



Cynulliad Cenedlaethol Cymru **The National Assembly for Wales**

Y Pwyllgor Iechyd a Gofal Cymdeithasol **The Health and Social Care Committee**

Dydd Mercher, 4 Chwefror 2014
Wednesday, 4 February 2014

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir
trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Alun Davies	Llafur Labour
Janet Finch-Saunders	Ceidwadwyr Cymreig Welsh Conservatives
John Griffiths	Llafur Labour
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Nathan David	Drugaid Cymru
Andrew Misell	Alcohol Concern Cymru
Dr Raman Sakhuja	Coleg Brenhinol y Seiciatryddion Royal College of Psychiatrists
Rowan Williams	Drugaid Cymru

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Amy Clifton	Y Gwasanaeth Ymchwil Research Service
Sian Giddins	Dirprwy Glerc Deputy Clerk
Elfyn Henderson	Y Gwasanaeth Ymchwil Research Service
Llinos Madeley	Clerc Clerk
Rhys Morgan	Dirprwy Glerc Deputy Clerk
Chris Warner	Clerc Clerk

*Dechreuodd rhan gyhoeddus y cyfarfod am 09:32.
The public part of the meeting began at 09:32.*

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. I welcome Members and the public to this morning's meeting of the Health and Social Care Committee, where we will start our oral evidence into substance misuse. Can I remind Members please to turn your mobile phones off, or any other electronic equipment that may interfere with the broadcasting equipment? There are no scheduled fire alarms this morning, so, if one does take place, please follow the directions of the ushers. The headphones are available for simultaneous translation from Welsh to English on channel 1, or, if required, for amplification on channel 2. We've not received apologies this morning, so we can go straight into the first item in public, which is the first oral evidence session.

09:33

Ymchwiliad i Gamddefnyddio Alcohol a Sylweddau: Sesiwn Dystiolaeth 1 Inquiry into Alcohol and Substance Misuse: Evidence Session 1

[2] **David Rees:** Can I welcome Andrew Misell from Alcohol Concern Cymru?

[3] **Mr Misell:** Thank you.

[4] **David Rees:** Can I remind Members that this is the first session, and can I thank Alcohol Concern Cymru for their written evidence? I know that you wish to perhaps give an introductory briefing, and then we'll go into questions.

[5] **Mr Misell:** Yes. I'll just push on, shall I?

[6] **David Rees:** Yes, please.

[7] **Mr Misell:** Thank you for inviting me here this morning. I'm Andrew Misell, Alcohol Concern's director for Wales. Alcohol Concern is an organisation you may have heard of. Founded back in 1985, which doesn't seem like a long time ago to people like me, our objective at the time was the 'relief of persons suffering from problems covered by alcohol misuse', which sounds a bit old-fashioned these days. I think, since then, the scope of our work has broadened enormously from what the general public would perhaps define as 'alcoholics' to the whole scope of the drinking population, which I suspect includes—well, it certainly includes me, and probably most of the people in this room.

[8] Now, just to be clear, we're not an anti-alcohol organisation. We are not a temperance campaign, whatever you may have heard on Twitter. We know—I know—that many people, including me, enjoy alcohol as part of their social lives, but we're also aware that alcohol can lead to poor judgment, and it makes us more prone to accidents and just general stupid behaviour, and also, more seriously, prone to a range of quite life-threatening illnesses. Heavy drinking is also linked to anxiety and depression, and violence in the home and outside. So, really, what we as an organisation are looking for is what we would call a healthy relationship with alcohol: one in which alcohol, recognising its dangerous properties, is treated with respect when being used in society. To that end, in the paper that we submitted earlier, we made the case briefly for controlling the price and availability of alcohol, which may be unpopular—it's not one of my favourite policies, but it's very effective—restricting alcohol advertising, particularly, with the intent to keep it away from children, reducing the drink-

drive limit in line with international standards, which seems to be working very well in Scotland at the moment, and the last point, which is harder to define, for really trying to remove some of the stigma around alcohol-related health problems in a way that I think people are also trying to do with mental health.

[9] **David Rees:** Thank you for that. Can I remind Members that we have a session that only lasts for 50 minutes, so can we keep our questions succinct? If you can keep your answers succinct, that will be very helpful, as well. Gwyn, do you want to start?

[10] **Gwyn R. Price:** What is your view on the overall effectiveness of the Welsh Government's approach to tackling alcohol and substance misuse, and do you think there are any gaps that could be plugged there?

[11] **Mr Misell:** I think we've been very happy with what the Welsh Government's been doing on substance misuse. We recognise that there are limitations on the Welsh Government's powers, which the Welsh Government themselves realise, and I know that that's under discussion. Research indicates that the main levers of alcohol consumption are around price and availability, and those are not devolved issues. But I think, in terms of what can be done, in terms of health promotion, the messages have been quite clear, and they've worked with us on those, so we are in agreement with them.

[12] In terms of the treatment sector, I think as with any health or social care system, you're never going to be able to fund it enough. I'm sure you'll have people in from treatment services later today, or later on, who will tell you about the gaps in their services, but that, to some extent, is a pit you'll never fill. I think there'll always be room for improvement there, but I'd say, on the whole, we're satisfied.

[13] **Gwyn R. Price:** Thank you.

[14] **David Rees:** John.

[15] **John Griffiths:** Andrew, do you see any issues in terms of the focus on alcohol or alcohol use or misuse as an issue compared with illegal drugs? Obviously, there's some interplay there anyway in terms of people perhaps using illegal drugs and misusing alcohol, but in terms of the focus of Government and service providers and actual service delivery, would you have any issues where you think perhaps the balance isn't quite right? I think a lot of people feel that alcohol use and misuse is far more widespread than illegal drug use, and the harms associated with alcohol are far greater. So, would that be your view and, if so, do you think we do need to tweak any of the arrangements in place?

[16] **Mr Misell:** Some of you may remember Professor David Nutt, who got into a lot of trouble a few years ago for saying that alcohol causes more harm than heroin. He didn't mean in terms of the individual user, just in terms of the simple number of people who use the substance. I think it has been an issue, but certainly the slant of the current Welsh Government's substance misuse strategy has been very much towards alcohol. As you say, John, it's often not a case of one or the other. I mean, I think my alcohol use is probably quite old-fashioned in that it simply involves drinking beer, but if you speak to people, particularly younger people, about how a lot of them will relax at the weekend, it will involve alcohol and another substance and a lot of these so-called 'legal highs' and emerging drugs.

[17] I don't want to get into a sort of turf war with the illicit drugs charities, who'll tell you how very important that issue is, but I think, in terms of the emphasis there needs to be on alcohol, it is a simple factor of the extent of use and the fact that it is used across the population. We would always come out very strongly against any idea that there are a group of social drinkers over here and a group of alcoholics over there and never the twain shall

meet. I think we know from our own experience that people move back and forth along that drinking spectrum, and all of us who use alcohol have a potential alcohol problem. So, I think the current emphasis on alcohol within the Welsh Government above other substances is very appropriate.

[18] **John Griffiths:** Can I just build on that, Chair? It leads me to think as well in terms of what you said, Andrew, about the sort of balance between drinking as a general problem, then, so the general use and misuse of alcohol and the harms that come from that as opposed to binge drinking as a sort of subset of the general problem. I think binge drinking gets a lot of publicity and concentration because it's out there on the streets, literally, and people can readily see at least some of the harms that come from it; whereas there's a sort of wider, more hidden problem. Personally, I think that binge drinking, nonetheless, is very, very important in terms of the harms that come from it, and it does need—I believe, anyway—quite a high level of concentration in terms of tackling general problems of drinking. What would be your take on the balance there?

[19] **Mr Misell:** I suppose we've got various issues there. There's the general issue of people's health, of perhaps people just drinking a bit too much, and then I'd say you've got two types of binge drinking, really. You've got your outdoor binge drinking at the weekends, generally, in pubs and clubs—and I know when we had our conference in Newport towards the end of last year we did a little local survey, and close to half of the people in Newport said that they didn't like to go into the town centre at night because of alcohol-related problems. Now, I'm not slagging off Newport, because Cardiff and Swansea and Pontypridd are much the same, but that is a particular issue, and I think, rightly, there's been a focus on it. There's been a lot of work done in Cardiff, basically around which pubs are sending most customers to accident and emergency departments. When people show up at hospital, where was it that they got drunk? It puts a tremendous strain on police resources. I was talking to the previous chief constable of Gwent, who was saying that she's short of officers during the week because she's got so many on duty at the weekend. So, I think we do rightly need to focus on that. It's not really good for the economic life of a city, I would argue, if the whole focus is on drinking in the evenings. It puts off families, it puts off older people from coming into town, and they're often the big spenders.

[20] That said, there is an awful lot of binge drinking going on on sofas, with the Sky tv. I guess the thing is, if you sit at home with your partner and you have a couple of bottles of wine, all you've got to do is get upstairs, and you're fine: you're unlikely to have contact with the police. But in terms of your long-term health, you know, the effect is much the same. I think we can't afford to be snobby about people who do outrageous outdoor public drinking, thinking that that's somehow a lot worse than those of us who perhaps like a bit too much fine wine at home.

[21] **David Rees:** Darren.

[22] **Darren Millar:** Thank you, Chair. I just want to explore this issue of minimum pricing, if that's okay. You refer in your written evidence to a study by the University of Sheffield's alcohol research group, which says that there could be a saving to the public purse of around £131 million over 20 years, and a reduction in the number of alcohol-related deaths by 53 per year, just by increasing the minimum unit price to 50p. We've, as part of this inquiry, engaged with some stakeholders, and the stakeholders have told us that they're not that keen, actually, on a minimum unit price. These are people who've been out there, got involved with substance misuse, and some of them have been serious alcoholics, but they are concerned that a minimum unit price could have an adverse impact, particularly on poorer people, poorer responsible drinkers. In addition to that, they say that there's a potential that it could shift people from alcohol to drugs and other substances, because of the availability—and the inexpensive availability—of things like ecstasy, for example. What do you say in

response to that?

[23] **Mr Misell:** Well, I think there are a few issues here, really. Firstly, on the Sheffield model, it's a mathematical model, so those figures are to some extent open to question. In terms of the effect on poorer drinkers, if you look at the 50p per unit minimum price, on general drinking patterns, people drinking within the chief medical officers' guidance would expect to be paying perhaps an extra 20p or 25p per week. Now, I appreciate that money is short for people, and I know what that's like from personal experience, but 20p is not a huge amount. Where it starts to become problematic is obviously where people are drinking more than is particularly healthy for them, and I don't know whether you could really make the case that that should be a cheap activity, particularly.

[24] The other issue with this is that, to some extent, minimum pricing is a regressive measure in that it applies regardless of your income, just like value-added tax. That said, when people have looked at the effects of minimum pricing around the world, and various forms of price control, it does seem to have an impact across the whole drinking population, and we need to remember, actually, that it's not just the poor who like to buy cheap alcohol. You know, lots of people like to get their three bottles of wine for a tenner.

09:45

[25] I mean, in terms of evidence from people who've worked in substance misuse, that is a very particular perspective, and I think that we do need to be aware. There is a subset of the drinking population—about 5% of drinking adults in this country—who are alcohol dependent, which is a medical condition. They can't stop drinking; their bodies are so used alcohol. I think, if and when a minimum price is introduced, preparation will have to be made for that. To draw a comparison, we were speaking with Essex Police a little while ago, who had done a campaign in the city of Chelmsford, to cut down on the supply of very strong cheap alcohol—the super-strength lagers and ciders. I was quite concerned at the start, but the way that they did it was that they went out initially and engaged with the street drinkers. They had the local volunteers and the substance misuse services on board, and they said to these people, 'Well, look, your supply's about to be drastically reduced and we want to help you to cut back on your drinking before that happens'. That actually worked quite well. So, I think, for that 5% who can't stop drinking, yes, we need to make preparations. In terms of the remaining 95%, well, those are all people who, however difficult it might be, are potentially able to reduce their drinking.

