



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

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

Dydd Mercher, 11 Mawrth 2014
Wednesday, 11 March 2014

Cynnwys
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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

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

Dr Jake Hard	Coleg Brenhinol yr Ymarferwyr Cyffredinol Royal College of General Practitioners
Dr Sarah J. Jones	Iechyd Cyhoeddus Cymru Public Health Wales
Richard Lee	Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services NHS Trust
Stuart Moncur	Bwrdd Iechyd Prifysgol Hywel Dda Hywel Dda University Health Board
Libby Ryan-Davies	Bwrdd Iechyd Prifysgol Hywel Dda Hywel Dda University Health Board
Josie Smith	Iechyd Cyhoeddus Cymru Public Health Wales
Sue Stone	Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Abertawe Bro Morgannwg University Health Board

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

Sian Giddins	Dirprwy Glerc Deputy Clerk
Elfyn Henderson	Gwasanaeth Ymchwil Research Service
Llinos Madeley	Clerc Clerk

Rhys Morgan	Dirprwy Glerc
	Deputy Clerk
Chris Warner	Clerc
	Clerk

*Dechreuodd y cyfarfod am 09:17.
The meeting began at 09:17.*

Cyflwyniadau, Ymddiheuriadau a Dirprwyon Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. Can I welcome Members and the public to this morning's session of the Health and Social Care Committee at the National Assembly for Wales? Can I remind Members please to make sure your mobile phones are either off or on silent, and any equipment that may interfere with the broadcasting equipment is switched off? There is no scheduled fire alarm this morning, so if there is an alarm, please follow the directions of the ushers. There is simultaneous translation from Welsh to English available on the headphone set. Channel 1 is for the translation. If you want amplification, it's channel 2. We've received apologies from Alun Davies this morning with no substitution. So, if Members are ready, we'll now move on to the sessions this morning, where we will be continuing our inquiry into alcohol and substance misuse.

09:18

Ymchwiliad i Gamdefnyddio Alcohol a Sylweddau: Sesiwn Dystiolaeth 4 Inquiry into Alcohol and Substance Misuse: Evidence Session 4

[2] **David Rees:** For the first evidence session, can I welcome Dr Sarah Jones, who is actually a consultant in environmental health protection at Public Health Wales, and Josie Smith, programme and national lead for substance misuse and health protection at Public Health Wales also? Can I thank you for your written paper? It's very much appreciated. Obviously, when you write papers, you tend to know that questions will follow naturally. So, we'll go straight into questions, if that's okay with yourselves, and we'll start with Gwyn Price.

[3] **Gwyn R. Price:** Good morning to you both. Can you tell us whether there are any gaps in the Welsh Government's approach to tackling alcohol and substance misuse, and where the future efforts should be targeted, in your opinion?

[4] **Ms Smith:** Essentially, we very much from a public health perspective, welcome the health-based approach of the 'Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018', which is currently in play up to 2018. We've seen certainly positive effects as a consequence of the strategy in terms of, for example, the key performance indicators to reduce waiting times to access specialist substance misuse services, both drugs and alcohol, along with a range of other issues. We have seen a subsequent reduction in hospital admissions from drugs and alcohol, across the board, but, certainly, there are always areas where we would recommend further action could be taken. Primarily from a public health perspective, these are around making sure that population-level-based approaches to reduction in the availability, consumption and social acceptability of alcohol and drugs is better targeted.

[5] We would like to see more proactive engagement at very early stages to prevent escalation, if you like, to problematic drug and alcohol use. So, it's very much around ensuring that services are geared towards less problematic but early warning signs of

problems and escalation of use, both in drugs and alcohol, including prescription-only medicines, which we're finding are becoming more of an issue in an older population.

[6] Thirdly, it's the better development or increase in really clear care pathways and the empowerment of a huge range of individuals to be able to feel they can make referrals or speak with individuals who are perhaps experiencing early signs of problematic use, so that referral and early access to specialist services can be made and so that they are made much earlier, rather than at the later stages of problematic use.

[7] Finally is adaptation of specialist substance misuse services to really recognise that, actually, over the last few years, drug and alcohol patterns of use have changed. We've seen a greater move towards older alcohol use in the home environment, whereas the focus perhaps has always initially been on younger people and binge drinking and the much more visible signs of alcohol misuse. Actually, from a health perspective, it's older people, middle-aged people, much like myself, who are consuming much higher levels of alcohol in the home environment and not seeing that as a health problem. But also, another example is the increase in steroid use—steroid and image-enhancing drugs—to change the physical appearance of the self and the acceptability of the use of substances for different reasons rather than purely for pleasure. So, lots to be done. Sorry; a very long answer.

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

[9] **Lindsay Whittle:** Oh, I thought you were joking when you said I was coming in second, Chair.

[10] I am a child, a teenager, of the 1960s, and, when I was growing up, we used to sneak a drink at 17 years of age; that was the age I first started drinking alcohol. But, today, I have friends whose 15-year-old children are going to nightclubs in Cardiff, and that worries me enormously. I wouldn't have let my daughter go to a nightclub at 15 in Cardiff, or anywhere else for that matter. What are you doing to raise awareness amongst schools and the nightclub owners, really, themselves to say, 'Look, this is actually not the correct way to behave', because we are introducing late-night drinking and all-night drinking sessions to children at too young an age, in my opinion. When I went home, I made sure my parents didn't even discover that I'd been having a sneaky drink of cider in the back lanes.

[11] **Kirsty Williams:** So you thought.

[12] **Lindsay Whittle:** So I thought. [*Laughter.*] But, today, the parents are picking them up at the nightclubs. That worries me.

[13] **Ms Smith:** Yes, I think you're quite right. I mean, certainly from a Public Health Wales perspective, there are a number of interventions. We do engage with the schools programme to provide information around both alcohol and drugs, and I know that there is an all-Wales schools programme that is run by the Welsh Government, but I can't answer to that directly, obviously, because we're from public health. I think there are a couple of issues here. There is, for us, the issue around social acceptability of drinking at a younger age, which you've touched on, but also the availability of alcohol to younger people in external environments. I think, if I can hand over to my colleague here—

[14] **Dr Jones:** We know that there are two very, very effective ways of reducing alcohol consumption, and they're around pricing and availability, and we know that the availability of alcohol, whether it's in nightclubs or at home through family, has increased in recent years. It's become more socially acceptable for parents to buy alcohol for their children on the basis that they would rather be buying it for them themselves than teenagers themselves going out and illicitly doing so. So, I think there is an enormous amount of work to be done. We also

know that there are issues around enforcement of laws of under-18s buying, which of course they often get around, especially now with their parents buying the alcohol, and around selling alcohol to intoxicated people. We believe we need much stronger enforcement of those laws, but we also need to support the people who actually have to do the selling to be able to take the right steps, to be able to understand why they shouldn't be selling to that person. But there is an issue around availability and social acceptability that we need to tackle, both from a Public Health Wales perspective but also from an all-Wales perspective, because it is a problem for us all.

[15] **Lindsay Whittle:** Do you have any evidence—. Sorry, Chair, through you—do you have any evidence that there is a certain level of young people who are—actually not students, who seem a lot more responsible today than 30 years ago—. There are more coffee shops in Cardiff than pubs now and—.

[16] **Dr Jones:** There are some fantastic student initiatives that have gone on recently. We've got the one in Cardiff University around helping people to get home safely. It's a student-led initiative, where they literally pick up drunk students and make sure they get home. There is definitely a change. Sam Warburton is the obvious example. He's a figurehead, if you like, for people who don't drink. He's a national sportsman, he's the captain of our national rugby team and he will quite openly admit that he would rather have a bar of chocolate than a pint. I think there is definitely a change in the student population, but, as Josie has said already, we know that there is a big shift from drinking among younger people to drinking among middle-aged and older people.

[17] **Lindsay Whittle:** That's interesting.

[18] **Ms Smith:** The data right across the UK would support that. Drinking levels in younger people and school-age children is reducing over time, and one would hope, with effective social marketing and community leadership—this is very much around grass-roots level awareness raising—that, actually, there may come a time when children are telling their parents, 'Actually, you're drinking too much' rather than the other way around.

[19] **Lindsay Whittle:** It's a bit like *Ab Fab* isn't it? [*Laughter.*]

[20] **Ms Smith:** Indeed.

[21] **David Rees:** One of the questions that Lindsay asked was actually about the licensees in one sense. Are you doing any work with the police to ensure that they get informed to ensure that they put into place the laws of the land, which effectively should not be selling alcohol to under 18-year-olds on your premises?

[22] **Ms Smith:** I'll hand over to Sarah in a second, but just very briefly, certainly, from a licensing perspective, we now have a Public Health Wales objective to support licensing committees in making their decisions around what potential impacts could affect the availability of alcohol in a given area. I think that that is something where Public Health Wales are very keen to support our colleagues who are working at a local level to ensure that they have appropriate and relevant health-based data to support licensing committees to make decisions, but there are much wider issues.

[23] **Dr Jones:** Yes, we've worked very closely with Professor Jonathan Shepherd from Cardiff University, who has done a lot of work around licensing and glasses that shatter so that they don't offer potential to be a weapon, and also he is very proactive, particularly in the Cardiff and Vale area, around licensing committees. We've worked with him and we talk to him extensively about what information we can provide to support them, but I think that, in discussions with local health board colleagues, from their point of view, what they're very

concerned about is that we can give them all the public health information and support that we can, but they don't feel that their competing on a level playing field, because a brewery can bring in a very expensive barrister who will argue the case for them, and the health board and the local authority are acting in very constrained circumstances. They don't have a great deal of funds to either bring in expensive barristers or to dedicate staff time and resources to arguing against the case made by the brewery. So, really, we will provide and we will continue to provide all the support we can, but local authorities, police and licensing committees need a lot more support to try and level the playing field.

[24] **Ms Smith:** And we would welcome your contribution to making that happen, I have to say.

[25] **David Rees:** I'm sure it's part of our deliberations. John?

09:30

[26] **John Griffiths:** Yes. As you say, I think it is very much about social acceptability and the culture that exists and whether that fosters problem drinking and drug-taking or not. It's very difficult to change behaviour once it's become embedded and people have got into particular habits but, nonetheless, I think the effort has to be made, doesn't it, through various campaigns that Public Health Wales and others run to try and persuade people to behave more healthily for themselves and others? But, I think what you've said so far suggests that that balance between trying to persuade people to behave better, as opposed to trying to change the structures and the systems that exist that either make it easier or more difficult to be a problem drinker, and the availability and price, for example, the licensing regime, the promotions that are run by the industry, the amount of outlets in a particular area and so on—. Is what you're saying really that tackling that sort of structure is an easier way—a more productive way—of getting the change that we need to see, rather than perhaps the long haul of persuading people that, in their own interests, they should change their behaviour? Would that be a fair way of—? I mean, it's a balance. You have to do both, I know, but in terms—

[27] **Ms Smith:** I mean, from our perspective it has to be hand in hand. You know, these two approaches need to operate in tandem. For example, awareness raising around—. You know, consistent evidence-based information around sensible drinking is a challenge, but it is clearly starting to effect change. We are seeing reductions in hospital admissions, for example; we are seeing reductions in self-report use by younger people, for example. It is a challenge, you are right. It is a long haul, but that's not to say that it can't be effective over time. Certainly, examples like Change4Life, that kind of approach where they're tackling, in a very accessible way and saying, 'Actually have a think about that extra glass of wine at home at night, the sugar swaps, the additional exercise'. All of these things, I think, form a very strong approach because it's not just tackling one behaviour, it's tackling a lifestyle. I think that's very much what we would support. But, alongside that, if an individual is starting to think, starting to get some dissonance around, 'Actually, maybe I'm not feeling great in the morning. Maybe I'm not—', it's a recognition that, actually, you don't need to be, to all intents and purposes, an alcoholic in order to seek support. This is about early intervention, really early engagement, and lowering that threshold such that the them-and-us approach—the perception of them and us in terms of a problem with alcohol or problem with drugs—and me is not there anymore. So, it's a slowly-slowly but consistent approach, I think.

