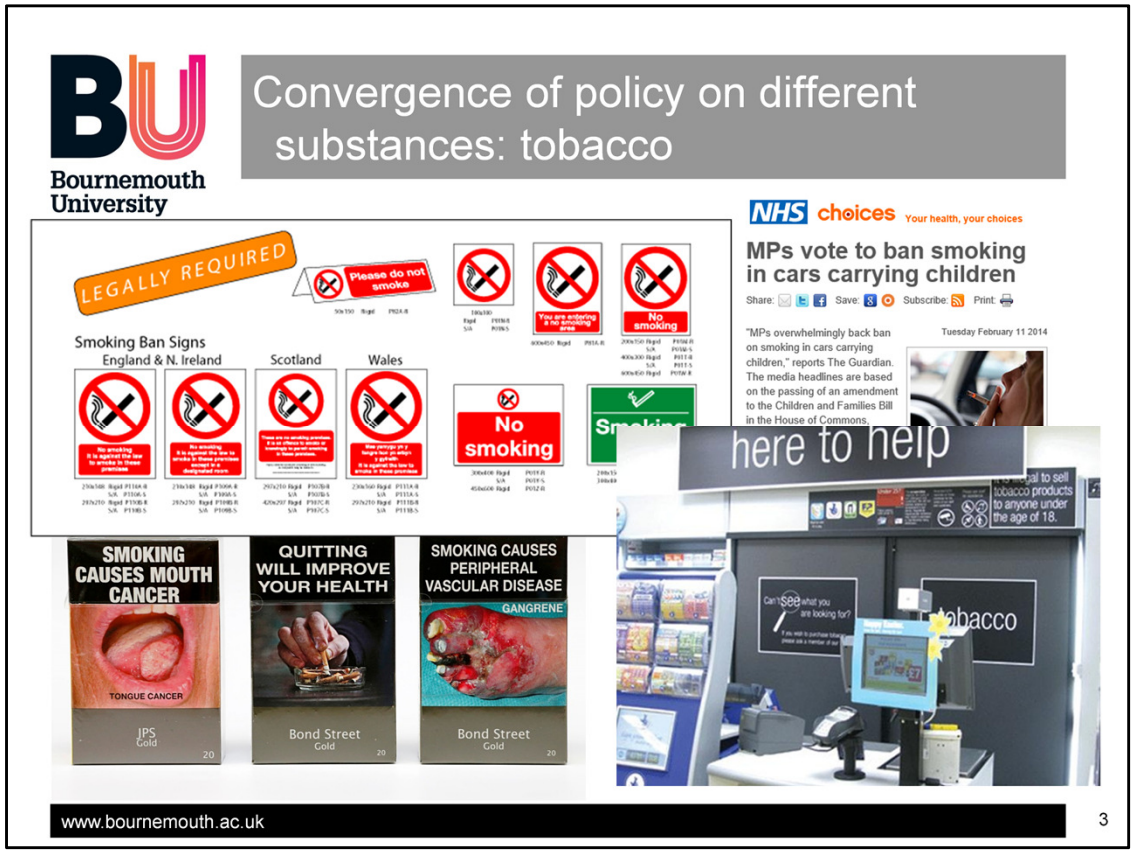
I thought I should begin this presentation with a bit of background about how I've come to be thinking about issues around substance use policy. I did a PhD a few years ago now on the sociology of young people's drinking in Bournemouth, focusing on how drinking reflected and constituted gender and class. 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.

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.



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.

Convergence of policy on different substances: caffeine

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)?

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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

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Issue

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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 exposés 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]) [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.

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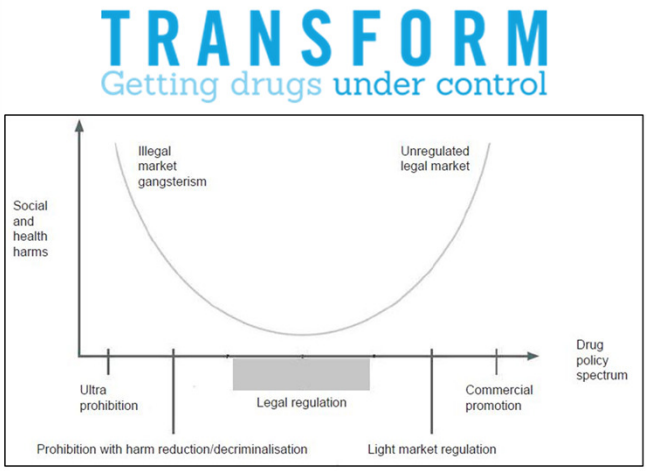
Convergence of policy on different substances: illegal drugs



www.bournemouth.ac.uk 5

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.