[26] **Darren Millar:** The other big issue that the reference groups raised was the availability of alcohol.

[27] **Mr Misell:** Yeah.

[28] **Darren Millar:** Particularly for those who've had problems with their drinking in the past, you know, they'll wander into a supermarket and there appears to be alcohol on every aisle and it's difficult to get away from it. Do you think there needs to be more effective control in the licensing system in terms of the display of alcohol within supermarkets and other settings in order to ensure that people who want to avoid it can avoid it?

[29] **Mr Misell:** We've certainly called, in the past, for the return of the drinks aisle, which you have in Scotland. In fact, as I understand it, in Scotland you actually have to pay at a separate till. When we've done survey work in the past, and you'll know this if you've ever been around a big supermarket: they put it next to the chicken, they put it next to the milk; it's all over the place. There is an issue with licensing in that there was a change in licensing law in the 1990s. It used to be that local licensing authorities could say that there was no need for additional licenced space in a given borough or county. That's now gone because there was a

belief that it wasn't appropriate to have magistrates controlling market forces. What they tried to do in Scotland is reintroduce that to a large extent with the concept of overprovision, whereby a local authority can say, 'Well, actually, we think there are enough off-licences, pubs, restaurants or whatever in a given area'. I mean, that's untested largely. The other thing that they've done in Scotland is introduce public health as a criterion under the Licensing (Scotland) Act 2005. That, again, is useful in theory but largely untested. On that specific point I think that we would certainly say that if local authorities can find a way within licensing conditions to say, 'Well, you can open your supermarket here, but you should have a drinks aisle and I don't want to see it in a big pile by the front door of the shop', that would be great. Interestingly, Asda at one point voluntarily said that they would remove all of their front-of-store displays—you know, the big mountains of beer—and they went back on it in a few months because beer sales were dropping, which, I guess, tells you why they do it.

[30] **Darren Millar:** Thank you.

[31] **David Rees:** Alun?

[32] **Alun Davies:** During the conversation, and in reading your paper, I couldn't help thinking—when I read your paper, I was considering it—that a lot of this is tinkering at the edges, because you can restrict the availability of alcohol, but we're not going to go back to the days when a pub closes at two o'clock in the afternoon. That's not going to happen. We're not realistically going to be in the situation whereby you're going to price people out of buying alcohol. We can put a minimum price in wherever we like, but realistically, as Darren has said, that might affect a particular part of society, but it won't affect everyone. Isn't the real issue here a cultural attitude towards alcohol and the place of alcohol in our society? And if we're going to change fundamentally the public view of alcohol—. One of the lines here—I don't remember exactly where it was in your paper—was that there's been an increase in the drinking-to-get-drunk culture. You know, I grew up with that culture in the Valleys. It's not a recent thing at all. It existed in the 1970s, as I remember, and into the 1980s, and it's there today. So, I don't think it's a recent thing, but I think there is a part of our culture that is alcohol based. It's a significant part of our culture and, unless we actually normalise alcohol, then all of this sort of thing is, essentially, tinkering.

[33] **Mr Misell:** Yeah, it's an interesting point. We do, as an organisation, to some extent, seek to engage with the drinking culture. You mentioned the Valleys there. We're doing some stuff at the moment with rugby clubs, trying to encourage them—recognising that they'll have a bar—to make sensible use of the bar and to have it open sometimes and closed at other times. However, if you look at the international evidence—and we commissioned a big review of the evidence by Bangor and Glyndŵr universities, I think it was about three or four years ago—the evidence is that the way to address culture is not to go directly for the drinking culture; the big levers do seem to be price and availability.

[34] I think the other concern about this idea that we can somehow talk people into drinking sensibly is that this is very much what we hear from the drinks industry, and again the research doesn't show that works. I mean, we run campaigns and the Welsh Government runs campaigns, but the research does not show that they work long term and, in addition, if you look at the campaigns that the drinks industry runs, a number of those have been shown to actually increase drinking and increase positive attitudes towards alcohol. I mean, the classic example is, 'Enjoy Captain Morgan responsibly', the first part of that sentence being 'Enjoy Captain Morgan' or, if you look at Johnnie Walker, which ran a drink-driving campaign, not on the hashtag #Imnotdrinking, which of course you wouldn't do as a whisky company, but #Imnotdriving. So, it's very much this idea of, 'Use our product but don't do the stupid things'. So, in short, education doesn't seem to work, and what does seem to work are these coercive measures around price and availability. I know it seems perverse, because I've been to places like Spain and Italy where you've always been up to get alcohol at 2 a.m.,

and the only drunk people you see are singing in English because they're on holiday from the UK.

[35] **Alun Davies:** Okay. I'm not sure where that takes us, but—. One of the numbers you have in your paper is, I think, about £121 million saved over 20 years. You know, if the problem is as great as we understand it is and if those measures you suggest were to be successful I'd be expecting a much bigger number over a much shorter period in terms of impact on healthcare in Wales. So, I'm not entirely convinced by some of those arguments. I understand what the drinks industry would say, and they would say that, wouldn't they? That's what their purpose is. You know, we understand where they're coming from. But from your point of view, I think things are different. I don't suggest, and I wouldn't suggest, that you launched some all-out campaign on 'the drinks culture', because clearly that would be absurd, but what I'm saying is that, surely if we're looking at normalising the place of alcohol in our society, which is what you said in your introduction—that's what I took from your introduction—one way of achieving that is to take away the 'mystique' of alcohol and actually normalise alcohol as a product that we use sensibly and that we use in a particular way as part of a lifestyle choice.

[36] **Mr Misell:** I'm going to completely disagree with you now. I mean, this is an argument we often hear around children—you know, that you should normalise children's exposure to alcohol. People will tell me, 'Oh, well, you know, in France, they give them watered down wine', but I've discussed this with people on the continent who say that the British perspective of what continentals do with alcohol and children is completely skewed. The extent to which children are given alcohol in mainland Europe is not half as great as we like to think it is. In terms of the mystique around alcohol and children, I'd certainly say to explain it to them, but, from my point of view, I've explained it to my children and I've said, 'Alcohol is a toxin. It's a poison. Ethanol is a poison.' So, it's not a normal product. I mean, I used the words 'healthy relationship with alcohol'. I think we are in a situation where alcohol use is normal, but I think we have a big circle that we can't really square. We are in the daily habit of using something that is basically dangerous. The medical evidence, regardless of occasional studies that say, 'Oh, you won't get cancer, you won't get heart disease, as long as you drink nice red wine', is that alcohol is no good for us. We have to come up with a way of using it in a way that will not do us too much harm. I guess, if you want to take away the mystique, yes, perhaps you could tell people that ethanol is toxic.

[37] **Alun Davies:** But you could also make that argument for a lot of food stuffs. You know, you can think of—. You know, we've discussed here a lot of lifestyle issues and diet issues, and if you pursue a particular product heavily, then that's going to have an impact on your lifestyle. That's true of alcohol, and it's true of others. Perhaps the difference between alcohol and other products is the level of addiction, which we can debate and discuss. My concern would be, and what I see in Wales today is a very, very unhealthy relationship with alcohol. I'm not convinced that some of these arguments and some of these measures will change fundamentally that relationship. I think that we can address issues around the edges, but we're not going to address fundamentally the 'Welsh' relationship with alcohol unless we have a far more fundamental debate and discussion.

[38] **Mr Misell:** That's what you would propose, is it? I don't know. I'm all in favour of that. I think that an open debate about alcohol is certainly what we try to do.

[39] **David Rees:** That's fine. Okay. We'll move on now. Lindsay?

[40] **Lindsay Whittle:** You certainly have great courage coming to Wales to speak about alcohol misuse two days before our biggest sporting event, but you're very realistic and I appreciate that. You mentioned the work that you do with rugby clubs. I've been in rugby clubs—I won't name them—where fathers are drinking with their 14 and 15-year-old sons,

but they're drinking responsibly and they're behaving. I have seen those same young people, sometimes younger than 14—sometimes 13 and 12—drinking vodka on street corners. Now, when I was a young man I drank—when I was 16—on street corners as well, but we didn't drink bottles of vodka. I believe that we should be educating young people more. What can the Welsh Government do, working with you, to educate young people about responsible drinking? You mentioned the continent, but whenever I go abroad, you know—

[41] **Kirsty Williams:** You're the person singing in Welsh. [*Laughter.*]

[42] **Lindsay Whittle:** No, I'm not. I'd be singing in Welsh, not English, but—. It really is important because you don't see the misbehaviour abroad. So, they must be doing something right. They must be. It's no good dismissing it, saying, 'They don't believe us'. They must be doing something right. I go on my holidays now to Scotland every year, and I've noticed the difference. You cannot buy alcohol in Tesco, Asda or whatever supermarkets you pop into, after 10 o'clock, but you can here. You can buy alcohol on my square, down in Abertridwr, 24/7. What are we doing?

[43] **Mr Misell:** I think there's an issue, certainly, with types of drinks. I've made the same point, not a particularly scientific one, but the point about beer drinking: it doesn't really appeal up to a certain age, whereas with the sort of the new range of sweeter drinks and mixed drinks, they're much easier for young people to consume. In a recent reported that we produced, we found a statement by Molson Coors saying that they're actually aiming to get young people on board who've grown up on Pepsi and Coke. They want their beers to taste like that. I think that what we've tried to do, as an organisation, is show young people some respect and engage with them on their own terms. What we often find is that young people are more concerned about drink problems than their parents. Sometimes, they're concerned about their parents' behaviour. So, we go to young people and we say, 'Well, what problems does alcohol cause in your peer group? What would you like to see change?'. We've got a few schools and youth groups in Wales working on that at the moment. It is often the young people, if you show them a bit of respect and let them take the initiative, who will lead the way. That, we found, to be a very positive approach, certainly more than telling young people what to do. I mean, probably like a lot of the people around the table, I used to drink alcohol below the legal drinking age and I thought that it was great at the time. Anyone telling me not to do it would have got very short shrift; so, I think that telling young people not to drink is not going to work, but engaging with them will.

[44] **Lindsay Whittle:** But not at 12, and not vodka.

10:00

[45] **Mr Misell:** No. I probably had some beer at 14 or 15. There is a question there as well. When you see children of that age with strong drink, they've either bought it from a shopkeeper, who's broken the law, or it's been bought for them by an adult, who's broken the law. So, perhaps the focus of our attention should be on either of those two adults initially because, obviously, if you cut off the supply, the consumption will stop as well.

[46] **David Rees:** Okay. Elin?

[47] **Elin Jones:** Bore da.

Elin Jones: Good morning.

[48] **Mr Misell:** Bore da.

Mr Misell: Good morning.

[49] **Elin Jones:** Roeddwn i eisiau gofyn i chi am rywbeth a gododd yn un o'n grwpiau trafod ni, sef bod un o'r grwpiau sy'n **Elin Jones:** I wanted to ask you about something that was raised in one of our round-table discussions, which was that one

gweithio gyda phobl sy'n cam-drin alcohol yn dweud mai'r datblygiad mwyaf newydd y maen nhw yn ei weld yw pobl hŷn, canol oed a hŷn, yn gorddefnyddio a dod yn gaeth i alcohol, drwy'r math o yfed rydych chi wedi disgrifio eisoes y bore yma, sef yfed yn guddiedig gartref, efallai gyda phartner, ac efallai beth sy'n gallu digwydd wedyn yw bod un o'r partneriaid yn marw, ac wedyn mae'r sefyllfa yn newid ac maen nhw'n dod yn llawer mwy problematig i gymdeithas yn ehangach.

