# Health and Social Care Committee

Meeting Venue:
**Committee Room 1 - Senedd**

Meeting date:
**Wednesday, 4 February 2015**

Meeting time:
**09.15**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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## Agenda

**At its meeting on 29 January 2015 the Committee resolved under Standing Order 17.42(vi) to exclude the public for item 1 of the meeting on 4 February 2015**

**1 Consultation on future care and support arrangements for Independent Living Fund recipients: consideration of draft letter (09.15 - 09.30)** (Pages 1 - 4)

**2 Introductions, apologies and substitutions (09.30)**

**3 Inquiry into alcohol and substance misuse: evidence session 1 (09.30 - 10.20)** (Pages 5 - 25)
Andrew Misell, Alcohol Concern Cymru

**Break (10.20 - 10.30)**

## 4 Inquiry into alcohol and substance misuse: evidence session 2 (10.30 - 11.20)

Dr Raman Sakhuja, Royal College of Psychiatrists

## 5 Inquiry into alcohol and substance misuse: evidence session 3 (11.20 - 12.10) (Pages 26 - 35)

Harry Shapiro, DrugScope
Nathan David, Drugaid Cymru

## 6 Papers to note (12.10) (Pages 36 - 39)

**Inquiry into alcohol and substance misuse: Note from the reference group event held on 21 January 2015 (12.10)** (Pages 40 - 49)

**Inquiry into alcohol and substance misuse: summary of survey responses (12.10)** (Pages 50 - 89)

**Inquiry into alcohol and substance misuse: consultation responses (12.10)**

**Consultation on future care and support arrangements for Independent Living Fund recipients: additional information from the Welsh Government (12.10)** (Pages 90 - 92)

**Safe Nurse Staffing Levels (Wales) Bill: correspondence from the Finance Committee (12.10)** (Page 93)

## 7 Motion under Standing Order 17.42(vi) to resolve to exclude the public from the remainder of the meeting (12.10)

## 8 Inquiry into alcohol and substance misuse: consideration of evidence (12.10 - 12.25)

## 9 Update on the European Commission's Work Programme 2015 (12.25 - 12.30) (Pages 94 - 97)

# Agenda Item 1

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# Agenda Item 3

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

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

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

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

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

**1. Action on price**

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

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

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

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

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

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

**2. Restrict alcohol advertising**

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

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

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

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

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

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

**3. Curtail the availability of alcohol**

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

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

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

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

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

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

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

**4. Cut the drink-drive limit**

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

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

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

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

## 5. Reduce the stigma associated with alcohol problems

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

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

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

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

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[2] Bennetts R. (2008) *IAS Briefing Paper: Use of alcohol as a loss-leader* London: Institute of Alcohol Studies
[3] See http://www.sheffield.ac.uk/news/nr/northern-ireland-minimum-pricing-1.423978
[4] Gilmore, I. et al. (2013) *Health First: an evidence-based alcohol strategy for the UK*, A report published in association with the British Liver Trust and the Alcohol Health Alliance UK.
[5] op cit. National Assembly for Wales Rural Development Sub-Committee.
[6] CAMRA submission to UK Government's alcohol strategy consultation (2013).
[7] Alcohol Concern press release (2012) *Welsh pubs back plans for minimum alcohol price*, online, available from: http://www.alcoholconcern.org.uk/projects/alcohol-concern-cymru/news/Welsh-pubs-back-plans-for-minimum-alcohol-price [accessed 04/02/2014].
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[21] Alcohol Focus Scotland and Alcohol Research UK (2014) *Using licensing to protect public health: from evidence to practice,* online, available from http://alcoholresearchuk.org/downloads/finalReports/FinalReport_0114.pdf [Accessed 23/12/2014].
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[23]See http://wales.gov.uk/statistics-and-research/drinking-driving/?lang=en&dm_i=4OQ,32PNU,ZJI92,B1I39,1
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[29] ibid.

**A significant rise in street drug purities, coupled with high levels of prescription drug and synthetic cannabinoid use among vulnerable communities, are raising concerns among drug services facing an ever more complicated drug scene - and a rising toll of drug deaths. *By Max Daly.***

The DrugScope annual snapshot survey of the UK drug scene was conducted in December 2014, and involved police, drug action teams and frontline drug workers in 17 towns and cities across the UK. In the majority of areas we spoke to, the street level purity of cocaine, ecstasy and heroin had gone up significantly, following several years of high adulteration across the board. Experts suggest the hike in quality is down to two interlinking factors: falling wholesale drug prices that have enabled Class A suppliers to improve their product in the face of competition from cheap yet potent new psychoactive substances.

Some areas reported the purity of cocaine, ecstasy and heroin doubling and tripling in the last year. In Bristol, police said cocaine purity jumped from an average of 10 per cent in 2013 to 30 per cent in 2014, while heroin had risen from an average purity of 10-15 per cent to 20-25 per cent. Police in Liverpool said cocaine had risen from a single figure average to 25 per cent, and heroin from 25 per cent to 40 per cent.

Several areas said that the better quality heroin had perhaps been responsible for a slight upturn in people coming into services because of heroin problems. In Glasgow, Nottingham, Cardiff and Bristol, the existing two-tier market in cocaine had, according to police and drug services, expanded to a three-tier market, with high purity cocaine being offered for between £100 and £200 per gram. However, while ecstasy pills have returned to 1990s purity levels, the average bag of cocaine and heroin is still far less pure than it was 20 years ago.

## Upsurge in prescription drug use

While illegal drugs have been increasing in purity, most areas covered by the survey highlighted the significant use of the prescription drugs pregabalin and gabapentin, chiefly among Britain's opiate-using and prison populations.

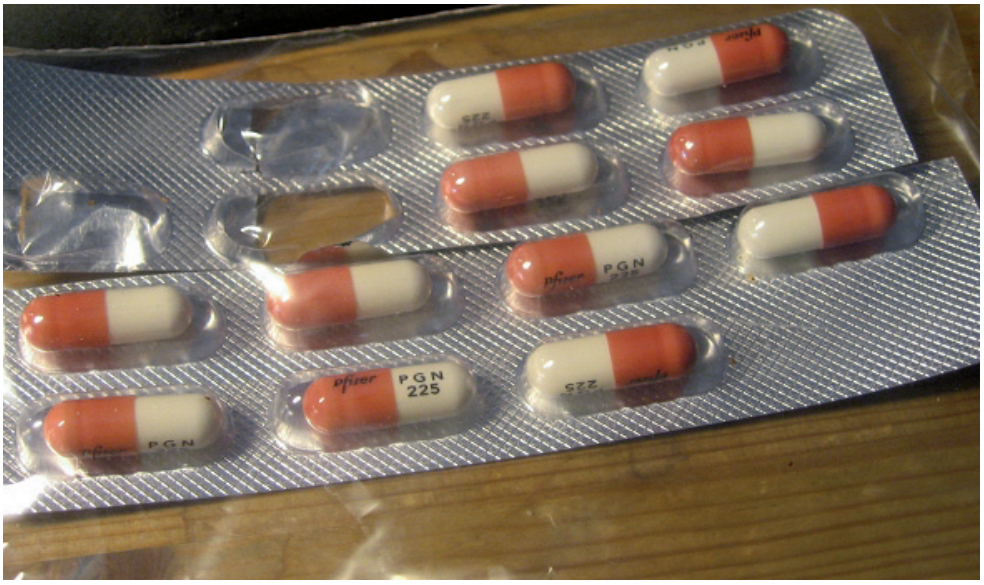
The drugs are prescribed to treat epilepsy, neuropathic pain and anxiety. But used in combination with other depressants, they can cause drowsiness, sedation, respiratory failure and death.

In 2011, according to the National Programme on Substance Abuse Deaths, there were 13 fatalities directly linked to the drugs in 2011, with another 18 people who had the drugs in their system when they died. In 2012, deaths linked to the drugs almost tripled, to 36, with the drugs present in another 33 deaths. The Office for National Statistics told DrugScope that pregabalin and gabapentin were mentioned on 41 death certificates in 2013 (pregabalin on 33 and gabapentin on 9).

> *"We've seen a big rise in the illicit use of pregabalin and gabapentin. The effects are horrendous and life threatening. People become so heavily intoxicated because they are mixing several drugs at a time."*

Growing concern around the misuse of these drugs has led to some organisations writing to prescribers requesting that more care is taken to prevent them appearing on the illicit market. In December, Public Health England (PHE) and NHS England published advice for prescribers on the risk of misuse of the drugs.

The PHE/NHS England bulletin reported that in England in 2013 there were 8.2 million prescriptions of both medicines, a 46 per cent rise in prescribing of gabapentin and 53 per cent rise in pregabalin since 2011. Prisoners are twice as likely to be prescribed these drugs as those in the community and the drugs have caused a number of deaths in jail.



Lyrica (Pregabalin)

One drug worker in York told the survey, “We’ve seen a big rise in the illicit use of pregabalin and gabapentin. The effects are horrendous and life threatening. People become so heavily intoxicated because they are mixing several drugs at a time. The drugs can reduce the heart rate and if taken with methadone can be extremely dangerous, so we now have to consider whether people are using these drugs when we prescribe methadone.

“Initially we had thought there was a batch of dodgy heroin with Rohypnol in it, but [we found instead that] they were using pregabalin and gabapentin alongside heroin. Often they don’t know what strength capsules they are taking because they look similar. Both drugs are readily available and certainly have a street value attached to them. We have sent a letter to GPs asking them not to prescribe it so much.”

The drugs are causing some opiate users to act in a more chaotic, disinhibited way, such as injecting in public; there are reports of sex workers getting robbed and beaten after taking uncharacteristic risks. A drug worker estimated that in one homeless hostel in Bristol, 70 per cent of residents were using pregabalin, with only some being prescribed the drug. Another drug sector professional said that there were large amounts of the drugs, particularly pregabalin, being used in the city and causing “more uninhibited behaviour” among service users.

The rise of these anticonvulsants as street drugs in the UK was initially spotted by criminologist Steve Wakeman during an investigation into austerity-era heroin use on a housing estate in north-west England. Writing for Druglink magazine in September 2013, Wakeman said the drugs were “in considerable demand” and used by all the heroin users he spoke to.

Wakeman found that pregabalin and gabapentin’s ability to enhance the effects of heroin and therefore reduce the amount needed, and also to facilitate self-detox, meant that most of the heroin users on the estate did not attend services, and could be part of a larger, hidden heroin-using population. If so, what appears to be a surprise decline in heroin use during hard times could actually be a case of diversification.

The survey also found that diazepam pills are still highly popular, even though their ingredients are unpredictable. Research carried out into a range of different batches of blue diazepam pills seized in Scotland found many contained very high doses of the drug, while some contained potent benzodiazepine analogues such as etizolam and phenazepam. Even pills marked with the same logo contained a wide variety of substances.

## Vulnerable groups at risk from NPS

New psychoactive substances (NPS) figured highly in the survey, with virtually every area reporting a continued rise in use by a varied population. Of most concern was the rapid rise in the use of synthetic cannabinoids such as Black Mamba and Exodus Damnation by opiate users, the street homeless, socially excluded teenagers and by people in prison.

> *One drug worker said that inmates at a Liverpool prison had become so used to emergency services being called out when people collapsed after taking Black Mamba that ambulances are now known as 'the Mambalance'.*

In Birmingham, a homeless charity described how a large number of their opiate using clients and street drinkers were smoking synthetic cannabinoids, leading to health emergencies. "It's a nightmare with our clients. When they come in for opiate treatment it's hard to deal with them after they've smoked it. They are collapsing in the street. One man needed CPR last month. Some of them have been hospitalised several times. They are using it because it's cheap, it's strong and because those who are out on license will not go back to jail if they are caught taking them because they're legal." As our survey found last year, synthetic cannabinoids continue to be sold not only in head shops, but in a variety of other outlets including newsagents. According to people interviewed for the survey, synthetic cannabinoids were readily available in prisons and many people referred into services from jails came out with dangerous levels of use of the drugs.

Two areas, Ipswich and Sheffield, reported that small synthetic cannabinoid production units had been uncovered. One drug worker said that inmates at a Liverpool prison had become so used to emergency services being called out when people collapsed after taking Black Mamba that ambulances are now known as 'the Mambalance'.

Injection of unknown white powder NPS, a practice flagged in the 2012 Druglink survey, continues in some parts of the UK, although it has remained largely confined to small towns, where drug users are more isolated and poorer, rather than in major cities.

## Drug-related deaths rising

In the wake of new statistics released by the government in September 2014, that found drug deaths had risen sharply in 2013, feedback from the survey revealed there is little hope of the situation improving in 2014.

In Northumberland there were 21 drug-related deaths in 2014, compared to six in 2013. In Nottingham, there were 10 non-fatal overdoses and four deaths in one six week period in 2014, the same total number of deaths for the previous year.

Organisations that have looked into the deaths in their area found a mixture of possible causes for the rise, including more heroin users dropping out of services, a downscaling of outreach work, people overdosing on higher strength heroin and in one area, an emerging group of inexperienced users.

A drug sector professional in Durham said that research her team had carried out by looking at coroner's reports in Northumberland, found that most deaths were not in fact overdoses but as a result of long-term organ damage in ageing opiate users. Of the areas that mentioned a rise in drug deaths, some said increased access to naloxone had prevented overdoses becoming fatal.

## A complex and unpredictable drug scene

The survey respondents also spotted a string of interesting trends that, although not repeated across the country, are nevertheless noteworthy.

More services in London, including needle exchanges, are seeing gay men seeking help for problems related to 'chemsex', the often intravenous use of crystal meth and mephedrone during sex parties. A pilot unit is being set up at a sexual health clinic at London's Charing Cross hospital in a bid to pull in more problem users. On a far smaller scale than London, Liverpool and Glasgow reported they had seen some service users involved in chemsex scenes there, although crystal meth was expensive and difficult to get hold of.

Also in London, experts flagged up the increased use of high strength, boutique strains of skunk such as 'Amnesia', 'Sour Diesel' and 'LSD' by young people. One drug worker said many of those getting into problems with these drugs were young offenders, who were often black or mixed race, buying from older friends who have the equipment and knowledge to cultivate this specialist cannabis where the focus is on growing quality strains, rather than high yield.

"Some kids as young as 15 are having problems with these strains of skunk, like paranoia, hearing voices and thinking adverts on TV are talking to them," he said. "Some are quite addicted, they smoke £40 a day and it's stronger than normal skunk. These strains like Amnesia are name-checked in the lyrics and YouTube videos of gang culture."

In Liverpool and Glasgow, cannabis cultivation, has been adopted as the major business of white British criminal gangs, who see it as far less risky way of profiteering than cocaine and heroin. Also in Liverpool, one interviewee said the use of nitrous oxide had reached new heights among students, with the used canisters (known as whip-its) littering the pavements in some areas.

The official statistics do show that what could be called 'traditional' drug use has been in overall decline for some years, albeit with recent spikes in cocaine, ecstasy and ketamine use. However, with the advent of the newer drugs and increasing use of prescribed drugs, it would seem that the drug scene has become more complex, diverse and difficult to predict.

**Max Daly is a freelance journalist**
**([redacted])**

### Average UK street drug prices as quoted by survey respondents

Cannabis herbal standard per quarter ounce: £35
Cannabis herbal skunk per quarter ounce: £50
Cannabis resin per quarter ounce: £30
Heroin sold in £10-£20 bag, weight per bag: 0.1g – 0-2g
Cocaine per gram: £52
Crack sold by £10-£20 rock, weight per rock: 0.2g
Ecstasy per pill: £5
MDMA powder per gram: £40
Speed per gram: £12
Ketamine per gram: £25
Mephedrone per gram: £18

For more information please contact the DrugScope Communications Team at [redacted] / [redacted]

The National Assembly for Wales' Health and Social Care Committee is a group of ten Assembly Members from across Wales who represent the four political parties who make up the Assembly. The Committee's job is to hold the Welsh Government to account on health and social care within Wales, including finance, administration, policy and legislation.

**The National Assembly for Wales's Health and Social Care Committee is c... looking into the issue of alcohol and substance misuse in Wales.**

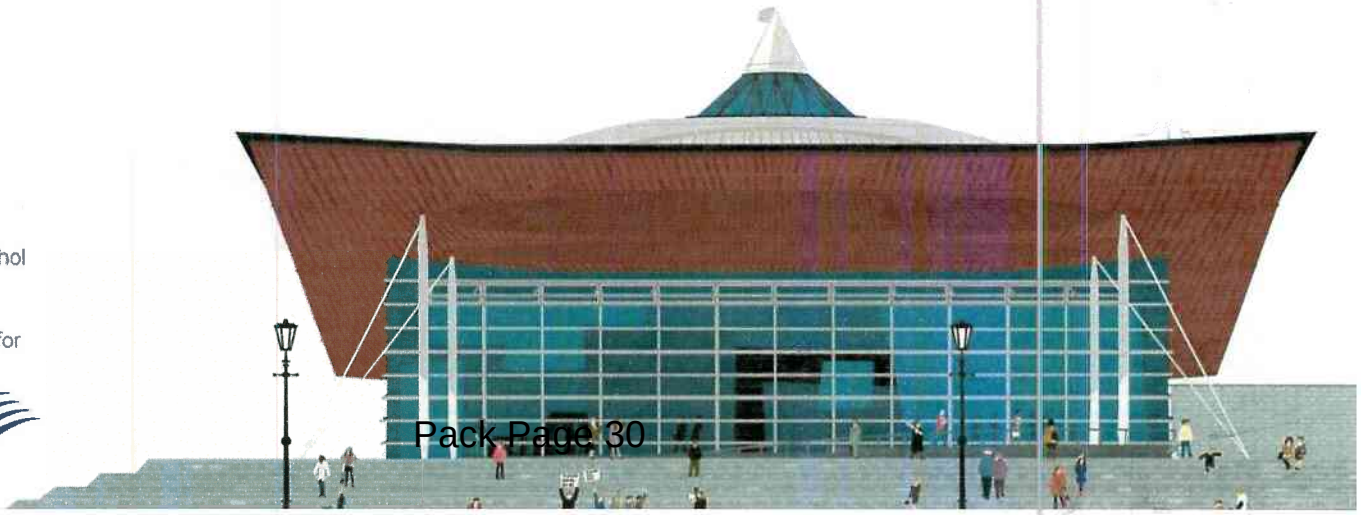
We have recently been doing some work on new psychoactive substances which are sometimes called "legal highs" - our report will be out in the New Year. We want to build on that work, and so we are now looking into issues of alcohol and substance misuse. As part of our inquiry we want to know about the effect that alcohol and substance misuse has on people in Wales, how well these issues are currently being tackled, and whether the right local services are in place across Wales to help people and make sure that they know about the possible harms.

Giving us your views will help us make sure that we can take into account how alcohol and substance misuse affects real people in Wales on a daily basis.

We will consider all of the written responses that we receive, as well as taking oral evidence from key organisations, and from the Welsh Government.
We will then write and publish a report which makes recommendations to the Welsh Government. You will be able to find the report on the **Committee's website**.

If you or somebody you know has been affected by alcohol or substance misuse, or if you would like more information about them you can contact DAN 24/7 for advice. DAN 24/7 is a free and confidential helpline for anyone in Wales wanting further information or help relating to drugs and or alcohol. You can find more information here:

Freephone: 0808 808 2234 or text DAN to: 81066 **www.dan247.org.uk**



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National Assembly for Wales

The National Assembly for Wales Commission is the data controller of the personal information you provide. Personal information will be processed in line with the principles of the Data Protection Act 1998. Your response will be stored on Assembly ICT equipment and in Survey Monkey, and deleted at the end of the inquiry, and any paper copies destroyed. Survey Monkey use servers outside the European Union.

