Health and Social Care Committee

Meeting Venue:
Committee Room 1 - Senedd

Meeting date:
4 February 2015

Meeting time:
09.15

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Agenda – Supplementary Documents
Inquiry into alcohol and substance misuse: consultation responses

Please note the documents below are in addition to those published in the main Agenda and Reports pack for this Meeting

Inquiry into alcohol and substance misuse: consultation responses (12.10) (Pages 1 - 158)

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Abertawe Bro Morgannwg University Health Board – ASM 01 / Tystiolaeth gan Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg – ASM 01

Abertawe Bro Morgannwg University Health Board

Response to the National Assembly for Wales Health and Social Care Committee inquiry into alcohol and substance misuse.

1.0 The ABM University Heath Board welcomes the terms of reference for this consultation, which are apposite. ABM University Health Board currently provides tier 3 addiction services. Tier 3 services are described by the National Treatment Agency (NTA) in 'Models of care for treatment of adult drug misusers' as *'structured community based drug treatment services.'* They suggest that the drug or alcohol misuser attending will normally have agreed to a structured programme of care, which places certain requirements on attendance and behaviour. Tier 3 services often tend to work with complex cases, which require multi disciplinary intervention and where there is often a medical component. In this context CDAT is defined as a 'Tier 3 service.'

1.1 In addition to three Community Drug and Alcohol Teams the service provides a five bedded in patient unit and access to residential rehabilitation. These services are deemed to be tier 4 services, defined as, 'Tier 4 interventions include provision of residential specialised drug treatment, which is care planned and care coordinated to ensure continuity of care and aftercare.

2.0 The impacts of alcohol and substance misuse on people in Wales, including young people and university students; older people; homeless people; and people in police custody or prisons.

2.1 Historically there has been a lack of national and international research regarding the efficacy of preventative and educational interventions for children and young people. The healthy schools programme requires revision and consideration of emerging international research regarding the most effective way of educating and raising awareness amongst young people.

2.2 Higher education establishments need to be engaged and supported in tackling the use of substances by the student population, particularly alcohol and new and emerging novel substances. There also needs to legislation to ameliorate ploys to encourage risky and unsafe drinking habits developing; for example, the promotions available in fresher's week that encourage and enable students to drink alcohol in excessive amounts.

2.3 There needs to be greater engagement with parents, particularly regarding alcohol and new and emerging novel substances, and how they can talk with their children regarding these areas to the best effect. There is emerging evidence that children who drink alcohol when under age are accessing alcohol via their parents, either via their drink cabinet or via their parents purchasing alcohol at their child's request.

2.4 Older people are not proportionately represented in those referred to specialist agencies. The Welsh core standards for substance misuse services could be used to encourage agencies to adopt flexible and creative ways of engaging with this age group. Primary care is ideally placed to screen, assess and sign post this age group but there is no incentive for primary care to participate in this area.

2.5 There has been an unhelpful legacy from the policy 'disconnect' caused by the separate commissioning processes for services provided across the regional service footprint and those services commissioned via the Home Office, now via Police Crime Commissioners, in terms of Integrated Offender Intervention Services. We would welcome this funding being devolved to a local level to ensure more effective integration of care pathways.

2.6 Our view is that custodial health care provision should mirror those interventions available in the community and that, in the same way adult mental health services are commissioned, community addiction teams should provide in reach services for the prison population. Additional resource would be required by those health boards covering prison estate.

2.7 Specialist substance misuse services for the homeless are variable, particularly outside of cities. Given the increasing rate of alcohol related brain injury being observed in this population it is essential that substance misuse and particularly alcohol is included in locally enhanced service contracts with primary care.

3.0 The effectiveness of current Welsh Government policies on tackling alcohol and substance misuse and any further action that may be required.

3.1 The priority actions identified against each of the substance misuse strategy's four key area

3.2 The increasing focus on alcohol and legislation such as proposed minimum unit pricing legislation is very welcome.

3.3 The roll out of the take home Naloxone scheme has been particularly beneficial in areas where there have historically been high rates of drug related deaths, including Swansea.

3.4 The increased involvement of service users and carers has been particularly evident in the planning and design of local specialist services.

3.5 There is concern regarding the additional capacity that will be required by services if tasked with the identification and review of alcohol related deaths, particularly as the review of drug related deaths has been devolved by Welsh Government to a local level.

3.6 We would welcome acceleration of the provision of LARC via specialist services and the expansion of initial work completed by Public Health Wales with local resource to train staff to deliver this intervention.

3.7 Whilst the increasing emergence of peer recovery led groups has been welcome there needs to be evidenced appropriate governance structures in place for any organisations receiving funding via local commissioning arrangements.

4.0 The capacity and availability of local services across Wales to raise awareness and deal with the impact of the harms associated with alcohol and substance misuse.

4.1 Within the health community there is often a lack of 'whole systems' approach to this client population. Services have developed in a manner that does not reflect the most natural sequence of engagement with progressive tiers of provision. Service models have been developed in an everted fashion, with most areas taking clients requiring detoxification or prescribing into a secondary care service, before transferring them to primary care – where primary care exists. There is a distinct lack of capacity in terms of services in primary care.

4.2 Models of service that exist in primary care are disparate, and in many areas non existent, resulting in secondary care services becoming congested with clients who could be treated in primary care.

4.3 Often enhanced service contracts in primary care provide solely for opiate users requiring long term substitute prescribing. This does not address the emerging issue and more commonplace presentation of hazardous and dependent alcohol use. Primary care is ideally placed to screen, assess, sign post and treat these clients but there is no financial or nationally agreed target incentive for General Practitioners to engage in this work.

4.4 Of great concern are those members of the public who are at risk of acquiring an alcohol related brain injury due to nutritional depletion, particularly of thiamine. Presentation of Wernicke Korsakoff syndrome is increasing. There needs to be an increased focus on raising awareness of this and the presenting signs and symptoms, as intra muscular vitamin replacement can be easily administered at primary care level. Again, primary care will not participate in treating this issue and the resulting damage and long term health and social care that is needed by these individuals is substantial.

4.5 Residential rehabilitation services for those diagnosed with Wernicke Korsakoff syndrome need to be developed across Wales. There is only one small unit on the Welsh border and this does not serve to meet the needs of those with alcohol related brain injury

who may make moderate to significant recovery when comprehensively assessed and rehabilitated.

4.6 Residential rehabilitation needs to be offered to service users as part of the menu of treatment options at an early stage in their contact with services. Research shows that rehabilitation of this nature works well for service users early on, or at the end stages, of their substance misuse, and should not be offered merely for clients who have tried and not succeeded in all other treatment elements.

Sue Stone
Service Manager
Addictions Services.

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Glyndŵr University Wrexham – ASM 02 / Tystiolaeth gan Prifysgol Glyndŵr Wrecsam – ASM 02

1. Alcohol and other drug use is a complex individual and societal consideration. I welcome the Health and Social Care Committee's exploration of the subject and the recognition that it is an important issue for Welsh society. This written response comes into two parts ; a) responses to the survey questions, and more detailed written response – this focuses on i) research/evidence base (including prevalence) and ii) appropriate responses. This has occurred because I was initially directed by a Welsh Government representative to fill in the public survey as an active and published researcher on alcohol and other drugs (living and working in Wales), and I found it hugely limiting. I also have over twenty years' experience of working in services which support those experience alcohol and other drug problems. I have therefore made some observations in the context of the survey questions (having gone onto consider the provider survey too) and then additionally provided a fuller written response in an attempt to better capture the complex details.
2. Public Survey - Firstly the separation of alcohol from other drug use in questionnaires implies this is what happens in life and that they are somehow uniquely different, in which they are not. Many of the reasons why and problems associated with drink are those of drugs[1]. Questions about excessive drinking; this seems are a very misleading set of question. You appear to be asking individuals to consider their informed understanding and experiences. These are clearly contextually bound considerations. Yet the questions posed are very limited and built upon narrow definition of excessive drinking and a singular interpretation of excessive drinking[2]. Further it is obviously preoccupied with an epidemiologically, whole population and health message perspective, where for many excessive drinking is perceived not by volume but by negative consequence[3]. This is then compounded by question five which departs form the tight use of excessive and into drinking too much – which is a wholly different set of perspectives. Thus a question asking folks about excessive drinking without regards to units would raise a very different set of answers. In addition a question about units within a week would raise different answers to those about units in a single day or session. Finally questions about general population drinking garner very different answers to those about self and immediate others, which notoriously experience under-reporting considerations. I try to answer these questions and found my immediate response were a) disagreement about definition of excess and b) questions not necessarily matching the answers sought.
3. Simply put – I can respond to this survey as follows: i) Yes (some) young people are drinking too much and in (short term risky) ways and with possibly (longer term) health consequences. Ii) Yes (many) adults also drinking too much, and with both short term negative consequences and long term health deterioration. Iii) My drinking is curtailed by opportunity and motivation. A busy quality of life. iv) It is better to encourage and support rich and rewarding lifestyles (positive action) than it is to castigate and try to curb alcohol intake (by finger pointing).

[1] Gossop, M (2013) Living with Drugs (7th edn), Farnham, Ashgate.
[2] Babor, TF, Higgins-Biddle, J C, Saunders, J B & Monteiro, M G (2001) AUDIT the alcohol use disorders identification test, Geneva, World Health Organisation.
[3] Plant, M. A & Plant, M (2006) Binge Britain: Alcohol and the national response, Oxford, Oxford University Press

4. However what the questionnaire does not allow me to consider is how we in Wales achieve a balance between the positive drinking of alcohol, individual freedom and responsibility with wider general health promotion considerations and irresponsible alcohol retailing leading to complex levels of inappropriate consumption.
5. Questions about substance misuse; the questions are not comparative. The opening statement indicates– we have excessive without a definition here and the inclusion of dependency - also without definition. These are two hugely different considerations and it is not possible to answer them as one. This is then compounded by the first question which just asks about all use – not excessive or dependent.
6. I can equally respond to these questions at a simple level as follows: i) Yes young people take drugs. Most of them however do so in the context of normal cultural expectations and experimentation and without any undue negative consequence other than running the risk of breaking the law/acts of excessive harm[4]. ii) Plenty of adults (including my peers) take drugs – legal, illegal and illict. On the whole they do it as informed and responsible – as most adults do with alcohol. iii) Yes some adults take too many drugs and with negative consequences. iv) Inappropriate use of drugs is best supported by ensuring that quality of life opportunities are available.
7. Provider (staff survey) Survey: Question 1 asks - *Do you currently work for an organisation which works with people who misuse alcohol or other substances?* Surely this applies to all organisations in Wales. It further asks - If so, please state which organisation and whether we should treat your response as being on behalf of that organisation, or as a personal response from you. This seems ambiguous and does not recognise the clear overlap between organisation understanding and personal knowledge frameworks especially in regards to professionals who work with alcohol and other drugs[5]. Question 3 - for this survey as opposed to the public one – elects to combine alcohol with other drugs – this seems a very inconsistent approach. Further it provides no definitions of excessive and as opposed to the public survey is either an assumption of knowledge or allows personal interpretation.
8. Overall the questions being asked of this survey are easy to answer in a simplistic manner; i) The reasons individuals experience problems with their alcohol or drug use are numerous and various and cross all three domains of the physical, psychological and social. ii) If there is a group of individuals who are over represented in service provision – then it is those who have experienced complex, often traumatic pasts, and with much larger elements of social exclusion and limited life opportunities. iii) Sustained drink or drug use is associated with acute periods of vulnerability, iv) It does not seem appropriate to (principally) ask providers about barriers to services rather than those who have not accessed services (despite the complex research methodologically considerations this raises – as in the following examples[6]. Privileged Access Interviewing (PAI) with Hidden Populations has been used extensively by renowned experts in this field –

[4] Practice standards for young people with substance problems (Gilvarry et al. 2012): https://www.rcpsych.ac.uk/pdf/Practice%20standards%20for%20young%20people%20with%20substance%20misuse%20problems. pdf

[5] Livingston, W (2014) Towards a comprehensive typology of knowledge for social work and alcohol. Social Work Education: The International Journal, 33(6) pp. 774-787.

[6] Burchess, I. & Morris, C. (2009). Access, barriers and facilitators to drug treatment programmes in Wolverhampton: A review of the literature. Journal of Health and Social Care Improvement, May Issue: Cottew, C. & Oyefeso, A. (2005). Illicit drug use among Bangladeshi women living in the United Kingdom: An exploratory qualitative study of a hidden population in East London. Drugs: Education, Prevention and Policy, 12(3), 171-188; Smith, I. & Honor, S. (2003). Building better drug services in Calderdale. Trafford NHS Mental Health Trust

Mike Smith and Stuart Honor (Hidden Populations Research Limited) – they have done work on this matter in wales[7].

9. A More Detailed Written Response is as follows.
10. It would be more helpful if in the first instance the Welsh Government adopted a more complex and sensitive use of language to describe these issues. Substance misuse – seems very inconsistent with much of the implied approach of the Social Services and Well-being (Wales) act 2014. For example - a*lcohol and other drug use* is the deliberately preferred expression by the British Association of Social Workers Special Interest Group[8] - this describes the behaviour rather than pathologise. Alternatively it is far more accurate to talk of those who experience problems with their or someone else's alcohol or drug use – than to use language that seeks to stigmatise an already marginalised group of welsh society. Finally substance misuse – places an emphasis on the substances and implies they are the problem - they are not, hence our cultural acceptance and regular use of many – the problems are clearly those that people experience, whether the cause or consequence of prolonged use rather than the substances themselves. It is akin to suggesting cars are the problem rather than poor driving and post-accident health care.
11. Alcohol and other drug use is significant element of current and past UK society[9] . The volumes, patterns and changes of use of alcohol and other drugs within the general population are well established[10]. These change over time, for example recent evidence shows that overall young people are consuming less drink and fewer drugs and starting at later ages, yet within this those that do use are using more; or that older people's use is increasing and changing in its presentation[11] . This use frequently manifests itself into a range of individual, familial and societal problems. Currently significant numbers of people in the UK drink at levels deemed to pose medium or high level risks to their health, with recent data showing that 36 per cent of men and 28per cent of women reported alcohol consumption above recommended levels on at least one day in the previous seven, with a substantial number (19 per cent of men, 13 per cent of women) drinking 'heavily' on more than one of the previous seven days[12] (Dunstan 2012). Levels of drinking within Wales[13] and associated consequences are well established[14]. Recent drug use data illustrates that in the general

[7] Hidden Populations Research has conducted over 20 surveys for commissioners across England and Wales, using Privileged Access Interviewer methodologies to reach drug users both in and out of treatment. The total number of users who have now been interviewed is in excess of 2,500. The majority of these studies were commissioned to examine patterns of drug use in an area and the impact of treatment.

[8] British Association of Social Workers (2014) Alcohol and Other Drugs: Special Interest Group https://www.basw.co.uk/special-interest-groups/alcohol-and-other-drugs/

[9] Carnwath, T & Smith, I (2002) Heroin Century. London, Routledge; Gossop, M (2013) Living with Drugs (7th edn), Farnham, Ashgate; Plant, M. A & Plant, M (2006) Binge Britain: Alcohol and the national response, Oxford, Oxford University Press

[10] Davies, C., English, I., Lodwick, A., McVeigh, J. & Bellis, M. A. (eds.) (2012) United Kingdom Drug Situation: Annual Report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) London, Department of Health; Robinson, S & Harris, H (2011) Smoking and Drinking Among Adults, 2009. A Report on the 2009 General Lifestyle Survey London, Office for National Statistics

[11] Roberts, M. (2010) Young people's drug and alcohol treatment at the crossroads: What it's for, where it's at and how to make it even better London, Drugscope; Wadd, S & 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 Vol. 33, No. 5 656-669

[12] Dunstan, S (ed.) (2012) General Lifestyle Survey Overview. A Report on the General Lifestyle Survey 2010 London, Office for National Statistics

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[14] Alcohol Concern. (2010) Children of problem drinking parents: Factsheet Wales, Cardiff, Alcohol Concern; Alcohol Concern. (2009) Alcohol and the workplace: Factsheet Wales, Cardiff, Alcohol Concern; Alcohol Concern. (2009) Young people and alcohol: Factsheet Wales, Cardiff, Alcohol Concern; Alcohol Concern (2009) Women and alcohol: Factsheet Wales, Cardiff, Alcohol Concern; Alcohol Concern. (2009) Men and alcohol: Factsheet Wales, Cardiff, Alcohol Concern; Alcohol Concern. (2009) Alcohol

population 36.5 per cent of people aged 16-59 years reported ever having taken an illicit substance with 8.9 per cent reporting use within the past year[15] (Home Office 2012b). The most widely used drug remains cannabis. Successive governmental alcohol and drug related policies have substantially detailed these patterns of use, associated harms and costs (Home Office 2012a, 2010, Scottish Government 2009, 2008, Welsh Assembly Government 2008a).[16] There is an increasing volume of evidence establishing heightened levels of use and consequences among particular social or client groups[17] , these have commonality and distinction.

12. In summary it is evident Wales, is no different to other UK, if not global countries. It has an inherent history of alcohol and drug use. This is both normative (culturally accepted and engrained) and creates problems. There is an increasing body of evidence that helps pinpoint this to patterns of use and consequences between substances and those who use. These all point the need for better targeting of epidemiological, whole population (health promotion and market management) responses and support services (treatment and beyond).
13. There has been an explosion of governmental policy and guidance on alcohol and other drugs since 2000. Where it is deemed a health and social care issue it is has become an increasingly fully devolved one. However setting exclusively Welsh agendas remains difficult as other policy aspects of alcohol and drug use like crime, policing and trade have a more complex relationship with devolution, and are often still the primary preserve of the UK government and associated political agendas. These policies have core common objectives of improving prevention, increasing treatment service provision, controlling supply, and protecting vulnerable individuals and communities. Despite these limitations we essential have more than enough policy, and policy which is predominantly honed in the right areas. It is the issues of implementation and interpretation of policy that is of far more concern.
14. A critical examination of these policies found that they established far more significance to crime and health agendas rather than whole societal perspectives[18] - this is discordant with say the Social Services and Well-being Act. The Welsh Government is to be applauded for leading the way in developing an integrated family support service model (IFSS)[19]. It is a statutory provision within part 3 of the Children and Families (Wales) Measure 2010. In particular the statutory requirement and move to a familial, early and strengths based model are noteworthy as developments. It is hoped the Welsh government builds on these alternatives to narrow individualistic treatment interventions. The Scottish Government, in particular, has been instrumental in the acceleration of recovery as a key policy objective, supported by a sustained

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and mental health: Factsheet Wales, Cardiff, Alcohol Concern; Alcohol Concern. (2009) Binge drinking: Factsheet Wales, Cardiff, Alcohol Concern.

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Home Office (2010) Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life, London, Home Office; Scottish Government. (2009) Changing Scotland's Relationship with Alcohol: A Framework for Action Edinburgh, Scottish Government; Scottish Government. (2008) The road to recovery: A new approach to tackling Scotland's drug problem, Edinburgh, Scottish Government; Welsh Assembly Government. (2008a) Working together to reduce harm: The substance misuse strategy for Wales 2008-2018, Cardiff, Welsh Assembly Government.

[17] Livingston, W. and Galvani, S (2014) Using evidence to inform working with people who misuse substances in Webber, M. (2014) Applying Research Evidence in Social Work Practice Basingstoke Palgrave Macmillan.

[18] Livingston, W (2013) 'Not From A Book': The Acquisition Of Knowledge And Its Use In Practice By Social Workers, With Particular Regard To Alcohol Bangor University

[19] I have not offered a set of references here to the policy, its rationale or those evaluations of its effectiveness – as these are well known to those reading this written statement

implementation approach[20]. There is an increasing depth of knowledge and research that supports the effectiveness of such interventions[21] (Best et al, 2010; Roth and Best, 2012. Critical here is the support of peer-led groups, interventions and services supporting broad based definitions of recovery beyond narrow (and often tokenistic recovery orientation) treatment services provision, and will include things like alcohol-free bars, conversational cafés, drama, film, mountaineering, music, walking, and yoga[22]. Wales has an increasing number of such peer-led groups and activities, for which commissioning and policy practice needs could be far more creative in its enabling of.

15. In summary, Wales has lots of policy on alcohol and other drug use. However given that we are having this conversation it might be argued to what extent are they or have they been effective. Increased devolution presents Wales with an opportunity to do something different; this moment is compounded by the possibilities within the Social Services and Well-being Act (Wales) 2014. Currently preoccupations with commissioning and performance management, have led all too frequently to the establishment (or continued provision) of services that deliver outputs which can be easily measured rather than outcomes. This has often been reinforced by a small number of organisations and individuals who consistently dominate Area Planning Board and associated resources. Policy and commissioning should become more enabling rather than restrictive and create environments for community and peer-led solutions as much as reinforce existing health care and especially expensive acute/secondary care.
16. Most drink or drug users that develop problems will tell you that it 'is easier to get off than stay off'. This implies the need for services to concentrate on post treatment support. Yet in drug and alcohol service provision we concentrate 90% of the resources on helping people to get off of substances (so in-patient/community detox, associated psychotherapy and chemical treatment interventions) and only 10% on enabling them to stay off (long term support, out of hours network, creative time filling activities, assisted education and employment, peer led recovery etc). It is clear we need a shift of emphasis (this means a shift of balance and power) to community and family run provision rather than a dominance of professional led provision. The Social Services and Well-being Act ought to present such an opportunity.
17. We have very successfully built up a complex treatment and performance monitoring situation. We have services that provide (good treatment) and some consistent outcomes. This situation does not need wholesale dismantling. Rather it needs to detract into its appropriate function. So at present we have big NHS and other providers working with commissioners to provide almost all services and these are concentrated on acute need. We need a treatment service framework that accounts for enabling individuals to gain sobriety (physical, psychological and poor behaviours (crime, parenting and violence). But this is only the start of the support journey people need not the end. It should represent a small, important and significant, but nonetheless a small part of rather than the dominant part of the service provision jigsaw.
1. At the core of these deliberations is service user and carer/community and familial involvement, The Welsh government is to be applauded for having service user involvement strategies for alcohol and drug services. The implementation of these strategies has sought too many easy and quick wins. Service user involvement has primarily been restricted to just that – involvement within the existing. It has struggled to create an environment where service user led provision has been able to play a much more significant role.

[20] Scottish Government. (2008) The road to recovery: A new approach to tackling Scotland's drug problem, Edinburgh, Scottish Government

[21] Best, D, Rome, A, Hanning, K A, White, W, Gossop, M, Taylor, A & Perkins, A (2010) Research For Recovery: A Review Of The Drugs Evidence Base Edinburgh, The Scottish Government; Roth, J & Best, D (2012) (eds) Addiction And Recovery In The UK London, Routledge

[22] Livingston, W, Baker, M, Atkins, B & 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' Journal of Groups in Addiction and Recovery, Volume 6, Number 1, pp176-196;

2. These observations can be wrapped up into three core considerations. Will the Social Services and Well-being Act truly provide an opportunity to move to a radical cultural change that includes alcohol and drug services being led by and of communities? Can Wales develop a more sophisticated understanding of recovery – that supports a recovery movement as much as it does the recovery orientation of existing services? Can existing and highly (self-interested parties) in particular commissioners and NHS providers really re-align their role and expertise into positions of enabling others to take responsibility for their needs and meeting those needs rather than as a present control resources and access to those resources?

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Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Wales College of Paramedics – ASM 03 / Tystiolaeth gan Coleg Parafeddygon Cymru – ASM 03

College of Paramedics response to the Welsh Government Inquiry into alcohol and substance misuse

1. Managing the burden of alcohol on ambulance and paramedic services is of global concern, however it is also an extremely difficult area influenced by many factors, including social and law enforcement. Whilst the College of Paramedics is in favour of attempts to reduce the burden of incidents involving alcohol, we feel that care must be taken to avoid implementing any strategy that could put patients at risk.
2. The College of Paramedics recognises how the damaging effects of alcohol can result in acute medical, surgical and traumatic emergencies. 70% of emergency department admissions at peak times are due to alcohol. As such alcohol related emergencies impact significantly on the Ambulance Service and paramedics in Wales, increasing the potential for anti-social behaviour and violence towards staff [1] and other members of our community. This has resulted in unremitting pressure, which negatively impacts on the ability to response to respond to life threatening situations.
3. In 2011 the College of Paramedics was invited to comment on the WG petitions committee consideration of charging for emergency treatment following alcohol use [2]. The College of Paramedics remains opposed to charging for emergency treatment following alcohol use, for reasons laid out in the previous response. The preferred approach continues to be a thoughtful debate surrounding the issues in Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018 [3], in aiming to reduce harm caused by alcohol through mechanisms of support, improved services, education and protecting families of substance misusers, whilst tackling the inappropriate availability of alcohol. The College of Paramedics also recommended in its previous response that this could be achieved by a well coordinated approach involving other agencies, and a realistic change in health and social policy, some of the examples given included:
    - Engaging with Police and the like to provide safe assessment areas (not necessarily the Emergency Department) staffed by paramedics and police.
    - Highlighting the public health message of the damaging effects of alcohol, in an attempt to 'modify help seeking behaviour'

4. The Ambulance Service in Wales has developed innovative and collaborative approaches to minimise the harms and negative impact of excessive alcohol consumption. Alcohol Treatment Centres have been established, most notably in Cardiff City which is provided during peak times such as weekends and when big sporting events are taking place. These centres are staffed by nurses, paramedics, advanced paramedic practitioners and volunteers, providing additional capacity to help emergency departments deal with people who have consumed too much alcohol.
5. Alcohol has become increasingly affordable, as its price relative to income has fallen, and the College of paramedics is concerned with the growing number of people drinking excessive amounts of cheap alcohol, such as those socially isolated in their own home, and vulnerable groups such as the young and homeless. In a current study being conducted as part of a Phd in collaboration with Swansea University and the Welsh Ambulance Service, Paramedic participants raised the significant role of alcohol when caring for people who Self Harm. Alcohol dependence and misuse are strongly associated with suicidal behaviour [4], and one study found 46.1% of self harm patients had consumed alcohol within 6 h of their Self harm [5]. Paramedics report difficulties in managing patients who lack capacity and refuse treatment; such is often the case in those who have consumed alcohol. These difficulties can be overcome by education, multidisciplinary support and guidelines which can increase competence and confidence in dealing with such patients, despite this, few such opportunities exist [6].
6. The College of Paramedics feels that paramedics should be seen as a vital contributor to care, policy and strategy in reducing harms from alcohol or substance misuse. Whilst innovations are emerging such as that of alcohol treatment centres, their impact should be evaluated through research to explore safety, benefits and more widespread adoption. As paramedics and ambulance staff are often the first health professionals to encounter patients following alcohol or substance misuse, we feel there are opportunities in areas such as health promotion and modifying help seeking behaviour.

The College of Paramedics would like to express their thanks for considering us in this consultation and look forward to future developments in this area.

Acknowledgements

Nigel Rees for contributing work from PhD studies: *Paramedics perceptions of care for people who Self Harm: An Evolved Grounded Theory.*

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National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from The Fostering Network – ASM 04 / Tystiolaeth gan Y Rhwydwaith Maethu – ASM 04

The Fostering Network

The National Assembly for Wales' Health and Social Care Committee inquiry into alcohol and substance misuse.

December 2014

EVERY CHILD • EVERY CARER • EVERY DAY

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The National Assembly for Wales' Health and Social Care Committee inquiry into alcohol and substance misuse.

1. Introduction

The Fostering Network was established in 1974 and is the UK's leading charity for everyone involved in fostering, bringing together all those who provide, plan and deliver foster care. Our UK membership includes almost all local authorities and Health and Social Services Trusts, over 57,000 foster carers, and 188 independent fostering providers. The Fostering Network Wales, based in Cardiff, was established in 2002 and works with foster carers, fostering services and care-experienced young people across Wales. We have a strong membership base in Wales with over 5,400 foster carers, all local authorities fostering services and the majority of independent fostering agencies.

All of our work is designed to improve the lives of children in foster care. We provide an extensive range of publications, training, information and advice on all fostering issues. We work with our members to implement good practice, informed by our research and experience, to ensure foster care is improved for children. We campaign to improve the support that foster carers receive and work with fostering services to address the shortage of foster carers. We also ensure that the voices of fostered children are heard at the heart of the foster care system. Our staff includes foster carers, registered social workers and other experts from across the spectrum of foster care, including those that have been fostered themselves. Together we have many years' experience and unrivalled expertise. That is why we are the voice of foster care.

The Fostering Network welcomes the opportunity to provide evidence to the National Assembly for Wales' Health and Social Care Committee inquiry into alcohol and substance misuse, and to highlight the need to focus on looked after children and care leavers, as part of this inquiry.

2. Children and young people in care and care leavers are a vulnerable group who are more likely to be affected by drugs and excessive drinking.

Looked after children and Care Leavers remain one of the most vulnerable groups of children and young people, their outcomes in terms of educational achievement, independent living and stable employment remain of acute concern. It is well evidenced that the first few years after leaving care are extremely problematic for many young people and that care leavers are disproportionately disadvantaged, including experiencing homelessness, poor education and employment outcomes, mental health problems, early parenting and contact with the criminal justice system.

Home Office research suggests that children and young people in care are more likely to use alcohol and drugs than many of their peers. It is important to note that a minority will be

completely adverse to drug and substance misuse because of the problems that may have been caused by such use in their homes.

Drugs and substance misuse -Statistics for Looked after children and young people

Looked after young people tend to start using drugs at an earlier age, at higher levels and more regularly than their peers. Thus, drug use may become more established and dangerous (Big Step
Partnership, 2002), (Newman and Pearson, 2002), (Ward, 1998) and (Save the Children, 1995).

Some studies indicate that they are 4 times more likely than young people who are not looked after to smoke, drink and take drugs (Meltzer and others 2003) and (Williams and others ,2001).

Looked after young people who have experienced parental drug/alcohol misuse may view excessive use as 'normal' (Ward and others 2003), (Newburn and Pearson 2002).

Recent research (FRANK) shows that a significant number of older children of substance misusing parents regularly use cannabis but don't regard it as a drug because their experience of drugs is of class A and Opiates.

In the December 2005 report for the Joseph Rowntree Foundation, researchers interviewed 68 dealers in four neighbourhoods in England and found that over half of them had lived in local authority care or secure accommodation.

When children and young people are abused through sexual exploitation, alcohol and other drugs are often involved in the grooming and enticement process. One study for example found that 78 per cent of sex workers who were also problematic drug users had been in care (Cusick et al, 2004).

Transition to independent living

- 73% of care leavers had smoked cannabis compared to 31% of the general population.
- 29% had taken ecstasy compared to 6% of the general population.
- 26% had taken cocaine compared to 4% of the general population.
- 21% had used solvents compared to 7% of the general population.
- 14% had taken crack compared to 2% of the general population.
- 9% had taken heroin compared to 0.6% of the general population[1].

Researchers from Goldsmith College carried out a survey of 400 young people in residential

and foster care[2], the research found that:

• Young people in care used drugs more regularly compared with the general youth population, reporting more frequent use of cannabis, cocaine, crack and heroin.

• In a number of cases, young people had grown up in families where heavy drinking or drug use led to parental neglect.

• Many young people in the study had experienced loss, bereavement and rejection. Some young people had turned to drugs to compensate for these negative experiences and to combat depression.

• Despite the somewhat bleak data, many young people in care perceived drug use as a minor problem compared to the difficulties they had already experienced.

The Fostering Network Wales is concerned that there is a lack of emphasis for the specific and unique needs of children and young people in care and care leavers. Their needs and circumstances are unique and require tailored intervention and support.

They require a more targeted approach based on need rather than age- a set of interventions and support that recognises of their lack of family support, and vulnerability.

Further, it is critical that statutory services working in partnership with the voluntary sector are able to prioritise, to support and to enable this unique and vulnerable group.

3. The stages of looked after children and young people in care and care leavers where the likelihood of taking drugs or drinking excessively might increase.

Evidence states that some looked after children and young people are using alcohol and substances more than their peers who are not in care. They start at an earlier age and are more likely to continue into later life – consequently affecting their future health and well-being.

A small percentage of looked after young people will go on to have serious alcohol or drug problems in their adult lives. Many will start experimenting with cigarettes, alcohol, cannabis and ecstasy earlier than their peer group.

The instability of their personal situation may also increase the risk of experimental or recreational drug use becoming challenging.

3.1 Looked after children risk factors associated with drug and substance misuse.

There are social issues behind problematic drug use i.e. social exclusion:

- Family breakdown and poor parenting.
- Developmental delay.
- Learning disability.
- Communication/ relationship difficulties.
- Failure at School and disrupted education.
- Low self-esteem.
- Separation and loss.
- Multiple fostering or residential placements.

3.2 Looked after children risks associated with family factors

- Abuse.
- Parental conflict and/or family breakdown.
- Rejection/neglect.
- Mental illness.
- Substance use.
- Violence.

3.3 Looked after children risks associated with environmental factors (socio-economic disadvantage)

- Crime.
- Poor accommodation.
- Homelessness.
- Discrimination.
- Chaotic lifestyle.

Many children and young people in care have experienced difficulties in their lives, and are unable to live with their birth family for a variety of reasons. Some will have lacked care and support from an early age. Being placed in to public care adds to this instability and insecurity. Many will have moved around several times between their family home and different foster homes or residential care- more than one in 10 children in care had three or more placements in the year ending March 2011. This compounds vulnerability. Many feel let down by adults and may find it difficult to trust and talk openly and immediately about alcohol and substances.

Some children and young people will be in foster care because of substance misuse in their family, and this will shape their knowledge and feelings regarding drug use. They may have grown up in homes or neighbourhoods where drug or excessive alcohol use is common.

As with all young people, the reasons for taking drugs include peer pressure and the enjoyment that taking drugs gives. However, it is important to consider that young people in foster care may take drugs for additional reasons including:

- To rebel against the ‘system’ that has taken them away from their parents and family.

- Easy access to drugs and substances.
- Because drugs help individuals to forget the difficulties and circumstances that led to them being placed in public care.
- Because drugs can help individuals to relax, sleep, and normalise their feelings caused by being in care.
- Because drugs can help relieve the stress associated with constantly moving and a sense of not sense of belonging.

It is not surprising that young people in foster care may need additional support to make informed and positive life choices about a whole range of things, including drugs and substance misuse.

Many young people experiment with drugs. Those in care have no wish to be singled out. However, they do need consistent support as early as possible to help them make informed and positive choices.

3.4 Case Studies

Sabrina

Sabrina is 15 and has been looked after by you since she was 9 years old. She was told 2 months ago that her mother had died from a heroin overdose. Sabrina was removed from her mother's care because of severe neglect and emotional abuse. Since hearing about her mother's death Sabrina has been drinking very heavily.

You suspect that she starts to drink as soon as she wakes up. She is also taking antidepressants prescribed her GP. Sabrina drinks alone in her room or in the local park, where she was recently found passed-out and bought home by the police.

Mark

Mark, who is 15, came to live with you 6 weeks ago on a short-term placement as his parents were finding it harder to cope with his behaviour. It is hoped that he will be able to go home to his parents when his behaviour improves. Mark has displayed challenging behaviour since he was 10 years old. The family went to Family Therapy Sessions for a while but these were not successful. Mark has been excluded from school because of his behaviour and attends alternative curriculum classes.