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).

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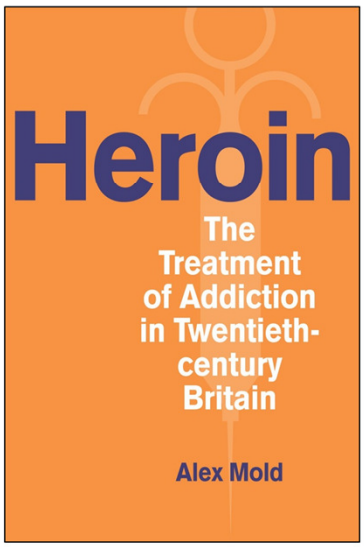
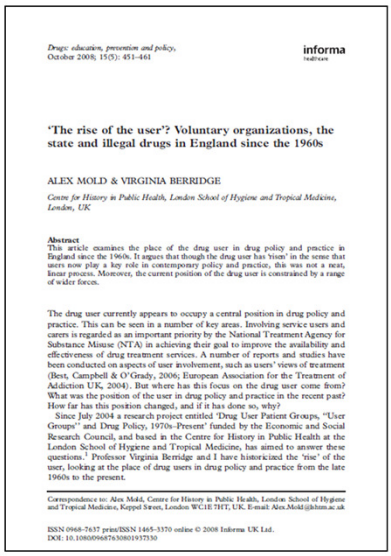
History of UK Drug Treatment