[28] **Dr Jones:** I think Josie is very, very right. We're all aware that the very process of drinking leads us to forget how much we've drunk. We know that when we look at the sales data for alcohol and we compare that with survey data where we ask people how much they've drunk, there's a big gap between the two. We've run an alcohol brief intervention programme in Public Health Wales, and in that programme we talk about the missing bottle of wine that exists for every drinker in Wales every week of the year. There's a bottle of wine

that goes missing. That's the gap between what we say we drink and what the sales data say we drink. So, there's education to do, because people just don't understand how much they drink. Very few people really understand well what a unit is. We're doing our best to help people understand this better. We've recently, in Public Health Wales, launched an app. This mainly, obviously, targets younger people, but the idea is that the app acts as a diary. So, instead of marking in your diary, 'I've drunk a pint', it's an app on a smartphone that you just tap, and you literally tap one button, 'I've had a pint; I've had another pint, and another pint'. The next day it actually says to you—the app messages you—'Are you feeling a bit rough this morning? I'm not surprised; you had a good few pints last night'. It'll also prompt you to have a glass of water. It's very new. There's not another one of these anywhere in the world. There's certainly not another one that's bilingual, in Welsh as well as English; this is the one and only Welsh drinks diary that exists, and it's really about just helping people to understand how much they're drinking. We know that, with food diaries, they're a good way of helping people to lose weight, because then they understand how much they're eating, and one of our big problems in Wales is we don't understand how much we are drinking.

[29] **John Griffiths:** I see. Could I just ask a follow-up question, Chair? In terms of the multidisciplinary approach and exercise, leisure—sport, for example—obviously people need other things to do than drinking alcohol and taking illegal drugs, and sport and leisure can be a good example of other things to do, and they also have a role to play, I think, in terms of people who've accepted that they have a problem and are trying to give up or moderate, but need again to find other things to do with their time. So, in terms of that wider approach, to what extent are leisure services and sports bodies in Wales part of the picture, and knitted into the multidisciplinary approach to make offers to people and, you know, show that there are other things to do with their time?

[30] **Dr Jones:** I think, rather than necessarily answer your question directly, sorry, I apologise—. With the alcohol brief intervention project that we run, which delivers training to anybody, really, who has contact with people who drink alcohol to excess, or drink harmful amounts of alcohol, even, this training helps people to talk to people who are drinking alcohol, and therefore helps them to cut their consumption. We're very, very broad in our approach to delivering that training, and so we've delivered it particularly in a number of rugby clubs throughout Wales, because, while you're very right in the fact that people often need something else to do, there is also a strong culture, particularly around rugby clubs in Wales, where you play a game and you have a drink. To come back to your earlier point, we know that, in the past, even 15-year-old boys, they played the game and were given beer tokens at the end of it. So, yes, it is important to foster the something else to do, but then also to avoid the situation whereby that something else to do is just another route back to drinking. We know that the rugby clubs that we've been out to have been hugely receptive of the message that we've been giving, again, helped by people like Sam Warburton.

[31] **John Griffiths:** Just on that, is the Welsh Rugby Union involved, then, in terms of trying to make sure that rugby clubs understand these issues and take appropriate action?

[32] **Dr Jones:** The RBS 6 Nations brought with it the 'Know the score' campaign that was launched with Alcohol Concern around encouraging people to really understand their consumption and, if necessary, moderate it, so, yes, they have been working with not just us, but other organisations that are involved in—

[33] **John Griffiths:** It would be interesting to know if the Welsh Rugby Union are sort of cascading down to all the rugby clubs in Wales some of these messages, I think.

[34] **David Rees:** We can write to them to ask that.

[35] **Ms Smith:** Absolutely, there's more to be done. Just touching on the wider point, it's

long been acknowledged in the substance misuse service provider sector that, actually, diversionary activities are hugely important in building re-engagement with the community and society more generally, and in improving self-esteem. Sport is but one part of that. Certainly, gardening and art and computers and cooking and all of the other elements of that are hugely important in upskilling individuals to better reintegrate into society. So, we would welcome further engagement, and I think, certainly from a Public Health Wales perspective, we're starting to see the benefits of engaging with a far wider range of organisations than perhaps we historically have.

[36] **David Rees:** Janet, do you want to ask a question on this particular point? Then we'll move on to Kirsty.

[37] **Janet Finch-Saunders:** Yes, okay. 'Drinkaware' is it called, your app?

[38] **Dr Jones:** No.

[39] **Janet Finch-Saunders:** Well, there's another app, then.

[40] **Dr Jones:** There are a couple of apps. There are a few apps. We know that there are a few apps. Our app is actually called, 'One Drink One Click'.

[41] **Janet Finch-Saunders:** Okay, but that's the first I've known of that. Do you have a marketing budget?

[42] **Dr Jones:** We've worked with our comms team; we launched it 10 days ago.

[43] **Janet Finch-Saunders:** Okay, so it's pretty recent.

[44] **Dr Jones:** It is very, very recent.

[45] **Janet Finch-Saunders:** I'll be tweeting that now, because I do get people in and I actually stumbled across the other day, about three weeks ago, Drinkaware, and that's quite good, because it not only tells you about the units, it tells you about the calories that you're consuming as well. That's a two-edged sword then, isn't it? People might not realise; 'Goodness me, if I have that extra glass of wine it's an extra goodness-knows-how-many calories'.

[46] **Dr Jones:** Well, the app that we developed, we actually developed the advice that comes back with focus groups, and in the focus groups we use men and women, and we use young people and older people, and we ask them what sort of messages they would like to come back. So, when you actually open the app, you can tell it what sort of messages you would like, so it will tell you if the bottle of wine that you drank last night is equivalent to sitting down and eating a whole Victoria sponge, which you would never do.

[47] **Kirsty Williams:** Oh, I don't know; I'd give it a go. [*Laughter.*]

[48] **Ms Smith:** I think it is about making sure that the right messages to the right—

[49] **Janet Finch-Saunders:** The point being, I mean, that technology is the way forward, and I know that that's quite an intrusive—. It doesn't intrude too much on people. If I was to say to—. Because I get people presenting to me, and there are no detoxification beds locally, and I get people who've got a bit of a problem and they just need that little bit of help, but they can't access it there and then. I think that, really, perhaps you ought to be almost advertising this app, because, as I say, I wouldn't have known about yours but for sitting on this committee. So, how do the wider public get to know about it? How do they?

[50] **Dr Jones:** Initially, we intend for people to be directed to it through the alcohol brief intervention training programme, but it is, of course, in the App Store, so, because it exists, it is—

[51] **Janet Finch-Saunders:** So, it's on the Apple App Store.

[52] **Dr Jones:** It's on the Apple App Store, so it can actually be downloaded by anyone anywhere in the world. So, it's a Welsh product that, theoretically, could be being used in New Zealand, in Australia, in Outer Mongolia.

[53] **Janet Finch-Saunders:** My point being that I would love to see you promoting it, because I think that's an easy way that doesn't need any external help. It's somebody taking responsibility themselves, which is something that we've all got to do; it's not always down to the state or yourselves. But if you can actually put out that you've got it—

[54] **Dr Jones:** I think we will happily take that on board.

[55] **David Rees:** I think you've also done a good job putting it out in this morning's session, because it's obviously important people are aware. Kirsty.

[56] **Kirsty Williams:** Is it okay if I move on?

[57] **David Rees:** Yes, move on, please.

[58] **Kirsty Williams:** If I could move on from alcohol, you say in your paper that alcohol and substance misuse in Wales is changing and, therefore, we need to change services, messages and research accordingly. I'm interested in over-the-counter medicines and prescription medicines and I'm just wondering what work you're doing in those fields at the moment and whether you feel that those issues are properly recognised and whether we're developing services to be able to intervene or spot the signs if people are becoming addicted to perhaps their prescriptions, their painkillers or their benzodiazepines. I'm just wondering what work you're doing in that field.

[59] **Ms Smith:** Currently, I sit on the advisory panel for substance misuse and we are just in the process of completing a piece of work looking at this very issue: in the first instance, prescription-only medicines and opiate-based analgesics—so tramadol, which you may have heard of—and moving to the wider range of opiate analgesics. We know that older people particularly are at an increased risk of misuse of prescription. We also know that there are other issues in that it is now possible, and the market is growing, to illicitly purchase prescription-only medicines over the internet. We have long had a substantial issue in, if you like—. Not fake Valium, benzodiazepine, but MSJs have been an issue for both recreational and problematic drug users who are younger, perhaps, for a number of years now, and both the police, the criminal justice and the health service have raised this as an issue. We have been working closely with services to ensure that, actually, the burden for trying to support people to move away from benzodiazepine addiction, for example, which is very challenging, is not falling primarily on primary care, but can be dealt with as part of a wider substance misuse issue, but also on its own as a withdrawal.

[60] We find that certainly addiction to or dependency on prescription-only medicines and misuse of prescription-only medicines, and some over-the-counter, is often allied to perhaps issues around problematic alcohol use and polydrug use. So, this is a much more complex issue, both for younger people, but also for older people. We are working with Welsh Government to support the development of services for older people.

09:45

[61] We're very clear, and certainly some of the guidance that we've produced over the last couple of years indicates, that, actually, services for older people need to be adapted, because it's not one-size-fits-all. So, we're proactively working with organisations right across Wales. Hence the need, I think, for those clear care pathways and adaptation of specialist substance misuse services to deal with the growing issue of prescription-only medicines. It's not an issue of prescribing practice, per se; this is a change in the drugs market, again, with the expansion of the internet and the availability of these types of drugs very excessively.

[62] **Kirsty Williams:** Can I ask, then, if you've recognised that there's a growing problem in the prescription-only, do you have any data to suggest that over-the-counter medicine misuse—so, people buying painkillers, laxatives, you know, a range of things they could get in their supermarket or they could get in a pharmacy—. Is there any evidence that that is becoming more problematic?

[63] **Ms Smith:** As I mentioned, with the advisory panel, the first part of the work that we've done is around tramadol and, very specifically, opioid-based analgesics. The second part was to explore the availability of over-the-counter data, such that we could then try to match that. There's certainly very little evidence available to us—that's not to say it doesn't exist—to evidence the harms associated with specifically over-the-counter medications, but it is on the agenda to explore. Certainly, because a lot of the pharmacies are privately owned—so, Boots and Lloyds, your large organisations, hold those data, but there are issues around, potentially, the validity of those data, but also the costs of accessing those data. I think that's something that the advisory panel is working towards exploring, certainly in the next year.

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

[65] **David Rees:** Can I ask a question on the particular issue of the prescription aspect and what discussions you're having with primary care to ensure—. Because, obviously, we have overprescription of antibiotics, to an extent. What discussions are you having with primary care to ensure that these drugs are not being overprescribed, in the first instance, and that proper, prudent—well, I'll use the words 'prudent healthcare', that's the terminology, but a prudent healthcare approach to this is actually being incorporated at primary care level?