Mark has admitted that he smokes heroin to 'calm him down' but you suspect that his friends, who are mostly older than him, inject the drug.

Cassie

Cassie is 13 and initially came to live with you on a short-term placement when she was 10 years old. It was hoped that she would return home quickly, but her mother's relationship with her partner is still violent and abusive. Cassie's younger brother is placed with foster carer in the

next county and they see each other every couple of months.

Cassie is often out in the evening with her friends, who include boys, and goes to the youth disco every weekend. You overheard her and her best friend talking about 'weed' and 'pills' and getting 'off their faces' this week.

The Fostering Network 2014

4. **Where efforts should be targeted to address the issue of alcohol and substance misuse amongst children and young people in care Wales -recommendations from The Fostering Network Wales:**

4.1. A focus on prevention- targeted effective alcohol and drug education. For children in care. Specialist health workers are ideally placed to provide alcohol and drug education. However, drug education is an important role that foster carers undertake in caring for a child or young person.

Foster carers are well placed to provide drug education and support to Looked after children and young people around drug use and other related risky activity. They are more likely to pick up on the signs that a young person might be using drugs, as they are with them 24/7 and will be familiar with their routines. They are very often the only stable adult in some young people's lives.

The Fostering Network recommends that foster carers receive, as part of their core training as to how to recognise, identify and support signs of misuse; the concerns for young people; How to go about discussing issues and developing trust; the services and support that could be accessed; what other support is needed and providing up-to-date information about substances used by young people and the terminology they use to talk about it.

It is crucial that children and people in foster care receive accurate information on drugs and substance misuse alongside the opportunity to talk about drugs. Developing trust and discussing issues around drugs is not always easy, but children and young people who talk openly about drugs are able to make more informed choices with regard to their use. Foster carers should be supported in this role.

There is also a call to offer this training and support to Looked after Children nurses.

4.2. Clarify the legal position for foster carers and fostering team staff in supporting young people.

4.3. Identifying the 'early warning signs' of care leavers who are most likely to have extreme outcomes, and targeting support to help them through the process of leaving care. We are currently missing crucial opportunities to intervene before many of these care leavers embark on paths that will, in the long term, be extremely costly both in financial and human terms.

4.4. Addressing the extreme loneliness and isolation felt by some care leavers, by finding

ways to support enduring and supportive relationships, with birth families, siblings, former foster carers and children's services that last beyond leaving care.

4.5. Screening and assessment for substance use should be part of core planning for young people in care, as they are more likely to use than their peers.

4.6. Utilising the ability of the voluntary sector to deliver support, especially where young people feel most alienated from their local authority and have the most complex needs.

4.7. Consider parental drug and substance misuse and the effect on children who are subsequently placed in care.

4.8. Foster carers need, clear policy guidelines on alcohol, substances and other drugs in order to undertake support young people competently and confidently. Some areas have developed policies for all children and young people's services to enable a consistent approach by professionals and staff. Other authorities have developed specific policies for looked after children and young people's services and have consulted carers, staff, and children and young people about what the policies should cover.[3]

4.9 .Consult with foster carers, staff, and children and young people about what the policies should cover.

4.10. Our recommendations listed here would increase the support given to children and young people in care around alcohol and substance misuse and provide vital opportunities for this vulnerable group.

Supporting children and young people from care should be an important element of the government's agenda and The Fostering Network are keen to support ongoing improvement work to this vital agenda.

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Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Alcohol Concern Wales – ASM 05 / Tystiolaeth gan Alcohol Concern Cymru – ASM 05

National Assembly for Wales Health and Social Care Committee inquiry into alcohol and substance misuse

Alcohol Concern Cymru is delighted to respond the National Assembly for Wales' Health and Social Care Committee inquiry into alcohol and substance misuse. There are five key areas in which Wales can make meaningful progress in tackling the harms associated with alcohol misuse, namely:

- Action on price
- Restrict alcohol advertising
- Curtail alcohol availability
- Cut the drink-drive limit
- Reduce the stigma associated with alcohol problems

1. Action on price

1.1 Alcohol is 45% more affordable than it was in 1980, and channels for its availability have multiplied far beyond the local pub. The majority of alcohol is now sold in the off-trade (such as in off licences and supermarkets),[1] where alcohol is routinely offered at knockdown prices to entice people into stores.[2]

1.2 Currently it is possible, for as little as £3, to buy a three litre bottle of strong cider (3 litres at 7% strength such as Frosty Jacks cider contains 22 units of alcohol in one bottle, the equivalent to a man's recommended maximum intake for a week). Much of this type of alcohol is drunk by the youngest drinkers (including under-18s) and vulnerable dependent drinkers (including street drinkers).

1.3 Action is urgently needed to effectively control the price of alcohol, and Alcohol Concern strongly contends that the best way to achieve this is to set a minimum unit price (MUP) below which drinks cannot be sold in the retail market. This method would ensure that such price increases reach consumers and could not be circumvented by retailers. It would also relate directly to the amount of ethanol – i.e. the number of 10ml units of pure alcohol – being sold. A new report, from the University of Sheffield's Alcohol Research Group (SARG), estimates that introducing a

50p MUP in Wales would reduce alcohol related deaths by 53 per year and save healthcare services £131 million over 20 years.[3]

1.4 This position is supported by a wide range of organisations including Public Health Wales, the Welsh Association of Chief Police Officers, , the British Medical Association, the Royal College of General Practitioners, the Royal College of Physicians and the Royal College of Nursing, as well as the Chief Medical Officer for Wales, the Scottish Government and the Northern Ireland Executive. In addition, a survey conducted by YouGov in 2012 of 2,075 randomly selected respondents showed high levels of public concern about alcohol harms and many more people supporting than opposing MUP.[4]

1.5 Moreover, although some parts of the drinks industry have been critical of MUP, this has by no means been universal. In 2010, the Rural Development Sub-Committee of the National Assembly for Wales noted that a number of representatives of the Welsh drinks industry (typically small-scale producers) were in favour of MUP as a means of "tackling binge drinking and irresponsible alcohol consumption".[5] The Campaign for Real Ale (CAMRA) has also indicated its support for MUP.[6] In 2012 an Alcohol Concern survey found that 77% of publicans in Wales were in favour of a minimum price of 50p per unit.[7]

2. Restrict alcohol advertising

2.1 There are significant links between advertising and young people's consumption. Alcohol advertising increases the likelihood that young people will start to use alcohol and will drink more if they are already using alcohol.[8] Evidence also shows that frequent exposure lowers the age of drinking onset,[9] and around 17% of males and 14% of females aged 11-16 in Wales drink alcohol at least once a week.[10] Compared with adults, children and young people in Wales are exposed to significantly more alcohol adverts than would be presumed given their viewership patterns. Children are highly aware of alcohol brands, with research showing 10 and 11 year olds in Wales are more familiar with leading alcohol brands than some leading biscuit or ice-cream brands.[11]

2.2 Current regulation is failing to adequately curb the activities of the alcohol industry both in terms of the volume of young people's exposure to alcohol advertising and the appeal of content. No regulation exists to tackle the volume of advertising to which audiences are exposed; the weak wording of the self-regulated codes and a failure by the Advertising Standards Authority to apply the codes in full, including the spirit behind the codes, means content frequently makes associations with prohibited themes. If restrictions on alcohol advertising are to have any meaningful effect, they must go beyond defining exclusions, which advertisers can work around or simply ignore.[12] [13]

2.3 The focus of alcohol advertising needs to switch to defining what advertisers <u>can</u> say, rather than what they cannot. Alcohol advertising content should be restricted to promoting just factual information about the product such as origin, composition and means of production. Removing lifestyle images of drinkers, characters, celebrities and drinking atmospheres is likely to reduce the appeal of content to younger audiences. Focusing on product provenance allows alcohol companies to continue to promote their brand identities and to differentiate themselves from

competitors. This is a measure, with precedence, that balances commercial and public health interests.

2.4 A phased ban on alcohol sponsorship of sports, music and cultural events in Wales is also needed. Sponsorship, like other advertising, gives companies a platform to develop positive associations with their products and, by its very nature, sponsorship of such events sends the message that alcohol consumption is normal, and indeed often necessary. Alcohol sponsorship of sport in particular sends contradictory messages about the health benefits of participation. Moreover, it is particularly difficult to monitor and prevent underage exposure to alcohol sponsorship and branded merchandise. The phased removal of tobacco sponsorship from Formula One motor racing and other sports demonstrated that these measures can be successfully implemented, and that with appropriate support sports bodies can find alternative sponsors.

2.5 The Welsh Government currently lacks the necessary powers to impose restrictions on alcohol advertising and sponsorship, and this is therefore an area of policy in which it will need to negotiate with the UK Government (and possibly the European Union) in order to achieve the best results for public health in Wales.

3. Curtail the availability of alcohol

3.1 In recent decades, Wales has seen the growth of a 'drinking to get drunk' culture. Qualitative research conducted on behalf of Alcohol Concern Cymru has found that many drinkers regard heavy consumption as an essential part of a 'good night out', with drunkenness seen by some as not only acceptable but something to look forward to, even though it often led to regrettable incidents, like causing nuisance and harm to others.[14] Alcohol-related anti-social behaviour and crime remains a particular concern in communities across Wales – a survey of 500 Newport residents in 2014 found nearly half (47%) of respondents said they regard their city centre as a "no-go" area at night due to alcohol-related problems.[15]

3.2 The number of premises licensed to sell alcohol has risen sharply, particularly in the off-trade, where off-licensed premises (including supermarkets) in England and Wales has more than doubled since 1950 (23,532 in 1950 compared to 49,074 in 2009);[16] over the same period, the British population grew by only a fifth.[17]

3.3 This growth is largely a result of a liberalisation of licensing regulations in the last few decades, especially since the implementation of the Licensing Act 2003, which introduced the requirement that local authorities must automatically grant licences to sell alcohol unless doing so would be contrary to one or more of the four licensing objectives. Consequently, we have increased high outlet density (the clustering of a large number of premises within a small geographical area) in our town and city-centres across the country, including the rise of 'superpubs' (modern drinking establishments with up to twenty times the capacity of a traditional pub), as well as an increase in overall number and variety of places where we can purchase alcohol, from corner shops and supermarkets, to bars and late night alcohol delivery services.

3.4 There is strong evidence that introducing restrictions on availability will have a positive effect in reducing alcohol-related harm. Several international studies, for example, have identified a link between outlet density and physical violence.[18] Limiting outlet density within a community may be effective because this will likely increase the time and inconvenience that a typical drinker

encounters in obtaining alcohol; limit competition between retailers and thereby reducing the likelihood of cut-price promotions and under-age sales; and avoid high crowd density that frequently accompanies the bunching of outlets and that may exacerbate incidences of violence.[19]

3.5 Restricting the availability of alcohol lowers overall consumption and associated harms; increasing availability has the reverse effect.[20] In Finland in 1970, following the relaxation of a state monopoly of alcohol sales in the previous year which allowed beer of up to 4.7%ABV to be sold in grocery stores, overall consumption increased by 46%. Five years later, liver cirrhosis rates had increased by 50%, hospital admissions for alcohol psychosis rose by 120%, and arrests for drunkenness increased by 80% for men and 160% for women.

3.6 A key means to restrict alcohol availability is through the licensing legislation. Alcohol Concern Cymru is calling for the introduction of a fifth licensing objective, namely the protection and improvement of public health, which will enable local authorities to turn down new applications and extension of hours based on local population health data. Scotland already has this fifth objective resulting in increased engagement of public health in the licensing process.[21] Again, this is an area in which the Welsh Government lacks clear powers, and so change may have to be negotiated with the UK Government.

4. Cut the drink-drive limit

4.1 A combination of law enforcement and sustained publicity campaigns has substantially reduced the number of drink-drive accidents in recent years, from a total of 1,640 in 1979 to a low-point of 230 in 2011.[22] However, the latest figures published by the Welsh Government suggests that around 7% of road accidents in Wales still involved drivers over the blood alcohol limit.[23] Alcohol Concern Cymru's survey of drivers in Wales in 2013 also highlights that many drivers do not know the permitted level of blood alcohol for driving - a majority of respondents (61%) thought that the limit was 30mg, 23% did not know what the limit was, and 8% thought it was 50mg. Just 9% were able to give the correct limit of 80mg.[24]

4.2 Wales, along with England, has one of the highest blood alcohol limits for driving in the world at 80mg of alcohol per 100ml of blood. Drivers with a blood alcohol level between 50mg and 80mg are 2 to 2½ times more likely to crash than those with no alcohol in their blood, and up to 6 times more likely to be involved in a fatal collision.[25]

4.3 There is international evidence that a reduction in such limits is accompanied by major falls in road fatalities.[26] The introduction of a national limit of 80mg across the USA produced a 15% reduction in fatal collisions on the roads. In Australia, the limit was reduced from 80mg to 50mg, with an 8% reduction in fatal crashes and an 11% reduction in crashes resulting in hospital admission. Estimates by the National Institute for Health and Clinical Excellence (NICE) and quoted in the North Review, suggest that around 7% of current road deaths could be avoided in the first year of 50mg limit.[27]

4.4 Alcohol Concern Cymru believes that, In line with common practice in most of the European Union, including Scotland since December 2014, the blood alcohol limit for driving in England and Wales should be reduced from 80mg/100ml to 50mg/100ml as soon as possible. This must be accompanied by national publicity explaining the change and its implications.

5. Reduce the stigma associated with alcohol problems

5.1 Local treatment services in Wales provide a unique pool of experience and expertise in addressing alcohol problems. They can often draw on staff and volunteers who have faced problems with alcohol and other drugs themselves, and are therefore able to bring that perspective to the treatment and support of current alcohol misusers.

5.2 However, a significant barrier to access to treatment is that, whilst our society in Wales is often tolerant of alcohol misuse, especially when there is still a social stigma attached to admitting a drink problem and seeking help for it. As one service provider commented during an Alcohol Concern Cymru analysis of the role of alcohol treatment services, a plan to site a pub on a street is likely to provoke less concern from local residents than a proposal for a new alcohol treatment centre.[28]

5.3 Alcohol Concern's snapshot survey of shoppers in Cardiff in December 2011 found that many people felt that seeking help for drink problem could be personally and socially difficult. Around 30% of respondents cited shame or embarrassment as reasons why people might not seek help, whilst over 40% referred to issues of denial: "they're either embarrassed or they don't realise it is a problem"; "[they] don't realise, and [are] afraid what will happen with [their] job, car"; "they don't want to be judged by other people".[29]

5.4 More work is needed to break down these barriers, and to promote the idea that recognising an alcohol problem is a positive step rather than a cause for shame. As part of this, we need to challenge the notion of alcohol as a neutral product; emphasising that whilst it is an established part of most of our social lives in Wales, it is also a toxic and addictive substance with a number of intrinsic dangers, and that a society that uses alcohol must be ready to dealing compassionately with those who fall into the trap of misuse.

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National Assembly for Wales / Cynulliad Cenedlaethol Cymru
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Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Hywel Dda University Health Board – ASM 06 / Tystiolaeth gan Bwrdd Iechyd Prifysgol Hywel Dda – ASM 06

Response to the Health and Social Care Committee - Inquiry into Alcohol and Substance Misuse

Impacts of Alcohol and Substance Misuse on People in Wales:

1. Patterns of drug use remain subject to change as we have seen over recent years with the increase in the use of the new psychoactive stimulants, and to more poly drug use. This is dependent on availability and trends with service users in different areas. It will remain important for drug services to be flexible in being able to respond to these changes, but fundamentally the overall approach remains consistent based on the evidence of effective intervention.

2. Alcohol continues to be the greatest presenting problem in the substance misuse field. In addition there is an increase being seen in respect of Alcohol Related Brain Damage, and this is an area that requires some consideration at an all Wales level regarding implications for the future support required for service users. Also in regard to an ageing population, use of alcohol amongst older adults is an increasing concern and it is likely we will see an increase in referrals to alcohol treatment services. There will be some particular challenges working with this older population, and currently there are limited links with the Tier 1 adult services who will have a key role to play. Links between alcohol related harm and areas of deprivation is becoming more apparent through research evidence and in respect of referrals to services. There is also a move from night time economy centred drinking to more home based and preloading patterns of use.

Effectiveness of Welsh Government Policies and Further Action Required:

3. The current Welsh Government strategy 'Working Together to Reduce Harm' clearly sets out the key interconnected areas of preventing harm, supporting substance misusers in their recovery, supporting and protecting families, and tackling availability and the wider community safety issues that are important in this field. This sets the frame for the local commissioning strategies and the supporting local delivery structures led by Area Planning Boards (APB's). The APB's provide the structure for the collective responsibility and engagement of the key agencies of police, probation, social care, health and the third sector. This is critically important in ensuring all aspects of the agenda are taken forward in a joined up approach.

4. The additional Substance Misuse Action Funding has made a significant difference to the provision and extended range of services now available locally. This funding makes up a substantial part of the investment in substance misuse services, alongside monies invested from the direct funding in statutory services. The associated performance structure is robust, and the data available via the NHS Wales Informatics Service provides useful information on the numbers accessing services, related demographic details and outcomes for service evaluation and planning purposes. The capital fund has been utilised effectively locally to support the development of shared multi agency facilities at key locations. This is particularly important in supporting joint working between specialist substance misuse agencies in being co-located, it is a cost effective use of resources and

is key in supporting ease of access for service users. Recognising the pressure on budgets within statutory services, and the benefits seen from the Substance Misuse Action Fund it is key to retain the level of investment currently within both revenue and capital. It will be important to balance the use of the resources across the key areas within the strategy.

5. Welsh Government should consider promoting certain settings as 'alcohol free zones' and in particular we would highlight schools. The use of Temporary Event Notices [TENS] for events at schools where alcohol is served to parents whilst children are present should be avoided and the Welsh Network of Healthy Schools Schemes should be promoting this view to primary and secondary educational settings as part of the National Quality Award or other award[s]. Figures obtained from local authorities in England suggest that over 8,000 TENS were granted to primary schools in 2012 / 13. This is the equivalent of almost one in every three primary schools in England selling alcohol at events for children. As children develop future drinking habits from their parents and they are most influenced between the ages of 6-10, we believe that this practice should be discouraged in Wales.

6. Welsh Government should be encouraged to pursue national policies such as Minimum Unit Pricing [MUP] and the introduction of public health as a fifth objective under the Licensing Act 2003. There has been a strengthening of the evidence base during the past year as indicated in reports from the Advisory Panel on Substance Misuse and from Sheffield University [as commissioned by Welsh Government] which indicate that MUP if applied in Wales would save lives and reduce hospital admissions. Alongside this, the role of Health Boards in the local licensing process has developed slowly and in no small part due to the challenges of providing representations to local authority committees that relate specifically to the legislation as currently written. In practice, this has restricted the ability of health bodies to provide evidence which offers a richer context to alcohol use in a specific locality. The introduction of an additional objective to the 2003 Act in order to protect and improve public health would greatly assist Health Boards to discharge their statutory responsibility more effectively.

7. There is a national role for Welsh Government [or an appointed body like Public Health Wales] in providing leadership on the prevention / education agenda in Wales to ensure best practice is promoted by use of evidence based interventions. At the moment this agenda is fragmented, inequitable and vulnerable to budget pressures when set against the competing demands and needs of treatment services. Clarity and consistency of approach in respect of population level communication, schools based substance misuse education programmes and preventative interventions with vulnerable groups such as young offenders would be best led at a national level.

8. Welsh Government investment in areas relating to harm reduction has been very positive and these remain key priorities for service delivery. These include the roll out of Take Home Naloxone, the Blood Borne Virus [BBV] Strategy to support increased testing, vaccination and treatment, and the Drug Related Death Review process for fatal and non fatal drug overdoses. It is important to highlight that new psychoactive stimulant use has led to increase in risky behaviours around injecting with a possible consequent impact on BBV infection rates, and has been a factor in a number of drug related deaths. For these reasons we believe that the general approach taken to substance misuse policy by Welsh Government, which focuses on a harm reduction approach, is the most appropriate way to reduce risk for this client group.

<u>Capacity and Availability of Local Services to Deal with the Impact of Substance Misuse:</u>

9. An area we consider important locally and have been very successful with is partnership working across the specialist substance misuse agencies. This has been underpinned by

us working within an agreed model for service delivery based on a tiered intervention approach - to ensure that the level of intervention is at the minimum level appropriate which is in line with prudent healthcare principles. The model is provided by both the third and statutory sector, and has a clear integrated pathway with a single point of contact, and weekly multi agency case management meetings. It has been supported by the development of joint working agreements, joint training programmes, and information sharing agreements between services. It has resulted in good response times for assessment and treatment, effective joint working with service users and being able to move service users through services effectively. A key element is that the statutory services work with those with more complex needs and who require case management, and the third sector services work with those with less complex needs. There is joint working also where appropriate, and mechanisms for advice and consultation between services - this supports a flexible approach to service delivery and the best use of available resources.

10. The move towards a more community reintegration and recovery focussed approach remains key, and the need to ensure that the range of services is available both in regard to specialist and mainstream. This applies both to aftercare and wraparound services, but also to ensure that there are therapeutic services available to enable service users to address any underlying psychological issues. There has been collaborative working locally with the Psychological Therapies strategy, where the needs of service users who misuse substances are being taken into account. There is evidence locally of an increase move through of primary drug service users who have successfully completed treatment. The key developments in Peer Mentoring, and Coastal were important in supporting this. Projects that support service users to develop skills so that they can return to the labour market have played a valuable role in aiding recovery and have enabled treatment services to refer onwards in the knowledge that their generic support needs will be met by such projects. However there have been gaps left with the loss of these EU funded aftercare projects that had made a significant difference to the lives of service users, and supported treatment services in moving towards a more recovery orientated approach. Whilst these services will be coming back on line in a revised format the gap that has been left has had a detrimental effect on service users recovery journey and a slow down in moving service users through treatment services. The shift towards more of a recovery orientated approach has been quite a challenging one to make particularly for drug services, and service users who have been with services for long periods of time. Progress is however being made, and the role of SMART recovery and other peer led psychosocial interventions plays a key part in this. However it is important to also ensure that access to opiate substitute prescribing remains as an effective treatment intervention, whilst being set in the context of the recovery journey. Service users who have be unable to progress fully within community based services continue to access Tier 4, and we have a robust assessment, preparation and aftercare process supporting these individuals. Tier 4 services remain a key part of the overall treatment service, and where appropriate placements are made within services in Wales.

11. There is an increasing range of medication interventions for primary alcohol users becoming available and it will be important to bed them into the treatment options available, and to review their effectiveness. Access to such medications needs to be carefully monitored in order to ensure both value for money for the health service in Wales and also the best treatment outcomes.

12. Initiatives such as the Integrated Family Support Teams have been very positive in working with parents who misuse substances, aiming to reduce the impact on them and their children. This intervention can only be welcomed in addressing intergenerational substance misuse that we see often, and assists with collaboratively working across adult and children services, and mainstream and substance misuse services.

13. In regard to working with those involved with the criminal justice system we have worked well locally with the roll out of the Integrated Offender Management Service. This has ensured effective joint working and risk management with service users coming out of prison, and in the community across substance misuse and criminal justice agencies. There has been agreement locally to bring together the funding for this client group and progress with an integrated model of provision for mainstream and criminal justice services users.

14. Co-produced responses to identified substance misuse concerns at a community level should be encouraged as these have been highlighted as a key principle of a prudent healthcare approach. Alcohol Concern Cymru is currently leading a community development project in the Fishguard and Goodwick area of Pembrokeshire identifying residents concerns in respect of alcohol use and misuse using an asset based approach which helps local communities to identify their own strengths and talents and their own capacity to effect positive change.

15. It should be noted that the all Wales Police schools programme is currently the only educational intervention that is applied consistently across Wales. Our understanding is that the programme received a budget cut last year which it was able to absorb. However, any continued reduction in central funding from Welsh Government will significantly affect its ability to deliver on the ground.

16. A key challenge with this field of work is that substance misuse cuts across so many areas of life and service provision. Specialist substance misuse services have a place in delivering treatment services, and in supporting and advising on wider service / practice developments. However there is a lot of work required in skilling up Tier 1 services to identity and where appropriate intervene or joint work with those with substance misuse issues. It is important that it is seen as everyone's business and that there is a joined up agenda and commitment to address associated issues. An example where this has worked well is the 'Have a Word' programme of training [as delivered by Public Health Wales nationally] on the use of alcohol screening and brief interventions should be noted. Over 600 health and social care professionals in the Hywel Dda area have received training in delivery of evidence based approaches to screening and brief interventions. This is a useful tool in engaging people in a conversation about their alcohol use but it should be noted that this will uncover hitherto unseen levels of hazardous or harmful drinking amongst the population and as a result of this there may well be additional pressures placed on treatment services who will have to assess and intervene with these increased referrals.

17. Inevitably there is always a place for further resources however the principles of the strategy remain sound, and the supporting framework and resources remain a key part in taking this forward robustly. The strategy is due for review in 2018. It is important to have mechanisms in place to share good practice across Wales, and to ensure that we review the strategic direction and local practice in line with the current thinking and evidence base on an ongoing basis. There is limited opportunity to do this currently across commissioners and provider agencies and this is an area that would benefit from some consideration. It will be important to maintain an overview of the changing patterns of substance misuse and the impact on treatment services, but to ensure that there is appropriate investment and actions across the key interconnected areas of the strategy.

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Aneurin Bevan University Health Board – ASM 07 / Tystiolaeth gan Bwrdd Iechyd Prifysgol Aneurin Bevan – ASM 07

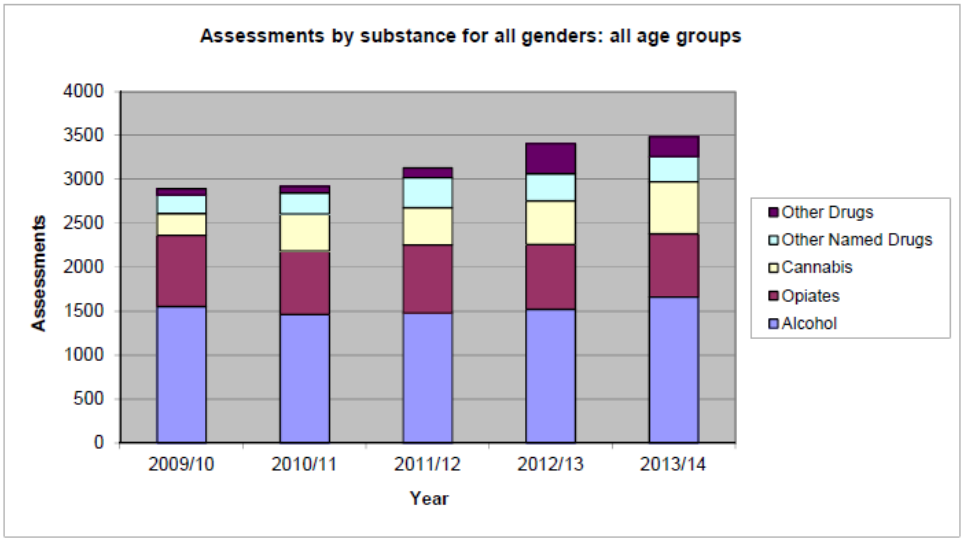
Aneurin Bevan University Health Board's Submission to the National Assembly for Wales' Health and Social Care Committee Inquiry into Alcohol and Substance Misuse

Introduction

1. The Aneurin Bevan University Health Board (ABUHB) covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and for specific services, South Powys. In the ABUHB area and across Wales substance misuse represent challenges to individuals, families, communities, health and social care services and criminal justice services.

Inquiry Term of Reference 1: The impacts of alcohol and substance misuse on people in Wales including young people and university students; older people; homeless people; and people in police custody and prisons.

2. As can be seen from the graph below, service user assessment by substance for all age groups indicates that alcohol is the greatest substance misuse issue for the ABUHB population.



Source: Welsh National Database for Substance Misuse (WNDSM) Services User Assessment Data for Substance Misuse Services in Gwent (2014)

3. There is specific evidence that an increasing proportion of people living in the ABUHB area are causing serious damage to their health through drinking too much alcohol. Applying the most recent Welsh Health Survey results to the population estimate for Gwent, there are around 206,100 people (117,900 men and 88,200 women) who are drinking more alcohol than is considered safe for their health on at least one day a week (PHW, 2014).
4. The Patient Episode Database for Wales (PEDW) data for 2012 clearly demonstrates that ABUHB has the highest rates for alcohol specific admissions as well as the highest rates of alcoholic liver disease admissions in Wales.
5. The ABUHB hospital admission rates for diseases that are wholly associated with alcohol (alcohol specific) is significantly higher than the average for Wales and the ABUHB alcohol specific hospital admission rate for men is double the rate for women (PHW, 2014).
6. Deaths from alcohol-specific diseases have increased over the last decade for both men and women living in the ABUHB area, although the death rate for men remains double the rate for women (PHW, 2014).
7. Alcohol (specific and attributable) deaths are highest in the most deprived communities in the ABUHB area. There is a paradox that a similar or slightly greater proportion of those people living in the least deprived parts of ABUHB drink above guidelines, but alcohol related deaths are highest in the most deprived communities (PHW, 2014).
8. The pattern of drug use continues to evolve throughout the UK: poly drug use and the use of New Psychoactive Substances (NPS) are growing. Amongst young people, patterns of substance misuse are also becoming more complex – more presentations are now being seen in young people with evidence of physical dependence on alcohol as well as chaotic use of New Psychoactive Substances. Young people can also present with complex substance misuse. In addition to the drug/alcohol misuse there may be mental health issues such as ADHD, autistic spectrum disorder, depression, early psychosis etc.
9. Older adults can present with substance misuse. Evidence suggests that this is most commonly seen with alcohol misuse or misuse of prescribed/over the counter medication
10. Nearly all of the Homeless People in Gwent who are “sofa surfing” or “rough sleepers” are known to have enduring alcohol or drug problems: many have co-occurring physical and mental health problems and because of their chaotic lifestyle have exhausted or refused treatment options available to them.
11. Local data indicates that Gwent is experiencing a similar pattern of NPS to Wales. The number of people in Gwent presenting for assessment and/or treatment where the primary drug is classified as ‘other substances’ has risen gradually since 2009/2010 (WNDSM, 2014). These might include substances not known at the assessment, or which are not in the drug list (i.e. classified under the Misuse of Drugs Act 1971), so could include NPS.
12. The age profile for NPS use in the Gwent area is similar to that of the rest of South Wales, the main users of NPS being teenagers and young people. It is recognised that the effects of drug use are more

pronounced amongst socially excluded groups and in the most deprived communities.

13. NPS use nationally has become increasingly associated with the risky behaviour of injecting the substances, which has been a factor in a number of drug related deaths and a related increase in Blood Borne Virus (BBV) prevalence.
14. There is also a high prevalence rate locally of the use of Steroid and Image Enhancing Drugs, which is illustrated by the fact that approximately half the needles that are issued at local Needle Exchanges are for that purpose.

Inquiry Term of Reference 2: Effectiveness of current Welsh Government policies on tackling alcohol and substance misuse and any further action that may be required

15. 'Working Together to Reduce Harm' (WG, 2008), the current Welsh Government Substance Misuse Strategy for Wales, provides an effective national tool for addressing all of the essential areas of focus to reduce harm from substance misuse in Wales:

16. • Preventing harm.
17. • Supporting substance misusers - aiding and maintaining recovery.
18. • Supporting and protecting families.
19. •Tackling availability and protecting individuals via enforcement activity.

20. Welsh Government promotion and investment in harm reduction initiatives within the substance misusing communities that are stipulated in the 'Substance Misuse Treatment Framework Health and Wellbeing Compendium' (WG, 2013) has been a very positive step, resulting in key priorities for service delivery such as the Drug Related Death Review process, which has encouraged the investigation of fatal poisonings and resulted in the 'Take Home Naloxone' initiative.
21. The Welsh Government's Blood Borne Virus (BBV) Strategy, which is designed to increase testing, vaccination and treatment for BBVs, has been welcomed by all services providing care for substance misusers.
22. The Liver Disease Delivery Plan provides many commendable recommendations which will be of great public health value, including recommendations designed to reduce BBVs and alcohol misuse.
23. The advocacy in the Liver Disease Delivery Plan of Alcohol Liaison Nurses has been particularly welcomed as a help in dealing with all of the patients suffering from alcohol specific diseases in the secondary care setting.
24. The roll out of the Public Health Wales 'Have a Word' (ABI) training has proved effective in ensuring health and social care practitioners are

suitably skilled at engaging with individuals to identify hazardous and harmful drinkers and encourage positive behavioural change.

25. There is extensive international evidence on interventions which have the greatest impact on tackling alcohol: making alcohol less affordable (as consumption is price sensitive), less available and accessible (as these are linked to consumption) and less attractive (through strengthening current marketing regulations). We support the introduction of the Welsh Government Public Health Bill in 2015 which is advocating the implementation of a 50p Minimum Unit Price (MUP) for alcohol, as there is evidence to prove that consumption of alcohol is price sensitive (WG, 2014).
26. The appointment of the Local Health Boards as a responsible authority has the potential to exert a positive effect on local licensing decisions.
27. The establishment of Area Planning Boards (2010) has been a positive thing as this provides the structure for the collective responsibility and engagement of the key agencies of police, probation, social care, health and the third sector to ensure all aspects of the agenda are taken forward in a joined up and effective approach.

Further action that we would recommend at a governmental level:

28. • Advocate for protection of Public Health as the fifth objective in the Licensing Act in England and Wales.
29. • Support actions to implement policies that make alcohol less accessible, less available and less attractive to the public.
30. • Reduce the legal limit for blood alcohol concentration for drivers to 50mg/100ml.
31. • Provide leadership on the prevention/education agenda in Wales to ensure that evidence based and standardised best practice is used nationally for all information communicated in campaigns and educational programmes for all target audiences both public and professional (a national communications strategy).

Inquiry Term of Reference 3: The capacity and availability of local services across Wales to raise awareness and deal with the impact of the harms associated with alcohol and substance misuse

32. Substance misuse is a wide ranging problem affecting all ages and all areas of society. Although there is evidence that certain groups have higher prevalence (e.g. younger males in deprived areas) it is by no means exclusive to those groups. Over many years government policy, with regard to treatment provision, has been directed at this 'typical' user. This has, however, left many others either without access to services or with the option of attending services they find unacceptable e.g. older people.
33. Local services are well placed to raise awareness of substance misuse as they have local knowledge but would benefit from a national lead on substance misuse prevention and education rather than seven Welsh Health Board areas providing ad hoc responses.
34. The commissioned services and statutory services have a good history of working together to provide good substance misuse services for the

population of Gwent. However, it is now apparent locally that greater provision needs to be made in the health sector for an increasing range of substance misusers who have complex clinical issues as they will require experienced clinical care.