Drugs: education, prevention and policy,
October 2008; 15(5): 451–461

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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 constrained 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.[1] 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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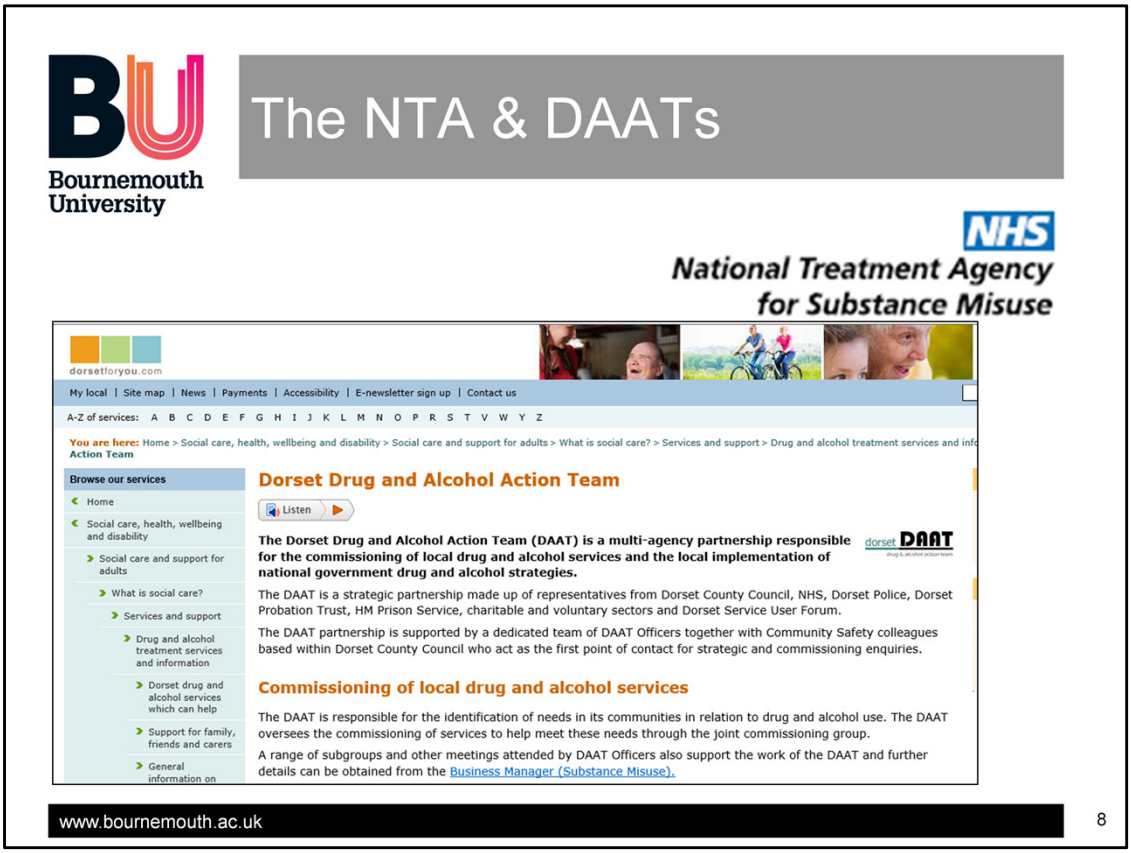
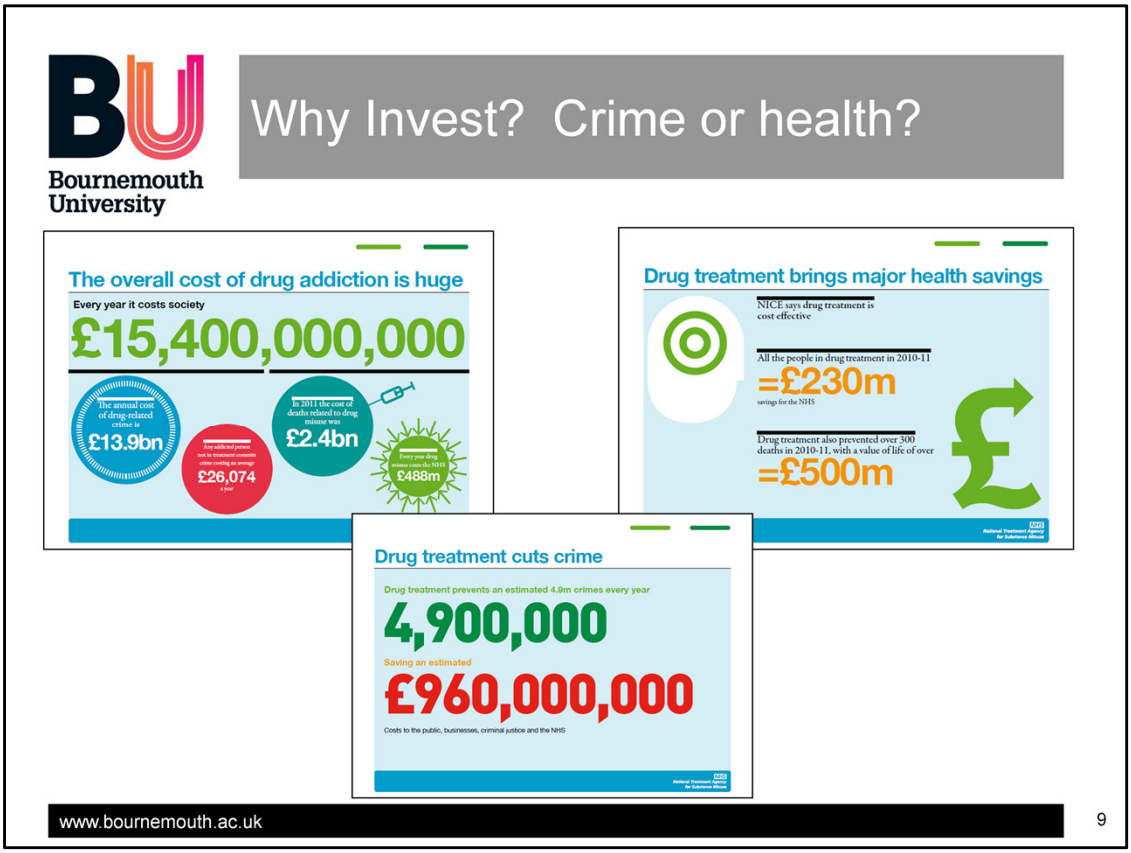
DOI: 10.1080/09687630801937530

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.