Please contact us for further information about how Survey Monkey handles information:

**outreachteam@wales.gov.uk**

**01** Do you currently work for an organisation which works with people who misuse alcohol or other substances? If so, please state which organisation and whether we should treat your response as being on behalf of that organisation, or as a personal response from you.

I CURRENTLY WORK FOR DRUGAID AT THE PHOENIX CENTRE IN CAERPHILLY, SUPPORTING PEOPLE WITH BOTH ALCOHOL AND OTHER SUBSTANCE MISUSE ISSUES. ALTHOUGH REPRESENTING DRUGAID SOME OF THESE RESPONSES SHOULD BE TREATED AS PERSONAL.

**02.** Which client group(s) do you work with? (For example, under 18s, older persons, homeless, or female only)

THE PHOENIX CENTRE ENGAGES WITH ANYONE OVER THE AGE OF 18 AFFECTED BY DRUGS OR ALCOHOL AND IS ATTENDED BY THOSE STILL USING CHAOTICALLY THOSE MAKING THEIR FIRST STEPS IN RECOVERY, AND SOME THAT ARE ABSTINENT. THE SERVICE ENGAGES THE HOMELESS, PEOPLE WITH MENTAL HEALTH PROBLEMS, ~~HEAR~~ HAND LEARNING DIFFICULTIES. WE WILL ALSO WORK WITH CONCERNED OTHERS.

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

**03.** What are the main reasons why your clients take drugs or drink excessively? Please tick all that apply.

If you work with more than one client group or you feel that there are other reasons as to why your clients take drugs or drink excessively, please comment in the box below.

- [x] Peer pressure
- [x] A way to deal with stress
- [x] Client(s) already substance reliant
- [x] Mental health
- [x] Boost confidence
- [x] Relieve social anxiety
- [x] Environmental factors (for example - excessive drinking and/or drugs normalised in the home/community)
- [x] Relationship problems
- [ ] Financial concerns
- [x] Self-medication
- [ ] Escapism
- [x] Other (please comment)

Comments

FOR MANY PEOPLE EXCESSIVE DRINKING IS A SOCIAL NORM, PARTICULARLY AT WEEKENDS OR WHEN THERE ARE MAJOR EVENTS (SPORTING, CONCERTS ETC) WHERE EXCESSIVE DRINKING IS OFTEN EXPECTED BY PEER GROUPS.
IN MORE RECENT YEARS BENEFIT SANCTIONS ARE PLAYING A GREATER PART AS WELL AS HOMELESSNESS.

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

**04.** Are there certain groups of people who are more likely to be affected by drugs and excessive drinking? If so, which groups might they be?

ALTHOUGH THERE DOES NOT APPEAR TO BE A PARTICULAR SOCIAL DEMOGRAPHIC THAT IS AFFECTED MANY OF THOSE THAT ATTEND THE PHOENIX CENTRE ARE UNEMPLOYED. THIS MAY BE DUE TO OPENING TIMES OF SERVICES.

**05.** Does a particular stage of your clients' lives influence their likelihood of taking drugs or drinking excessively? If so, what stage might that be? (i.e. age, relationship breakdown, unemployment etc.)

MANY CLIENTS STARTED TAKING SUBSTANCES RECREATIONALLY BUT THEIR USE GRADUALLY INCREASED UNTIL IT BECAME PROBLEMATIC. CHATASPHROPHIC LIFE EVENTS, (ALTHOUGH IN SOME CIRCUMSTANCES MAY HAVE BEEN THE INITIAL REASON) OFTEN EXACERBATE AN EXISTING SUBSTANCE MISUSE PROBLEM. IT IS ALSO OFTEN A CAUSE FOR RELAPSE.

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

**06.** What barriers exist for your client(s) when trying to access support and services?

WORKING IN THE SOUTH WALES VALLEYS GEOGRAPHY AND TRANSPORT LINKS ARE A MAJOR BARRIER.
ALSO LACK OF HOUSING ( HOSTEL ACCOMODATION.

**07.** What barriers exist for services when trying to access support for client(s)?

HOUSING AND LACK OF HOSTEL PROVISION IN THE CAERPHILLY BOROUGH.
SOME SERVICE USER "FALL THROUGH THE NET" DUE TO HAVING COMPLEX NEEDS WHICH DON'T FIT THE REQUIREMENTS FOR ONE PERSON WITH SOME SERVICES NOT WANTING TO TAKE RESPONSIBILITY
THIS IS USUALLY IF THERE IS A CO EXISTING MENTAL HEALTH/ SUBSTANCE MISUSE ISSUE.
SOMETIMES THE LACK OF A SINGLE CARE COORDINATOR CAN BE A CONCERN.

**08.** What do you consider to be barriers for staff and frontline services in working with your client group(s), or substance misuse generally?

HIGH CASE LOADS.
TRYING TO ENGAGE CLIENTS FROM RURAL AREAS.
LACK OF INFORMATION PARTICULARLY REGARDING NPS's.

**09** Where do you think efforts should be targeted to address the issue of alcohol and substance misuse in Wales?

TOO MANY TO MENTION I WOULD LIKE TO SEE MORE RESIDENTIAL SERVICES / SUPPORTED HOUSING, MORE NEX SERVICES IN RURAL AREAS. OPEN ACCESS / DROP IN PROVISION IN RURAL IN NORTH GWENT. EDUCATION.

**10** In which local authority area do you work? If you work outside of Wales, please write your local authority area below.

CAERPHILLY.

- ☐ Blaenau Gwent
- ☐ Bridgend
- ☑ Caerphilly
- ☐ Cardiff
- ☐ Carmarthenshire
- ☐ Ceredigion
- ☐ Conwy
- ☐ Denbighshire
- ☐ Flintshire
- ☐ Gwynedd
- ☐ Isle of Anglesey
- ☐ Merthyr Tydfil
- ☐ Monmouthshire
- ☐ Neath Port Talbot
- ☐ Newport
- ☐ Pembrokeshire
- ☐ Powys
- ☐ Rhondda Cynon Taf
- ☐ Swansea
- ☐ Torfaen
- ☐ Vale of Glamorgan
- ☐ Wrexham

**If you would like to be kept updated about the progress of the Committee's inquiry into alcohol and substance misuse in Wales, please leave your name and e-mail address below:**

NATHAN DAVID [redacted]

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

# Agenda Item 6

## Health and Social Care Committee

| | |
|---|---|
| Meeting Venue: | **Committee Room 1 – Senedd** |
| Meeting date: | **Wednesday, 21 January 2015** |
| Meeting time: | **09.19 – 10.31** |

This meeting can be viewed on Senedd TV at:
http://senedd.tv/en/2644

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

## Concise Minutes:

| | |
|---|---|
| Assembly Members: | **David Rees AM (Chair)**<br>**Alun Davies AM**<br>**Janet Finch-Saunders AM**<br>**John Griffiths AM**<br>**Elin Jones AM**<br>**Darren Millar AM**<br>**Gwyn R Price AM**<br>**Lindsay Whittle AM**<br>**Kirsty Williams AM** |
| Witnesses: | **Alistair Davey, Welsh Government**<br>**Stephen Gulliford, Welsh Government** |
| Committee Staff: | **Llinos Madeley (Clerk)**<br>**Helen Finlayson (Second Clerk)**<br>**Sian Giddins (Deputy Clerk)**<br>**Gareth Howells (Legal Adviser)**<br>**Amy Clifton (Researcher)**<br>**Philippa Watkins (Researcher)** |

**Transcript**
View the meeting transcript.

## 1 Introductions, apologies and substitutions

1.1 Apologies were received from Lynne Neagle.

## 2 Consultation on future care and support arrangements for Independent Living Fund recipients: factual briefing

2.1 Apologies were received from Gareth Griffiths. Stephen Gulliford acted as substitute.

2.2 Members received a factual briefing from Welsh Government officials on the consultation on future care and support arrangements for Independent Living Fund (ILF) recipients.

2.3 The officials agreed to provide the Committee with:

- case studies demonstrating how the level of care and support currently provided to recipients of the ILF will differ to that provided via direct payments;
- confirmation of whether responsibility for the ILF has been transferred from the UK Government to the Welsh Government by a transfer of function order; and
- clarification of whether legislative competence has been transferred to the National Assembly for Wales to enable the Welsh Government to bring forward any primary or secondary legislation which may be required following the transfer of responsibility for the ILF to the Welsh Government.

## 3 Motion under Standing Order 17.42(vi) to resolve to exclude the public from the remainder of the meeting

3.1 The motion was agreed.

## 4 Consultation on future care and support arrangements for Independent Living Fund recipients: consideration of evidence

4.1 The Committee considered the evidence received.

4.2 The Committee agreed to write to the Minister for Health and Social Services to seek clarification in relation to the arrangements for the transfer of the ILF from the UK Government to the Welsh Government on 1 July 2015.

## 5 Legislative Consent Memorandum: Medical Innovation Bill: consideration of evidence

5.1 The Committee considered the evidence received.

5.2 The Committee considered and agreed the draft report of its consideration of the Legislative Consent Memorandum on the Medical Innovation Bill, subject to minor changes.

## 6 General and financial scrutiny of the Minister for Health and Social Services and the Deputy Minister for Health: preparation for scrutiny session

6.1 The Committee agreed to write to the Ministers to request information in advance of the session on 19 March 2015, and discussed issues Members may wish to raise during the session.

## Health and Social Care Committee

## Alcohol and Substance Misuse Inquiry

## Note of reference group discussions 21 January 2015

The Health and Social Care Committee invited providers and users of alcohol and substance misuse services in Wales to participate in reference groups, arranged in partnership with NewLink Wales. Participants and Committee members divided into two groups, one of which focused on issues relating to children and young people, and the other on issues relating to adults. Members chaired each group, and sought participants' views on a number of themes, as well as any other points that they wished to raise. This note consolidates and summarises the discussions held by each of the groups.

### Children and young people

- **Stakeholders felt strongly that messages on the harmful effects of alcohol and drugs should start early and be given to children in primary and secondary schools**. However there's great difficulty in getting schools to accept they have an issue, for a number of reasons (for example potential backlash from parents or a fear of the school being placed in special measures). Teachers also say the issue is covered in 'Personal and Social Education', but stakeholders say these lessons are by no means enough. Stakeholders agreed that schools could also be too quick to exclude students for alcohol or substance misuse.

- Children are particularly vulnerable as they transition from primary to secondary school; it's a big new complex world and drugs and NPSs are readily available. NPSs are, in some cases, replacing the use of other drugs. Some stakeholders suggested that every school in Wales has an issue to a greater or lesser degree. Stakeholders said that there is variability in the willingness of schools to engage with the issues of alcohol and substance misuse. While some are eager to work with alcohol and substance misuse organisations, others deny that there are issues within their schools.

**Stakeholders felt that there was a need for greater consistency in schools' policies in relation to alcohol and substance misuse education**.

- Stakeholders said that it was important to work with children and young people who were misusing alcohol or substances at a young age before they come into contact with the criminal justice system.

- School children may also be affected by the actions of others or know other people who are affected by alcohol or substance misuse. The issue is therefore wider than just the school environment; the home environment is also important. Stakeholders felt there was a **reluctance among teachers and parents to confront the issues**. This is frustrating because teachers could be a gateway to talking about alcohol and substance misuse.

- **Choosing the correct methods is crucial when trying to communicate messages to school children**. Service providers talked about the importance of engaging with children and young people in relation to alcohol and substance misuse, and of building trust and relationships with them before necessarily talking directly about alcohol or drugs. They said that young people could be more receptive than older people because habits were less engrained.

- Stakeholders agreed that scare tactics don't work but that information provision does. The most important thing is that children are given the tools to make the right decisions. This includes information about harm reduction rather than just telling children not to do it. There's also a need to be creative in communicating messages, the example was given of using a play to get the messages across.

- Stakeholders were concerned that the information given to children and young people is not always consistent, as there are different organisations providing the information which could have different agendas. One service provider referred to the importance of Alcohol Brief Interventions, in which opportunities were taken as they arise to provide signposting information, or brief advice.

- **Stakeholders also said that education and advice needed to be available to children and young people outside of educational settings, to ensure that all young people are able to access advice and information**. One service provider described working with a vulnerable client who was in school before being excluded for substance misuse. The service provided was not available to the young person following their exclusion, with the result that the misuse worsened.

**Further and higher education students**

- **Stakeholders said that there was variation between different colleges and universities about the level of information and advice provided to students about alcohol and substance misuse and the associated harms and behaviours**. There was discussion of the extent of the duty of care that universities have towards students who are over the age of 18. Stakeholders acknowledged that it is more difficult to include alcohol and substance misuse education in college or university curricula than in pre-GCSE education.

- Stakeholders discussed the backlash which universities and student unions can face from students if they introduce initiatives to reduce alcohol consumption or increase pricing. They agreed that while universities may have initiatives in place during Freshers' Weeks, there is a need to have ongoing initiatives and multidisciplinary approaches during the rest of the year as well.

**Service users**

- Some stakeholders felt **service users weren't being listened to as much as they had been previously**, and there were now people in positions who lacked first-hand experience of alcohol or substance misuse. They said the effectiveness of services was suffering as a result. Once comment was: 'Unless you've been through it, you don't know what it's like'. Young people with experience of alcohol and substance misuse said that it could be frustrating if progress was slow and that they did not feel that anything was changing.

- Other stakeholders said there's certainly been a drive to 'professionalise' the sector and qualifications are now more important than they used to be. All agreed that the **input of service users was valuable and definitely shouldn't be lost**. Additionally, many services rely on the goodwill of workers and volunteers.

- Young people with experience of alcohol and substance misuse said that they had found it difficult to access the support they had needed, and that they had not known where to seek help. One had received support from a teacher, but another, who had been excluded from school for substance misuse, had found it difficult to access support.

- Stakeholders said that some service users who were disclosing substance misuse problems when applying for supported housing were being housed, but that the result of zero tolerance policies was that they were being evicted. Different supported housing providers have different policies, which could create confusion for service users. There was a feeling that zero tolerance policies did not reflect the needs of chronic drug users.

**Primary care services**

- Stakeholders were **critical of the role GPs play in recognising alcohol and substance misuse and referring patients to appropriate services**. Some said that GPs give little or no information on alcohol and substance misuse to patients. They also said there's a perception that GPs treat addicts differently and that 'all ailments are blamed on the substance misuse', even though there could be some other underling condition. It was suggested that there is a need for some GPs to specialise in alcohol and substance misuse, which could reduce the need for specialist drug and alcohol services.

- Stakeholders felt that in many cases there is a need to address the reasons for the substance or alcohol misuse, for example, an underlying mental health issue. They also said that there was insufficient information sharing and joint working between GPs and alcohol and substance services, and that this could result in individuals' conditions deteriorating. They suggested

that support services could be provided from GP practices to improve access to support or advice.

- One stakeholder pointed out that GPs do have guidelines to follow on the clinical treatment of drug misuse, 'the Orange Book', and that they have been revised as recently as December 2014. Whether or not they're always adhered to is another matter.

- Stakeholders also said there are a number of **barriers to accessing GPs**. Long waiting times and early morning windows for booking appointments make it difficult for people with chaotic lifestyles or mental health issues to even get to see a GP. Also, the perception that people need to be 'clean' to access certain services puts people off trying to access them.

- Stakeholders highlighted similar experiences in **A&E departments**. They felt stigmatised as addicts and that they were treated differently. Some areas have a specific resource, for example there's an 'alcohol officer' at Prince Charles Hospital, but this isn't a consistent provision across Wales. There's also a single point of contact in Swansea for alcohol and substance misuse referral.

- Some addicts are **self-referring to detoxification services** due to long waiting times and other barriers to primary care.

- Stakeholders also said that limited pharmacy opening times could cause problems for those with methadone prescriptions who had found work. Some clients had had to give up work as they could not otherwise access the pharmacist during opening hours. Conversely, some clients who were in receipt of twice-weekly methadone prescriptions had been found to be selling their methadone.

## Specialist services

- The term '**postcode lottery**' was used a number of times. Stakeholders stressed that service provision across Wales is inconsistent. Rural Wales ('Dyfed' and Powys) was identified as lacking services. Some stakeholders said that service users sometimes had to travel significant distances to

access services, and that consideration needed to be given in budgets to travel costs associated with rural areas.

- Some stakeholders felt there's a need for **specific services for women**. Alcohol and substance misuse can be linked to domestic abuse and some vulnerable women need protection from 'predatory males'.

- There was a call for a **mixture of services to support the family unit**. Users with children need services that allow their children to stay with them. Stakeholders mentioned instances where social services were taking children away from their parents due to a lack of family focused services.

- Stakeholders agreed that **more joint working is needed** between different services. This would allow for 'joint care plans' to support people with complex needs (alcohol and substance misuse combined with mental health problems was given as an example). Rhondda, where statutory and non-statutory services are co-located, was given as a good example of where joint working does take place. Some stakeholders said that the recent consortium approach to tendering and commissioning was resulting in some services being left out, and creating gaps in service provision.

- **One size doesn't fit all; services need to be tailored**. For example community detoxification may not work for some because the same influences are still present in their home community, so relocation may be an option. Home detoxification is only an option for those with a stable home environment.

- Stakeholders said that there could be significant waiting times for specialist services such as counselling. They said that counsellors' lists were frequently populated by clients who were now stable, increasing waiting times for new clients in need of the service. Detoxification waiting times were also raised, with clients in some areas having to wait up to eight weeks for assessment and even longer to be admitted to rehabilitation. The long wait for services could lead to people deteriorating or talking themselves out of wanting or needing help by the time the service was available.

- Service providers said that they faced barriers in accessing detoxification and rehabilitation for their clients, and that provision in Wales was inadequate. There were also concerns about the level of aftercare and support provided following detoxification to help prevent relapse. One young person who had experienced detoxification said that they had received very limited aftercare. Stakeholders agreed that engagement with service users was required before and after treatment.

- Some stakeholders said that the number of detoxification beds in Wales is decreasing. However others said this wasn't the case.

- Service providers said that access to Rapid Access Prescribing needed to be improved to help stabilise people and enable services to work with them to reduce their dosage. They also said that there was need for more account to be taken of individuals using more than one substance.

- Stakeholders said that different individual service providers may have different approaches. An example was given of a service provided by two support workers which had imbalanced caseloads as the children and young people requested to see one of the support workers.

- Stakeholders said that the transition from services for children and young people to those for adults could be difficult. Some service users ceased to engage with services, while others found that the services that they had been engaging with were no longer available to them. Providers of services to children and young people said that they received calls from former clients, now over the age of 18, seeking advice and support. This was also reflected in the experiences of the young service users who participated.

- Stakeholders recognised that services needed to develop and adapt to meet the evolving needs of their communities, and that some service providers could be resistant to the need to change their approach or their services.

## Alcohol

- Stakeholders felt that alcohol consumption is socially acceptable in Wales, and that alcohol is widely available. They said that alcohol misuse is more

prevalent among young people than substance misuse. They said that while children are starting to drink at an earlier age, studies have shown that this generation of young people is drinking less than previous generations of young people, perhaps because of increased health consciousness.

- Some stakeholders were strongly **against introducing a minimum unit price for alcohol**. They said it could have unintended consequences such as pushing some people onto other drugs (ecstasy for example), or glamorising alcohol and making it more desirable. They also felt this would disproportionately affect poorer people who drink moderately. Opinions among other stakeholders varied, with some saying that it **might** be effective.

