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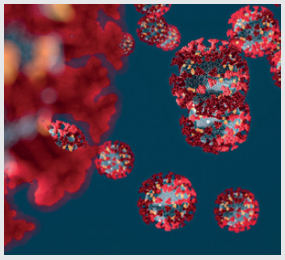

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'We have a unique role in breaking county lines'

THE PRESSURES OF THE PANDEMIC are diverting services into new ways of working, with plenty of energy spent adapting systems to ensure continuity of service. But this month's cover story (page 6) is a reminder that drug dealing is also having to adapt its business model. And unfortunately the varying stages of lockdown have opened up new opportunities – and necessity – for exploitation.

Shropshire's experience shows that there is no let-up in county lines activity, with lines changing and being replaced regularly. The only way we can tackle this violent and highly lucrative business effectively is by working closely with police and social services – and by realising that substance misuse services have a unique role to play in 'working holistically and without judgement' to help young people and vulnerable adults out of a trap that has become modern slavery.

Those young people – anyone's child – at the receiving end of youth justice, are themselves victims of crime and need our support at this vital time. This could be the crossroads at which they are able to escape from a cycle of crime and get the support they need to leave this terrifying situation behind – and we have to do better than let them join an even bigger training ground in the criminal justice system.

Claire Brown, editor
Keep in touch at www.drinkanddrugsnews.com and @DDNmagazine

Treatment services risk being overwhelmed, warns royal college

England's addiction services are not equipped to deal with the 'soaring numbers' of people drinking at high risk levels during the pandemic, warns the Royal College of Psychiatrists (RCPsych). Treatment services should be given 'a multi-million pound funding boost' in the next spending review to reverse years of harmful cuts, it states.

Almost one in five adults were drinking above the recommended weekly guidelines in June – around 8.5m people – up from just one in ten in February, while the number seeking help for opiate issues is at its highest level for five years, according to RCPsych's analysis of data from PHE and NDTMS. People with alcohol use disorder are also more likely to develop serious complications if they become infected with COVID-19, including acute respiratory distress syndrome, the royal college warns. A recent RCPsych report, *Next steps for funding mental health care in England*, also called for an extra £43m for children's drug and alcohol services along with £30m to improve existing services.

'COVID-19 has shown just how stretched, under-resourced and ill-equipped addiction services are to treat the growing numbers of vulnerable people living with this complex illness,' said chair of the royal college's addictions faculty, Prof Julia Sinclair. 'There are now only five NHS inpatient units in the country and no resource anywhere in my region to admit people who are alcohol dependent with co-existing mental illness. Drug-related deaths and alcohol-related hospital admissions were already at all-time highs before COVID-19. I fear that unless the government acts quickly we will see these numbers rise exponentially.'

'COVID-19 has shown just how stretched, under-resourced and ill-equipped addiction services are...'

PROF JULIA SINCLAIR

'It is understandable that the government is focussing on the most immediate harms of the pandemic,' added executive director at Change Grow Live, Nic Adamson. 'However, it is now essential that the government acts to address this increase in higher-risk drinking. The stakes have never been higher. Unless we have the capacity to reach and support over 3m more people who are now higher risk, the long-term implications for public health will be disastrous.'

Report at www.rcpsych.ac.uk

New alcohol strategy needed 'urgently' says commission

A NEW UK-WIDE ALCOHOL STRATEGY is now 'required urgently', according to a report from the Commission on Alcohol Harm. It should be evidence-based and science-led, and include targeted measures to support families and protect children, including from alcohol-related violence, the commission states. The commission – which is made up of cross-party MPs and peers as well as health experts – also wants to see the strategy 'changing the conversation and challenging alcohol's position in our culture', including addressing the stigma around harmful alcohol use.

Alcohol is 'inflicting long-lasting harm across all areas of society and family life', the commission states, with children living with an alcohol-dependent parent twice as likely to develop alcohol dependence themselves and three times as likely to consider suicide. 'Alcohol harm is a hidden health crisis that impacts us all,' said commission chair Baroness Finlay. 'For too long, the onus has been on individuals, with drinkers urged to "drink responsibly". We need to finally acknowledge the true scale of the harm caused by alcohol, which goes far beyond individuals who drink, and put the responsibility squarely with the harmful product itself. By doing so we will help to do away with the stigma and shame that surrounds those who are harmed by alcohol, and often stops them from accessing the help that they need.'

It's everywhere – alcohol's public face and private harm at ahauk.org/commission-on-alcohol-harm-report

'We need to... put the responsibility squarely with the harmful product itself.'

BARONESS FINLAY

Transparency loophole

THE AMOUNT OF RESEARCH FUNDED BY ALCOHOL COMPANIES or their affiliated organisations has increased by almost 60 per cent in just over a decade, according to research by the University of York. The industry is increasingly funding academic research into alcohol consumption, including studies that make claims about the health benefits of drinking, it says. Researchers found almost 13,500 studies that had been funded either directly or indirectly by the drinks industry, and add that this is likely to be the 'tip of the iceberg'.

The study identified a 'worrying trend' said co-author Dr Su Golder. While there had been a decline in the industry conducting its own health research there had been an increase in its funding of studies 'by providing financial support to researchers or via alcohol-related organisations', she said. This allowed companies to exploit a 'transparency loophole' as many people 'assume these organisations are charities and don't realise the connection to the industry'. Many of the studies made claims 'about the protective cardiovascular effects of alcohol and suggest that substance abuse problems are down to individual choices rather than industry behaviours'.