[50] Mae ystadegau hefyd yn dangos bod y camddefnydd a'r goryfed o alcohol yn fwy yn y canol oed, yn y bobl sydd yn y dosbarth canol ac yn broffesiynol, ac mae hwn yn deip newydd, o bosib, o gamddefnyddio a goryfed. Nawr, y cwestiwn sydd gyda fi i chi—. Rydych chi wedi adnabod y broblem yma eich hunan, ond nid wyf yn hollol siŵr a ydy'r pump maes rydych chi'n cyfeirio atyn nhw fel rhai y mae angen i ni edrych arnynt yma yng Nghymru—nad oes un o'r meysydd yna, i ryw raddau, yn mynd i gwrdd, i drafod y bobl yma sy'n yfed eu Malbec a'u gwin—potel neu ddwy y nos—yn guddiedig. Nid wyf yn siŵr a yw un o'r pump argymhelliad yna, i ryw raddau, yn mynd i gwrdd â, a thaclo'r broblem newydd yma mewn cymdeithas.

[51] **Mr Misell:** Gallaf weld eich pwynt, ond mi fuaswn i'n anghytuno i raddau. O ran pris, rydym wedi gweld, er enghraifft, fod pris yn effeithio ar bawb. Mae pob rhan o'r gymdeithas yn ymateb i bris, ac mae hyd yn oed pobl hŷn a mwy parchus efallai, sy'n yfed gartref, yn hoffi bargaen. Maen nhw'n hoffi'r tair potelaid am £10 neu rywbeth o'r archfarchnad. A hefyd, o ran hysbysebu, y peth sy'n ein poeni ni fwyaf yw'r hysbysebion sy'n cyrraedd plant. Er enghraifft, mi es i efo'r meibion i weld ffilm efo tystysgrif 12, ac roedd pedair hysbyseb am ddiodydd alcoholaidd cyn y ffilm, a'r lle yn llawn teuluoedd. Ond, mae'r marchnatwyr yn glyfar ac mae nhw'n sylweddoli bod pobl hŷn hefyd yn gwsmeriaid posib, ac mae'r hysbysebu yn eu targedu nhw. Un peth rydym yn gweld yn ddiddorol—roedd Alun wedi sôn am normaleiddio mewn rhyw ffordd arall—o ran gwneud yfed a goryfed yn normal, yw'r hysbysebion sydd o'n cwmpas ni drwy'r amser, sy'n dweud, 'Wel, dyna

of the groups working with people who misuse alcohol said that the most recent development that they've seen is older people, middle-aged people, overusing and becoming dependent on alcohol through the kind of drinking that you have already described this morning, namely drinking secretly at home, perhaps with a partner, and what can then happen is that one of the partners may pass away, and then the situation changes and they can become far more problematic to society in a wider sense.

Statistics also demonstrate that the misuse and excessive consumption of alcohol is greater among people who are middle-aged, people who are middle-class professionals, and that this is a new type, perhaps, of alcohol misuse and excessive consumption. Now, my question to you—. You've already identified this problem yourself, but I'm not exactly sure whether the five areas that you refer to as ones that we need to address here in Wales actually deal with and meet the needs of these people who are drinking their Malbec and their wine—a bottle or two a night—secretly. I'm not sure whether any of the five recommendations, almost, which you've set out in your evidence, will address and tackle this new problem in society.

Mr Misell: I understand your point, but I disagree to a certain extent. In terms of pricing, we have seen, for example, that pricing impacts everyone. All parts of society respond to price changes, and even older, perhaps more respectable people, who drink at home, like a bargain. They like the three bottles of wine for £10 or whatever from the supermarket. Also, in terms of advertising, what concerns us most is the adverts that reach children. For example, I went with my sons to see a film with a 12 certificate, and there were four adverts for alcoholic drinks before the film, with the cinema full of families. But, the people involved in marketing alcohol are clever and realise that older people are also potential customers, and the advertising targets them. One thing we see as interesting—Alun talked about normalising in some other way—in terms of making drinking and excessive consumption normal, are the adverts that surround us all the time and which tell us, 'Well, that's how

siwd rydych chi'n ymlacio; dyna siwd rydych chi'n mwynhau', ac mae hynny'n berthnasol i bob oed.

you relax; that's how you enjoy yourself', and that is relevant to all age groups.

[52] Hefyd, o ran y stigma ac o ran y cywilydd, dyna lle, a dweud y gwir, efo'r to hŷn, dyna lle mae'r broblem fwyaf, o ran cywilydd cydnabod problem gyda'r ddiod. Rwy'n cofio rhywun yn dweud wrthyf i 'O, fuaswn i byth yn mynd lawr i'r gwasanaeth alcohol lleol achos mae'n llawn pobl ifanc ar heroin gyda chŵn ar gortyn.' Un peth rydym ni wedi'i ddweud yw bod eisiau i ni feddwl, 'Wel, os yw pobl hŷn yn poeni rhywfaint am eu hiechyd, ble buasen nhw'n mynd?' Efallai fod gyda nhw ryw glwb y maen nhw'n mynd iddo fe; mae'n dipyn o ystrydeb, ond clwb bowlio neu glwb cinio neu rywbeth, neu'r Llang Brydeinig Frenhinol neu rywle fel yna. Efallai fod yna lefydd eraill i bobl fynd iddyn nhw—pobl fuasai ddim eisiau mynd i wasanaeth alcohol.

Also, in terms of the stigma and the shame, I think that is where, to be honest, with the older generation, the greatest problem exists, in terms of the shame of admitting to problems with alcohol. I remember someone telling me, 'Oh, I'd never go down to the local alcohol service because it's full of young people on heroin with dogs on a string.' One thing that we've said is that we need to think, 'Well, if older people are somewhat concerned about their health, where would they go?' Perhaps they have some club that they go to; it's a bit of cliché, but a bowling club or a lunch club or something, or the Royal British Legion or somewhere like that. There may be other places where people could go—people who wouldn't want to go to an alcohol service.

[53] **Elin Jones:** A ydych chi'n meddwl bod problem ambell waith yn codi lle mae rhai pobl yn meddwl bod yfed gwin, er enghraifft, yn rhywbeth iachus i'w wneud, yn enwedig gwin coch? Mae tipyn o gyhoeddusrwydd wedi bod o gwmpas y ffaith bod gwin coch, neu wisgi hyd yn oed, yn gallu bod yn iach i rywun.

Elin Jones: Do you think that a problem that arises occasionally is the fact that some people think that drinking wine, for example, is good for them, particularly red wine? There has been some publicity around the fact that red wine, or even whisky, can be healthy.

[54] **Mr Misell:** Mae yna bethau mewn grawnwin sy'n dda ichi, ond gallwch chi fwyta grawnwin, wrth gwrs. Yn ôl beth rwyf wedi clywed, maen nhw hefyd i'w cael mewn tomatos. Roedd rhywbeth yn yr *Independent* yr wythnos diwethaf yn dweud bod golygyddion papurau newydd wrth eu bodd gyda straeon sy'n dweud bod diota'n dda ichi—maen nhw'n gwerthu papurau. Mae'r astudiaethau fel arfer yn rhai bach ac maen nhw'n dangos rhyw effaith fach ar ryw garfan benodol o bobl. Ond, rydym yn brwydro o hyd yn erbyn y syniad bod gwin coch yn dda ichi. Mae'n rhyfedd achos yn anaml mae rhywun yn dweud bod seidr gwyn neu fodca rhad yn dda ichi—dim ond y gwin, a gwin da.

Mr Misell: There are things in grapes which are healthy, but you could just eat grapes, of course. I've also heard the same of tomatoes. There was something in the *Independent* the other day saying that editors of newspapers love stories that say that drinking is good for you because that sells newspapers. The studies are usually very small and they show a minor impact on a particular cohort of people. But, we are constantly battling against this idea that red wine is somehow good for you. It is strange, because it is very rarely that anyone says that white cider or cheap vodka is good for you, but wine and good wine is seen as being good for you

[55] **Elin Jones:** Océ, fe wnaif i ei adael e.

Elin Jones: Okay, I'll leave it.

[56] **David Rees:** Janet.

[57] **Janet Finch-Saunders:** Thank you, Chair. This is something I'm very interested in. I

believe it's a multifaceted problem that does need a multifaceted approach. This is my theory. It picks up on the point that Alun made about culture. If you go abroad, if you go on the continent, there is a culture there of food and drink. Yet, we have outlets that predominantly just push the alcohol. I think we need to do things about that and try to encourage—. It is happening in my own town now. We're having more bistro-type facilities now where people—you wouldn't just go in for a drink; you would go in to eat and drink. Social—I remember we used to go out in my teens and we would go out and you'd have some alcohol whilst you're out. Now, the youngsters have the alcohol before they go out so that they're quite well inebriated before they go out, because drink is so cheap. So, I agree with your point about the cost of alcohol.

[58] **David Rees:** Is there a question coming?

[59] **Janet Finch-Saunders:** Oh, yeah. Mental health—I know of significant people who are using alcohol as a prop because they cannot get the services that they need for their mental health. On the point that Elin made—loneliness—elderly people and that cohort of people, I agree with you about trying to find things—. We shouldn't have people at home who feel that their comfort there and their company is a bottle of wine. People do not see the damages in alcohol—any of us—professional people who regularly consume. For all we know—nobody knows really. But, I know that the amount of liver damage that is still undetected—. As we're sat here, it's a ticking time bomb. Exercise is something else, and sport—the work that John's done in this Government towards driving youngsters towards sport. It's a well-known fact, and I know this from within my own family, that if people are very involved with sport they do not see alcohol. The endorphins are released through the activity of sport and, goodness me, alcohol is really seen as a barrier to a fit body. I take the point that Elin made about red wine and going to the gym. Addiction—that is completely separate issue—

[60] **David Rees:** Are we coming to the question?

[61] **Elin Jones:** I didn't mention the gym.

[62] **Janet Finch-Saunders:** The point being, then, is that we're talking about addictions, because this whole inquiry is about how people then go on—. When the alcohol stops working, they go on to other psycho-whatever—

[63] **David Rees:** Can we get to the question?

[64] **Janet Finch-Saunders:** Yeah, I am. The points you've made are fantastic. Media—I don't know what influence we have as a Welsh Government with media but when you watch any—

[65] **Alun Davies:** We're not the Welsh Government, Janet.

[66] **Janet Finch-Saunders:** Alun, please don't split hairs. I gave you the chance to speak. Chair, would you—

[67] **David Rees:** Janet, just go to the question, please.

[68] **Janet Finch-Saunders:** You let other Members speak for quite some time. The point I'm making now: it is a multifaceted problem. Some of the points you've made are fantastic, but how does the Welsh Government, the UK Government, and how do your organisations influence the media to actually—. It used to be the teapot on the table, if you watch *Coronation Street*; it's now the bottle of wine. How do you break that culture with media and advertising? The price—we've seen debates on the price on alcohol, but we're not winning that battle on that one. The drink drive limits you've mentioned. We raised it here in the

Assembly. I can't say that it was widely supported. So, if we know the solution, why are Governments, and why are we not doing what we can? But, at the end of the day, it goes back, of course, to choice. The one thing I'd never want to see Government doing is impeding anybody's choice in what they do. But, it's about getting the dangers of alcohol—the fact that there's ethanol in there, the fact that if you drink a lot of alcohol you will put on weight—fact. How do we get those hard facts out there? It's on cigarette packets how dangerous tobacco is, but we haven't got that same—. There isn't that will to do anything about it. How can we crack that, on all those multifaceted issues?