- Stakeholders felt that the **sale of alcohol should be more restricted**, perhaps more similar to the way in which cigarettes are sold. They mentioned how difficult it was for recovering alcoholics to see alcohol positioned and promoted throughout supermarkets and how easy it was to buy in local corner shops. They also felt that alcohol should not be advertised on television.

- Some stakeholders said that **drinking is so ingrained in our culture** that it's sometimes difficult to persuade young people that consuming alcohol (or other substances) doesn't have to be a prerequisite to having fun. They said messages need to be promoted to young people that 'sober things' can also be fun.

- Some of the **language used around alcohol isn't helpful**. For example 'alcohol unit' isn't a measurement readily understood by the public.

- Stakeholders noted that a successful initiative among university students had been highlighting the **calorie content** of alcoholic drinks, as young people may be more concerned about putting on weight than causing long-term health damage. There was a suggestion that **nutritional information** should be included on the labels of alcoholic drinks.

- Stakeholders raised the importance of multidisciplinary approaches to addressing alcohol related issues in particular localities, for example the Night Time Economy Group in Aberystwyth, consisting of organisations including police, local authority, students union and ambulance services.

## Other comments

- All stakeholders had concerns over the **continuity of funding for services**. Much of the funding they receive, be it from the Welsh Government or charities like Comic Relief or the Big Lottery Fund, is usually short term. As a result they're often 'budgeting blind'. One stakeholder said that Supporting People Programme funding is crucial to the services that he provides.

- Need to target **hard-to-reach groups** such as the LGBT community, the Gypsy and Traveller community and refugees/asylum seekers.

- **Methadone** users need an exit plan. They're in danger of becoming 'forgotten people', locked into using methadone for many years.

- Stakeholders said that if sent to prison, people with alcohol misuse issues could develop opiate issues while in prison.

- Some stakeholders referred to the over-prescription of drugs such as Valium, which were then being sold on and misused. One participant suggested that patients who were being prescribed Valium on a long-term basis should undergo periodic drug tests to identify whether they were using their prescribed doses.

- Stakeholders agreed that boredom could be a key factor in alcohol and substance misuse, and that there was a need to work jointly with leisure services to help people to access sports facilities or other pastimes. They agreed people needed to change their environments when they were recovering from alcohol or substance misuse, and that housing was an important element to this.

- Some stakeholders raised the need to address the harms associated with alcohol and substance misuse, such as sexually transmitted diseases, or diseases transmitted through sharing needles. One participant suggested that mandatory sexual health education sessions could be linked to the prescription of methadone.

# Health and Social Care Committee
# Inquiry into alcohol and substance misuse

## Summary of alcohol and substance misuse inquiry survey

## Background

This document provides a summary of responses received to the alcohol and substance misuse inquiry survey conducted by the Outreach team.

This survey was open for consultation and responses between 17 November and 09 January 2015.

## Methodology

As part of the Health and Social Care Committee Inquiry into alcohol and substance misuse the Outreach Team conducted a survey in both online and paper-based formats.

Two surveys were produced for the purposes of the inquiry. One survey was created with the aim of targeting the general public as a whole. Participants were asked a range of questions on the effect that alcohol and substance misuse has on people in their local area, their attitudes towards alcohol and substance misuse and whether the right local services are in place to help people. The results of this survey can be found on pages 2 – 30.

The second survey aimed to target professionals who work directly or indirectly with clients who misuse alcohol and substances. In this instance, participants were asked a range of questions relating to factors that affect their clients when alcohol or substance reliant and the level of support available to both clients and professionals when making referrals for services. The results of this survey can be found on pages 31 – 44.

## Awareness Raising

In order to promote awareness of the survey and attract participants the Outreach Team contacted a broad-range of organisations. Those contacted were able to raise awareness using a range of methods including – placing articles on websites; signposting on social media including Facebook and twitter; and emailing participants directly.

The surveys were also promoted by Assembly staff with relevant groups visiting the Senedd and receiving education visits, and during the Assembly's presence at summer shows.

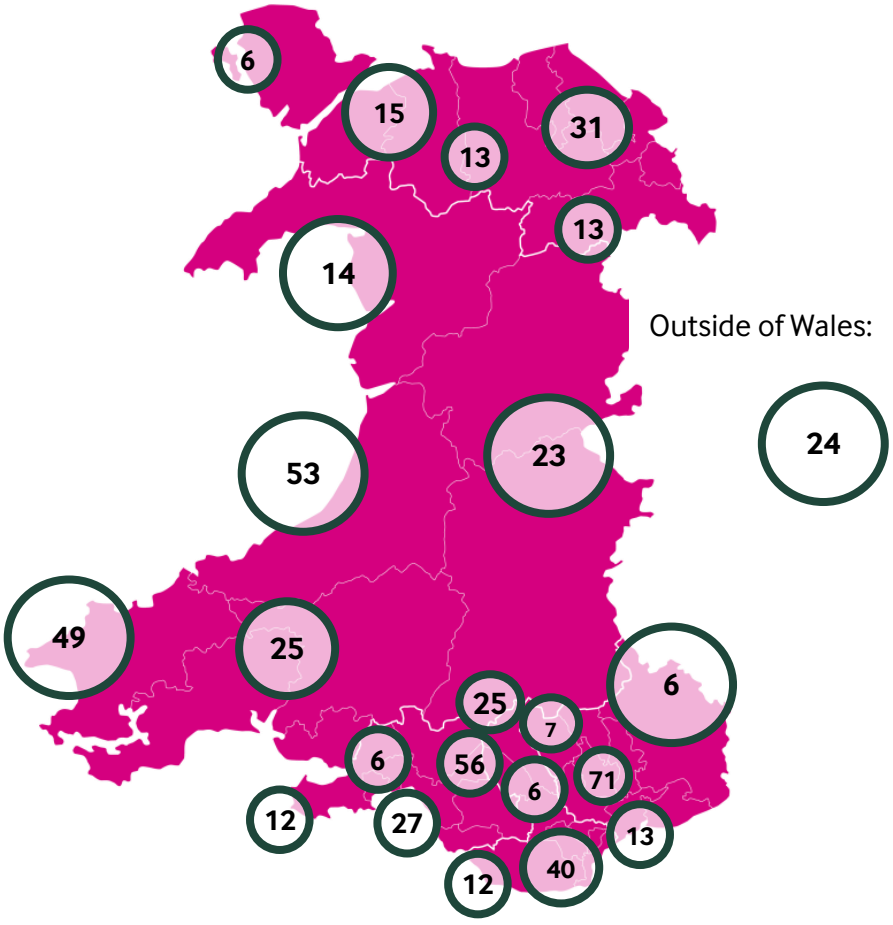
# Survey analysis
# General public

## Key Statistics

**607** Total number of survey responses received

## Geographical Summary of Responses

**Number of survey responses broken down by local authority area**




Blaenau Gwent: 25
Bridgend: 27
Caerphilly: 71
Cardiff: 40
Carmarthenshire: 25
Ceredigion: 53
Conwy: 15
Denbighshire: 13
Flintshire: 13
Gwynedd: 14
Isle of Anglesey: 6
Merthyr Tydfil: 12
Monmouthshire: 6
Neath Port Talbot: 6
Newport: 13
Pembrokeshire: 49
Powys: 23
Rhondda Cynon Taf: 56
Swansea: 12
Torfaen: 7
Vale of Glamorgan: 12
Wrexham: 31

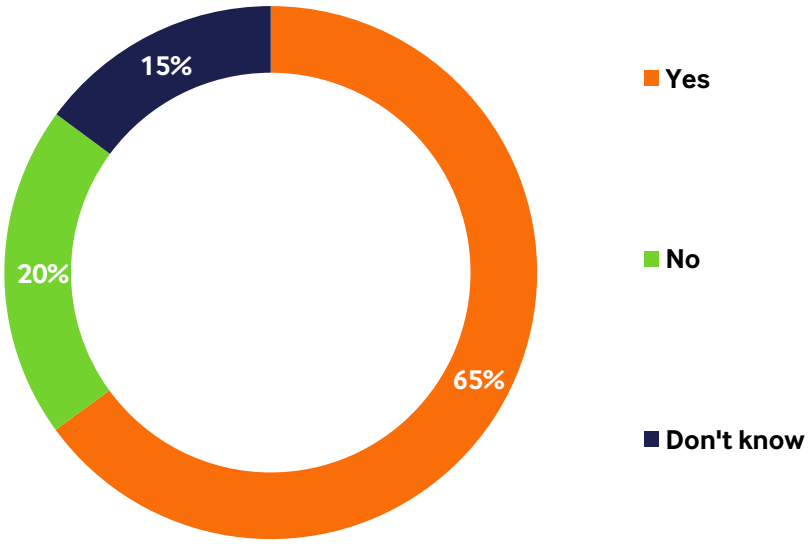
## Summary of responses

**Question one – "Excessive drinking" means drinking regularly above the recommended daily guidelines. These guidelines are different for men and women and are based on the units of alcohol consumed: one unit of alcohol is equivalent to consuming 10ml of pure alcohol. According to these guidelines, men should not regularly exceed 3 – 4 units of alcohol per day (which is equivalent to a large 250ml glass of wine), and women should not regularly exceed 2 – 3 units of alcohol per day (which is equivalent to a pint of cider).**

**In your opinion, do you think a problem exists around young people excessively drinking in your area?**

*Total number of responses: 605*

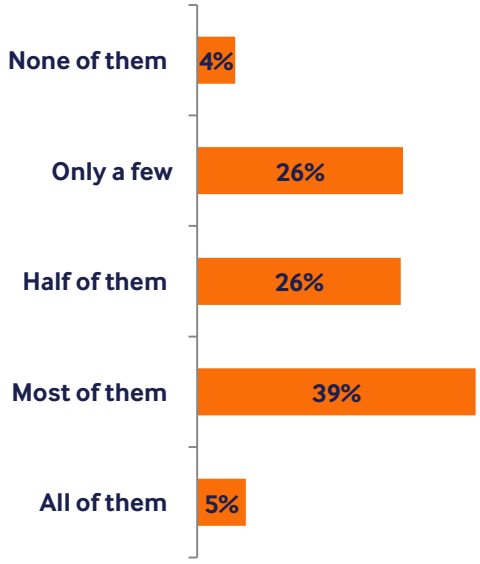
- Yes: **64.95% (393)**
- No: **20.16% (122)**
- Don't know: **14.87% (90)**



**Question two – Thinking of people your own age, how many of them do you think drink alcohol excessively?**

*Total number of responses: 601*

- All of them: **5.15% (31)**
- Most of them: **38.93% (234)**
- Half of them: **25.79% (155)**
- Only a few: **26.12% (157)**
- None of them: **3.99% (24)**



## Breakdown by demographic

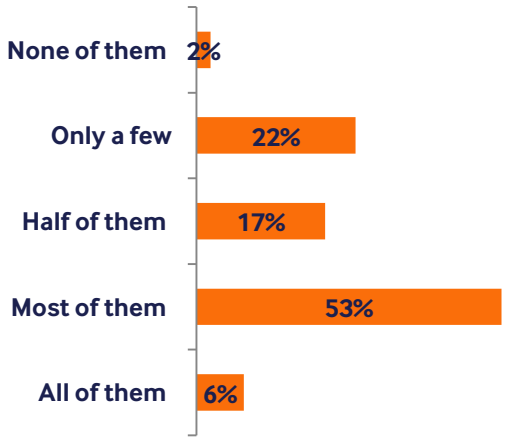
This section of the survey provides a short breakdown of the answers to question two by respondents' stated demographic.

Question two – Thinking of people your own age, how many of them do you think drink alcohol excessively?

### 16 and under

*Total number of responses: 122*

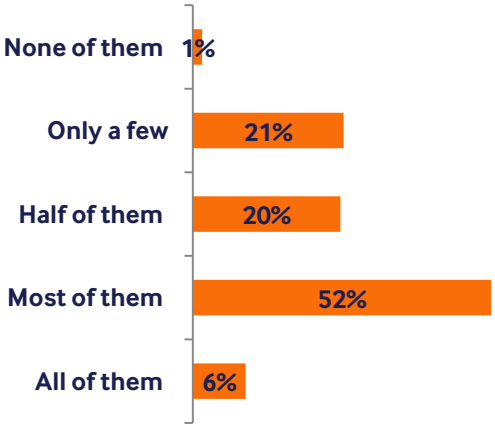
- All of them: **5.73% (7)**
- Half of them: **17.21% (21)**
- None of them: **1.63% (2)**
- Most of them: **53.27% (65)**
- Only a few: **22.13% (27)**



17 – 24

*Total number of responses: 188*

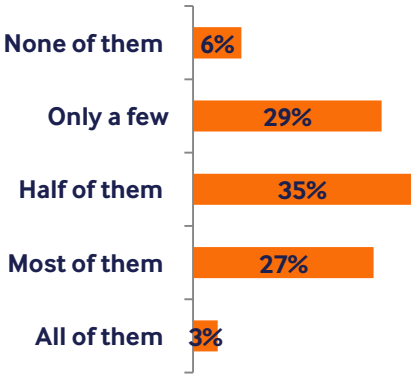
- All of them: **6.38% (12)**
- Half of them: **20.21% (38)**
- None of them: **1.06% (2)**
- Most of them: **51.59% (97)**
- Only a few: **20.74% (39)**




25 – 34

*Total number of responses: 66*

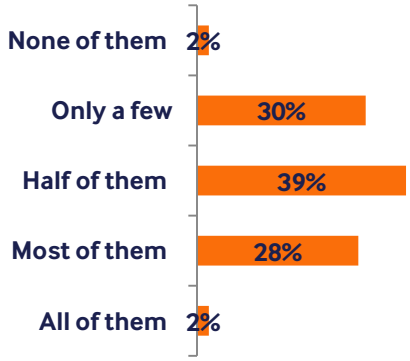
- All of them: **3.03% (2)**
- Half of them: **34.84% (23)**
- None of them: **6.06% (4)**
- Most of them: **27.27% (18)**
- Only a few: **28.78% (19)**



35 – 44

*Total number of responses: 61*

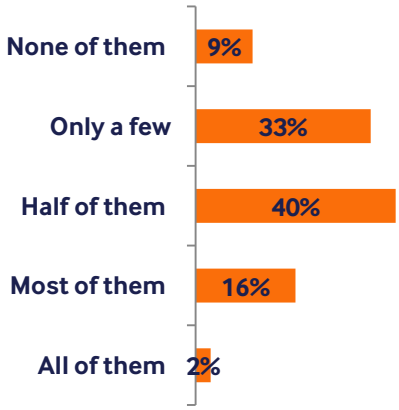
- All of them: **1.63% (1)**
- Half of them: **39.34% (24)**
- None of them: **1.63% (1)**
- Most of them: **27.86% (17)**
- Only a few: **29.50% (18)**




45 – 59

*Total number of responses: 91*

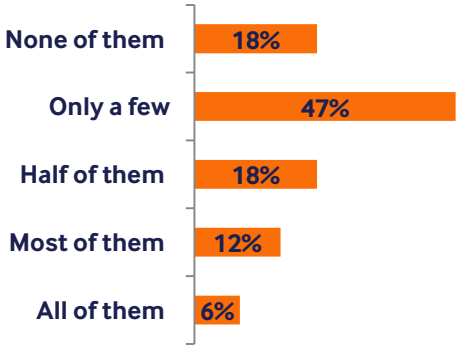
- All of them: **2.19% (2)**
- Half of them: **39.56% (36)**
- None of them: **8.79% (8)**
- Most of them: **16.48% (15)**
- Only a few: **32.96% (30)**



60 – 64

*Total number of responses: 17*

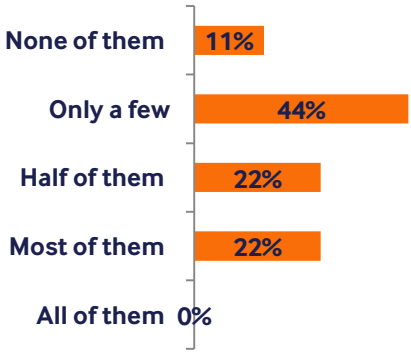
- All of them: **5.88% (1)**
- Half of them: **17.64% (3)**
- None of them: **17.64% (3)**
- Most of them: **11.76% (2)**
- Only a few: **47.05% (8)**




65 or over

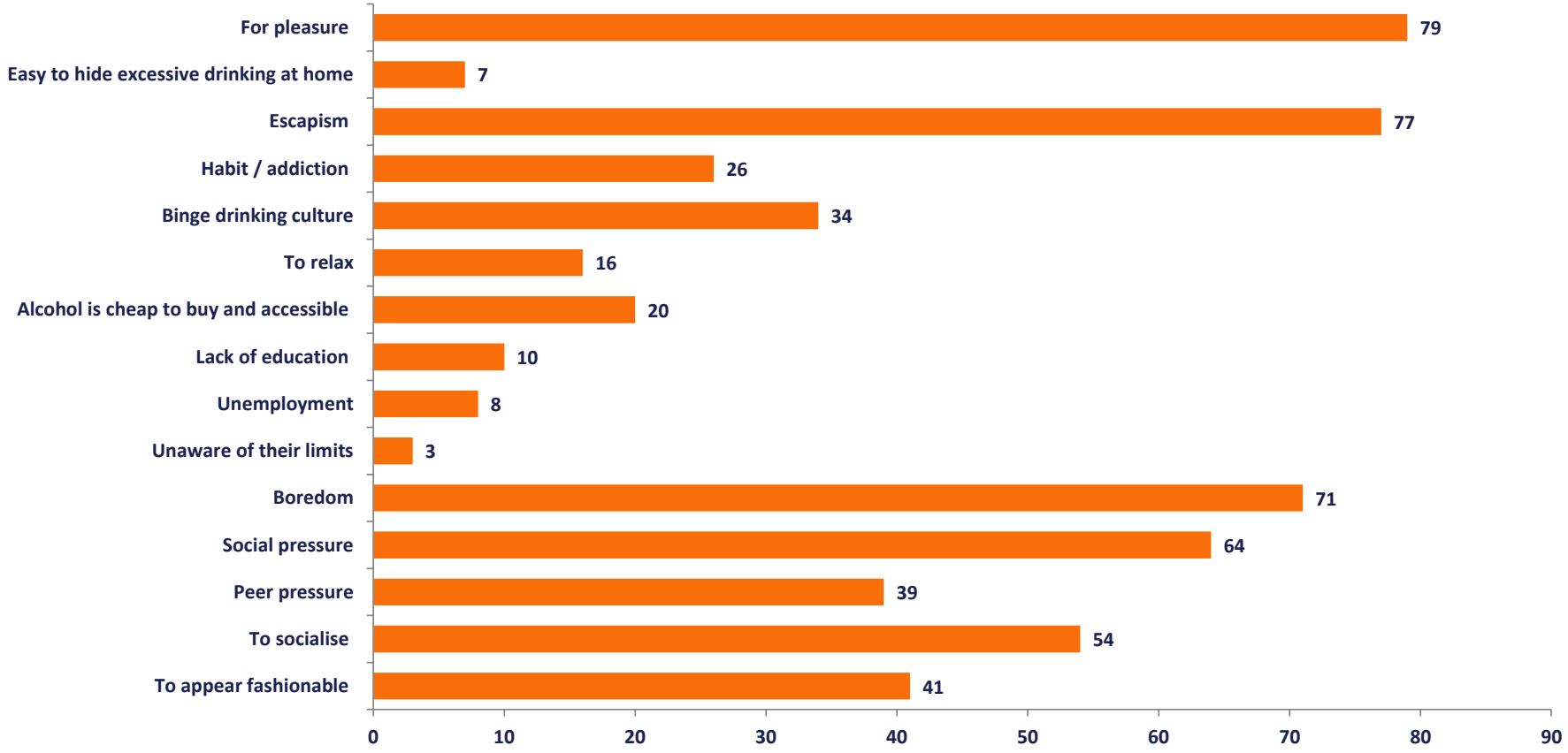
*Total number of responses: 9*

- All of them: **0.00% (0)**
- Half of them: **22.22% (2)**
- None of them: **11.11% (1)**
- Most of them: **22.22% (2)**
- Only a few: **44.44% (4)**