35. **More presentations are being seen in young people with evidence of physical dependence on alcohol as well as chaotic use of NPS.**

36. **In Europe and the UK it is predicted that the number of people over 65 with a substance misuse problem will more than double from 2001-2020 (European Monitoring Centre for Drugs and Drug Addiction, 2008). However, in most instances the use of substances in this age group remains undetected. Individuals do not present with it, professionals do not ask about it and addiction services are not geared to deal with it. Treatment regimes for older adults (e.g. alcohol detoxification) require alteration to deal with declining liver function with age and the presence of multiple co-morbidities but only specialist prescribers have the expertise to manage this. With the reduction in NHS addiction service provision (and with fewer consultants in addiction), this expertise is not always available.**

37. **Individuals with serious mental health problems are increasingly presenting with additional substance misuse issues. It has been estimated that up to 75% of drug using patients have a mental health problem (Scottish Advisory Committee on Drug Misuse, 2003) and Community Mental Health Teams report that 8-15% of patients have co-occurring substance misuse problems (Department of Health, 2002). Their use often exacerbates their mental illness and vice versa. In addition, the risk of suicide in drug users is twenty times higher than for the general population (Appleby et al 1999). Engaging these individuals can be quite difficult and very often assertive approaches are required. Standard treatment services are often not commissioned to take such an approach and may not have the expertise of staff to deal with the complex interplay of morbidities.**

38. **Physical ill health can also present alongside addiction issues. In some cases this is a direct result of the addiction (e.g. cirrhosis in alcohol dependent patients) and in others, incidental. Prescribing in these patients requires specific knowledge and expertise around the potential for drug interactions and the potential for exacerbating the physical illness.**

39. **In some cases patients may become addicted to medication prescribed to treat a physical illness. For instance there is a growing recognition in Wales of the problem of addiction to prescribed opiates in chronic pain. Treatment requires knowledge of a range of potential management strategies outside of the standard addiction service tool bag. Treatment also requires close working between addiction services, pain teams (where they exist), primary care and the patient themselves. These patients are often not the 'typical' service user and may find the traditional set up of drug treatment services difficult to engage with. As a result they may drop out of treatment.**

40. **Alcohol Related Brain Damage is a growing issue and more patients are being referred to alcohol treatment services because these patients fall between the gaps in other services (e.g. memory services, neurology).**

Performing detoxification processes in these patients, as with alcohol dependent patients with other physical health issues, requires considerable clinical support and again, these services have often not been considered in Wales.

41. **The ABUHB welcomes the Welsh Government recommendation for the provision of Alcohol Liaison Nurses to help with their overstretched workloads caused by alcohol misuse locally. The Health Board will seek to develop this resource as soon as resources can be identified.**

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Riana Griffiths – ASM 08 / Tystiolaeth gan Riana Griffiths – ASM 08

I am writing to register my strong opposition to the proposal to close the CADT and hope that you can help in this matter.

The service provided by the CADT is a successful and highly regarded one that has been established for nearly 30 years. A provision such as this, with a wide, far reaching remit in attenuating the negative effects of alcohol and drug related issues and preventing the continuation of these is not available anywhere else in South Wales. There will be no counselling service in Cardiff for people with alcohol and drug problems if the CADT closes. There are other services providing valuable support, but they do not provide professional counselling from qualified staff capable of working on their issues in a structured and efficacious way.

Cost effective services of such high quality take time to become established and to be fully effective, so why destroy it when it is working so well and when there isn't a service to take its place? The closure of the CADT will leave a massive gap in services if it is to be taken away from the people who really need it and ignoring these needs will not make them disappear. Furthermore, the knock on effect of this closure will be enormous and ironically, much more expensive than keeping it.

Since 1986 the CADT has successfully supported thousands and thousands of clients with alcohol and or drug related issues. If this service hadn't existed some of those clients would not be with us today, but the CADT does not just save lives. It supports people in a way that enables them to function effectively in all aspects of their day to day living. People with substance misuse issues don't live in isolation, they live with their families, go to work and are connected to friends, their communities and society in general. All those connected people are effected by someone with substance issues and a huge circle of people benefit when that person is helped in living more positively. If someone with alcohol and or drug related problems is not taken care of, that individual and the work that they do can suffer the consequences. Substance issues are experienced by people from all walks of life ranging from judges to psychiatrists and if they are not supported properly, the services that they provide will, in turn be hindered.

People's lives can be very complex and it takes highly trained counsellors to understand the diversity of factors that sometimes effect people in a negative way. Substance misuse if often the tip of the iceberg because it can be a manifestation of other underlying circumstances. People go to the CADT with a wide variety of issues they need help with including childhood sexual abuse, post-traumatic stress, bereavement, depression, anxiety,

stress and a whole host of other mental health problems. The professionals at the CADT have extensive training and experience in dealing with these and many other concerns that are associated with substance misuse.

The small number of highly qualified employees do not carry out their crucial work alone, they are helped by a team of 8 volunteer counsellors who have been trained and are supervised by the staff. This enables the CADT to provide an evening counselling service for those people in work who cannot come during the day. If the CADT closes these volunteers will have nowhere to provide their free service.

In fact, the Council will only save £218,000 a year if the CADT is dismantled, but the real cost of closing the service will amount to much more than this. This proposal to close the CADT is not only short-sighted, it is also life-threatening and I am asking you to support its continuation.

Health and Social Care
Committee
National Assembly for
Wales
Pierhead Street
Cardiff
CF99 1NA

[redacted]

7th January 2015

Dear Mr Rees,

Response to Inquiry into alcohol and substance misuse

1. We welcome the opportunity to give feedback to the Committee in response to it's inquiry into alcohol and substance misuse. Our comments are given from the perspective of a family affected by alcohol misuse issues. We hope that we can offer a glimpse of our experience of the local services available and how the issues were tackled in the hope that it might be of some use in informing the Committee's Inquiry.

2. We appreciate that each person's experience of services and responses to substance misuse issues will be different and will depend on individual circumstances.

3. Our introduction to the devastation that alcohol misuse can cause began at Morriston Hospital's A&E Department where a close family member was admitted following deliberate overdose of prescription medication and alcohol. At this stage, the family were completely unaware of the backdrop to the crisis that had led to the hospital admission. Following treatment at the Clinical Decision Unit in the hospital, the patient (reference used to protect the identity of our family member) was discharged and no attempt was made by hospital staff to discuss care, treatment or follow up services with the family.

4. It is not our intention to rehearse the precise details of the history of the issues in this letter but we consider that the information relayed earlier is relevant in so far as it makes the point that the A&E Department and CDU at Morriston hospital were aware that the patient was physically dependant on alcohol.

5. Following discharge from hospital, we encountered a lack of follow up services and the family were left to deal with a situation which worsened resulting in a second deliberate overdose two months later. Still reeling from the shock of what had happened the first time and in the complete absence of any treatment plan since the first hospital admission we took it upon ourselves to research the treatment options and services that might be available in these situations. We insisted on meeting with the psychiatrist at Morriston hospital and requested that crisis intervention services be made available to the patient. Although we were told that the decision would have to be made by mental health services, this opened a dialogue

between the hospital staff, mental health services and the family eventually led to a treatment plan for the patient.

6. It is only at that point that referral was made to the Community Drug and Alcohol Team which was subsequently followed by hospital detoxification. We fear that without the family proactively pressing for treatment, services and involvement in the process, timely intervention might not have been forthcoming.

7. Before commenting further, it is worth mentioning that in this patient's case, the diagnosis is alcohol dependency co – existing with moderate to severe depression. Therefore, the alcohol dependency is linked with mental ill health.

8. We, as a family, consider that the following matters are of relevance when looking at how issues are tackled by relevant local services.

9. As noted earlier, the hospital will have recorded against the patient's notes that the patient was dependent on alcohol. There does not appear to be an early engagement with GPs about the patient's case so that issues can be identified, signposted and treated appropriately and early enough. We note that resources are often cited as a significant barrier in terms of the provision of treatment. However, we take the view that this rather basic step of flagging issues to the GP could and should be improved without radically impinging on resources.

10. Taking account of the confidentiality which underpins medical treatment, we consider that much better engagement with family and carers should be undertaken by hospitals and other service providers where the patient

gives consent. In our case, we had to persistently press hospital staff to speak to us notwithstanding the consent of the patient. This is quite an important point because NHS information encourages discussion with carers in these situations but that was not evident in practice.

11. Another aspect of service provision that needs further work is the link between primary and secondary care. We found that joined up working between mental health services and primary care could be improved. Whilst the mechanisms may be in place to enable cross working, in practice it was evident in our case that there were gaps.

12. Similarly there appears to be a need to improve expertise in the handling and treatment of patients suffering from mental ill health and co-existing conditions such as substance misuse.

13. One of the most positive aspects of treatment services has been the patient's engagement with WGCADA (West Glamorgan Council on Alcohol and Drug Abuse). We are fortunate to be able to report that the input of this particular service has made significant inroads to the patient's recovery. We note that a vital aspect of the service is that many of the counsellors are recovered alcoholics/drug addicts and this places them in a unique position to connect with substance users. We cannot emphasise enough the enormously constructive role that this organisation has played in influencing and improving the recovery of our family member. We hope that funding for this service is at the very least maintained because without their invaluable contribution it is highly likely that resources would greatly increase elsewhere. We also wonder

whether it is a factor that the success of the service is partly due to the fact that many of the counsellors have experience of substance misuse themselves.

Yours sincerely,

[redacted]

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Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Royal Pharmaceutical Society – ASM 10 / Tystiolaeth gan Cymdeithas Fferyllol Frenhinol – ASM 10

Health and Social Care Committee
Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff
CF99 1NA

10th December 2014

Dear Sir / Madam

Inquiry into alcohol and substance misuse.

The Royal Pharmaceutical Society (RPS) welcomes the opportunity to respond to the National Assembly for Wales' Health and Social Care Committee's inquiry into alcohol and substance misuse.

The RPS is supportive of the need to control the use of alcohol and substances of misuse. We strongly believe that there is a need to increase public education and awareness of the harm associated with the misuse of alcohol and other substances, ensuring that the public are aware of the potentially devastating consequences.

We believe that steps should be taken to raise awareness among young people in particular. This could be achieved through targeted public health approaches in schools and colleges across Wales, developing and implementing campaigns and making promotional materials available to young people. Pharmacy could play a key role in national campaigns in respect of delivering public facing messages and advice on the implications of alcohol and substance misuse, increasing the opportunity to provide interventions and support to encourage motivational behaviour change in this group

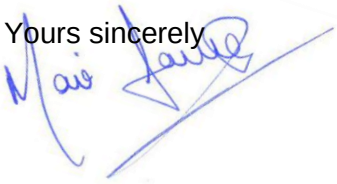
The RPS responded to a consultation on 'illegal highs' in September and we would like to reiterate that we believe a more preventative approach is needed, where substances that currently fall into the category of 'legal highs' should be banned until they can be approved by the appropriate regulator, wherever practicable. The RPS would also welcome the implementation of any legislation that would allow the prosecution of those individuals that may be supplying psychoactive substances to the public, with particularly strong repercussions of supplying to young people under the age of 18.

Community pharmacy plays an important role in increasing access to substance misuse services through, for example, the delivery of local needle exchange programs,

supervised methadone administration, and the provision of health promotion advice. The pharmacist is often the healthcare professional who has the most contact with patients that access theses service and can often pick up on changes in behavior as well as health and wellbeing. The pharmacists' input into the patients wider treatment regimen and care is however very limited and is often dependent on individual pharmacists building relationships with other healthcare workers rather than an official process that incorporates the pharmacist into further discussion about the patients care. We recommend that opportunities should be explored for formally involving pharmacists with a special interest in substance and alcohol misuse in local service delivery arrangements, and to further incorporate the pharmacist into the multidisciplinary care team.

I trust this information is helpful. Please do not hesitate to get in touch if you require any further information.

Yours sincerely



Mrs Mair Davies

Chair, Welsh Pharmacy Board

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain. We represent all sectors of pharmacy in Great Britain and we lead and support the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession's policies and views to a range of external stakeholders in a number of different forums.

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Public Health Wales – ASM 11 / Tystiolaeth gan Iechyd Cyhoeddus Cymru – ASM 11

Submission to the National Assembly for Wales' Health and Social Care Committee Inquiry into Alcohol and Substance Misuse

Authors: Josie Smith and Dr Sarah Jones, National Leads for Substance Misuse and Alcohol, Health Protection, Public Health Wales

Date: 9th January 2015	**Version:** 1c

Purpose and Summary of Document:

This document is the Public Health Wales submission to the National Assembly for Wales' Health and Social Care Committee Inquiry into Alcohol and Substance Misuse

1 Introduction and summary

We welcome the opportunity to give evidence to the Assembly Committee Inquiry into Alcohol and Substance Misuse.

In Wales, and across the UK, alcohol and drugs represent significant challenges to both individual and public health. Users of alcohol and other drugs are at risk of a number of serious adverse effects; acute and chronic, direct and indirect, on physical and mental health. Problematic use also results in substantial social consequences for the individuals, their families and the wider community and a significant burden on the NHS and other social care and criminal justice services. The Welsh Strategy for Substance Misuse 'Working together to reduce harm' incorporates both drugs and alcohol and as such this term will be used to include both drugs where relevant in this submission.

The harm reduction approach being taken in Wales in relation to substance misuse is the right one. It is multi disciplinary and focused on health. We wish to see it further developed in the following ways:

- **Primary prevention of substance misuse by the increased use of powers and population-level interventions to reduce consumption and prevent escalation to problematic use –** through legislation including the introduction of minimum unit pricing for alcohol, restriction of sales, taxing alcohol products at a level proportionate to the volume of alcohol

- **Early engagement and the provision of credible, timely and tailored information and advice** for individuals who are consuming alcohol and/or other drugs and experiencing harms to themselves or impacting on their families, carers and the wider community

- **Development of clear pathways for care** – from early or initial contact with health and social services (for example ambulance, police, primary care, youth services and clinical practitioners) to specialist substance misuse services (from low threshold and outreach community work through to clinical treatment)

- **Adaptation of specialist substance misuse services** - to meet the needs of current and future alcohol, drug and poly-drug users in a timely and accessible way. Services are currently focused on treatment of one primary substance be that alcohol or drugs. Services should further adapt to address all substance misuse needs and poly-drug use and wider social care needs.

2 The impacts of alcohol and substance misuse on people in Wales

Information from a number of sources in the UK, including Wales, suggests that patterns of alcohol and substance misuse have evolved considerably both across the population as a whole and within specific vulnerable groups. These include:

- Access to, and experimentation with, a wider range of emerging and illicit drugs, as well as prescription only medicines, particularly amongst younger people and students, along with long term drug users, including those who are homeless or in prison
- Changes in patterns of alcohol consumption, with a move away from drinking in community settings, e.g. public houses, to drinking at home, which is less visible and less expensive. Pre-loading, the consumption of alcohol and/or drugs at home before going out, is not uncommon particularly amongst younger people and university students
- Increased identification of alcohol related brain damage in later, or even earlier, middle age amongst problematic alcohol users
- Increased poly-drug use in terms of alcohol and drugs, including prescription only medication

There are also some research indicating that:

- Young people are more inclined than ever before to drive under the influence of drink or drugs and have higher drink and drug driving rates than any other age group[1],[2]
- Older people are drinking more at home, in part to deal with loneliness and social exclusion[3,4]
- Pregnant women are drinking to excess risking harm to themselves and their unborn child[5]
- 'Drunk walking' on the way home from a night out is placing people at risk of accidental harm or intentional harm by others[6].

The impacts of these changes, are reflected in terms of physical and

[1] https://www.gov.uk/government/statistical-data-sets/ras51-reported-drinking-and-driving
Table RAS51006
[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277556/rrcgb2012-05.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236989/young-drivers-2011.pdf
http://www.rac.co.uk/advice/motoring-news/young-drug-drivers-on-the-rise/
[3] http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0071792
[4] http://alcoholresearchuk.org/downloads/finalReports/FinalReport_0085
[5] http://online.liebertpub.com/doi/abs/10.1089/tmj.2012.0247
[6] http://www.bbc.co.uk/news/uk-scotland-30428683

mental ill-health. This is evidenced by the rates of disease, hospital admissions, self-reported substance use and mental well-being and drug and alcohol related deaths:

- In 2013-14, 308 young Welsh residents (aged up to 24 years) were admitted to hospital specifically due to alcohol and 503 due to drug use although hospital admissions for substance misuse amongst younger people are declining year on year.[7]
- In terms of wider social harms there were 4,935 of cases of children in need where parental substance misuse (including alcohol misuse) was recorded as the relevant parental factor, representing 25 per cent of all cases of children in need in Wales. Children in care, particularly those in local authority care, are more likely to progress to later substance misuse than the general population.[1]
- In 2012, one in four motor vehicle drivers killed in traffic collisions were over the drink-drive limit[8]. In 2013, there were 119 accidents where the reporting police officer considered that a pedestrian(s) being 'impaired by alcohol' was a contributory factor to that accident.[2] In relation to drug driving, it is reported that, for every 5 accidents where the driver was impaired by alcohol, there was around 1 accident where he/she was 'impaired by drugs', both illegal and medicinal[2]. In addition, young drivers are more susceptible to the effects of drink than older drivers and are more likely to crash if they have consumed alcohol but are below the drink drive limit.
- Amongst older people hospital admissions due to alcohol remain relatively stable year on year. However, hospital admissions for drugs and referrals to specialist substance misuse treatment services, for both drugs and alcohol are increasing within this age group; a 15.8 per cent increase between 2009-10 and 2013-14.[1] This represents a challenge to services to best meet the needs of this ageing population.

Those who are homeless are particularly vulnerable both due to existing substance misuse issues and to the risk of developing problematic patterns of drug and alcohol use due to their homelessness. Homelessness can and does affect individuals of all ages including very young and older people. In terms of prison and custodial settings, the crimes most prominently associated with alcohol are those involving violence,[9] including domestic violence.

As shown above, the harms associated with substance misuse are wide

[7] http://wales.gov.uk/docs/dhss/report/141029submisuseprofilewalesen.pdf
[8] http://wales.gov.uk/docs/statistics/2014/141127-drinking-driving-2013-en.pdf
[9] Sivarajasingam V, Matthews K, Shepherd J. Price of beer and violence-related injury in England and Wales. Injury. 2006;37(5):388-94.

ranging, complex and dynamic. As such, it is recommended that efforts to improve primary prevention through increased powers to reduce availability and secondary prevention to prevent escalation to problematic use be explored. This should be undertaken alongside adaptation of the range of organisations and services designed to engage, identify and treat problematic drug and alcohol use in Wales

3 Effectiveness of current Welsh Government policies and any further action required

The current Welsh Government substance misuse strategy for 'Working together to reduce harm', along with specific policies to tackle the availability and harms associated with substance misuse, both drugs and alcohol, have been shown to be effective. This is evidenced by the decrease in hospital admissions and deaths related to alcohol and drugs. However, there is always more that can be done to:

- Limit access and work to make alcohol and drug use less socially acceptable
- Prevent initiation to problematic use of drugs and alcohol
- Identify and diagnose early signs of problematic substance misuse
- Provide timely and effective treatment for those with substance misuse problems including pharmacological, psychosocial and clinical care

The implementation of the alcohol brief intervention (ABI) training by Public Health Wales has ensured that both NHS and non-NHS staff are suitably skilled to engage with individuals to identify potentially harmful drinking patterns and encourage behavioural change. Over 7,000 such staff have now been trained to deliver ABI across Wales, ranging from military personnel to midwives. The Welsh Government has been a key driver in the development of this programme.

The proposed introduction of minimum unit pricing as policy in Wales is welcomed as are the policies of reviewing fatal and non-fatal drug poisonings and alcohol related deaths, to ensure that lessons learned and recommendations may be implemented to reduce future deaths.

The proposed Liver Disease Delivery Plan should ensure that health boards are well placed to prevent, diagnose and treat alcohol related liver disease and hepatitis infection as a consequence of problematic substance misuse, specifically injecting drug use.

In addition to these existing policies, the following recommendations are made to further tackle substance misuse:

- All alcohol products should carry a health warning from an independent health regulatory body
- The sale of alcohol should be restricted to specific times of the day
- The availability of uncontrolled new psychoactive substances should be regulated
- Tax on alcohol products should be proportionate to the volume of alcohol
- Licensing authorities should be further supported to utilise existing powers to tackle alcohol-related harm by controlling total availability in their area
- Alcohol advertising should be limited to newspapers and other adult press while its content should be limited to factual information. All advertising should also contain a evidence-based health warning specified by an independent regulatory body and displayed at an independently regulated size.
- The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml. Scotland has already taken a lead in this area, bringing them in to line with mainland Europe.
- All health and social care professionals should be trained to provide early identification and brief alcohol and wider substance misuse advice[10]
- People who need support for substance misuse (drugs and/or alcohol) problems should be routinely referred to specialist alcohol services for assessment and treatment[4]
- Existing laws to prohibit the sale of alcohol to individuals who are already heavily intoxicated should be enforced in order to reduce acute and long term harms to their health and that of the individuals around them
- Sanctions should be fully applied to businesses that break the laws on under-age sales[4]
- Efforts should be made to implement Graduated Driver Licensing (GDL) in Wales. The GDL programme has three main components: a night time driving restriction, a passenger restriction and a 'zero tolerance' on alcohol consumption. This reflects the fact that young drivers are more susceptible to the effects of alcohol than

[10] Alcohol-use disorders: preventing harmful drinking | Guidance and guidelines | NICE

older, more experienced drivers

We believe that a harm reduction and health-centered approach is likely to be more effective than one based on criminal justice. If Wales were to adopt legislation prescribing health in all policies, this would be strengthened. We believe this should be achieved through the Wellbeing of Future Generations Bill with health included in its common aim.

4 Capacity and availability of local services to raise awareness and deal with the impact of the harms

There are a wide range of services across Wales with a remit to raise awareness and address the harms associated with substance misuse including statutory health, social and criminal justice organisations, third sector and private organisations. The primary issue relates to the capacity of services offered locally, rather than their range.

Local services across Wales are well placed to raise awareness of the harms associated with both drug and alcohol using knowledge of local trends.

However, existing substance misuse services tend to be accessed once problematic alcohol or drug use is firmly embedded rather than seeking support at earlier stages when psychosocial and other treatments may be very effective in reducing progression to severe harms. It must be recognised that there remains a great deal of social stigma in relation to problematic use of alcohol and/or drugs. As such individuals may be fearful of association with specialist services, or even of discussing issues with primary care practitioners, and therefore fail to engage with these services. It is these types of issues that the ABI programme aims to address, but there is much work still to be done.

Adapting services, based upon evidence of the needs of the substance using population, in particular the needs of vulnerable groups e.g. older people, would address this along with increasing levels of expertise amongst the staff. In addition, the development of a clear pathway to services would support engagement and reduce harms.

Local services, including local authorities, need to be supported by increased powers to reduce the availability, promotion and problematic use of alcohol and drugs. The introduction of policies to achieve this, including minimum unit pricing, could support the individual and societal change required if the harmful impact of alcohol and other substances is to be addressed.

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Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol
Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from NSPCC Wales - ASM 12 / Tystiolaeth gan NSPCC Cymru - ASM 12

Response to the Inquiry into Alcohol and Substance Misuse

Date: January 2015

NSPCC Cymru/Wales, Diane Englehardt House, Treglown Court, Dowlais Road, Cardiff, CF24 5LQ

Tel: [redacted] Email: [redacted]

MAE POB PLENTYNDOD WERTH BRWYDRO DROS
EVERY CHILDHOOD IS WORTH FIGHTING FOR

About the NSPCC

We're leading the fight against child abuse in the UK and Channel Islands. We help children who've been abused to rebuild their lives, we protect children at risk, and we find the best ways of preventing child abuse from ever happening.

Abuse ruins childhood, but it can be prevented. That's why we're here. That's what drives all our work, and that's why – as long as there's abuse – we will fight for every childhood.

We help children rebuild their lives, and we find ways to prevent abuse from ruining any more. So when a child needs a helping hand, we'll be there. When parents are finding it tough, we'll help. When laws need to change, or governments need to do more, we won't give up until things improve. Abuse changes childhood. But so can we.

The NSPCC welcomes the opportunity to input into the Health and Social Care Committee's inquiry into alcohol and substance misuse to highlight the impact of parent/ carer substance misuse on children.

Children and young people can be affected by alcohol and substance misuse both as misusers themselves and as victims of the effect parental misuse can have. We are focusing on the latter in this written evidence.

Prevalence and impact

The precise number of children affected by, or living with parental substance or alcohol abuse is difficult to establish. It is estimated that 2 million children and young people in the UK are affected by parents' drug or alcohol misuse.[1] Parental substance misuse can harm children's development in two very distinct ways: directly through exposure to substances in utero and also indirectly through its impact on parenting capacity.

Research has clearly linked maternal alcohol use in pregnancy with impaired brain development in the foetus.[2] Most drugs cross the placenta, so the misuse of drugs during pregnancy affects both the mother and the foetus. Research evidence into the misuse of drugs by pregnant women show a range of negative impacts on the foetus, including congenital malformations, low birth weight, poor growth and premature delivery.[3] In addition, children exposed to drugs before they are born may suffer from

[1] Manning, V., Best, D., Faulkner, N. and Titherington, E. (2009). 'New Estimates of the Number of Children Living with Substance Misusing Parents: Results from the UK National Household Surveys'. *BMC Public Health*. 9 (377).

[2] National Scientific Council on the Developing Child (2006) *Early exposure to toxic substances damages brain architecture.* Retrieved from www.developingchild.harvard.edu and Welch-Carre, E. (2005) "The neurodevelopmental consequences of prenatal alcohol exposure," *Advances in neonatal care 5(4): 217-29*

[3] Greenough, A. et al. (2005) "Effects of substance misuse during pregnancy" in *The Journal of the Royal Society for the Promotion of Health* 125(5): 212-13

drug withdrawal after birth and exhibit a variety of negative effects including irritability, inability to sleep, poor feeding and weight gain, and regurgitation.[4]

Research has shown that parents misusing substances are at risk of a wide range of difficulties associated with their role as a parent. These may include a lack of understanding about child development issues, ambivalent feelings about having and keeping children and lower capacities to reflect on their children's emotional experience.[5]

Whilst harm from parental substance use is not inevitable, children living in these circumstances are at increased risk of harm and neglect. Drug misuse can manifest itself in a variety of ways including physical ailments such as infections, overdoses and accidental and non-accidental injuries and psychological impairments such as being dominated by the drug and addiction, withdrawal symptoms such as erratic and irritable behaviour, psychosis and serious memory lapses.[6] These symptoms show how it is very likely that children living with parents who engage in drug misuse are at high risk of significant harm. Evidence also generally shows that parents who misuse substances often suffer other adversities, such as domestic violence or mental ill health, which makes the outcome of abuse or neglect more likely. [7]

The Wales Children in Need Census 2013 showed that of the 19,920 children in need included in the Census, parental substance or alcohol misuse was present in 20 per cent of all referrals (3890 children).

Child neglect

Parental abuse of drugs or alcohol, or both, is found in more than half of parents who neglect their children[8]. NSPCC funds Cardiff University to undertake child protection systematic reviews and summarises the research into bilingual leaflets for practitioners to help them identify the signs of abuse and neglect[9]**.** In November 2014 NSPCC launched the latest systematic review into child neglect and emotional abuse in children aged 5-14 which complements the leaflet that summarises the features of emotional neglect and abuse in pre-school children launched in 2012. The research reports that the key features of emotional abuse and neglect are poor school performance and lower IQ, impact on behaviour (may present

[4] Hunt, R.W. et al (2008) "Adverse neurodevelopmental outcome of infants exposed to opiate in-utero" in *Early Human Development* 84: 29-35

[5] Suchman, N.E. et al (2005) How early bonding, depression, illicit drug use and perceived support work together to influence drug-dependent mothers' caregiving, American Journal of Orthopsychiatry 73(3) 431-445.

[6] ACMD. (2003) *Hidden Harm. Responding to the Needs of Children of Problem Drug Users: The Report of an Inquiry*. Advisory Council on the Misuse of Drugs (ACMD), London.

[7] Kroll, V. (2004) *Living with the elephant: Growing up with parental substance misuse,* Child and Family Social Work 9(2):129-40

[8] Greenough, A. et al (2005) *Effects of substance misuse during pregnancy* in the Journal of the Royal Society for the Promotion of Health 125(5): 212-13

[9] http://www.core-info.cardiff.ac.uk/category/leaflets

as aggressive or be quiet and withdrawn), difficulty with friendships and have few friends. NSPCC Cymru/ Wales recommend that these Welsh produced research and leaflets are made available to all professionals who work with families; these bilingual leaflets are available to download free of charge from the website:
http://www.core-info.cardiff.ac.uk/category/leaflets

NSPCC Cymru/ Wales in 2015 will be providing a range of neglect assessment and intervention services in both our Cardiff and Swansea Service Centres and is pleased to have been commissioned by Welsh Government, alongside Action for Children, to deliver the Welsh Neglect Project. The project aims to improve multi-agency responses and services for neglected children and their families, and it works across the spectrum of need. In 2015 the project will produce a range of practical resources to help practitioners identify, assess and address neglect. For further information please contact Vivienne Laing, Policy and Public Affairs Manager [redacted].

Contacts to ChildLine

Through ChildLine, the NSPCC has a unique insight into how children and young people experience the effects of parental alcohol and substance misuse. In 2012/13, ChildLine dealt with 3,930 contacts from young people across the UK who were concerned about their parents' drinking. This was almost twice as many as in 2011/12.

One young person who spoke to ChildLine said:

"My mum drinks all the time and leaves me alone lots of times. I feel scared and lonely. I look after my mum when she drinks. I put her to bed. Mum shouts and hits me; she is worse on a Friday. I don't want to feel pain. I want to die." (Angel, aged 10)

Another said: "*I want to run away from home. Both my parents use drugs and alcohol and they fight. My mum brings men home all the time. I really hate their way of living and would like to get away. I did try to get away with my sister but my sister is partly disabled so she couldn't keep up and we came back home. I am really unhappy to be left alone in the house all night."* (Sanjay, aged 14)[10]

Those children who are cared for by habitual alcohol or drug users are also at risk of turning to alcohol and drugs themselves in order to cope with life's challenges – for children contacting ChildLine, if a significant person in their life is misusing drugs, there is almost six times the

[10] Mariathasan, J. Hutchinson, D. (2010). *Children talking to ChildLine about parental alcohol and drug misuse*. London: NSPCC. 33.

likelihood that the young person will discuss themselves misusing drugs compared with all children counselled by ChildLine.[11]

Services available for families affected by parent/ carer substance misuse

NSPCC Cymru/ Wales welcomes the Welsh Government's Intensive Family Support Service which focuses on families where parents have substance misuse problems that affect the welfare of their children.

The NSPCC is looking at solutions to reduce the negative impact of parental alcohol and drug misuse on children. As part of this work, the NSPCC provides FED UP – Family Environment: Drug Using Parents. The NSPCC runs the programme at a number of its UK service centres, including in Cardiff.

FED UP (Family Environment: Drug Using Parents) Programme

This is a face-to-face intensive intervention for families in which there is parental substance misuse. It aims to reduce the negative impact of parental alcohol and drug misuse on children and ensure they are kept safe. Children aged between 5 and 12 years can be referred to FEDUP, if they have a parent who is dependent on drugs or alcohol. The programme is delivered over 12 weeks. Specially trained NSPCC practitioners work with the child to provide emotional support, improve self-esteem, help the child make sense of their world and offer a space for them to talk about their experiences. At the end of the group work programme two sessions will be spent with the parent and child to put in place an agreed safety plan.

The work with parents can begin before the child starts the group and will continue throughout the programme. As well as helping parents understand the effect the substance misuse has on the child, the NSPCC will work with them to improve their parenting skills.

An interim evaluation of the programme was published in October 2014. Our interim findings provide promising evidence that FEDUP can help reduce the negative impact of parental drug and alcohol misuse on children. Key findings include:

- Children and young people reported a decrease in their emotional and behavioural problems at the end of the programme. At the start of the programme 37 per cent of children and young people reported a clinical level of difficulties, but by the end of the

[11] Ibid.

programme only 25 per cent still reported a clinical level of difficulties.

- The factors identified by children that helped facilitated change included: developing their skills to deal with their emotional wellbeing; providing a safe space to discuss issues that they previously found difficult to talk about; enabling them to meet other children in similar situations, thereby helping them realise that they were not alone and to build new friendships; and having supportive practitioners who made them feel valued.

- Parents reported being less unhappy; being more confident about their parenting; and having a greater knowledge about children's needs at the end of the programme.

- The factors parents identified as helping them bring about changes in their parenting included: having the time to reflect on how their drug/alcohol taking behaviour impacted on their child; beginning to see situations from their child's perspective; learning new skills to address challenging behaviours; having a greater understanding about their strengths, thereby increasing their confidence; and having supportive practitioners.

A final evaluation report will provide more insight into whether the programme was effective in changing parents' understanding, attitudes, and behaviour in the long-term.

The full interim report is attached for your information.

We hope that the Committee will place a high importance on the considerable impact of alcohol and substance misuse on children and young people as part of the inquiry.

We are happy to provide further information and would like to offer members of the Committee the opportunity to meet FED UP practitioners, together with parents and children who have participated in the programme in our service centre in Cardiff. Please don't hesitate to contact us if this would be of interest.

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Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Gwent Police – ASM 13 / Tystiolaeth gan Heddlu Gwent – ASM 13

National Assembly for Wales' Health and Social Care Committee -

Inquiry into alcohol and substance misuse.

The effects of alcohol and substance misuse on people in police custody.

Gwent Police Response-

1.1 Whilst police custody figures can provide a useful perspective on the prevalence of drug or alcohol misuse in the population, they are subject to a significant number of biasing influences. These influences can range from simple logistics - the number of officers available to patrol and make arrests – to the effect of such debates as whether hospital or custody is the right place for someone suffering from the ill-effects of alcohol misuse. This means that the figures must be approached with caution and any conclusions drawn should be tentative.

1.2 Gwent Police made approximately 16,000 arrests in 2013, this contrasts with approximately 14,000 in 2014. Broadly, the figures show the same trends in alcohol and substance misuse across the period. There were 800 arrests for being drunk and disorderly in a public place in 2013 (about 5% of the total), which is approximately equivalent to the anticipated 550 (about 4% of the total) for 2014, taking into account the decrease in overall detainee numbers.

1.3 This is reflected in the returns for the number of people arrested for driving whilst above the legal limit for alcohol, some 700 in 2013 against 500 in 2014. Again, these are not significantly different when overall numbers are considered.

1.4 When considering trends in drug misuse, the arrest numbers for possession of controlled substances are very low. Cannabis remains the drug most commonly possessed and is about 3 times more prevalent than any other drug when considering the number of people arrested. In 2013 arrests for possession of Amphetamine and Cathinone derived substances were approximately equivalent and about double that for possession of either Heroin or Cocaine.

1.5 2014 has seen arrests for Amphetamine, Cathinone derived substances and Cocaine all drop significantly. Arrests for Heroin possession have remained about the same. That said, the dataset is too limited to allow any conclusions to be drawn from these apparent variations and they are more likely to result from differences in officer numbers or behaviour than from any actual variation in behaviour on the part of the drug-using population in Wales. Significantly more data would be needed to support any conclusions.

1.6 The final area where custody figures can reflect on the questions at hand is in the risk assessments made by custody staff when considering detainees brought before them. Custody sergeants are required to assess the demeanour of detainees on their arrival at the custody facilities and this assessment includes whether the detainee is apparently intoxicated or not. In 2013 some 17% of detainees, for all offences, were recorded as displaying intoxication, whether from drink or drugs. In 2014, this increased to about 27% of all detainees arrested. Again, it would be inappropriate to draw firm conclusions from such a limited dataset – which is as likely to derive from changes in local recording practices as any other factor - but it would be interesting to see whether this was reflected in results from the other three Welsh forces.