[69] **Mr Misell:** I'll try and be concise, then. I think there are a few points here. We've called—and other organisations have called—for factual health warnings on alcohol bottles. We're not talking about diseased lungs like you see on cigarette packets, but factual statements about the nature of the alcoholic drink—exactly what we are consuming. We and other organisations do work with creative media around things like soap operas and things. I mean, obviously, the media are free to do what they want, and we have a free press who can report all sorts of stories about red wine being good for your heart if they really want to. We try and present the contrary point of view and we do work with directors and writers and say, 'Would you like to introduce an interesting story to *Pobol y Cwm* or *Coronation Street* about someone who's got a drink problem or who's stopped drinking or something?' I'm trying to remember the other point.

[70] **Janet Finch-Saunders:** The media side of it—

[71] **David Rees:** How do we as a Welsh Government actually tackle some of these issues?

[72] **Mr Misell:** Well, as I said in answer to Gwyn's question, I think my own feeling is that the Welsh Government is doing a lot. It's doing well in terms of provision of services and in terms of raising awareness. The big levers, as I said, are around licensing, price and availability, and those are matters for the UK Government in terms of England and Wales, and the position that we have always taken—we don't have a position on the UK constitution—but the position that we have always taken is that the job needs doing. If the UK Government doesn't wish to do it across England and Wales, we would be happy to see Welsh Government do it, but, ideally, we'd like to see it done across the UK so there is no inconsistency, which we already have with the drink-drive limit. I mean it's great that Scotland pushed ahead with it, but it would be much better if the drink-drive limit didn't change at Carlisle. It would be better if it was lower across England as well.

[73] **David Rees:** So, the situation is that there are some areas that are down to the responsibility of the UK Government, clearly, to ensure that there is a UK-wide approach as well.

[74] **Mr Misell:** Yes. I mean, Darren's raised this in the past—the issue of the Welsh Government's powers, and I understand it comes down to an interpretation of two Supreme Court decisions. You know, I think that's one for the Welsh Government's lawyers.

[75] **David Rees:** Okay. Kirsty?

[76] **Kirsty Williams:** I think the points I wanted were covered.

[77] **David Rees:** John.

[78] **John Griffiths:** Yes, I think that, if we are going to make the progress we need to make, then organisations and sectors within Wales have to step up to the plate and understand their own responsibilities and the role they can play in tackling the problems. When we were

taking evidence, we discussed universities and their responsibility to their students. Thankfully, an awful lot more people go to university now, which I personally think is a very good thing. But they can get into habits while at university that will stay with them throughout their lives. Some of them—too many of them—get into heavy drinking habits at university. So, you know, there are issues, I think, around the way student unions are run, the sort of promotions they have, and whether there's enough pastoral care. You know, universities often used to employ GPs—I don't think many of them do now—or a wider workforce that could deal with the issues. Do you have a view on universities in Wales and, you know, whether they are properly fulfilling their responsibilities to their students in these terms and, if not, what they ought to do?

[79] **Mr Misell:** I think the universities are in a bit of a bind. I mean, we've complained in particular about—Cardiff University's on the doorstep of our office—promotions like 'On the lash' and 'Drink the bar dry', which we thought perhaps suggested overconsumption. But universities and the students unions are in a bit of a bind because if they organise the most sensible drinking environment with lots of nice cheap soft drinks and support for all the students, it's perfectly possible for most students just to go into town and get cheap alcoholic drinks there. So, the universities obviously have a responsibility to look after their students, but, in terms of sales of alcohol, I think from a pragmatic point of view there's only so far they can go before they're no longer running a viable business. We certainly wouldn't want them to run irresponsible promotions, but if they make their prices very high, people will simply go and drink in town and then there is no support, there is no management there particularly.

[80] **David Rees:** That's exactly what we actually heard in evidence—that they did actually prefer to ensure that students were in a safe environment—

[81] **Mr Misell:** Yeah.

[82] **David Rees:** —as they competed with the off-licence trade in town. Can I ask a question? Obviously, there's a very serious question about inconsistency across Wales in services. What's your view as to the level of inconsistency we see in services provision across Wales? You said the Welsh Government are doing things right, but what are the different pictures across Wales?

10:15

[83] **Mr Misell:** I'm not particularly an expert in alcohol services. I mean, local problems come our way. Some of them are simple, professional disagreements about how a service should be run. Obviously, I think, across Wales, people would like more funding for alcohol services, but I think those of us who are realistic recognise that, you know, there isn't a bottomless pot of cash. No, aside from isolated local issues that have been brought to my attention around particular centres, I'm not the best person to discuss the overall pattern of treatment services.

[84] **David Rees:** One final point from me. We've talked, obviously, very much about the culture of people's drinking and the increasing number of young people being introduced to alcohol via media and advertising amongst everything else. Are we, as a nation, doing enough to educate young people on a counter-direction of that? Are we making sure there's a balanced picture provided to young people, so they understand not just the glamour, advertising side of it, but they also understand the realities through the education process?

[85] **Mr Misell:** I think, again, there are two sides to that. One thing that we've been very keen to do is to take the glamour out of alcohol advertising. If you look at the law in France on alcohol advertising, you can describe the product, what it's made from, where it comes

from, and it's alcoholic strength. So, French adverts are quite boring but informative; whereas British alcohol adverts have got James Bond and girls in swimsuits and all sorts of things. So, we're quite keen to change that, and also, to have a much tighter definition of what people mean by reaching a child audience. At the moment, you can't advertise during programmes or films that are specifically aimed at children, but as I found out when I went to see *The Theory of Everything*, you can advertise in media that reach children along with adults.

[86] In terms of the counter work, the sort of countering of that glamorisation, we launched something just last week. If anyone wants to have a look at the Drink Wise Wales website, we do publish information for parents on how to discuss alcohol with your children, and it is very much along the lines of being truthful with them about the nature of alcohol and being honest with them about your own drinking. Children are very alert to hypocrisy, as you'll know if you've ever been around children. There are also a lot of protective factors. Professionals and academics talk about resilience, and resilience is built up in children by things like family mealtimes, family rituals, definite structures of discipline, and having trustworthy adults around them. These are things that are nothing to do with alcohol, but overall, children who are brought up in a stable environment, however that is created, where they know the score, they know the rules, they know there's going to be food on the table at regular times, and they're going to be treated with respect, those children are less likely to be depressed and anxious, they're less likely to misuse alcohol, they're less likely to be in trouble at school or with the police, or to have all sorts of health problems. So, these are things that I think, in the broader social perspective, we could all work on that, to some extent, alcohol-proof our children.

[87] **David Rees:** Are there any other Members with questions? No. In that case, can I thank you very much for your evidence?

[88] **Mr Misell:** Thank you. That's all right.

[89] **David Rees:** You will receive a copy of the transcript to check for any factual inaccuracies, so please let us know if there are, and your evidence will be obviously considered as part of our report. Thank you very much.

[90] **Mr Misell:** Okay, thank you.

[91] **David Rees:** I now propose we have a 10 minute break. We will restart at 10.30 a.m..

*Gohiriwyd y cyfarfod rhwng 10:18 a 10:31.
The meeting adjourned between 10:18 and 10:31.*

Ymchwiliad i Gamddefnyddio Alcohol a Sylweddau: Sesiwn Dystiolaeth 2 Inquiry into Alcohol and Substance Misuse: Evidence Session 2

[92] **David Rees:** Can I welcome Members and the public back to this morning's session of the Health and Social Care Committee, where we're continuing on with our inquiry into alcohol and substance misuse? We now have the next session this morning. Can I welcome Dr Raman Sakhuja, from the Royal College of Psychiatrists? Can I thank you very much for your paper that you've submitted? We received it yesterday and it's been distributed to Members. Obviously, we have questions based upon that, so we will go into our questions shortly, but can I remind Members please to keep your questions succinct? We have a limited time so if you could actually make sure that answers are as succinct as possible as well, I'd be grateful.

[93] **Dr Sakhuja:** Okay.

[94] **David Rees:** Gwyn, do you want to start the questions?

[95] **Gwyn R. Price:** Thank you, Chair. Good morning.

[96] **Dr Sakhuja:** Morning.

[97] **Gwyn R. Price:** What is your view on the overall effectiveness of the Welsh Government's approach to tackling alcohol and substance misuse, and do you think there are any gaps that we could possibly fill?

[98] **Dr Sakhuja:** Well, yes, I think the No. 1 thing, the good thing about the Welsh policy is that there is a strategy, and we are delivering against that strategy, which is always a good thing, but clearly there are certain gaps. As I put down in the briefing paper sent to the committee, there are a number of issues that might need to be brought up. I think the key points are that the nature of addiction has changed. The traditional way, or what the clinicians such as myself used to see of patients has changed. To give you an example, when I started off as a consultant we used to get referrals for people who were opiate users or heroin users, and there were very little alcohol users, but now, this ratio has completely reversed. So, we're getting loads and loads of people who have problems with the alcohol as opposed to the core heroin addicts, so to speak. The age span has changed, so we're seeing more and more elderly people with problems in terms of, you know, alcohol and other sorts of drugs that they've been using.

[99] What the Welsh strategy does not include is the behavioural elements of addiction. We did a survey a couple of years ago, where we looked at how many people had problems with gambling addiction, for example. The survey results I probably have over here, as a snapshot. There were about 66 people who took part in that survey, out of a conference for substance misusers at that time, and one in six who had sought help for alcohol misuse admitted that they also had problems with gambling, and half of them said that their gambling increased when their drinking increased. Out of that, 94% or close to 95% said that the addiction services should actually be looking into offering services for gambling. So, that was a snapshot survey. I don't think there are any facilities or services, at least within healthcare, that look at behavioural addictions, so to speak.

[100] So, that's one element, and the other things are that we're seeing more and more people with prescribed medication dependence. Over-the-counter medication dependence is gradually becoming an issue, and there are lots of data available that tell us that that's a growing epidemic coming from the west, and that's equally valid for us.

[101] We must keep in mind that the landscape has changed, and, you know, the funding arrangements, the resources and the workforce required to deal with it need to go hand in hand, which hasn't really happened. The old funding arrangements are still there, so the clinical services are meeting the demands without having additional resources to tackle these problems. So, there's clearly a need for lots of things to add in.

[102] If I look at the district general hospitals for example, now, there are loads of people who come with problems with alcohol and drugs. I think, up to a few years ago, the statistic used to be possibly every one in five admissions had problems with drugs or alcohol. I don't have the statistics for any recent surveys, but there's a lot of the burden happening in district general hospitals for that.

[103] The number of repeat attendees or people attending the district general hospitals with problems has gone up. When I say 'repeat attendees', well, there's a small element or an area of good practice in one of the health boards that I work in. They've done a small little pilot study to look at these so-called 'repeat attendees'—or the frequent flyers, as they've termed

it. They looked at a 12 month period and had a snapshot of activity during that part. They evaluated who are these people who attend—and they constantly attend—and they found close to 90%—the exact figure I have is 89%—of that group actually had problems with alcohol and substance misuse, and out of those, a third required in-patient admissions and treatment or whatever. The costs for any health service provider, or the health board, are obviously much, much more when the same kind of people keep coming again and again. As far as I'm aware, there are no dedicated liaison services as such in the healthcare services across Wales. There may be a couple of health boards that have dedicated services, but not all of them. In the ones that have alcohol-related services, there's a focus more on brief interventions, which is very good, but they also need much more specialist input, as opposed to just brief interventions, because brief interventions can take someone up to a certain point, but then you need the specialist input to tackle those.

[104] Clearly, the morbidity associated with alcohol is much more. The age of complications is getting lower. I think you might have some evidence later on from the liver plan, from the Royal College of Physicians, but I've certainly seen it: the youngest gentleman in my clinic's aged about 24 years. He had cirrhotic liver disease with lots of complications secondary to alcohol. So, clearly, there is a need there.

