

## From Methadone and the National Treatment Agency to Alcohol Brief Interventions and Public Health England

Reflections on the Direction of Travel in Local  
Government Substance Misuse Policy

Will Haydock  
*December 2014*

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I thought I should begin this presentation with a bit of background about how I've come to be thinking about issues around substance use policy. I did a PhD a few years ago now on the sociology of young people's drinking in Bournemouth, focusing on how drinking reflected and constituted gender and class. Since then I've been writing mostly about alcohol policy, but I've also been working for Dorset County Council as part of their Drug and Alcohol Action Team, which commissions NHS and third sector providers to deliver treatment for people with substance misuse issues.

My presentation today is something of a reflection on the day job using my academic social policy perspective. However, rather than offering some definite conclusions about what's happening in relation to substance use policy in local authorities, as I'd initially planned, I'm going to identify what I hope could be a useful perspective for policy researchers in the field to apply.

You've already heard today about the broad brush trends in substance misuse policy, and like Virginia Berridge, I think we can trace something of a convergence in approaches to substances. If we consider those substances that we might think of as being legal and legitimate, restrictions (or at least concern) have been growing in recent years.

**BBC NEWS DORSET**

4 October 2013 Last updated at 04:41

## Weymouth adopts super-strong alcohol campaign

Off-licenses in Weymouth have begun signing up to a voluntary ban on selling super-strength beer and cider.

Seven shops in the Dorset seaside town have agreed to stop selling the drinks as part of a campaign by police, councils and health officials.

The scheme has been inspired by the Reducing the Strength campaign in Ipswich, where 65% of off-licenses stopped stocking the drinks.

Suffolk Police said the scheme had cut crime and anti-social behaviour.

Weymouth and Portland Borough Council said the initiative was aimed at limiting the ability of street drinkers to buy cheaply-sold beers and ciders with an alcohol volume of more than 6.5%.

*It is initially being run across Weymouth town centre and Abbotsham Road*



There were hundreds of incidents of anti-social behaviour in Weymouth

Related: Super-strength, Anti-drugs cuts

**YOU ARE IN A DESIGNATED PUBLIC PLACE**



If you continue to drink alcohol in this area when asked not to do so by a police officer, police community support officer, or local authority warden, or fail to surrender any alcohol to a police officer when asked to do so in this area, you may be arrested and would be liable on conviction to a **Maximum fine of £500**

The following items are restricted from the Designated Public Place:

- 1) The consumption of alcohol (beer, wine, spirits, cider, etc.) in the designated public place.
- 2) The possession of alcohol (beer, wine, spirits, cider, etc.) in the designated public place.
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Mansfield District Council  
POLICE

**BBC NEWS UK**

23 March 2012 Last updated at 18:15

## Minimum alcohol price planned for England and Wales

**COMMENTS (1522)**

The government is proposing a minimum price of 40p per unit of alcohol in England and Wales in an effort to "turn the tide" against binge drinking.



Home Secretary Theresa May: "People who like going to their local pub have nothing to fear"

It believes this could transform the behaviour of those who cause the most problems for hospitals and police.

A new **alcohol strategy** also aims to help local areas tackle problems and work with the drinks industry to encourage responsible drinking.

Some in the industry suggest minimum pricing would face a court challenge.

The industry said a minimum price was misguided and would hit consumers hard.

Related Stories: Welcome for minimum drink prices

Take alcohol. Despite the idea that licensing laws have been liberalised in the UK, there's an underlying philosophy with considerable traction that emphasises that alcohol is harmful in itself – and population measures such as minimum unit pricing are genuinely being considered. There's also designated public place orders and Reducing the Strength' campaigns that restrict where and when people can drink alcohol, and even what can be sold.

# Convergence of policy on different substances: tobacco

**LEGALLY REQUIRED**

**Smoking Ban Signs**

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**SMOKING CAUSES MOUTH CANCER**  
TONGUE CANCER  
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**SMOKING CAUSES PERIPHERAL VASCULAR DISEASE**  
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**NHS choices** Your health, your choices

**MPs vote to ban smoking in cars carrying children**

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Tuesday February 11 2014

"MPs overwhelmingly back ban on smoking in cars carrying children," reports The Guardian. The media headlines are based on the passing of an amendment to the Children and Families Bill in the House of Commons.

here to help

prohibited to sell tobacco products to anyone under the age of 18.

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On tobacco, advertising restrictions have been imposed over the past few decades, and we've recently had standardised packaging introduced in Australia, and packs being kept behind closed doors in the UK.

Drug and alcohol prevention

## Caffeine and energy drinks

**Questions for schools**

1. How do we know whether this is an issue among our pupils?
2. Is caffeine covered in drug education / PSHE?
3. Do we have any rules or guidance about pupils' use of energy drinks?
4. Who else might we want to talk to about this (for example parents or local retailers)?