Collated by Insp Nick McLain, 07/01/15.

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Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Brynawel Rehab – ASM 14 / Tystiolaeth gan Brynawel Rehab – ASM 14

dewis gwellhad
Brynawel Rehab
choosing recovery

Brynawel House Alcohol and Drug Rehabilitation Centre response to the National Assembly for Wales Health and Social Care Committee inquiry into Alcohol and Substance Misuse.

1. **Brynawel House Alcohol and Drug Rehabilitation Centre, Llanharan, known as Brynawel Rehab, is a residential substance misuse service regulated by the Care and Social Services Inspectorate Wales, that offers a programme of detoxification and rehabilitation to adults aged eighteen and above (with no upper age limit), who are dependent on alcohol or other drugs and who wish to achieve and maintain abstinence. Brynawel Rehab is situated in Rhondda Cynon Taff but accepts clients from all over Wales; residents of Scotland and England also received treatment at Brynawel.**

2. **Brynawel offers treatment and rehabilitation to more than eighty clients a year. It has a staff of twenty two and delivers only evidence based psychological and psychosocial therapeutic interventions to supports its service users to achieve and maintain recovery, the approach through which an individual is enabled to move from dependency on alcohol or drug use towards an alcohol or drug free life.**

3. **Research commissioned by the UK government's Department of Health undertaken by its then lead researcher Dr David Best clearly concludes that "The only type of formal treatment service which was a key factor in helping drug users to stay**

abstinent was residential rehabilitation. They concluded that formal long term structured treatments (other than residential rehabilitation) played only a peripheral role in the recovery journeys." (Statement by researchers Dr David Best, Jessica Loaring and Safeena Ghufran quoted in Addiction Today 27th May 2011).

4. **Residential rehabilitation placements in Brynawel Rehab are spot purchased on an individual case by case basis by specialist local authority teams (community care teams) following a social work "community care assessment" to assess the needs of the person and match a service to meet those needs. The rehabilitation programme lasts sixteen weeks at a cost of £770 a week.**

5. **This method of funding a drug and alcohol muse service is unique to residential rehabilitation services. Services such as community based substitute prescribing for opiate dependency or community based services to treat alcohol dependency are funded through the global NHS budget, in the case of NHS Community Drug and Alcohol Teams, or by block payments as may be the case with voluntary sector community delivered drug and alcohol treatment services.**

6. **This method of spot purchasing, with its failure to guarantee income streams, means that all the financial risk associated with delivering the service rest solely with the board of management and trustees of Brynawel. It is a model that inhibits growth, is not conducive to stability, and most fundamentally undermines sustainability and contributes to the fragility of residential rehabilitation.**

7. **To ameliorate the situation the Minister for Health and Social Services has ring-fenced one million pounds of the Substance Misuse Action Fund Budget to provide inpatient and residential rehabilitation services. However a significant proportion of this fund is channeled directly to Local Health Boards to deliver hospital based detoxification. In addition the contraction of local authority budgets has reduced the capacity of local authority social services departments to use their community care budgets to fund placements at Brynawel Rehab.**

8. **Given the evidence base for the efficacy of residential rehabilitation it is the view of Brynawel Rehab's board of management that to ensure the effectiveness and efficiency of**

residential rehabilitation services a planned and commissioned service should replace the system of spot purchasing. This approach would involve the commissioning of all treatment bed placements throughout the year on an area or regional basis. It would require care managers, service planners, commissioners and the service to embrace new thinking and a new way of working to meet the challenge of delivering a planned, sustainable recovery focused substance misuse service for Wales.

9. A sustainable recovery service should be commissioned for at least a three year period subject to the services continuing to meet agreed standards. In addition to offering the most effective use of resources, this approach would both fit with the commissioning responsibilities of Area Health Boards and their substance misuse area planning boards and would free residential rehabilitation services from the vagaries of a market driven system.

10. A comprehensive assessment underpins integrated care for people who misuse drugs and alcohol and have the most complex problems. It is also the lynchpin for specialist staff to engage with, and offer treatment and interventions such as residential rehabilitation.

11. The aim of the assessment is to identify the need, including the impact of substance misuse on their physical, psychological and social functioning. In order to recognise the treatment and interventions required, staff that perform these assessments need to be appropriately qualified and competent to be able to interpret the findings of the assessment and use these to plan appropriate care and or support. In relation to residential rehabilitation these assessment are carried out by specialist social workers under the umbrella of community care assessments. It is therefore an essential prerequisite to meeting need and ensuring that there is an integrated service planned that every locality in Wales (local authority) is committed to offering an assessment to identify a community care need for treatment or intervention for drug and alcohol misuse and assessing the potential for that need to be met by residential rehabilitation.

12. The NHS and Community Care Act 1990 Section 47(1). imposes a duty on local authorities to carry out an assessment of need for community care services with people who appear to them to

need such services and then, having regard to that assessment, decide whether those needs call for the provision by them of services. An assessment is triggered where:

- The person appears to be someone for whom community care services could be provided and
- The person's circumstances may need the provision of some community care services

13. A person with drug and alcohol dependency who wishes to become abstinent has a need for community care service and the local authority has a statutory duty to undertake an assessment. That assessment should have regard to how that need may best be met and should therefore include residential rehabilitation services. Consequently no local authority should operate an access policy that does not include residential rehabilitation in the range of community care services available to meet assessed need and the right of a person to access residential rehabilitation services should the needs assessment so indicate.

14. As it stands there is no general power for social services authorities to delegate this function to other bodies. Even if there is no hope from the resource point of view of meeting any needs identified in the assessment, the assessment may serve a useful purpose in identifying for the local authority unmet needs which will help it to plan for the future. Without assessment this could not be done.

15. It is the view of the trustees and board of management of Brynawel Rehab that the implementation of the Social Services and Wellbeing Act Wales in April 2016 should provided the opportunity to strengthen and build on these provisions by not only maintaining the obligation on the local authority but also ensuring that assessments are undertaken by the most appropriate professional.

16. Brynawel Rehab is an innovative service, responsive to the expressed needs of the organisations with which it works in partnership. It is this environment that has lead to the development of an initiative relating to Alcohol Related Brain Damage.

17. Alcohol related brain damage (ARBD) is the subject of the report “All in the mind” produced by Alcohol Concern Cymru and published in March 2014. it explains that ARBD is the term used to describe the effects of long term alcohol consumption on the function and structure of the brain, a condition that has

a variety of related symptoms, including confusion, memory loss, and difficulty reasoning and understanding. They are the result of the physical damage that alcohol, as a poison does to brain tissue, coupled with nutritional deficiencies resulting from heavy drinking. There is considerable anecdotal evidence of patients with ARBD being passed between services who feel reluctant or ill-equipped to take them on. Once ARBD diagnosis is established, the prognosis for recovery can be split broadly into quarters:

- 25% make a complete recovery
- 25% make a significant recovery
- 25% make slight recovery
- 25% make no recovery.

18. This means that, overall, 75% can make some recovery if they are identified at an early stage and offered appropriate treatment In all cases, research suggests that recovery is enhanced by developing a rehabilitation programme specific and relevant to each patient, helping them to acquire (or regain) the skills they need to manage their own lives and their own environment.

19. A task and finish group drawn from health and social service departments across south Wales has for the past six months been working to shape a response to an identified deficit in the provision of services for people with ARBD.

20. The initiative arose from the recognition by social work specialists in Rhondda Cynon Taf of increasing numbers of people with ARBD, a need for local services and the potential for Brynawel Rehab to offer a service. The initiative is timely as the Welsh Government has commissioned a report from Public Health Wales, estimating the number of people in Wales effected by ARBD and Alcohol Concern Cymru has produced " All in the Mind" with recommendations to the Welsh Government.

21. Individuals on the spectrum of Alcohol Related Brain Damage (ARBD) have the potential for recovery. A service should support people to move through services to greater independence. There is continuum of need and related services offering services from rehabilitation to continuing support in independent living. A key function of a service would be to

support recovery and facilitate transition between different levels of support.

22. **It is the view of trustees and management board that Brynawel Rehab has the potential to be the nucleus of a service providing accommodation initially of five beds, therapeutic support and offering transition to independent supported living. Brynawel could offer a five bedroom ensuite facility, in a safe environment. A range of psychosocial activity based therapy such as horticulture: social therapeutic programmes outdoor activities as well as psychological interventions: physical health and nutritional support and the introduction of new therapeutic treatment models tailored to individual clients, which are evidence based, all would involve new and additional staff. However there are major obstacles to be overcome in developing and implementing such a service. A residential rehabilitation service needs a whole system approach. It is insufficient to establish a free standing, residential rehabilitation resource without the associated architecture of community based health social care services and supported living services focussed on delivering services to people with ARBD. This may not require a new, discrete service but community based health and social care services would need to be strengthened to ensure that they have the capacity to deliver a service. Any service and in particular the rehabilitative residential component of the service cannot be created on the financially unsustainable basis of spot purchasing. If appropriate facilities are to be developed they must be on the basis of centrally funded start up costs with the costs of the ongoing service met through the process of long term commissioning of places.**

23. **The timely diagnosis of, and response to ARBD is critical if the prospect of recovery is to be realised and significant social and economic costs averted. To ensure timely diagnosis health and social care professionals need to have the skills and knowledge to identify people with ARBD and comprehensive, assessment and reassessments need to be carried out by health and social care staff competent in assessing and care managing ARBD.**

24. **In order to illustrate the impact of ARBD on people and the health and social care responses currently available to people with ARBD four case examples drawn from local authority social work teams in Wales are included at annex A.**

Annex A

Case examples

Mr. A

25. **Mr A is a 54 year old divorced man who lived alone in the community for several years, moving from public house to public house until a referral was made to the substance misuse team as part of a hospital discharge referral. He had a long history of alcohol dependence, self neglect, was homeless, was quite isolated in the community and did not have contact with his remaining family. He was also dependent on diazepam, had peripheral neuropathy and had poor independent living skills.**

26. **Mr A was placed in Bed and Breakfast accommodation whilst suitable housing was found. Eventually he moved into a 1 bedroom ground floor local authority flat.**

27. **The local authority attempted to support Mr A in his own home in the community for a few years; however, it became apparent that his needs were substantial and complex and that the local authority was no longer able to meet them in the community.**

28. **The significant issues were his mental capacity and possible ARBD with memory loss, marked confabulation; peripheral neuropathy which affected his mobility and Mr. A subsequently experienced pressure sores to buttocks: double incontinence**

and pressure sores: low mood :misuse of diazepam resulting in frequent calls for emergency services by neighbours due to him experiencing diazepam withdrawal: increased dietary neglect including hiding food: vulnerable adult concerns regarding possible financial abuse despite the local authority having appointeeship in relation to his finances.

29. Mr A was eventually admitted to hospital suffering from a twisted bowel. Whilst as an in-patient a request was made for a mental capacity assessment and assessment for ARBD. Problems arose attempting to establish a diagnosis as medical staff was unable to agree whether the Older Persons Mental Health or Adult Mental Health Services were most appropriate to assess his needs.

30. Mr. A was transferred to another hospital for rehabilitation and assessments including a continuing health care assessment. After 18 months in hospitals, Mr A was moved to a local nursing home, whilst it was appreciated that this did not entirely meet his needs, it was preferable to remaining in hospital. Both the hospital and residential care setting had limited scope for rehabilitation of his physical and cognitive health issues. Mr A would have been a candidate for assessment at a local Alcohol Related Brain damage facility; however, this was not available at this time.

31. Further referrals were made to the adult mental health services for an assessment of Mr A's mental health; however, despite vulnerable adult concerns with his behaviour impacting on other residents both Adult Mental Health and Older Persons Mental Health services were unable to agree which service should take this assessment forward. Both the Health Board and Local authority Social Services Department shared the cost of the a residential placement whilst financial responsibility was disputed, a dispute that has now been resolved and Mr. A's care is being met from the continuing health care budget

Mr. B

32. Mr B is a sixty two years of age, separated from his wife. He has three adult children, two of whom have a "tense, strained" relationship with him. Mr B worked all his life, retiring two years ago years ago. He had many active interests including gardening, 'foraging', metal detecting and darts.

33. Mr B drank alcohol all his life and said that this was never a problem. However, his estranged family provided a conflicting opinion. It appears that alcohol use increased at the time of retirement and significantly following his separation from his wife.

34. Following the separation Mr B lived in sheltered accommodation. Following a fall approximately a year after moving into the accommodation, he was admitted to the District General Hospital. It appeared that he was malnourished on admission to hospital and quickly became confused and agitated and, it appeared that his short term memory was impaired.

35. Mr. B spent several months on a rehabilitation whilst there he received an appropriate diet, hydration, medication, physiotherapy and occupational therapy. Though his memory improved significantly whilst on the ward however, there remains some residual memory loss, he also reports dizziness when he moves about which affects his confidents in mobilising and managing some tasks of independent living and increases anxiety – this is thought to be due to damage to his cerebral cortex.

36. As Mr B had been in hospital for approximately 6 months with little activity, there has been some atrophy to the legs, which also impacted upon his confidence to move around. At this point in Mr B's rehabilitation, he would have been a good candidate for placement at a specialist Alcohol Related Brain Damage unit to build on independent living skills. However this type of facility is not available in the local area as a result Mr B was placed in residential care home and remains in long term care

Mr. C

37. Mr. C is forty six years old and had been homeless and in the early stages of ARBD He was hospitalised with acute cirrhosis, ascites and was gravely ill. His parents could not face him sleeping rough but could not cope with his illness and were very distressed by his condition. Mr. C reacted with understandable fear expressed as aggression borne of confusion at his situation.

38. Mr. C was referred to the Community Drug and Alcohol Social Work Team. The Social Worker conducted her assessment and intervention over a sustained period in order to gain his trust in her. Mr. C accepted that he could not drink again and after working with the Social Worker. However the appropriate service to meet Mr. C's needs on discharge from hospital simply did not exist.

39. Mr.C was eventually placed in the local authority's supported accommodation. The manager of the accommodation was anxious about accepting the Mr. C because of the degree of his health and social need. Since the placement Mr. C's health has improved dramatically though there is the occasional fluctuation because of the damage to his liver. He is now in regular contact with his children and parents.

Mr. D

40. Mr. D was a 53 year old man referred, by his anxious relatives, to the local authority's Community Drug and Alcohol Social Work Team Mr. D lived alone but was wealthy. His circumstances meant that he could do as he pleased and it pleased him to drink a bottle of vodka during the day.

41. Mr. D was a gregarious person well known for his generosity and spirited company. As he grew older use of alcohol became dependent and by slow degrees his temperament changed, relationships disappeared, his wife left him, he became estranged from his children and his dependency on alcohol grew until only those few remaining close relatives sustained him. When the social worker visited it was immediately evident that Mr. D needed hospital admission, detoxification and residential rehabilitation. He had been seen by NHS general medical staff but they had not referred him the specialist team at that time. Mr. D was by now consuming 75cl bottle vodka and 2 bottles of red wine a day. His intoxication was unusually profound so that he lacked any capacity His cerebellum had atrophied and he had lost the use of his legs.

42. Mr. D was referred to the specialist team and his faculties returned with detoxification. He could not access the steps to his own privately rented flat and he was accommodated in unsuitable bed and breakfast accommodation with a very caring and generous owner who looked after him more than one would normally expect. Mr. D relapsed to a slightly less

dangerous pattern of drinking but dangerous nonetheless. Following an episode of Deep Vein Thrombosis brought on by immobility and smoking and very badly managed by general medical services he was referred to Physiotherapy services at the local hospital saw him but rejected the referral on the grounds that he had been drinking and any work with him would be "pointless." This may be seen as is typical of the multiple oppressions endured by people with problems of substance misuse.

43. Mr. D was referred to Brynawel who were sympathetic to his physical and mental health needs and after an interview offered him a place. Unfortunately Mr. D could not be persuaded to take the place because of his resistance to counseling and anything he would perceive as therapy. The social worker, consultant psychiatrist and the specialist nurse all tried their utmost to persuade Mr. D to accept residential rehabilitation. In desperation the social worker suggested that he forgot the therapy and suggested that he needed, at very least, a sustained break from alcohol. Mr. D remained convinced that he could win his battle with alcohol and that one day he would walk again. Sadly he passed away after a seizure and a fall.

44. The social worker wrote " I remain convinced that if Mr. D could have accessed an abstinence based service for people with ARBD immediately after detoxification he would have done well. He often said that he regarded me as a friend rather than a social worker and friendly professionals have the power to give people like Mr. D the support that not even a caring relative can. It is not true to say that Mr. D was a great drain on health or social care resources for the year and a half that he lived following detoxification because he could not access them. Social Workers work with marginalised and oppressed people - presently it is difficult to think of any group so marginalized that they do not have a module in the Treatment Framework for Wales".

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Age Cymru – ASM 15 / Tystiolaeth gan Age Cymru – ASM 15

Consultation Response

Inquiry into alcohol and substance misuse in Wales

January 2015

1. Introduction:

1.1 Age Cymru welcomes this inquiry by the Health and Social Care Committee, and in particular the focus upon the experiences of older people. We are pleased that this issue is being taken seriously in Wales as demonstrated by the work of the Committee and the Welsh Government's Substance Misuse Treatment Framework – Improving Access for Older People[1] published in October 2014.

2. General comments:

2.1 As a consequence of the recent publication of this Framework, it is not possible for us to comment at this stage upon its implementation or impact. However, it is clear from its content that the issue of substance and alcohol misuse among older people, and its treatment or lack thereof, has remained a 'hidden' problem for a population group whose needs are often overlooked

2.2 There is a clear gap in the existing research upon alcohol and substance misuse which largely focuses on younger adults. Yet, the recent publication on alcohol use in Wales by the Public Health Wales Observatory (PHWO) demonstrates that whilst levels of alcohol consumption are decreasing slightly among younger adults, they are persisting or indeed increasing amongst the 45+ age group[2]. According to the Welsh Government Substance Misuse Treatment Framework

[1] http://wales.gov.uk/topics/people-and-communities/communities/safety/substancemisuse/policy/treatmentframework/?lang=en

[2] Public Health Wales Observatory (2014): *Alcohol and Health in Wales 2014*: p5
It is worth noting that there is little consistency in the available literature with regard to definitions of an older person. For some substance misuse reporting, 'older' can include anyone from the age of 40 or over.

Consultation Document, there were 3783 people aged 50 or above who were referred for substance misuse treatment in Wales in 2012-2013[3] largely for alcohol misuse. This figure may belie the true scale of the issues given that alcohol and substance misuse often goes undiagnosed among older people, suggesting high levels of unmet need.

2.3 Further data needs to be collected to establish the extent of alcohol/substance misuse among older people in Wales, and referral rates for treatment or support.

2.4 Across the EU, there is a rise in alcohol-related mortality in older groups. Currently rates of alcohol-related disease are several times higher for men than for women[4]. As social norms with regard to alcohol consumption by women have changed, however, we may see rates amongst women increasing, in the same way that lung cancer rates continue to rise among women due to a later peak in female smoking rates.

2.5 Wales has an ageing population so demand for services/treatment for older people with alcohol or substance misuse problems is likely to increase. This trend is compounded by the fact that the consumption of alcohol has become more socially acceptable over recent decades[5].

2.6 Alcohol use places the health service under pressure, but also has broader implications for society and impacts upon the work of other agencies, such as social services and the police. Alcohol consumption can exacerbate chronic health conditions, and can have consequences for both physical and mental health. Hospital stays for alcohol-related admissions may be longer. There are risks associated with mixing alcohol with prescription medications.

2.7 The physiological changes associated with ageing influence our reaction to alcohol. The Royal College of Psychiatrists (RCP)[6] has argued that 'safe levels' of alcohol consumption are based upon research carried out with younger adults and may be too high for older people who have an increased risk of adverse physical effects.

2.8 Alcohol and substance use may be a sensitive subject for some older people who may see it as a private issue or who see a stigma attached to excessive use. For that reason, when developing approaches to treatment, it needs to be recognised

[3] Welsh Government WG20340, February 2014: p4

[4] M Hallgren, P Högberg & S Andréasson (2009): *Alcohol consumption among elderly European Union citizens. Health effects, consumption trends and related issues* (Expert conference on alcohol and health)

[5] Drugscope (2014): *It's about time. Tackling substance misuse in older people*

[6] Royal College of Psychiatrists (2011): *Our invisible addicts. First Report of the Older Person's Substance Misuse Working Group of the Royal College of Psychiatrists* (College Report CR165): pp35-36

that older people are not a homogenous group and that their reasons for drinking and how much they drink will be based on their personal circumstances, their biography and their socio-economic background[7].

2.9 Older people who misuse alcohol or substances will present to a wide range of agencies, not just healthcare. Often, due to the presence of other conditions or because symptoms are atypical, the underlying cause of misuse may be missed[8]. This highlights the importance of raising awareness among healthcare and other professionals. A range of services and agencies need to be able to identify and respond to problems effectively, requiring joint working and case management[9].

3 Early-onset and late-onset:

3.1 It has been estimated that around two-thirds of older people who drink excessively can be identified as early-onset drinkers[10], that is that they have been drinking heavily since their teens or twenties. They may be faced with certain chronic health problems that are associated with long-term alcohol misuse, for example liver cirrhosis, but they may also face problems associated with ageing that do not result from, but are aggravated by, their alcohol consumption. They may have a history of treatment for misuse, and longer-term support may be required for these individuals, especially if they feel they have 'failed' with previous treatment routes.

3.2 With regard to the other third of older people who drink excessively, these are generally identified as 'late-onset' drinkers, usually increasing their alcohol consumption during their 50s or 60s, often as a consequence of major changes in their lives or lifestyles. These can include bereavement, retirement and divorce[11]. According to the RCP, older men are more likely to be at great risk of becoming late-onset drinkers[12].

3.3 There is general agreement in the existing literature that late-onset drinkers have a better prognosis once diagnosed than early-onset drinkers, as they may have greater motivation to change their drinking habits, and tend to be drinking to excess rather than dependent on alcohol. However, they may not know where to go for help or what help is available[13], and this situation is compounded by the fact that the public health focus on alcohol has targeted the drinking behaviours of younger adults.

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[7] L Ward, M Barnes & B Gahagan (October 2008): *Cheers!? A project about older people and alcohol*
[8] RCP, 2011: p39
[9] Drugscope, 2014: p13
[10] Drugscope, 2014: p7
[11] *ibid*
[12] RCP, 2011: p7
[13] S Wadd, K Lapworth, M Sullivan, D Forrester & S Galvani (2011): *Working with older drinkers*: pp6-7

3.4 The triggers highlighted above can often lead older people to a greater feeling of loneliness or isolation. A number of the services that may have helped to tackle this root cause, such as day centres or Meals on Wheels, have been suffering from cut backs as a consequence of funding pressures, a situation further aggravated by the loss of public transport routes that are vital to older people, especially in rural areas.

3.5 There is a need to accord prevention among older people a higher priority. On the one hand, this requires recognition that there is a place for soft-outcome services, such as befriending and neighbourhood schemes, which can help to support late-onset drinkers who may be triggered by adverse life effects and loneliness. On the other hand, it also means that there is a need for awareness-raising of the impact of excessive alcohol consumption in prevention campaigns that are suitable for older people. Clearly there is value in campaigns that target excessive alcohol consumption among younger adults, but this is unhelpful if it leads to the issue being viewed as solely a young person's problem. Older people who may wish to seek help or advice need to know how to access a service that is appropriate to their particular needs.

4 Substance misuse:

4.1 Substance misuse among older people can take different forms. Increasingly, as a consequence of the ageing of those generations that were more accepting of experimentation with substances during the 1960s and 1970s, there are older people for whom substance use has been on-going over a long period of time. They may already be in the system, but now face additional problems of older age that may or may not relate to their substance use.

4.2 There are also older people who start using illicit substances during later life, for a range of reasons, including adverse life events, pain management or because they have or had a partner who used illicit drugs[14]. For both of these groups, services need to be available that are age-appropriate and which understand the risk of co-morbidities with both the physical and mental health issues that may be present either as a consequence of substance misuse or deriving from the ageing process.

4.3 Another issue is the inappropriate use of prescribed and/or over-the-counter medicines. Unlike alcohol use, here it is women that are at greater risk than men of misusing the medicines or developing a dependence on them[15]. Medicine usage should be followed up during interactions with healthcare professionals to ensure that medicines are being used safely and appropriately.

[14] Welsh Government WG20340, February 2014: p3
[15] RCP, 2011: p7

5 **Treatment:**

5.1 Prevention and the shaping of age-appropriate prevention messages are crucial. Many who are drinking to access may not need specialist treatment, but could find appropriate support through other services highlighted below. In order to do so, however, they need to be aware that they are drinking to excess.

5.2 It should be recognised that many people do not find the use of units a useful measure with regards to alcohol consumption[16]. There are also concerns about whether the current safe levels are appropriate for older people, given that they are based on research into younger adults.

5.3 The Add To Your Life programme, a free online health check provided by NHS Wales for those aged 50 and over, refers to alcohol consumption in terms of units, which may lead to people under-estimating or confusing their levels of consumption. Given the targeted nature of Add To Your Life, this may offer a useful channel for disseminating age-appropriate messaging about alcohol consumption, but concerns have been raised that it lacks signposting to relevant further advice and help.

5.4 In addition to the questions raised about the appropriateness of the currently recommended safe levels for older people, concerns have been raised about whether the principal screening/diagnostic tools are appropriate for older people[17]. Once the Welsh Government's Framework to improve access for older people has been implemented, a review should take place to ensure that appropriate screening/diagnostic tools are being used in assessment.

5.5 A number of barriers have been identified that may prevent the diagnosis of alcohol or substance misuse among older people[18]. These include ageism, under-reporting, misattribution, stereotyping and a general view that alcohol and substance misuse among older people is very rare, leading to the possibility of it being overlooked. Therefore healthcare and other professionals require training to ensure that symptoms are recognised. They need to be supported by having referral procedures in place. Effective referral can be undermined by the lack of a clear mechanism and by the time and other constraints existing within the health and care systems.

5.6 In particular, it has been suggested that professionals need to be open to considering the possibility of alcohol or substance misuse among older people who are frequently using primary care[19], A&E (fracture clinics) and mental health services, with some specific issues being identified as frequent unexplained falls,

[16] See for example, the British Heart Foundation Alcohol Survey summary: https://www.bhf.org.uk/heart-matters-magazine/news/alcohol/alcohol-survey-in-depth
[17] RCP, 2011: p28
[18] See, for example, Wadd et al (2011): p15; RCP, 2011: p26
[19] Regular presentation at primary care may also be an indication of loneliness or isolation.

or patients doing much better in hospital but then deteriorating following discharge[20].

5.7 Whilst recognising the need for sensitivity, practitioners should not feel embarrassed to raise the issue with patients or, where appropriate, with family members, friends or carers, even where they are reluctant to discuss the issue. There is a need to understand the context in which the misuse is occurring and, indeed, a need to be aware that friends etc may be complicit or even, in extreme cases, that there is a safeguarding issue where alcohol is being used as a form of control[21].

5.8 The issue of alcohol or substance misuse is often dealt with in primary care. In order to ensure timely treatment, and the minimising of physical and mental health harms, early detection is crucial. The RCP has called for annual GP screening as a way of identifying excessive alcohol consumption[22].

5.9 However, even when a problem is identified/diagnosed, older people have been less likely to be given adequate treatment or, where appropriate, referred to specialist services[23].

5.10 Available specialist services are often targeted at, or sometimes even funded for working age adults – some services commissioned in the UK have an upper age limit for those they will treat[24]. Relevant services need to be open to/suitable for all ages with recognition that older people may benefit from one-to-one, rather than group support and that older people may feel uncomfortable in an environment oriented towards younger people or that tensions may develop between older and younger service users[25].

5.11 Many services that can benefit older people misusing alcohol or substances are facing funding pressures, or even discontinuation. This is not just true of specialist treatment services, but broader services such as transport – lack of transport facilities can be a barrier in accessing appropriate help[26] – or befriending which can help to tackle loneliness where this may have been a trigger for excessive alcohol consumption. In some instances, the third sector may be the appropriate source of a cost-effective service that is local, peer-led and operates in a way that doesn't judge lifestyles. However, funding pressures in the sector means that useful services are being lost or only operate for a short period of time. Many older people who are drinking to excess may need support

[20] RCP, 2011: p29
[21] Wadd et al, 2011: p8
[22] RCP, 2011: p8
[23] *ibid*: p28
[24] Drugscope, 2014: p11
[25] *ibid*
[26] *ibid*

but not in the form of specialist services and the services that can help them are also being lost.

5.12 There is also concern in the existing body of literature about the suitability of the current detoxification model for older people, even where it is available. The Welsh Government consultation recognised that outpatient detoxification treatment may not be appropriate for older people who lack the necessary support to achieve the targeted outcomes[27]. Treatment/care plans need to take account of the availability of support networks, the age of onset and the presence of co-morbidities *inter alia* to ensure the older person gets the treatment or care most appropriate to their individual needs[28].

5.13 There are particular challenges associated with addressing the issue of alcohol or substance misuse among people with cognitive impairment which health and other relevant professionals need to be made aware of in order to ensure the most effective care and support possible[29].

6 Concluding remarks

6.1 Older people can, and do, benefit from treatment for alcohol and substance misuse. No-one should be denied access to effective treatment on the basis of age.

6.2 There is an evident need for awareness-raising, training and clear referral pathways for staff, supported by a clear local policy to which professionals can refer. This local policy should be derived from the WG framework to ensure its effective implementation, thereby enabling a subsequent review of its impact.

6.3 With regard to research, two issues need to be address: firstly, there is a clear need for further research into the effective treatment of these issues among older people; secondly, we need better data to establish the scope of the issue among older people in Wales so that services and treatments can be targeted effectively.

[27] Welsh Government WG20340, February 2014: p8
[28] Wadd et al, 2011: p20
[29] See RCP, 2011 for a discussion of these challenges.

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Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from BMA Cymru Wales – ASM 16 / Tystiolaeth gan BMA Cymru Wales – ASM 16

ALCOHOL AND SUBSTANCE MISUSE

Inquiry by the National Assembly for Wales' Health and Social Care Committee

Response from BMA Cymru Wales

9 January 2015

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the inquiry by the National Assembly for Wales' Health and Social Care Committee into alcohol and substance misuse.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

In the experience of BMA Cymru Wales members, current drug and alcohol services in Wales are overwhelmed and have long waiting times. As a result, interventions by relevant service professionals are

not provided at an optimal time in too many cases. This often leads to individuals suffering a worsening of their problems in the interim.

In our view, greater resources should be devoted to health education around the dangers of both alcohol and substance abuse. We believe that the dangers of addiction, and the resultant potential for loss of employment, should be stressed. Sporting associations, in particular, should be made aware of the increasing problems that individuals can face from the abuse of anabolic steroids. Risk and harm reduction should, in our view, be at the centre of any campaign.

We consider that citizens need to be sufficiently educated regarding the adverse impacts of drugs and alcohol to better equip them to take control of their own destiny. We also feel that the media should cease what can at times come across as a glamorisation of drugs and alcohol consumption – often portrayed as the benefits of a successful lifestyle.

It is important that any education campaigns that might be employed are effective. We would note that increased knowledge does not always in itself translate into altered behaviour from those who might benefit most, and that awareness programmes can vary in their effectiveness.[1, 2] There is also a role for brief interventions which are aimed at modifying behaviour in both primary[3] and secondary[4] care settings.

We observe that alcohol and drugs are contributing increasingly to crime and accidents of all types. Alcohol consumption, in particular, is adversely affecting hospital accident and emergency departments to a significant extent – especially at weekends and evenings. This is manifesting itself through an increased prevalence of unacceptable and threatening behaviour towards staff (if not actual physical assault) in addition to the enhanced workload that is generated from accidents, assaults and incidences of severe intoxication linked to excess alcohol consumption and drug taking.

The culture of binge drinking also appears to be escalating. We observe that alcohol-related liver disease is increasing, and is affecting more people at a younger age than ever before. Recent figures from drug and alcohol charity CAIS have shown that 80% of its referrals are now related to alcohol addiction, whereas five years ago those seeking its assistance were evenly balanced between those related to alcohol addiction and those related to drug addiction.[5]

In line with BMA policy at UK level, BMA Cymru Wales supports the introduction of minimum unit pricing for alcohol as a key first step in reducing excessive alcohol consumption.[6] Modelling produced for the Scottish Government using the Sheffield Alcohol Policy Model[7] would indicate the effectiveness of such an approach.

We consider that a current price of 50p per unit should be regarded as the minimum that will have a sufficient impact, but this should be kept under review once introduced to ensure that that alcohol does

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1 Ferri M, Allara E, Bo A, Gasparrini A & Faggiano F (2013) *Media campaigns for the prevention of illicit drug use in young people (review).* Cochrane Drugs and Alcohol Group. Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009287.pub2/abstract

2 Faggiano F, Minozzi S, Versino E & Buscemi D (2014) *Universal school-based prevention for illicit drug use.* Cochrane Drugs and Alcohol Group. Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003020.pub3/abstract

3 Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B & Pienaar ED (2007) *Effectiveness of brief alcohol interventions in primary care populations (review).* Cochrane Drugs and Alcohol Group. Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004148.pub3/abstract

4 McQueen J, Howe TE, Allan L, Mains D & Hardy V (2011) *Brief interventions for heavy alcohol users admitted to general hospital wards (review).* Cochrane Drugs and Alcohol Group. Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005191.pub3/abstract

5 http://www.bbc.co.uk/news/uk-wales-30518021

6 http://bma.org.uk/-/media/files/pdfs/working%20for%20change/alcoholreducingaffordability.pdf

7 http://www.shef.ac.uk/scharr/sections/ph/research/alpol/research/completed/scotland

not return to becoming more affordable over time. We would observe that a minimum unit price at this level will have little economic impact on the average drinker in a public house and would mainly impact on off-trade sales, such as from supermarkets.

Any increased tax revenue obtained as a result of higher alcohol prices should, in our view, be invested in the prevention of alcohol misuse as well as in the rehabilitation of alcohol abusers.

We believe that a restriction in licensing hours and more stringent licensing regulations could give governments within the UK greater control over the availability of intoxicants. We also consider that current alcohol supply regulations should also be more effectively enforced (e.g. refusing to supply further alcohol to someone already deemed to be drunk). Additionally, we would advocate a total ban on the advertising of alcohol, as well as a ban on "happy hours".

In line with the recent policy change in Scotland, the BMA further believes that the drink driving safe limit should be reduced in the rest of the UK from 80 mg to 50mg of alcohol in 100ml of blood – thereby bringing us into line with the majority of European countries. Modelling studies have predicted that lowering the limit to 50mg/100ml would reduce serious and fatal crashes, and could expect to save 65 lives and prevent 250 serious injuries per year in the UK.[8]

In a number of regards, we note that Scotland has been leading the way in reforms to alcohol policy. We consider that such reforms should be applied throughout the UK, including within Wales. If such uniformity of alcohol regulation is not achieved, then we would be concerned that a problem of "alcohol tourism" might ensue.

Whilst our response to this inquiry mostly concentrates on issues relating to alcohol abuse, we would also note that the complex issue of substance abuse needs a public debate in order to develop a consensus approach.

In relation to new psychoactive substances (so-called "legal highs"), we consider that the focus should be on understanding the risks associated with their use, as well as on educating against risk behaviour.