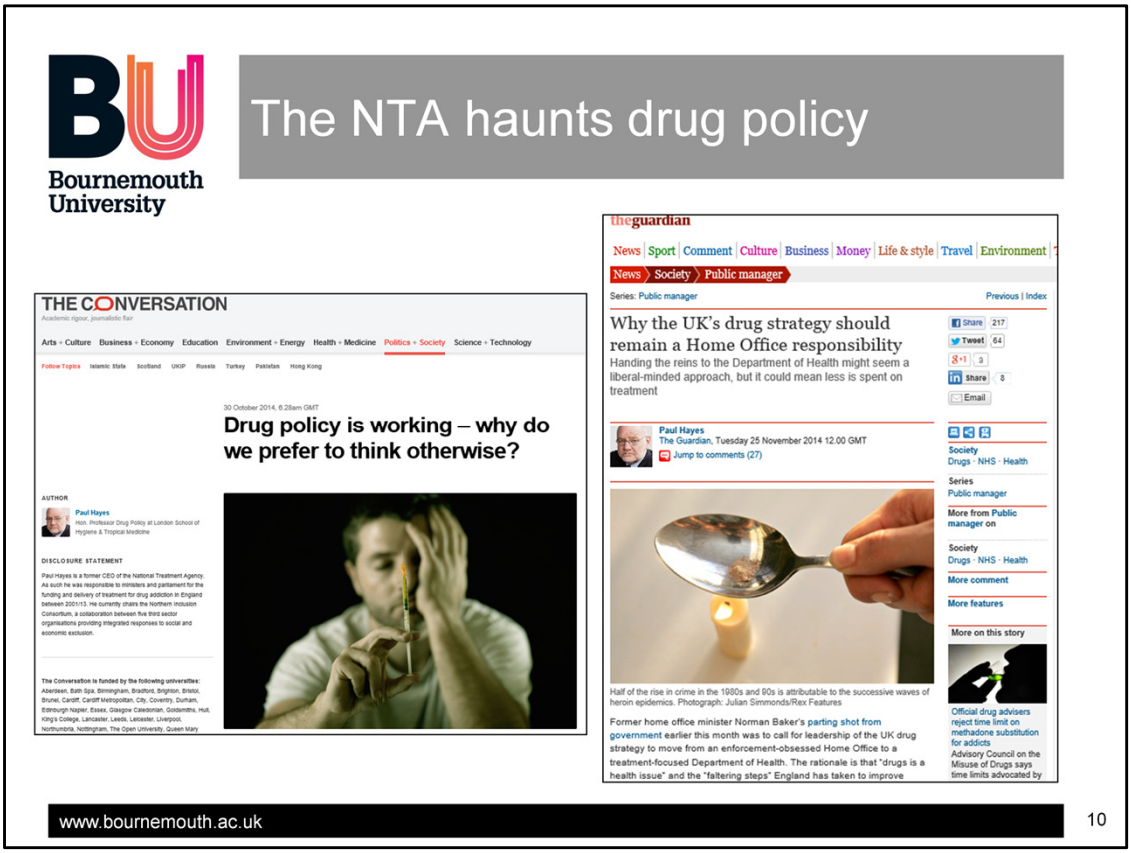


Now, apologies to those of you for whom this is stating the obvious, but I'll just sketch things relatively quickly. [SLIDE] The NTA was very much a New Labour creation, and focused on a specific group of drug users, whether referred to as PDUs (problem drug users), OCUs (opiate or crack users) or more 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.