**mentorADEPIS.org**  
Addiction Education Prevention Intervention Services

ADEPIS, c/o Mentor, 67-69 Coopers Street, London EC3M 8PU  
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y > Addiction > Vol 109 Issue 11 > Abstract

## Addiction

EDITORIAL

**Caffeine addiction? Caffeine for youth? Time to act!**

Alan J. Budney and Jennifer A. Emond

Article first published online: 1 JUL 2014  
DOI: 10.1111/add.12594  
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Issue  
Addiction  
Volume 109, Issue 11, pages 1771-1772, November 2014

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**Keywords:**  
Addiction; caffeine; children; energy drinks; marketing; policy

*While data accumulate and discussion evolves on the clinical importance of caffeine addiction and its classification, the growing practices of (i) adding increasing amounts of caffeine to drinks and other consumables, (ii) promoting these as performance enhancers and (iii) targeting youth as the consumer raise concerns that require immediate action.*

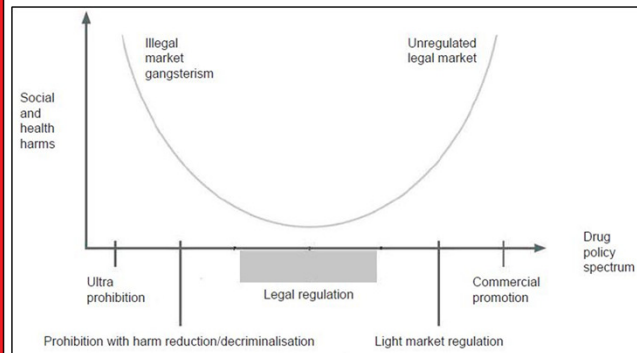
To the average Joe, questioning the existence of caffeine addiction probably seems absurd. The web abounds with quotes and exposes about the addictive nature of caffeine using catchy slogans about coffee that borrow from other substance addiction phraseology: 'My blood type is coffee'; 'Coffee, if you're not shaking you need another cup'; 'Espresso—just our little way of free-basing coffee'. Academics and clinicians, however, have not yet reached consensus about the potential clinical importance of caffeine addiction (or 'use disorder') [1]. The DSM-5 designated caffeine withdrawal as a formal disorder, an important step towards recognizing the potential to develop clinically significant problems related to caffeine use [2]. Moreover, caffeine use disorder was included in Section III (conditions for further study), acknowledging the merit of the condition while conveying the need for further research before an official designation. Of note, the World Health Organization (WHO) has long included caffeine on its list of psychostimulants that produce withdrawal or dependence disorders in the ICD-10.

Restrictions on caffeine are being debated, and I've heard plenty of substance misuse professionals and youth workers worrying about energy drinks.



## TRANSFORM

Getting drugs under control



At the same time, thinking about currently illegal substances, there's a great deal of media coverage for the Global Commission on Drug Policy, which follows Transform's ideal of heavily regulated legalised substance use. And in practice, a number of US states (and other countries) have liberalised their policies on certain previously illegal substances – notably cannabis – that mean consumption and sometimes even retail is legal. Transform's model of legalised consumption isn't so far away from where we currently are with tobacco in the UK: condemned and controlled, but legal.

**Bournemouth University**

# Disruptive innovations: e-cigs & NPS

International Journal of Drug Policy  
Volume 25, Issue 4, July 2014, Pages 653-655

Editorial  
**Disruptive innovations: The rise of the electronic cigarette**  
Gerry V. Stimson  
Betsy Thom  
Paddy Costall  
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Disruptive innovations and psychoactive substances  
The history of psychoactive substances is replete with examples of technologies that change the production and consumption of drugs, alcohol and tobacco. Business analysts use the term 'disruptive innovation' to describe innovations that lead to relatively rapid and dramatic transformations in manufacture, marketing, and consumer behaviour (Christensen, 2003). A classic instance is the 'Kodak moment' when, with the rise of digital processes, photographic film manufacturers were left with an obsolete technology. But as we will suggest, disruption is far broader than the technical impact of the innovation, for it has social ramifications affecting a wide range of social groups. This is especially the case with psychoactive substances where innovations can challenge the position of powerful groups and established wisdoms.

HM Government  
Government response to  
New Psychoactive  
Substances Review  
Expert Panel Report  
October 2014

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Throw into this mix the 'disruptive innovations' we'll be hearing about later of e-cigarettes and 'legal highs' and there's an interesting mix where the old lines between licit and illicit substances aren't so clear.