[66] **Ms Smith:** Absolutely. Well, certainly, as part of the advisory panel's work, we are working with the All Wales Therapeutics & Toxicology Centre, and they are working very closely with us on providing primary care with prescribing guidance. I think there's been a reduction—. Yes, I can absolutely confirm there's been a reduction in the prescribing of tramadol, for example, as a consequence of the guidance that was issued a couple of years ago. Likewise, a couple of years before that, there were serious issues, and you mentioned it, with benzodiazepine prescribing, and the variation across Wales, even, was fairly considerable. That has been addressed by trying to work with specific GPs, but, more generally, primary care, to reduce to levels that are clearly indicated in the guidance. I think tramadol is one of many that will be coming up. Certainly, you mentioned antibiotics, which, for Public Health Wales, is clearly an issue. But, certainly, for the drugs that are open to misuse and the development of dependency, we are working very closely with the All Wales Therapeutics & Toxicology Centre to influence prescribing practice.

[67] **David Rees:** Thank you. Elin.

[68] **Elin Jones:** I watched an excellent BBC programme last night on prostitution in Wales and the fact that people who were also substance misusers were using prostitution—women were using prostitution—to fund their substance misuse, but it seemed as if part of the

root cause of their inability to seek rehabilitation and rehabilitate themselves was their inability to access safe homes for themselves. You refer in your paper to the issues around homelessness and the links with substance misuse. Can you tell us, really, of some of the interventions that you would think, as Public Health Wales, would be useful to link appropriate homes—safe, independent homes—for substance misusers and how that could work better than it's working currently, as in tackling homelessness in order to enable people to start on a route to tackle their own substance misuse?

[69] **Ms Smith:** I think there are a number of interventions that have been put in place and that are being developed. One example is that Public Health Wales produced guidance as part of the health and wellbeing compendium to recognise that, actually, sex workers, commercial sex workers in this instance, are a particularly vulnerable group—vulnerable with regard to their own health and wellbeing, but also vulnerable from other people's influence. I think that also came across last night. We have just initiated the provision of long-acting, reversible contraception, specifically within substance misuse services, so individuals can perhaps better access and take control over that element of their health and wellbeing. That is a new initiative in Wales to really target unwanted pregnancy as a consequence. I know that, certainly, having worked in the homelessness environment, sex workers are at risk of unwanted pregnancies as well as sexually transmitted infections et cetera. The link between commercial sex work and substance misuse is a long-standing one, and it's kind of a chicken-and-egg situation often, with the influence of, perhaps, other individuals forcing females to go into commercial sex work to raise funds, and that is an ongoing issue.

[70] In terms of the homelessness and the safe housing issue, I think that the resources available for supported and appropriate safe housing need to be explored better. I think we would welcome any support and focus on a reduction in homelessness, particularly for younger females. They are highly vulnerable to escalation of problematic drug use and a range of other harms, including violence. So, we would welcome support. I know that, certainly, our chief executive is currently engaged with Cymorth Cymru, which is an oversight organisation for homelessness agencies across Wales. I think there is a move there for there to be a four-nations or five-nations approach to how we might address the issues of homelessness and substance misuse, but we would welcome any support in addressing the availability, the accessibility and the safety within homeless environments and hostels and supported housing.

[71] **David Rees:** Okay, Elin?

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

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

[74] **Darren Millar:** Can I just ask you about the consistency of access to support services across Wales? It strikes me that, even in my own constituency, it depends very much where you are in terms of the services that might be available to you, whether that's peer mentoring-type services, whether that's a service you can access through the health side of things or through a local authority-supported scheme or even a criminal justice-supported scheme. I'd just like to know what your view is on how we can achieve a better level of consistency and also avoid some of the duplication that is out there in order that taxpayers can get better value for money from the investment that's made in these services.

[75] **Ms Smith:** Absolutely. I think, certainly, in the last few years, a lot of progress has been made with regard to consolidating the accessibility issues around substance misuse—both drug and alcohol—with the development of the single point of entry approach that has been adopted right across Wales, and that means that there is one point at which you can access. So, regardless of where you are referred from or if you are self-referred, be it primary

care, myself or a colleague referring me, there would be a single point of entry, a single point of assessment, and the move towards relevant services as a consequence of that would be more streamlined. I think there's more work that can be done with that, but I know it's certainly improved access to relevant services and it's reduced waiting times to access the relevant services. But, you're right: I think there are challenges across Wales in terms of rurality and ensuring that, actually, both drugs and alcohol are recognised as challenges, but also that poly drug use, from a public health point of view, is recognised, so that you're not just able to deal with one issue or the other issue, but that you can deal with all of the issues at the same time. So, we would welcome further development of services at various levels, and we've touched on it in the written evidence, that early engagement point, so that we can add reduce the need for more specialist detox services or services aimed at dependency, and encourage early accessibility to lower threshold services across Wales.

[76] **Darren Millar:** So, you see the gap being at the lower end, if you like, of the spectrum. So, for those people who have serious substance misuse problems, there are schemes available, in a sense.

[77] **Ms Smith:** There are. I mean, as I said—

[78] **Darren Millar:** But for the lower level interventions, I know that you mentioned earlier on your intervention programme—

[79] **Dr Jones:** We deliver the alcohol brief intervention at a lower level, and—

[80] **Darren Millar:** How extensive is that? What proportion of the front-line workforce might come into—

[81] **Dr Jones:** Alcohol brief intervention training, as I say, is delivered to anyone who is in touch with someone who may be drinking too much, whether they are in touch with someone in the NHS or not. So, we've delivered it to police custody sergeants; we've delivered training to midwives; we've delivered training to military personnel; we've delivered training to practice nurses, in order to try and reduce the contact with the NHS that's needed before they actually receive some help to reduce that harm.

[82] **Darren Millar:** You mentioned that about 7,500 people have received this training.

[83] **Dr Jones:** Seven and a half thousand people have now been trained all over Wales. This is a training programme that, when we started it, there were a few voluntary organisations, maybe in north Wales or in west Wales, that offered their own programme. Since we've started the programme within Public Health Wales, in discussion with those voluntary organisations and to avoid the duplication that you mentioned, the programme that we run has become the recognised alcohol brief intervention training programme for Wales. So, anyone in contact with those voluntary services who required that sort of training would actually be referred to our programme rather than a programme that was specific to a local area. But no, you're right: there are specialist services, there are our further-down-the-chain services, if you like, which aim to reduce harmful drinking before it becomes a problem, but I think there is a gap.

[84] **Darren Millar:** So, in terms of the ABI programme, if we call it that—the brief intervention programme—7,500 people have been trained. Is that enough? What proportion of the front-line workforce is that?

[85] **Ms Smith:** I think it's ongoing, isn't it?

[86] **Dr Jones:** It's not enough. We actually call it Have a Word because that's what we're

encouraging people to do, which is to have a word with the people that they're in contact with, and their friends and family, as well as the people that they're in touch with professionally. Have a word about their alcohol consumption. 7,500 is not enough, but then 3.2 million is not feasible. *[Laughter.]*

[87] **Darren Millar:** So, what's the aim? What proportion of the workforce are you aiming for here?

[88] **Dr Jones:** The aim is, because we're not targeting a specific workforce we can't ever say, 'We're going to train 10 per cent of NHS staff'. We know that there are specific NHS staff, for example, who are better able to deliver this than others. Midwives are in a fantastic position, but we know that, in the community, youth workers are superb at delivering alcohol brief intervention because they're in touch with young people; they're talking to them all the time; they've got that engagement. The issue is: we will never train enough people in Wales to reduce the harm related to alcohol just through ABI, through Have a Word alone. It needs to be a population-wide approach.

[89] **Darren Millar:** But what are your targets, and what resources do you have available to expand the programme?

[90] **Ms Smith:** Just to be clear, the training programme also trains trainers, so we are not just training individuals.

[91] **Darren Millar:** They can cascade it down.

[92] **Ms Smith:** It's cascaded right through a range of organisations, and that is ongoing.

[93] **Dr Jones:** Including now the Ministry of Defence.

[94] **Darren Millar:** Is it part of an induction programme for front-line staff in youth work and the NHS?

[95] **Dr Jones:** It can be. There are some student programmes, including pharmacists, which relate to some of the issues around prescribing and the mixing of alcohol with prescription drugs. We are training student pharmacists to deliver alcohol brief intervention. The programme's only been running for three years. We've trained 7,500 people in three years. We've got too few staff. They're very passionate and they do a grand job. I think, three years ago, we never imagined that we'd have trained 7,500 people at this stage.

10:00

[96] **Darren Millar:** So, that's people you've trained.

[97] **Dr Jones:** Yes.

[98] **Darren Millar:** Are you able to monitor how many they've trained as a result?

[99] **Dr Jones:** Unfortunately, we've got some data on how many they've trained—some people have gone on to deliver 50 brief interventions when we've asked them; some of them haven't. But, we've gone back and examined the reasons why they haven't, why their professional role wasn't suited, perhaps, to doing it, but also then to change our training session to emphasis the fact that we all know people who drink. You don't necessarily need to deliver this in a professional capacity, you can also deliver it to your family and friends, but the professional capacity often brings that weight. The custody sergeant, when he's signing somebody out of the cells after they've been sleeping off a drunk and disorderly, is in the

perfect position to have a chat with that young man or that young woman about their drinking behaviour. It's called a teachable moment and it's finding that teachable moment whereby we can all be receptive to changing our behaviour. But, on its own, it can never be enough. We need things like the changes in the availability and—

[100] **Darren Millar:** So, just one final—

[101] **David Rees:** We need to move on.

[102] **Darren Millar:** Yes. It's just on this one final question. So, you alluded to the fact that you'd like to have extra capacity to be able to deliver more; yes? So, is there greater demand than you're able to meet at present?

[103] **Dr Jones:** We manage our demand. We've got a dedicated team that manages its demand. We are booked up for training three months in advance.

[104] **Darren Millar:** Okay.

[105] **Ms Smith:** And, Chair, just to touch on that, that's part of changing the social acceptability, because, as my colleague noted, this isn't just talking to people who you work with; this is talking to everyone—your friends, your family, everyone—so, it's part of that social change.

[106] **David Rees:** Thank you for that and thank you for your evidence this morning, it's been very helpful and it'll help us consider our deliberations as we come to our report. Thank you very much. You will receive a copy of the transcript; for any factual inaccuracies you may identify, please let us know as soon as possible.

[107] **Ms Smith:** Thank you very much for the opportunity to present.

[108] **Dr Jones:** Thank you.

10:02

Ymchwiliad i Gamddefnyddio Alcohol a Sylweddau: Sesiwn Dystiolaeth 5 Inquiry into Alcohol and Substance Misuse: Evidence Session 5

[109] **David Rees:** We will now move on to item 3 and await the witnesses for the next session. Our next set of witnesses represent the health boards and the Welsh Ambulance Services NHS Trust.

[110] Good morning. May I welcome you this morning to an evidence session for the alcohol and substance misuse inquiry of the committee? Just to let you know, the microphones will come on automatically and if you need simultaneous translation from Welsh to English, the headphones are there and they should be set on channel 1, but if you need amplification, they should be set to channel 2.

[111] Can I welcome Richard Lee, head of clinical services at the Welsh Ambulance Services NHS Trust? We have Stuart Moncur and Libby Ryan-Davies, both from Hywel Dda Local Health Board. Stuart is the assistant director of assurance, safety and improvement and Libby is the director of mental health and learning disabilities. Can I also welcome Sue Stone, service manager for substance misuse services in Abertawe Bro Morgannwg University Local Health Board? Thank you for the written evidence we've received from the boards. We will move straight into questions if it's okay with you. Gwyn, do you wish to start?

[112] **Gwyn R. Price:** Thank you, Chair. Good morning, everybody. Could I just start off with Richard? Could you outline the impact that alcohol and substance misuse has on the ambulance service across Wales?