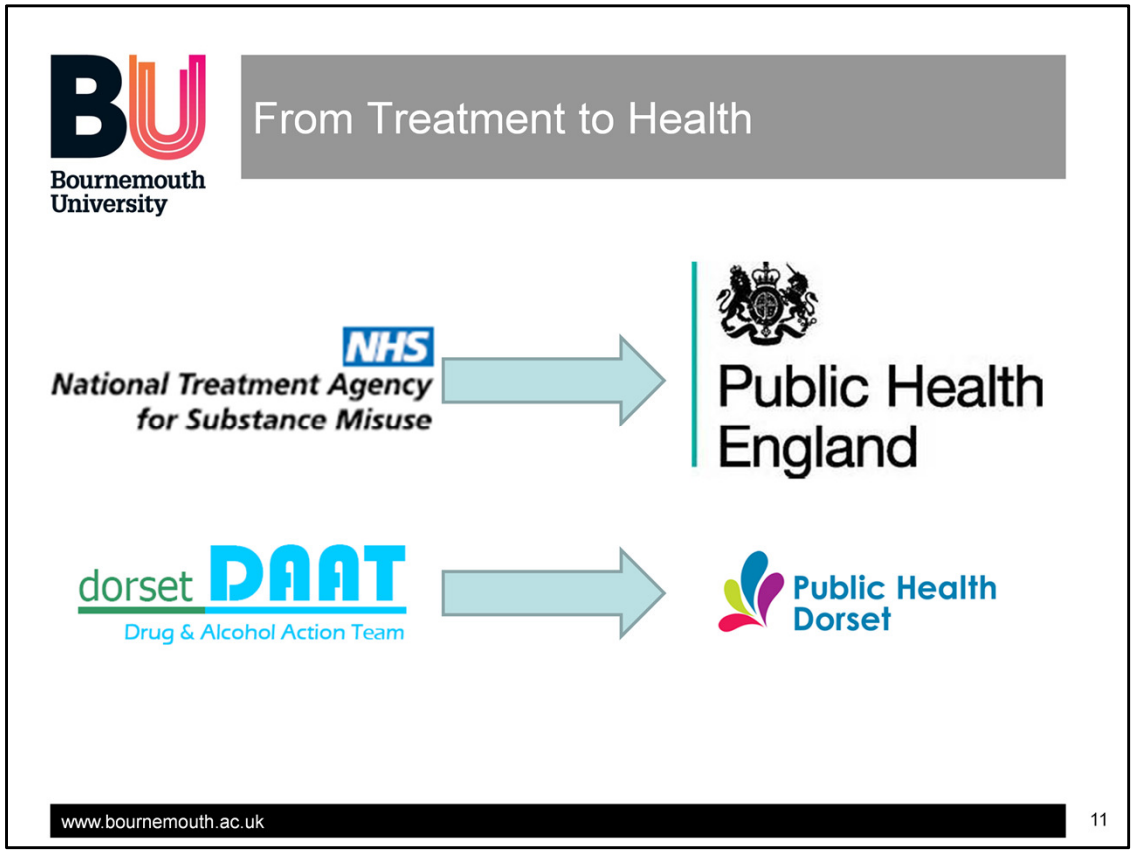
Regardless of the many potential justifications for funding drug treatment, the public rationale unfailingly focused on criminal justice issues. Drug treatment was a way of being 'tough on the causes of crime'. Benefits in terms of reducing the prevalence of HIV or Hepatitis C were mentioned, but to 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.