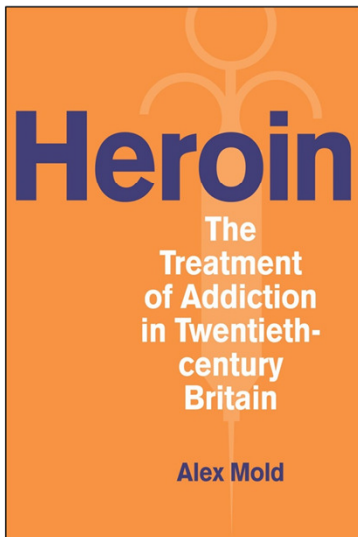
The planned approach of the Coalition to 'legal highs', where all psychoactive substances would be illegal by default except where they have already been legalised, highlights the inconsistency in allowing alcohol, tobacco and caffeine consumption, for example, and some people would hope this will open up a debate about why these differences exist.

But this sort of analysis is primarily based on big, largely national policy announcements. I don't think there's anything wrong with this sort of approach – and it's exactly how I approached my academic articles. But, working in a local authority over the past few years, I've been acutely aware of how approaches can differ from one area to another, and how the big picture might vary when considered in detail.

The perspective and examples I'll be giving today are only one element of policy – even only one element of what local areas have control over – but it should give you an idea of how there's quite a variety of types of intervention on offer to policymakers, and these reflect different ideas of what is problematic about

substance use, which in turn reflect broader priorities and implications. My focus on treatment is relevant when it's one of the few directly allocated spending budgets in relation to psychoactive substances.

The starting point for this analysis is to consider the changes in funding and governance that have happened in relation to substance misuse treatment in the past few years. If you look at my main job, as a commissioner of substance misuse treatment services, for a decade or so before 2013, local areas used to be given funding for drug treatment by a specialist agency of the Department of Health: the National Treatment Agency (NTA).



*Drugs: education, prevention and policy,*  
October 2008, 15(5): 451-461

informa  
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## 'The rise of the user'? Voluntary organizations, the state and illegal drugs in England since the 1960s

ALEX MOLD & VIRGINIA BERRIDGE

*Centre for History in Public Health, London School of Hygiene and Tropical Medicine, London, UK*

### Abstract

This article examines the place of the drug user in drug policy and practice in England since the 1960s. It argues that though the drug user has 'risen' in the sense that users now play a key role in contemporary policy and practice, this was not a neat, linear process. Moreover, the current position of the drug user is constructed by a range of wider forces.

The drug user currently appears to occupy a central position in drug policy and practice. This can be seen in a number of key areas. Involving service users and carers is regarded as an important priority by the National Treatment Agency for Substance Misuse (NTA) in achieving their goal to improve the availability and effectiveness of drug treatment services. A number of reports and studies have been conducted on aspects of user involvement, such as users' views of treatment (Best, Campbell & O'Grady, 2006; European Association for the Treatment of Addiction UK, 2004). But where has this focus on the drug user come from? What was the position of the user in drug policy and practice in the recent past? How far has this position changed, and if it has done so, why?

Since July 2004 a research project entitled 'Drug User Patient Groups, "User Groups" and Drug Policy, 1970s-Present' funded by the Economic and Social Research Council and based in the Centre for History in Public Health at the London School of Hygiene and Tropical Medicine, has aimed to answer these questions. Professor Virginia Berridge and I have historicized the 'rise' of the user, looking at the place of drug users in drug policy and practice from the late 1960s to the present.

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ISSN 0968-7637 print/ISSN 1465-3370 online © 2008 Informa UK Ltd.  
DOI: 10.1080/09687630801937330

As an aside at this point, I should note that if you're interested in the longer and broader history of drug treatment in the UK, as well as Virginia Berridge, Alex Mold has written some excellent engaging articles.



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**Dorset Drug and Alcohol Action Team**

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**The Dorset Drug and Alcohol Action Team (DAAT) is a multi-agency partnership responsible for the commissioning of local drug and alcohol services and the local implementation of national government drug and alcohol strategies.**

The DAAT is a strategic partnership made up of representatives from Dorset County Council, NHS, Dorset Police, Dorset Probation Trust, HM Prison Service, charitable and voluntary sectors and Dorset Service User Forum.

The DAAT partnership is supported by a dedicated team of DAAT Officers together with Community Safety colleagues based within Dorset County Council who act as the first point of contact for strategic and commissioning enquiries.