Cocaine purity at its highest in a decade

The purity of cocaine at retail level has increased every year since 2009, according to the latest *European drug report* from EMCDDA, while seizures of the drug are at an all-time high. More than 180 tonnes of cocaine were seized in 2018, with the number of people entering treatment for cocaine for the first time increasing across 22 countries.

'The high purity of the drug, along with data from treatment services, emergency presentations and drug-induced deaths, suggest that cocaine is now playing a more important role in the European drug problem,' the agency states. Alongside cocaine, there are also ongoing concerns around high-potency cannabis and ecstasy pills containing high levels of MDMA.

While COVID-19 has caused disruption to drug markets, there are fears that 'innovative drug distribution models developed during lockdown, along with the economic impact of the pandemic on vulnerable communities, will add to the challenges already posed by an abundant supply of drugs'. Although smuggling via passenger airlines has declined, trafficking via maritime shipping has continued at pre-pandemic levels, with customers and dealers also making increasing use of social media, the dark web and home delivery services to buy and sell drugs.

The volume of heroin seized in the EU almost doubled between 2017 and 2018, to just under ten tonnes, with access to OST remaining limited in some countries. Overdoses among the 50-plus age group increased by 75 per cent between 2012 and 2018, with an estimated 8,300 fatal overdoses in the EU in 2018. An increasingly complex drug market has also seen more seizures of substances such as GHB, LSD and ketamine, with 53 NSPs also detected for the first time in 2019. While many drug services were forced to close or provide a reduced service in the early days of lockdown, the sector had managed to successfully 'adapt and innovate' through use of online and mobile technology. 'As the economic repercussions of the crisis take effect, some in our communities may become more vulnerable to drug problems and drug market involvement, putting greater pressure on our already stretched services,' said EMCDDA director Alexis Goosdeel.

> The number of people entering treatment for cocaine for the first time increased across 22 countries.

European drug report 2020 at https://www.emcdda.europa.eu

Hearts and minds

SCOTTISH ATTITUDES TO MUP have become 'more favourable over time', according to analysis by Public Health Scotland. Researchers looked at responses to the 2013, 2015 and 2019 Scottish Social Attitudes Survey and found that the proportion in favour increase from 41.3 to 49.8 per cent. By 2019 respondents were almost twice as likely to be in favour of MUP as against (27.6 per cent). 'One interpretation is that the public's understanding of the policy and what it means for them has improved,' said public health intelligence advisor at the agency, Dr Karl Ferguson. 'A related possible explanation is that some concerns the public may have held prior to implementation have not been observed. For example, MUP did not increase prices across the board in the off- and on-trades, as it only directly influences the pricing of a minority of off-trade products.'

Strong words for opioids

STRONGER WARNINGS will be provided to people who take over-the-counter drugs containing opioids for non-cancer pain, according to the Medicines and Healthcare products Regulatory Agency (MHRA). The agency is asking healthcare professionals to warn anyone taking or planning to take the medicines about the risk of dependence, as well as agree a treatment plan to minimise potential problems. New warnings will also be added to patient information leaflets 'making it clear that the medicine is an opioid, which can cause addiction, and that there can be withdrawal symptoms if people stop taking it suddenly'.

'Patient safety is our highest priority and that is why we continually monitor the benefits and risks of opioid medicines,' said the agency's director of vigilance and risk management of medicines, Sarah Branch. 'Last year, we announced that opioid-containing medicine packaging must carry warnings. Now we are strengthening those warnings to ensure that opioid medicines are supplied with consistent information on how to manage the risk of addiction.'

> 'Patient safety is our highest priority.'
> SARAH BRANCH

Local News

Leading the way
Red Rose Recovery's Emma Daggers has become patient representative and national lead for the recovery community at the Royal College of Psychiatrists. 'This is a brilliant opportunity for us all and I hope you all know how grateful I am for the continued support I have received from RRR and the encouragement and belief from partnership organisations,' she said.

Skilling up
WDP has renewed its partnership with leading adult education college City Lit to offer service users a wide range of learning opportunities in return for Capital Card points. The collaboration will allow service users to 'learn new skills, develop their interests or take up a new hobby,' said WDP chair Yasmin Batliwala.

Challenging times
Outside Edge Theatre Company has launched a crowdfunding campaign to meet a 40 per cent growth in demand for its services since lockdown. 'More people than ever are reaching out to us for help with acute feelings of loneliness, boredom and depression, which often trigger relapse,' it says. *edgetc.org*

Just a child

The exploitation involved in 'county lines' is an urgent call for action, as **DDN** reports

The brutal killing of a 16-year-old boy shook his community in Shropshire. How had this happened on the streets of Shrewsbury? As the investigation began, a picture emerged that took all of the support services by surprise.

Michael had been living in the county, miles away from his home in Merseyside, for 18 months. Not only was he hidden from sight; his life had been taken over – and ended – by a drug dealing network that has become known as 'county lines'.

'What we uncovered was a turf war battle between two gangs,' says Sonya Jones, service manager and safeguarding lead at We Are With You, Shropshire. 'Michael was killed as part of a turf wars gang.' In the days that followed, Jones and her colleagues discovered 'many active lines' in the county: 'It changes on a regular basis – between ten to 20 lines are running actively at one time in Shropshire. As soon as one is taken out by the police, another one springs up,'

The term 'county lines' was coined in 2015 and has become recognised as a business model. County lines evolved as a result of market saturation, where gangs from London, Manchester, Birmingham and Liverpool began to work out of regional markets, says Jones. Children are used because they are an 'easily controlled and quite an inexpensive resource – often referred to as Bics, as in Bic razor, because they are so disposable'.

