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 Brynawel Rehab – ASM 14 / Tystiolaeth gan Brynawel Rehab – ASM 14

dewis gwellhad
Brynawel Rehab
choosing recovery

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

support recovery and facilitate transition between different levels of support.

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

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

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

Annex A

Case examples

Mr. A

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

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

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

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

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

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

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

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

Mr. B

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

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

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

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

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

Mr. C

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

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

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

Mr. D

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

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

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

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

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

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