Further information concerning the BMA's view on substance misuse can be found in a 2013 report produced by the BMA's Board of Science, entitled *'Drugs of dependence – the role of medical professionals'*.[9]

Conclusions and key recommendations

BMA Cymru Wales welcomes this Health and Social Care Committee inquiry which is highlighting two key related issues that are having an increasingly adverse impact on Welsh society.

We call for:

- Greater resources to be devoted to education concerning the dangers of both alcohol and substance abuse.
- The introduction of minimum unit pricing for alcohol, set initially at 50p per unit.
- A restriction in licensing hours, more stringent licensing regulations and more effective enforcement of existing alcohol supply regulations.
- A total ban on the advertising of alcohol.
- A ban on "happy hours".
- A reduction in the drink driving safe limit from 80 mg to 50 mg of alcohol in 100 ml of blood.

[8] Allsop R E (2005) *Some reasons for lowering the legal drink-drive limit in Britain*. London: Centre for Transport Studies, University College London. Available at: http://discovery.ucl.ac.uk/1425/1/REA_WP051.pdf

[9] British Medical Association (2013) *Drugs of dependence – the role of medical professionals*. London: British Medical Association. Available at: http://bma.org.uk/news-views-analysis/in-depth-drugs-of-dependence/full-report

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from The British Psychological Society – ASM 17 / Tystiolaeth gan Cymdeithas Seicolegol Prydain – ASM 17

The British Psychological Society
Promoting excellence in psychology

British Psychological Society response to the National Assembly for Wales Health Select Committee

Alcohol and substance misuse

About the Society
The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries
We are content for our response, as well as our name and address, to be made public. We are also content for the Committee to contact us in the future in relation to this inquiry. Please direct all queries to:-

Joe Liardet, Policy Advice Administrator (Consultations)
The British Psychological Society, 48 Princess Road East, Leicester, LE1 7DR
Email: [redacted] Tel: [redacted]

About this Response

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We hope you find our comments useful.

Mary Clare O'Connell
Chair, Welsh Branch

British Psychological Society response to the National Assembly for Wales Health Select Committee

Alcohol and substance misuse

	The impacts of alcohol and substance misuse on people in Wales, including young people and university students; older people; homeless people; and people in police custody or prisons;
	Comments: It is widely accepted that substance misuse causes considerable harm not only to individuals and their social networks but to the wider society. These harms are many and include both physical and mental problems, harms to the well being of families and children as well as harm to the wider community through the crime and antisocial behaviour associated with substance misuse. Recent reports suggest that the economic and social cost of Class A drug use in Wales is estimated to be in the region of £780 million with drug related crime accounting for 90% of this ('Working Together to Reduce Harm, Welsh Assembly Governments Strategy 2088-2018). The Welsh National Database for Substance Misuse (WNDSM) was set up in 2005 and provides information regarding referrals to treatment for drug and alcohol problems. In the period of 2011-2012 a total of 31,071 referrals were registered and of these 54% of the referrals identifies alcohol as being the main concern whilst 40% identified drugs and being the main issue. Males accounted for the majority of referrals in both cases and the median age for alcohol referrals was higher than that for drugs. Alcohol and cannabis are the main substances for which young people are referred into treatment (aged 10-19 years) and the rate of underage drinkers, despite a decline, remains one of the highest in Europe and North America. According to the 2011 Welsh Health survey, around 2 out of 5 adults report drinking above the recommended guidelines on at least one day in the past week, including a quarter who report binge drinking (Substance Misuse and treatment services in Wales, National Assembly for Wales, 2013) The impact of substance misuse can be seen across a variety of domains and populations including mental health services, medical services, older adult services, young people and homeless services. There is also a recognised level of co-morbidity which can occur which has been traditionally difficult to bridge.*(*A Service Framework to Meet the Needs of People with a Co-occurring Substance Misuse and Mental Health Problem, Welsh Assembly Government 2007*).* Research from North Wales suggests that in an inpatient sample of service users undergoing detoxification when screened during admission, 84% of patients were found to be within the clinical range for low mood and 77% were found to be within the clinical range for anxiety. Additionally, 96% of this sample was found to have impaired social functioning as detected by the GHQ 12 (Hogan et al, 2013)

Following the evaluation of two community services in North and Mid Wales information was produced regarding service users with substance misuse and co-occurring mental health problems.

Data from Conwy refrain, a counselling service based in North Wales, suggested that of the 121 service users who attended from assessment, 95% of people reported elevated levels of anxiety with 86% of the total in the moderate or severe range. Further, 85% of people reported symptoms of elevated levels of depression with 51% of the total in the moderate or severe range (Hogan et al, 2014).

HG2G was a group-based service located in Mid Wales Data from this service suggested that of the clients assessed (n = 321), 88% were found to have clinical levels of dependency, 94% reported clinical levels of anxiety, 78% reported low mood and 81% reported clinically impaired social functioning. Outcomes including Psychosocial Interventions appeared extremely effective (see Hogan, Elison, Ward & Davies, 2014; Hogan, in preparation).

As part of 'A Service Framework to Meet the Needs of People with a Co-occurring Substance Misuse and Mental Health Problem' (Welsh Assembly Government), a joint liaison or collaborative approach was recommended as the preferred model for the delivery of care to people with a co-occurring substance misuse and mental health problem. Via the Care Planning Approach, it was recommended that older people, with special consideration to the use of alcohol and tranquillisers, should be considered within this revised delivery system. The needs of young people, the homeless, ethnic minority groups, women, prisoners and people with a diagnosis of personality disorder were also to be included within this proposal.

Individuals with a dual diagnosis generally experience poorer outcomes with regard to their mental health, and their engagement with services and treatment compliance may also be compromised and or delayed. Conversely, individuals with substance misuse issues risk deterioration of their mental health and the emerging presence of serious mental illness. This may be compounded by the development of physical health problems which may necessitate the use of medical services (Department of Health, 2002) Mental health policy implementation guide: dual diagnosis good practice guide. London).

Given the broad range of mental health disorders – ranging from severe and enduring mental health disorders to milder mental health disorders such as anxiety in combination with the various types of substances used, assessing which condition is the 'primary' and which the 'secondary' diagnosis may be challenging and may often present as a barrier to accessing appropriate services.

The long term effects of alcohol on the brain can be both psychological (mental health problems) and physiological (damage to brain tissue). People who drink heavily are particularly vulnerable to developing mental health problems, and alcohol has a role in a number of conditions, including anxiety and depression, psychotic disorders, and suicide. Over a long period of time, however, heavy drinkers may also develop various types of physical brain damage.

It has been suggested that Alcohol Related Brain Damage accounts for 10% of the dementia population and 12.5% of dementias in the under 65's (Harvey et al, 1998) and whilst evidence of increasing levels of prevalence is suggested, estimates differ widely. Current provision for specialist assessment and rehabilitation of people with Alcohol Related Brain Damage within Wales is very limited. The lack of prevalence rates amongst local populations has meant that opinions about the extent of the problem have been divided across services. To date there are no clear estimates of prevalence of ARBD within South Wales and this has caused a delay in the development of services. Literature does suggest that if a diagnosis of ARBD can be confirmed early and the service user receives medical support and rehabilitative aftercare, that the progress of this disorder can be halted and in many cases reversed. This will have important implications for the development of services for this group as the long term care and support required for a comparatively young population is likely to be costly for the community (All in the Mind 2014).

	Within addiction services we are seeing the emergence of younger people being diagnosed with ARBD and locally within Cardiff and Vale this has been noted in individuals under the age of forty (Roberts, 2012 unpublished). However, older people with ARBD often present to Older People's Mental Health Services with various cognitive changes. Ongoing alcohol use in conjunction with even mild cognitive fluctuations can result in this group of service users presenting as more problematic in terms of management in the community due to relationship breakdowns, public disturbances and unplanned emergency hospital admissions (Wilson, 2013). Once admitted to hospital, it is often difficult to ensure a long lasting discharge back home if they continue to use alcohol there is an increased chance that they become 'revolving door patients'. Links have been established between Clinical Psychology services for Addictions and the Memory Team in Cardiff and Vale LHB Trust where clients presenting with alcohol related with memory problems are discussed prior to assessment. However, there is an awareness that this joint working has to be limited due to limited staff numbers and availability. As such, follow up of these cases can be limited. Discussions are underway within Cardiff and Vale LHB in relation to piloting a rehabilitation unit for people who have cognitive impairment due to alcohol abuse. However, preferences appear to favour a medically based model, rather than considering models of best practice, in which psychological assessment and therapies would form an integral part of the service. Concern has been expressed among Clinical Psychologists locally about the quality of neurocognitive assessments that are being advocated and a failure to understand principles of cognitive rehabilitation. Links between Older Peoples Mental Health Services and Community Drug and Alcohol Teams do not seem to be well established across Wales and whilst older service users with established Korskoff's are easier for older peoples' services to manage due to the similarity between this and other dementias, for those individuals who continue to use alcohol, the services are less consistent and many service users often risk losing accommodation which in turn, has implications for an already very stretched homelessness provision. Another area of increasing concern is the emergence of 'new highs'. These substances are often referred to as 'recreational drugs' and by this term there is an immediate implication of safety and less potent substances. In reality, many have not been tested and there is no information about the long term mental and physical health problems associated with their use. More recently, services have attempted to improve the spread of what knowledge there is via social media outlets and this is potentially an effective way of communicating to the largest using age group which appears to be between 20-34 years (WEDINOS, 2014). Recent changes in the classification of Khat will likely have specific implications for South Wales as currently Cardiff is home to the largest Somali population in the UK and this has been a traditionally used substance within this culture. In 2014 the Advisory Council on the Misuse of Drugs undertook a review of the available scientific evidence on harms relating to Khat and whilst they did not recommend banning the use of this substance it was acknowledged that due to the lack of evidence in relation to its properties and the effects of these, that it should be classified as a Class C drug. Many of the research studies conducted at Bangor University, North Wales, suggest that hazardous drinking is common among university students (Cox et al, 2014, Shamloo et al, 2010) Moreover, in research studies, which have evaluated the effectiveness of interventions to reduce students' problematic drinking, they were found to be effective both for reducing alcohol consumption and for bringing about other positive changes in students' lives (Cox et al, 2014).
	The effectiveness of current Welsh Government policies on tackling alcohol and substance misuse and any further action that may be required;
	Comments:

There is now overwhelming evidence to support the use of psychosocial interventions for the treatment of substance misuse and co-occurring mild to moderate mental health problems (Dutra et al., 2008; Miller & Wilbourne, 2002). Indeed, recent policy documents from the Welsh Assembly Government (2011) and the Public Health England (formerly the National Treatment Agency) in collaboration with the Society (Pilling et al., 2010) have provided frameworks that recommend evidence-based psychosocial interventions (NICE, 2011) Their focus on evidence-based interventions is crucial given the continued widespread practice in treatment services of psychosocial approaches that are ineffective (Miller et al., 2006).

It is clear that no one psychological approach is suited to all individuals and the choice of the most suited intervention for an individual is highly complex (Miller & Carroll, 2006). Providing a choice of approaches is important in terms of successful outcome. There are a vast array of evidence-based psychosocial treatment approaches aimed at helping people with substance use difficulties (Carpenter & Brooks, 2006), including Motivational Enhancement Therapy (Miller et al., 1995), Motivational Interviewing (Miller & Rollnick, 1991, 2002), Cognitive Therapy (Beck, et al., 1993), Contingency Management (Higgins, Silverman, & Heil, 2007), Community Reinforcement Approaches (Hunt & Azrin, 1973), Behavioural Couples Therapy (Fals-Stewart, et al. 2006), and Family Therapy (Szapocznik Hervis, & Schwartz, 2003)

Welsh Government Policy as set out in the 'Working Together to Reduce Harm - The Substance Misuse Strategy for Wales 2008-2018' forms a reasonably inclusive and comprehensive document. The Action Areas included within this document address harm prevention, support for service users to improve their health and maintain recovery, supporting and protecting families and addressing protection within the community and availability of substances.

There is an emphasis upon prevention which addresses both areas of education within schools and support for families where there are issues with substance misuse In addition there is the promise to focus upon the needs of older students where there may be a development of substance misuse problems with an emphasis on early diagnosis and intervention.

While we acknowledge that services for substance misuse have progressed, there is recognition in this document that there is a need for expanding outreach and other services across Wales. These include addressing treatment outcomes, making services more efficient, improving capacity of services, focusing upon the areas of greatest harm, reducing barriers to treatment access, and reintegrating services users back into the community and engaging service users in the planning and development of services. The aims for these services are that they are made available to all areas across Wales and that there will be an investment in engaging priority and hard to reach groups.

Within this report there is recognition for better service integration and 'wrap around services' especially for housing, education training and employment. In addition there is an acknowledgement of the need for action in relation to prescription and OTC medications, steroids and solvents. Improvement in services for young offenders and increased options for adult prisoners are also discussed.

A large section of the policy addresses the reduction of risk of harm to children and adults as a consequence of substance misuse within the family. Closer working between statutory services both in health and Local Authority is emphasised and a multi-agency approach is recommended for identifying and supporting families.

In 2014, the Welsh Assembly annual report was published which looked at the progress made so far in relation to the original aims. This outlines the various ways in which the policy has been implemented across Wales including the potential for legislative change in minimum unit pricing, the publication of guidance for 'Improving Access to Substance Misuse Treatment for Older people', publication of guidance aimed at further reducing drug related deaths and the publication of an updated service user involvement framework. It details the conclusion of the Peer Mentoring Scheme and the publication of a document which addresses 'Improving

	Access to Substance Misuse Treatment for Veterans'. This report also outlines the investment of over £32 million from the substance misuse action fund to the delivery of harm based services. Built into this report is information about improved waiting times for treatment and evaluation of the impact that the investment is having upon local services.
	The capacity and availability of local services across Wales to raise awareness and deal with the impact of the harms associated with alcohol and substance misuse.
	Comments: Despite research findings demonstrating that a number of favourable treatments are available, there is a clear dilemma in implementing such approaches into 'real-world' services. For example, the expertise in these approaches is often unavailable, the training needs to deliver such services can be significant and the implementation of such treatments can be extensive. In the PHE/BPS framework, and independently in the Welsh Assembly Government framework, the NICE-recommended psychosocial approaches are classified as either low-intensity or high-intensity interventions. The distinguishing features between low and high is that the former require far less training, they are typically briefer to deliver, and they are offered to those with less severe problems or as a first step in a treatment journey, whereas the latter are more formal psychological therapies delivered by those with more specialist training and supervision. The PHE/BPS framework made a further distinction between their recommended interventions, in that they had interventions specifically for substance misuse and interventions for co-morbid mental health problems. As outlined above, the evidence is clear that the majority of people who meet the criteria for substance dependence will also meet a diagnostic criterion for a co-morbid mental health disorder (Kessler, 2004). It is typical that service users will present with some degree of anxiety, depression, or past trauma. In addition to these established techniques, there is a growing interest in the use of the newer, so-called, "third wave" psychotherapies specifically for the treatment of substance misuse. There is emerging evidence that these third-wave therapies, which were developed to treat a variety of mental health problems, might be effective in the treatment of people with co-morbid substance misuse problems. For example, mindfulness-based interventions (Zgierska et al, 2009), Acceptance and Commitment Therapy (Twohig et al, 2007) and Dialectical Behaviour Therapy (Dimeff & Linehan, 2008) have all been used effectively to treat people with substance misuse problems. Despite research findings demonstrating that a number of favourable treatments are available, there is a clear dilemma in implementing such approaches into 'real-world' services. For example, the expertise in these approaches is often unavailable, the training needs to deliver such services can be significant and the implementation of such treatments can be extensive. In the PHE/BPS framework, there are two low intensity interventions for drug misuse (i.e., Motivational Interviewing and Contingency Management) and additionally, two low intensity interventions for mental health difficulties (i.e., Guided self-discovery and Behavioural Activation) There is just a single high intensity intervention for drug misuse namely, Behavioural Couples Therapy and a single high intensity approach for mental health difficulties (i.e., cognitive behavioural therapy). Behavioural Couples Therapy is an approach specifically aimed at those substance misusers who have partners who are able and willing to participate directly in therapy primarily to resolve relationship difficulties and to promote abstinence. The Welsh assembly framework also recommends the interventions promoted in the PHE/BPS framework. In the Welsh Assembly framework they describe separate interventions for drug-related and alcohol-related problems. For both alcohol and drug misuse the framework recommends low intensity interventions including Motivational Interviewing and Contingency

management. In relation to drug use, they recommend CBT (including Relapse Prevention) and Behavioural Couples Therapy whilst for alcohol use the recommendation is the same but with the addiction of Twelve-step facilitation, Motivational Enhancement Therapy, and Social Behaviour Network Therapy.

It is of note to this review that there are certain omissions in the frameworks from the NICE-recommendations for psychosocial interventions and that there is a lack of clarity in terms of treatment modality. For instance the PHE/BPS and Welsh Assembly frameworks do not advocate family-based interventions, despite the recommendations from NICE (2011). NICE additionally recommended Multidimensional Family Therapy, Brief Strategic Family Therapy, and Functional Family Therapy. In terms of treatment modality, the Welsh Assembly, in particular, advocates individual therapy rather than group-work where structured, formal CBT is delivered. Researchers, however, have begun to advocate the use of a hybrid MI and CBT-based group programmes due to the efficacy and cost effectiveness of this treatment modality (Sobell et al., 2009).

The simplistic conceptual framework of advocating low intensity and high intensity interventions has some benefits over traditional frameworks, but nevertheless, it continues to have several drawbacks. First, these high intensity interventions require practitioners to have high-level professional training, which many teams do not routinely possess (Davies, 2007) Secondly, the high intensity intervention of Behavioural Couples Therapy is specific to only a relatively small proportion of service users (i.e., those in a stable relationship *and* those with a partner who is willing and able to undertake psychological therapy). In addition, although recognising that Motivational Interviewing is an effective evidenced-based approach, its popularity and delivery within "real-world" services is often unstructured, lacking in specific assessment, devoid of clearly defined treatment plans or goals, and delivered without regular reviews (Forseburg et al., 2010), all of which are recommended within NICE guidelines for psychosocial interventions (NICE, 2007). One issue with the provision of low and high intensity approaches is that it may hinder services ability to adequately provide "stepped-care" approaches and it would appear that these low intensity interventions do not fully utilise the extensive range of practitioner skills available within substance misuse services.

Many of the Cognitive-Behavioural-based interventions can draw on more innovative, third-wave evidence-based approaches. Group programmes can benefit from greater structure and maintain greater treatment fidelity than can individual approaches. The group-based approaches can foster a sense of shared "recovery journey" amongst service users, thus equipping them for ongoing recovery within their community groups.

Many structured skills-based approaches can also *bridge the gap*. Node-link mapping (Dansereau et al., 1993), for example, draws on CBT-based techniques. With training, suitably qualified practitioners (i.e., those with professional training in the delivery of client-centred approaches), can deliver elements of Mindfulness-based approaches, DBT skills, and ACT when applied in structured formats.

Whilst there is increasing evidence of investment in third sector agencies there continues to be a marked lack of funding for the provision of services for people with co-occurring mental health problems and despite limited liaison provision, demand continues to outweigh the services' ability to respond. Where projects have been developed in North Wales which have provided favourable outcomes for this group, recent financial cuts have resulted in a loss of these services.

In Cardiff and Vale almost half (47%) of adults report drinking above the recommended alcohol limits in the previous week, and more than a quarter (28%) report binge drinking (drinking too much alcohol in a short period of time). One in ten teenagers report drinking one or more drinks weekly, and around the same number report having been drunk at least four times in their lifetime. Boys drink slightly more than girls. In those over 65, one-third of men (36%) and nearly one-fifth of women (17%) drink above the recommended limits (S Moore, V Sivarajasingam, M Heikkinen, 2013)

Estimates show that the National Health Service (NHS) in Wales spends about £70 - £85

million per year on treating alcohol related health problems12. Nearly 3000 people attended the Emergency Unit in Cardiff and Vale with an alcohol-related issue in 2010 – 11 and numbers attending are higher at weekends.

There has been a gradual rise in hospital admissions (planned and unplanned) entirely due to alcohol in Wales in the past ten years and across the 22 unitary authority areas of Wales, hospital admissions 'entirely or partly' due to alcohol in 2007 – 09 were 3rd highest in Cardiff and 10th highest in the Vale of Glamorgan for males and 5th highest in Cardiff and 7th highest in the Vale of Glamorgan for women.

Pilot services such as the Cardiff Alcohol Treatment Centre (ATC) aims to provide additional capacity to offset the high volume of acutely intoxicated individuals currently attending University Hospital of Wales Emergency Department and this has successfully diverted patients away from the Emergency Department and was resulted in a significant reduction in alcohol-related attendances, a reduction in ambulance referrals to the Emergency Department and a decrease in ambulance handover times at the Emergency Department

At present the delivery of alcohol screening and brief interventions specifically in Cardiff and Vale Health Board is limited across both primary and secondary care. In primary a number of general practitioners have attended Royal

College of General Practitioners Wales, (RCGP) 'Alcohol Management in Primary Care' course. However, with no agreed system of recording any interventions provided, it is not possible to assess the impact of the training. In secondary care:

Training in brief interventions for nursing staff has been offered, however, interventions are not currently routinely recorded. Despite the development of a one-day training course in Alcohol Brief Interventions to nursing staff since October 2010, releasing staff for training remains a challenge.

Cardiff University Health Board (UHB) currently employs two Hospital Substance Misuse Liaison Nurses, who receive substance misuse referrals from across hospital services. Over a period of four years (2008-2011), there were 1795 referrals of which 82 percent were related to alcohol. Around one fifth of patients referred for alcohol were able to be offered brief advice or an extended brief intervention, (motivational interviewing) but the majority were patients with more severe alcohol issues, who required specialist support.

If these patients could be identified and offered support at an earlier point in their drinking career, for example in primary care, it is though that this could help prevent their health deteriorating further, the impact on families, and the use of hospital resources.

Owing in part of the development of the Substance Misuse Liaison Nurse posts, the identification of services users showing signs of cognitive impairment has increased. Currently there are no specialist facilities available in South Wales to care for the needs of these individuals and there is a significant lack of availability of specialist staff able to assess, diagnose and offer interventions with this population. Currently, within Cardiff and Vale, formal neurocognitive assessment is offered by one Clinical Psychologist within Addictions whilst many of the service users identified are having to wait on sometimes lengthy waiting lists for Neuropsychology services. This is likely to impact on the availability of comprehensive capacity assessments taking place. To date, many of the service users assessed as having ARBD are cared for in care homes in England which remains extremely unsatisfactory for those families who wish to be accommodated in Wales.

There are a number of areas which should be the focus of service development and improvement including holistic rehabilitation for people with alcohol related brain damage (where at present no specific services exist in Wales), a specific care pathway (including a requirement for collaborative working alliances) between mental health and substance misuse services is needed to better serve the needs of individuals with co-occurring mental health and substance misuse problems and a need to address unplanned drop out from substance misuse services. Some of the issues identified (Public Health Wales and Welsh Government 2010)

	appeared to relate to the need for improvement in service delivery and staff training (e.g. long waiting times, inconvenient opening times, lack of pre-contact treatment, poor staff attitude). The capacity to manage older people who have an alcohol problem in older adult services is very limited across Wales, with the service already trying to address the needs of a growing population of clients and carers dealing with dementia. Access to CDAT was previously age restricted and although this is no longer the case, it is apparent that their remit is specific to those clients willing and motivated to change. Following financial restrictions and the focus on community based recovery services; there is no Tier 4 residential service available to clients across most of Wales with the exception of those which are provided by generic older adult mental health inpatient services which are often wholly inappropriate to the needs of the client and their family. Clients and families have now to self fund residential rehabilitation where required. Whilst much work has been completed on the development of third sector services in South Wales there needs to be a continued move towards recovery orientated services and integrated pathways between substance misuse services, through care, aftercare and peer led recovery organisations. In Cardiff and the Vale, the Footsteps to Recovery Programme includes three organisations (Recovery Cymru, Newlink and Solas) which are working in partnership to provide an integrated, recovery oriented programme of support for individuals who are transitioning from NHS services to the next stage of their recovery journey. This project is still in the early stages, so no outcome data is available yet. If the outcomes of this programme are promising, the move to a system of delivering evidence based psychological and psychosocial interventions by skilled practitioners will need to be fostered with an emphasis upon the training and support needs of those staff delivering the interventions. Exploration of the Family Drug and Alcohol Court model, currently available in England would also be welcomed in relation to what this could contribute to substance misuse outcomes for families in Wales. Initial findings from the London programme are promising in terms of improvements for families and economic outcomes (E.g. Harwin et al. 2014) A recognised system for upskilling the substance misuse workforce should be considered. For example, in Scotland STRADA collaboration between Glasgow University and Drugscope) provide a range of university accredited professional development programmes (practice/skills development and academic) for substance misuse practitioners. Attempts have been made to offer liaison specialists across services where there is a likelihood of co-morbidity, in real terms; joint working between these services remains patchy. Whilst services for substance misuse have undergone a period of redevelopment to accommodate the 'peer led' and third sector agencies, there has been a noticeable period of disinvestment amongst statutory services generally and Local Authority services in particular. At the same time as new recovery led services are being tendered and are establishing across South Wales, many of the experienced professionals who have in-depth understanding of legislation and clinical procedures relating to addiction are no longer in place and this has resulted in a loss of the 'seamless move across services' as limited staff who have a limited knowledge of the service group are left trying to manage cases. Despite the promise of further training for non addiction staff as highlighted in the strategy, there continues to be a lack of training and expertise amongst professionals within other specialisms about the nature and course of addiction.
	Any other comments
	The Society has no further comments to make.

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End.

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from The Wine and Spirit Trade Association – ASM 18 / Tystiolaeth gan Y Gymdeithas Masnach Gwin a Gwirod – ASM 18

National Assembly for Wales - Health and Social Care Committee

Inquiry into alcohol and substance misuse

Submission from the Wine and Spirit Trade Association

9th January 2014

About the WSTA

The Wine and Spirit Trade Association (WSTA) is the UK organisation for the wine and spirit industry representing over 340 companies producing, importing, transporting and selling wines and spirits. We work with our members to promote the responsible production, marketing and sale of alcohol and these include retailers who between them are responsible for thousands of licences.

We work with our members and other partners to reduce anti-social behaviour related to alcohol through initiatives such as the Retail of Alcohol Standards Group, which is administered by the WSTA and developed Challenge 25 and Community Alcohol Partnerships both of which have proven successful in reducing alcohol related crime and anti-social behaviour. We also work closely with the Government on its Public Health Responsibility Deal.

The WSTA fully supports the Welsh Assembly's overall aim of trying to reduce alcohol misuse, alcohol related harm and alcohol related crime and anti-social behaviour. However, we believe that all initiatives should be targeted, evidence based and focused on constructive partnership working between the trade, government and other stakeholders. For this consultation we have looked to highlight one area of concern with current proposals, as well as provide information about the work of the trade to reduce alcohol related harm.

Minimum Unit Pricing

In April 2014 the Welsh Assembly Government published a Public Health White Paper which contained proposals to implement Minimum Unit Pricing for alcohol in Wales in an attempt to tackle alcohol related harm and crime. The WSTA responded to the consultation on behalf of its members and outlined the following concerns with the proposals:

- Licensing is not a devolved issues in Wales and therefore they could not implement this in the same way that Scotland and Northern Ireland are looking to, through the licensing regime;
- Any law or policy that attempts to coordinate pricing between retailers would run the risk of breaching either EU or UK competition law;

- The Scotch Whisky Association have taken legal action against the Scottish Government for attempting to bring in Minimum Unit Pricing and this is currently before the European Court of Justice;
- MUP will have little impact on those that misuse alcohol as its benefits are calculated on a model that assumes a simple link between price, consumption and harm;
- There are better, more targeted, ways of dealing with alcohol related harm including through Community Alcohol Partnerships and the Responsibility Deal;

The full WSTA response is available here:
http://www.wsta.co.uk/images/PAN/2014/WalesConsultationResponseDraft.doc

As outlined in the WSTA consultation response, The Government of Wales Act 2006 enables the Welsh Government to bring forward its own programme of legislation only in the 20 areas devolved to Wales, which does not include licensing of alcohol.

The WSTA view is that any attempt to bring in a pricing mechanism for alcohol through another means would raise a number of legal issues, initially around EU and UK competition law, but additionally on the powers of the Welsh Assembly.

Given the legal uncertainties around the proposals, as well as the limited evidence that the proposal will have the desired effect, the WSTA therefore does not believe that this would be the most effective way of dealing with alcohol related harm. It is only through partnership working between the trade, national, regional and local Government, police, trading standards and other stakeholders such as educational partners, that real progress on these issues can be made. Key examples of these types of partnerships include:

Public Health Responsibility Deal

The WSTA is at the forefront of the Government's Public Health Responsibility Deal to tackle alcohol misuse. Government, businesses and NGOs have come together to improve public health through a series of voluntary commitments. Successes of the Responsibility Deal include:

Labelling – the industry committed to ensuring that 80% of labelling on shelves contain the Chief Medical Officers Recommended Guidelines, a warning about drinking while pregnant and unit information. In November 2014 an independent report found that the 80% target had been met and that over 90.7% of labels now contained pregnancy warnings, up from 17.6% in 2008. The independent report can be read here: https://responsibilitydeal.dh.gov.uk/wp-content/uploads/2014/11/Campden-BRI_Audit-of-PHRD-labelling-compliance-2014-_FINAL-report_October2014-final.pdf

Unit reduction – the industry committed to reducing the number of units in the UK market by promoting and developing low alcohol products and reducing the strength of existing products. In December 2014 an independent report found that the industry had achieved its target two years early, having removed 1.3bn units from the market between 2011 and 2013. The independent report can be read here: https://www.gov.uk/government/statistics/units-of-alcohol-sold

Underage drinking – The industry has made a number of pledges around working to reduce underage drinking. This included pledging to continuing to support the charity Drinkaware, to rigorously enforce Challenge 21 and Challenge 25 and to not advertise alcohol within a certain proximity to schools.

Local Alcohol Action Areas – the WSTA has committed to working with a range of industry partners to support the Government's Local Alcohol Action Area project. This includes working across the

Social Responsibility Alliance to ensure that all industry social responsibility schemes are made available to the local authorities in these areas, which include Pembrokeshire and Swansea.

Community Alcohol Partnerships

Community Alcohol Partnerships (CAPs), developed by retailers and coordinated by the WSTA, aim to tackle the problems caused by underage access to alcohol. This is achieved through co-operation at a local level between alcohol retailers and other partners such as trading standards, police, local authority licensing teams, schools and health networks.

In 2012 a Community Alcohol Partnership was launched in Brecon, Powys, in order to tackle underage drinking in the local community. The scheme has been operational for over 2 years and has recently received funding from the Welsh Assembly. An evaluation report found that incidents of alcohol related youth anti-social behaviour complaints decreased over the duration of the Brecon CAP project, from 129 to 78 (a 40% decline).

More details can be found at: www.communityalcoholpartnerships.co.uk

Challenge 25 in Wales

Challenge 25 is a retailing strategy that encourages anyone who is over 18 but looks under 25 to carry acceptable ID if they wish to buy alcohol. The scheme was introduced as a way of giving staff a buffer zone, should they not be able to accurately guess the age of a customer. Importantly, the scheme went further to ensure that all staff were given detailed training about underage sales and the application of the scheme and support with additional training like conflict resolution or on proxy purchasing.

In 2014 the Retail of Alcohol Standards Group, which is administered by the WSTA, undertook research into the effectiveness of the Challenge 25 scheme in reducing underage purchases and consumption. The report found that:

- It is estimated that 850,000 people are trained in the application of Challenge 25 each year;
- Around 11m people have been challenged through Challenge 25 and similar schemes;
- 67% of the public, including 86% of 18-24 year olds, are aware of Challenge 25;
- 79% either strongly support (51%) or tend to support (29%) retailers adopting Challenge 25;
- 65% of shop workers have been subjected to verbal abuse as a result of asking for ID;
- Only 4% of under-age consumers would attempt to obtain alcohol from a large supermarket main till compared to the 74% that would attempt to obtain alcohol from their parents;
- The level of young people has dropped from 17% drinking once a week in 2004, to just 6% in 2012
- Since Challenge 21 was introduced consumption by 16-24 year olds has dropped by 24%.

However, more needs to be done to promote the scheme outside of the national supermarkets, where there is universal coverage. Despite the effectiveness of the scheme, Wales showed some of the lowest levels of recognition. Polling found:

- People in Wales showed some of the lowest recognition of Challenge 25 with just 61% of people asked having heard of the scheme, compared to the average of 67%;
- Wales again had the second lowest number of people saying they had been Challenged by a scheme like Challenge 25 with just 19% of people reporting this was the case;

- However, despite this, people in Wales showed the second highest level of support for the scheme of any region in the UK (84%).

This shows that not only is the scheme is very popular in Wales, but by working to support the proliferation of the scheme outside national retailers there is more scope to increase the number of challenges made across Wales which could have a big impact in reducing underage sales.

The full report is available: http://www.wsta.co.uk/challenge-25

Further industry schemes to tackle alcohol related harm include:

- **The Portman Group** is the social responsibility body for alcohol producers. They operate a strict Code of Practice to ensure alcohol is marketed responsibly and does not appeal to children. This Code applies to all pre-packaged alcohol sold or marketed in the UK and they have recently launch a code to cover alcohol sponsorship too. Since the Portman Group was set up in 1989, they have banned over 130 irresponsible products in co-operation with retailers.
- **Drinkaware**. An independent charity supported by voluntary donations from across the drinks industry to equip people with the knowledge to make sensible decisions about how much they drink. They provide accessible, evidence-based information about alcohol and its effects to employers, young people, teachers, parents and community workers. Using a range of mediums, such as film, multimedia and TV, they help dispel myths and present the honest facts about alcohol.
- **Best Bar None.** Best Bar None (BBN) is a national award scheme, supported by the Home Office, aimed at promoting responsible management and operation of alcohol licensed premises. Piloted in Manchester in 2003, **it has since been adopted by 100 towns and cities across the UK** and is now being taken up internationally.
- **Pub watch.** Pubwatch is a voluntary organisation set up to promote best practice through supporting the work of localised Pubwatch Schemes. Its aim is to achieve a safer drinking environment in all licensed premises throughout the UK. An evaluation report showed that the vast majority of local authorities (76%), Police (70%) and licensees (70%) who responded to the survey believe Pubwatch to be contributing to a safer drinking environment in the areas in which they operate.

You can read more on these and other schemes at:http://www.portmangroup.org.uk/docs/default-source/recruitment-jds/local-alcohol-partnerships-.pdf?sfvrsn=0

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Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Public Health Wales – ASM 19 / Tystiolaeth gan Iechyd Cyhoeddus Cymru – ASM 19

Response Of the North Wales Local Public Health Team to the National Assembly for Wales' Health and Social Care Committee Inquiry into Alcohol and Substance Misuse

Authors: Melfyn Thomas, Senior Public Health Practitioner, Public Health Wales; Louise Woodfine, Principal Public Health Practitioner, Public Health Wales.

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Purpose and Summary of Document:

This document is the North Wales Local Public Health Team submission to the National Assembly for Wales' Health and Social Care Committee Inquiry into Alcohol and Substance Misuse

1 Introduction and summary

Over the last few decades there has been a change in the culture in Wales as regards deinking alcohol and the use and abuse of illegal substances.