The business model is built on exploitation – of vulnerable adults as well as children. Properties are taken over, or 'cuckooed', and the young people are used to 'run' the drugs, travelling between urban and county locations to replenish stock.

Recruitment usually takes place using free or extremely cheap cannabis, to entice children into the gang. The grooming starts at about 13, and many of the children are previously unknown to services, explains Jones. Before they know it, they are ensnared by debt bondage – a police 'stop and search' or a fake robbery removes £60 worth of cannabis – and they are trapped in the gang, 'modern day slaves'.

'Gangs are always looking at ways to keep them within their control and power, dehumanising their thoughts about the adult service users who they would be selling to,' she says. 'Once they are in debt bondage, the distribution of class A drugs really takes hold and the children have no control of anything.'

Some of these children are 'vulnerable' – young people with complex mental health needs, with 'looked after' status, excluded from school, or experiencing poverty and family breakdown. But equally, it can happen to anyone's child.

'I spoke to a father yesterday who had paid off two thousand pounds of a drug debt to a gang,' says Jones. 'His son is 16, an A level student who started smoking cannabis. He was offered free cannabis to sell to a friend, took that opportunity, and has ended up in debt which his parents have paid off.'

Over the past few months, however, COVID has changed the business model. A heightened police presence has prompted the

'Youth justice is set up to work with perpetrators – but what we know is that these children are not perpetrators, they are actual victims of crimes themselves. They are victims of modern slavery.'

SONYA JONES

16- and 17-year-olds who have become quite well known to local police – and who are still in debt bondage themselves – to recruit younger children of 12, 13, 14, to do the drug running. 'County lines are becoming increasingly hidden,' says Jones, with many young people being moved around the county under the cover of darkness.

Dr Paul Andell, senior lecturer in criminology at the University of Suffolk, is in a position to give further insight into gang culture, having interviewed young people and gang members in three regions, on six sites, over ten years, and undertaken numerous policy reviews.

The transition of some gangs from 'street-based collectives' to organised crime networks has raised important safeguarding issues, he says, where young people are both perpetrators and victims of crime.

'Young people were committing horrendous acts on each other and there was a culture of violence emerging because globalised gangster culture was playing its part on how people should behave, mediated of course through social media,' he says. He mentions scaldings with sugared water, slashings which were videoed, and people being bundled into the boots of cars and kidnapped.

The workforce has a structure, with junior members kept in check with 'symbolic violence' – they are given a beating, and everyone gets to know about it. If somebody robs the line or encroaches on custom, it becomes more extreme. 'We've seen an increase in these violent acts,' says Andell.

Top left: 28 February 2020, London. British Transport police in operation as part of operation Sentinel, tackling drug crime.
Credit: Paul Iwala / Alamy
Top: Clacton, Essex, 6 February 2020. Essex Police execute county lines drug dealing search warrants across Essex and London, resulting in a number of arrests and seizure of class A drugs and cash.
Credit: Ricci Fothergill / Alamy

Lethal violence is prompting many of the 'smarter' kids to leave the drugs business, which leaves 'a pool of more vulnerable young people' taking their place. The incentives are social capital, bonding, a need to belong and be part of a family and a social network, he says, as well as 'the promise of a glittering future in the drug-dealing world, the promise of riches'. Coming from a background of social exclusion can increase the odds, when 'young people might not make it in the legitimate economy, so they try their luck in the illegitimate economy'.

His research matches Jones' experience that cannabis is usually the access drug: 'Cannabis markets are the talent pool,' he says. 'If you can be trusted in the cannabis market, you can be trusted in the class A market.' The other element is the 'boyfriend model', which involves young girls through ecstasy: 'The girls think that the perpetrators are their boyfriends and often this happens in a party setting, hence the high level of party drugs used by the young females,' says Jones.

Dame Carol Black's *Review of drugs* (*DDN*, February, page 4) talks of young people and children being pulled into the drugs supply on an alarming scale, especially at the most dangerous end of the market. This very violent business model earns profits of more than £800,000 a year from an individual line, she says, with 'the rise in the county lines business model a major factor in increased drug-related violence'.

Much of this chimes with *The Lammy review* (September 2017) and its recommendations for the youth justice system. Joining the cross-party parliamentary group discussion, shadow justice secretary David Lammy said there was nothing new about adults recruiting young people into organised crime.

'When we talk about these young people caught up with knives and drugs, the poverty and austerity that led them into that, we must realise that this is nothing new – it's old. All you need to do to understand that is to read *Oliver Twist*.

'Until we get serious about dealing with organised crime – and resource it – we're not going to crack the problem,' he added. This meant reforming prison and probation systems, because 'recidivism rates are the worst in Europe. There's something not working when there's a cycle of crime and people are committing crimes over again and the system is not rehabilitating them.'

While waiting for national strategy reform, there is also much that can be done to improve knowledge locally with stakeholders, says Anders. There needs to be 'a focus on situational and social prevention – interventions which bring about neighbourhood improvement' and eradicate childhood poverty, 'because many of the young people involved in county lines come from relatively deprived neighbourhoods'. Social and agency interventions need to move away from incarceration – 'those recruitment grounds for gangs' – and towards community supervision and peer-led work.

Just as Shropshire's services learned from the shocking case in their county, there are important lessons for all concerned with youth justice and safeguarding. 'We need to re-examine the traditional victim-perpetrator dynamic because it's more complex than that,' says Anders, and has ramifications for training and practice across all the services.

Supporting the 'absolutely crucial' multi-agency approach, Sonya Jones points to the 'quite unique' role of substance misuse services in having the knowledge and expertise to work holistically and without judgement.