[105] The number of in-patient beds that we have is, again, very, very variable across Wales, so not all health boards have in-patient facilities to treat these people. It's very, very variable, so the south Wales Valleys, for example, they mostly send people to Cardiff, so it's Cardiff-centred, but not everyone has their own in-patient facilities. *[Interruption.]*

[106] **David Rees:** Can I apologise to Members? Obviously, there's noise coming in from next door, with some kind of disturbance. We are trying to sort it out—just in case you've been disturbed by the noise.

[107] **Dr Sakhuja:** Okay.

[108] **David Rees:** Gwyn, any further questions?

[109] **Gwyn R. Price:** I just asked it, thanks.

[110] **David Rees:** Okay, thanks. Can I ask one question? You've identified there, in your figures, that the larger proportion of people who have been identified as coming back in—your words were 'frequent flyers'—have been identified as having an alcohol issues, or alcohol-related, in the one sense. Your personal referrals: have you seen an increase in referrals coming from accident and emergency units themselves or are they still as you would expect them to be or as they have been in the past?

[111] **Dr Sakhuja:** I think in the health board that I work in, certainly there have been peaks and troughs of referrals coming in and the kind of people who I go and see are often much, much more physically morbid as opposed to the ones who I used to see, and the age has gone up. So, giving you an example, last afternoon, I had seen someone who was 72 years of age and was having problems with alcohol and once you are dealing with the elderly population, it becomes clinically relevant to understand their needs in a very different context. So, what I'm trying to say here is, yes, there is definitely an increase. The physical complications are much more and the age span has gone up and more elderly people are coming in.

[112] **David Rees:** Janet.

[113] **Janet Finch-Saunders:** How do you think we can get a more joined-up approach to this, given that there are all of these different facets to it?

[114] **Dr Sakhuja:** I think, you know, there are two ways of doing it: either we look at the political arrangements of substance misuse, generally, or look at the healthcare side of things. Obviously, the political arena is not for me to comment on, but from the health point of view, I think it would be useful to, first of all, look at the stigma attached to drug and alcohol problems. I think I wouldn't be wrong in saying that not only the general public, but lots of professionals also still have the feeling that for someone who has a problem with drugs and alcohol, it is a lifestyle choice as opposed to it being—

[115] **Janet Finch-Saunders:** Yes, I wanted to just come in on that. Is addiction almost like genetic? Are we talking, if they move from alcohol, then they can move to whatever they become addicted to at that time and that, in the health profession, you're always fighting that individual's addictions, whatever they may be?

[116] **Dr Sakhuja:** Yes. You know, No. 1, I think one thing that has to be made loud and clear to all professions and the public is that, when we are dealing with an addicted brain, we are really dealing with a chronic brain disorder, because an addicted brain works very, very differently to someone who is using alcohol recreationally or on social occasions. Until clinicians start understanding that, and the public start understanding that, things probably may not move that much, and we will be always battling between whether the addiction services or the substance misuse problem needs to sit under the crime agenda or the health agenda. We would argue, from the college point of view, that it has to be under the health umbrella as opposed to crime.

[117] **Janet Finch-Saunders:** Finally, are the numbers of addicted people in various age groups, in your opinion, worryingly increasing?

[118] **Dr Sakhuja:** They are, definitely, and we are seeing a different spectrum of addiction problems now. When we talk of addiction, the common image that is conjured up is someone who is a heroin user or a cocaine or a crack user, but what we're seeing is that it is not that, but is also prescribed medication, over the counter, alcohol and younger and older age groups, much more severe addiction problems and, sometimes, specifically in the elderly, they don't see it as a problem. So, one has to approach that with a very, very different clinical skill, which I don't think everyone is equipped in Wales to tackle, because there have never been services catered to look at the elderly population with addiction problems.

[119] **David Rees:** Okay. Kirsty.

[120] **Kirsty Williams:** Dr Sakhuja, you say that the nature of the patients is changing and you just questioned whether people had the appropriate skills. I'm interested in your views on workforce issues and whether we have enough people like yourself and other clinical staff, who support you in your work, and whether those people have the correct training and understanding to deliver what should be a modern, up-to-date alcohol and substance misuse and addiction services.

10:45

[121] **Dr Sakhuja:** Well, the simple answer is, 'no'. I don't think we have enough of a workforce to meet the demands and the changing demands, really. And I think if I was to group the problems with substance misuse or addictions into three sort of—. You lose different parts, where someone is a recreational user, versus someone who is a harmful user and someone who's an addicted person. We obviously, as specialists, tend to see one extreme end of the spectrum, where you're dealing with addictive problems, and sometimes, with the workforce that we have across Wales, there is a general feeling that there is an inter-mix of boundaries. Those boundaries are probably clinical, but then there's an understanding of

which services need to be placed at what point to be able to map a journey of an individual who starts off using recreationally and then ends up developing an addiction. So, there is a place for everyone. So, there is a place for tier 2 services; there is a place for tier 3; there is a place for specialist intervention in-patient services. I don't think those are clear enough in many of the area planning boards and the workforce generally.

[122] Talking about the specialist services, I think it would be fair to say that, because the demanding nature is changing, there is definitely a need for people to be upskilled and cater to the needs of that changing population.

[123] **Kirsty Williams:** Can you give us a flavour? So, for instance, somebody that you may see, would they have waited a long time before they got to see you, or—

[124] **Dr Sakhuja:** That is actually variable. In our health board, we've been successful in actually having no waiting list at all. So, people can access our services much faster. Sorry, do you mind repeating that question?

[125] **Kirsty Williams:** I'm just trying to get a feel for whether the workforce issues constrain the ability then to see people in a timely fashion. Do people get to see you and your colleagues quickly, or are people languishing, waiting, before they get to see you or your equivalents in other health boards?

[126] **Dr Sakhuja:** Well, you know, there is a standard in terms of what the waiting lists are. I think I'm fortunate that I work somewhere where there is no waiting list, so if a GP wants an assessment, or an opinion from me, I'm more likely than not to just see them and provide an opinion, plan or whatever. But other health boards might have a waiting list, and the systems that are in place may not be as in other health boards. So, there is a huge variation.

[127] **Kirsty Williams:** Forgive me, I haven't got your paper in front of me; which health board do you work for?

[128] **Dr Sakhuja:** I work for Cwm Taf.

[129] **Kirsty Williams:** Cwm Taf. Thank you.

[130] **David Rees:** Obviously, you're also representing the Royal College of Psychiatrists today. Do you have any anecdotal information from the other health boards, or from your colleagues in other health boards, as to whether they're facing difficulties with waiting lists?

[131] **Dr Sakhuja:** Yes. I think colleagues generally feel that there is a long waiting list, and sometimes that seems to be specifically for in-patient facilities. So, for example, if I've seen someone who needs in-patient treatment, that's probably one of the biggest challenges in our clinics. If somebody is ready for an in-patient intervention, and if you don't have the beds available for them, then those people have to wait an x amount of weeks, or sometimes even months, to get that in-patient treatment. That waiting period for some of them may be very crucial, and sadly, sometimes they need an acute admission because they've suddenly deteriorated that badly, physically, that they would be better off with an acute management as opposed to a planned in-patient treatment. Perhaps sometimes we lose some of the patients because they've waited, and that certainly happens in our clinical area of work.

[132] **David Rees:** Okay, thank you. John.

[133] **John Griffiths:** You mentioned that one of the issues is around prescribed medicines. Is that partly due to GPs prescribing inappropriately and inaccurate reviews of people's

medicines as time goes on? Are there issues there for the GPs or other health professionals that are partly responsible for producing these problems?

[134] **Dr Sakhuja:** Well, yes. I think there is no one single factor responsible for that, so I wouldn't be here saying that it's all the GPs' fault; no, it's not. What seems to be happening is that, if patients are started on a particular medication, the review systems need much more improvement, because once they've been started they need monitoring as well. I'll quote a study from Canada—I don't have any figures from locally in Wales—and what they found was people who've had, for example, day surgery on a knee, or some procedure, have been prescribed some opiates for pain relief and probably, about one year down the line, they found over 60% of them were still on that opiate, because that's just gone with the patient at the time of discharge and never been reviewed. A lot of the patients themselves didn't know whether they were supposed to stop or not. So, at this point in time, we are just trying to look within our local health board and across Wales as to how that can be tackled, how many people are actually going out on certain medications and from what area—is it secondary healthcare, is it primary healthcare? I don't have any figures to corroborate that, but all I can say is that it's an area that needs further investigation as to how best to tackle it.

[135] I remember talking to an advisory panel on substance misuse about the same issues a few months ago, and certain pilots do need to be put in place, such as screening those individuals in primary care where you could sort of predict whether or not someone is more vulnerable to develop an addiction to prescribed medication or not, and being a little bit more careful when you're deciding on a long-term opiate in primary care. So, it's probably going to be a mixture of primary care specialists, the pain teams—all of those together to come up with options and tackle that.

[136] **John Griffiths:** Just a follow-up question, Chair, which is at a slight tangent because it's more general, but picking up on what you said about some people being more vulnerable, perhaps, to developing an addiction with regard to prescribed medicines, because there is a theory, isn't there, that some people are more prone to developing addictions in general? Is that a theory that you would agree with or not?

[137] **Dr Sakhuja:** Absolutely. I think from whatever research and clinical experience we have, it runs in the families. There are lots of studies on gambling, alcohol, you know, stimulant addiction and individuals with a strong family history and strong genetic background can range from about 40% to 80% chances of developing an addiction to substances. An individual who is already genetically vulnerable is placed in an environment of parenthood or whatever culture they are in and are exposed to those drugs or addictive behaviours, I would quite clearly say might be up to eight times more likely to develop addictions.

[138] **John Griffiths:** Is that more about circumstances, then—you know, their family and social and economic circumstances—rather than any addictive personality that's genetic or whatever?

[139] **Dr Sakhuja:** Well, they are genetically prone anyway, but if they're that plus getting into the right environment, those risks go up. You know, it's always the question of nature versus nurture argument, but both of them have a role to play.

[140] **David Rees:** Okay, thank you. Darren.

[141] **Darren Millar:** Thank you, Chair. I just wanted to ask about two issues. You refer in your paper to the need to invest in an alcohol-related brain damage service in Wales. Can you just tell me: what's the prevalence of alcohol-related brain damage amongst the Welsh population? Where would such services be located?

[142] **Dr Sakhuja:** I think one of the fundamental issues over here is that we don't know the prevalence figures, because they are widespread and we're not really collecting enough data. It's only since we started seeing more physically co-morbid people with memory problems and alcohol-related brain damage problems—. Traditionally, if we look at the alcohol-related brain damage, it's a broad, clinical sort of concept where there is reversible, static brain damage that is entirely preventable; all that needs to be done is to give them high doses of thiamine and essential vitamins to prevent a specific complication. So, that is one aspect. If those people develop that complication, unfortunately they don't seem to belong anywhere, because no-one seems to take the onus on to them, as opposed to, for example, someone who has developed Korsakoff syndrome, which is irreversible brain damage secondary to alcohol. The substance misuse services are not really equipped to deal with their needs; mental health can't deal with their needs; and, elderly services are not able to deal with their needs. So, they belong sort of nowhere.

[143] **Darren Millar:** So, there's a specific cohort of people, but we don't know how many, that we may be missing and not giving appropriate support to.

[144] **Dr Sakhuja:** Yes.

[145] **Darren Millar:** So, have studies been undertaken elsewhere in the UK about prevalence levels?