**Question three – Why do you think they drink excessively?**

*Total number of responses: 549*



**Comments**

- 79 respondents explained that many people drink excessively for pleasure and their own enjoyment;

- 77 individuals stated that for many, excessive drinking provides escapism from their reality. This would include their social circumstance, work pressure or ill-health (both physical and mental);

- 71 people argued that boredom can give rise to excessive drinking;

- 64 respondents explained how social pressures can influence and/or promote excessive drinking. It was felt that alcohol has become intrinsic to socialising in Welsh/British culture and it is this social pressure that can compel many to drink excessively. Many respondents elaborated on how the majority of their social engagements involve "going to the pub";

- 54 individuals stated that excessive drinking takes place in order to socialise, and be comfortable in socialising;

- 41 people argued that many who do drink excessively do so in order to appear fashionable or "cool". Many highlighted the glamorisation of both alcohol and substance in the media, in addition to soaps on television that centre their fictitious communities around the local pub;

- Alternatively, 39 respondents explained that peer pressure leads to excessive drinking, and the desire to "fit in" can overwhelm many, particularly when starting University;

- 34 individuals stated that it is socially acceptable to drink excessively due to the "binge-drinking culture". Cheap drinks and promotions by supermarkets, pubs and clubs actively encourage people to drink;

- 26 people felt that it is the addiction to alcohol, and the habit of drinking that compel individuals to excessively consume alcohol;

- 20 respondents argued that alcohol is very cheap to buy and more accessible now than ever, particularly with 24 hour licensing and deals in supermarkets (some of which are also accessible 24 hours a day);

- 16 people stated that many people drink in order to relax;

- 10 individuals felt that it was a lack of knowledge and education on the harmful effects of excessive alcohol consumption that affected people's drinking habits;

- Eight respondents explained how unemployment, redundancy or lack of job opportunities can encourage people to drink excessively;

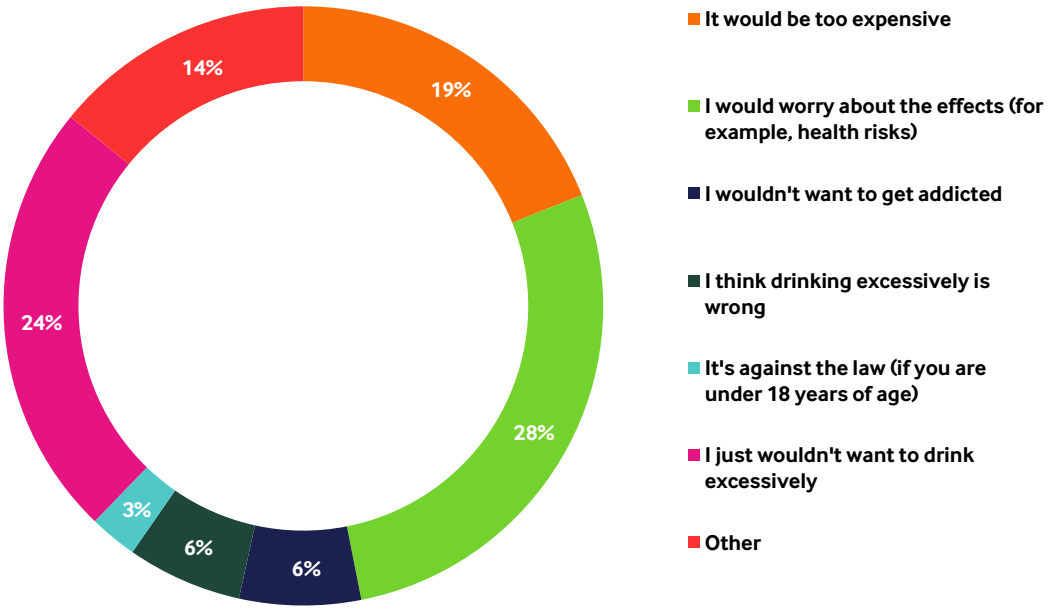
- Seven people argued that excessive drinking can take place and easily hidden at home, as opposed to a pub or club;

- Three individuals stated that many people drink excessively because they are unaware of their limits, and do not understand the Government's recommended guidelines.

**Question four – What would be the main reason for you to not drink excessively?**

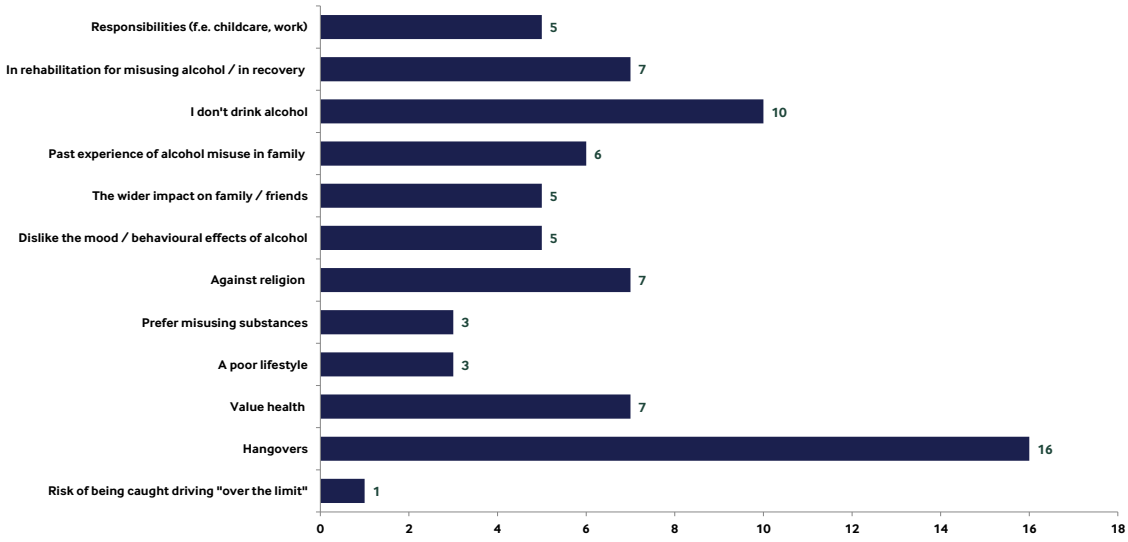
*Total number of responses: 569*

- It would be too expensive: **19.33% (110)**
- I would worry about the effects (for example, health risks): **28.47% (162)**
- I wouldn't want to get addicted: **6.67% (38)**
- I think drinking excessively is wrong: **6.32% (36)**
- It's against the law (if you are under 18 years of age): **2.63% (15)**
- I just wouldn't want to drink excessively: **24.07% (137)**
- Other: **14.41% (82)**



### Question four - Comments

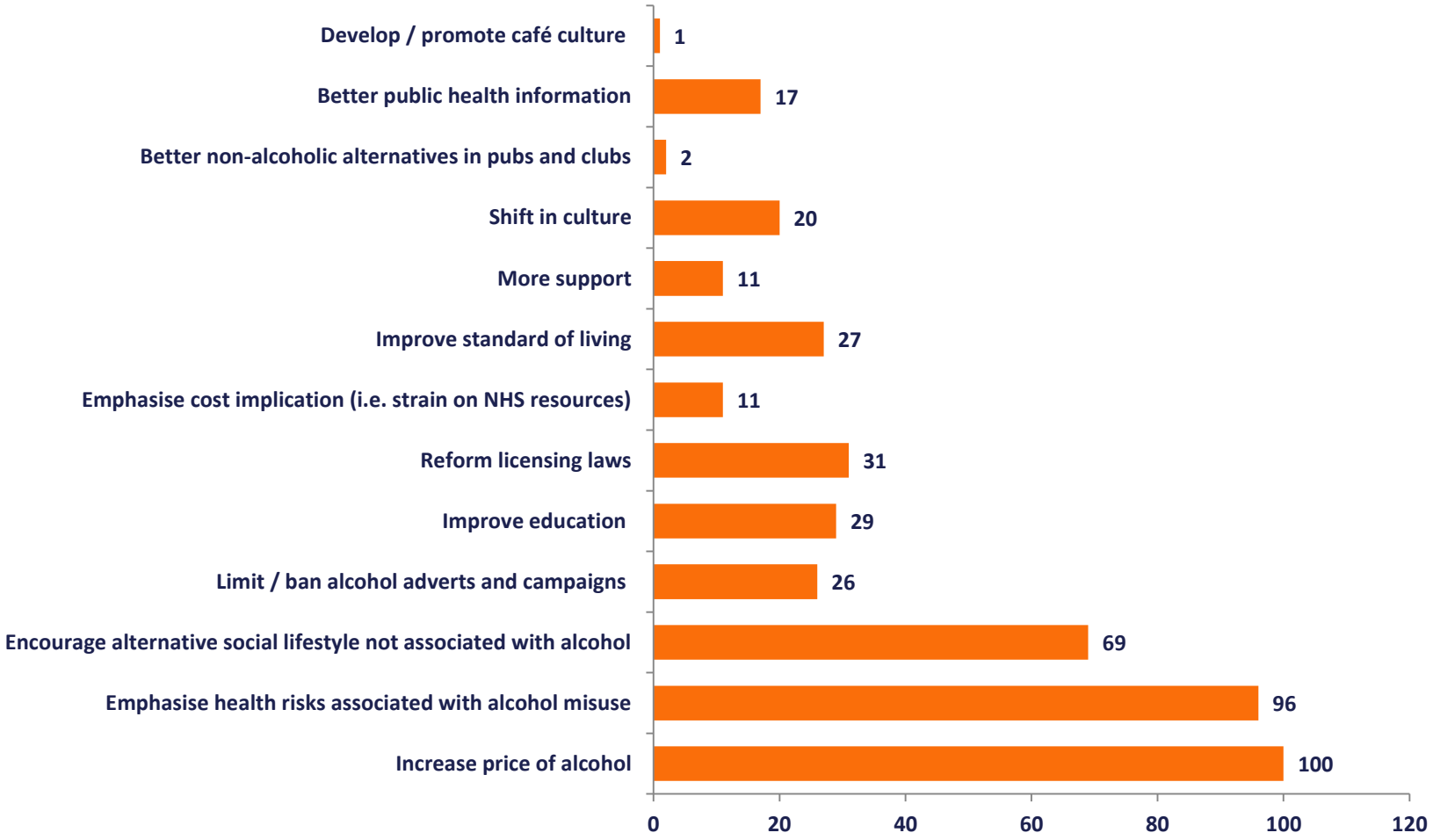
*Total number of comments: 75*




- 16 respondents stated that hangovers were the main reason for them not to drink excessively;
- 10 people said that they didn't drink alcohol at all;
- Seven individuals argued that they wouldn't drink excessively as they value their physical and mental health above all else;
- Seven respondents stated that it is against their religion to drink alcohol;
- Seven people said that they are in rehabilitation or in recovery for alcohol misuse, and would not drink excessively;
- Six individuals argued that their past experiences of alcohol misuse in their families / social circles have stopped them wanting to misuse alcohol;
- Five respondents stated that their responsibilities (childcare or work commitments for example) would disuade them from drinking excessively;
- Five people said that they would be concerned about the wider impact exessive drinking would have on their family and friends;
- Five individuals stated that they dislike the effects excessive alcohol consumption has on their mood and behaviour;
- Three respondents argued that they prefer misusing substances over alcohol;
- Three people dislike the poor lifestyle associated with alcohol misuse and excessive alcohol consumption;
- One individual explained that they wouldn't drink excessively because of the risk of being caught driving over the limit the next day.

**Question five – What could encourage people to stop drinking too much?**

*Total number of comments: 440*



**Comments**

- 100 respondents stated that increasing the minimum pricing of alcohol would encourage people to stop drinking too much;

- 96 individuals felt that there should be a greater emphasis on the health risks associated with alcohol misuse;

- 69 people argued that an alternative social lifestyle should be encouraged amongst the public that is not associated with alcohol;

- 31 respondents stated that there should be reform to licensing laws;

- 29 individuals felt that education on the harms of alcohol misuse should be improved;

- 27 people argued that an improvement in the standards of living (poverty, employment opportunities etc.) would encourage people to stop drinking too much;

- 26 individuals felt that there should be a limit or a ban on alcohol advertisements and "cheap special offers";

- 20 people argued for a shift in culture away from "binge-drinking";

- 17 respondents stated that should be better public health information on the harms of alcohol misuse;

- 11 individuals felt that more support should be given to those who are misusing alcohol, or at risk of being alcohol dependent;

- 11 people argued that the cost / resource implications for public health services and the NHS of those who require treatment due to alcohol misuse should be published;

- Two respondents stated that there should be better non-alcoholic alternatives to drink in pubs and clubs;

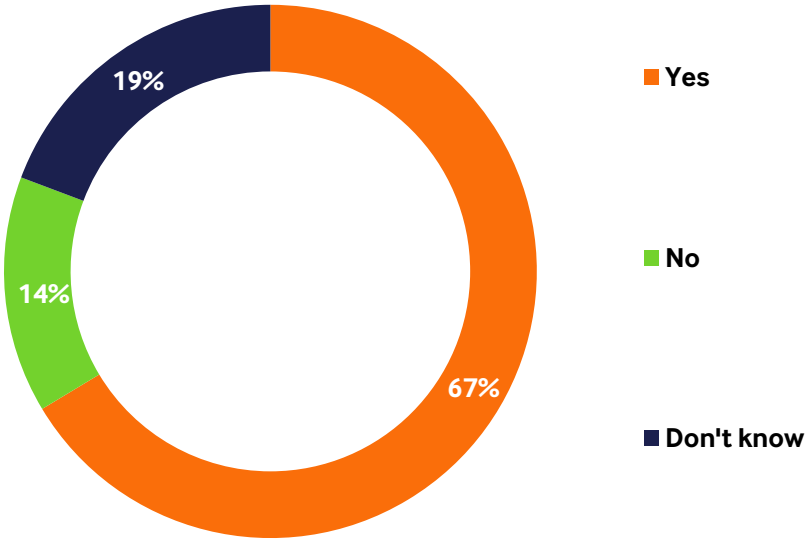
- One individual felt that more could be done to develop a café culture in society.

**Question six – "Substance misuse" means the excessive consumption and/or dependence on psychoactive substances – or drugs. This includes substances like cannabis, cocaine, heroin and prescription drugs, as well as new psychoactive substances – or legal highs.**

**In your opinion, do you think a problem exists around young people taking drugs in your area?**

*Total number of responses: 571*

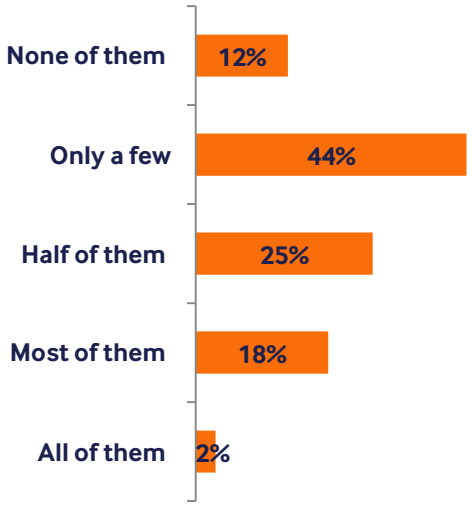
- Yes: **66.37% (379)**
- No: **14.35% (82)**
- Don't know: **19.26% (110)**



**Question seven – Thinking of people your own age, how many of them do you think take drugs?**

*Total number of responses: 571*

- All of them: **2.27% (13)**
- Most of them: **17.51% (100)**
- Half of them: **24.86% (142)**
- Only a few: **43.78% (250)**
- None of them: **11.55% (66)**



# Breakdown by demographic

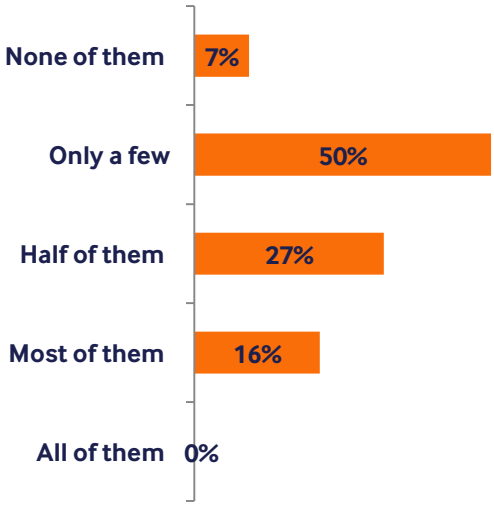
This section of the survey provides a short breakdown of the answers to question seven by respondents' stated demographic.

Question seven– Thinking of people your own age, how many of them do you think take drugs?