**Commissioning of local drug and alcohol services**

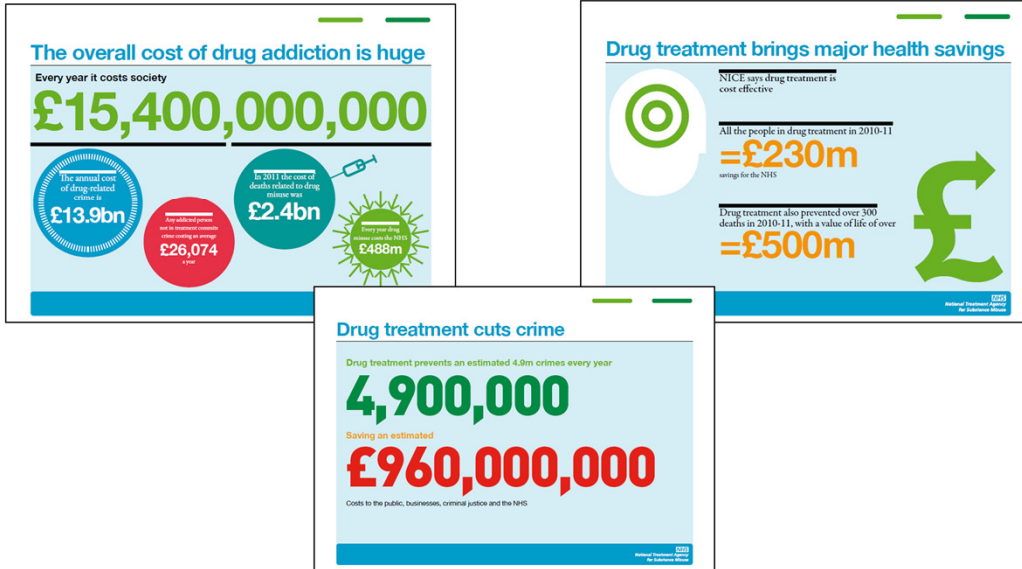
The DAAT is responsible for the identification of needs in its communities in relation to drug and alcohol use. The DAAT oversees the commissioning of services to help meet these needs through the joint commissioning group.

A range of subgroups and other meetings attended by DAAT Officers also support the work of the DAAT and further details can be obtained from the [Business Manager \(Substance Misuse\)](#).

Now, apologies to those of you for whom this is stating the obvious, but I'll just sketch things relatively quickly. [SLIDE] The NTA was very much a New Labour creation, and focused on a specific group of drug users, whether referred to as PDUs (problem drug users), OCUs (opiate or crack users) or more recently simply opiate users – that is, heroin. The NTA determined what funding each local authority area would receive for drug treatment, and set out prescriptive requirements for local areas in terms of how they had to plan and arrange their treatment systems. The key approach was methadone maintenance treatment, which had the logic of stopping someone injecting street heroin in favour of drinking a different, prescribed opioid. The rationale is that by reducing injecting the risk of blood-borne virus transmission is cut, and you also remove the need for that person to steal to fund their (physical) dependency because you're giving them the methadone free.

The funding for this was channelled through Drug and Alcohol Action Teams (DAATs), which were intended to be local partnerships of all interested organisations: local authorities, PCTs, Police, Probation, Prisons and so on. And crucially, in fact, much of the funding that ended up going towards drug treatment had originated from a patchwork of sources from all these organisations.

## Why Invest? Crime or health?



Regardless of the many potential justifications for funding drug treatment, the public rationale unfailingly focused on criminal justice issues. Drug treatment was a way of being 'tough on the causes of crime'. Benefits in terms of reducing the prevalence of HIV or Hepatitis C were mentioned, but to give just one example, when the NTA released a Value for Money calculator, the detail – and the biggest 'savings' to the public purse – related to crimes that would be avoided if a drug user were engaged in methadone maintenance treatment.

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30 October 2014, 6:28am GMT

**Drug policy is working – why do we prefer to think otherwise?**

**AUTHOR**  
Paul Hayes  
Has Professor Drug Policy at London School of Hygiene & Tropical Medicine



**DISCLOSURE STATEMENT**  
Paul Hayes is a former CEO of the National Treatment Agency. As such he was responsible to ministers and parliament for the funding and delivery of treatment for drug addiction in England between 2007/8. He currently chairs the National Treatment Consortium, a collaboration between five third sector organisations providing integrated responses to social and economic exclusion.

The Conversation is funded by the following universities: Aberdeen, Bath Spa, Birmingham, Brunel, Brunton, Bristol, Brunel, Cardiff Metropolitan, City, Coventry, DePaul, Edinboro, Glasgow, Glasgow City, Glasgow Caledonian, Goldsmiths, Hull, King's College, Lancaster, Loughborough, Liverpool, Liverpool John Moores, Northumbria, Nottingham, The Open University, Queen Mary

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**Why the UK's drug strategy should remain a Home Office responsibility**  
Handing the reins to the Department of Health might seem a liberal-minded approach, but it could mean less is spent on treatment

**Paul Hayes**  
The Guardian, Tuesday 25 November 2014 12:00 GMT  
Jump to comments (27)



Half of the rise in crime in the 1980s and 90s is attributable to the successive waves of heroin epidemics. Photograph: Julian Simonetti/Reax Features