[113] **Mr Lee:** I think we supplied some written evidence to the committee. The effect that alcohol has is probably split into two, really. There's the chronic effect that we see lots of patients who have chronic conditions that are exacerbated by long-term alcohol consumption, and then there's the short-term impact of accidents and people being drunk and needing our services, as a result of that, in public places or at home, following one-off binge drinking.

[114] **Gwyn R. Price:** So, there are pressures, really, and when there are internationals, you pointed out again, is when you've got to take action to alleviate some of the problems caused by alcohol.

[115] **Mr Lee:** Absolutely. I think we supplied some information about the operation we put in place in Cardiff. The operation we put in Cardiff every weekend covers 16 hours, overnight, of a Friday into a Saturday, and a Saturday into a Sunday. In those 16 hours, in the year's data we've provided you, we attended 700 patients in a 1 square mile area. Now, of those 700 patients, over 600 were taken to the alcohol treatment centre, which we run in conjunction with the health board. So, 600 patients in a 1 square mile area required treatment for alcohol consumption in a 12-month period in one area of Wales. So, you can see the effect on us is huge.

[116] In Cardiff, we can run bespoke operations to deal with that, because of the volume, but, actually, in lots of the rural towns across Wales, we see a similar pattern, just with smaller numbers, because as the population get smaller, the numbers get smaller. We're not able to run a bespoke operation in every town centre in Wales, because of, you know, the logistical requirements of that. So, it does sometimes mean that ambulances are tied up dealing with somebody who's got an alcohol-consumption-related problem—somebody who's fallen in the street, or somebody who's drunk and can't get themselves home—when the ambulance could be dealing with somebody who's had a stroke or a heart attack.

[117] **David Rees:** On that particular point, your paper highlights the example of the number of occasions you went in one month, or six weeks, to one individual. How typical is that? Clearly, it could be an extreme situation, but how typical is that type of number?

[118] **Mr Lee:** We've put quite a lot of work into managing frequent callers in the last 12-18 months. Alcohol and other substance misuse play a part in a huge number of our frequent callers. Most of our frequent callers have either mental health or substance abuse issues. The patient who we highlighted in the evidence called us 41 times in six weeks, sometimes for alcohol-related symptoms, sometimes for falls in the house, falls outside the house, or for other minor injuries sustained whilst drunk. One of the things we need to do to provide a better service for these patients is for us to be able to refer patients into secondary care for alcohol treatment. There is no emergency treatment for somebody who is drunk, so we have a bit of a battle on our hands to manage those patients at scene. Quite often they require conveyance, for their own safety, to somewhere where they can be observed till they're sober. That is a demand on our resources.

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

[120] **Lindsay Whittle:** Thank you. I'd like to question Richard as well on this very issue. I know that black Friday is an extremely busy day for the ambulance service and I would much rather see you respond to people who are very ill and need your services. I'm a rugby fan. I will be in Cardiff on Saturday. I've noticed a difference from the 1970s era, when, you know,

people did have a few drinks, but it was never as bad, I think, as it is now. I think the Welsh Rugby Union have some responsibility here, but it's not all about rugby internationals, let's be fair. Do you work closely with, say, the Cardiff licensing trade group, the police, Arriva Trains Wales and the British Transport Police, because I notice—and, again, I will notice it on Saturday—that people are drinking on the stations, on the trains and they're drunk, sometimes, as early as 11 or 12 o'clock in the morning? That's not a rugby fan, for me. You go to the game to see the game. These people probably don't even see the game half the time. Other groups have responsibilities to assist you, I think, because you are at the front line here.

[121] **Mr Lee:** Absolutely. You're absolutely right; it's not just rugby internationals. They are the most notable events, but there are other events as well. What we see is the weekend workload—. So, for a non-large-event workload, we will start attending to patients in the late evening and the early hours of the following morning. On a large-event day, you're absolutely right: at tea time, we are starting to attend to patients who are presenting with conditions that we would, on a non-event weekend, see later in the evening. The whole day works backwards.

[122] Interestingly, your perception about black Friday—absolutely. Traditionally, the last working day before Christmas is horrendous; it's like a new year's eve for us. But, for the last couple of years, it hasn't been. For the last couple of years, the demand has been spread out over the entire weekend before Christmas, which causes a bigger problem for us, our fellow emergency services, local authorities, the street pastors and everybody that has to be involved in these operations.

[123] We are working with Arriva Trains Wales at the moment on specific plans for people who are unwell on trains and how we can get a better service to those people, because, of course, something like a train is a really good example of what I was talking about earlier. In Cardiff, we can lay on a bespoke operation to deal with volume, but actually, if someone collapses drunk on a train between Merthyr and Caerphilly, they might be in a very remote area where we're going to take longer to get an ambulance. So, actually having a plan to deal with that, and the biggest part is about prevention—. We work closely with the police; the police are absolutely engaged in our night-time economy operations across Wales and, certainly, in Cardiff, one of the notable practices has been that the police are present in the alcohol treatment centre to make sure that patients are well-behaved while they're there.

[124] **Lindsay Whittle:** It would be interesting, Chair, to know whether the number of arrests goes up every Saturday as well. Perhaps that's a question that we can ask outside.

[125] **David Rees:** We'll ask someone else. John.

[126] **John Griffiths:** In terms of joint working, as you say, the police are present in the alcohol treatment unit in Cardiff. There's an initiative in Swansea, I think, as well, isn't there, which is along similar lines? But it's not consistent across Wales. In Newport, for example, I think they did trial a similar approach, but didn't actually run it in the city centre, which was, sort of, counterintuitive in terms of where the problems were. I think it had limited effect as a result. But, you know, there are other urban centres in Wales. They may not be as big as the cities, but, nonetheless, they have considerable problems of this nature.

[127] **Mr Lee:** In Wrexham and Rhyl, we've run similar operations.

[128] **John Griffiths:** So, to what extent is there, you know, some sort of strong system to share good practice and to roll out the successes that you've had right across Wales?

[129] **Mr Lee:** Well, it's not just right across Wales; it's right across the UK. So, the UK ambulance services have done a lot of benchmarking, which we've been involved in, about

various alcohol support programmes. I think one of the things that I would just say about the police point is that, of course, patients have to be fit to be detained, so your comment about arrests—it's not just that easy. It's probably something that I've seen change over my career. Your perceptions about the changing things that you see—. You know, years ago, the police would arrest people who were drunk and put them in a cell, and we know now that, actually, that probably wasn't a safe thing to do. Somebody who's very drunk and can't look after themselves really shouldn't be left in a room on their own. So, we work with the police—part of our role now is to work with the police—and, as I said to your colleague, we do, sometimes, have to take patients into medical care because they're not well enough to be detained. So, I think that's one of the big changes that I've seen in practice in managing drunk patients over my 20 years of service.

[130] To go back to your point about the geographical spread, we've run operations in some of the larger centres: Wrexham and Rhyl. We've run a project in Gwent. The project you mentioned in Gwent wasn't run in the city centre, because the idea was that the Aneurin Bevan health board area has the big centre of Newport in terms of population, but then lots of populations that are spread in the Valleys. The idea was to try and find a central location that would serve the population in the Valleys as well as picking up the workload from Newport. So, that was the idea of that system. We ran it in Newbridge. We ran it in partnership with the health board in Newbridge, where there's a facility that we used, and, certainly, new year's eve—I was working new year's eve—that facility saw a number of patients who would otherwise have travelled to an emergency department.

[131] **David Rees:** Can I ask the health boards as to how you've been involved in such schemes to ensure that, you know, the right service is provided in the right place? Perhaps Sue from ABMU first, and then we'll go to Hywel Dda.

[132] **Ms Stone:** There is currently a similar scheme, which was recently started, in Swansea. In terms of the planning of services of that nature, the area planning board has got all the responsible partners around the table, so that's where those discussions take place and where local demand is considered, I guess, because Swansea, Wind Street and that kind of area is a particular issue in the ABM area.

10:15

[133] **Mr Moncur:** Just to add to that, Chair, one of the things that we do—. Richard quite rightly called out these kind of large-event issues, so, for us, in a much more rural area, one of the challenges we have is that, if somebody is going to run a big festival or something, there's the potential for exactly the same sort of effect. So, we will make sure that we work with whoever's organising that to actually target those things. Sometimes that's with WAST, and I can think of a number of examples where we've worked very closely with WAST on festivals down in Pembrey, and places like that, where we've had on-site triage, and we've had GPs working as first-line responders alongside WAST to try and make sure that we manage and we treat people as effectively as possible. Richard's point is absolutely right, though: the risks around some of these individuals who become, frankly, incapable of even sometimes being able to talk to somebody puts a huge burden on the service, and often it is about a kind of place-of-safety issue rather than actually trying to understand medically or clinically what's wrong with them. It adds a factor of 10 onto the ability of front-line clinical staff to be able to deal with them.

[134] **David Rees:** Thank you. John. Have you finished?

[135] **John Griffiths:** Yes.

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

[137] **Janet Finch-Saunders:** Yes, two points. Is the Welsh Government and the Minister for Health and Social Services doing enough as regards these problems? Could you expand further on your comment that there needs to be a national lead within Wales? I'm assuming you mean 'national' as in 'from here'. Could you expand on what you mean?

[138] **David Rees:** Who are you asking?

[139] **Janet Finch-Saunders:** Well, that's come from Hywel Dda.

[140] **Mr Moncur:** Right. In terms of—

[141] **Janet Finch-Saunders:** What do you mean by 'national lead'?

[142] **Mr Moncur:** In terms of the evidence we gave, it was in relation to a specific point about having that focus around education. So, I think the issue was around education for people and a consistent message. To answer your question about whether the health Minister is actually doing enough, I think over a period of years the Welsh Government has been very successfully engaging with services. If I reflect back—and I'm probably showing my age slightly—over the past 10, 15 years there's been a significant, I would say radical, change in the way the Welsh Government approach substance misuse, as well as health boards and their predecessor organisations. We had a very, to be fair, fragmented service based on a number of statutory and voluntary sector organisations. We've gone through a process, which is entirely consistent with current Welsh Government policy, of changing the way we provide services from our own local health board. Perhaps I should declare an interest in that I actually chair the Hywel Dda area planning board—which is why I'm here as well as Libby—and we've actually just retendered all our younger people's service last year, and we've just gone through the same process with adult services, to try and make sure that we have a well-coordinated, well-balanced service provided across a wide geographic area.

[143] **Janet Finch-Saunders:** I'll come back and challenge you on that now, from the perspective of how that links in with mental health issues, because certainly, as an Assembly Member, I have people who present and can't access treatment. Indeed, this committee met recently with a stakeholder group of service users, and it fundamentally, as far as they were concerned—and some of them were people who'd had problems for many years—was about access to treatment for mental health issues, and they were actually then using alcohol and drugs as a prop. So, access to services in the first place, and then, in north Wales—and Darren can confirm this—I remember when there were 18 detoxification beds in Wrexham. They're now down to five. So if, on the ground, the service doesn't seem to be—. That's why, I think—

[144] **Mr Moncur:** I understand the point you're making. Perhaps if I answer part of that and then Libby comes in, because mental health is her area of expertise. I think in terms of beds, if I could urge just a bit of caution: I think we have moved significantly—in fact we were discussing this earlier—and if you look at the number of people who went through in-patient detoxification in beds 10 years ago, it's radically changed. The success measure for us has got to be that we need to catch these people much earlier. If you get to the point where you're having to put people in a bed to detoxify them, you know, you've missed the tier 3 opportunities, the tier 2 opportunities and the tier 1 opportunities. So, we actually spend significantly less putting people through that process now, because we don't have them. It's not that there's a waiting list there. We don't need to do it. So, I would say that's a success from our point of view.