'We are not social services, we are not youth justice, we are a service where young people feel that they want support... we become their advocates,' she says. 'Youth justice is set up to work with perpetrators – but what we know is that these children are not perpetrators, they are actual victims of crimes themselves. They are victims of modern slavery.' **DDN**

Discussion in this article took place at the latest Drugs, Alcohol and Justice Cross-Party Parliamentary Group's Zoom meeting on county lines, gangs and youth justice.

SUPERVISED HUMILIATION?

In the real world, methadone provision too often means diversion, using on top – and humiliating supervised consumption, says **Alex Boyt**

Janine Wiedel / Alamy

Methadone can be a life saver, both metaphorically and literally. However, many heroin users do not welcome daily methadone consumption – it's harder to get off than heroin and does not address trauma in the way that heroin does – it doesn't hit the sweet spot. With methadone, withdrawals go on twice as long, it's a nastier habit, it hooks you in deeper. Many users want methadone occasionally – it makes complete sense to them – but they must take it every day, or not at all. The treatment system demands it.

In contrast, I was diagnosed with ADHD some years back and after being prescribed Ritalin, I found that my daily dose of the long-acting time-release drug did not suit me, I didn't want to be permanently medicated. My consultant told me that my prescription was appropriate for my condition and that I should continue with it. I told him that his job was to help me reach my desired outcomes, not have me comply with his regime. He relented, I received a mixture of short and long- acting pills of different strengths, and for many years I've used Ritalin at the dose I want and when I need it – I often have days off.

NO SUBSTITUTIONS

When I was a heroin user, there were times I received a methadone prescription. Like many of my peers, I did not want to substitute heroin for methadone – I wanted methadone for when I could not get heroin, so that I didn't go into withdrawals. Heroin withdrawal generates a degree of physical and psychological distress that is all-consuming. I wanted methadone so that I did not do crazy things to get money, so that I did not inject other people's old dried blood clots or crushed up pills, hoping for relief.

There was a time when I was prescribed methadone in a way that worked for me. I went to the chemist weekly to collect my take-home supply. Eighty ml a day was the prescription, and two or three times a week I took some. The unused methadone went into lemonade bottles and was kept under the sink. The dose was 'a swig out of the bottle when needed'. Some methadone I gave to friends when they were stuck, some I sold to buy heroin or food, but that awful dread of withdrawal was gone – methadone was insurance.

My partner fell pregnant and, worried that her drug use may be reported to social services and risk having our baby taken into care, she disengaged from treatment. Her smaller methadone prescription was stopped. She cut down her heroin use and my methadone was sufficient to both keep her steady and give me an occasional emergency dose.

The service, however, grew increasingly concerned that my drug use was not reducing. My urine tests, when I gave them, were sometimes clean when I was able to manipulate the process – once or twice I would have shown up as pregnant myself – but too often heroin was detected. The service response was to increase my methadone dose to 90 then 100 up to 120ml a day. The service did not understand – and I was unable to say – that my prescription largely served a different purpose to my street drug use.

One day, collecting my script, I was called into a room and given the news that I was to be put on supervised consumption – my daily dose was to be consumed at the chemist watched by the pharmacist as I could not be trusted. Each day I was to consume 120ml of methadone that I did not want or need. My partner was now in trouble. I tried containers in the neck of my shirt to pour the methadone in while pretending to drink my dose, but it didn't work and I left with methadone dripping down my clothes. The daily ritual humiliation did not last long – I disengaged with the service.

USING ON TOP

Many years later, I was working as the service user coordinator for Camden Council in central London. The commissioners wanted to know why 30 per cent of those on methadone were using on top of their script. I took the question to the user forum, where 50 people with lived experience laughed. Taking a straw poll of raised hands, the majority thought the figure was more like 90 per cent. Reporting back to the commissioners, the issue was dropped – they could not be the first to reveal the emperor had no clothes.

> 'I did not want to substitute heroin for methadone... I wanted methadone so that I did not do crazy things to get money, so that I did not inject other people's old dried blood clots or crushed up pills, hoping for relief.'

The client wants to be well thought of and definitely doesn't want to be punished with supervised consumption, so they under-report drug use. The worker wants to think they are doing well and to report success to their manager, so the under-reporting suits them. The service wants to report low drug use to the commissioners who in turn want to perform favourably compared to other areas. So, on one level, the worker says to the client 'what's the problem?' and the client replies 'I'm not going to tell you, and the worker says 'great, I don't want to know'. The therapeutic relationship is too often based on this agreement. I remember service users telling me that when asked for a urine sample, suggesting 'next month might be better' often worked.

DEATH IS NO DETERRENT

Methadone is a powerful drug. It is mentioned in significant numbers of drug-related deaths, but those numbers are lower than those mentioning heroin. Those not in treatment are more likely to die than those who are supported by a service, and methadone prescribing is the number one evidenced intervention in reducing drug-related deaths. Supervised consumption may be considered to increase safety, but it drives people out of treatment and prevents people from engaging. I remember a client who was cut off his script for missing three days methadone consumption at the pharmacy and was back on street drugs. He told me, 'I can die, as long as I don't die on their methadone.'

Supervised consumption may have a place in the treatment system, but it is over-used – a recent small study questioned how much safety it provides, and many more would consider engaging it if wasn't a requirement. Methadone is diverted – it is not always the name on the prescription that gets the dose. It is not helpful to consider users as failing to comply with the regime, or showing they cannot be trusted, as too many workers and services do. It is traumatised people helping friends or coping as best they can with the daily emergency of battling withdrawals, anxiety, self-hatred, and the judgement of others.