Former home office minister Norman Baker's parting shot from government earlier this month was to call for leadership of the UK drug strategy to move from an enforcement-obsessed Home Office to a treatment-focused Department of Health. The rationale is that "drugs is a health issue" and the "faltering steps" England has taken to improve

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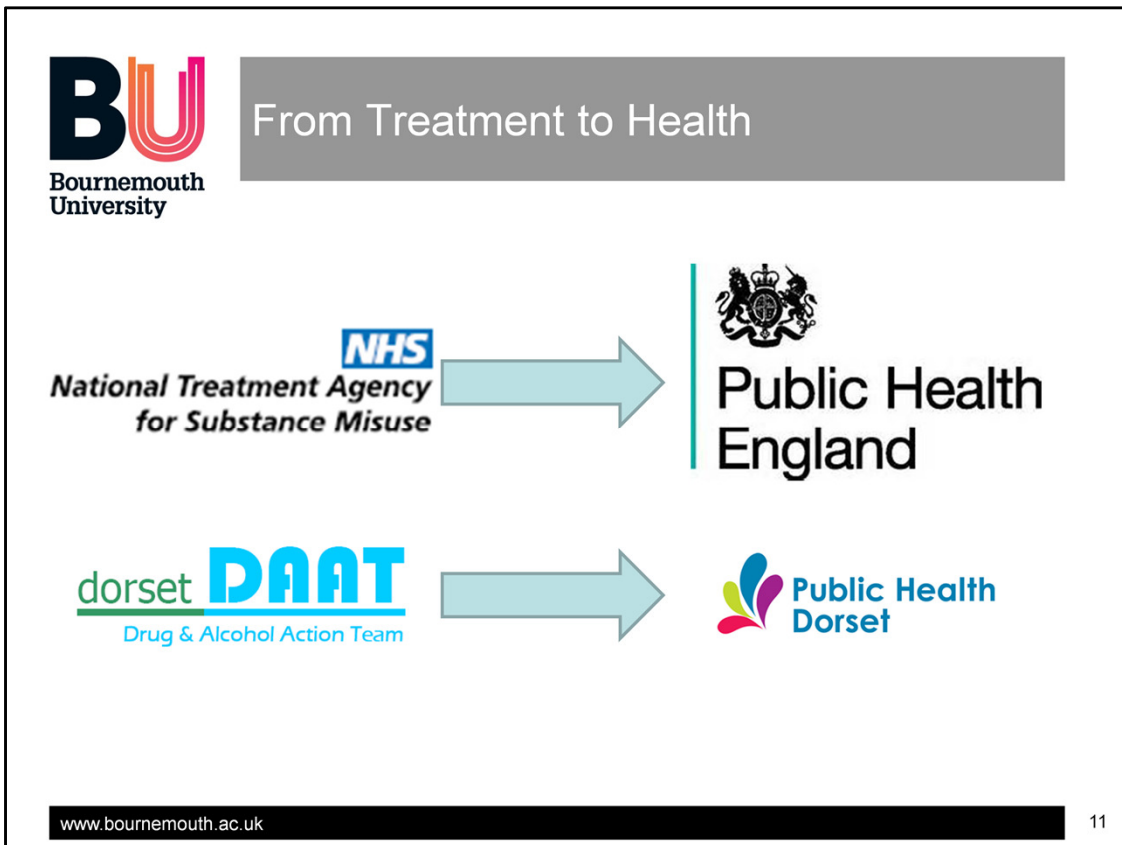
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Official drug advisers reject time limit on methadone substitution for addicts  
Advisory Council on the Misuse of Drugs says time limits advocated by

Paul Hayes, the former Chief Exec of the NTA has continued to make this argument since the demise of the organisation, most recently in a Guardian article just a couple of weeks ago.

This model of treatment is based on providing intensive, focused support for a relatively small group within society. The NTA provided estimates of the number of heroin and crack users in each local area, and commissioners had to show what proportion of this specific group they were engaging in treatment. Funding was to a large extent determined by how many of these people accessed drug treatment.

In the new commissioning world, two things have become standard orthodoxies: First, alcohol has been the 'poor relation' in terms of treatment, because the NTA never explicitly granted funding for it; and Second, the old model focused on getting people into treatment rather than moving them through to 'recovery', however that is defined. I'll spend more time today on the first of these claims.



The apparent rebalancing of treatment towards alcohol is about more than making sure that services are open to alcohol users as well as heroin users – in Dorset, for example, because of the nature of the area, we’ve already got a much higher proportion of alcohol users in our system than most other areas. The shift is emblematic of the change in governance, from the NTA to PHE (there’s always got to be an impenetrable abbreviation) – that is, Public Health England.