[146] **Dr Sakhuja:** I think these services gradually—. In England and Ireland, they are making more services available for alcohol-related brain damage. In fact, if you're looking at specific figures, then I would point the committee to a paper—I don't have it with me—that the college has done: a report on alcohol-related brain damage, which is the college report 185. I can always send that separately.

[147] **Darren Millar:** So, we're not sure what proportion, basically, of people who misuse alcohol end up with alcohol-related brain damage, but there is an inconsistency in the availability of those services in Wales.

[148] **Dr Sakhuja:** Yes.

[149] **Darren Millar:** Okay. Can I ask also: you make mention of the fact that there are very few dedicated alcohol and substance misuse services for children, what is currently out there, and where are they located?

[150] **Dr Sakhuja:** As far as I'm aware, there's only one dedicated service within the CAMHS network, which is the child and adolescent mental health services network. I think that is within the Cwm Taf area, but no other health board, to my knowledge, up until this morning, has had a dedicated service.

[151] **Darren Millar:** So, currently, children and young people are treated within the generic CAMHS services, but again, their needs may not be fully met.

[152] **Dr Sakhuja:** Absolutely.

[153] **Darren Millar:** So, what proportion of—. What are patient numbers like? What's the prevalence like in terms of young people in our CAMHS service who have a substance misuse problem?

[154] **Dr Sakhuja:** I think, again, speaking with colleagues in CAMHS, they've started noticing it's not just the recreational heroin that is causing problems, but the younger

population coming up with newer sorts of drugs, novel psychoactive substances, or even something like self-image-enhancing drugs, which include steroids, and the legal highs. Those groups of drugs are being used much, much more, and because there's no pharmacological support yet available for those, or prescribing services as such, they tend to lie more in the tier 2 supportive psycho-social interventions as opposed to pharmacological management. But, again, giving you a specific figure probably is difficult at this stage.

[155] **Darren Miller:** And just in terms of the Cwm Taf service, do you see referrals from outside of Cwm Taf because of the specialised service that's available there for children and young people?

[156] **Dr Sakhuja:** No, it's only Cwm Taf related, really.

11:00

[157] **Darren Millar:** Okay. Thank you.

[158] **David Rees:** Thank you. Elin?

[159] **Elin Jones:** Yes. Thank you for your paper. When we held a round-table event with people who were addicts and had been treated in the various services, some of them weren't particularly complimentary about GP services that they had tried to access or as a first point of contact in their treatment. You don't mention GP primary care much in your paper, but you do hint at various clinical attitudes that are in the system somewhere, where even clinicians can be quite dismissive of people with addictions and seeking treatment. So, I wanted to ask you about that particular issue: where you find, within the NHS, that that attitude prevails, what can be done to improve that, but also whether you have any comments on the GP role and the GP practice role in providing a, possibly, first point of contact for people who want to access more intense services to help with their addiction?

[160] **Dr Sakhuja:** Well, I think the clinicians' attitudes are, again, very, very variable and they go all the way from primary care to specialist care. I categorically remember doing a talk at a primary care meeting, and there were certain clinicians who stood up and said that we should not treat them because it is a lifestyle choice. I was actually taken aback by that attitude. For some of them, it may start off as a lifestyle choice, but by the time they are using it in addictive sorts of ways, it is no longer a lifestyle choice. If it was a lifestyle choice, they could just, you know, snap out of it, but that doesn't happen. All the health resources and the specialist inputs that are there are there for a reason. So, yes, that attitude is still there, and even, sometimes, in the secondary care specialist hospitals. For example, people coming in for an acute alcohol-related problem—. There have been instances, certainly, where the clinicians have got up and said that, 'This is a lifestyle choice. We don't have, sort of, time for them. They're blocking a bed.' That needs, certainly, to be changed, because not only are we dealing with an addicted person, the first thing is that we're dealing with a human being. No matter what problems come up in the health sector, you simply can't treat human beings with those stigmatising and degrading sorts of attitudes.

[161] So, how do we tackle that? I think I've suggested in the paper maybe having a national campaign to deal with stigma and making people much more aware of substance misuse or addictions, what they are, what treatments are available and how we tackle them, and, also, making the public aware that if they have a problem, then they have a problem, and there are appropriate services available to go to and access.

[162] **Elin Jones:** And then, in terms of GPs as a first point of access, we certainly heard that some of the people who'd tried GP services or tried to access services via GPs hadn't given particularly good feedback. Those were the individuals we talked to. Do you think that

there's an issue around GP services that needs to be improved, in their understanding of the services that are available, then, more widely, for an individual who presents to a GP?

[163] **Dr Sakhuja:** Yes, I think that, again, GPs, as you rightly said, are the first port of call. So, again, I don't think that any first-line clinician should be in a position to have a choice whether to treat someone or not to treat someone. So, if there are issues in terms of primary care physicians choosing not to look after people with a drug or alcohol problem, then they simply send it to the secondary care services. So, obviously work needs to be done in that area where they need to be able to be much more trained in picking up those clues, screening them, and then getting the access part of it for those patients much more. Again, that might be down to the culture of stigma associated with drug and alcohol services, because people who access primary care are sometimes seen as troublemakers and, actually, one of the GPs I know who has done really well in terms of alcohol and drug services, quite clearly mentions that they're a lovely bunch of people to work with once you start understanding and start treating them as any other human being.

[164] **David Rees:** Okay?

[165] **Elin Jones:** Yes.

[166] **David Rees:** Kirsty.

[167] **Kirsty Williams:** On the issue of stigma, you describe a horrible scenario, and I'm assuming that's towards alcohol users. If people have a stigma towards alcohol users, or traditional opiate drug users, what's the attitude like with people coming forward with, perhaps, new problems, such as addiction to tramadol or diazepam, or addiction to over-the-counter painkillers or laxatives or other things that people tend to get addicted to? I mean, is the stigma equally as great for those patients, as well?

[168] **Dr Sakhuja:** I think I might want to say, 'yes', but what happens with that stigma is that, because the society sees that as such, some of these people who are genuinely having problems, they find it difficult to access, because they will be seen as, you know, 'junkies', so to speak. I think I would like to address the public and say, 'Look, for a clinician, it does not matter what problem you come up with, you know, whether it's alcohol, drugs, or prescribed medication over the counter, we're there to help'.

[169] **David Rees:** Can I expand that a little bit further, because we've also heard evidence of, clearly, people who are more of middle age and older age becoming addicted, particularly to alcohol, in one sense. Is there a stigma they feel with actually presenting and asking for support, or is it an issue that we need to actually educate people to understand that there are issues that need to be addressed and they should not be afraid of, basically, looking them in the face and saying, 'I need to go and get some help on this'?

[170] **Dr Sakhuja:** Yes. I think there are two elements to that, and when I say 'two elements', I'm relating to a specific recent clinical scenario, where I'd seen an elderly lady. First, it was difficult for her to recognise that the amount of drink that she was using was way over what we would consider a safe limit. What I would normally directly ask an individual in the adult population is whether or not they would have a problem with the drink, or alcohol, but that question, sometimes, cannot be directly approached with an elderly person who's not keen to get engaged. So, you know, that's one element to that. The other part of that is that, again, there needs to be an education part from us to make people understand that if they are using x amount of drugs or alcohol at some point, then gaining access to services like any other shouldn't be that much of an issue. Although, they very often find that as stigmatising, as well, because for many of them, they've lived with alcohol, for example, for a number of years, socially, but then, one fine day, they find themselves in the hospital only to realise that

they've been drinking far too much and they've a clinician sitting on their bed saying, 'Look, you're drinking far too much'. They might turn around and say, 'You're just a little baby, a youngster, so who are you to tell me what I'm supposed to do?' So, those issues are real-life issues and they need to be managed much more subtly as opposed to with a different population.

[171] **David Rees:** Okay. Just one final question from me. Your paper highlights the concerns you've expressed over, perhaps, the lack of involvement of mental health issues in the design of services—I think you've already mentioned that quite a bit this morning, in one sense. Is there anything you want to add to what you've been saying this morning as to how we can strengthen services and how we need to include those issues as part of the delivery of those services for all forms of addiction, whether it's substance misuse, drugs or alcohol, or whatever?

[172] **Dr Sakhuja:** I think, specifically for alcohol, the college certainly advocates the introduction of a minimum price, and you might hear that from a number of individuals across Wales, because there's a lot of evidence for reducing the harm. What I would also want to say is that the area planning boards within Wales are bodies that oversee how the services are being conducted, and there seems to be a lack of standardised understanding of the Welsh guidance and, sometimes, some of the health boards have been taking on various roles in their own little perception of whether or not they can commission or not commission. So, I think it would be useful for the Government to provide a standardised framework for area planning boards and demonstrate some clinical governance structures there.

[173] In terms of mental health, one of the issues that we've found is that, again, there is a wide variation in practice, in terms of people who are having problems with drugs and alcohol, if they need to gain access to core mental health services. With the introduction of the Mental Health (Wales) Measure 2010, sometimes access to those services has become slightly more challenging, because it has to be via a certain route. If, for example, I've seen someone in my clinic and want them to be referred further on, I have to go through the GP as opposed to gaining access directly.

[174] So, I think a better understanding of all of those is crucial, and implementing, or increasing the resources that we have. Those resources could go into training across all tiers of healthcare, as opposed to, you know, just one. Social care, the criminal justice system—there's a lot of people out there, and in the prison services, for example, as well, who need access to treatment services, whether they are in prison or out of prison. So, communication links and the integration of all of those things are important. I think training more people in psychiatry who can deal with the addiction side of things is also going to be really helpful. Perhaps having more in-patient facilities across the LHBs would be useful, and having increased liaison services across the—

[175] **David Rees:** Disciplinary teams.

[176] **Dr Sakhuja:** —disciplinary teams will be useful.

[177] **David Rees:** Okay. Thank you for that. Do any other Members have questions? Elin.

[178] **Elin Jones:** Can I ask a question for information? Excuse my lack of understanding here. I understand tier 4 services, and residential rehabilitation services, but can you explain to me the role of in-patient facilities in the NHS, then, and the links that you have with the services that are provided by the third sector, and how you cater for different needs in that respect—or are they similar needs, just undertaken in different settings?

[179] **Dr Sakhuja:** I think the principles are similar, but why we need in-patients is simply

because physically related health issues are becoming more and more difficult to manage and the number of referrals is going up. You know, in a month, if I am getting 18 referrals, and out of those 18, if I have to treat, say, half of them in an in-patient environment, purely because they need monitoring 24/7 if they are doing an in-patient detox, then I would rather have that patient within our own local health board, to oversee their treatment, monitor them and then move them on, as opposed to just making a referral into an in-patient unit, which is x number of miles away from me and they're going to take x amount of weeks for that patient. So, that is one reason I think that we need to have in-patient facilities across the health board, under these specialist services.

[180] What was the second part?

11:15

[181] **Elin Jones:** Well, I just wanted to understand, then, after what you've explained there, are there any statistics on the various treatments that are available—in-patient detox, for example—and on the success rates of those facilities in making sure that people then become rehabilitated in the community, and whether you have any—. Because there's nothing in the paper, but is there anything on the importance and the success of hospital in-patient provision of services?