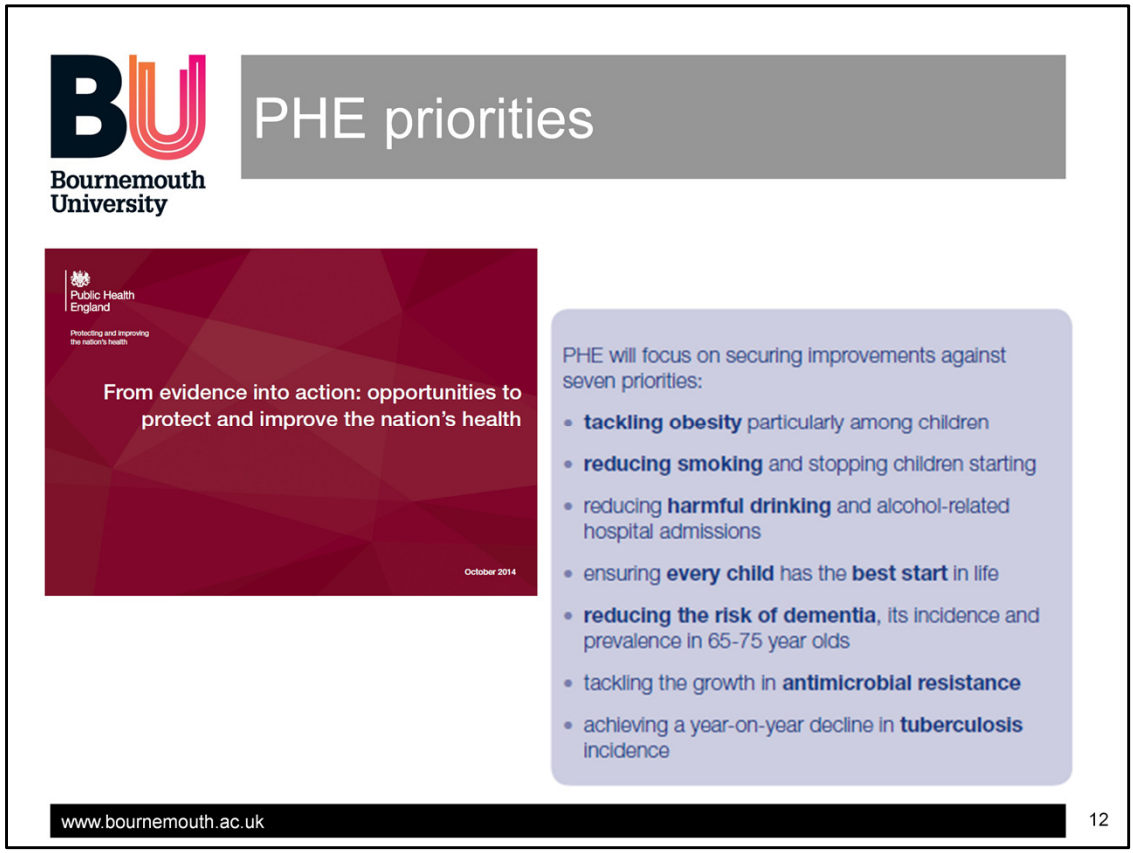
Paul Hayes, the former Chief Exec of the NTA has continued to make this argument since the demise of the organisation, most recently in a Guardian article just a couple of weeks ago.

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.



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.

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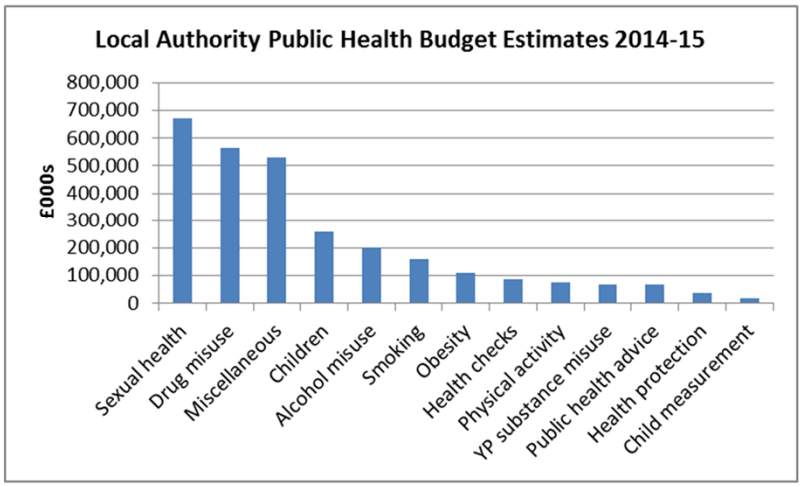
Spending within Public Health



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.

