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