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

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

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

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

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

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

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

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

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

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

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

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

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

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

[11] Roberts, M. (2010) Young people's drug and alcohol treatment at the crossroads: What it's for, where it's at and how to make it even better London, Drugscope; Wadd, S & Galvani, S (2014) Working with Older People with Alcohol Problems: Insight from Specialist Substance Misuse Professionals and their Service Users Social Work Education: The International Journal Vol. 33, No. 5 656-669

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

[13] Gartner, A., Cosh, H., Gibbon, R. and Lester, N. (2009) A profile of alcohol and health in Wales, Cardiff, Wales Centre for Health.

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

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

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

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

[15] Home Office (2012) Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales, 2nd ed London, Home Office

[16] Home Office (2012) The Government's Alcohol Strategy, London, Home Office; Home Office.
Home Office (2010) Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life, London, Home Office; Scottish Government. (2009) Changing Scotland's Relationship with Alcohol: A Framework for Action Edinburgh, Scottish Government; Scottish Government. (2008) The road to recovery: A new approach to tackling Scotland's drug problem, Edinburgh, Scottish Government; Welsh Assembly Government. (2008a) Working together to reduce harm: The substance misuse strategy for Wales 2008-2018, Cardiff, Welsh Assembly Government.

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

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

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

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

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

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

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

[22] Livingston, W, Baker, M, Atkins, B & Jobber, S (2011) 'A Tale Of The Spontaneous Emergence Of A Recovery Group And The Characteristics That Are Making It Thrive: Exploring The Politics And Knowledge Of Recovery' Journal of Groups in Addiction and Recovery, Volume 6, Number 1, pp176-196;

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