[182] **Dr Sakhuja:** Okay. I can certainly get those statistics. You know, I'll have to ask neighbouring colleagues who deal with the in-patient services, but I'd like to point out that a detox is actually just a beginning for most of these people. Doing a detox successfully in an in-patient environment is one thing, but then treating the other bits afterwards is the most challenging part. That requires a host of pharmacological therapies, psychosocial interventions, and other things. That is something where we probably are not that brilliant in terms of employing newer treatments available. There's a little research going on in terms of how best to tackle these things. In the paper, I've just put down that there's only one research, but that is not true, so I want to correct that. There's other research happening. So, recently, from Cardiff they've done a systematic meta-analysis of the psychological interventions for problems with addictions, and what they have clearly pointed out is that there's clearly a lack of number of psychologically-trained therapists to deal with co-morbid problems—for example, post-traumatic stress and alcohol. That is a huge component. Lots of people with post-traumatic stress would be using alcohol as a means to self-medicate, and often we have the struggle of gaining access to psychological therapies for them, and there's a sort of argument that bounces around where one would say that you get your alcohol sorted first and then we look at PTSD, or PTSD first and then we look at alcohol. Well, that's not the best way of dealing with it, and the meta-analysis is also pointing towards that. I don't think that we have enough trained psychologists to deal with that part of things as well. Plus, the newer ones, such as—. Sorry.

[183] **David Rees:** I'm conscious of the time. We're coming to an end now. Was there anything else? You did indicate that you would give us some statistics, if possible. If you can get that, it would be very helpful for us.

[184] **Dr Sakhuja:** Okay.

[185] **David Rees:** Can I thank you, therefore, for your evidence this morning?

[186] **Dr Sakhuja:** Thank you.

[187] **David Rees:** You will receive a copy of the transcript for any factual inaccuracies that you identify. Please let us know. Your evidence today, and the written evidence, obviously, will be considered as part of our consideration for the report. Thank you very

much for your time.

[188] **Dr Sakhuja:** Thank you.

[189] **David Rees:** Members, be aware—as we swap over panels—that we are now going to the third and final panel for this morning.

11:18

Ymchwiliad i Gamddefnyddio Alcohol a Sylweddau: Sesiwn Dystiolaeth 3 **Inquiry into Alcohol and Substance Misuse: Evidence Session 3**

[190] **David Rees:** Can I just inform Members that we were aware that Harry Shapiro had a problem with travelling this morning because of difficulties that he was facing due to the disruption of the train service? Unfortunately, he's unable to make it. Harry Shapiro from DrugScope. So, we're just having the two representatives from Drugaid this morning—*[Interruption.]* No, not that Rowan Williams. I remind Members that we are still in public.

[191] Good morning. Just to inform you that the microphones should come on automatically, so you haven't got to touch anything. If there are questions in Welsh, the headphones for simultaneous translation should already be set up for you, okay?

[192] **Ms Williams:** Okay, thank you.

[193] **David Rees:** Can I welcome Nathan David and Rowan Williams, both from Drugaid Cymru. Good morning and, first of all, thank you for your written evidence. We've got limited time so, if it's okay with you, we'll go straight into questions.

[194] **Mr David:** No problem.

[195] **Ms Williams:** Yeah.

[196] **David Rees:** Gwyn.

[197] **Gwyn R. Price:** Thank you, Chair, and good morning everybody. What is your view on the overall effectiveness of the Welsh Government's approach to tackling alcohol and substance misuse, and do you think there are any gaps that need filling in there that people are perhaps falling through?

[198] **Ms Williams:** I think we've been forward thinking in some areas in Wales, for instance with the roll-out of naloxone across the country; this hasn't happened in England. Naloxone is an opiate antagonist that's used in overdose situations and is given to drug users so that they can use it in the case of an emergency with their peers. So, it's given to drug users and their families. I think, in that way, we're really forward thinking in Wales. We in Drugaid have supported minimum unit pricing for alcohol. I think that we're losing the battle with the new and emerging psychoactive substances that are coming onto the market very quickly now. I mean, Nathan and I were just speaking; we're dealing with a different animal now. When we first started working in this field many moons ago, we were working with just a small number of drugs, with heroin and crack cocaine being the most problematic, but now we've got an influx of new psychoactive substances of which the long-term effects are completely unknown. So, our substance misuse service has had to change the way that it's operating to accommodate that. In terms of legislation, I think we've done the right thing with alcohol and minimum unit pricing.

[199] **Mr David:** I also think one of the ways we've been really forward thinking as well

has been with WEDINOS, the Welsh emerging drugs and identification of novel substances project, where people can actually sort of send samples in anonymously for testing to actually find out what substances there are in there. I think some things have been highlighted from that where people are buying some of the new psychoactive substances that haven't been legislated against, sending them off for testing and they're actually coming back with illicit substances in them as well. So, for those who are using these substances there is an opportunity to find out what sort of products are in there. I think one of the dangers of any sort of illicit substance misuse is not knowing what the product is when buying it. So, I think that that, for certain people, can be a bit of a safety net as well.

[200] **Ms Williams:** Just to add to that, WEDINOS is a project supported by Public Health Wales, and is being rolled out again across Wales—content testing of illicit drugs.

[201] **Mr David:** As far as I'm aware, there's nothing like that anywhere else in the world at the moment.

[202] **David Rees:** Thank you both. Kirsty.

[203] **Kirsty Williams:** A lot of the evidence we've heard this morning is about the different nature of patients coming forward into services, away from traditional opiate addiction or even alcohol. We've heard this morning about an increase in the prevalence of prescribed medication addiction and people being addicted to over-the-counter medication. I'm just wondering whether that trend is reflected in the nature of the work you do and the clients that you see in your services.

[204] **Mr David:** Yeah, definitely. I think quite often with benzodiazepines, and with some of the prescribed opiates as well, there is a certain amount of them that do sort of filter from prescriptions, whether they're being sold on or whatever, and people do end up either—. I think there are a few ways that people find that problematic: one where they might have been over-prescribed and prescribed long term and people are ending up dependent on these substances; and some of them do actually filter out and they are sold on as well, and people start using them recreationally and then become dependent that way as well.

[205] **Ms Williams:** Also, a lot of these normally controlled drugs are available quite readily on the internet, either via normal internet purchases or via the dark net. So, we're hearing a lot about internet purchasing and people are presenting at our services, yes, with problems that—. And we've also got an older demographic in terms of alcohol users. We're seeing more older age alcohol users coming forward as well.

[206] **Kirsty Williams:** When we were looking at our inquiry into new psychoactive substances, there was a lot of feedback that it's quite hard for services on the ground, the way that they're commissioned, to keep up with some of these changing demands. I'm just wondering whether, you know, in trying to deal with this different type of client group that you've got potentially coming forward, whether you think we need to look again at how services are commissioned and provided.

[207] **Ms Williams:** I think that, as long as we're putting some effort into harm reduction interventions, that's where the issue is, that our therapeutic interventions will be used—whatever substance people are using, we'll be using cognitive behavioural approaches, motivational interviewing. A lot of the different talking therapies are generally what are used by drugs services across Wales. So, that won't matter, whatever the substance. But, in terms of the harm reduction advice that we're giving, like what impacts these drugs are having on people's bodies, long-term effects, et cetera, we're unable to give that information, because we just do not know it ourselves.

[208] **Kirsty Williams:** Okay. Thank you very much.

[209] **Mr David:** Regarding the interventions that you provide, I think, like Rowan says, you tend to treat the person, not the actual drug itself. Like Rowan says, a lot of the harm reduction advice, some of it might be sort of similar across substances, say for injecting practices, but then other things about the sort of effects and whether that drug is a central nervous system suppressant or a stimulant, that's where some of our knowledge is lacking. So, research into a lot of these substances, and if we can get this sort of knowledge out there to the front-line workers so that we can then educate our service users on the effects as well.

[210] **David Rees:** Lindsay.

[211] **Ms Williams:** Sorry. We definitely have holes in our evidence base in terms of this issue.

[212] **Lindsay Whittle:** Just a small question from me. We visited your sector, and thank you for the courtesy shown to us. Have you noticed an increase in different socioeconomic classes coming to you?

[213] **Mr David:** I think, at the centre where I work, traditionally, since it was set up, there's been quite a large homeless cohort attending the centre, although that's not the main focus. I'd say demographically, no, there's not a lot of difference, really. I think, with access to services, sometimes opening times can be a little bit of a barrier to that, and I don't know whether we are sort of tending to engage a lot more unemployed people, because not all, but some services, tend to be opening nine-to-five hours, so for people who are in employment that do have problematic substance misuse, it's going to be hard for them to access that.

[214] **Lindsay Whittle:** So, are we missing a whole sort of group of people, then, who are, shall we say, the better off?

[215] **Ms Williams:** In terms of commissioning services, I think it's really important that we use web-based approaches and some of the new technologies to communicate with people. I think drugs services across Wales are trying to respond to that and do that now. We are definitely seeing an older demographic, but it's a cross-cutting issue. Have things changed considerably? No, in my opinion, not that we've particularly noticed.

[216] **Mr David:** I think it's about how you define problematic, as well. There's a large population, in my opinion, that might be working nine-to-five and, come the weekend, they might—. I mean, alcohol is one of the main ways that people socialise in this country, and people that are working nine-to-five, they're going out and they're drinking excessively at the weekends, binge drinking, et cetera. They go back to work on a Monday morning and they might be feeling a bit rough, but they don't necessarily identify it as a problem, even though it might be damaging to their health in the long term.

[217] **Lindsay Whittle:** Okay. Thank you.

[218] **David Rees:** Elin.

[219] **Elin Jones:** I wanted to ask you whether you've got any views on how the statutory services—the NHS services—could be improved, or whether they need to be improved in any way. We've already discussed GP services here this morning, and, when we had a round-table with recovering addicts, they were certainly not particularly complimentary of their experiences as individuals with the GP practices. So, I wondered whether you have any views or ideas as to where the services could be improved in the NHS.

11:30

[220] **Ms Williams:** I think it's really important that the statutory services work in partnership with the voluntary sector and the third sector, and that, wherever possible, drugs services are reaching out to GPs, mainly through our local neighbourhood care networks, et cetera. I think it's really important that the voluntary sector work in partnership with statutory provision. Statutory provision is definitely more rigid than the provision that we're able to offer. We were talking just prior to coming in this morning. What was the example we used? I was saying about CCTV in one of the statutory services' needle-exchange outlets—and, in Drugaid, we certainly wouldn't do that, we wouldn't put CCTV up, but they may have to because of health and safety legislation. I'm not sure of the reason behind it, but we've got a bit more flexibility working for the voluntary sector and we're able to—.

[221] **Elin Jones:** So, is there a lot of cross-referral between the GP practices into the voluntary sector?

[222] **Mr David:** Very much. I think one of the barriers to that is if a service user goes in to see their GP and they've got a problem with substance misuse. That first port of call and that first step to engage is a very, very difficult step—people are going to be extremely nervous and they might be reluctant to disclose, they might be ashamed of their drug use. They would go to their GP to report the problem, to seek help, but then their GP has to refer them on to another agency, which is another hoop that that person has to jump through and it can create a barrier—they can be referred to a variety of services before they get that initial help. I think that if GPs are able to provide sort of brief interventions a little bit more, that might be a useful way forward.

[223] Also in certain areas, as well, there are some good links with A&E departments. In Bristol, in particular, people going into hospitals with bladder problems, they might be referred to the urology department, and they've got links with drug services there, as that can often be because of excessive ketamine use. So, they've got direct referral pathways into specific ketamine services in Bristol, and I think, again, with A&E, if there could be sort of more links established, then—.

[224] **Ms Williams:** I also think the three-year commissioning cycle can cause problems, because we have changes of phone numbers quite frequently, so GPs often aren't too sure—in different areas of Wales, it is different—who to refer to and which is the referring agency. So, a lot of commissioning bodies now are commissioning single points of contact, so one phone number for whole regions, where boroughs are coming together and commissioning on a regional basis and there's one contact point, which makes it much easier for the referrers in and the service users and all of the related health professionals.

[225] **David Rees:** Okay. John.