A BREATHING SPACE

Standing in the dock at court nearly 20 years ago, I feared the worst. The judge sentenced me to two years in prison, but before they could take me down, I swallowed the methadone from a bottle in my pocket that a friend had given me. I was not going into withdrawals alongside the shock of the sentence. It gave me breathing space before I was seen by prison healthcare the next day – methadone met my need perfectly.

There are some good services and drug workers. I like to think somewhere a user is saying to a drug service, 'Your job is to help me meet my desired outcomes, not to get me to comply with your regime', and the drug service saying, 'Sure, how can we help?'

My son is happy and healthy and has just finished his first year at Bristol University. We rarely see his mother – she is still a chaotic drug user. Every now and then she engages with a drug service, but she cannot do the supervised consumption. Some days she is stuck in bed, some days she has enough drugs – she never lasts more than a week or two.

Positive signals

Giving families a clear and consistent route to help makes all the difference, as **DDN** reports

'When you work with families in an uncoordinated way and you've got lots of different professionals trying to address issues separately, it doesn't work,' says Teresa Leitäo, senior policy advisor at the Troubled Families Programme. 'It's very overwhelming for the family and can be quite ineffective for the services involved.'

Contributing to a 'parental alcohol and drug use' webinar, she shared experience from the programme, which had been designed to support families with multiple vulnerabilities – mental and physical health problems and other interlinked issues.

Services needed to work together to make referral procedures easy, spot problems early on, and put the right support in place as soon as possible, she said. This coordination would make it easier to measure data and track outcomes, and make sure that the right services were involved – including bringing together the 'two worlds' of family guidance and substance misuse support.

Discussing adverse childhood experiences (ACEs) had resulted in some strong partnerships, said Sheena Carr, deputy head of the Children, Young People and Families Team at Public Health England. But we needed to consider that ACEs 'sit within a broader context of vulnerability'. A public-health informed approach was helpful in looking at causes of inequality and circumstances where activity should be prioritised, she said, and making sure children had supportive networks around them was important in helping them to deal effectively with stresses they might encounter at home.

Dr Wulf Livingstone, reader in social science at Wrexham Glyndwr University, talked about multiple vulnerabilities which often overlapped – child protection relating to substance misuse, domestic abuse and mental health. Issues such as school exclusion, food poverty and the responsibility of being a young carer – with maybe a parent that is entering end of care through drug and alcohol use – were bound to have an impact.

Often it was impossible to determine where the starting point was, or the trigger, and 'it's probably not helpful to look for whether or not one causes the other,' he said. But we could be sure that 'merely the stopping of substance use in itself is never really a solution... if that's all we concentrate on we will probably just return people to the very difficult situation that they live in without a coping mechanism.'

Strength-based interventions were vital instead of 'negative, deficit-based conversations', with screening tools used whenever possible. The other really important element – as the previous speakers had said – was to work inclusively with the entire family, even if work took place independently with different members. Putting this time in would help to kick-start the appropriate interventions and identify the 'practical day-to-day barriers' to progress, such as no food on the table or a leaky bathroom – things that needed to be solved to create the capacity for change.

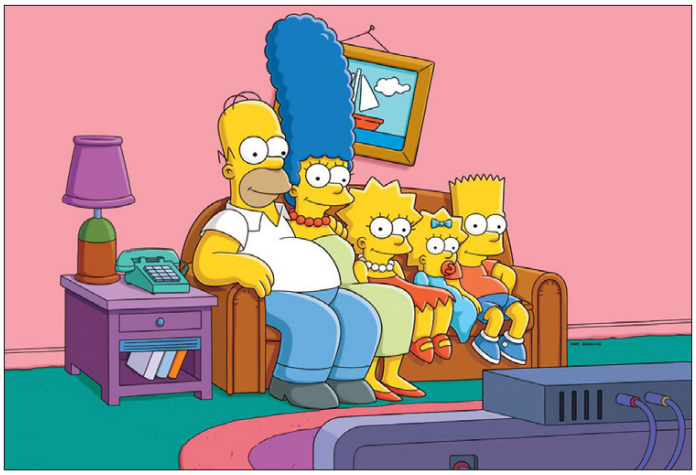
'...you've got lots of different professionals trying to address issues separately, it doesn't work.'

TERESA LEITÄO


Saklakova/iStock

The recurring conversations about a 'multi-agency approach' were frustrating, he added. After all the reports that had been produced, 'it shouldn't really even be a conversation anymore'. We were still having people being referred to as 'hot potatoes' and still having families experiencing 18 hours from 18 agencies instead of 18 hours of interventions from one or two workers and agencies. Good communication should be coupled with 'greater levels of respect between agencies and disciplines' to bring about holistic family interventions, he said.

The Building Bridges project in St Helens, Merseyside, shared some techniques from their programmes working with families. James Mawhinney and Kayah Woods of the social work team at Change Grow Live explained that they focused on 'behaviour and behaviour change as opposed to specific substances, because that allows us to address a realm of issues.'



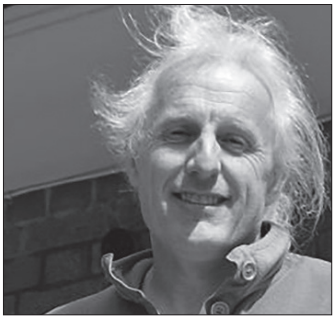
One effective tool was to use the Simpson family (the Matt Groening animated sitcom) to help people understand the roles played within the family relating to addiction, as it was much easier to talk about a family other than their own. Homer was the person experiencing addiction, with the other family members feeling powerless to make any positive change themselves. Marge was in the 'enabler' role, while trying to hold the family together; Bart was the clown, deflecting attention from the addiction; and Maggie was the lost child, left in the background.