[145] In terms of access—and I know this isn't unique—we've got three single points of contact, one in each county, that we provide services for. Those clients are assessed on a

weekly basis to make sure they have access to the right services. As I said before, that's very different from what used to happen before, 10, 15 years ago. If you were somebody with a substance misuse problem, the likelihood is that you'd either pick up a leaflet or you'd look in a phone book or something, or somebody might recommend a particular service to you. Whether that service was best placed to meet your particular needs, frankly, would've been a little bit like Russian roulette—probably not quite that serious, but it was very, very different. Now we've got professionals lining up saying, 'Yes, we need to look at this person from a harm reduction point of view, rather than an abstinence point of view'. So, we can try and tailor those services to fit individuals. So, I genuinely think we've come an awfully long way in terms of addressing that.

[146] I think one of your previous speakers made the point about the waiting times. One of the things that that's done is it's significantly brought waiting times down for services. So, if you walked in, from our point of view in Carmarthen, Pembrokeshire or Ceredigion, and you needed access to a service now, it would be much, much faster than it was. And we'd be pretty sure that you've receive a kind of service that was appropriate for your needs at that point in time. Libby, do you want to—

[147] **Ms Ryan-Davies:** Yes, I think I'd echo what my colleague says about the integrated service model that's developed in terms of Hywel Dda. A lot of work has gone into being very partnership focused about the way that those services are delivered. So, it's very much a tiered approach with a focus on intervening as early as possible.

[148] To pick up your query around mental health issues, I think it is the key issue. Co-occurring mental health and substance misuse, we know that's definitely on the increase. We see a lot of service users come into mental health services who, as you say, are self-medicating. Sometimes, it's a bit like the chicken and the egg—which comes first? Does the substance issue come first or does the mental health issue come first? Locally, we're doing a lot of work around that, but I think there's an awful lot more work to do. Some focus on that nationally, I think, would be very much welcomed around co-occurring.

[149] There are other issues we're seeing, especially within our older-age population, around alcohol use, particularly. Again, we're seeing that within some of our mental health services around some memory and cognitive impairment, and functional mental illness within old age as well, which, again, we're locally doing some work around. But, certainly, I think it is an area that needs some focus around: co-occurring.

[150] **Janet Finch-Saunders:** Okay, and can I just finally ask about Korsakoff's syndrome? I know a centre opened in north Wales a good few years ago. I don't know of any people who've gone there, but I noticed that you've made comments. Is that because the numbers are now on the increase, are they?

[151] **Ms Stone:** We're seeing an increasing number of people coming in with alcohol-related brain damage, and there is a lack of facility to deal with those clients. What we know is that people who have Korsakoff's, about 25% of them can make a full recovery, and about 25% of them can make a fairly good recovery if they have intensive residential rehabilitation. There isn't that facility in Wales, but Brynawel House Treatment Centre in Llanharan are conducting a feasibility study to look at opening a five-bedded unit. I think they've got a steering group who are looking at that work, and I think it's very much on the agenda. There was a conference in the Pierhead building last week where a lot of professionals from Wales came together to discuss just that issue. So, it's very topical.

[152] **Janet Finch-Saunders:** I just wondered what's happened. I'll have to do some inquiries now as to what's happened to the one in Old Colwyn, because it was definitely for Korsakoff sufferers.

[153] **David Rees:** Okay, I want to move on, but before we move on, you've mentioned examples you had of perhaps, shall we say, good practice in Hywel Dda, for example. What discussions have you had with other health boards to ensure that that good practice is actually shared around, because one of the issues we often hear is inconsistency across Wales? So, how are you actually ensuring good practice is shared, so you're all addressing the issues by tackling it in a recognised, evidence-based way?

[154] **Mr Moncur:** I think probably we can answer that collectively. I suppose there are two ways. Firstly, I think the establishment of area planning boards has made a difference, because what that's done is it's provided both a local focus and a national focus, because the APBs all actually meet together. I know that, although substance misuse is a very big problem, in some ways, from a professional point of view, it's quite a small community. The number of experts—and I'm not really sure I'd count myself in that field, but people like Sue, who live this day-in, day-out—are not huge. I know that we do swap ideas and we do feed off each other. Certainly, some of the innovations that we've taken forward have been based on things, not just in Wales, but elsewhere, and I know other people, vice versa, look at things that we've done.

[155] **Ms Stone:** Can I just say that the Welsh Government's substance misuse division have got a SharePoint that all agencies can access, where examples of good practice are highlighted? Substance misuse have also contributed a chapter on prudent healthcare and the way that that's being delivered in substance misuse agencies locally, and that was put on the website recently. So, from an IT perspective, you can access those examples.

[156] **David Rees:** We'll move on now. Elin?

[157] **Elin Jones:** Yes. Two issues. One is primarily for Hywel Dda and that's about the challenges of providing services in a rural context where the numbers are fewer, but the needs of the individual for support services are just as great. So, what are the particular challenges for substance misuse services in a rural context?

[158] And then, more widely for all of you, we've had consistent evidence throughout, and I think it's been touched on here already, that the older population is now presenting to the service especially with alcohol-related issues. How is that changing the services that you're having to plan for now, and how do you see that changing your services into the future?

[159] **David Rees:** Can we focus on the Hywel Dda question first and then we'll go to all panel members?

[160] **Mr Moncur:** Okay. So, perhaps if I start on that particular point, it's a really timely question, in a sense. One of the things that we've done, and I mentioned the retendering of our adult and young people services, so part of particularly the adult services that we've built into the specification is a kind of process of engagement. So, if you take perhaps Ceredigion as a good example, the services that are based in Aberystwyth and Cardigan have to outreach through to GP surgeries. So, if a particular problem emerges in a particular practice area, they will use that GP practice as a basis to try and engage with people locally. You're absolutely spot on. The difficulty of somebody who, inevitably, will have a very chaotic lifestyle and expecting them to travel what might be 30 miles with not always the best public transport infrastructure means that, potentially, they're at a disadvantage unless we can find some way of getting the services out to them.

[161] The other thing that we've done this year—and it's not up and running yet, but it will be shortly—with support from Welsh Government, is purchased a mobile outreach vehicle, which is basically a large bus, which will allow us to take services out to harder-to-reach

people, both in terms of education, but also potentially treatment provision as well. So, we're very conscious of the challenge of actually running our services across a rural area. The fact that we've actually been able to retender the services has actually allowed us to be much clearer about the fact that we want the same level of services available to our whole population because, historically, those services had grown up around smaller health organisations or third sector organisations. So, even in a county such as Ceredigion, you might have one service available in the north of the county, but not a similar service available in the south. So, the process we've gone through has allowed us to provide, (a) much more cost-effective, but (b) much more equitable services across the piece.

[162] **David Rees:** Okay. Perhaps we'll start from left to right of my view. Richard, do you want to comment upon the older persons aspect?

[163] **Mr Lee:** So, I think, not just in this sphere of our workload, but right across the workload, one of the triumphs of twenty-first century healthcare is that we're all living longer and we're fitter for longer. So, inevitably, we are encountering older patients who are suffering with diseases and engaging in activities that, years ago, older people didn't do, and that is relevant to this inquiry in terms of alcohol. We now come across older patients who have consumed too much alcohol and have tried to do something that an older person maybe a few years ago wouldn't have tried to do. So, not just in this sphere, but right across our case mix, we are having to look at our skills at assessing older patients, because there are specific disease processes that, as you get older, no matter how fit you are, you have, and they do make the pre-hospital management of older patients more challenging.

10:30

[164] **David Rees:** Can I ask one quick question? We've been hearing evidence obviously that the older person tends to drink more at home because of isolation issues. Therefore, are you seeing that in your call-outs, as a consequence, that you are actually attending more older people at home rather than perhaps in a public place?

[165] **Mr Lee:** So, to put this in context, the evidence that we've provided about the patient who called us 41 times in six weeks was about an older patient.

[166] **Ms Stone:** I think, Elin, when you said that older people are increasingly presenting to services, one of the issues that we have is that they're not presenting to specialist services. I was speaking to our professor of old-age psychiatry last year, and he was saying that they're actually turning up in the district general hospitals, particularly, people who are relatively recently retired. They start drinking very heavily quite quickly and then go off legs and end up in a general hospital bed. I think the challenge is how to engage with that population more. They don't want to be seen coming into substance misuse agencies, and I think an ideal way of engaging with them would be at a primary care level, but there is a real disconnect between secondary and primary care in many areas of Wales in terms of interventions that are delivered for people with substance misuse issues. When you consider the contacts that older people naturally have with primary care, I think they're ideally placed to deliver some of those interventions earlier on.

[167] **David Rees:** And do you want to comment on that last point?

[168] **Ms Ryan-Davies:** Yes, just one point. I obviously echo what's been said, but one point that I would want to mention is in terms of a development in Hywel Dda around alcohol liaison workers in A&E. It is a relatively new development, but it's starting to find alternative ways of having that access to some specialist within A&E, within our district general hospitals, because, it's quite right what my colleague said: especially older people and some other groups are not necessarily going to present to secondary or tier 2, tier 3 services with an

alcohol issue. So, we need to be able to provide opportunities for access at different levels and in different settings. Similarly, in terms of the approach with the tendering process that we've been through, it's providing that range of not only health, but also third sector provision so that there are different opportunities to engage and access information at various levels. I think that's the key to engagement with a number of groups, not only older people.

[169] **David Rees:** Do you want to add to that?

[170] **Mr Moncur:** Can I just add something, Chair? I think one of the things that perhaps would be helpful just to share with you just relating to that is that that was funded through the substance misuse action fund. I think that fund has given colleagues who work in the substance misuse arena a degree of flexibility to be able to bring in initiatives like this, which are absolutely crucial. I think we would've absolutely struggled, if not completely failed, to be honest with you, without that sort of additional funding stream that allows you to create those kind of hybrid roles that deliver different sorts of services. In fact, on the alcohol liaison nurses, two of them have been funded through the substance misuse action fund. We've actually convinced our police and crime commissioner to put some money into those posts as well, because they actually see the advantage of trying to pick up some of these people who are starting, much as Richard said, to fall into that quite difficult area. At a point in time, even if they are not breaking the law today, it is inevitable they will do unless we do something to proactively deal with that.

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

[172] **Darren Millar:** Just a follow-up first, before I ask another question: you've mentioned older people and other groups as well, but what about veterans in terms of their access to services and engagement with alcohol and substance misuse services? We know that the propensity to abuse alcohol and other substances is higher in the veteran community. I know that there are some specific organisations helping to try and address those problems, but do we have sufficient cover in all parts of Wales?

[173] **Ms Stone:** I've recently spoken with Combat Stress, and one of the issues that veterans have is in actually navigating specialist substance misuse services. So, I think there's an issue around care management and direction. We, as will all other health boards, will prioritise veterans who are referred to us, but they themselves find it quite difficult to navigate those specialist services. So, there is an issue around care management.

[174] **Darren Millar:** In terms of the Veterans' NHS Wales service, which, obviously, is wider and has mental health access as well, is that effective in being able to address alcohol and substance misuse concerns?

[175] **Ms Stone:** We don't get a significant number of referrals via that route, I think it fair to say, and whether that's because they will try and deal with addiction issues in-house, I don't know, but we did look at the number of veterans that we had referred into our services last year, and the number was very low.

[176] **Darren Millar:** Does there need to be more engagement between NHS veterans Wales service and the substance misuse services more widely in your organisations, then?