Alcohol is much more easily available in Wales now than it has been for many generations; is cheaper than it was at any time in the 20th century; and is more socially acceptable than it has been since the turn of the last century. Illegal substances are also cheaper, more available and much more widely used than they have been in past generations.

We are now seeing the physical effects of low-cost, easily available alcohol at clinics across Wales and the financial cost will continue to grow for many years even if the widespread over-use of alcohol in our society were to stop today; social and health related problems linked to illegal substance use in our communities are also more apparent now than they have been for a long time and show no sign of stopping.

The challenge from a public health point of view is a huge and growing one and one that needs to be addressed both from a preventative and treatment point of view. The changes in alcohol and substance misuse have gone hand-in-hand with cultural changes within our society which has become more tolerant of their misuse leading to a greater barriers to teach about and treat them.

The inquiry asks for a response to the following terms of reference for alcohol and substance misuse in Wales and this paper will follow these headings subsequently:

- *the impacts of alcohol and substance misuse on people in Wales, including young people and university students; older people; homeless people; and people in police custody or prisons;*
- *the effectiveness of current Welsh Government policies on tackling alcohol and substance misuse and any further action that may be required;*
- *the capacity and availability of local services across Wales to raise awareness and deal with the impact of the harms associated with alcohol and substance misuse.*

2: Alcohol & substance misuse on the North Wales population:

"The impacts of alcohol and substance misuse on people in Wales, including young people and university students; older people; homeless people; and people in police custody or

prisons"

The changing in drinking and substance misuse culture is perhaps more evident and more visibly seen among young drinkers. Because the price and availability of alcohol have changed greatly since the turn of the century young people can now more easily afford to buy alcohol and have far more outlets that sell alcohol than ever before.

This has directly impacted on the drinking culture in the UK in that the financial difference between buying alcohol at traditional outlets such as public houses and the growing alcohol retail outlets such as supermarkets and corner shops is great. Supermarkets can afford to sell alcohol at a loss (loss-leaders) and make up their profits on other products while public houses cannot do this and tend to try and make more profits on non-alcoholic drinks.

This has led to the development of a culture of pre-loading among the younger generation, where cheaper alcohol bought at supermarkets or other lower-price outlets are drunk before they go out to the more traditional pubs and clubs.

The net result of this is to shift the time that young people go out to socialise to later on in the evening and also that they arrive at those places under the influence of alcohol to varying degrees already.

This leaves public houses generally more empty earlier in the evenings than they might have been in previous generations and also that alcohol-related problems can be perceived to be associated with pubs and clubs but where the bulk of the alcohol drunk by the perpetrators of anti-social activity has actually been bought at other outlets.

The development of a wider home-drinking culture has also been linked with a greater amount of drinking in that traditionally a drinker might have been buying their drinks in a public setting might have some mitigating effect on their consumption. Drinking at home, or drinking alone at home is much harder to gauge how much and how fast they are drinking.

The change in drinking culture has also affected the more elderly members of our society and there has been a rise in the number of more elderly drinkers presenting with alcohol related problems. The social element of drinking in a public house might have been minimised with this cultural change, and the price of alcohol at other outlets has seen an increase in more elderly members of the population drinking at home and alone.

3: ***"the effectiveness of current Welsh Government policies on tackling alcohol and substance misuse and***

any further action that may be required"

- One of the best evidence interventions into reducing drinking in populations is to increase minimum unit pricing. The proposed introduction of minimum unit pricing as policy in Wales is welcomed as are the policies of reviewing fatal and non-fatal drug poisonings and alcohol related deaths, to ensure that lessons learned and recommendations may be implemented to reduce future deaths.

- Communicate the whole range of harms associated with alcohol and substance misuse that includes a range of cancers; a link to these abuses being also closely linked to child sexual, physical and verbal abuse; the clear link to road traffic deaths

- Communicate the negligible health benefits that have been associated with alcohol consumption in the past

- Stop all alcohol advertising reaching under 18's – in Wales the 10-15 year olds are exposed to 11% more alcohol advertising than adults; advertising has been shown to increase consumption in children and also increase the appeal of drinking in later life

- Rigorous and proper regulation of advertising and mis-advertising of alcohol by the industry

- All health and social care professionals should be trained to provide early identification and brief alcohol and wider substance misuse advice

- People who need support for substance misuse (drugs and/or alcohol) problems should be routinely referred to specialist alcohol services for assessment and treatment

- Existing laws to prohibit the sale of alcohol to individuals who are already heavily intoxicated should be enforced in order to reduce acute and long term harms to their health and that of the individuals around them

- All alcohol products should carry a health warning from an independent health regulatory body that is 1/3 of the label size

- All alcohol products should carry a clear calorie notification as well as unit levels.

4: The capacity and availability of local services across Wales to raise awareness and deal with the impact of the harms associated with alcohol and substance

misuse.

- Local services should seek and be responsive to the needs of their service users. Service users should be regularly and meaningfully consulted as regards the services available and if those services are fulfilling or failing in their duties. There should be a service user element in the evaluation of service providers and in making recommendations for further service development in the future.

- Clear effective and truthful information about substances and the likely consequences of using them or selling them should be made clear to the population in a non-judgmental way.

- Harm minimisation and harm reduction policies in North Wales have had a practical and beneficial effect for both drug users and communities. They should be further invested in and expanded.

- The implementation of the alcohol brief intervention (ABI) training by Public Health Wales has ensured that both NHS and non-NHS staff are suitably skilled to engage with individuals to identify potentially harmful drinking patterns and encourage behavioural change. Over 7000 such staff have now been trained to deliver ABI across Wales, ranging from military personnel to midwives. Welsh Government has been a key driver in the development of this programme.

- Establish working partnerships between accident and emergency departments, the police service and ambulance service, the local APB and Las to accurately pinpoint areas where violence results linked to alcohol use in communities. This data can then be used effectively to oppose licensing applications.

- Ensure sanctions are fully applied to businesses that break the laws on under-age sales

- Promote campaigns that make reckless behaviour under the influence of alcohol or other substances socially unacceptable.
- Make prevention a clear aim of services and other institutions so that a shift in culture towards a more respectful and mature use of alcohol and substances can be achieved.

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Lundbeck Ltd – ASM 20 / Tystiolaeth gan Lundbeck Ltd – ASM 20

National Assembly for Wales Health and Social Care Committee inquiry into alcohol and substance misuse

Submission from Andy Hockey, Head of Policy and Access, Lundbeck.

On behalf of Lundbeck Ltd.

Lundbeck welcomes the opportunity to respond to the National Assembly for Wales' Health and Social Care Committee's call for evidence into alcohol and substance misuse as part of its inquiry.

1. Introduction to Lundbeck

1.1 Lundbeck is an ethical research-based pharmaceutical company dedicated to becoming a world leader in the development of pharmaceuticals for psychiatric and neurological diseases. The company is unique in that it focuses entirely on finding new and effective therapies for central nervous system (CNS) disorders. This strategic focus allows Lundbeck to establish strong links with academics, clinicians and patient organisations with interests in CNS disorders, such as depression and anxiety, schizophrenia, Alzheimer's, Parkinson's disease and alcohol dependence.

1.2 The Lundbeck Foundation owns approximately 70% of Lundbecks shares. It was established in 1954 by the widow of the company's founder, Hans Lundbeck, and is one of the largest private contributors to natural science research. As a result, each year Lundbeck invests around 20% of its revenue in R&D and the development of new, innovative drugs; substantially above the industry average of around 15%. This has allowed the company to develop novel therapies in a variety of areas including alcohol dependence.

1.3 In May 2013, Lundbeck launched Selincro® ▼ (nalmefene) in the UK. This is the first and only medicine approved for the reduction of alcohol consumption in certain patients with alcohol dependence and has been accepted for use by the Scottish Medicines Consortium[1] and the All Wales Medicines Strategy Group within its licensed indication.[2]

1.4 In November 2014 the National Institute for Health and Care excellence (NICE) recommended nalmefene within its licensed indication in its technology appraisal guidance TA325.[3]

1.5 Selincro is indicated for the reduction of alcohol consumption in adult patients with alcohol dependence who have a high drinking risk level, without physical withdrawal symptoms and who do not require immediate detoxification. It should only be prescribed in conjunction with continuous psychosocial support focused on treatment adherence and reducing alcohol consumption; and should be initiated only in patients who continue to have a high drinking risk level two weeks after initial assessment.

2. The impacts of alcohol and substance misuse on people in Wales, including young people and university students; older people; homeless people; and people in police custody or prisons

2.1. The estimated health service cost in Wales of alcohol related chronic disease and alcohol related acute incidents is between £70 million and £85 million each year.[4]

2.2. Alcohol is toxic to most organs of the body and is a causal factor in more than 60 types of disease and injury[5]

2.3. Alcohol misuse has been linked to disorders including high blood pressure, heart disease, liver disease, stroke, depression and some cancers. Cancer Research UK has noted that the more alcohol a person drinks, "the higher the risk of developing cancer and other diseases."[6]

2.4. The harmful use of alcohol in Wales is far more widespread than that of illegal drugs and other substances, to the extent that few individuals, families and communities in Wales are exempt from the effects in one way or another.[4]

2.5. More people die from alcohol related causes than from breast cancer, cervical cancer, and MRSA infection combined.[7] Excessive alcohol consumption is a major cause of serious liver disease, which is often fatal. In addition, alcohol is a major contributing factor to the risk of dementia and acquired brain injury, cancer of

the breast, mouth, gullet, stomach, liver, pancreas, colon and rectum,[8] even, in some cases, at levels of consumption within recommended limits.[9]

2.6. Alcohol-related harms place a significant burden on the health of people in Wales and on NHS Wales. More broadly, the consequences of excessive alcohol consumption in Wales place a significant burden on public services, including the policing and criminal justice systems, and on society as a whole. Alcohol misuse represents a significant health challenge in the workplace, and can place a serious burden on both the health and mental wellbeing of employees, and also in terms of other organisational outcomes; including increased levels of absenteeism and presenteeism.

2.7. Nearly 40 per cent of adults in Wales admit to consuming more than the recommended limits and 20 per cent admit to binge drinking.[10]

2.8. The comparison of alcohol sales with the reported alcohol use also suggests that people are consuming more alcohol than they think they are.[11]

2.9. This burden has been recognised in the Welsh Government's 2008 strategy for tackling harms associated with substance misuse (including alcohol).

2.10. Alcoholic liver disease is responsible for around 1,600 hospital admissions per year.[4]

2.11. Over 54,000 incidents of violent crime in Wales in 2006-07 were linked to the consumption of alcohol.[4]

2.12. 30,000 bed days are related to the consequence of alcohol consumption.[4]

3. The effectiveness of current Welsh Government policies on tackling alcohol and substance misuse and any further action that may be required

3.1. The Substance Misuse Strategy for Wales outlines the following: "There is a clear consensus that this strategy should have a much greater focus on tackling the problems caused by hazardous and harmful consumption of alcohol. We need to focus more of our efforts on preventing longer term health damage, including that from the use of alcohol in combination with illegal drugs such as cannabis and cocaine. We need to intervene earlier with those at most risk, to prevent drug and alcohol misuse from developing

and becoming entrenched. We also need to do more to educate people about the significant health risks associated with exceeding safe limits of drinking".[4]

3.2. The Healthcare cost burden of dealing with alcohol misuse is continuing to increase across the UK. In Wales this increasing burden is exacerbated by the fact that the current service provision is primarily focused on specialist Tier 3 and 4 treatment services for those with moderate to severe dependence on alcohol. Based on the NICE CG115 costing report, over 80% of alcohol dependent drinkers suffer from mild dependence[12] and we believe may have limited access to treatment in Wales currently, given the focus on specialist services.

3.3. A radical redesign of alcohol treatment services is needed to ensure provision of service for patients at all levels of severity of alcohol dependence. Provision of identification/screening, brief interventions and treatment for those who are drinking hazardously or harmfully and are mildly dependent, particularly within the primary care setting is necessary.

3.4. The introduction of effective identification/screening programs in primary care will help ensure problems are identified before people become moderately to severely dependent on alcohol. Treatment should involve ongoing psychosocial support (i.e. talking based therapy) and pharmacological therapy, where appropriate.

4. The capacity and availability of local services across Wales to raise awareness and deal with the impact of the harms associated with alcohol and substance misuse

4.1. Alcohol dependence creates a huge burden and Lundbeck urge the Department of Health & Social Care and Health Boards to take an 'invest to save' approach by increasing funding for alcohol treatment services, particularly in primary care.

4.2. Lundbeck believe that commissioners should ensure effective identification/screening for alcohol misuse in all settings and ensure that frontline staff can deliver brief advice and are aware of local referral pathways to specialist support; identifying problems early, before people become more severely dependent. This should take place in every GP practice and at all other available 'gateways' where alcohol misuse can be identified.

4.3. Lundbeck has committed to local project funding and the provision of an online psychosocial support service in Wales, and is also investing in the training and support for both primary care professionals and addiction specialists in a number of the Health Boards.

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[1] http://www.scottishmedicines.org.uk/SMC_Advice/Advice/917_13_nalmefene_Selincro/nalmefene_Selincro

[2] All Wales Medicines Strategy Group. Final Appraisal Recommendation – 0414: Nalmefene (Selincro®) 18 mg film-coated tablets. January 2014.

[3] http://www.nice.org.uk/guidance/TA325

[4] Working Together to Reduce Harm. The Substance Misuse Strategy for Wales 2008-2018.
http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good%20Practice/welshstrategy.pdf

[5] World Health Organisation, Global Status Report on Alcohol and Health 2011

[6] Cancer Research UK, Alcohol and Cancer. Accessible online at:
http://www.cancerresearchuk.org/cancer-info/healthyliving/alcohol/

[7] GILMORE I and SHERON N. (2007) Reducing the harms of alcohol in the UK. British Medical Journal, 2007, 335: pp 1271-1272.

[8] NATIONAL PUBLIC HEALTH SERVICE FOR WALES. Alcohol and health in Wales: A major public health issue. Cardiff: National Public Health Service for Wales, 2006.

[9] WORLD CANCER RESEARCH FUND. Food, nutrition, physical activity and the prevention of cancer: a global perspective. London: WCRF, 2007.

[10] WELSH ASSEMBLY GOVERNMENT. Welsh Health Survey 2005-06. Cardiff: Welsh Assembly Government, 2007.

[11] HM GOVERNMENT. Safe Sensible Social. The next steps in the National Alcohol Strategy. London: HM Government, 2007.

[12] National Institute for Health and Clinical Excellence. Alcohol-use disorders: alcohol dependence. CG115 Costing Report. 2011.

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from British Beer & Pub Association – ASM 21 / Tystiolaeth gan Cymdeithas Cwrw a Thafarndai Prydain – ASM 21

National Assembly for Wales' Health and Social Care Committee - Inquiry into alcohol and substance misuse – draft British Beer & Pub Association comments

The British Beer & Pub Association (BBPA) is the leading organisation representing the brewing and pub sector. Our members account for 90% of beer brewed in the United Kingdom and own around half of Britain's 49,500 public houses. The beer and pub sector is committed to reducing the harmful use of alcohol and encouraging responsible consumption and we welcome the opportunity to contribute to this inquiry by the Welsh Assembly's Health and Social Care Committee into alcohol and substance misuse.

Our brewing and pub operating member companies work in collaboration with the UK Government through the Public Health Responsibility Deal and with a range of other stakeholders on developing initiatives to reduce the harmful use of alcohol and we would welcome closer dialogue with the Welsh Government. Whilst issues relating to alcohol misuse remain, there have been some substantial achievements, including:

- 80% of products on shelf now including clear unit content, NHS guidelines and a warning about drinking when pregnant
- One billion alcohol units removed from the UK market through product innovation and reformulation of existing brands
- Robust industry commitment to preventing underage sales including full implementation of the Challenge 21 and 25 campaigns and industry funding for the re-launch of PASS the Proof of Age Standards Scheme
- Roll out of customer alcohol unit awareness information in the on and off-trade
- Ongoing support of £5 million annually for Drinkaware, the independent alcohol awareness charity
- A robust system of self-regulation to ensure responsible advertising and marketing of alcohol brands

- Support for Pubwatch, Best Bar None, Purple Flag, Business Improvement Districts, Community Alcohol Partnerships and other local partnership initiatives which operate in local communities and bring together licensees, police and other local stakeholders to reduce crime and anti-social behaviour and promote a safer night-time economy

We are committed to working with the UK and Welsh Government wherever we can to continue to reduce alcohol misuse. However, it is important for any additional action to be taken in the right context and in recent years there has been a decline in overall consumption and more importantly, a number of trends indicating levels of harmful drinking and the effects of harmful consumption also show a decline. Key trends include:

- Overall alcohol consumption in the UK (15+) down 19% since the peak in 2004 and is down 9% since 2000.
- The percentage of frequent drinkers in fell between 2005-2012. For men, the figure dropped from 22% to 14% and for women, from 13% to 9%. (Great Britain)
- The percentage of those drinking over the recommended guidelines on their heaviest drinking day also fell from 2005-2012. For men this dropped from 41% to 34% and for women from 34% to 26%. (Great Britain)
- The proportion of young people in England (11-15 year olds) that have tried alcohol fell from 59% in 2000 to 39% in 2013.
- As a proportion of total hospital admissions, alcohol-related admissions have remained broadly flat since 2004 at around 1.3% of total admissions. (Public Health England caution against highlighting definite trends in admissions data due to changes in admissions coding methodology). (England)
- In Great Britain, drink driving casualties fell by 45% between 2000 and 2012.
- Alcohol related crime in England and Wales has fallen by 26% since 2001 (British Crime Survey)
- Since 2000, in England and Wales there has been a 28% reduction in drink driving convictions.

Whilst we do not intend to minimise problems that remain it is important that policies pursued are targeted and proportionate and do not unduly penalise responsible drinkers or place unnecessary burdens on business.

We would therefore suggest that the Welsh Government, alongside the UK Government, continue to prioritise a targeted approach to tackling alcohol and substance misuse. Alongside partnership working which has proved so successful through the Public Health Responsibility Deal consideration should be given to further support for low alcohol drinks such as beer through the duty regime. Pubs are of importance to local communities and provide a space where alcohol is consumed in a managed, social environment therefore further support in reducing the regulatory and taxation burden on the sector would be welcomed. We have previously set out where we believe further action is required.[1]

[1] BBPA Responsibility Statement http://www.beerandpub.com/industry-briefings/bbpa-responsibility-statement

We welcome the chance to be able to submit information to the committee and would be very happy to discuss any of this further.

British Beer & Pub Association - January 2015

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Her Majesty's Chief Inspector of Prisons – ASM 22 / Tystiolaeth gan Prif Arolygydd Carchardai Ei Mawrhydi – ASM 22

Response to the National Assembly for Wales' Health and Social Care Committee: Inquiry into alcohol and substance misuse

by Her Majesty's Chief Inspector of Prisons

Introduction

1. We welcome the opportunity to submit a response to the National Assembly for Wales' Health and Social Care Committee's inquiry into alcohol and substance misuse.

2. Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent inspectorate whose duties are primarily set out in section 5A of the Prison Act 1952. HMI Prisons has a statutory duty to report on conditions for and treatment of those in prisons, young offender institutions (YOIs) and immigration detention facilities. HMI Prisons also inspects court custody, police custody and customs custody (jointly with HM Inspectorate of Constabulary), and secure training centres (with Ofsted).

3. HMI Prisons coordinates, and is a member of, the UK's National Preventive Mechanism (NPM), the body established in compliance with the UK government's obligations arising from its status as a party to the UN Optional Protocol to the Convention Against Torture (OPCAT). The NPM's primary focus is the prevention of torture and ill treatment in all places of detention. Article 19 (c) of the Protocol sets out the NPM's powers to submit proposals concerning existing or draft legislation.

4. The following response is based on inspection evidence. All inspections are carried out against our *Expectations* - independent criteria based on relevant international human rights standards and norms.

5. This submission covers all three areas of interest to the inquiry, and evidence is limited to those areas specifically with our statutory remit relating to prisons, namely:
   - the impacts of alcohol and substance misuse on people in Wales, specifically young people and adults in the five prisons in Wales: HMP Cardiff, HMP Parc, HMP Swansea, HMP Usk and HMP Prescoed;
   - the effectiveness of current prison service policies in Wales in tackling alcohol and substance misuse and any further action that may be required; and
   - the capacity and availability of prison-based services across Wales to raise awareness and deal with the impact of the harms associated with alcohol and substance misuse in Welsh prisons.

6. HMI Prisons has inspected all five Welsh prisons within the last two years, as follows:
   - HMP Cardiff: Inspected 18-22 March 2013[1]
   - HMP/YOI Parc: Inspected 9-19 July 2013[2]
   - HMP Swansea: Inspected 1-10 October 2014[3]
   - HMP Usk and HMP/YOI Prescoed: Inspected jointly 22 April-3 May 2013[4]

   Full details of our prisoner survey results from the five Welsh prisons can be found in the appendix.

HMI Prisons' submission

7. In its inspections, HMI Prisons evaluates specific outcomes for prisoners relating to alcohol and substance misuse. Our overarching expectation is that prisoners with drug and/or alcohol problems are identified at reception and receive effective treatment and support throughout their stay in custody. Specifically, we also look at whether:
   - Prisoners dependent on drugs and/or alcohol receive clinical treatment which is safe, effective and meets individual needs
   - Prisoners have prompt access to a range of psychosocial interventions and services, which are consistent with the assessed needs of the population.[5]

8. Alcohol and drugs, often of unknown composition, may be a direct threat to the health of the prisoners who consumes them immediately or, after repeated use, in the longer term. We are also aware that most of misused substances in prisons cause trouble that has the potential to de-stabilise prison regimes and safety. Alcohol and drugs affect behaviour, usually negatively, and lead to debt with associated bullying and assaults.

I. Alcohol in prisons

The availability of alcohol in Welsh prisons

9. The bringing of alcohol into prisons, its brewing or distilling in prisons and its consumption on prison premises are all prohibited by law.

10. During our inspections we have noted that the illicit supply and use of alcohol is a much smaller problem than is the case with drugs, but illicitly brewed alcohol (IBA), known in prisons as 'Hooch', is not uncommon in some prisons. Category C establishments and open prisons (Category D) have the greatest problems in this regard. We have also seen a small increase in the discovery of distilled alcohol in some prisons in England.

11. In open prisons, commercially produced alcohol is often purchased and brought back by prisoners who have been released on temporary licence (ROTL), either for home visits or regular work in the community as part of their open prison conditions.

12. Christmas, New Year and events like the World Cup are recognised as times when illicit alcohol use will be more likely to become available in prisons. IBA and distilled alcohol are

[1] Report available at: *http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/cardiff-2013.pdf*
[2] Report available at: *http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/Parc-2013.pdf*
[3] Report forthcoming.
[4] Report available at: *http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/usk-prescoed-2013.pdf*
[5] HMIP Expectations: Criteria for assessing the treatment of prisoners and conditions in prisons. Available at: http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/02/adult-expectations-2012.pdf

usually very strong forms of alcohol and have been known to cause significant harm to prisoners' health. As a disinhibitor, alcohol has well-documented links to violent behaviour.

13. At HMP Usk, significantly fewer prisoners than the comparator[6] (3% v 30%) said it was easy to get alcohol. At HMP/YOI Prescoed (Wales' only open prison) slightly fewer than the comparator (22% v 25%) said that it was easy to get alcohol.

Alcohol problems among prisoners arriving at Welsh prisons

14. Our survey results showed that in the three local[7] Welsh prisons, more people arrived at these prisons with what they described as an alcohol problem than at comparator prisons (HMP Cardiff: 35% v 27%; HMP/YOI Parc 21% v 16%; HMP Swansea 39% v 22%).

15. Local prisons will see the most acute alcohol related problems, as prisoners frequently come into the prison either under the influence or in an acute state of withdrawal.[8]

Clinical and psychosocial treatment for prisoners with alcohol problems in Welsh prisons

16. In two out of the three Welsh prisons with a 'local' function, significantly fewer prisoners than the comparators said they had received help for their alcohol problems (HMP Cardiff: 33% v 60%; HMP/YOI Parc: 54% v 63%). At HMP Swansea the figure was similar to the comparator at 62% v 58%.

17. Whilst clinical alcohol detoxification (i.e. the removal of the physical dependency and withdrawal effects on the body) is generally found to be satisfactorily delivered in prisons that we inspect, we have noted that psychosocial support can be varied. At HMP Cardiff, fewer prisoners than at comparator establishments (33% v 60%) said that they had received help for their alcohol problems. The range of available interventions addressing such problems encompassed one-to-one sessions and group work, including the Building Skills for Recovery programme. Alcoholics Anonymous groups were held fortnightly, but were not available to remand prisoners, which may have contributed to the poor survey results.

18. Moreover, HMP Cardiff was the only one of the three Welsh local prisons where the answer to our survey question 'Was the support [with their drug or alcohol problem] helpful?' scored significantly worse than the comparator: 33% v 66%.

19. At HMP/YOI Parc, fewer prisoners said they had received help or support with their alcohol problem than at comparator prisons (54% v 63%). However, Alcoholic Anonymous meetings, Building Skills for Recovery and COVAID (Control of violence for angry impulsive drinkers) courses were available. One-to-one sessions and access to a recovery unit were also available.

20. Despite HMP Swansea scoring higher than comparator prisons regarding access to help or support, we found that the only help available to prisoners with alcohol problems was clinical detoxification and no supporting psychosocial interventions were being delivered at the time of our inspection. This was due to discipline-staff shortages and an insufficiently resourced psychosocial team.

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[6] The comparator is all similar prisons in Wales and England

[7] Local prisons are those that receive prisoners directly from the courts, either on remand or sentenced, prior to their allocation to other establishments. Local prisons also receive prisoners recalled for breaching their release or parole licence conditions.

[8] N.B. the comparators for local prisons change as more data from inspections is gathered and added to the database.

II. Substance misuse in prisons

The availability of drugs in Welsh prisons

21. In 2008, David Blakey produced a report for NOMS entitled 'Disrupting the supply of illicit drugs into prisons' which cited five routes that are still widely used to get drugs into prisons:
    - with visitors
    - over the prison wall
    - in post and parcels
    - brought in by prisoners
    - brought in by corrupt staff[9]

22. HMI Prisons inspections show that in recent years, the use of street drugs in prisons has been largely overtaken by prescription medication, which is often diverted from the patient to whom it was prescribed. Medication is either willingly sold or taken by bullying. Prisoners may also fake symptoms in order to get medication, either for their own misuse or to sell on.

23. The most commonly abused types of drugs in prisons are those substances that have a depressant effect on the central nervous system. Depressants commonly abused include:
    - opioids (painkillers) e.g. buprenorphine (Subutex), tramadol, codeine, dihydrocodeine and (less commonly) street heroin
    - tranquillisers e.g. benzodiazepines like diazepam (formerly Valium) and mirtazepine
    - anti-epileptics e.g. gabapentin and pregabalin
    - anti-psychotics e.g. thienobenzodiazepines like olanzepine and quetiapine
    - cannabinoids e.g. herbal cannabis and synthetic cannabinoids found in new psychoactive substances (NPS) such as Spice or Black Mamba.

24. As we reported to the National Assembly for Wales Health and Social Care Committee in October 2014, as the use of new psychoactive substances (NPS) gains momentum in Welsh communities, it can be predicted with some confidence that Welsh prisons should expect a rise in the incidence of NPS misuse, as is certainly the case in England. Prisoners find NPS an attractive alternative to more traditional drugs for a number of reasons related to the lack of detectability and reduced risks of penalties.[10]

25. Our survey results across the five Welsh prisons showed that in three of the prisons the availability of drugs was higher than the comparator: HMP Cardiff (34% v 29%), HMP Swansea (44% v 33%) and HMP/YOI Prescoed (47% v 32%). In the other two prisons, survey results indicated that the availability of drugs at HMP/YOI Parc was similar to comparator prisons (32% v 30%) and was much lower than comparators at HMP Usk (9% v 32%).

26. Mandatory drug testing (MDT) is conducted on a random sample of either 5% or 10% of a prison's population each month. The 5% rate is for populations of more than 400 prisoners and the 10% rate for populations of less than 400 prisoners.

27. The populations and random positive MDT rates of the five Welsh prisons when last inspected were not any higher than comparator prisons elsewhere. The specific results were as follows:
    - HMP Cardiff (Category B, public sector prison) population: 763; random positive MDT rate: 9.7%

[9] http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good%20Practice/blakeyreport.pdf
[10] See HMI Prisons' submission to the National Assembly for Wales Health and Social Care Committee for a full response on new psychoactive substances:
http://www.senedd.assembly.wales/documents/s33106/LH%2018%20HM%20Inspectorate%20of%20Prisons.pdf

- HMP/YOI Parc (Category B, private sector prison) population: 1326; random positive MDT rate: 5.5%
- HMP Swansea (Category B, public sector prison) population: 436; random positive MDT rate: 9.2%
- HMP Usk (Category C, public sector prison) population: 270; random positive MDT rate (combined with the rate from HMP/YOI Prescoed): 3.4%
- HMP/YOI Prescoed (Category D, public sector prison) population: 230

30. In general, HMI Prisons has noted a general decline in the positive rates resulting from the mandatory drug testing of prisoners – both in random testing and that carried out under 'reasonable suspicion'. However, this trend does not mean that prisoners' illicit drug use has reduced. While MDT rates provide an indicator, they do not reliably measure drug availability in establishments – nor does testing necessarily deter prisoners' use of illicit drugs. In our survey, 31% said that illegal drugs were easy or very easy to obtain in their prison, and 7% told us they had developed a problem with illegal drugs and 7% with diverted medications since coming to prison.[11]

31. The main reason for this is that the current MDT does not detect new psychoactive substances and most diverted prescribed medications.[12] The list of drugs detectable under MDT rules had remained unchanged since the addition of buprenorphine (Subutex) in 2009. Two widely diverted and misused drugs – tramadol (a painkiller) and Gabapentin (an anti-epileptic) – were not on the MDT panel, although tramadol was reclassified as a controlled drug in June 2014 and will be added.[13]

32. The apparent differences then, between prisoners' views on the availability of drugs in HMP Cardiff, HMP Swansea and HMP/YOI Prescoed and the contrastingly relatively average or low MDT figures, can probably be explained by prisoners' use of diverted medication and, to a lesser extent, of NPS.

33. Significantly more prisoners in HMP/YOI Parc and HMP Swansea than in comparator prisons said they had developed drug problems whilst in prison (11% v 7% and 18% v 8% respectively). However, only in HMP Swansea was the figure higher than the comparator for developing a problem with diverted medication in the prison (17% v 9%).

34. HMI Prisons has reported its concerns that reduced staffing to conduct drug testing in prisons in England and Wales has made some suspicion testing programmes virtually inoperable.[14] In one recent inspection, frequent shortages of discipline staff led to inconsistencies in the administration of opiate substitution medication, and where this was supervised by inexperienced officers, these were not alert to potential trading in medication.[15] These can all be factors in making it easier for prisoners to obtain and use drugs in prisons and would be applicable in Welsh and English prisons.

Drug problems among prisoners arriving at Welsh prisons

35. HMI Prisons surveys of the three local prisons in Wales showed that significantly more prisoners arrived with existing drug problems than at comparator prisons (HMP Cardiff: 44%

[11] *Annual Report 2013-2014*, http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/10/HMIP-AR_2013-141.pdf
[12] See HMI Prisons' submission to the National Assembly for Wales Health and Social Care Committee: http://www.senedd.assembly.wales/documents/s33106/LH%2018%20HM%20Inspectorate%20of%20Prisons.pdf.
[13] *Annual Report 2013-2014*, http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/10/HMIP-AR_2013-141.pdf
[14] *Annual Report 2013-2014*, http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/10/HMIP-AR_2013-141.pdf p.30
[15] *HMP Elmley Report* http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/11/Elmley-web-2014.pdf (para 1.85)

v 36%; HMP/YOI Parc: 29% v 22%; HMP Swansea: 51% v 33%). At HMP Usk the figure was significantly lower than to comparator (10% v 23%) and at HMP/YOI Prescoed it was similar to the comparator (9% v 10%).

Clinical drug treatment in Welsh prisons

35. One of the striking differences between English and Welsh prisons is that the integrated drug treatment system (IDTS) has been introduced in England but not in Wales.

36. IDTS aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on:
    - close support and care for opiate dependent prisoners during early custody;
    - improving the integration between clinical and psychosocial services (known as CARAT - counselling, assessment, referral, advice and through-care services); and
    - reinforcing continuity of care from the community into prison, between prisons, and on release into the community.

37. The absence of the funding that accompanied the development of IDTS in English prisons has left drug services the two public sector local prisons in Wales (HMP Cardiff and HMP Swansea) lagging behind and, in our view, providing a less safe service in comparison to their English counterparts.

38. Whilst drug treatment therapies are provided in Welsh prisons, first night initiation onto opiate substitutes is not available in HMP Cardiff or HMP Swansea. Instead, men who arrive at these prisons with no previous history of community-based opiate substitution treatment will be rapidly detoxified.

39. Furthermore, no distinction is made between remanded or sentenced prisoners. So it is not uncommon for an opiate dependent prisoner to be remanded for 2-3 weeks, detoxified (regardless of their own wishes or intent to stop using drugs), and then be returned to court and subsequently released. The implications of this are that the prisoner, having been rapidly detoxified from opiates, will lose all physical tolerance to the drug in an average of 14 days. If that prisoner then uses opiates on release, their risk of overdose is extremely high, especially for those who had been previously using high doses over a long period of time.

40. In HMP/YOI Parc prison, prescribing is more flexible. First night prescribing of opiate substitutes is available, and remand prisoners are routinely given maintenance doses that keep their opiate tolerance high, so reducing the risk of overdose should they be released from court.

Psychosocial drug treatment in Welsh prisons

41. The introduction of IDTS in England also allocated funding for the development of integrated psychosocial support. Over the last few years, this has developed into a comprehensive package of one-to-one sessions with key workers, group-work and self-help fellowships, like AA, NA and SMART Recovery[16], in many English prisons.

42. The integration of clinical and psychosocial services means that prisoners should receive a more holistically focused drug treatment service that combines any necessary clinical treatment (either at maintenance levels or as a reducing dose) with psychosocial support that should ultimately encourage them to into recovery and a life free from drugs. HMI Prisons

[16] SMART: self management and recovery training

Expectations and National Guidelines on the treatment of drug dependence both encourage the delivery of integrated services.[17]

43. Whilst we found some good psychosocial work being conducted in HMP Cardiff, it was poorly integrated with clinical treatment. In HMP Swansea, there was also poor integration of clinical interventions with psychosocial interventions. The psychosocial team was understaffed and so could do little more than conduct initial assessments and brief interventions. Officers on the drug recovery wing who had been trained to deliver group work programmes were so frequently re-deployed to other duties that they had ceased all programme delivery. In HMP/YOI Parc the picture was better, with the psychosocial service providing a similar package of options to those found in English prisons.

44. Drug services in HMP Usk and HMP/YOI Prescoed did not accept men requiring opiate substitution. There were no group programmes at either prison, which can be a limiting factor in the effectiveness of a drug and alcohol service. However, at HMP/YOI Prescoed where evening one-to-one sessions were available, an impressive 100% of respondents who said they had a drug or alcohol problem said they had received support against 65% in comparator prisons.