[226] **John Griffiths:** In terms of a joined-up service and helping people to get off whatever substance, you know, they're currently on and to recover and get themselves into a more productive lifestyle, is there much of a role at the moment, do you think, for leisure services? We heard when we were taking evidence that people need things to do with their time, you know, they need diversionary possibilities and so on, and it would be valuable if there was a strong joining-up between health and leisure services and sports bodies and so on. Does that happen much at the moment?

[227] **Ms Williams:** I think it's happening more—there's more of a focus on after-care provision. Unfortunately, we lost the peer-mentoring scheme, which was a national scheme. It was an excellent scheme—it was ex-users supporting users in the community. What a lot of drugs services aim to do is to help drug users build their social capital—so it is not just

looking at the drug use, it's looking at their relationships and trying to encourage pro-social relationships, social inclusion, access to employment, training and education and things to alleviate boredom, to create something different for people to do and help them sustain the gains then that they make in treatment, because, often, there is a big sort of gap and they come back to what they have always—. They come through treatment, our treatment services, at the end, but we don't see that as the end stage in Drugaid. We do a lot of work following that work, usually for up to around nine months, following people leaving. They can return again—[*Inaudible.*] But that aftercare stage is absolutely crucial in sustaining the gains that are made in treatment, and so links with these different activities, so that people can get new hobbies, new interests, something different to do, something different to fill their time, are really important.

[228] **Mr David:** One of the interventions that we provide there is a group intervention, and it's a four-point programme, and one of the elements of that programme is around leading a balanced life, and we would encourage people, as well as encouraging things around sort of self-development, and your sort of day-to-day maintenance of your own health, that you also need to have fun activities and enjoyable activities within that as well. I think one of the things within Drugaid and the Phoenix Centre is that we have been very proactive in providing those activities, and that ranges from art classes right through to rock climbing. Those who engage in those activities, in my experience, tend to stay longer engaged in services and tend to be more successful in treatment, and then, when they finish their treatment, they're far more willing to volunteer and sort of give their time back to services as well. So, keeping people occupied I think is extremely important, and boredom is an extremely big precursor to relapse as well.

[229] **John Griffiths:** And you think that the peer-mentoring service was a very important part of that picture, and enabled that sort of activity?

[230] **Ms Williams:** Absolutely. There is a big gap right at this minute. I know that there are plans to relaunch it this year, and I think that's a great idea, with a bigger mental health focus. I think that's needed too, but the peer-mentoring scheme was successful in service users seeing role models and being supported by people who'd been there, worn the T-shirt, and had had similar experiences to themselves.

[231] **David Rees:** Okay, John? Janet.

[232] **Janet Finch-Saunders:** I'm well aware of the peer-mentoring scheme and I would agree it's good—it was obviously withdrawn because of funding, was it?

[233] **Ms Williams:** There were issues in terms of the administration. It was an ESF-funded project, and there were some issues of administration between Welsh Government and the European social fund.

[234] **Janet Finch-Saunders:** Oh, what a pity. So, how will those problems be overcome for it to be launched again, do you know?

[235] **Ms Williams:** I'm not sure how. I really don't know. The substance misuse division within Welsh Government have overcome the issues, and it is being launched again. There's a new tender coming out this year, 2015.

[236] **Janet Finch-Saunders:** Would you say—

[237] **Ms Williams:** But I fear there's been a gap, and we've lost some people, which is unfortunate.

[238] **Janet Finch-Saunders:** Would you say the peer-mentoring scheme, though, catches everybody? Because we've got a growing cohort now of older people—

[239] **Ms Williams:** No. We do need to look at the different demographics and make sure—. I mean, often—. You'll find that the peer-mentoring scheme will often have people from similar sorts of types of background.

[240] **Janet Finch-Saunders:** And ages as well.

[241] **Ms Williams:** And we need to offer different support groups—

[242] **Janet Finch-Saunders:** Yes, I would agree.

[243] **Ms Williams:** —and a range of support groups for people, where they feel comfortable to attend.

[244] **Janet Finch-Saunders:** Do you find it also harder for older people to identify themselves, perhaps, as having a problem?

[245] **Ms Williams:** Yes, particularly, but, again, we're trying to offer support groups for older people. There's a national pilot happening across the UK, called 'Drink Wise, Age Well'. That's starting in April this year, I understand. Rhondda Cynon Taf is going to be the pilot area, with a control area in Denbighshire, and there are also pilot sites and control sites in England and in Scotland and Northern Ireland. So, we'll see the results of that—. I mean, that sounds really interesting.

[246] **Janet Finch-Saunders:** Yes, it will be worth having a look to see how they do that. Thank you.

[247] **David Rees:** Can I ask a question? We've talked about the services provided. Are you facing or are you are experiencing an issue regarding waiting times? Obviously, once you get a referral in, that's one thing, but what about people getting referred in?

[248] **Ms Williams:** We certainly don't. Drugaid offers open-access services. We can experience waiting times to get from somebody. So, we will work with somebody as soon as they walk through the door. We've been able to do that. That's our sort of forte—engagement and engagement services. But the issue can be if people want prescriptions, opiate-substitute prescriptions in particular. There are sometimes waiting lists for them. Then what we have to do is work with people to try and keep them motivated until the time arises that there's a space on a waiting list. That is particularly for opiate substitute prescribing, I would suggest, or for substitute prescribing—it's not always opiates.

[249] **David Rees:** And have you lost service users in that waiting period?

[250] **Mr David:** I think it can, and it does, happen. It can be a window of opportunity to sort of look at harm reduction, but I think when people are looking for prescribing they want abstinence—that's going to be their main port of call when they come into the service.

[251] There have been some massive changes since I started working in drug services. When I first started working in 2003, certainly in Cardiff, there were up to one-year waiting lists for prescribing places through statutory services. Unfortunately, as a result of that, there was a certain cohort that would actually go out and offend, because there was a quicker route into prescribing services through criminal justice services than through statutory services.

[252] **Ms Williams:** But I think that's changed now.

[253] **Mr David:** That has changed now, in that those waiting lists have dropped an incredible amount since then. But there still could be a couple of weeks and, in that time, those individuals might be committing offences. They could be putting themselves at risk as well, whether through risky injecting practices or overdose, while they're in that waiting period.

[254] **Ms Williams:** And it's different from borough to borough—so, in certain boroughs there are no waiting lists at all. We think rapid access to prescribing is absolutely essential when somebody presents with an issue; they are really wanting to address it right there and then, generally, and it is hard to keep people motivated over a number of months. In certain areas, we can get immediate access. In other boroughs in Wales, there are a few months' waiting lists still in existence now.

[255] **David Rees:** Kirsty, do you want to come in?

[256] **Kirsty Williams:** Sometimes, there's a stereotypical image of where these problems occur, and often people have a very idealised view of what life in rural Wales is like. But, you know, no community is immune from drug and alcohol issues, and I'm just wondering whether you have any perspective on the challenges of providing peer support and appropriate support in more rural communities.

[257] **Ms Williams:** It is—. Sorry.

[258] **Mr David:** It depends how you define 'rural'. Even in south Wales, in the Gwent valleys or the Rhondda, there is a sort of idea that people tend to stick to their own valley and their own town. They're very reluctant to move out of their own area as well. So, quite often—. I mean, for example, you have people in the north of Caerphilly borough, say in somewhere like Rhymney, they won't cross—. Their main sort of hub might be in Caerphilly, where their treatment services are, because that's the local authority that they live in. They might be closer to Tredegar or Ebbw Vale, where there are services, but because it's across the valley they won't necessarily do that. Transport links are a big barrier to people accessing services, and I don't know whether outreach hubs or satellite services might be a way to address that.

[259] **Ms Williams:** I think it's really important we take our services to them. Drug services are flexible enough to take our services to the service users, using maybe mobile units, new IT technologies and actually offering services out in—. We do a lot of work out in community venues—church halls are good for me, with my name, Rowan Williams. *[Laughter.]* I get quick access to a church hall if I—

[260] **Kirsty Williams:** They get a surprise when you turn up.

[261] **Ms Williams:** Yes. *[Laughter.]* But, you know, I think it's important that drug services are flexible enough and have the flexibility built in to their contracts to be able to take our services to service users. We're doing that either physically or by using information technology—Skype, et cetera.

[262] **Kirsty Williams:** Thank you.

[263] **David Rees:** One final question from me, then. We focused very much upon, obviously, service users and their needs. We haven't discussed the preventative agenda in one sense. Is the Welsh Government doing enough to look at how we can prevent people becoming users or addicts in the first instance? Are our education programmes enough? Are we getting to the right groups of people? And the change in actually people needing services,

particularly the older groups—do we need to look at how we tackle each different age group now?

[264] **Ms Williams:** I think the preventative agenda needs some work, because we've got different things going on in different schools, and it's very much the headmaster or the headmistress of the school who is the person who takes the lead and assesses how much substance misuse education is on the curriculum. I'd like to see it as mandatory on curriculums and aimed at different ages as well, so you've got different subjects and topic areas that are age-specific. I don't think we've got anything across the board at the moment. Odd things happen.

11:45

[265] **Mr David:** I think, like Rowan says, it's sort of the difference between different areas, in how different schools or services might be and their sort of perception of drug services and what sort of image they give out as well. I think, with the harm reduction message, and when you sort of provide an education, it's a very fine line between actually making people aware of the effects and the dangers of the substance. You need to give people an informed choice in that as well, and it's a fine line between sort of highlighting the danger and actually highlighting the effects that some people might deem as positive as well. So, there does necessarily have to be careful wording in there. I have spoken to service users who have said that, when they did drugs education in school, they were provided with the effects of a certain substance, and it almost became attractive to them. It's like talking about hallucinogens—it might change your vision and perception—and people were almost like, 'I want to try that'. So, I think you've got to be very, very careful in the message that you portray as well.

[266] Regarding getting that message out there, like Rowan says, I don't think there's a one-size-fits-all. The information that you're going to give to an 18-year-old is going to be very, very different to the information that you give a 50-year-old. And even within schools as well, you might be providing a harm reduction message, but you're not going to teach children of that age safer injecting practices or something like that. So, I think it does need to be tailored to specific demographics.

[267] **David Rees:** Okay. Have any other Members got questions? No. Can I thank you very much for your evidence this morning? You will receive a copy of the transcript for any factual inaccuracies that you identify; please let us know. Your written evidence on this will be considered as part of our inquiry, and hopefully, will come into our report. Thank you very much.

[268] **Mr David:** Thank you very much.

[269] **Ms Williams:** Thank you.

11:46

Papurau i'w Nodi Papers to Note

[270] **David Rees:** Members, we have some papers to note. The first one is the minutes from the meeting on 21 January. Are you happy to note that? Then we have the notes from the reference group event we held on 21 January as part of this inquiry. Are you happy to note those? The summary of the survey of responses as part of this inquiry into alcohol and substance misuse. Again, are you happy to note those? The written evidence consultation responses received as part of the inquiry; you should all have received a copy of those. The

additional information from the Welsh Government on the independent living fund consultation arrangements from the Minister. Are you happy to note that? And then, correspondence from the Finance Committee regarding the Safe Nurse Staffing Levels (Wales) Bill. I'm aware that Kirsty is here at the moment. It's only purely correspondence, just asking the committee to look at the financial aspects, and not for the Finance Committee to do that. Are you happy to note that? Thank you very much. We will move on to the next item.

11:48

**Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r
Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the
Remainder of the Meeting**

[271] **David Rees:** I propose that, in accordance with Standing Order 17.42(vi), we resolve to meet in private for the remainder of this meeting.

Cynnig:

Motion:

y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog 17.42(vi). *the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).*

Cynigiwyd y cynnig.

Motion moved.

[272] Is everyone content? Thank you.

Derbyniwyd y cynnig.

Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:48.

The public part of the meeting ended at 11:48.