[177] **Ms Ryan-Davies:** I think it can only be of benefit, to be honest, because, talking from our mental health veterans service point of view, you're talking about very, very small services to deliver within, in our case, very large rural captures. Within Hywel Dda, we forge those links within our own services, but, I think, especially with veterans particularly, any links and support from the all-Wales veterans service can only be welcomed, really, in supporting health boards and APBs in delivering services.

[178] **Darren Millar:** Okay, thank you for that. Just moving on, and we've touched on it earlier, to the whole issue of alcohol-related brain injury and—I think it's in both of your papers—you refer to an increasing prevalence of this being diagnosed. What is the current prevalence rate in Wales? How has it changed? Has it doubled; has it tripled?

[179] **Ms Stone:** It's very difficult to know. Public health have just published a paper on this, but I haven't actually seen it as yet, so I don't know whether you've—.

[180] **Darren Millar:** Okay.

[181] **Ms Ryan-Davies:** I wouldn't have that detail today.

[182] **Mr Moncur:** Chair, I was going to make the point that I don't think we actually know, and I suspect that it's one of those things that is out there and it's a bit of an unknown known, if you know what you mean.

[183] **Ms Stone:** The commission in Cardiff and Vale wrote to the assistant directors of all local authorities in Wales, asking for the demand for services from this client group and didn't have one response. So, I think you're quite right; the prevalence is unknown.

[184] **Darren Millar:** Is it going undiagnosed, then, or is it just that the data are not being collected sufficiently well?

[185] **Ms Stone:** It's both.

[186] **Darren Millar:** It's a bit of both.

[187] **Ms Ryan-Davies:** And I think it's presenting in a lot of different places. With some of these areas that are increasing, you know, where we're seeing maybe more people coming in, from my point of view, to our memory assessment services, we're starting to see some early cognitive decline that maybe presenting in other parts of the service. So, I think what we haven't got is a broad, collective view of what that feels like.

[188] **Darren Millar:** So, what do we need to do to get a better grip of that, so that we can understand the scale of the problem and ensure there's proper intervention?

[189] **Ms Stone:** I think some of it's around the wider awareness raising in professional groups, but there was also, I think, an issue around the Welsh dementia funding, which did not preclude people whose dementia was caused by alcohol, but in fact have been precluded at the health board level. That population isn't served well by dementia services. So, I think it's awareness and I think it's a lack of service. I mean, I saw a gentleman six weeks ago in the Rhondda valley who was 42, and his cognitive function had declined to the point that he couldn't remember having a drink three hours earlier. It's kind of at that age level, and I think that some services are seeing those clients but aren't actually aware of what they're seeing—they don't have the awareness.

[190] **Darren Millar:** So, let me get this right: you said the dementia services funding didn't preclude engagement with people with alcohol-related brain injury, but, in practice, many local health boards are doing that.

[191] **Ms Stone:** Yes.

[192] **Darren Millar:** Why would a local health board do that?

[193] **Ms Stone:** I think because of the demand from clients who have got dementias of other origin.

[194] **Darren Millar:** Right. So, this quite small but significant group with significant and increasing needs, presumably, unless there's treatment or action taken to stem their alcohol consumption, is really being disadvantaged through the—

[195] **Ms Stone:** They're being unrecognised. They're not being picked up; they're being inappropriately placed in nursing homes—you know, people in their 40s and 50s, who are sitting with a much older population. They're having no rehabilitation, and, in fact, the rehabilitation of people who have things like Korsakoff's disease can take between 18 months and three years. It's quite intensive, but, in terms of the wider saving to social care of nursing home fees over maybe decades, there isn't a whole-systems approach.

[196] **Darren Millar:** So, we need better diagnosis, increased access to dementia services, and better identification within dementia services for this particular group.

[197] **Ms Stone:** And access to specialist rehabilitation facilities.

[198] **Darren Millar:** And you—

[199] **David Rees:** Can I clarify one or two things? Sorry, Darren. Education-wise, in the sense of the awareness of those people of the consequences, but also education for professionals to understand it.

[200] **Ms Stone:** Yes.

[201] **Darren Millar:** But we've got to get a better handle on data. Can I just ask you about data collection, Sue? You raised some concerns about the additional capacity that might be required in order to collect extra data in terms of morbidity rates—alcohol related morbidity. Do you think you've got sufficient resources to be able to collect this other data as well within health boards on alcohol-related brain injury and Korsakoff's?

[202] **Ms Jones:** No, I don't think that we've got sufficient capacity to do that. The only thing that you would have are postmortem studies, where you'll be able to see the incidence of alcohol-related brain injury, and I know that that has increased. There is some evidence; I think Anne Lingford-Hughes from Bristol had provided that. So, we know that there's an increase on autopsy studies, but, in terms of identification of current prevalence, I don't think that we've got the capacity to do that within health boards.

[203] **Ms Ryan-Davies:** I think education is definitely one of the proactive things we can do at the moment at health board level in terms of across all our services, by starting to have the discussion around the needs of the older population, not necessarily older, but in terms of presentation with brain injuries as a result of alcohol abuse. I think the other thing that I would say around dementia funding is that the element of dementia funding that was allocated to what we call early-onset memory services was very, very small in terms of delivering services. I think what we need to be doing as health boards is being flexible about the way that we think about utilising dementia funding, because the pressures on health boards are very wide in terms of dementia. I think this is a very small element of that. We know dementia rates are rising. We've got significant pressures around dementia. So, I think we need to take the point about not missing these smaller groups but we need to think how the funding is currently allocated and used within health boards to address that.

[204] **David Rees:** The last and final question.

[205] **Darren Millar:** Yes, it is just related to the issue of beds, as you've mentioned it a few times, Sue. How many beds does Wales need? You've talked about this potential of five beds in south Wales, but is that really sufficient?

[206] **Ms Jones:** If you look at Glasgow, Glasgow has got a specialist unit of 22 beds that just serves Glasgow.

[207] **Darren Millar:** Okay. So, there is potentially a much more significant—

[208] **Ms Jones:** So, there is a significant need there.

[209] **David Rees:** Okay, on that point, we'll end. Can I thank you for your evidence this morning? It's been very helpful for us as we deliberate on our report. You will receive a copy of the transcript to check for any factual inaccuracies you may identify and, if there are any, please let us know as soon as possible. Thank you very much, once again.

[210] I recommend that we now break for 10 minutes and come back at 10.50 a.m.

- a. *Gohiriwyd y cyfarfod rhwng 10:42 a 10:54.*
- b. *The meeting adjourned between 10:42 and 10:54.*

Ymchwiliad i Gamddefnyddio Alcohol a Sylweddau: Sesiwn Dystiolaeth 6 Inquiry into Alcohol and Substance Misuse: Evidence Session 6

[211] **David Rees:** I welcome Members back to this morning's session where we will continue taking evidence on our inquiry to alcohol and substance misuse. Our third evidence session this morning is with a representative of the Royal College of General Practitioners, Dr Jake Hard. I welcome you this morning and thank you for the written evidence you provided. I understand that you are here representing the RCGP, but also you have possibly some views with regard to your own role as GP and the work you do in the prison service and the community drugs and alcohol team in ABMU as well.

[212] **Dr Hard:** Well said.

[213] **David Rees:** We'll go straight to the questions if that's okay with you. We'll start off with Gwyn Price.

[214] **Gwyn R. Price:** Good morning. Could we have your views on Public Health Wales's evidence that there is a need to develop clear pathways for care from an early contact through specialist services? Is there anything currently preventing this?

[215] **Dr Hard:** From my view, as a GP and as a doctor that's worked within a number of different services and third sector organisations, the single thing that needs to change is that services need to be brought together into a more cohesive service. At the moment, you have quite a considerable number of silo services. You have your drug intervention programme teams, your integrated offender intervention teams, your drug rehabilitation requirement teams, and you have your third sector organisations delivering bits of substance misuse. They vary across south Wales. Then, of course, you have your statutory services. People, in my experience, pinball around amongst these services, and there's no cohesion there. That would be the single biggest thing that I would want to see change.

[216] **Gwyn R. Price:** Do you see more of that—I noticed—in Swansea prison, in connection with leaving prison and going out, with misuse and the connection with other agencies after that?

[217] **Dr Hard:** Absolutely. I will just declare that I've actually left Swansea prison now, but I'm working in Eastwood Park prison. Of course, there are no female prisoners in Wales; the majority are housed in Eastwood park. So, probably 50% of the ladies I see there are Welsh, which is great for me, because I know some of them. In terms of the male estate, when I worked there, and the female estate, and people going back out to services when they're on a treatment, say buprenorphine or methadone; arguably, it will be those front-line IOIS and DIP services that will pick them up, rather than the statutory sector. That provides a problem, because those services, the DIP and the IOIS services, will only have funding to provide a certain length of treatment—so many weeks of detox. They're allowed 26 weeks, unless there are significant factors to indicate that they would be entitled to longer. That, in my view, doesn't follow national guidance with the Orange Book and doesn't sit comfortably as a clinician in terms of engaging with people in order to get them to a place where they're ready to stop using. What it does is it keeps the churn going. So, people will come into a service, they may not be using but, of course, after a certain period of time, you have to start reducing their treatment, and they then, given that they're not ready, will fall off the wagon and you're back to square one and then you're pinged to another service, potentially, unless you're involved with the criminal justice system, in which case you go back to the one you came from.

[218] **Gwyn R. Price:** In my constituency of Islwyn, we're getting follow-up from a tragic accident that happened there. The follow-up from prison really wasn't there after a certain time. You've just confirmed that they could drop through the net when they're left out on their own.

[219] **Dr Hard:** Some people obviously choose that that's what they're going to do when they leave prison. They don't want to engage with services. What I would say is that where you have perhaps a view on the number of people that are currently in service, obviously there will be a pool of people who are not in services. I might see them in the prison, or colleagues in the police custody settings would see them there. So, there's also a mass of people outside of the services at the moment. Not everybody is being catered for, in my view.

[220] **David Rees:** Before we move on to Lindsay, can I just ask one question? You now say you've moved from Swansea to a female prison. The evidence you presented was based upon males because you were in Swansea prison, but are you starting to see similarities in some of the issues that you spot, and talked about in your evidence, within the women's sector as well?

[221] **Dr Hard:** Without a doubt. In fact, it's probably worse in the female estate because the bar for incarceration tends to be that much higher. The young women and the older ladies that are coming in most definitely have just as many if not more substance misuse and alcohol problems than those in the male estate, without a doubt. That's well documented, actually; there's evidence to support that.

[222] **David Rees:** Thank you for that. Lindsay.

[223] **Lindsay Whittle:** Thank you, Chair. Good morning. I'm really interested in your views that some of your patients will be homeless on release from prison. I was a housing manager in a previous life in this city, and I share your view.

11:00

[224] The chief inspector of prisons in previous evidence has told us that he feels there is a good service for people who need detoxification from alcohol but not so good for people who need detoxification from opiates. Do you share that view? Would you say that there is a

difference between one substance misuse and another, and what could be done to bring them together?

[225] **Dr Hard:** I believe that, on the first part of your question, hopefully, the change will come when the integration between health and social care comes along. The ability to involve somebody with the decision about their housing before they leave prison and resettlement—so, in terms of involving the National Offender Management Service with that—is going to help organise appropriate accommodation for people when they leave. Obviously, some people, and this is sort of going on to the second part of your question, will leave prison on licence and they will have aspects of their licence that say, ‘You need to be in such and such accommodation as a condition of your release’. My experience of a lot of those places is that they are not suitable environments for people who want to change. So, they may be suitable for people who don’t want to change and are still locked into their cycle of addiction; there are other people perhaps using there or misbehaving in some way there and they get involved in that circle of friends, if you like, or colleagues. However, if you’re of a mind to not want to do that any more, then those are not appropriate places, and, of course, you have no choice—it’s part of your licence condition and, you know, that’s it. If you’re going back to the bail hostel, the Waterton hotel, that’s what you’re going to find there.