## 16 and under

*Total number of responses: 122*

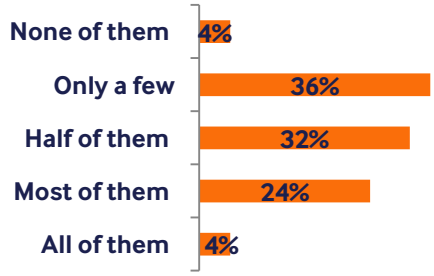
- All of them: **0.00% (0)**
- Half of them: **27.04% (33)**
- None of them: **6.55% (8)**
- Most of them: **16.39% (20)**
- Only a few: **50% (61)**



17 – 24

*Total number of responses: 188*

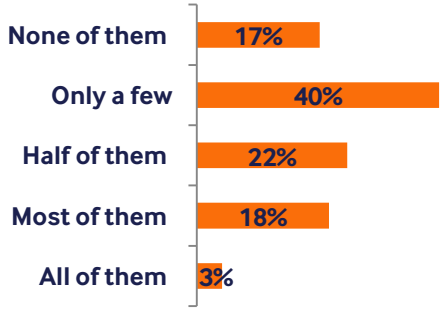
- All of them: **3.72% (7)**
- Half of them: **31.91% (60)**
- None of them: **3.72% (7)**
- Most of them: **24.46% (46)**
- Only a few: **36.17% (68)**




25 - 34

*Total number of responses: 65*

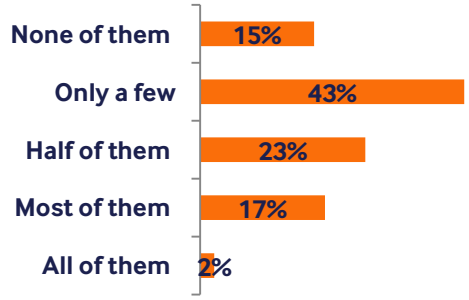
- All of them: **3.07% (2)**
- Half of them: **21.53% (14)**
- None of them: **16.92% (11)**
- Most of them: **18.46% (12)**
- Only a few: **40.00% (26)**



35 - 44

*Total number of responses: 60*

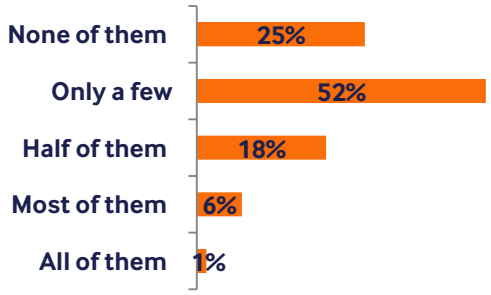
- All of them: **1.66% (1)**
- Half of them: **23.33% (14)**
- None of them: **15% (9)**
- Most of them: **16.66% (10)**
- Only a few: **43.33% (26)**




45 – 59

*Total number of responses: 89*

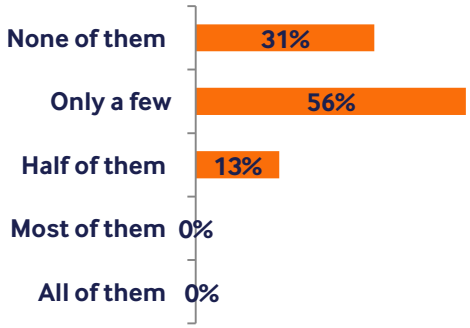
- All of them: **1.12% (1)**
- Half of them: **17.97% (15)**
- None of them: **24.71% (22)**
- Most of them: **5.16% (5)**
- Only a few: **51.68% (46)**



## 60 – 64

*Total number of responses: 16*

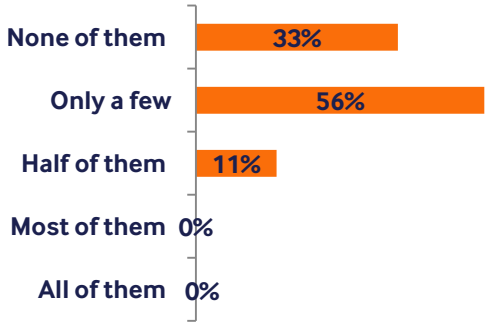
- All of them: **0.00% (0)**
- Half of them: **12.5% (2)**
- None of them: **31.25% (5)**
- Most of them: **0.00%**
- Only a few: **56.25% (9)**




## 65 or over

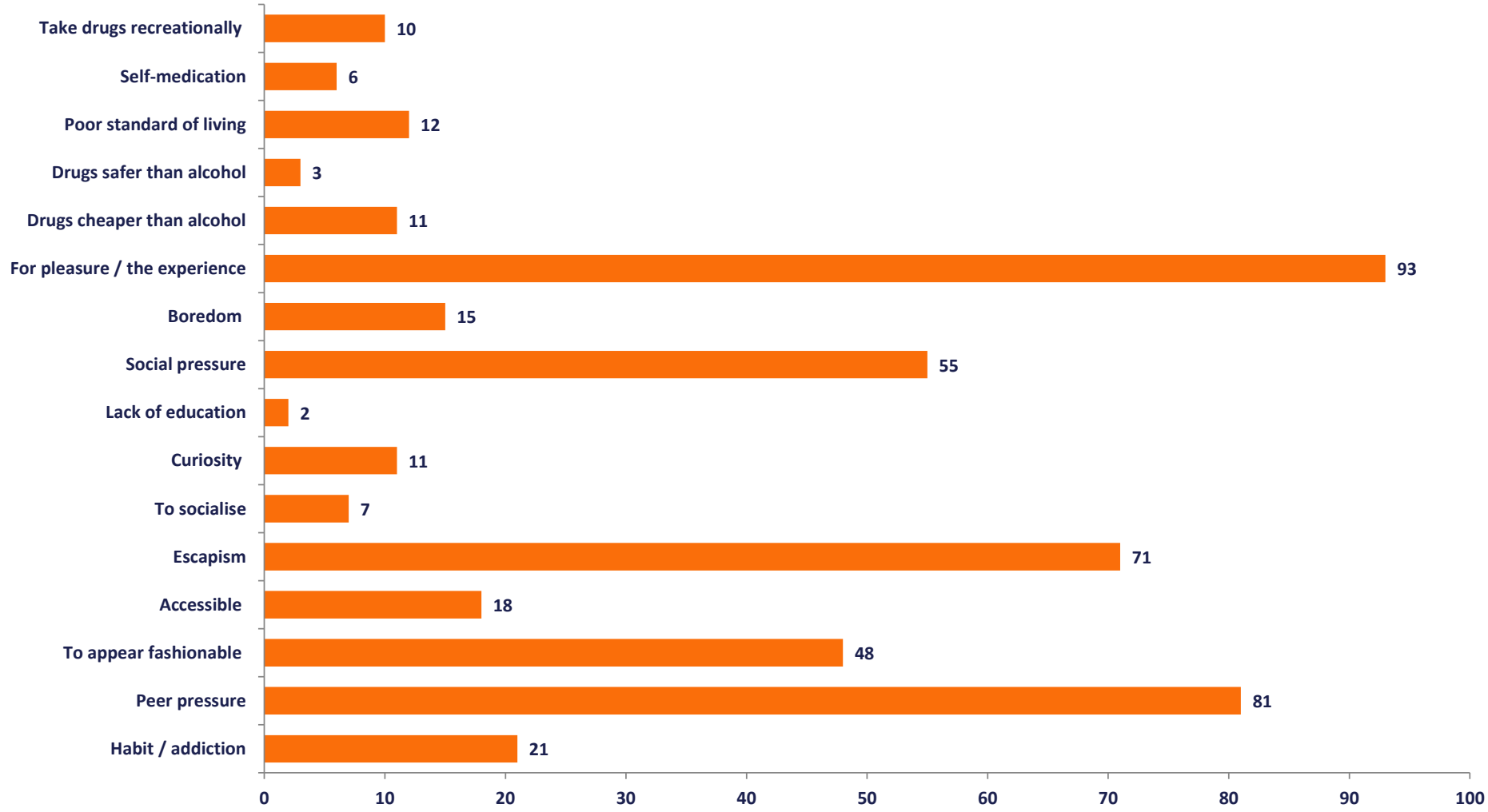
*Total number of responses: 9*

- All of them: **0.00% (0)**
- Half of them: **11.11% (1)**
- None of them: **33.33% (3)**
- Most of them: **0.00%**
- Only a few: **55.55% (5)**



## Question eight – Why do you think they take drugs?

*Total number of responses: 464*



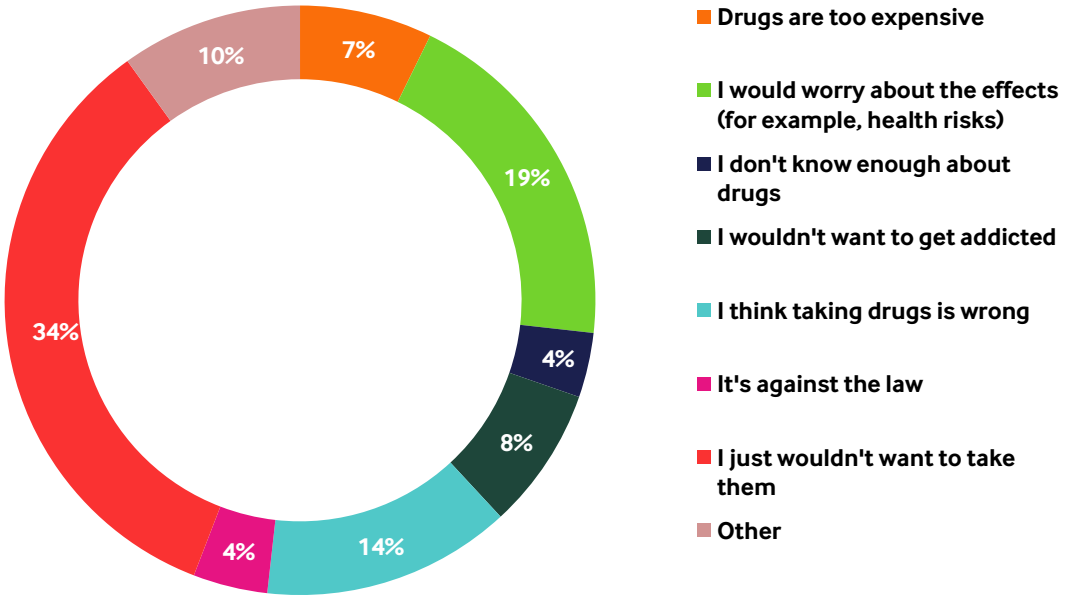
**Comments**

- 93 respondents stated that many people take drugs for pleasure and the experience of "getting high";
- 81 individuals argued that pressure from peers influence drug taking;
- 71 people felt that escapism (from reality, personal problems etc.) is the main reason for misusing substances;
- 55 respondents stated that many people, under social pressure, misuse substances. As with alcohol consumption, drug taking is glamourized by the media and is now perceived as a "social norm" by some demographics;
- 48 individuals argued that many people take drugs to appear fashionable or "cool". As mentioned above, many individuals misuse substances in their social circles in order to "fit in";
- 21 people felt that the addiction itself to substances makes people take, and continue to take, drugs;
- 18 respondents stated that drugs are very accessible in their communities, which may explain why some individuals take them;
- 15 individuals argued that boredom influences people's decision to take drugs;
- 12 people felt that an individual's poor standard of living (for example, unemployment, poverty etc.) can encourage some to take substances;
- 11 respondents stated that curiosity is the main reason for taking drugs;
- 11 individuals argued that in some areas, drugs are cheaper to buy than alcohol;
- 10 people felt that some individuals take drugs for recreational purposes;
- Seven respondents stated that many people take drugs in order to socialise;
- Six individuals argued that many people take drugs in order to self-medicate;
- Three people felt that misusing substances is safer than alcohol;
- Two respondents stated that a lack of education on the dangers of substance misuse contributes to drug use.

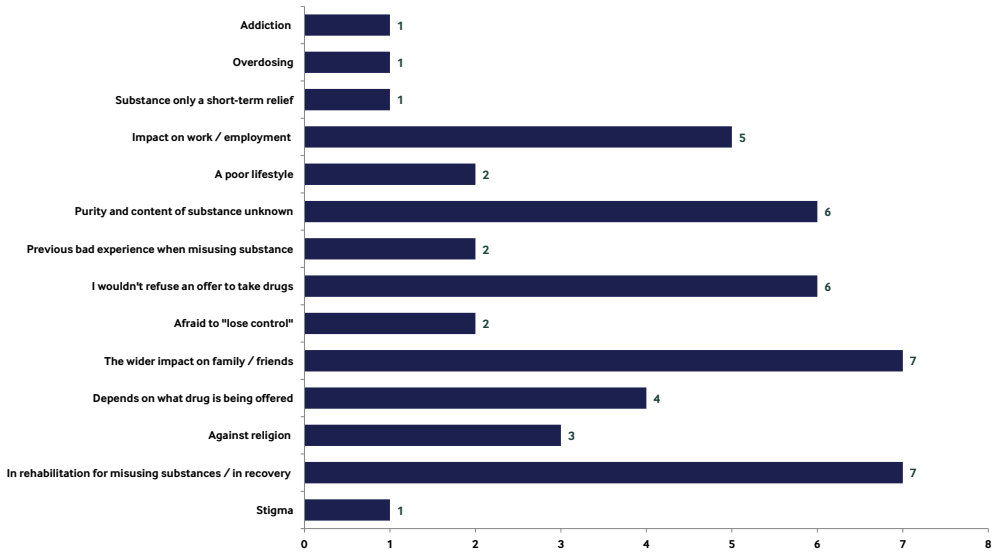
**Question nine – What would be the main reason for you to refuse an offer to take drugs?**

*Total number of responses: 564*

- Drugs are too expensive: **7.26% (41)**
- I would worry about the effects (for example, health risks): **19.50% (110)**
- I don't know enough about drugs: **3.54% (20)**
- I wouldn't want to get addicted: **7.80% (44)**
- I think taking drugs is wrong: **13.65% (77)**
- It's against the law: **4.07% (23)**
- I just wouldn't want to take them: **34.21% (193)**
- Other: **9.92% (56)**



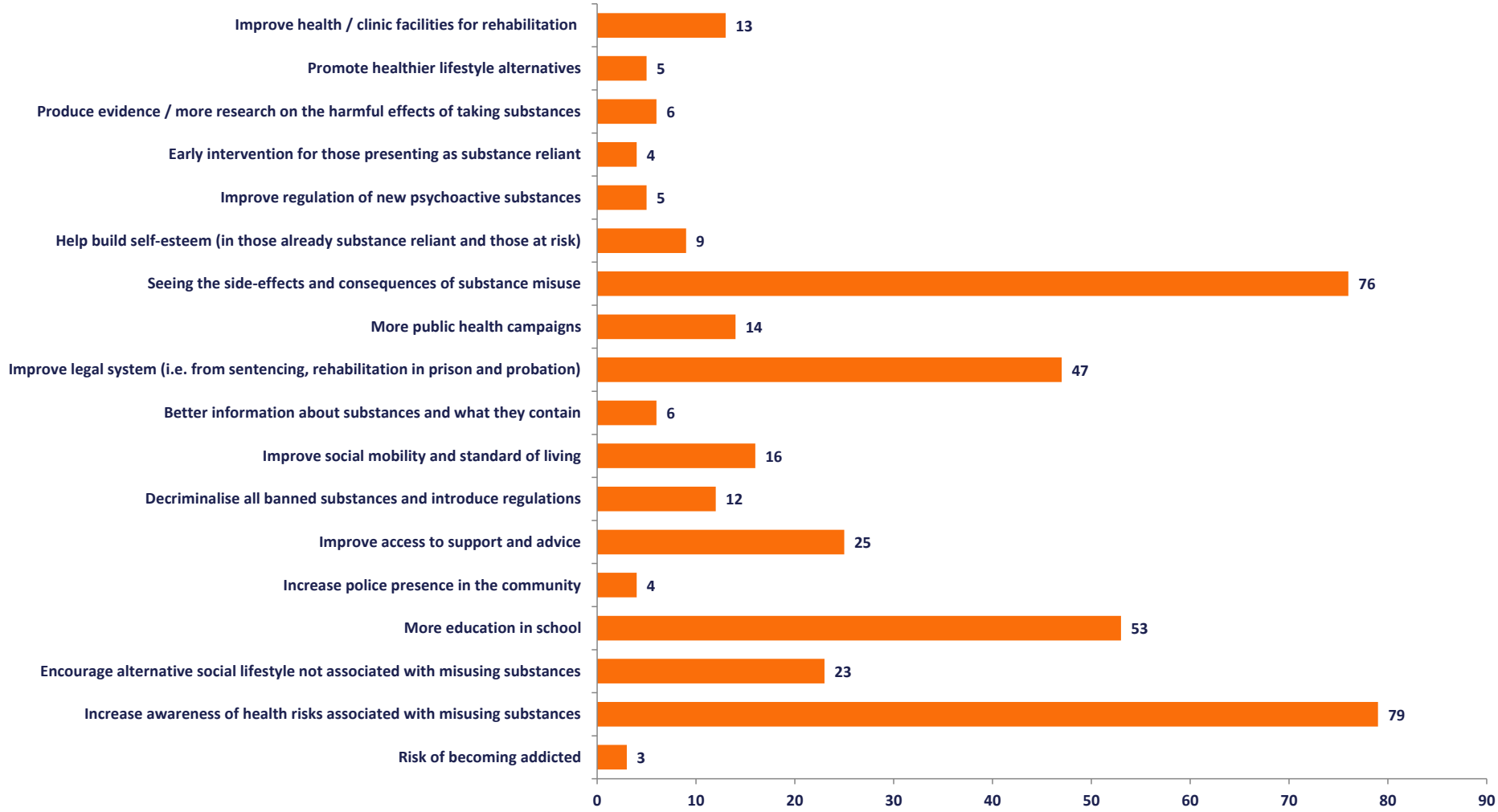
## Comments




- Seven respondents would refuse an offer of drugs as they are in rehabilitation for misusing substances or in recovery;
- Seven individuals expressed concerns of misusing substances and the wider impact it would have on their family and friends;
- Six people would not refuse an offer of drugs;
- Six respondents would question the purity and content of a substance that they were offered;
- Five individuals would refuse an offer because it would have a direct impact on their ability to work;
- Four respondents would refuse an offer / accept an offer depending on what substance it is;
- Three people would refuse an offer because it is against their religion;
- Two individuals would be too afraid to "lose control";
- Two respondents would refuse an offer having previously experienced a "bad high" with a substance;
- Two people disagree with the poor lifestyle associated with misusing substances;
- One individual would be concerned about the stigma surrounding taking substances;
- One individual stated that the escapism proffered by taking a substance is only temporary, and would be the main reason why they would refuse;
- One respondent would refuse for fear of overdosing;
- One person would refuse for fear of becoming addicted.

## Question 10 – What could encourage people to stop taking drugs?

## Total number of responses: 400



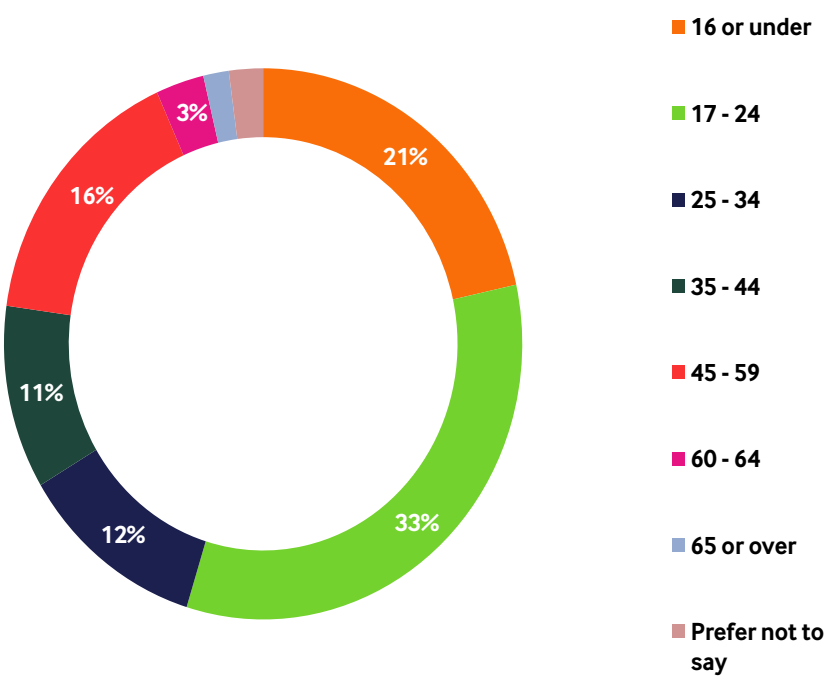
## Comments

- 76 respondents felt that there should be an increased awareness of the health risks associated with misusing substances;
- 76 individuals argued that seeing the hard-hitting side-effects and consequences of substance misuse would deter people from taking drugs;
- 53 people stated that there should be more education in schools and colleges. This education should be frank and unbiased, and a true reflection of the consequences of substance addiction;
- 47 respondents felt that the legal system should be reformed. This includes reforming sentencing guidelines on prison terms for taking substances (in addition to dealing); rehabilitation in prisons for those substance reliant and monitoring substance misuse whilst on probation;
- 25 individuals argued that more support and advice should be given to those who are / are at risk of becoming substance reliant;
- 23 people stated, as with alcohol, more could be done to encourage an alternative social lifestyle not associated with misusing substances. More youth clubs, groups and cafés were cited as examples;
- 16 respondents felt that an improvement in social mobility and standard of living would encourage people to stop taking substances, or discourage them on the whole;
- 14 individuals argued for better public health campaigns;
- 13 people stated that there should be improved facilities available for detox and rehabilitation;
- 12 respondents felt that substances should be decriminalised and regulations introduced;
- Nine individuals argued for greater support for those who are substance reliant / at risk of becoming substance reliant to build their self-esteem;
- Six people stated that more information should be made available on what the current dangerous substances are;
- Six respondents felt that more "honest" research could be done, that outlines the content of substances available and what risk they in fact pose to health;
- Five individuals argued for the promotion of alternative healthy lifestyles (for example, a "drug-free diet" without caffeine, sugar etc.)
- Five people request an improvement in the regulation of new psychoactive substances (or "legal highs");
- Four respondents felt that intervention should happen much earlier for those individuals who have identified themselves as substance reliant;
- Four individuals argued for increased police presence in the community;
- Three people argued that more could be done to raise awareness of the risks associated with misusing substances, namely addiction.