Resettlement from Welsh prisons for prisoners with alcohol and drug problems

45. The introduction of the Wales Integrated Offender Intervention Service (IOIS), which has a remit to reduce re-offending, has improved post release support for prisoners with substance misuse problems.

46. At HMP/YOI Parc we found strong links with IOIS providers at a strategic and operational level (the head of community engagement led the drug strategy and was responsible for community IOISs), and prisoners could access designated prison link workers from South, West and North Wales who regularly attended the prison and were able to meet those due for release at the gate.

47. At HPM Cardiff, support for prisoners with drug and alcohol problems nearing release was also very good. A dedicated 'continuity of care' post was provided by the psychosocial team each week, ensuring that community drug and alcohol agency appointments were arranged for prisoners on release. The transitional support scheme, co-ordinated by G4S (in partnership with the prison and the Wales Probation Trust), provided reintegration planning help for prisoners with a history of substance misuse, including alcohol. Mentors worked with newly released prisoners for up to three months to help with practical and motivational issues.

48. At HMP Swansea, improvements in joint working between CARATs and the offender management unit had contributed to better reintegration planning outcomes for prisoners with substance misuse problems. Release planning started with initial CARAT assessments and the CARAT team had effective links with the provider's own network of community support (the Welsh Centre for Action on Dependency and Addiction) and other regional agencies.

49. In our inspections of HMP Usk and HMP/YOI Prescoed, psychosocial case files demonstrated good quality relapse prevention work with drug as well as alcohol users, and men were given appropriate harm reduction advice and information during their sentence and before release. CARAT staff on both sites had developed good links with local drug intervention

[17] http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/02/adult-expectations-2012.pdf (Expectation 29.5); UK National Clinical Guidelines for drug misuse treatment: http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

programmes and community drug services, including residential rehabilitation providers.

Conclusion

50. Based on evidence from our inspections, we can draw the following broad conclusions concerning the ways in which Welsh prisons tackle alcohol and substance misuse problems and the outcomes for prisoners in Welsh prisons:
    - Prisoners requiring clinical alcohol detoxification in the three local prisons generally receive a good service.
    - Prisoners requiring psychosocial support for alcohol problems received a better service at HMP/YOI Parc than at either HMP Cardiff or HMP Swansea. At HMP Usk and HMP/YOI Prescoed there was a lack of group-based support.
    - Prisoners requiring clinical treatment for opiate dependency get a reasonably good service at HMP/YOI Parc but at both HMP Cardiff and HMP Swansea outcomes for prisoners are much poorer.
    - As with psychosocial support for alcohol, outcomes for prisoners requiring psychosocial support for drug problems could expect a better service at HMP/YOI Parc than at either HMP Cardiff or HMP Swansea. At HMP Usk and HMP/YOI Prescoed there was a lack of group-based support.
    - Resettlement outcomes for prisoners with both alcohol and drug problems returning to addresses in South Wales can expect a very good service that links well with community providers.

We hope that you find this information useful and should you require anything further, please do not hesitate to contact us.

Paul Roberts
Specialist Substance Use Inspector

on behalf of

Nick Hardwick
HM Chief Inspector of Prisons

9th January 2015

Appendix

HMIP Survey results from prisons in Wales 2013 -2014

Notes

All figures are in percentages. Comparators are similar prisons across England and Wales	
	Any percentage highlighted in green is significantly better than the comparator
	Any percentage highlighted in blue is significantly worse than the comparator

	Most recent inspection	Comparator		Most recent inspection	Previous inspection
Did you have a drug problem on arrival at this prison?					
Cardiff 2013	44	36		44	29
Parc 2013	29	22		29	43
Swansea 2014	51	33		51	66
Usk 2013	10	23		10	12
Prescoed 2013	9	10		9	16

Did you have an alcohol problem on arrival at this prison?					
Cardiff	35	27		35	17
Parc	21	16		21	30
Swansea	39	22		39	43
Usk	12	17		12	13
Prescoed	12	8		12	12

Is it easy/very easy to get alcohol in this prison?					
Cardiff	13	13		13	
Parc	20	18		20	
Swansea	17	14		17	
Usk	3	18		3	
Prescoed	22	25		22	

Is it easy/very easy to get illegal drugs in this prison?					
Cardiff	34	29		34	25
Parc	32	30		32	30
Swansea	44	33		44	21
Usk	9	30		9	6
Prescoed	47	32		47	43

	Most recent inspection	Comparator		Most recent inspection	Previous inspection
Have you developed a problem with drugs since you have been in this prison?					
Cardiff	8	8		8	
Parc	11	7		11	13
Swansea	18	8		18	7
Usk	2	7		2	2
Prescoed	1	3		1	2

Have you developed a problem with diverted medication since you have been in this prison?					
Cardiff	10	8		8	
Parc	7	6		7	
Swansea	17	9		17	
Usk	5	6		5	
Prescoed	2	2		2	

Have you received any help or support with your drug problem while in this prison?					
Cardiff	48	65		48	
Parc	49	65		49	
Swansea	46	61		46	
Usk	72	65		72	
Prescoed	100	65		100	

Have you received any help or support with your alcohol problem while in this prison?					
Cardiff	33	60		33	
Parc	54	63		54	
Swansea	62	58		62	
Usk	85	64		85	
Prescoed	91	74		91	

For those who have received help or support with their drug or alcohol problem: Was the support helpful?					
Cardiff	66	79		66	
Parc	78	80		78	76
Swansea	76	76		76	87
Usk	83	80		83	81
Prescoed	89	86		89	83

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Inroads – ASM 23 / Tystiolaeth gan Inroads – ASM 23

This response is on behalf of Inroads Drug and Alcohol Service. Inroads is a registered charity that has been operating in Cardiff and the Vale of Glamorgan for the last twenty years. We are a harm reduction agency providing a holistic easy access service for people with drug and alcohol problems.

Our response will focus on the capacity and availability of local services across Wales to raise awareness and deal with the impact of the harms associated with alcohol and substance misuse

It is our firm belief that the harm reduction model has been diluted at the cost of an enhanced recovery model. There is a need for a balanced approach which ensures that one doesn`t lose out to the other as individuals needs in relation to substance misuse issues span both philosophies. Harm reduction services keep people alive and you have to be alive to be able to recover.
The example for us as a local agency is that the newly commissioned service has reduced needle exchange hours in real terms. Services need to be expanded not reduced. Needle exchange is an invaluable public health service and is vital in reducing drug related harm. It`s reduction cannot be tolerated and the public health service being aware of this should take immediate action.
A reduction in syringe exchange scheme will mean an increase in blood borne virus infection and risks to the community of discarded syringes. The Vale of Glamorgan service has since July 2014 seen a reduction of 15 hours per week in needle exchange service. The newly commissioned third sector service slashed the hours three months after winning the tender and at the same time as the statutory provision in the area curtailed their needle exchange service. The rationale behind the third sector service reducing the hours was that they had undertaken a scoping exercise and that there were times when the service was busier so called hot spots and therefore times when the service was not so busy it would be closed. Even if one person came in the so called quiet hours this would be enough to justify the protection of public health. Welsh Government prudent care key principle" Do no harm" comes to mind!

The issue with regard to the older population and alcohol related brain damage is also an area of work that is neglected through the emphasis on the recovery model. There are a significant number of individuals who are suffering from Korsakoffs who are in unsuitable accommodation but even the ones that have a package of care there is a low level of input and work that could be undertaken to improve their quality of life is not being undertaken. There are examples of good practice in Scotland. There is a need for a day service for these individuals with support from specialist professionals. Improvement in the individual could be made and measured.

Along this could be efficient screening through primary care to prevent Wenicke`s developing into Korsakoffs.
Inroads receives funding from Children in Need to provide substance misuse services for young people with complex needs and there is a significant number of young people who are looked after by the local authority who are embroiled in problematic use. We also work with adults who have been in the care system in the past and have gone on to significant harmful use of both drugs and alcohol.
Individuals also use drugs to cope with emotional pain and trauma and self medicate to cope with very difficult issues from the past. There are not enough counselling services in place for these people. They often need a longer term intervention and the newly commissioned services do not address the needs of this client group. There is an emphasis on group work and so called pod working. Clients often shy away from group interventions and if this is what`s on offer there will be a significant group of people that will drop out of services. This is one of the key performance indicators for the Welsh Government Substance Misuse Strategy.
Value for money and the bottom line seems to have won and the quality and appropriateness of services seems to not be a priority. Certainly that seems to be the case in Cardiff and the Vale.
Harm reduction services can also be the vehicle that instigates the change process. Well being work and structured interventions can also be utilised in people who are still actively using. There is not enough emphasis on co production. The recovery coach model seems to suggest that only people who have stopped using can become involved in delivery, when actually the case is that current users could equally have a role to play in co production and this in itself could be the catalyst for them to think of making the transition themselves.
In conclusion, Inroads is committed to continue to keep up meaningful service user consultation . Services need to make a concerted effort to engage with meaningful consultation with a large cohort of clients to ensure that as many views as possible are heard. Current service user involvement in Cardiff and the Vale of Glamorgan does not demonstrate a cross section of users and they need to think of different ways of gathering information which doesn`t necessary involve attendance at forums.

For and on behalf of Inroads

Steve Lyons

Project Co-ordinator

Inquiry into alcohol and substance misuse

RCP (Wales) response

Key points

- The Welsh Government liver disease delivery plan must be implemented in full, supported by adequate funding
- Alcohol and substance misuse services should be established as a matter of urgency where there are service gaps and existing services should be integrated across primary, secondary care and public health teams
- The RCP strongly supports the introduction of a minimum unit price for alcohol as well as other measures including:
    - a major review of licensing legislation
    - restrictions on alcohol availability
    - an independent regulator for alcohol promotion
    - a reduction in the drive-drive limit
    - a public health licensing objective.

For more information, please contact:

Lowri Jackson
Senior policy and public affairs adviser for Wales
[redacted]

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From the RCP vice president for Wales
O'r is-lywydd yr RCP dros Gymru
Dr Alan Rees MD FRCP
[redacted]

From the RCP registrar
O'r cofrestrydd yr RCP
Dr Andrew Goddard FRCP
[redacted]

09 January 2014

Dear colleague,

Thank you for the opportunity to respond to your inquiry into alcohol and substance misuse.

About us

The Royal College of Physicians (Wales) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in Wales and across the world with education, training and support throughout their careers. As an independent body representing 30,000 fellows and members worldwide, including 800 in Wales, we advise and work with government, the public, patients and other professions to improve health and healthcare.

Our response

The RCP welcomes this inquiry into alcohol and substance misuse. In particular, we recommend:

Liver disease delivery plan

1. The Welsh Government liver disease delivery plan must be implemented in full, supported by adequate funding. Local health boards will not be able to deliver outcomes without resource. Health boards must all appoint clinical leads for liver disease and give them the power and budget to do the job effectively. Reporting mechanisms outlined in the plan should be clarified to ensure that the processes are accountable and transparent.

Alcohol and substance misuse services

2. Alcohol and substance misuse services should be established as a matter of urgency where there are service gaps and existing services should be integrated across primary, secondary care and public health teams. All health and community professionals should be trained to routinely provide early identification and brief alcohol advice to their clients.

3. People who need support for alcohol problems should be routinely referred to specialist alcohol services for comprehensive assessment and appropriate treatment. This will require substantial investment in recruitment and service development in Wales: we know that there is historic underinvestment in alcohol treatment services. However, well-designed alcohol treatment services are highly effective in terms of clinical outcomes as well as being highly cost-effective.

There is an estimated return on investment of £5 (in the form of cost savings) for every £1 invested. The RCP therefore strongly supports increased investment in 'brief interventions' for alcohol, from which it is estimate that 7.1 million hazardous or harmful drinkers may benefit.

4. Every acute hospital should have a specialist, multidisciplinary alcohol care team tasked with meeting the alcohol-related needs of those attending the hospital and preventing readmissions. This will require trained hepatologists in every hospital.

5. Health boards should be meeting NICE guidelines on harmful alcohol use eg NICE QS11 Alcohol dependence and harmful alcohol use quality standard[1] and NICE QS23 Quality standard for drug use disorders.[2]

Minimum unit pricing (MUP)

6. The RCP strongly supports the introduction of a minimum unit price for alcohol. We were instrumental in establishing the Alcohol Health Alliance, which, together with the University of Stirling, produced an independent, evidence-based alcohol strategy for the UK, Health First, in 2013. This strategy set out a series of recommendations to reduce alcohol consumption and harm from alcohol and was endorsed by over 70 organisations, including Alcohol Concern Cymru. At the heart of this strategy was the introduction of a minimum unit price of 50p together with a mechanism to regularly review the price. Canada has already introduced minimum unit pricing, where it has been shown that a 10% increase in average price results in approximate an 8% reduction in consumption, a 9% reduction in hospital admissions and a 32% reduction in deaths which are wholly attributable to alcohol.[3]

7. The UK's alcohol consumption has risen 80% in the last three decades.[4] In 2010, alcohol was 48% more affordable than in 1980[5] – the heaviest drinkers currently pay only 33p/unit of alcohol, with some high-strength ciders costing the equivalent of only 6p/unit.[6] The average low-risk drinker already pays around £1/unit of alcohol and so the impact of minimum unit pricing on low risk drinkers is negligible, and on pubs it is zero.[7] Indeed, recent research has found that patients with alcohol-related cirrhosis drink an average of 146 units of alcohol per week[8] and that alcohol misuse is the single greatest cause of working years of life lost in the UK – even more than tobacco.[9] We therefore believe that a minimum unit price of 50p/unit would precisely target the heaviest drinkers.

8. Moreover, evidence suggests that minimum unit pricing would play a pivotal role in tackling health inequalities without penalising moderate drinkers on low incomes: as lower income households disproportionately suffer the harms of alcohol, they would see the most benefits as a result. University of Sheffield data suggests that routine and manual worker households would account for over 80% of the reduction in deaths and hospital admissions brought about by a

[1] http://www.nice.org.uk/guidance/qs11
[2] https://www.nice.org.uk/guidance/qs23
[3] Stockwell, T. Is alcohol too cheap in the UK? The case for setting a Minimum Unit Price for alcohol. British Colombia, 2013.
[4] Ibid.
[5] University of Stirling. Health First: An evidence based alcohol strategy for the UK. March 2013.
[6] Sheron, N, Eisenstein, K. Minimum unit price — how the evidence stacks up. BMJ 2004;348:g67
[7] University of Sheffield. Modelled income group-specific impacts of alcohol minimum unit pricing in England 2014/15: Policy appraisals using new developments to the Sheffield Alcohol Policy Model (v2.5). July 2013. **Available online**.
[8] Sheron, N., et al. Minimum unit pricing impacts financially on patients with alcohol related liver disease four hundred times more than on low risk drinkers. Submitted for peer review to Clinical Medicine, 2014.
[9] Alcohol is attributable for 82,860 of working life years lost, compared to 61,210 for tobacco.

minimum unit price and yet the consumption of moderate drinkers in low income groups would only drop by the equivalent of 2 pints of beer a year.[10]

9. However, minimum unit pricing will only be effective if it is regularly reviewed and updated to take account of inflation and rising incomes. While 50p is a reasonable starting point, delays in implementation continue to erode the effect of this level, and the original work of Sheffield University showing a marked impact (nearly 3000 lives a year saved) were modelled on 2007-8 prices. With inflation, this would be equivalent to nearer 40p now.

Other measures to reduce harm

10. The RCP would also welcome the introduction of other measures to reduce the harms associated with excessive alcohol consumption, including a major review of licensing legislation, restrictions on availability, an independent regulator for alcohol promotion, and a reduction in the legal limit for blood alcohol concentration for drivers.[11] We support moves in Scotland to reduce the drink-drive limit to 50mg in every 100ml of blood. This must be accompanied by national publicity explaining the change and its implications.

Public health licensing objective

11. Public health and community safety should be given priority in all policy-making about alcohol. This is why we support the introduction of a public health licensing objective. This would empower local authorities to make alcohol licensing decisions which fully take into account the public health impact of licensed premises in their area. Licensing authorities must be empowered to tackle alcohol-related harm by controlling the availability of alcohol in their area.

The RCP in Wales also endorses the response from Alcohol Concern Cymru.

For more information

If you have any questions, please contact our colleague, Lowri Jackson, RCP senior policy and public affairs adviser for Wales, at [redacted] or on [redacted].

With best wishes,

Dr Alan Rees
RCP vice president for Wales
Is-lywydd yr RCP dros Gymru

Dr Andrew Goddard
RCP registrar
Cofrestrydd yr RCP

[10] University of Sheffield. Modelled income group-specific impacts of alcohol minimum unit pricing in England 2014/15: Policy appraisals using new developments to the Sheffield Alcohol Policy Model (v2.5). July 2013. **Available online**.
[11] University of Stirling. Health First: An evidence based alcohol strategy for the UK. March 2013.

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from The Association of Convenience Stores – ASM 25 / Tystiolaeth gan Cymdeithas Siopau Cyfleustra – ASM 25

National Assembly of Wales

Health and Social Care Committee inquiry into Alcohol and Substance abuse

Introduction

1. ACS (the Association of Convenience Stores) welcomes the opportunity to respond to Health and Social Care Committee's inquiry into alcohol and substance misuse. ACS represents 33,500 local shops across the UK including the Co-operative Group, Spar UK, Nisa Retail, Costcutter and thousands of independent retailers. In Wales there are 3,219 convenience stores that account for 24,530 jobs[1].

2. Retailers have a considerable interest in the regulatory and voluntary framework surrounding the sale of alcohol. Alcohol sales in the UK convenience market, on average, account for 12.8% of total sales[2]. Retailers take their responsibility for the sale of alcohol very seriously and have proactively worked with the Welsh Government to create both a regulatory and voluntary framework to deliver responsible retailing and marketing of alcohol products.

Health Data on Positive Action

[1] ACS Local Shop Report Wales 2014
[2] ACS Local Shop Report 2014

3. We hope that the committee recognise that evidence from a large number of sources shows that significant progress has been made in preventing alcohol harm across Wales and the UK in last 10 years. Consumption levels across the UK population have dropped significantly[3] between 2005 and 2012. The percentage of those drinking over the recommended guidelines on their heaviest drinking day has also fallen between 2005 and 2012. Men dropped from 41% to 34% and the women from 34% to 26%.[4]

4. National policies on preventing alcohol harms must be proportionate and build upon the successes that have already been achieved. We understand that retailers have an important role to play in encouraging this change too, and we have been working through the UK's Government Responsibility Deal Alcohol Network to achieve this. One of the pledges of the responsibility deal has already reached its target to reduce the number of alcohol units in the market 1 billion by the end of 2015. It reached its target ahead of the goal in December 2014 with 1.3 billion units pledged to be removed from sale[5] through product reformation and range reviews.

Industry Action to Prevent Alcohol Harm to children

5. The industry has also taken proactive action to prevent young people from accessing alcohol. The off-trade has led the way in introduction age verification schemes such as 'Challenge 25' and partnership schemes such as Community Alcohol Partnerships. This has helped to significantly reduce the number of young people consuming alcohol; the Health and Social Care Information Centre identifies the number of 11-15 year olds that reported drinking alcohol in the past week has fallen from 25% in 2003 and 12% in 2011 to 9% in 2013[6].

Age Verification Policy

6. Retailers have been heavily engaged with a number of age verification schemes including 'Challenge 25'. Polling of ACS members in 2012 showed

[3] ONS: Drinking Habits Amongst Adults 2012
[4] Portman Group: Trends in Alcohol – A compilation of data from across the UK
[5] Responsibility Deal: Monitoring the number of units of alcohol sold – Second interim report 2013 data
[6] HSCIC Smoking, drinking and drug use among young people in England in 2013

that 70% of retailers had an age verification policy in store and it was found that more than a quarter of retailers refused age restricted sales more than ten times a week[7]. The policy ensures that anyone that looks under 25 is challenged for proof of age. It is made up of several components including training, display of signage, staff support, record keeping and guidance and clarity on acceptable forms of ID. ServeLegal, an independent test purchasing company, found in 2014 that convenience stores had an 82% pass rate[8].

7. The success of preventing underage sales in the off trade has resulted in an increase in proxy purchasing where family members or others buy alcohol on behalf of young people. Data shows that young people are more likely to access alcohol by buying from friends (53%) or someone other than family or friends (34%)[9]. We believe more action is needed to tackle proxy purchasing and educate adults about the risks and penalties associated with this. ACS commissioned research by the think tank Demos that made a number of policy recommendations including tougher penalties for proxy purchasing and naming and shaming parents/ siblings[10].

Community Alcohol Partnerships

8. Age verification schemes like 'Challenge 25' are only one part of a wider programme of activity supported by the industry to prevent young people accessing alcohol. Community Alcohol Partnerships (CAP)[11] bring together local retailers & licensees, trading standards, police, health services, education providers and other local stakeholders to tackle the problem of underage drinking and associated anti-social behaviour. This partnership approach should be taken across the UK. ACS is committed to working with partners to see more CAPs established in Wales, and we would welcome any support the Welsh Assembly Government could offer in promoting these effective partnerships.

[7] ACS Voice of Local Shops May 2012 Data
[8] Serve Legal, Independent Test Purchasing Key Trends 2014 YTD
[9] HSCIC Smoking, drinking and drug use among young people in England in 2012
[10] Demos: Sobering Up
[11] Community Alcohol Partnership

9. ACS is a founding member and funder of CAP, and their work to prevent under age sales is unrivalled. We urge the committee to consider how they can promote the work of CAP in their recommendations to the Welsh Government. The development of more CAP programmes across Wales would be a positive step to preventing young people accessing alcohol.

Industry Action to Prevent Alcohol Harm to Street Drinkers

10. We recognise concerns about the problem of street drinkers and the high strength alcohol products associated with this. Convenience stores have a role to play in preventing this form of alcohol harm, and almost half (43%) of convenience stores do not stock high strength lager and ciders in their stores[12].

11. We have seen over the last 18 months the proliferation of local authority "Reducing the Strength" schemes, which attempt to partner with retailers in order to remove high strength alcohol products from their shelves. Analysis by the British Beer and Pub Association suggests there are 84 different Reducing the Strength Schemes now running across England and Wales. The industry has faced significant challenges keeping pace with the numbers of Reducing the Strengths Schemes and the varying quality and approach of different authorities to running these schemes.

12. The most effective schemes work with a range of partners including; retailers, police, local charities and health agencies to tackle the problem. Ipswich and Portsmouth are great examples of best practice of these schemes. However, some schemes lack focus and fail to engage retailers or recognise the competition risks they present for retailers. ACS believes if schemes are managed effectively they can reduce alcohol related harm. We welcome that the Competitions and Market Authority have published guidance to clarify the legal status of these schemes. We also welcome Local Government Authority's guidance which discusses good practice in local schemes. We

[12] ACS Voice of Local Shops November 2014 Data

would like to see more consistency on how these schemes are run throughout the UK.

Non-Duty Paid Alcohol

13. We urge the Committee to also look at the problem of irresponsible retailers selling non duty paid alcohol and associated alcohol harm problems with these premises. Research from Portsmouth Council has shown a strong correlation between retail premises selling non-duty paid alcohol at low costs and breaching other licensing conditions. The audit of off trade premises by Portsmouth Council found that out of 156 stores, 28 stores were found to be selling products that the Portman Group had noted that are not for the UK market, which suggests possible links to duty fraud.

14. Targeting enforcement action against irresponsible retailers selling non-duty paid goods is likely to be more effective by removing not duty paid goods and cheap high strength product that is associated with street drinking. Local authorities already have the power to revoke licenses of premises selling non-duty paid alcohol and we would to see this used more frequently. ACS is working with HMRC by chairing the Joint Alcohol Anti-Fraud Taskforce Illicit Trade at Retail Level Working Group to encourage local authorities to use their existing licensing powers to remove licences from retailers involved with duty fraud.

15. Targeting retailers operating illegally would be a fairer, more effective way of addressing alcohol than any suggestion of implementing arbitrary limits on the number of premises selling alcohol, or imposing new regulatory restrictions on responsible retailers.

Health Policy Wales

16. The Welsh Government is currently considering the development of its Public Health Bill and ACS' submission to the consultation is available here[13]. We welcome the opportunity to consult on future proposals we urge the

[13] ACS Response to Welsh Public Health Consultation

committee and Welsh Government to engage with the retail industry on future proposals and recognise the significant progress that has already been made.

For further information on this submission please contact [redacted]

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Welsh Ambulance Services NHS Trust – ASM 26 / Tystiolaeth gan Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru– ASM 26

Inquiry into alcohol and substance misuse

Alcohol consumption or intoxication is a factor in many of the patients that the ambulance service encounters.

In order to provide information to the enquiry we are offering evidence demonstrating the effect of alcohol on calls within the Cardiff City Centre area during the night-time economy of the weekend and large sporting events and the effects of a frequent caller on the service whose chief complaint is related to alcohol addiction.

Cardiff City Centre

This data relates to the periods of 8pm until 4am on Friday and Saturday nights (16 hours per week) over the period 1 November 2013 – 31 October 2014. This data includes the 2013 Autumn Internationals and RBS Six Nations.

Because of the volume of calls generated in the CF10 area during the weekend night time economy peaks WAST deploys a ring fenced rapid assessment triage vehicle and a transport ambulance crew. The resources are tasked by either WAST following a 999 call or the door staff of venues via a “City Net” radio. The “triage” covers an area covering from City Hall in the North to Cardiff Central railway station in the South and from Cathedral Road in the West, to Queen Street in the East. This area is a little over one mile square. These resources were deployed to over 700 calls over the reference period.

This activity accounted for 10% of the total call volume of the Cardiff and Vales UHB area for the reference period. Patients who are merely intoxicated are not taken by the triage to hospital. Cardiff and the Vale UHB collaborate with WAST and the Safer Cardiff Partnership to provide an alcohol treatment centre (ATC). Of the 700 calls attended by triage over the reference period 608 were conveyed to the ATC.

Hour of Call (Alcohol Treatment Centre Activity)							
0	1	2	3	20	21	22	23

				10	18	26	41
46	58	45	17	23	33	44	40
74	46	61	26				

Frequent alcohol related callers

The following call data relates to a single alcohol dependant patient in Cardiff. This data lists all calls from this patient over the period 9 October 2014 until 19 November 2014. This is a six week period. WAST attended to this patient on 41 occasions over this period and conveyed the patient to hospital on 26 occasions. On the remaining 15 occasions the patient was referred to NHS Direct or treated on scene or referred to the patients GP.

Managing this patient committed 38 hours, or a little over three whole ambulance shifts, and many hours of NHS Direct nurse advisor and GP time. The cost of the ambulance call outs at £232 per incident was over £7,600.

Selected Location: XXXXXX, CARDIFF Total Vehicle Workload: **2328 minutes** – 39 hours

Warning:

ID	DateTime	PatientName	Age	Disp Code	Priority	Best Resp	CSign	Mins Engaged	MPDSproblem	StopCode
P1325931	09/10/2014 19:24:24		45	21D04	RED2	10.7	PSA3001	158		transported
P1325931	09/10/2014 19:24:24		45	21D04	RED2	10.7	PSR1235	51		transported
P1330580	16/10/2014 16:13:55		45	17B01	GREEN1	58.1	PSA1007	83	MALE, ALCOHOL FALLEN	transported
P1330580	16/10/2014 16:13:55		45	17B01	GREEN1	58.1	PSA1008	29	MALE, ALCOHOL FALLEN	transported
P1330580	16/10/2014 16:13:55		45	17B01	GREEN1	58.1	PSR1235	2	MALE, ALCOHOL FALLEN	transported
P1331830	18/10/2014 12:06:09		45	26O01	GREEN3				MALE ALCOHOL WITHDRAWAL NEEDS TO STOP DRINKING	Transferred NHSD Nurse Advisor
P1331875	18/10/2014 13:09:23		45	35A01	GREEN3	185.6	PSTAXI	83	NHSD P/B - ALCOHOLIC/SEVERE WITHDRAWAL ABDO PAINS ANXIOUS	transported
P1331875	18/10/2014 13:09:23		45	35A01	GREEN3	185.6	PTAXI1	86	NHSD P/B - ALCOHOLIC/SEVERE WITHDRAWAL ABDO PAINS ANXIOUS	transported
P1333250	20/10/2014 14:03:07		45	10D04	RED2	17.7	PSA1030	137		transported
P1334398	22/10/2014 14:32:16		45	10D05	RED2	17.7	PSA1001	0		transported
P1334398	22/10/2014 14:32:16		45	10D05	RED2	17.7	PSA1070	86		transported
P1337147	26/10/2014 22:21:50		45	17B01	GREEN1	10.2	PSA1009	139	MALE ALCOHOL WITHDRAWAL	transported
P1337147	26/10/2014 22:21:50		45	17B01	GREEN1	10.2	PSR4015	1	MALE ALCOHOL WITHDRAWAL	transported

P1337735	27/10/2014 20:17:12		45	26A04	GREEN3		PSR1235	2	MALE ALCOHOL WITHDRAWAL-SHAKING HALLUICINATIONS	Transferred NHSD Nurse Advisor
P1337741	27/10/2014 20:29:38		45	21B02	GREEN1	48	PHC1	23	MALE ALCOHOL WITHDRAWAL- VOMITING	transported
P1337741	27/10/2014 20:29:38		45	21B02	GREEN1	48	PSA1003	271	MALE ALCOHOL WITHDRAWAL- VOMITING	transported
P1338785	29/10/2014 16:05:34		45	25O01	GREEN3		PSR1206	1	MALE - FALLEN, HALLUCINATING AND NOT EATING	Transferred NHSD Nurse Advisor
P1338804	29/10/2014 16:26:09		46	30D02	RED2	13.7	PSR1204	67	MALE HEAD INJ POSS LOST CONSCIOUSNESS SLURRED SPEECH	Refd To GP Out Of Hours
P1341779	02/11/2014 22:58:10		45	17O02	GREEN3		PSA1068	8	MALE ALCOHOL WITHDRAWAL HALLUICNATIONS	Transferred NHSD Nurse Advisor
P1341787	02/11/2014 23:30:50		45	25O01	GREEN3	15.2	PSA1009	80	NHSD PASSBACK - ALCOHOL WITHDRAWAL HEAD INJ 4HOURS AGO	transported
P1342569	04/11/2014 02:58:26		45	10D04	RED2	15.1	PSA1521	128	MALE ALCOHOL WITHDRAWAL	transported
P1345355	08/11/2014 06:43:14		45	21B01	GREEN1	53.8	PSA1030	75	ALCOHOL WITHDRAWAL	transported
P1345355	08/11/2014 06:43:14		45	21B01	GREEN1	53.8	PSR4006	3	ALCOHOL WITHDRAWAL	transported
P1346763	10/11/2014 04:13:56		45	10D04	RED2	29.1	PSA3002	85	ALCOHOL WITHDRAWAL UNWELL	transported
P1346981	10/11/2014 11:38:02		45	17B01	GREEN1	87.7	PSA1046	132	ALCOHOL WITHDRAWAL FALLEN OVER	transported
P1348028	11/11/2014 23:24:39		45	26C02	GREEN1	20	PSA1002	107	MALE SUFFERING ALCAHOL WITHDRAWAL	transported
P1348028	11/11/2014 23:24:39		45	26C02	GREEN1	20	PSA1022	8	MALE SUFFERING ALCAHOL WITHDRAWAL	transported
P1348296	12/11/2014 12:46:10		45	17B01	GREEN1	20.9	PSA1068	125	RI	transported
P1348296	12/11/2014 12:46:10		45	17B01	GREEN1	20.9	PSR1235	4	RI	transported
P1349630	14/11/2014 11:40:29		45	26O01	GREEN3		PSR1235	1		Transferred NHSD Nurse Advisor
P1349671	14/11/2014 12:43:23		45	17B01	GREEN1				MALE SUFFERING SEVERE ALCOHOL WITHDRAWAL	Transferred NHSD Nurse Advisor
P1349692	14/11/2014 13:13:32		45	35A01	GREEN3		PEMS	36	HCP	Patient Deteriorated
P1349729	14/11/2014 13:56:40		45	26C01	GREEN1	16.9	PSA1002	79	MALE WITHDRAWING FROM ALCOHOL	Referred To GP
P1351096	16/11/2014 11:04:38		45	26C02	GREEN1	15	PSA1002	2	MALE SUFFERING FROM EXTREME ALCOHOL WITHDRAWAL	Patient Treated At Scene
P1351096	16/11/2014 11:04:38		45	26C02	GREEN1	15	PSA1009	39	MALE SUFFERING FROM EXTREME ALCOHOL WITHDRAWAL	Patient Treated At Scene
P1351096	16/11/2014 11:04:38		45	26C02	GREEN1	15	PSR4006	2	MALE SUFFERING FROM EXTREME ALCOHOL WITHDRAWAL	Patient Treated At Scene
P1351751	17/11/2014 10:31:41		45	17B01	GREEN1	12.3	PSA1022	86	ALCOHOLIC FALLEN OVER	Referred To GP
P1351751	17/11/2014 10:31:41		45	17B01	GREEN1	12.3	PSR4006	2	ALCOHOLIC FALLEN OVER	Referred To GP
P1352009	17/11/2014 15:17:20		45	17A03	GREEN3	29.4	PSA1030	84		transported
P1353308	19/11/2014 14:19:40		45	17B01	GREEN1		PSCD	23		Transferred NHSD Nurse Advisor

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from The Gwent Area Planning Board Substance Misuse Team and Provider – ASM 27 / Tystiolaeth gan Tîm a Darparwr Bwrdd Cynllunio Camddefnyddio Sylweddau Ardal Gwent – ASM 27

The Gwent Area Planning Board Substance Misuse Team and Provider response to the HSC Inquiry into Alcohol and Substance Misuse.

January 2015.

1.0 Introduction

1.1 The National Assembly for Wales Health and Care Committee inquiry into alcohol and substance misuse has requested a written response from various key partners on current alcohol and substance misuse in Wales. The HSC have particularly requested views on the following in adherence to their terms of reference:

- the impacts of alcohol and substance misuse on people in Wales, including young people and university students; older people; homeless people; and people in police custody or prisons;

- the effectiveness of current Welsh Government policies on tackling alcohol and substance misuse and any further action that may be required;

- the capacity and availability of local services across Wales to raise awareness and deal with the impact of the harms associated with alcohol and substance misuse.

1.2 The Gwent APB covers Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen and contains representatives of these five local authorities, Aneurin Bevan University Health Board (ABUHB), Gwent Police, Gwent Probation, and Prisons as well as Public Health Wales (PHW) and a representative for service users and carers.

1.3 The Gwent APB provides advice and support to responsible authorities in order to plan, commission and monitor delivery of high quality treatment and prevention services that are based on the need to improve the lives of substance misusers, families and communities.

1.4 Public Health Wales (PHW) recently conducted a regional substance misuse needs assessment on behalf of Gwent APB. The Gwent PHW team in partnership with ABUHB are responding to this inquiry separately using key messages from this needs assessment document with particular reference to the first two bullet points outlined in the terms of reference. Therefore, taking this into consideration and in order to reduce duplication this report will focus on SMAF substance misuse capacity followed by the Gwent substance misuse provider's response to the consultation questionnaire.