[226] **Lindsay Whittle:** Yes. It’s a totally different aside, but you say ‘hostels’. I don’t like the word ‘hostels’—

[227] **Dr Hard:** Bail hostels.

[228] **Lindsay Whittle:** I don’t like those words. I’d much prefer ‘supported housing’. It gives a more friendly feeling of people belonging in a community, because these people are all from our communities and, when you mention a bail hostel, the public become sort of quite worried, and understandably so, but, if you mention supported housing, it is a different issue. Do you think we should work with housing professionals to change this terminology in order to give this support? We do need to have people in supported housing, as opposed to living on the street, because, if I was living on the streets, I’d get drunk every night just to go to sleep.

[229] **Dr Hard:** I totally agree. The more and the better the supported housing in my view, definitely—

[230] **Lindsay Whittle:** Yes. Thank you.

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

[232] **Darren Millar:** I just wanted to ask you, in terms of the Royal College of General Practitioners’ view, do you think there is sufficient awareness amongst your GP colleagues of the dangers of alcohol-related brain injury? Are they diagnosing sufficient cases and making appropriate referrals to secondary or tertiary care?

[233] **Dr Hard:** It’s a good question and one that I listened to earlier. I know it’s come up a couple of times. I would probably say, in short, the answer is ‘no’. It’s not certainly a diagnosis as a jobbing GP that I would come up with frequently, unless it’s somebody who I know very well has an alcohol problem and I’m aware that it’s something that’s going to be a consequence for them if they’re drinking very heavily. So, picking up somebody who may be in that sort of middle age—50, 60, perhaps early 70s—and you’re just not sure what sort of cognitive impairment they have, it’s not something where you’re immediately going to think, ‘Ah, this is definitely alcohol-related’. To my mind, even somebody who works within the substance misuse field, unless you, you know, are really refined on it, you’re not necessarily going to know immediately which sort of dementia it is, unless it’s obviously Parkinson’s or

something like that. So, I think it would be very challenging just to simply go, 'I'm now going to diagnose this condition as alcohol-related brain injury' without getting that secondary care opinion and the detailed tests that they would do to make that diagnosis.

[234] **Darren Millar:** Is it routine for GPs to ask somebody who's got suspected dementia what their alcohol consumption is, for example, to assist in a diagnosis?

[235] **Dr Hard:** I would have thought so, yes, absolutely. I mean, it's a common question for all sorts of things. We would ask about alcohol. So, yes.

[236] **Darren Millar:** And, should alcohol-related brain injury be diagnosed, what sort of treatment is available in your experience to be able to refer people to?

[237] **Dr Hard:** I think, given the answers that were relayed to you before, to my knowledge, if anybody presented with a memory-type problem, I would be referring them into a memory clinic and to secondary care services for their opinion on that. With respect to a younger population, I would be looking at neurologists et cetera for their opinion if I thought it was something else, and obviously it may be then relayed back to me that I got the diagnosis wrong, for example. So, it is a very difficult area. It is a very difficult area. I think it would be challenging. I don't think many of my GP colleagues would feel comfortable making the diagnosis themselves without further advice and support from specialists.

[238] **Darren Millar:** We were told by the previous panel of witnesses that, very often, even if someone has been referred into a dementia service, if they are diagnosed as having alcohol-related brain injury, they're taken out of those services and not really well provided for. Would you concur with that view?

[239] **Dr Hard:** I think, as the point was made earlier, the numbers are small, so, I haven't experienced that myself. What I have seen is—. In my past life as an SHO in psychiatry, I remember a young man—he must have been early 50s—who had an alcohol-related brain injury. Occasionally, some of the patients that I deal with in CDAT who are getting older and growing old, and I've known them for some years, are starting to present with signs of these things. But it can be a very difficult area in which to know when to put your foot in and say, 'Right, we need to do something about this at this time'. It's very difficult because, often, there are complex other problems going on, whether it be medication or physical health problems. So, the picture is never straightforward in my view. As with most general practice, it's becoming more complex, isn't it?

[240] **Darren Millar:** We were also exploring issues in relation to those harder-to-reach groups, shall we say, who have got substance misuse and alcohol problems—

[241] **David Rees:** Before we go on to that, Kirsty, was your question specifically on alcohol-related brain injury?

[242] **Kirsty Williams:** No, I wanted to ask about jobbing GPs.

[243] **David Rees:** Okay. We'll come back to that, then. Darren.

[244] **Darren Millar:** Yes. About those harder-to-reach groups or groups where there is a higher prevalence of alcohol and substance misuse—the prison population is one of them, but what about veterans groups in terms of your experience with them as a GP?

[245] **Dr Hard:** Yes, that's a very good question. I'm glad you raised that because I have sat on the armed forces committee locally in Cardiff and Vale briefly, and I actually do a lot of work with the military, and alcohol, as was in the papers not that long ago, is a massive

issue. It is a cultural issue, and it's also a coping strategy for a lot of soldiers. I have a lot of conversations with soldiers about their alcohol use. As I leave that one secure environment surrounded by barbed wire and military police in Hereford, I drive off to a prison where I see young men who have, some years down the line, become incarcerated probably as a consequence of their alcohol problem or drug problem and happen to be veterans. So, I see both ends of that spectrum. I think it's a very difficult area in terms of wanting to address both the cultural aspects of it—as we know, in wider society, alcohol is legal and acceptable.

[246] **Darren Millar:** You will be familiar then, of course, with the Veterans' NHS Wales service, which focuses more on mental health challenges faced by the armed forces family, shall we say. Do you think that there ought to be an element of that that is more specifically trying to address the alcohol and substance misuse problems in a more holistic way perhaps than approaching it just from the mental health aspect?

[247] **Dr Hard:** Absolutely. In fact, at the meeting that I attended, the lady from Public Health Wales who delivers the brief interventions was there to showcase that. But, certainly, having it more hand in glove would be better, absolutely, because, as you've commented several times, it's a coping strategy for people.

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

[249] **David Rees:** Elin, and then Kirsty.

[250] **Elin Jones:** Yes, I'd like to ask about the older population drinking alcohol in particular and misusing alcohol. We've had consistent evidence really that that's a part of the population presenting with problems. That's a change in the nature of the abuse, substance misuse. The previous evidence session referred to the fact that they don't present in the usual places that others have been presenting, and it may well be that the majority may not present at all but will end up, at some point, due to their older nature, with GP services and in GP practices. How do you think GP practices are adapting their services to meet the demands of this group of the population, and is there any additional training that's required for GPs in meeting the needs of substance misuse in an older population?

[251] **Dr Hard:** Well, the training that's available at the moment through RCGP Wales, and is funded by the Welsh Government, is around the certificates of substance misuse and alcohol misuse, so the training is already available there, and, as long as we keep going with the funding, we'll keep training GPs. Obviously, the agenda on that may need to change and accommodate the changes that are going on in society, as you say, with the older population. It's been some years since I've done the certificate, so I can't recall whether that's a specific item on there. GPs probably will be aware of the falls and the issues that relate to excessive alcohol use and, equally, will see it in terms of picking other pathology, when they're blood testing and doing other investigations with patients. So, I think they'll be aware of it; I guess it may need to be highlighted more specifically. I would suggest that as being a route to encouraging a focus, perhaps, on the older population.

[252] **Elin Jones:** Do you think, then, that the services are in place for the GPs to pass on these people with alcohol problems? Where would they go to next? Would GPs be clear as to what services would be available for this older population in particular, who may be very reluctant to go to some of the service providers that are already in society due to them not seeing themselves as people who would use those services.

[253] **Dr Hard:** I think it's a good point. I don't think there's a—. The service isn't geared up for that type of population. The other health consequences may be the route that you end up going down. So, if you've got liver cirrhosis, because of years of alcohol misuse, you're more likely to end up in the gastroenterology services, et cetera. So, in terms of those

permutations, with brain injuries, as we've discussed, you're more likely to end up in the mental health services, rather than necessarily accessing acute detox, as was discussed earlier.

[254] It is a difficult area. Certainly, as a young GP, challenging an older person about their alcohol use, when they say, 'Well, I've done it for years', you know, it can be a difficult one. Certainly, as GPs, you don't want to disturb the relationship you have with your patients. You know, people quite rightly justify their drinking, and they will do that. So, it's a very difficult area, I think.

[255] **John Griffiths:** Just on that point about the GP relationship with the patient—

[256] **David Rees:** Kirsty's going to ask her question on GPs. I'll come back to you. Kirsty.

[257] **Kirsty Williams:** Thank you, Dr Hard. You referred to jobbing GPs, who've got loads of things that present in front of them. In some of the reference groups that the committee has met with, and in the evidence that was supplied by the Royal College of Psychiatrists, there was a suggestion that, actually, there is reluctance amongst some GPs to treat alcohol and substance misuse patients. Is that a scenario that you recognise? If it is, what do you think lies behind that? Is it pure prejudice? It's not a lack of skills, because you've just said that there's lots of training available; we're constantly training GPs. Is it because there's not the appropriate services that GPs feel they can refer on to, so it's, 'I don't even want to get started here, because there's nothing I can do for this patient'? Do you recognise that picture and, if so, what do you think underlies that, and what can we do to fix it?

[258] **Dr Hard:** Excellent question. There are lots of parts to this. I certainly feel—from my own view, as somebody who has had a life that's touched by alcohol and substance misuse, I know that it is a taboo subject. Historically, amongst GPs and doctors it's still regarded as something over which you may express a prejudice and I've seen that for myself.

[259] What I would like to say is that, over the last few years, what I've seen is medical students coming into the prison, junior doctors coming into the prison, coming into the substance misuse service, and I see people's attitudes changing at the younger generational level, which I am very reassured about. That change, for me, is quite exciting and I think we need to build on that. That needs to go more into the curriculum. The training that medical students get is scarce—I mean absolutely. When I ask them, and I ask them, 'How much training have you had?', they'll say, 'We've had an hour' or 'We get a day with you', and it's just not enough.

[260] Certainly one of the questions I will always ask is, 'What's your view and what are you expecting to get out of today?' I'm always assessing their level of prejudice, because I want to see whether that's changed for myself. I would like to reassure that, actually, I see that changing, and I don't know whether that's because, in the younger population, whose lives have, perhaps, been touched, in the family, by alcohol and drugs, that view is changing and it's becoming more acceptable to discuss these things.

[261] 11:15

[262] **Kirsty Williams:** We also have, perhaps, a prejudiced view of what alcohol and substance misuse actually means. You said in your paper that you yourself have treated people who have a dependency on prescribed medication, often for chronic pain, and I'm just wondering what role you see for GPs in appropriately managing patients who, quite rightly, they have prescribed tramadol for, because it's the right thing to do, or perhaps, quite rightly, have prescribed benzodiazepine for, because that's the right thing to do. What role is there, then, for ensuring that that initial prescription doesn't lead on to a long-term dependency or abuse of that medication?

[263] **Dr Hard:** Again, another very good question. It's an expanding field, on which, as a jobbing GP, I have, on a number of occasions, addressed people's concerns, or attempted to address my concerns about somebody's use of an opiate that's prescribed by me. A great example is a lady who, for many weeks, would come back; she'd always come back early for her medication. I knew there was a problem and I told her that I knew there was a problem. I work in a substance misuse service; for me, it was barn door. But, rather than deflecting her or becoming judgmental about her, I just said, you know, 'You need to keep coming back. When you want to talk to me, please do so'. This went on for, probably, about two or three years or so until, eventually, we got into a position where she wanted to discuss it with me. At that point, I was able to engage. Now, a lot of GPs won't have that patience: they will get annoyed, they will get frustrated and they may, you know, cite a communication breakdown, or a breakdown in patient relationship and off-list them, or do some other catastrophic event that then disturbs that relationship permanently.