**Question 11 – What is your age?**

*Total number of responses: 566*

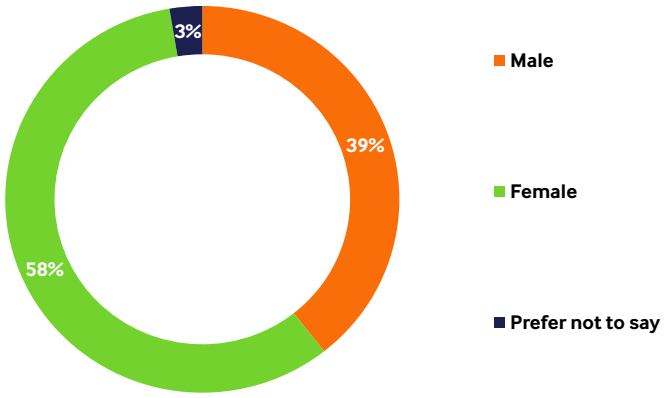
- 16 or under: **21.5% (122)**
- 17 – 24: **33.21% (188)**
- 25 – 34: **11.66% (66)**
- 35 – 44: **10.77 (61)**
- 45 – 59: **16.08% (91)**
- 60 – 64: **3.00%(17)**
- 65 or over: **1.59% (9)**
- Prefer not to say: **2.12% (12)**



**Question 12 – What is your gender?**

*Total number of responses: 561*

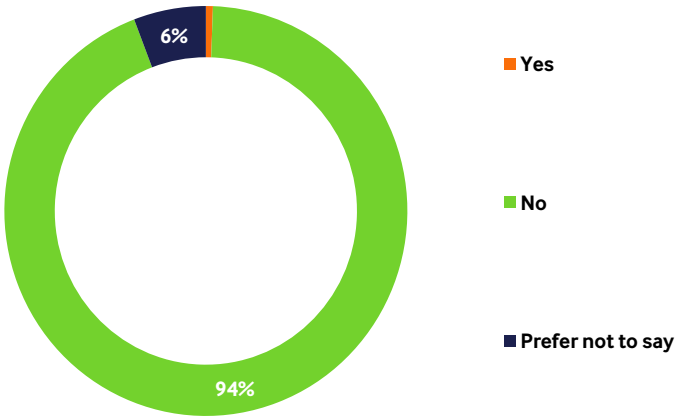
- Male: **39.39% (221)**
- Female: **57.93% (325)**
- Prefer not to say: **2.67% (15)**




**Do you identify as transgender?**

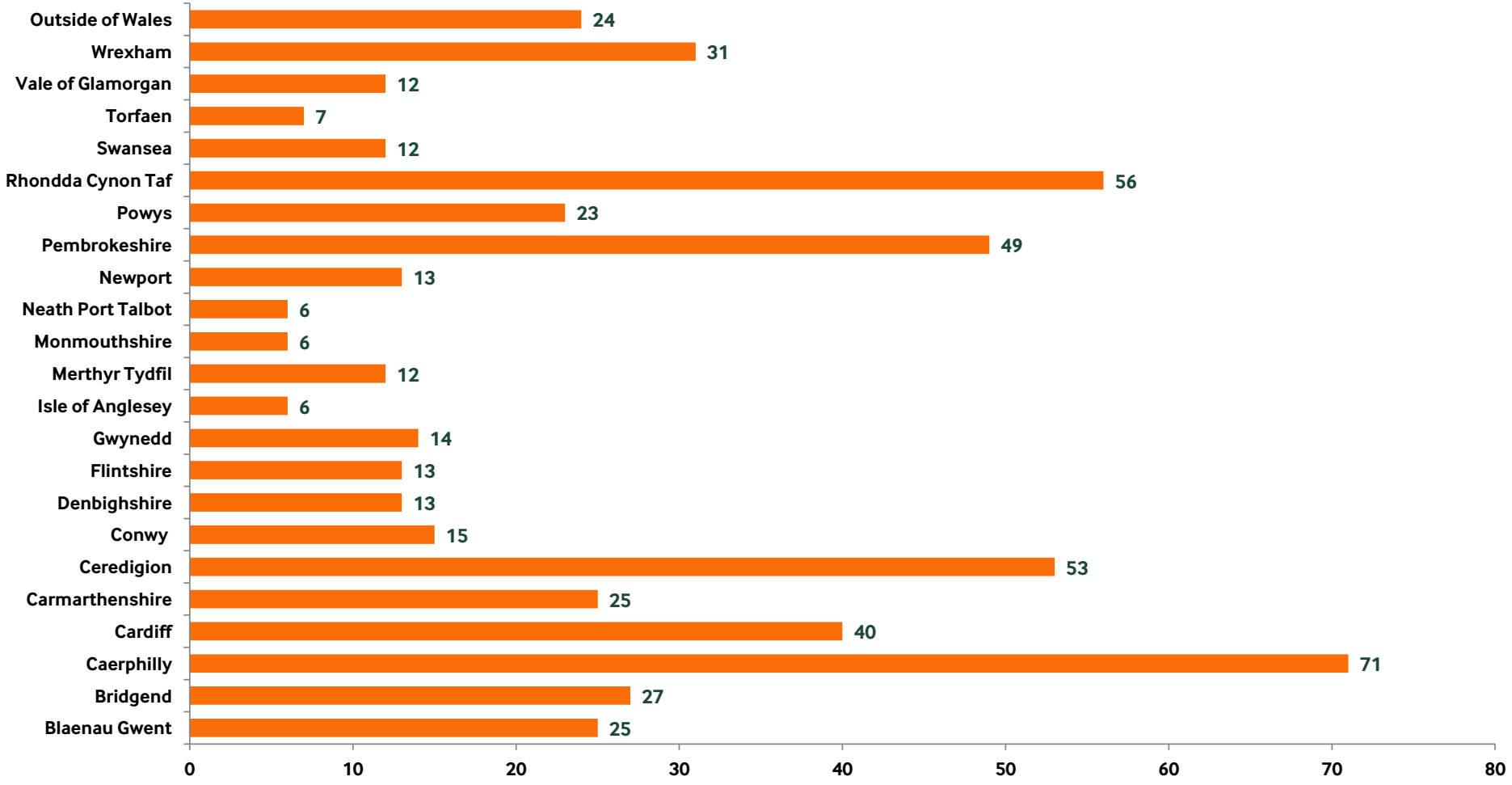
*Total number of responses: 535*

- Yes: **0.56% (3)**
- No: **93.64% (501)**
- Prefer not to say: **5.79% (31)**



## Question 13 – In which local authority area do you live?

*Total number of responses: 553*



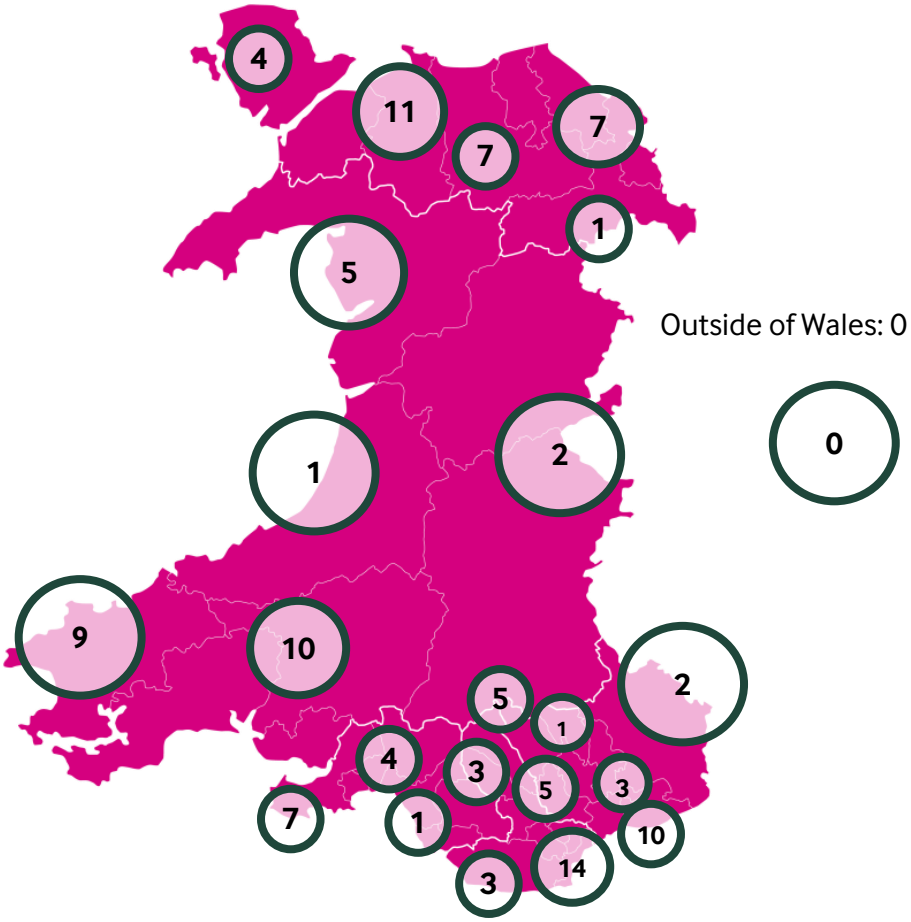
## Survey analysis
## Professionals and service providers

## Key Statistics

**170** Total number of survey responses received

## Geographical Summary of Responses

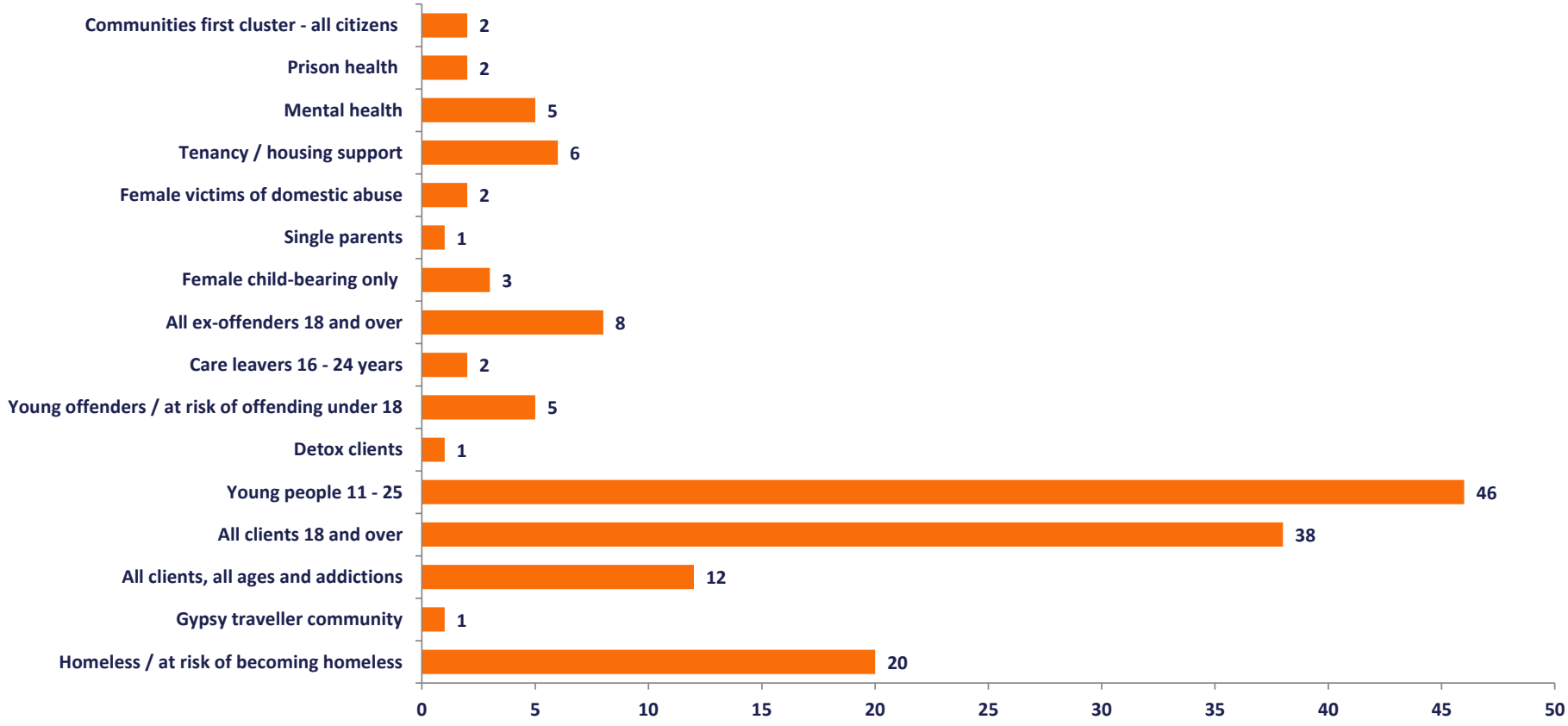
**Number of survey responses broken down by local authority area**



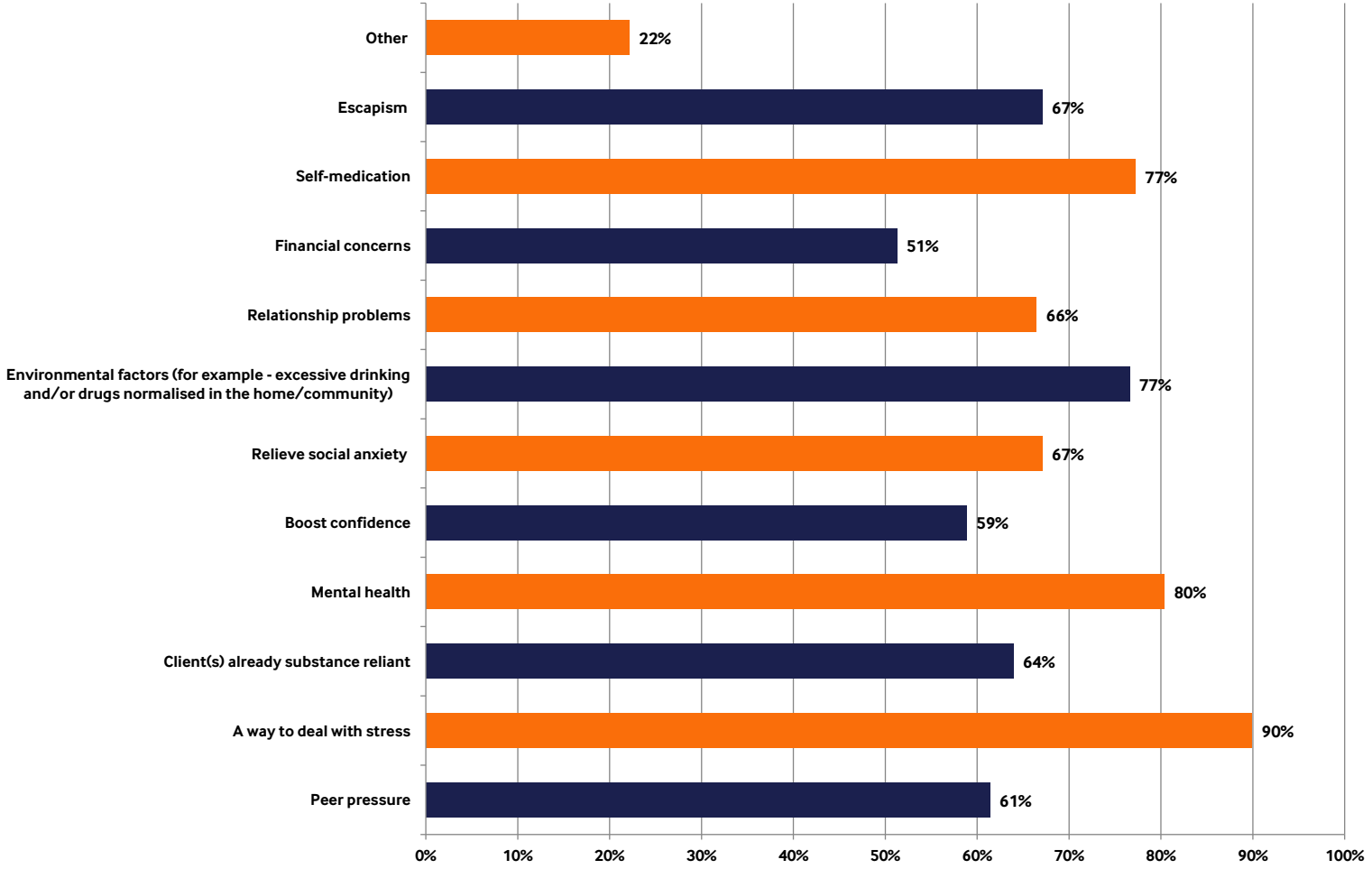

Blaenau Gwent: 1
Bridgend: 3
Caerphilly: 5
Cardiff: 14
Carmarthenshire: 10
Ceredigion: 1
Conwy: 11
Denbighshire: 7
Flintshire: 7
Gwynedd: 5
Isle of Anglesey: 4
Merthyr Tydfil: 1
Monmouthshire: 2
Neath Port Talbot: 4
Newport: 10
Pembrokeshire: 9
Powys: 2
Rhondda Cynon Taf: 5
Swansea: 7
Torfaen: 3
Vale of Glamorgan: 3
Wrexham: 12