2.0 Capacity

2.1 The Gwent APB currently discharges an annual regional Substance Misuse Action Fund (SMAF) budget of £4,380,943 on behalf of the 5 local authorities to provide adult and young person's drug, alcohol and family support services within the region.

2.2 All Gwent substance misuse services operate at capacity, as demand for alcohol and substance misuses services for both adult and young people in Gwent is consistent. However, all commissioned treatment providers produce ongoing successful treatment outcomes which enable continuous access into services. This is achieved by delivering multi tiered; evidence based medical and/or psychosocial treatment modalities.

2.3 62% of all new community adult treatment referrals in Gwent during 2013-14 were for alcohol, 31% for substance misuse and 7% for family support services. Alcohol referrals are the most prevalent within Gwent for the same period of time for children and young people at 61%, followed by cannabis at 16%. However, there has been an increase in New Psychoactive Substance (NPS) misuse in both adult and young persons' services in the last 2 years. Increasing the complex support that individuals require, particularly regarding mental health, housing and harm reduction.

3.0 Barriers

3.1 From the questionnaires provided and through commissioner's performance management reports, reoccurring common barriers that impact on provider's capacity and ability to access additional support services are:

- Dual diagnosis assessment and access to mental health support services
- Employment
- Access and availability of suitable accommodation
- Waiting lists- CAHMS, mental health, counselling services etc
- Availability and access to GP shared care services
- Local tier 4 aftercare services

3.2 More detailed information is provided in the appendices below.

4.0 Appendices.

4.1 Please find attached Gwent APB substance misuse service provider's response to the consultation questionnaire; please note that these are the individual organisations comments.

Appendix A: CRI are commissioned to deliver Drug Interventions Programme (Gwent), Adult Alcohol Services (Blaenau Gwent and Caerphilly), Children and Young Persons' Services (Blaenau Gwent and Caerphilly).

Appendix B: Drugaid are commissioned to deliver Community Open Access Adult Drug Services (Gwent with the ex. Newport) and Children and Young People Services (Monmouthshire and Torfaen).

Appendix C: Kaleidoscope who are commissioned to deliver Adult Alcohol Services (Monmouthshire, Torfaen and Newport), Adult Drug Services (Newport) and Community Prescribing (Gwent).

Appendix A

HSC Inquiry into Alcohol and Substance Misuse Gwent Provider response: CRI

Do you currently work for an organisation which works with people who misuse alcohol or other substances? If so, please state which organisation and whether we should treat your response as being on behalf of that organisation, or as a personal response from you.
CRI organisational response for Gwent.
Which client group(s) do you work with? (For example, under 18s, older persons, homeless, or female only)
CRI cover Criminal Justice Services, Community Alcohol Service, Children and Young Person's services within Gwent. Through these services CRI work with various client groups including: Under 18's NEETS Homeless Older Persons Women only Concerned others Veterans Sex workers, BME
What are the main reasons why your clients take drugs or drink excessively? Please tick all that apply. **If you work with more than one client group or you feel that there are other reasons as to why your clients take drugs or drink excessively, please comment in the box below.** ☑ Peer pressure ☑ A way to deal with stress ☑ Client(s) already substance reliant ☑ Mental health ☑ Boost confidence ☑ Relieve social anxiety ☑ Environmental factors (for example - excessive drinking and/or drugs normalised in the home/community) ☑ Relationship problems ☑ Financial concerns ☑ Self-medication ☑ Escapism

☑ Other (please comment below)

Comments:

- Dealing with trauma,
- Sexual abuse,
- Domestic violence,
- Habitual,
- Pressure from work
- Undiagnosed mental health
- Historic abuse including institutional

C&YP perspective:

- Service users under the age of 18 usually present with substance misuse issues relating to peer pressure. Service users also state that parents and siblings are using and therefore it becomes the norm in the family household and community where they live.
- The younger age group are usually experimental users and the older age group participating in social use with tendencies towards dependency increasing.
- Service users state that they use substances to increase their confidence and boost their self esteem
- Young people often present using substances because they like using them and like the effects. They have not yet entered problematic use. This cohort of service users are usually referred reluctantly into service and are historically difficult to engage and frequently drop out of service.
- Boredom is also another reason stated by our service users. They often state there is nothing for them to do and a lack of amenities and activities in the deprived, rural communities they live in.
- Cost and availability is another reason they use, drugs and alcohol are often cheaper and more easily accessible than cinema trips, bowling, go carting etc

Are there certain groups of people who are more likely to be affected by drugs and excessive drinking? If so, which groups might they be?

- Professionals (particularly nurses and teachers),
- Homelessness
- Mental Health
- Sex Workers
- Ex Service Men
- Vulnerable Adults
- Individuals involved within the Criminal Justice System
- Young people who are not in education, employment or training (NEET) are high risk of substance misuse and criminal activity
- Over 16 year olds whose accommodation is unsatisfactory and problematic
- In C&YP there are a high percentage of clients who are living in the Looked After System

Does a particular stage of your clients' lives influence their likelihood of taking drugs or drinking excessively? If so, what stage might that be? (i.e. age, relationship breakdown, unemployment etc.)

In general we see a high amount of learnt behaviour from using alcohol as a coping

mechanism.

- Home environment and family relationships
- Peer Pressure
- Stress/Anxiety
- Unemployment
- Social Exclusion
- Bereavement
- Historic abuse
- Being made homeless
- Young people who are not in education, employment or training (NEET) are high risk of substance misuse and criminal activity
- Over 16 year olds whose accommodation is unsatisfactory and problematic
- Looked After System

What barriers exist for your client(s) when trying to access support and services?

- Stigma within their own community of accessing services,
- Overcoming culture of normalised behaviour to use alcohol at high levels,
- Clients commonly have low self esteem and little self confidence to feel able to make changes and access support.
- Waiting times
- Confidence/low self esteem
- Trust
- Personal Finances
- Chaotic lifestyle
- Lack and cost of transport
- Lack of motivation
- Geographical barriers
- Age restrictions (particularly for C&YP services)

What barriers exist for services when trying to access support for client(s)?

- **Dual diagnosis –** when there is a mental health issue and an alcohol issue local mental health services decline to intervene until the client is abstinent from alcohol, which can be difficult for the client to achieve especially if they are self medicating through alcohol.

- **Employment** – this is often a long term goal for clients to be able to achieve employment once abstinent however it can be difficult for services to access the appropriate support for clients to achieve this.

- Inpatient detox and rehab waiting times are too long (months in most cases)
- Information Sharing
- Integrated Approach
- Waiting Times
- Suitable Accommodation
- Lack of funding for activities
- Lack of diversionary activities
- Smaller projects loosing funding and closing eg youth provisions, anger management courses
- Waiting lists eg counselling, New Pathways, CAMHS etc

What do you consider to be barriers for staff and frontline services in working with your client group(s), or substance misuse generally?

- Waiting times for alcohol inpatient detox are too long (months in most cases) and also rehab waiting times are the same. This can be difficult for staff to support a client's motivation and prepare for inpatient detox and rehab when their physical and mental health declines further from the length of time they are waiting.
- Specialism's with staff teams (mental health worker, housing worker)
- Partnership working and appropriate information sharing
- Paperwork
- Not enough staff
- Lack of Substance Misuse knowledge and understanding in other sectors
- Lack of Substance Misuse training
- Difference, variations and criteria between Statutory versus voluntary agencies

Where do you think efforts should be targeted to address the issue of alcohol and substance misuse in Wales?

- Greater working links and recognition between specialist alcohol and substance misuse services and mental health.
- More direct pathways set up for specialist services in alcohol to be able to refer clients directly to rehab where appropriate.
- More funding for naloxone
- More support for dual diagnosis
- Supported accommodation
- Direct access Hostels
- Night Shelter Provision all year round
- Stimulant detox
- Rehabs
- Wet House
- More funding for qualifications for staff
- Shared IT system with relevant partners
- Young Person services as a preventative measure to support the reduction of entry into adult SM services and reducing SM related illnesses and issues
- Training for statutory services e.g Social Services Health, Education

In which local authority area do you work? If you work outside of Wales, please select "Outside Wales"

CRI operate in various areas throughout Wales including South Wales and Gwent as well as outside of Wales.

However, it should please be noted that this response is from a Gwent perspective only.

If you would like to be kept updated about the progress of the Committee's inquiry into alcohol and substance misuse in Wales, please leave your name and e-mail address below.

[redacted]

Appendix B

HSC Inquiry into Alcohol and Substance Misuse Gwent Provider response: Drugaid

Do you currently work for an organisation which works with people who misuse alcohol or other substances? If so, please state which organisation and whether we should treat your response as being on behalf of that organisation, or as a personal response from you.
Drugaid. This is an organisation response.
Which client group(s) do you work with? (For example, under 18s, older persons, homeless, or female only)
Drugaid works with adults and young people (under 18's). This includes those using substances both alcohol and drugs, those previously using substances in addition to family members, concerned others and those affected by someone else's substance use. The client group includes both male and females. Some of our client group will include homeless people and ex service personnel (veterans). Drugaid also works with other professionals and members of the public providing training, treatment, aftercare and recovery services.
What are the main reasons why your clients take drugs or drink excessively? Please tick all that apply. **If you work with more than one client group or you feel that there are other reasons as to why your clients take drugs or drink excessively, please comment in the box below.** X Peer pressure X A way to deal with stress X Client(s) already substance reliant X Mental health X Boost confidence X Relieve social anxiety X Environmental factors (for example - excessive drinking and/or drugs normalised in the home/community) X Relationship problems X Financial concerns X Self-medication X Escapism All of the above plus: X Boredom X Experimentation X Improve body image X Homeless or accommodation issues X Isolation
Comments: Homelessness – we work with a large number of young people that are living in homeless

hostels as well as a number of adults of no fixed abode.

Are there certain groups of people who are more likely to be affected by drugs and excessive drinking? If so, which groups might they be?

As above including

- Those not in employment, training or education
- Those living in deprived areas or affected by poverty or with low household income
- Those part of social groups/networks using substances
- Adults – with housing issues; with time on their hands e.g. retired; with access to money
- Young people - living in hostels; with any social services involvement; with substance misusing parents; with access to money.

Does a particular stage of your clients' lives influence their likelihood of taking drugs or drinking excessively? If so, what stage might that be? (i.e. age, relationship breakdown, unemployment etc.)

There are often a number of factors and triggers that influence substance misuse behaviour and despite commonality they will be unique to an individual and will be relevant to their own treatment journey.

We have experienced service users patterns of use as follows –

- Age – younger people experimenting, trying to fit in, peer pressure, mid to late teenage years parallel with widening social network and activities. Uneducated or unaware of substance related issues. Transitional stages such as moving from Primary to Comprehensive School, Leaving school at 16, Puberty, Changes in relationships. Summer holidays with a lack of structure and routine. Also any changes out of a young persons control such as parental separation, moving home/schools, Caring for parents etc.
- Age – older people who have possibly retired, no longer have routine and responsibilities e.g. parental responsibilities as children become independent or leave home
- Relationship issues – breakdown of relationships or relationships of others e,g parents divorcing, isolation
- Bereavement – loss of family member or friend
- Employment – unable to find employment, loss of employment, change in status, unhappy with employment
- Family issues – relationships, caring responsibilities
- Abuse – victims of abuse including physical, emotional, neglect, financial, sexual etc. Additionally perpetrators will use substances due to guilt
- Health – to cope with symptoms, pain relief etc of both physical and mental health conditions and diagnosis.
- Financial issues – loss of income, living in poverty
- Housing – loss of home
- Other coping mechanisms

What barriers exist for your client(s) when trying to access support and services?

- Lack of awareness and understanding of services available
- Uncertainty how to access or refer into service
- Lack of continuity between services – no clear care pathway

- Inconsistency of services across areas or projects
- Stigma – embarrassment, shame, feeling of failure asking for help, not wanting family members or concerned others to be aware of their use.
- Transport – unable to get to places of assessment and ongoing support
- Opening Hours – times of appointments and services opening hours may not be convenient to client eg individual may be working or child care responsibilities
- Location – as per transport. Some rural areas and valleys locations do not have substance misuse bases.
- Lack of motivation to change
- Peer group influences
- Young people having to access locations/venues that are predominantly for 18+

What barriers exist for services when trying to access support for client(s)?

- Waiting lists, capacity issues, demand outstripping supply (e.g. counselling)
- Lack of understanding of other services
- Limited access for some other core services eg mental health support
- Locality **–** being able to see service users in a location close to or convenient for them
- Good services only provided for short term contracts due to funding
- Inconsistency in age requirements for access to services – some are under 18 some are under 25
- Inconsistencies with agencies across areas e.g. social services support
- Lack of referrals from health care professionals eg. GPs'

What do you consider to be barriers for staff and frontline services in working with your client group(s), or substance misuse generally?

- Capacity – high caseloads and workloads (only in some areas and generally for adult services)
- Client expectations too high e.g. some service users might expect a substitute opiate prescription immediately on presenting to services
- Multiple needs – substance misuse clients generally present with more than one need and if that need cannot be met by our service the overriding reason for someone using may remain
- Inconsistencies in service delivery across areas e.g. Some receive funding for recreational counselling whereas others don't
- Lack of young person specific service buildings to use e.g. to offer drop in sessions
- Limited resources to do more assertive outreach work
- Restrictions with job role/remits
- Joined up working and integrated care
- Third sector working more closely with statutory service and ensure mutual trust and respect

Where do you think efforts should be targeted to address the issue of alcohol and substance misuse in Wales?

- Outreach – a greater outreach provision to provide equality of services especially to redress geographical disparities
- More consistent Harm reduction service provision, this would include needle exchange, BBV testing, Naloxone prescribing and brief interventions
- Aftercare and Recovery services
- Access to mutual aid groups eg NA, AA and Smart recovery
- Peer mentoring services
- Services to include mental health/substance misuse specialists including those for young people

- More appropriate housing for homeless people and more specialist supported housing including for young persons
- Young person's services to have the option to work up to 25 where appropriate
- More drop in venues including young people specific
- Compulsory training for schools and other services on substance misuse education
- More engagement and consultation with service users
- More engagement with primary care and local community provision
- More opportunities for individual to build recovery capital in the community
- Fostering a sense of hope throughout the treatment system
- More communication about the issues and the services in Wales
- More work targeting specific communities in Wales e.g. LGBT community and travelling community, non-English speaking migrant community

In which local authority area do you work? If you work outside of Wales, please select "Outside Wales"

- Gwent
- Cwm Taf
- Dyfed

If you would like to be kept updated about the progress of the Committee's inquiry into alcohol and substance misuse in Wales, please leave your name and e-mail address below.

Caroline Phipps
[redacted]

Appendix C

HSC Inquiry into Alcohol and Substance Misuse Gwent Provider response: Kaleidoscope

Do you currently work for an organisation which works with people who misuse alcohol or other substances? If so, please state which organisation and whether we should treat your response as being on behalf of that organisation, or as a personal response from you.
Kaleidoscope Gwent (all services)
Which client group(s) do you work with? (For example, under 18s, older persons, homeless, or female only)
Adult Substance misuse (Over 18's) including alcohol.
What are the main reasons why your clients take drugs or drink excessively? Please tick all that apply. **If you work with more than one client group or you feel that there are other reasons as to why your clients take drugs or drink excessively, please comment in the box below.** ☑ Peer pressure ☑ A way to deal with stress ☑ Client(s) already substance reliant ☑ Mental health ☑ Boost confidence ☑ Relieve social anxiety ☑ Environmental factors (for example - excessive drinking and/or drugs normalised in the home/community) ☑ Relationship problems ☑ Financial concerns ☑ Self-medication ☑ Escapism ☐ Other (please comment)
Comments: • Bereavement • Relationship breakdown • Redundancy / unemployment • Domestic / sexual abuse • Post traumatic stress
Are there certain groups of people who are more likely to be affected by drugs and excessive drinking? If so, which groups might they be?

- Family History of Substance misuse
- Lower economic background and environment
- Service users with mental health issues
- Alcohol misuse does not discriminate for gender, class, or ethnic background.

Does a particular stage of your clients' lives influence their likelihood of taking drugs or drinking excessively? If so, what stage might that be? (i.e. age, relationship breakdown, unemployment etc.)

There are many factors and triggers that can be associated with influencing the likelihood of substance misuse. Research suggests that alcohol misuse can develop in early years from experimental use. Or can develop in later years after periods of recreational use that has caused no long term negative effects. Alcohol misuse can increase due to dependence, or through negative life experiences such as bereavement, homelessness, financial insecurity, domestic abuse, sexual abuse, relationship breakdown, pain relief / other health concerns, loss of social or family support through moving area or lifestyle change eg loneliness, isolation particularly in old age.

What barriers exist for your client(s) when trying to access support and services?

- Single point of access
- Lack of GP shared care within community
- Lack of Tier 4 aftercare support
- Advertisement of services on offer
- Geographical
- Financial
- Emotional
- Lack of awareness of services
- Stigma
- Lack of occupational support
- Expectations
- Past experiences
- Concerns over confidentiality
- Family members and peer pressure
- Religious expectations
- Social and cultural norms

What barriers exist for services when trying to access support for client(s)?

- Lack of GP shared care services in community
- Lack of Tier 4 aftercare services in Wales

What do you consider to be barriers for staff and frontline services in working with your client group(s), or substance misuse generally?

- Integrated care pathways
- Service users own GP support from their registered surgery
- Geographical
- Financial
- Emotional
- Lack of awareness of services
- Stigma
- Lack of occupational support

- Expectations
- Past experiences
- Concerns over confidentiality
- Family members and peer pressure
- Religious expectations
- Social and cultural norms
- Excessive paperwork
- Lack of knowledge from other professionals
- Lack of regional commissioning from other services
- Homelessness and lack of housing support
- Poor communication between mental health and other social care partners.
- Lack of perpetrator schemes to reduce re-offending of domestic abuse.

- C-Card scheme is only available for under 25yrs. This increases the chance of risk taking sexual behaviour by sex workers and other substance users who may not feel comfortable accessing mainstream services.

Where do you think efforts should be targeted to address the issue of alcohol and substance misuse in Wales?

Finding adequate premises to run clinics or multi agency bases for substance misuse services in rural areas.

- Mental health support for substance misusers, lack of joint working with CMHT's.
- Support the training and development of professionals including primary care services.
- Support the provision of flexible and local services that are able to respond to trends and local needs.
- Support the development of service user involvement to ensure peer led provision is also available.
- Support the continued funding or Tier 4 placements to provide individuals with complex care needs appropriate responses.
- Ensure that family and friends are included in services and their needs are met.
- Support the development and improvement of communication and joint working between statutory and voluntary services.
- Support the development of a regional education plan that is enforced in schools and other education facilities based on best practice and involving the local young person's provider.
- Ensure continued supply of best practice needle exchange and harm reduction advice is available throughout Wales.
- Support the development of multiagency bases to improve joint working and single access to services.
- Support the provision of 5 year contracts to enable continuity and appropriate development of services rather than to encourage competition and apathy.

In which local authority area do you work? If you work outside of Wales, please select "Outside Wales"

Gwent

If you would like to be kept updated about the progress of the Committee's inquiry into alcohol and substance misuse in Wales, please leave your name and e-mail address below.

Jim Henton [redacted]

Additional comments:

- the impacts of alcohol and substance misuse on people in Wales, including young people and university students; older people; homeless people; and people in police custody or prisons;

what are the impacts of alcohol and substance misuse on people in Wales, including young people:
Alcohol can impact on development physically and emotionally. Young people can have their education interrupted by non-attendance or through affect on concentration and a safe space at home to complete their allocated work. Cognitive development can be negatively affected by substance use from conception. Foetal Alcohol Syndrome is an area of continued research, and Kaleidoscope fully supports the Public Health Wales No alcohol No risk campaign and provides accredited PHW brief intervention training with pregnancy and alcohol information. This should be supported to increase delivery across Wales. Alcohol and substance misuse can lead to an increase in unprotected sex and other risk taking behaviour. Substance misuse can also exasperate or initiate mental health problems including substance induced psychosis. Young people can be affected by their parents substance use which can result in them acting as carers for their parents or younger siblings. They can also be indirectly or directly affected by domestic abuse between their parents which is linked to substance use. Substance use can result in neglect of children whether intentional or through lack of stability and financial independence.

University students; increase in risk taking behaviour and the continued impairment of cognitive development. Isolation can lead to feelings of loneliness and alcohol use for confidence and self esteem. Peer pressure is a factor that increases alcohol use, and lack of consequences from family members when too much alcohol has been drunk.

***Older people*;** Health implications are increased in older age. This can be as a direct physical response to alcohol in the body, or that they are unable to recover from other illnesses. Falls and trips can have long lasting consequences and are increased in likelihood by the consumption of alcohol. Alcohol interacts negatively with many medications that are prescribed in older age, and many professionals do not feel comfortable giving advice or asking the correct questions about alcohol use to older people. Older people have less social support if they are isolated and living alone, they are often embarrassed and unable / unwilling to ask for help and support. Older people can also be carers for their younger family, and this can cause stress and financial difficulties which they do not have the resources to address.

***Homeless people*;** Alcohol and substance use can leave people in vulnerable living conditions open to financial and physical abuse, by those who they are reliant for some temporary accommodation and from member of the public when living on the street. There is a lack of social support, and increased isolation and this can increase the risk of overdose and self neglect. There is lack of access to structured treatment appointments and travel opportunities to get to appointments. There is a lack clear communication between services

and a culture of seeing these service users as non compliant. Homelessness has increased stigma attached to it, and can be a barrier to engaging and accessing in services.

***People in police custody or prisons*;** Alcohol and substance misuse can lead to an increase in physical and verbal aggression against authority figures and therefore increase the likelihood of criminal justice involvement. Dependence can also lead to acquisitive crime and increase the offending behaviour. When withdrawing from substance use within police custody or prison this can lead to physical and mental health implications. Often medication is not provided through lack of previous prescribing history or lack of access to medical supervision.

- the effectiveness of current Welsh Government policies on tackling alcohol and substance misuse and any further action that may be required;

Current policy for limited prescriptions on DIP does not always work, and does not encourage sustained recovery. Perception of staff who work in a drop in environment that includes DIP service users is that this is perceived by service users to be an enforced reduction and before they are ready and therefore they do not engage their motivation to provide negative tests and reduce off methadone.

Current NWIS guidance do not require data on family support and therefore monitoring and outcomes of services are only at a local level and not Wales wide. This does not allow for review, or development at policy level and changes on a national level.

As highlighted above dual diagnosis and substance misuse need to be more joined up. The new guidance that is being developed will hopefully support this.

Housing policy allows for limited provision for vulnerable adults and often leads to our service users being classed as 'intentionally homeless" as they are unable to manage their finance, health or social obligations to live independently.

Outcome monitoring is via TOPs form. The data that is submitted for number of days alcohol use and not amount of alcohol. Therefore does not reflect substantial reduction of alcohol use that may be achieved when a service user is still drinking every day.

Kaleidoscope supports minimum unit pricing to reduce consumption of alcohol

national union of students

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from National Union of Students – ASM 28 / Tystiolaeth gan Undeb Cenedlaethol y Myfyrwyr – ASM 28

NUS and NUS Wales: Information for the HSC Committee

Existing research on students and drinking behaviours:
There are currently 2.5 million students in British higher education, which incorporates 43% of the entire 18-24 year old population[i]. There are 165 higher education institutions. Evidence suggests that students consistently report higher levels of consumption than the wider young adult group, claiming to drink nearly double the amount in a week of every type of drink[ii].

Students report consuming nearly double the amount for every type of drink, with glasses of wine at nearly three times as many[iii]. It is also more common for students to go out with the intention of getting drunk than it is for the wider young adult audience, with 53%[iv] vs. 48%[v] reporting doing this at least once a week, although students report unintentionally getting drunk less (32%[vi] vs. 37%[vii]).

Starting university presents a significant life change for students, with many moving away from home, establishing new groups of friends and living alone for the first time. This level of life change means that students are particularly susceptible to developing new habits and behaviours while at university[viii]. This appears to be particularly key around alcohol consumption, with the expectations around the university lifestyle, as well as new peer pressures having the potential to make new students vulnerable to adopting harmful drinking patterns.

85% of students report believing that drinking and getting drunk is a fundamental part of the student experience and drinking to excess is expected[ix]. This belief creates a vicious cycle where perceptions that other students are drinking, and that being drunk is an integral part of the university experience push students to drink more than they might otherwise.

Despite the belief that getting drunk is fundamental to the university lifestyle, 40% of students report that drinking alcohol has had a negative experience on their university life in general[x]. Students report experiencing the same alcohol-related harms as the wider population, with a slightly higher tendency to get into trouble with the police (although not statistically significant)[xi].

Young people in Wales are more likely to be referred by their GP for alcohol addiction and/or abuse than for any other substance. The strain that this puts on the Welsh NHS cannot be underestimated. The figures for referrals have been dropping year on year, and that is to be welcomed. We hope that such a trend will continue. Further information on this can be found here.

British universities' response towards binge drinking has been mixed, university staff recognise some of the issues surrounding students' excessive alcohol consumption, but as yet, it is not a priority. While most appear to have alcohol policies, they are different at each university, not enforced, and the level of knowledge about them among staff is very low.

It is important at this point to clarify that students are certainly not a homogenous group and their drinking behaviours reflect this. Student drinking behaviours are influenced by a wide range of different factors. Many students choose not to drink for a variety of social or cultural reasons.

Many of the articles on British university students and binge drinking are limited to single university studies or specific student groups so caution should be taken before extrapolating these findings to the wider population. Students' unions and chaplaincies have traditionally taken a lead in this area, but the efforts have been localised to specific areas of the campus and again are dealing with consequences rather than prevention. To effect change we need an institution wide approach to responsible alcohol consumption.

Previous NUS work on responsible alcohol consumption:
In the past NUS has worked with Drinkaware to deliver the 'Why let good times go bad?' campaign to students' unions across the UK, with most displaying campaign materials and a smaller sample bringing the campaign to life on their campus through sponsored club nights.

Although the campaign achieved some successes over its five year period, Drinkaware's own evaluation identified that it had not achieved a significant shift in young adult's behaviour and suggested a different approach needed to be taken (Independent review of the Drinkaware trust, 2013[xii]).

NUS have also worked with Drinkaware, the Home Office and the Association of Chief Police Officers to produce guidance for both students' unions and license enforcement officers on how to work in partnership and tackle the problems associated with commercial bar crawls. This was in recognition of the high levels of alcohol consumption and anti-social behaviour that took place during these events, as well as the resulting impacts to students' health and wellbeing.

With a growing literature on social norm perceptions as both predictors of drinking behaviour, and the focus of interventions, there have been various pilots of challenging social norms in order to change the drinking patterns of students. This includes work conducted in 2011, by DECIPHer, in partnership with NUS Wales and Drinkaware, to assess first year university students' perceptions of peer drinking behaviour and consequences in four Welsh Universities. Further information can be found here. However drawing any conclusions around the effectiveness of these interventions is difficult, as the evidence for their success is mixed.

While there is lack of evidence of approaches towards behaviour change in the UK involving alcohol, there are examples from other areas, particularly around environmental initiatives in universities. The Green Impact scheme run by NUS is an accreditation and awards scheme for teams or departments throughout an institution whereby staff are encouraged and supported to change their habits and working practices to more environmentally sustainable ones.

First developed in 2006, it has now become a successful behaviour change and staff engagement model that over 155 organisations from different sectors use. Last year, over 40,000 staff made

25,000 changes as a result of the programme across 46 universities and colleges and 105 students' unions. The programme has become so successful that it has now been extended to run in hospitals, small businesses, dentists and a number of schools.

There are a range of factors, unique to the university campus, that influence students to drink more than the wider young adult audience, and these need to be tackled before direct student messaging can be successful. There is also evidence to suggest that once harmful drinking patterns have been established at university, they are more likely to continue into later life.

Introduction to Alcohol Impact

NUS and NUS Wales takes the welfare of students very seriously and our new Alcohol Impact Scheme works with students' unions and institutions to change attitudes towards drinking and building healthier, safer, more productive student communities.

Our pilot runs across England and Wales. We are working with **Swansea University** in Wales, other institutions that we are working with in England can be found on page 3 of this document. Once effective behaviour change can be shown we would hope for the programme to expand rapidly across institutions nationally.

The information we have is still limited and we are not able to fully understand the picture of university students and what works in changing this groups drinking behaviours. We hope with the learnings from our Alcohol Impact pilot to be able to identify and go on to recommend effective policy. A brief summary of our pilot is detailed below.

Summary of Alcohol Impact pilot

We have submitted this paper in conjunction with our first Baseline survey data report. As the baseline survey data report is not yet published, we would ask the committee to not share this data externally. We will look to publish our data, once we have completed our extensive research programme.

1. Background

In April 2013, we begun to explore how we might change student behaviours by creating a social norm of responsible alcohol consumption at a key moment of change in student lives. This built on NUS' established and successful pro-environmental behaviours change work that received catalyst funding from Defra in 2010/11.

The result is that NUS will seek to reduce alcohol-related crime and disorder associated with higher education through the piloting of an innovative, institution-wide behaviour change programme called Alcohol Impact. We will achieve this through the creation of an accreditation mark that universities will see as a 'badge of honour', that will provide a framework for institutions and students' unions to undertake important, impactful interventions through policy, procedure, retailing and accommodation that ultimately lead to an institution-wide social norm of responsible consumption with excellent potential legacy through behaviour change and habit formation.

As well as demonstrating impact attributable to the interventions, we will create a robust evidence base from our work, identifying the links between students, alcohol and crime and disorder, which will future support the development and evolution of the programme.

2. How the universities were chosen

Our model is based on a creating a strong partnership between students' unions and their parent institutions. A range of institutions were selected for the pilot to ensure it was representative of the diversity of the sector. These variances included institutional mission groups (e.g. Russell Group, Million+, etc.), their geographical location (campus *vs*. urban; northern *vs*. southern); demographic trends (ethnicity and age of the student profiles), as well as attempting to cluster them to create local exchange and dialogue, and help us with ease of delivery. Some institutions were also identified by the Home Office as being in their local action areas.

During the pilot year we will be working with the following eight institutions:

Name of Partnership	Number of students
Liverpool John Moores University and Students' Union	22,585
Loughborough University and Students' Union	15,460
Manchester Metropolitan University and Students' Union	32,465
Royal Holloway University of London and Students' Union	9,565
Swansea University and Students' Union	14,360
University of Brighton and Students' Union	21,310
University of Central Lancashire and Students' Union (control)	28,720
University of Nottingham and Students' Union	35,540
	180,005

3. Accreditation criteria and scores

In March 2014 a collaborative workshop was held to give all seven pilot partnerships the opportunity to meet us, the Home Office and each other, to find out more about current trends in research around alcohol and students, and share interventions that have previously been delivered. It also served to collect ideas from them for the criteria that formed the backbone of Alcohol Impact.

Subsequently the accreditation criteria were developed collaboratively with the Partnerships and the Home Office through a series of open discussions, the process helping to instil an important sense of ownerships with the partner institutions.

We have 46 criteria [A1-01 – A1-46], which includes 17 Mandatory and 29 optional criteria. This gives a total overall score of 181 and we have set the threshold score for accreditation at 60% of the marks, a score of 109 or more including points from the mandatory criteria (70 points). In addition to this there is the option to form three site specific criteria [A1-47–A1-49] this allows pilot partnerships to craft the workbook, making it bespoke to suit their own local needs. Each criterion is scored between 1 and 10 in terms of difficulty (with 1 being the least impactful and easiest to implement and 10 being the most impactful and difficult to implement).

4. Workbook and microsite

The workbook includes further information on why we are asking for each criterion to be met, the research behind this, how we will audit each criterion and linking to examples of good practice. We have also launched our microsite, this will continue to be updated over the coming months, with examples of interventions being delivered and sharing of good practice, so please do refer back to it!

5. Steering groups

Pilot partnerships are now working through the criterion to see how they might attain and what they want to do as a result of them.

One of the mandatory criteria asks for pilot partnerships to form a steering group - a group of key individuals that can support and implement Alcohol Impact through the life of the pilot. All pilot partnerships have now formed their steering groups. Due to the nature of the programme, the variety of members of the group varies locally. Steering groups should be student led and are likely to include commercial services, student services, teaching staff, policy makers, senior university management, students' union staff and officers.

Alongside a diverse blend of internal roles and remits, some steering groups include some non-financial involvement from external stakeholders such as the NHS, Police, city council and fire services.

6. Interventions

Through carefully planned interventions, formulated through the use of the Individual, Social and Material model (ISM), and with the support of ISM author Andrew Darnton, have worked with the pilot institutions and their students' unions to develop interventions that form the criteria. As part of the mandatory criteria [A1-35], each partnership needs to pilot one or more innovative interventions on responsible alcohol consumption.

Partnerships have focused on a variety of different local issues, which have included:

- Pre-drinking in groups in halls
- Damage in halls
- Peer-pressure to drink more than students want
- House party safety
- Student safety after a night out
- Drink-driving
- Binge drinking

Interventions have included:

- Use of breathalyser's as an educational feedback tool
- Communication campaigns, video clips
- Alcohol/quiet spaces at large events
- Safer taxi schemes
- Working with fresher's helpers to develop pledges to shift the culture of welcome weeks to focus on non-alcohol related events such as 'raveminton' and other events.
- Working with external companies to deliver alcohol free events such as giving out free food and non-alcoholic drinks.

7. The pilot

The initial pilot will run from April 2014 to April 2015. Subject to the results of this pilot, The Home Office will consider recurrent funding for a second year to allow the NUS to take the project to scale, with the aim of no grant being required in year three, at which point NUS would plan for the scheme to be expanding rapidly on a self-funded basis, with institutions paying to be audited and accredited.

8. Monitoring and evaluating impact

Three surveys, alongside diary studies and focus groups will be deployed to monitor changes in attitudes, behaviours, and experiences of crime & disorder over the period of the pilot.

9. Auditing

A team of volunteer student auditors will be recruited from nearby universities and colleges and trained (alongside staff from the organisation where appropriate) to audit the programme in March/April 2015. Each Partnership is audited to verify the results of the programme, provide teams with support, and identify good practice examples. NUS will oversee the audit process to ensure credibility, consistency and fairness.

Once results have been verified, a national Alcohol Impact awards event will take place in June 2015 to celebrate the individual and collective achievements of our seven pilot partnerships. The plan is that Partnerships will be reassessed every three years for the accreditation.

Colum McGuire, NUS VP Welfare
Beth Button, NUS Wales President
07 January 2015

Endnotes

[i] Geall, J. Youth Marking Strategy 2013 conference, held 16th April 2013

[ii] NUS Services Limited (2013), 'Why let good times go bad?' campaign evaluation, commissioned by Drinkaware

[iii] Ibid

[iv] NUS Services Limited (2013), op. cit.

[v] Millward Brown (2012), op. cit.

[vi] NUS Services Limited (2013), op. cit.

[vii] Millward Brown (2012), op. cit.

[viii] Thompson, S. et al (2011),"Moments of change" as opportunities for influencing behaviour: A report to the Department for Environment, Food and Rural Affairs', The New Economics Foundation, Defra, London

[ix] NUS Services Limited (2013), *op. cit.*

[x] NUS Services Limited (2013), op. cit.

[xi] Drinkaware KPI research, prepared by Ipsos MORI, 2013

[xii] Independent review of The Drinkaware Trust (2006–2012), prepared by 23red, 2013