[264] So, it's about engagement and that works across all of the services that I've discussed—prison and substance misuse services. It's about engagement with people and keeping those links going until people are ready to change. Nobody ever seems to see that, because it's not something that you can add data to.

[265] **Kirsty Williams:** You said it was easy for you—'it was barn door'—

[266] **Dr Hard:** For me, yes.

[267] **Kirsty Williams:** —because you have a specific interest in these things. Would it be easy for your jobbing GP to recognise that, 'Hang on a minute, somebody's becoming dependent on these prescriptions'? And, if so, how do you respond to that? We've got clusters of GPs and, supposedly, that's the answer for primary care as we go forward—GP practices working together. Do you think that, actually, there is a need, in those clusters, to have someone within the practice or the group of practices that has a specialism in drugs and alcohol misuse whom other GPs, perhaps, could refer to to get specialist advice, help and support?

[268] **Dr Hard:** I suggest you've probably got some of those GPs already there and, certainly, increasing that resource would be useful, and adding to that the training around the prescribed opiates—that and over-the-counter opiate-based remedies et cetera; they are the big unknown for the moment. Of course, going back to the issue about disturbing the relationship that you have with a patient, when you challenge somebody who is 10 months following a knee surgery and they're still taking a lot of tramadol, you know, it's a very difficult area, unless you've got the right tools to do it and want to do it safely, with the patient in the right place.

[269] **Kirsty Williams:** Thank you very much.

[270] **David Rees:** You identify in your paper that there's perhaps a policy disconnect between the commissioning of services, particularly for prison service healthcare and services that would be found outside the prison sector. Can you expand upon that a little bit, as to the concerns you have in relation to those services that are available to people in the prison service? In previous inquiries on NPS, we were clearly informed that there were concerns over the use of substances in the prison service and people coming out having been addicted to one. So, can you expand upon your concerns about the services available to those inside prisons and when they leave prison?

[271] **Dr Hard:** Could you just clarify that point for me? I can't remember what I said in there specifically about that. Is it that I'm saying that they're better inside prison?

[272] **David Rees:** No. I think you were saying that they're not the same, therefore, there were different experiences inside and outside.

[273] **Dr Hard:** I think, inside prisons, as a prison GP, we're very much more attuned to dealing with somebody who has been launched into the prison; it's an unexpected arrival, in many senses, of somebody who is now going to have to be detoxed of a medication. You wouldn't do that in the community. So, I wouldn't suddenly admit a patient from my GP surgery and say, 'Right, you're being detoxed today'. The only reason they end up in the prison office is that they go to the court, they come in and it's an unexpected event, in that respect. Obviously, you've got to do it safely. So, you kind of have a primary/secondary care hat on then, because you're doing something that might otherwise be done in a hospital. It's not being done in a hospital; it's being done in a prison. So, they have to be configured differently. The question then is what you do with that individual. I've detoxed somebody—. The same will apply in your hospitals, if you've got somebody coming in and they've broken something in a fall, but they also had an alcohol detox, about the handover of that care and the maintenance of that abstinence once they leave the hospital or the prison. So, it's about connecting those things up, if that makes sense.

[274] **David Rees:** Yes, thank you. The other issue you talked about in your paper is the environment in which many people find themselves and, perhaps, the history of those individuals as to the reasons why they become dependent upon alcohol or drugs. Are we doing enough in terms of preventative measures to tackle those issues, once we identify them at an early age, to try and avoid people becoming dependent upon these substances?

[275] **Dr Hard:** I'm not sure I could answer the question in terms of prevention, but, certainly, in my view, as somebody who deals with unravelling some of these issues later on down the line. So, when people stabilise their drug or alcohol problem, perhaps start to withdraw off their medication and get back to a so-called normal life, a lot of these issues will then come to the fore, because if you think of any drug or alcohol, it's an anaesthetic, so you're dealing with some form of pain, whether it's physical or emotional. I know, obviously, in terms of what I've written down there, most of it's emotional pain, whether it's post-traumatic stress disorder, past sexual trauma or violence. So, it's how you deal with that and having the facilities to deal with that. Now, I'm not a trained counsellor. I know that there are services available, although they're difficult to get people into at the right time, when they want to deal with these issues, and so a lot of it's about making more availability of those organisations like New Pathways. I know that they've done some work and have become more widely available in south Wales now. I've had a few patients who have got to the point where they're in their 40s, and their drug problem is no longer an issue. They may still be in treatment with me, but now they want to address these other things. I can't answer the question at the front end. I don't know whether that would help or not.

[276] **David Rees:** But are you, as a GP, concerned, therefore, that, as you address some of the issues on your side, because there's a waiting list or a lack of other services, the patient may actually regress, in one sense?

[277] **Dr Hard:** Absolutely.

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

[279] **Kirsty Williams:** Say, for instance, somebody goes into their GP surgery in Powys this morning, and is highly anxious—because you talk about anxiety—and the GP says, 'What you need is counselling, but, actually, it'll be six months before we can get you into a counselling service'. That six months is an awfully long time to deal with anxiety on your own without resorting to whatever substance it might be to help you get through the day. So,

you know, if we were actually able to build some resilience into those services in primary care, do you think it would, potentially, divert at least some people away from beginning to fall into the trap of using other substances to self-medicate?

[280] **Dr Hard:** Undoubtedly. One of the other issues for me that is a big issue here, particularly where somebody, perhaps, has started to deal with their anxiety by self-medicating, whether it be with alcohol, drugs or something that's prescribed by me, unless it's a mental health medication, is the disconnect between primary care and the mental health services, and obviously, the judgment that then comes out as a consequence of that. So, you know, in many ways, the secondary care mental health services or even the primary mental health services might say, 'Well, you know, he's got a drug problem or an alcohol problem. We're not dealing with that.' Do you see what I'm saying? I'll even add to that: that's even coming from somebody who works in a secondary care setting with substance misusers trying to get them, as their substance misuse or alcohol problem stabilises, but a mental health problem comes out, whether it's a bipolar disorder or a severe disabling anxiety—. Getting that secondary care mental health service to work with me is difficult. I know it's one of your next issues for consultation, and I will be responding to that.

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

[282] **David Rees:** I've got two final questions. I think they're on a similar topic. Darren, then Lindsay.

[283] **Darren Millar:** I just wanted to ask, earlier on, you referred to the duration, if you like, of the rehabilitation services that are available out there and that, very often, the limited duration can allow people to repeat the cycle of abuse, rather than actually deal with it once and for all and break that cycle. You said it's very difficult to be able to make a case to justify, sometimes, a longer intervention period. Can you just elaborate on that a little bit more?

[284] **Dr Hard:** So, I haven't worked in a drugs intervention programme service. My wife is a GP who works quite considerably for a lot of the services in Gwent, so for Kaleidoscope, and what she sees frequently is somebody she's seen many times before, but she won't be able to convince the team leader that that person should have entitlement to a longer path of treatment, unless they've got a significant health problem—for example, they're on treatment for their hepatitis C or HIV, or they've got some major physical health problem in that respect. But anything else that's more common or garden, just the fact that they're using on top of their prescription, is not good enough to justify extending their treatment.

[285] **Darren Millar:** But it's counterproductive then, isn't it?

[286] **Dr Hard:** Absolutely.

[287] **Darren Millar:** Because they'll pop up again and need to go back into treatment for a period of time, whereas if they were both concurrent, it may have been sufficiently long enough to—

[288] **Dr Hard:** Or they'll get incarcerated and they'll come and see me. So, as I said, they pinball around, and the thing that bothers me most about that is that it does not follow UK orange book guidance on managing substance misuse. It falls way outside of that.

[289] **Darren Millar:** Remind the committee: what does the orange book say?

[290] **Dr Hard:** So, it is the UK guidance on substance misuse, and I think it's being rewritten at the moment. I think it was written originally by John Strang, or at least co-

authored by John Strang, and it is the bible that we all look to, whether we're a prison GP or a GP with substance misuse specialism, as our guide for how we should be managing patients. Nowhere in there is the evidence base that we should be detoxing people before 26 weeks and saying 'You're only allocated that amount of funding—end of'.

[291] **Darren Millar:** So, how have we arrived at this 26-week mark?

[292] **Dr Hard:** Funding. It's commissioned specifically—.

[293] **Darren Millar:** It's basically rationed.

[294] **Dr Hard:** Absolutely. You're only entitled to 26 weeks, but, as I said, nowhere in the guidance does it say that that is an effective treatment for somebody with a significant substance misuse problem.

[295] **Darren Millar:** Okay; thank you.

[296] **David Rees:** Lindsay, you have the last question.

[297] **Lindsay Whittle:** Thank you for your evidence; I think it's been most helpful. The Scottish Parliament is adopting a tougher attitude towards alcohol in particular, with a minimum price per unit of alcohol. You can't buy alcohol after 10 o'clock in any outlet, to take away, whereas in Wales, outlets are open 24/7 if you want. Do you think this would help us here in Wales?

[298] **Dr Hard:** I think it would, and I think, historically, where availability was not as much as it is today, in your petrol station, supermarkets, late shops et cetera—. Making it less available is going to help in some way, without a doubt.

[299] **Lindsay Whittle:** It probably won't help those addicted, but it might head some people off at the pass, do you think?

[300] **Dr Hard:** Well, I heard the answer to the question about brain injury earlier, and the thing that worries me about that is that, currently, the statistics suggest there are about 2 million people in this country who are currently dependent on alcohol—I mean the UK, not Wales, obviously—and approximately 20 million people who are drinking at harmful levels. So, making it less available has got to help.

[301] **Lindsay Whittle:** Okay. Thank you very much.

[302] **David Rees:** Thank you for that, and I'm sure that's a topic we will be visiting when the Public Health (Wales) Bill comes forward to us. Thank you for that and thank you for your evidence today. It's been very helpful and I'm sure that it will form part of our deliberations in our consideration of the report. You will receive a transcript of the session to check for any factual inaccuracies; please let us know if there are any as soon as possible. Once again, thank you very much.

[303] **Dr Hard:** Okay. Thank you very much for having me.

11:28

Papurau i'w nodi
Papers to note

[304] **David Rees:** On item 5, can we just note some papers? It's not on the agenda, but we have the minutes from the meeting on 25 February 2015 to note. Are we all happy to note those? We have the letter from the Minister for Health and Social Services in relation to the independent living fund and a response that we received, dated 5 March. Are you happy to note that? Thank you.

Cynnig o dan Reolau Sefydlog 17.42(vi) i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod
Motion under Standing Orders 17.42(vi) to Resolve to Exclude the Public from the Remainder of the Meeting

Cynnig:

Motion:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod ac ar gyfer eitem 1 y cyfarfod ar 5 Mawrth 2015 yn unol â Rheol Sefydlog 17.42(vi) and (ix).

that the committee resolves to exclude the public from the remainder of the meeting and for item 1 of the meeting on 5 March 2015 in accordance with Standing Order 17.42(vi) and (ix).

Cynigiwyd y cynnig.
Motion moved.

[305] **David Rees:** Can I now move, in accordance with Standing Order 17.42 (vi) and (ix), that we resolve to meet in private for items 6 and 7 on the agenda? Are we content? Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:29.
The public part of the meeting ended at 11:29.