# Summary of Responses

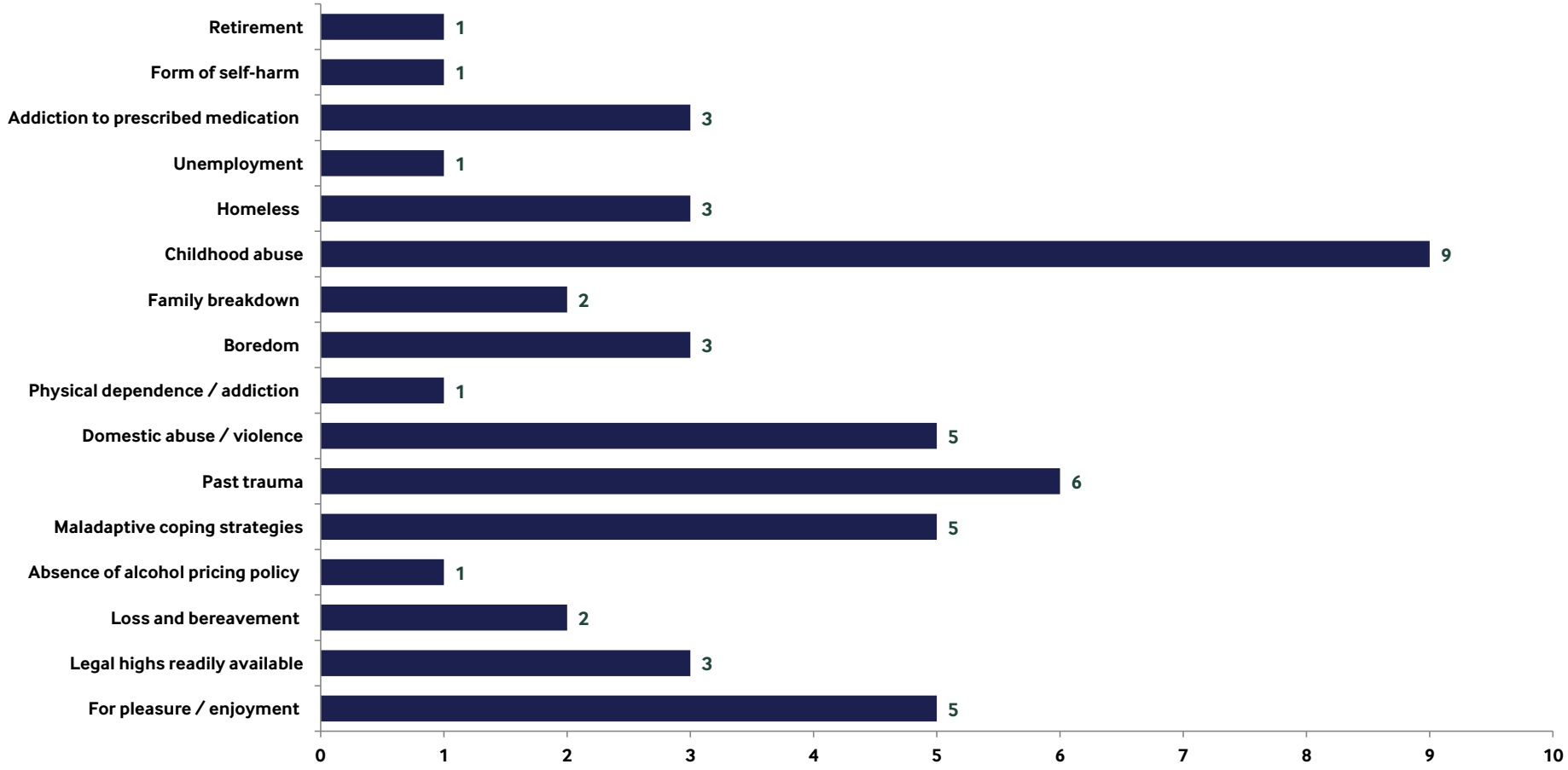
**Question one – Which client group(s) do you work with? (For example, under 18s, older persons, homeless, or female only)**



**Question two – What are the main reasons why your clients take drugs or drink excessively? Please tick all that apply.**



**If you work with more than one client group or you feel that there are other reasons as to why your clients take drugs or drink excessively, please comment.**



**Comments**

- Nine respondents stated that incidences of childhood abuse played a factor in why their client(s) take drugs or drink excessively;

- Six people cited past trauma as a reason for alcohol and substance misuse amongst their client(s);

- Five respondents stated that their client(s) simply misused alcohol and substances for their own pleasure and enjoyment;

- Five people cited that their client(s) have developed maladaptive coping strategies during childhood (for example, due to neglect). This has meant that in later life, they have been unable to "cope" with general life stresses;

- Three respondents stated that the prevalence of new psychoactive substances (and the ease with which you can purchase them) have contributed to misuse amongst their clients;

- Three people cited boredom as a reason their clients misuse alcohol and substances;

- Three respondents felt that becoming homeless / at risk of becoming homeless was a reason why their client(s) began misusing substances in the first instance;

- Three people cited that their client(s) have developed an addiction to prescribed medication for pain relief;

- One respondent argued that retiring was a reason for their client to start misusing alcohol and substances;

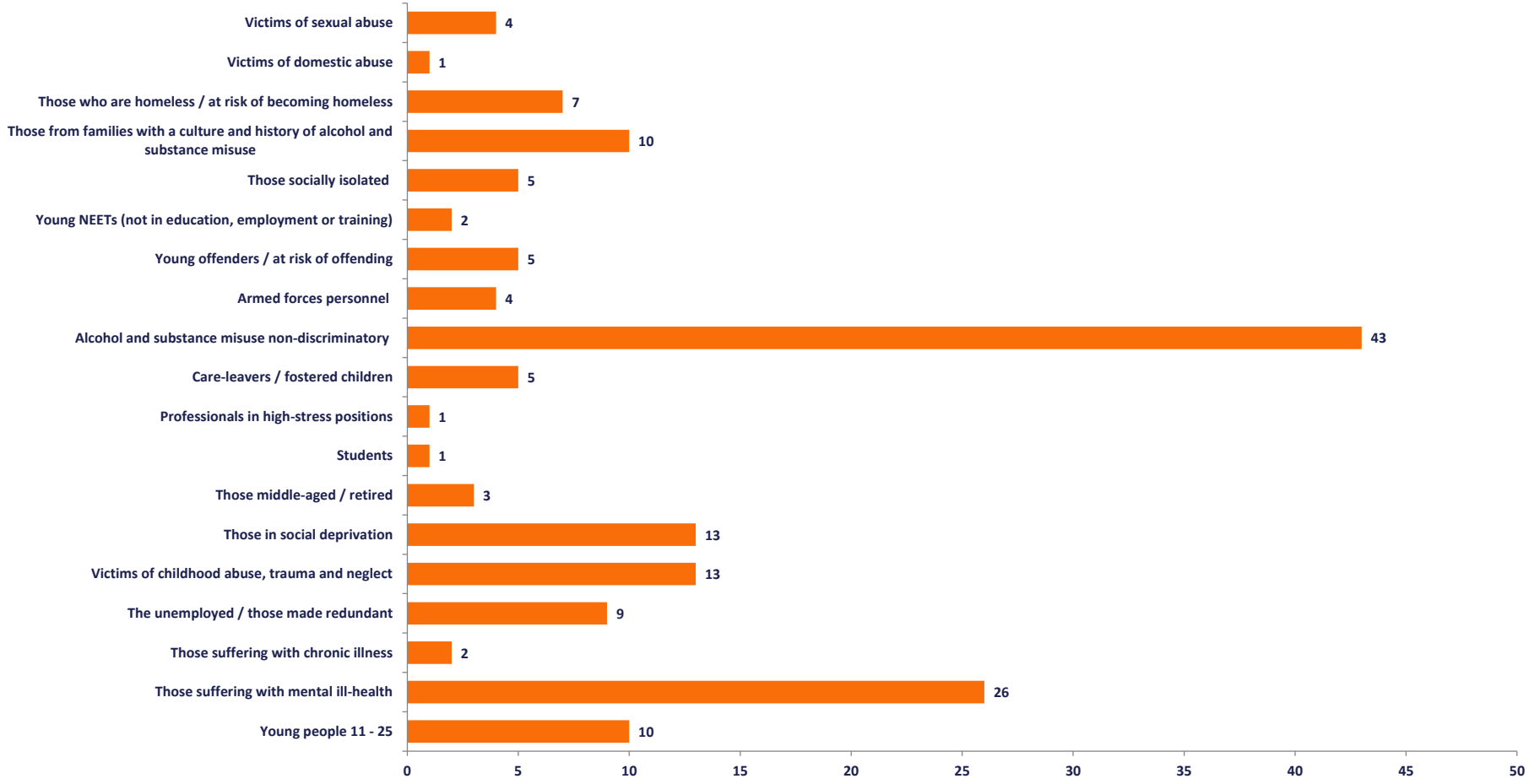
- One individual explained that substance and alcohol misuse can begin as a form of self-harm;

- One respondent cited unemployment / redundancy;

- One individual cited physical dependence / addiction;

- One respondent cited that the absence of a minimum alcohol pricing policy contributes to the prevalence of alcohol misuse amongst their client(s).

**Question three – Are there certain groups of people who are more likely to be affected by drugs and excessive drinking? If so which groups might they be?**



**Comments**

- 43 respondents argued that alcohol and substance misuse is non-discriminatory, and crosses all social boundaries;

- 26 people felt that those suffering with mental ill-health were more susceptible to becoming affected by drugs and excessive drinking;

- 13 individuals stated that people in social deprivation / areas of high deprivation are more likely to be affected;

- 13 respondents argued that people who are victims of childhood abuse, trauma and neglect are more susceptible to becoming affected by substance and alcohol misuse. During these formative years, most clients may have been unable to form adaptive coping mechanisms to stress / trauma;

- 10 people felt that young people and adolescents (aged 11 – 25 years) are impressionable, and therefore more likely to be affected by drugs and excessive drinking;

- 10 individuals stated that the majority of their clients have come from families where alcohol and substance misuse are culturally acceptable;

- Nine respondents argued that being unemployed / becoming redundant puts people at risk of becoming alcohol and substance dependent;

- Seven people felt that those who find themselves homeless or at risk of becoming homeless are susceptible to becoming affected by drugs and excessive drinking;

- Five individuals stated that people who live socially isolated lives (for example, in rural areas) are more likely to be affected by drugs and excessive drinking;

- Five respondents argued that care leavers and those in foster care have a higher risk of developing alcohol and/or substance dependence;

- Five people felt that young offenders and young people at risk of offending are at risk of being affected by alcohol and substance misuse;

- Four individuals stated that victims of sexual abuse are more likely to be affected;

- Four respondents said that armed services personnel (when returning from duty) are at risk of becoming affected by alcohol and substance misuse;

- Three people believed those who are middle-aged and recently retired are more likely to be affected by alcohol and substance misuse;

- Two individuals felt that NEETs (young people not in education, employment or training) were susceptible to being affected by alcohol and substance misuse;

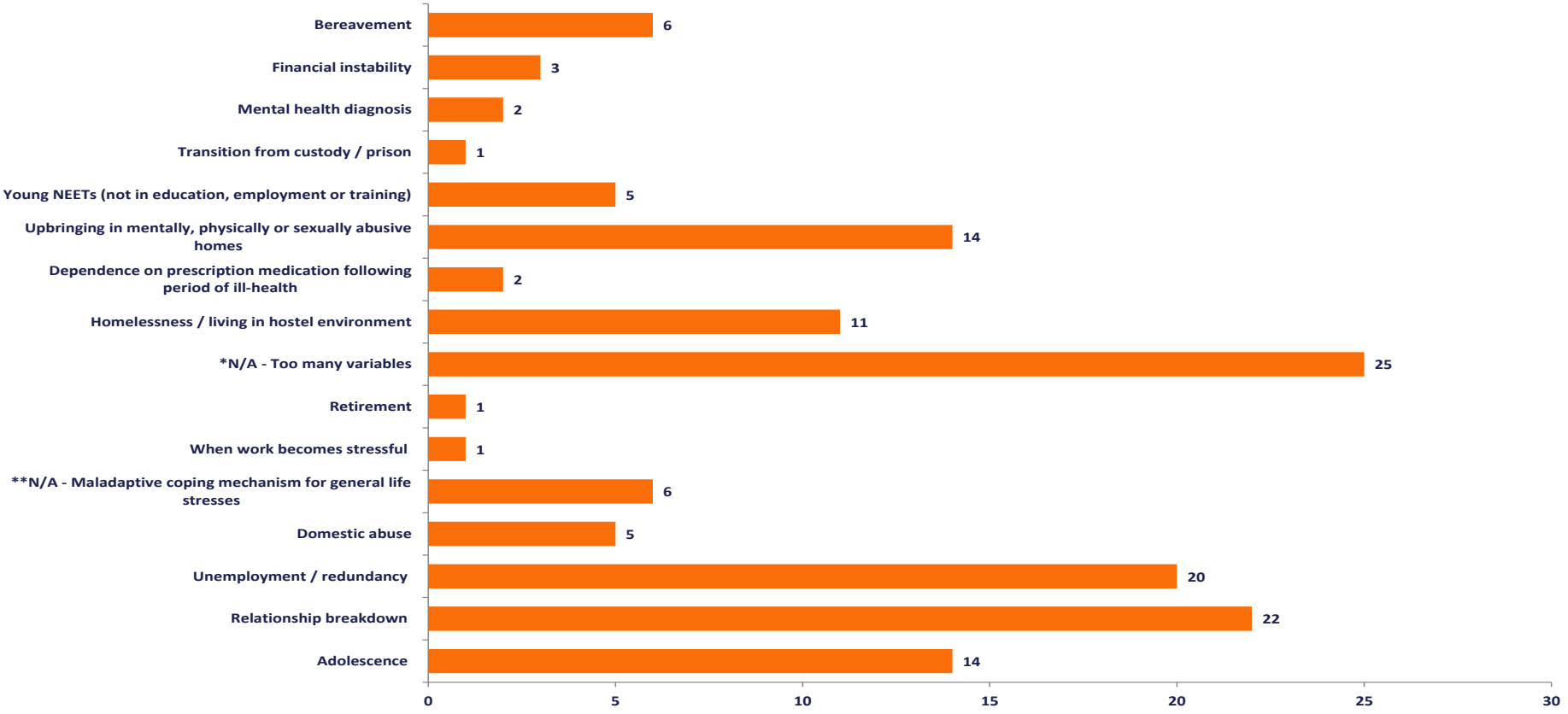
- Two respondents cited that individuals suffering from chronic illness can be at risk of misusing substances (prescription medication);

- One individual outlined that someone suffering domestic abuse could be affected by alcohol and substance misuse;

- One person stated that a professional working in a highly-stressful environment / position could be affected;

- One respondent argued that new university students, or "freshers" are likely to be affected by alcohol and substance misuse.

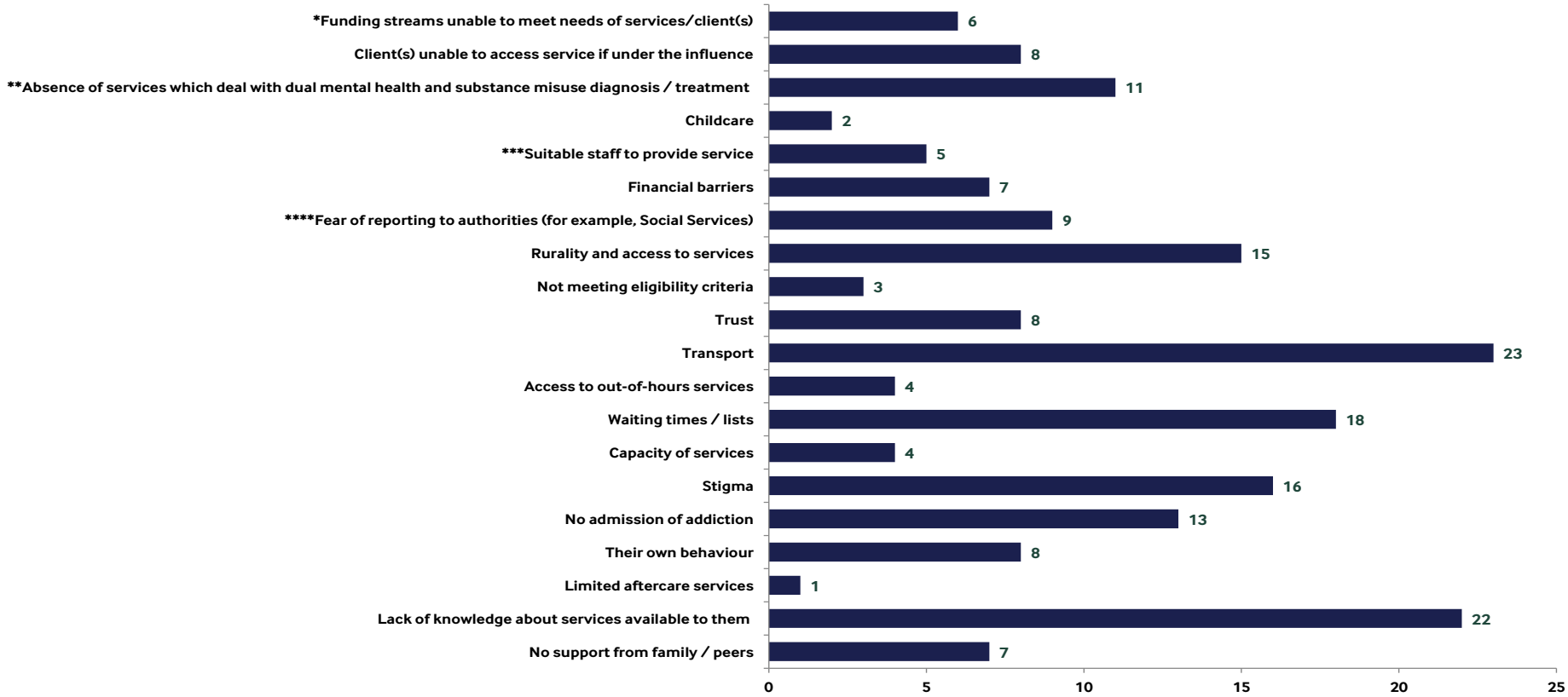
**Question four – Does a particular stage of your clients' lives influence their likelihood of taking drugs or drinking excessively? If so, what stage might that be? (i.e. age, relationship breakdown, unemployment etc.)**




**25 respondents explained that there are too many variables in their clients' history – the predisposing, precipitating and perpetuating factors of their misuse must be considered, and cannot be attributed to one point in their lives;*

***Six individuals referred again to the issue of "maladaptive coping mechanisms" – these are developed during their client's formative years (through neglect, abuse for example) that can impact on their likelihood of taking drugs or drinking excessively.*