Talking in this way had helped families with extremely complex needs to understand their situation and the perspectives of others in the family, and talk about what support they needed. The programme was achieving very positive results in improving family relationships, giving children the confidence to engage with school again, and helping adults to stop their alcohol use.

A key part of this success was the positive focus on a strength-based approach, which was cancelling out feelings of shame and stigma. Lesley Davies, senior manager in prevention and early help at North Tyneside Council, added to this by explaining positive progress of the Bottled Up project. The North East's drinking culture meant the area had a reputation as a 'party capital' and North Tyneside had 'the lowest number of abstainers in the North East', so they wanted to work with a wide variety of partners, including the voluntary sector, to see what they could do differently.

The initiatives that were rolled out aimed to get people talking about alcohol, particularly in families, and enable children to be more open about it instead of feeling they had to hide it. A 'whole systems pathway' for North Tyneside included different training packages to include the whole workforce, from brief interventions to a more specialist approach.

Where there were problems relating to drugs and alcohol, the aim was to identify them early and use a strength-based approach with the family, 'helping them identify what they can do to move on and change things.'



'...merely the stopping of substance use in itself is never really a solution.'

DR WULF LIVINGSTONE

Getting to the stage of using evidence-based interventions effectively depended on workers going out to meet the family within the community and forming a team around them from the beginning – a team with 'a really creative and flexible approach'. 'We have had some parents that hadn't engaged in programmes and treatment before,' said Davies, so going out to do work with them in the community had had 'a huge impact'.

The situation around COVID had obviously brought challenges with the lockdown restrictions, particularly as there had been no let-up in referrals. But it had also brought opportunities in reaching vulnerable children, as many of them enjoyed having online diary sessions and had started 'really engaging and getting their voice across'. It had given an opportunity to talk to someone during lockdown about their parents' drinking, 'and also to be able to talk to other people of similar ages who are going through the same thing,' she said.

One of the main themes to emerge from the session was that there was evidence-based practice to implement and no shortage of expertise throughout the health and social care sectors. The challenge was to streamline the approach to the family so they could take one step, then the next, with a consistent professional partner. **DDN**

The webinar, 'Children of alcohol dependent parents', was held by Public Health England. Resources are available at the Innovation Fund Knowledge Hub: https://khub.net/group/parental-alcohol-and-drug-use

One effective tool was to use the Simpson family to help people understand the roles played within the family relating to addiction

We need to talk abou

While it may be nominally legal, medical marijuana needs to be far more easily available and its use encouraged by treatment services, says **Nick Goldstein**

The curse of COVID makes writing about substance misuse treatment virtually impossible. Not only has localism fractured treatment policy and practice over the years, but now COVID has completely overshadowed everything. Who knows what's going to come out the other end? We're seeing society unalterably changed and it's happening at breakneck speed. Only a fool would claim to have an overview of this chaos and although I've been called many things, 'fool' was never one of them – yet, anyway.

Nil desperandum though, guys. There are some things that are so large that whatever happens with COVID they will make a significant impact on arrival, and one of those is medical marijuana.

Medical marijuana is the use of the cannabis plant and its derivatives for their healing properties. These medicinal effects aren't exactly hot news. In fact we've been using medical marijuana for thousands of years – it's mentioned in Chinese medical texts from around three thousand years before Christ put in an appearance. The list of ailments it can alleviate and treat is far too long to get into here but it includes many serious conditions and illnesses that really have no other treatments. Medical marijuana's benefits are great enough for its use to be an accepted treatment in many countries – despite the demonisation and prohibition of cannabis for decades – and even America has seen the light and offers medical marijuana as a treatment choice.

For those who've been living in a dark cave, marijuana was made available on prescription in the UK in November 2018. But before we all rush off to the doctor's I should point out that – as is sadly far too often the case – our medical profession wimped out. I guess after all those years at medical school they're reluctant to risk the ire of the tabloids and the BMA disciplinary committee and have consequently sat on their prescription pads and used the hackneyed excuse that there's not enough evidence medical marijuana is worthy of treatment on the NHS. They're right in that there is a shortage of research – drug companies believe medical marijuana will cost them money rather than make it. So, no money, no research and no research, no prescription – we're back at square one. But to add insult to injury medical marijuana is now legal and available – in theory. You gotta love doctors. What was it, guys? Ah yes, 'first, do no harm.'

> Marijuana offers a much safer alternative than central nervous system depressants for those desperately trying to maximise their under-prescribed dose

And this deeply ironic state of affairs is how things have been stumbling along for the last couple of years – until recently. At the end of 2019 Professor David Nutt's Drug Science started the Twenty21 project, the aim of which is to sign up 20,000 patients by 2021. Hopefully this will not only offer relief to the 20,000, but also provide the evidence to enable medical marijuana to be offered universally on the NHS whilst saving the medical profession from requiring a spine.

Carly Barton, a medical marijuana campaigner, has recently produced the 'Cancard' which would allow anyone stopped while in possession of cannabis to prove their cannabis was medicinal and not for recreational use and so avoid prosecution – an approach supported by none other than the Police Federation and National Police Chief's Council. The Cancard aims to reach over a million people who will benefit from medical marijuana by November 2020.

Medical marijuana dispensaries are becoming common in the United States as individual states adopt laws legalising cannabis to treat medical symptoms. Credit: Bdingman, Peter Kim, Jonathan Weiss, Dmitry Tishchenko / Dreamstime.com

t medical marijuana

The Cancard will allow anyone stopped whilst in possession of cannabis to prove their cannabis is medicinal and not for recreational use and so avoid prosecution

One way or another, like it or not, medical marijuana will soon be a fully integrated medicine and then it's going to come into contact with substance misuse treatment.