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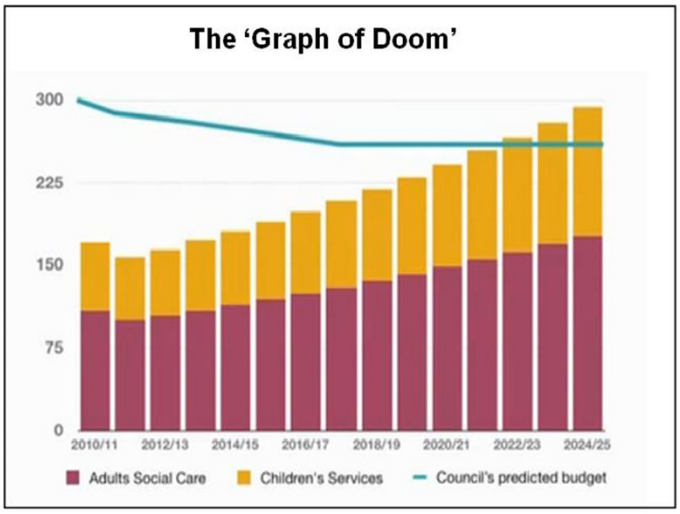
The Graph of Doom



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'?

Alternatives to drug treatment

"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.

Convergence at PHE?

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.

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The global goes local…

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

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.

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Police or Trading Standards?

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 multimediadesk@thekmgroup.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.

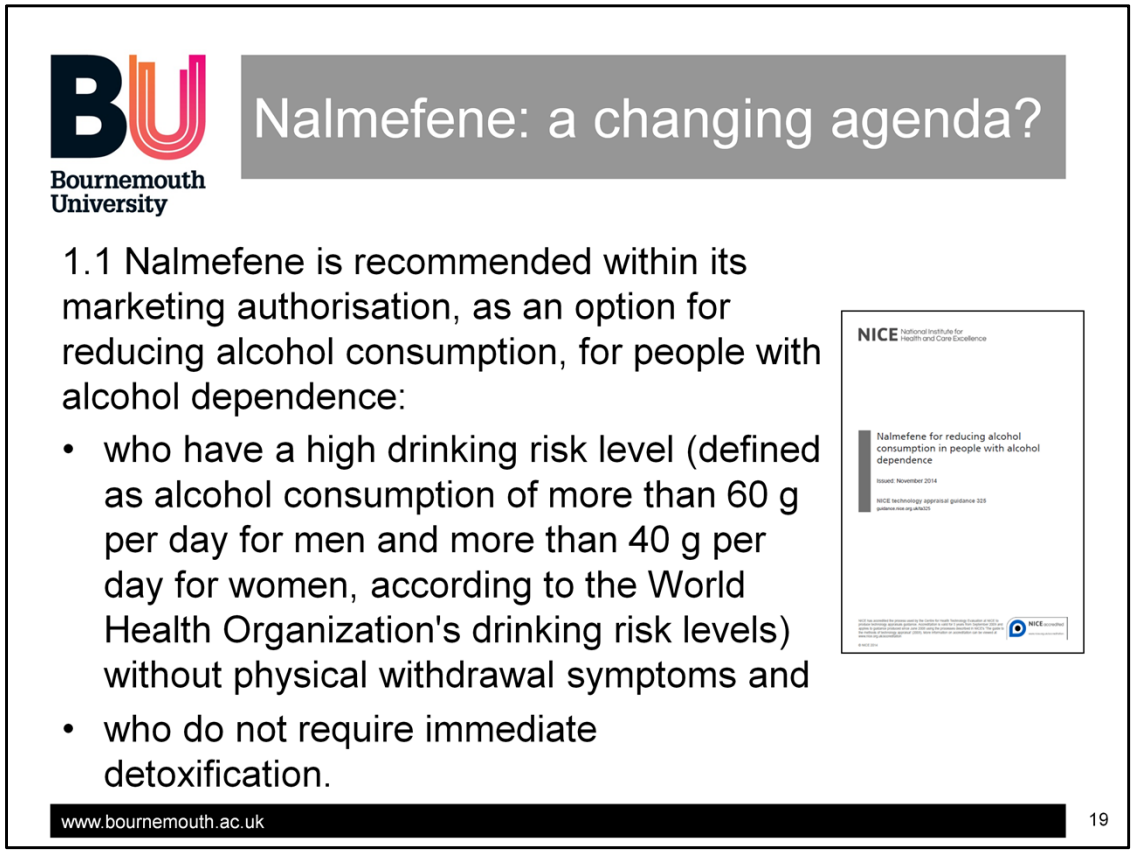
See http://www.kentonline.co.uk/canterbury/news/court-orders-forfeit-of-hundreds-27923/

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.