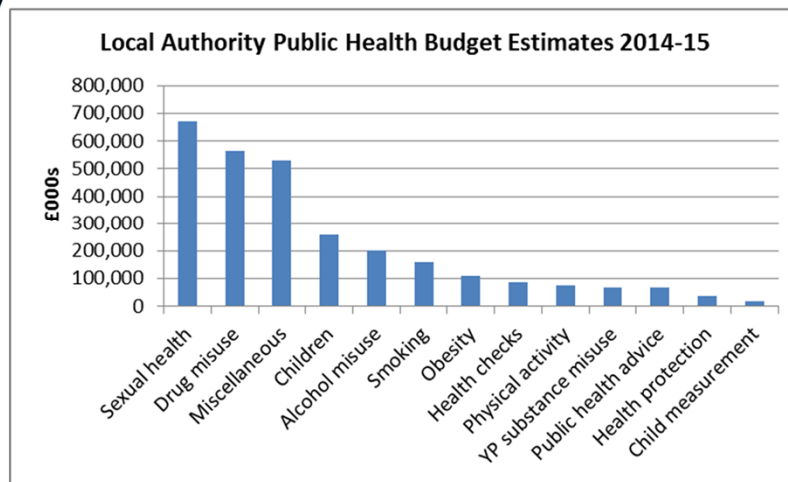
PHE will focus on securing improvements against seven priorities:

- **tackling obesity** particularly among children
- **reducing smoking** and stopping children starting
- reducing **harmful drinking** and alcohol-related hospital admissions
- ensuring **every child** has the **best start** in life
- **reducing the risk of dementia**, its incidence and prevalence in 65-75 year olds
- tackling the growth in **antimicrobial resistance**
- achieving a year-on-year decline in **tuberculosis** incidence

And here's the shift, signalled in the name: 'treatment' to 'public health'. The approach of public health is to think in terms of small shifts across a whole population: if we all reduce our alcohol consumption by a unit or two a week, we'd reduce the total numbers of alcohol-related deaths by a big number at an aggregate level, though the change in our individual risk would be barely noticeable. Alcohol Brief Interventions are the big tool available to local commissioners on this agenda, hence the title of my presentation. The old model of intensive treatment for heroin users doesn't fit this new philosophy – and note that alcohol is one of PHE's identified priorities, whereas drugs are not.

People at DrugScope like Marcus Roberts and Andrew Brown have written and spoken about this point, so I don't want to labour it here.

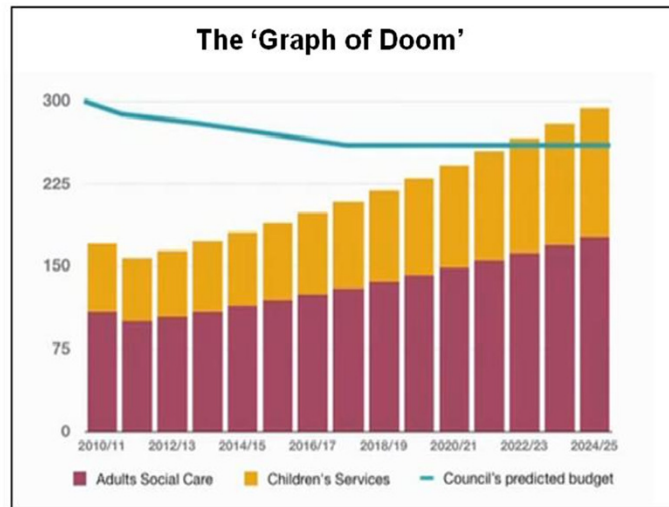
Another crucial change in the funding approach is that money is no longer ring-fenced for drug treatment (and soon won't even be ringfenced for public health activities more broadly) – and it's not based on performance metrics relating to heroin users.



Source: Local authority revenue expenditure and financing England: 2014 to 2015 budget (revised), published 22-10-14, <https://www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2014-to-2015-budget>

Perhaps just as importantly, this is no longer (even if only in principle) a patchwork of funding tied up through partnership arrangements; it's been wrapped up into the general local authority grant from central government (though as I say for the moment it remains ringfenced for public health). You can see how important this debate about the nature of substance use is when you look at how much of the public health budget is currently consumed by drug and alcohol treatment services.

## The Graph of Doom



Barnet 'Graph of Doom', Source: <http://inlogov.files.wordpress.com/2012/05/game-graph-2.jpg>

How much would public health want to get their hands on that for streams of work they feel have been underfunded historically? And how much would local authorities want to siphon that off to fund the forthcoming crisis in adult social care, illustrated by Barnet's 'graph of doom'?

“Councils spend about 30 per cent (£830 million a year) of their entire public health budget on drug and alcohol misuse – more than any other service. They argue this clamp-down would help reduce this staggering sum – so funds could be freed up for other health priorities.”