A civilised country with a good substance misuse system would see medical marijuana as a boon and encourage suitable users in need to access it, but we don't have a good treatment system – and, to be honest, I'm not sure how civilised the country is these days. Anyway, it should be seen as a boon because medical marijuana could play several roles in treatment. Firstly, it can help in recovery. Apologies to all the NA crew, but it's perfectly sane to encourage those in post-acute withdrawal to take marijuana to relieve the minor aches and pains and, more importantly, offer significant help with the psychological aspects of withdrawal.

Secondly, marijuana can also play a role for those on longer term maintenance treatment where it can be used in conjunction with OST to improve compliance. It's also worth pointing out that after a decade of sub-optimal dosing many users are struggling on too low a dosage and quietly making the difference up with benzos and booze, which is the most dangerous drug combination out there. Marijuana offers a much safer alternative than central nervous system depressants for those desperately trying to maximise their under-prescribed dose.

On top of the specific benefits, service users are people too. So, all the general advantages that everyone else derives from medical marijuana also apply to them, and considering service users are an ageing group with a whole range of aches, pains and illnesses will only mean a larger intersection between service users' needs and medical marijuana use.

So, medical marijuana will be a boon, right? Well, maybe – if service users are allowed to use medical marijuana, but that is by no means certain. Maybe I'm paranoid to question treatment providers' approach to medical marijuana, but history suggests that while I might be paranoid, they really are out to get me. I won't be surprised to see treatment providers disapprove of service users also using medical marijuana. Let's face it, many doctors, key workers and others have a negative, black and white view of drug use. So, perceiving cannabis as medication rather than kicks might be a step too far.

This has happened before. America is years ahead of the UK in regards to medical marijuana and many American substance misuse clinic users are prohibited from using medical marijuana. They face being booted from treatment (even if they pay for it) for using what is essentially a legal medication. I appreciate America is a different land but it would take a brave man to bet against the same blinkered approach happening in treatment services here.

In rising Spice use we already have an example of what can happen when marijuana is poorly classified, and its use punished rather than accepted and even valued. Personally, I'm going to use weed anyway, but as I age my reasons for using change and now I often use to relieve assorted aches and pains. It would be sensible, not to mention compassionate, to let me access medical marijuana legally and openly. To be clear, encouraging medical marijuana use for clients in need should be seen as best practice. Sadly, sense and compassion are in short supply these days.

Nick Goldstein is a service user

I AM A...

Leanne Smullen-Bethell is head of house at **Phoenix's National Specialist Family Service**, where people can seek treatment for their substance use problems while staying together as a family. She tells us about her role

I've worked here for 11 years. I have a passion for supporting people with addiction problems and the opportunity to work with mums and dads who are trying to overcome addiction really interested me.

The day starts by checking how the parents are feeling. We discuss activities for the day and arrange appointments. There will be a group session of therapy followed by lunch. The children will be cared for by our lovely childcare team whilst the parents take part in the therapy session. Afternoons can vary – sometimes there will be a one-to-one session with a key worker, activities like bowling, swimming, walks to the park or parent and child play sessions. There may also be appointments with midwives, health visitors or social care professionals. Children are settled in the evening for adults to take part in recreational group sessions and relaxation time before bed.

Our family service provides comprehensive care focused on assessing child development and wellbeing, as well as making observations around parenting. The work done by our childcare team is crucial in helping us deliver our programme. Our nursery is Ofsted registered, and rated 'outstanding'.

We give parents a chance to come to our service with their children– this is unusual as we are the only service in the UK that supports dads as well as mums. We really believe in giving all parents an opportunity to be with their children, and for children to be with their parents. There are 2.9m lone parent families in the UK and 90 per cent of those are children with an absent father.

We help families to stop using drugs or alcohol dependently and become more stable parents. We offer support through the later stages of pregnancy, childbirth and into the early stages of parenting. We work with mums and dads to work through difficult emotions and daily challenges so that they no longer feel the need to use substances to function.

When we see people come to the service completely broken, desperate for help, we offer them a safe place to work on their recovery with their children. Without the work that we do most of those kids would end up in the care system. We give hope to families where they may have had none – and the programme works.

The service has a really high success rate – 85 per cent of families successfully recover and leave the service with their children, which is a wonderful thing – particularly considering the national average success rate for residential treatment is 57 per cent.

Christmas is just around the corner and it's a really magical time here at the family service. We have a big Christmas lunch with presents and lots of food and activities. We decorate the house and everyone really gets involved. We really try to create opportunities for families to make memories.

If there's one thing I would change it would be to give more chances to enter the service. Access to a specialist residential service such as the one I manage in Sheffield is really hard – not because we can't or won't accept more families but because accessing the opportunities for parents with addiction problems can be more challenging. A big fear for families is that if they ask for help they are at risk of their children being taken into care. If more local authorities invested in supporting mums and dads to improve their lives earlier, that may prevent parent and child separation further down the line through the courts.

'The work done by our childcare team is crucial in helping us deliver our programme. Our nursery is Ofsted registered, and rated "outstanding".'