## Question five – What barriers exist for your client(s) when trying to access support and services?



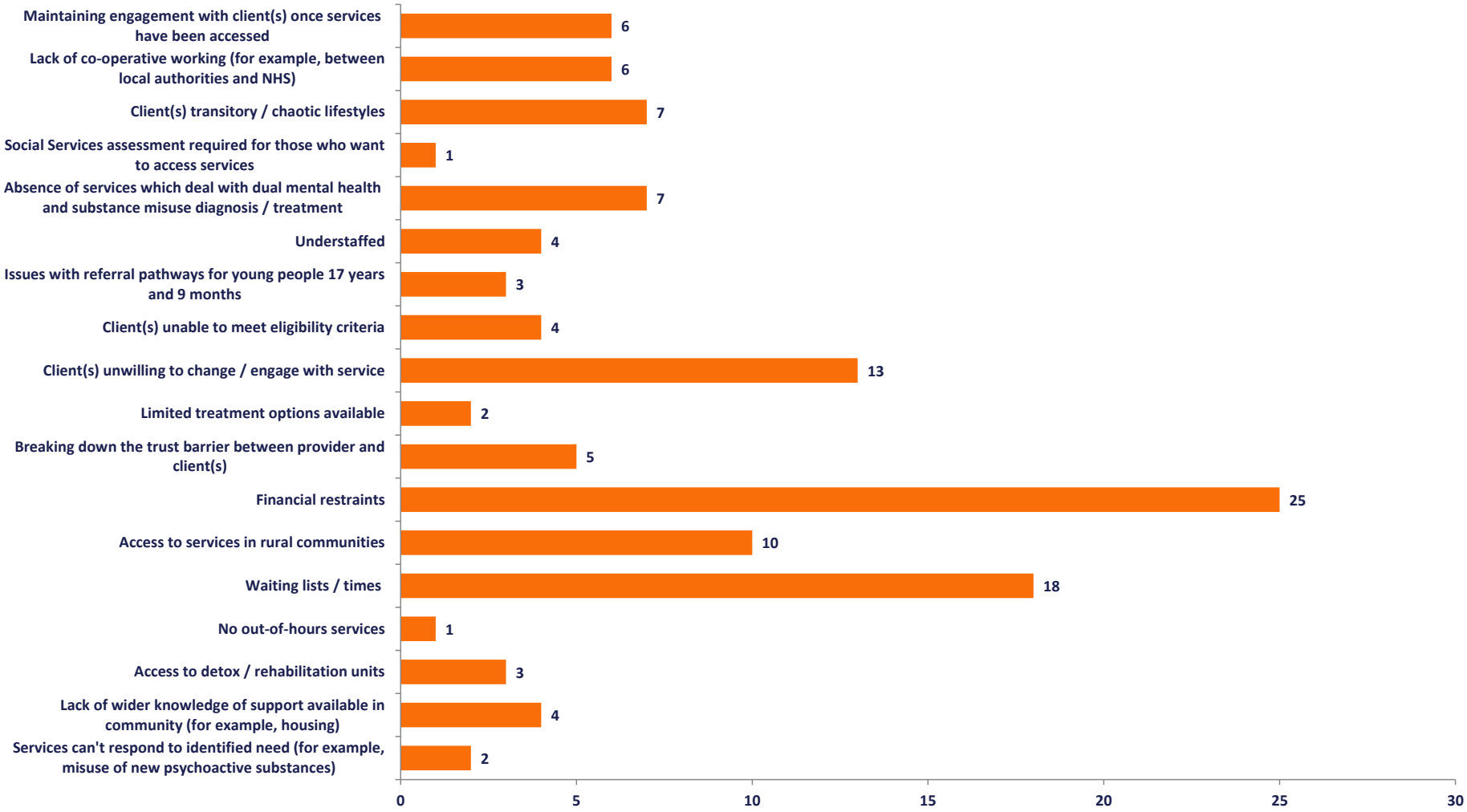

**Six respondents felt that funding streams to meet the needs of their clients and the service they try and provide are a barrier. The system of funding is rigid, and cannot be adapted – for example, treatment for new psychoactive substance addiction;*

***11 individuals explained that in order to access mental health treatment, the majority of their clients need to be free from addiction. This is a barrier as, for many clients, their mental ill-health is a precipitating and perpetuating factor of their substance and alcohol misuse;*

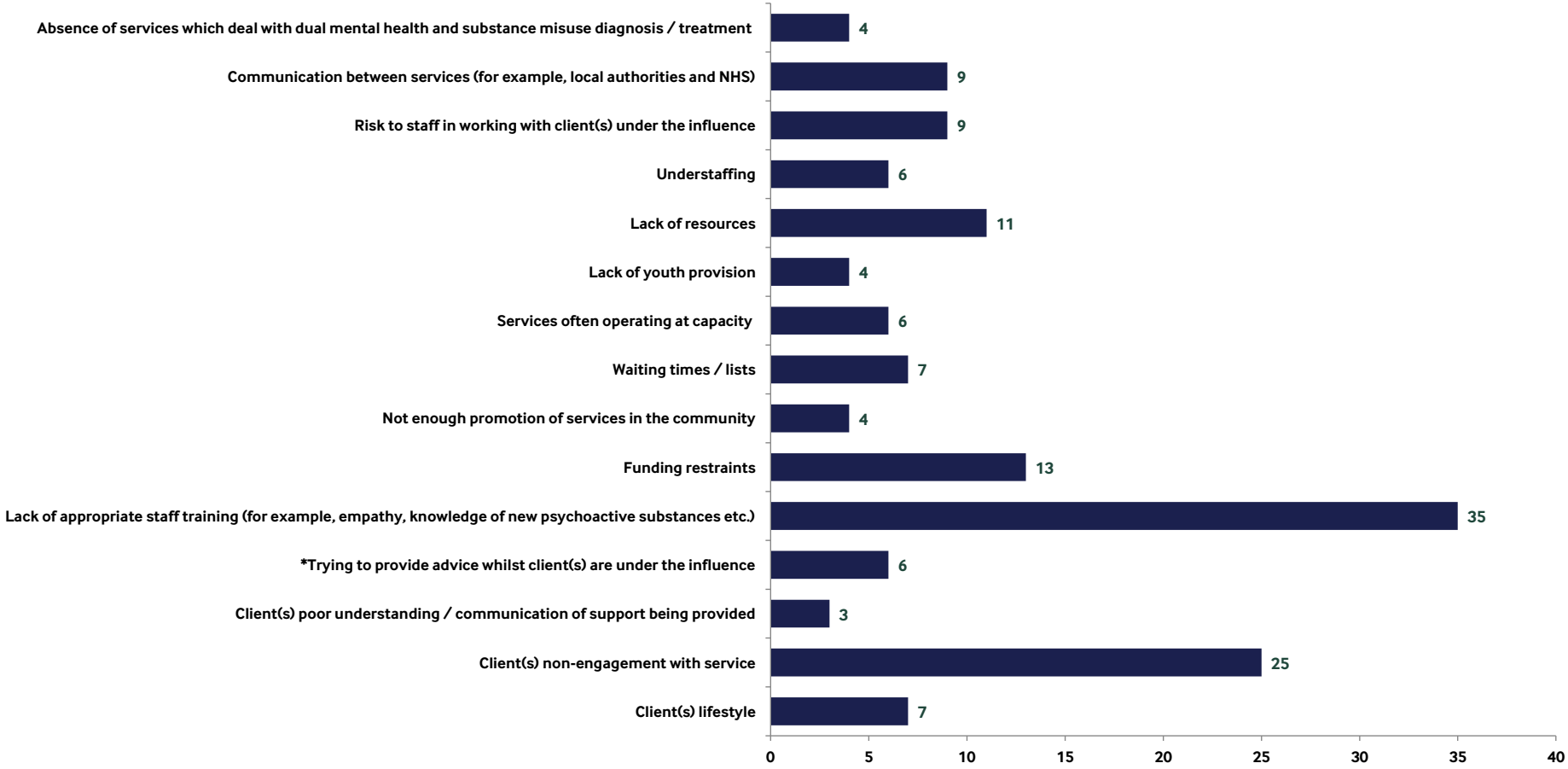
****Five respondents felt that staff themselves can be a barrier for their clients. Many staff lack the appropriate training and empathy in order to adequately respond to their needs;*

*****Nine individuals explained that in order for some of their clients to access their services, they need to be assessed by Social Services. This can simultaneously discourage them from accessing the service, and perpetuate their fear of reporting to the authorities.*

## Question six – What barriers exist for services when trying to access support for client(s)?

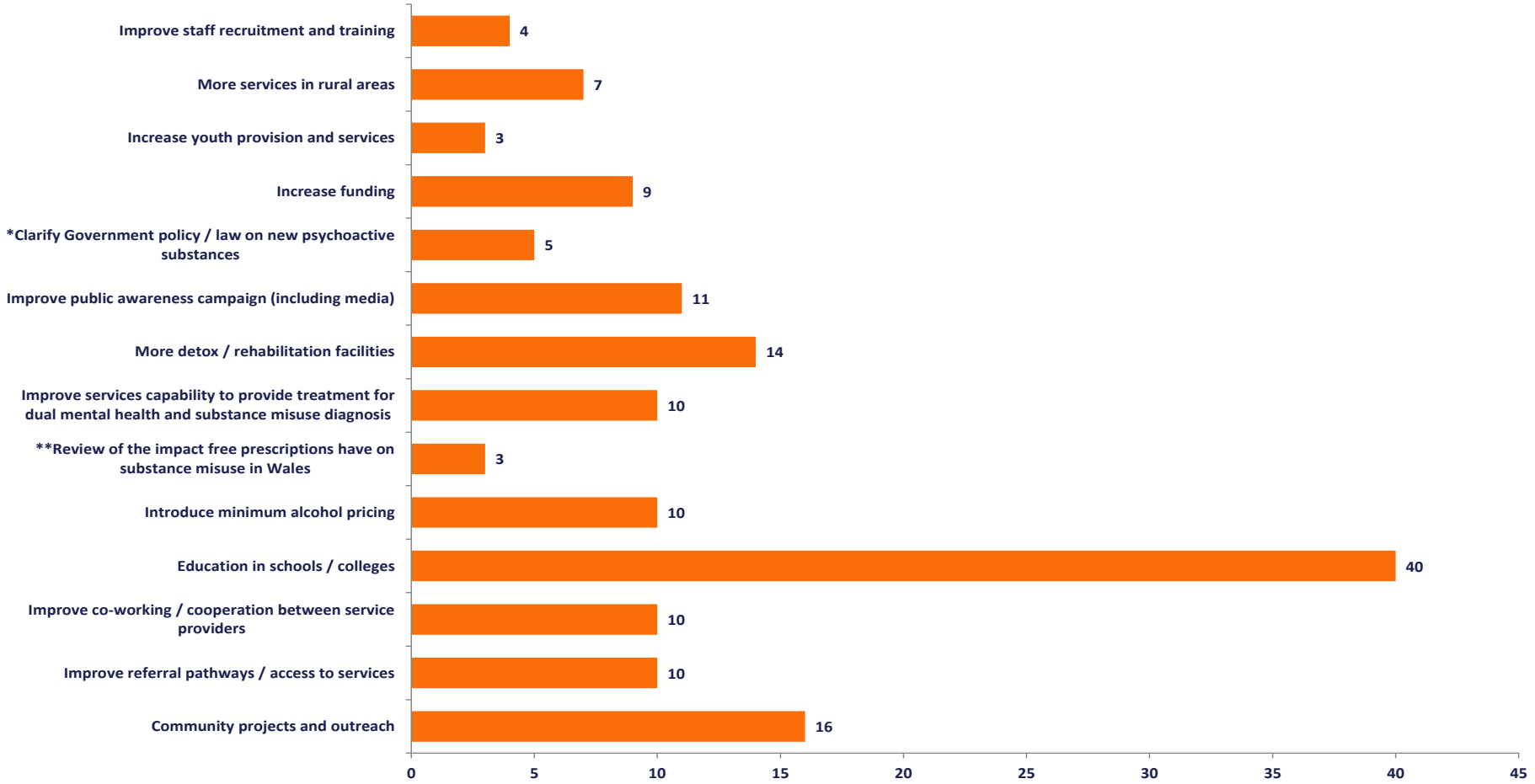


## Question seven – What do you consider to be barriers for staff and frontline services working with your client group(s), or substance misuse generally?




**Six respondents explained that services cannot be accessed if the client presented himself/herself under the influence of alcohol and/or substances. This particularly feeds in to the issue of waiting times / list. On average, a client will have had to wait three months for an appointment, and should they attend under the influence for the majority, they will be turned away and placed back at the end of the waiting list.*

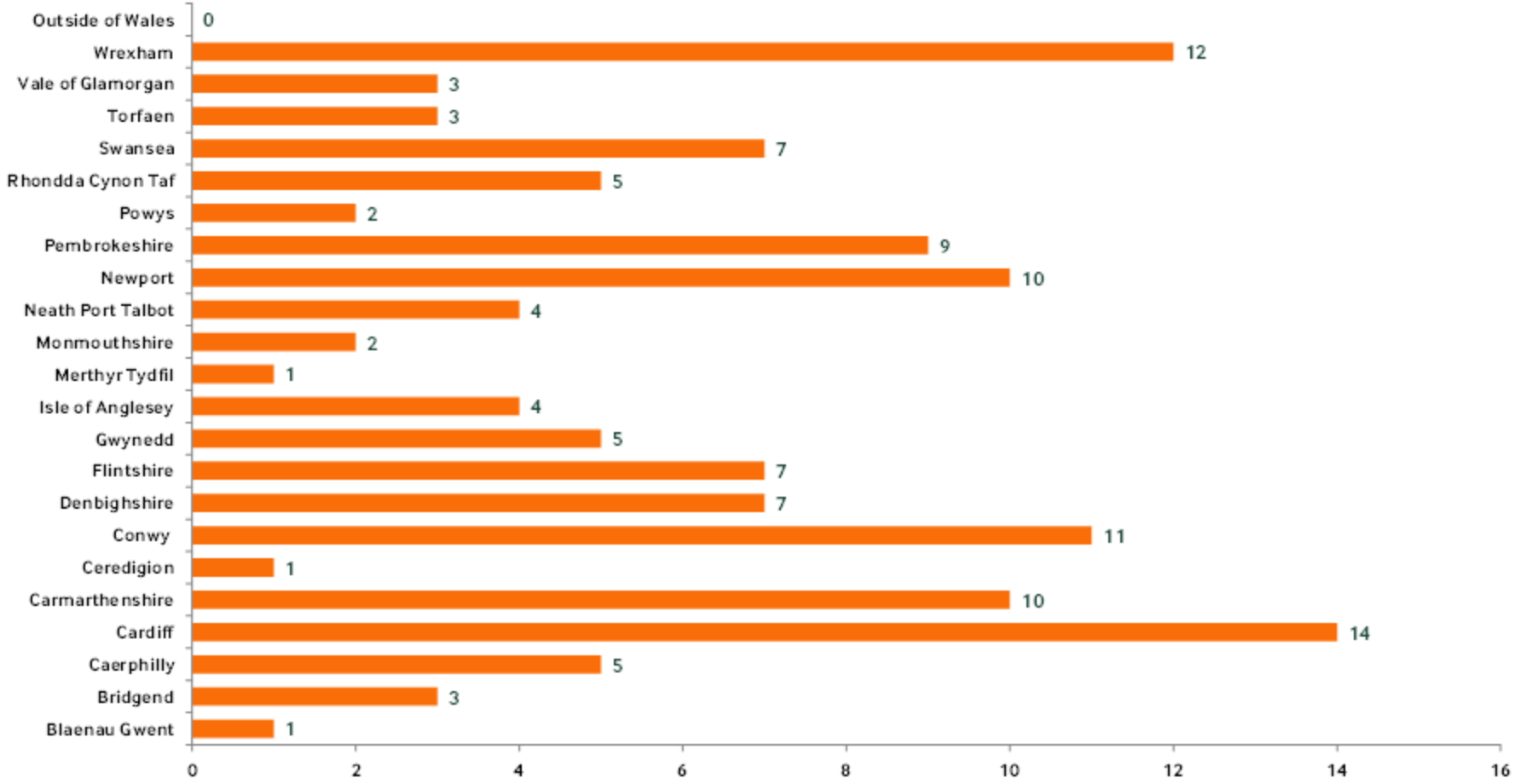
## Question eight – Where do you think efforts should be targeted to address the issue of alcohol and substance misuse in Wales?




**Five respondents felt that efforts should be targeted to address the legal issue of buying and supplying new psychoactive substances. Staff and service providers have difficulty in keeping abreast of the new substances that appear on the market;*

***Three individuals argued for a review into the impact free prescriptions have on substance misuse in Wales. Many of their clients have developed substance reliance of medication used to treat a chronic illness.*

**Question nine – In which local authority area do you work? If you work outside of Wales, please write your local authority area below.**



# Agenda Item 6.4

National Assembly for Wales

Health and Social Care Committee

Factual briefing from Welsh Government officials on the consultation on future care and support arrangements for Independent Living Fund recipients

Additional information from the Welsh Government

During the Committee's meeting on 21 January 2015 Welsh Government officials agreed to provide the Committee with:

- case studies demonstrating how the level of care and support currently provided to recipients of the ILF will differ to that provided via direct payments;
- confirmation of whether responsibility for the ILF has been transferred from the UK Government to the Welsh Government by a transfer of function order; and
- clarification of whether legislative competence has been transferred to the National Assembly for Wales to enable the Welsh Government to bring forward any primary or secondary legislation which may be required following the transfer of responsibility for the ILF to the Welsh Government.

The Committee received a response from Welsh Government officials on 29 January 2015.

- case studies demonstrating how the level of care and support currently provided to recipients of the ILF will differ to that provided via direct payments;

  There are no case studies available on the differences between ILF and Direct Payments (DP) to illustrate the potential different levels of care and support in respect of these funding streams. This is because ILF do not have rates that compare directly to DP rates as these vary across local authorities and are based on local needs and resources. There are swings and roundabouts that work both ways in relation to this.

Whilst the ILF has tended to use the direct payment rate as a guide to a reasonable local wage to pay a personal carer this has not been binding, therefore some ILF users may employ support that is paid at rates of pay above that allowed by the local authority. Conversely, the ILF may be paying slightly less than the direct payment rate, in particular if following a transfer review visit there had been a subsequent uplift in the direct payment rate paid by the local authority.

For example, if an ILF user had a previously agreed an hourly rate with their agency or Personal Carer that was higher than the locally applied DP rate and the DP rate was subsequently increased by the Local Authority, the ILF user would continue to pay for their care on their currently agreed rate which then may be lower than the revised DP rate.

- confirmation of whether responsibility for the ILF has been transferred from the UK Government to the Welsh Government by a transfer of function order;

  The short answer to this is no. The UK Government has decided that funding previously allocated to the DWP to administer ILF across Britain should, from 1 July this year, be distributed to the devolved administrations to determine how these funds should be used. The ILF is a discretionary Trust which was set up by virtue of a Trust Deed which set out its functions. There is no statutory responsibility for the fund which could be transferred from the UK Government to the Welsh Government.

- and clarification of whether legislative competence has been transferred to the National Assembly for Wales to enable the Welsh Government to bring forward any primary or secondary legislation which may be required following the transfer of responsibility for the ILF to the Welsh Government

  Should the National Assembly for Wales wish to legislate in light of acquiring funds that were previously provided to the ILF whether it

has competence or not will depend on exactly what the Assembly wanted to do. That is, what organisation, agency or body it may wish to administer ILF in the future. The National Assembly already has the competence to enable it to administer a scheme which is the same or similar to the ILF. The National Assembly has legislative competence in relation to Health and Health Services (Heading 8 Schedule 7 to the Government of Wales Act 20006 (GOWA) and Social Welfare (Heading 15 Schedule 7 GOWA). Therefore if the purpose of any equivalent ILF fund was to give financial support to disabled people to enable them to live in the community any legislative provision would relate to one or more of the subjects under those headings and therefore be within the Assembly's competence. Questions of competence always have to be considered with the proposed provisions in mind, however, if the purpose of any legislation was to enable or support the distribution of funds to support disabled people then it is considered that it would already be within the Assembly's legislative competence.

Y Pwyllgor Cyllid
Finance Committee

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

David Rees AM
Chair
Health and Social Care Committee

29 January 2015

Dear David

**Safe Nurse Staffing Levels (Wales) Bill**

At the Finance Committee meeting of 21 January 2015, the Committee considered the financial implications of the Safe Nurse Staffing Levels (Wales) Bill.

At this stage the Committee will not be undertaking any further financial scrutiny of the Bill. We would like to request that during your scrutiny of the general principles of the Bill that you give consideration to the financial implications and should you feel there is any financial implications which we should be aware of and may benefit from further scrutiny by our Committee I'd be grateful if you could let me know.

Whilst the Committee agreed not to undertake any further scrutiny, Members did have concerns that most of the costs of the Bill would result from regulations and the RIA contains limited details of costs in this area, I would be grateful if you could consider this as part of your wider scrutiny.

I am copying this letter to Kirsty Williams as the Member in charge.

Yours sincerely

**Jocelyn Davies AM**
Chair

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