A recent press release from the Local Government Association actually stated this explicitly.



News story

## Alcohol, drugs and tobacco joint strategic needs assessment support pack

From: [Public Health England](#)  
First published: 1 October 2014  
Part of: [Public health](#)

PHE's alcohol, drugs and tobacco division has published a joint strategic needs assessment (JSNA) support pack.



PHE's alcohol, drugs and tobacco division has published a [joint strategic needs assessment \(JSNA\)](#) support pack on 1 October 2014 to help local areas develop joint strategic needs assessments and local joint health and wellbeing strategies that effectively address public health issues relating to alcohol, drug and tobacco use.

The support pack, which now in its third year is reviewed and updated annually, consists of 8 resources covering young people's substance misuse

From PHE, we see the move away from that kind of exceptionalism afforded heroin (and crack) use in the past. Guidance for alcohol, illicit drugs and tobacco are now all lumped together by PHE, in another example of that convergence I was talking about earlier.



Mike Power in Mixmag: <http://www.mixmag.net/words/features/small-towns-crap-drugs>

[www.bournemouth.ac.uk](http://www.bournemouth.ac.uk)

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But the change is more than this. The changes relating to funding are part of a broader shift to local autonomy. At a UK level, lots of elements of alcohol policy at least are devolved, and you'd find a different approach to drug treatment in Scotland. This is also played out at local level – and here's where some of my personal experience comes in. PHE guidance just doesn't carry the same weight as NTA requirements. That's actually the aim of the government's localism approach, and has lots of strengths: Dorset no longer needs to produce a crack strategy when there's hardly any crack use in the county, and it can develop a different approach to legal highs from Kent, where the supply operates much more through 'head shops' than in Dorset. On that issue of legal highs and local trends I can highly recommend this recent article in Mixmag by Mike Power called Small Towns, Crap Drugs.

Tuesday, December 02 2014

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Legal highs forfeited by court after raids on  
Heads and Phone Doctor in Folkestone, Third  
Eye in Canterbury, Bong Shop in Margate

by KentOnline reporter [multimediasdesk@thekmgroupp.co.uk](mailto:multimediasdesk@thekmgroupp.co.uk) 02 December 2014

A ground-breaking court case has led to hundreds of so-called legal highs seized at four shops in Kent to be permanently removed from use.

The shops - Headz and Phone Doctor in Folkestone, Third Eye in Canterbury and the Bong Shop in Margate - have been prevented from selling the products since enforcement action by KCC Trading Standards in July.

In a co-ordinated series of raids, officers from Kent and Medway Trading Standards, with the support of police, seized samples of so-called New Psychoactive Substances from shops across the county and suspended the sale of many more.

See <http://www.kentonline.co.uk/canterbury/news/court-orders-forfeit-of-hundreds-27923/>

But, as any political scientist worth their salt would point out, policymaking isn't a neutral, objective process of fitting a tailored solution to a specific problem identified through detailed evidence. This autonomy means that decisions are shaped by local views, sensibilities and beliefs. It's also important to note that, as in that Kent example, the regulation of psychoactive substances comes under the remit of Trading Standards as much as the Police, for example; there are a lot of perspectives and agencies involved with this agenda.

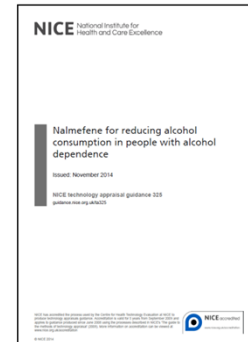
If this presentation has any key message, it's not really to identify detailed patterns in substance misuse governance and priorities at a local level; it's more to note that we can't yet tell how this is playing out. So I want to stress how important it is that future research doesn't only take the approach of my academic work – which some might describe as a little lazy – of reading policy documents and government announcements. We need research that looks at how drug and alcohol policy plays out locally.

I'm not saying we should only take a micro-level approach: if you read about small towns, crap drugs, it's clear the situation is the result of local dynamics mixed with national policy and international treaties and trade. But – though I'd be happy to be persuaded otherwise – I think there's an opportunity to do more policy-oriented local research. Where research in the field does look at micro areas in the UK, in my experience it's less about policy-making and more about

analysis of situations – for example, how well are individual treatment or A&E services dealing with substance use issues, or what does the night-time economy look like.

1.1 Nalmefene is recommended within its marketing authorisation, as an option for reducing alcohol consumption, for people with alcohol dependence:

- who have a high drinking risk level (defined as alcohol consumption of more than 60 g per day for men and more than 40 g per day for women, according to the World Health Organization's drinking risk levels) without physical withdrawal symptoms and
- who do not require immediate detoxification.