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.

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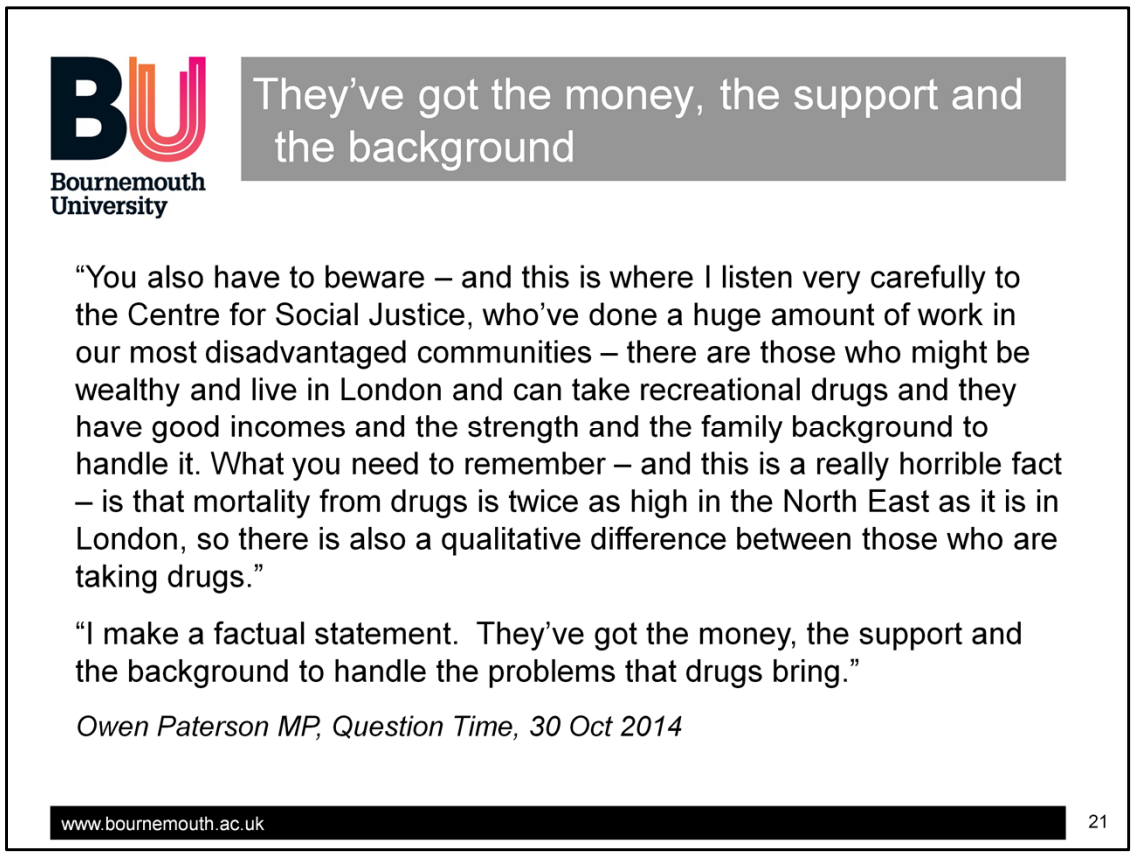
Explaining proportionate universalism

"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.



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.

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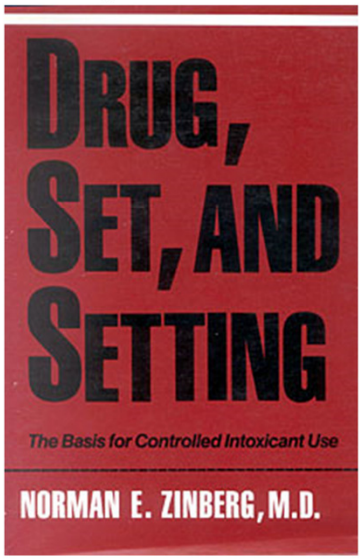
Drug, Set, and Setting



"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.

Bournemouth University

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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