To give another example of the sort of thing I have in mind, [SLIDE] let's consider Nalmefene. This is a drug to reduce alcohol consumption by people who are drinking more than guidelines, but without being physically dependent.

There's important high-level national and international context for this. The drug has been developed by pharmaceutical company Lundbeck, which sponsors Alcohol Concern (note that both have an interest in problematising what some might see as relatively low levels of alcohol consumption) and it may not be a coincidence that the development of this use for an opiate derivative comes at a time when the treatment agenda has been moving away from prescribing for opiate addiction towards greater psychological input, and more focus on alcohol treatment even for those at the lower levels of the consumption spectrum.

But what does all that actually mean for drinkers themselves? Well, that will depend on what arrangements are made by local commissioners – and they have considerable influence over how these sorts of developments pan out. And I'm not just interested in whether (or how) Nalmefene is prescribed, but why that situation has come about.

And this isn't just dependent on views of substances, but also broader ideas of budgets and responsibilities. A question like "can crime and community safety be seen as a public health responsibility?" is crucial in this respect, and might be

answered very differently in different parts of the country. A case could be made that illicit use and crime damage population health as much as by affecting people's use of public space and eroding social capital within a community, as by transmitting of Hep C. That's an argument that will be played out in town and county halls across the country; not Westminster.

But I'm here not only as a researcher but as something of a practitioner, and although this may not be the right setting, I'd like to finish with some practical or political reflections on the implications of the apparent convergence of attitudes on different psychoactive substances – and maybe this amounts to a local policy position of mine that another researcher should be analysing.



“Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.”

(p.15)

My concern is not in identifying convergence as much as recommending it – as Transform do. For all its intellectual coherence and consistency, this position poses issues for setting strategic priorities. Not all drugs carry the same risks, for a variety of reasons. An argument of exceptionalism drove the investment into heroin treatment. This approach had its downsides (potentially stigmatising and singling out heroin users as unusual and pathologically criminal) but it did provide a framework that meant support was focused on some of the most vulnerable people in society – those who have the least ‘recovery capital’ to use the currently fashionable phrase. This might be seen as fitting with the public health idea of ‘proportionate universalism’, but this is a very difficult concept to understand and convey, and remains focused on the directly health-related outcomes relating to substance use. If policy is to be effective, we can’t simply understand substance use through a public health lens.

## They've got the money, the support and the background

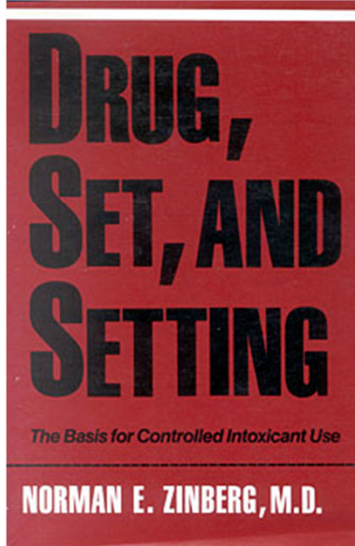
“You also have to beware – and this is where I listen very carefully to the Centre for Social Justice, who’ve done a huge amount of work in our most disadvantaged communities – there are those who might be wealthy and live in London and can take recreational drugs and they have good incomes and the strength and the family background to handle it. What you need to remember – and this is a really horrible fact – is that mortality from drugs is twice as high in the North East as it is in London, so there is also a qualitative difference between those who are taking drugs.”

“I make a factual statement. They’ve got the money, the support and the background to handle the problems that drugs bring.”

*Owen Paterson MP, Question Time, 30 Oct 2014*

And this is where I’m going to finish – with a slightly uncomfortable echo of Owen Paterson’s claim on Question Time the other week: drug use isn’t the same for everyone.





“I contended, first, that in order to understand what impels someone to use an illicit drug and how that drug affects the user, three determinants must be considered:

- drug (the pharmacologic action of the substance itself),
- set (the attitude of the person at the time of use, including his personality structure), and
- setting (the influence of the physical and social setting within which the use occurs).

Of these three determinants, setting had received the least attention and recognition; therefore, it was made the focus of the investigation. Thus the second hypothesis, a derivative of the first, was that it is the social setting, through the development of sanctions and rituals, that brings the use of illicit drugs under control.”

But I'd like to attempt to cover this point with the veil of academic legitimacy by noting how use does vary by our understandings of drug, set, and setting – and that goes for policymakers and those involved with service provision as much as users themselves. Let's remember to keep thinking about the detail and range of perspectives in this field, and local variations, and how those might shape policy in the future.

Thank you.

## From Methadone and the National Treatment Agency to Alcohol Brief Interventions and Public Health England

Reflections on the Direction of Travel in Local  
Government Substance Misuse Policy

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*December 2014*

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