To anyone considering a similar career, I would say: if helping people is your passion, then go for it. A career in addiction services can be the most rewarding job of all. Knowing that you can help someone who is broken to rebuild their life is just amazing. You get to meet lots of really interesting people and have the privilege of hearing their stories and being a part of their recovery journey. What can be better than that? **DDN**

OUR 'I AM A...' CAREERS SERIES aims to share knowledge and experience of different careers in the sector. You can take part through the 'get in touch' button on our website: **www.drinkanddrugsnews.com/i-am-a/**

THE RIGHT CHOICES

Lockdown has been a reminder that residential rehabs are an essential part of the treatment landscape and must remain so, says **Hannah Shead** of Trevi House, part of the Choices network

Ijzendoorn | Dreamstime.com

It feels too soon to start reflecting on COVID. We are still very much living it, and will do so for some time to come. However, it does feel the right time to stop and recognise the remarkable collaboration and innovation of people working in the residential rehab sector. It also feels important to acknowledge that against a backdrop of uncertainty and fear, a significant number of people have made great gains in their recovery – some good things have happened during some crazy, scary weeks.

Like most rehabs, Trevi quickly implemented a lockdown model. We reduced the footfall of staff coming onto project and moved to a model whereby small teams came and lived and worked on site for three days. Groups were 'Zoomed' into the home, as were the women's sessions with their one-to-one therapists, and everyone pitched in with cooking and cleaning. Staff knew that keeping Trevi open was a top priority, as many of the women only have their child in their care as a result of being placed together with us. If Trevi had closed not only could it have jeopardised their recovery, it would also have meant separation from their child.

> '...a significant number of people have made great gains in their recovery – some good things have happened during some crazy, scary weeks.'

One of the interesting trends from rehabs in the Choices network is how few unplanned exits we saw during this period. At Trevi, no one left during the lockdown. The women trusted us to keep them and their children safe whilst they continued to focus on their recovery. This is a theme echoed through the network, with many rehabs in the Choices network reporting 100 per cent completion rates during lockdown.

Rehabs also found ways to innovate, despite fewer staff attending on site. At Yeldall, for example, the residents worked together to create a prayer garden. 'It's been beautiful to see everyone come together and do their own little bit of the prayer garden, and it's really helped me mentally and spiritually to come down here and meditate,' says James, a resident.

Sadly, not all rehabs were able to keep their doors open – it just wasn't safe enough. Hebron House made the difficult decision to close before the peak of the pandemic. Using a mix of phone calls, Zoom and WhatsApp, the team soon put together a seven-day-a-week programme of groups or one-to-one support that residents could access from their homes.

'We thought that this would be a "holding zone" until we re-opened but it soon became clear that these women were working hard and progressing on their journey,' says Emma, Hebron's CEO. 'A wonderful secondary benefit of this programme meant that we also connected with up to 40 ex-graduates who joined in some of the activities, and all participated on WhatsApp.' Hebron has now reopened and is including Zoom for pre-admission interviews and its aftercare programme.

As we look to the future, those of us in the Choices network are all wondering what 'living with COVID' is going to be like. We are trying our hardest to adapt to our new normal, but anyone who has ever worked in a rehab will know how counterintuitive it is to enforce social distancing – learning how to connect with people physically is often part of the recovery journey.

I hope that one thing the last few weeks has demonstrated is that residential rehab remains a vital part of the treatment landscape. The Choices network have worked with a large number of incredibly vulnerable people during lockdown, not just keeping them safe and alive but sowing the seeds of recovery and helping to prepare them for a life free from addiction.

As those in power start to make some tough decisions about budgets, drug and alcohol treatment funding and the longer term COVID recovery, I hope that investment in the residential sector is recognised as an essential, not a luxury.

Find out more about the Choices network and the work of its member rehabs at choicesrehabs.com

MAKING CAPITAL

Bill Nelles reports from Canada's first virtual recovery capital conference

It takes several days and nights to cross Canada by rail and longer to drive, so attending national conferences here isn't like the UK. But a conference took place at the start of September unlike any other I have attended – the virtual *Recovery Capital* Conference of Canada 2020 was organised by Last Door, a long-standing residential project in Greater Vancouver that provides care in various settings to around 150 clients, and beamed live across the country.

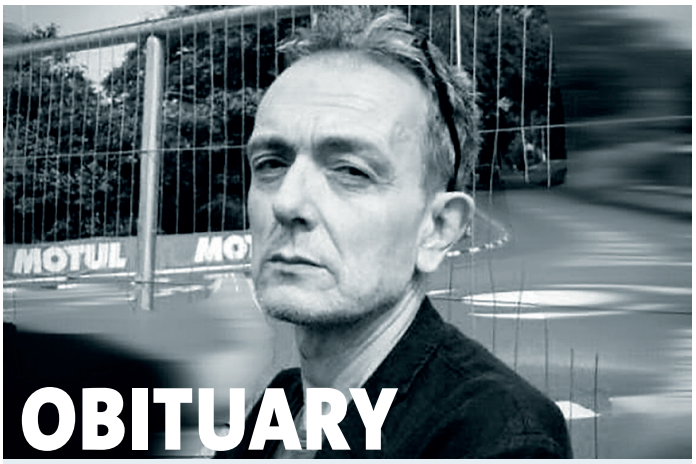
Last Door announced that they would not be holding their usual recovery champion conference, which usually brings around 300 people together, and instead decided to hold this year's conference as a virtual event. With sponsorship from all sorts of institutions, and government and political participants involved, they welcomed 1,600 people from all across Canada, with participants able to message other attendees and ask questions of the speakers.

The concept of recovery capital is not as familiar in Canada as it has become in the UK, and Dr David Best – well known in the UK for his work in this area – gave one of the best-rated presentations of the day, where he explained both recovery capital and the importance of becoming resilient. And resilience is becoming the watchword here in British Columbia because the number of fatal overdoses continues to rise, despite all the efforts being made. More people died of illicit drug overdoses in BC in the first eight months of 2020 than in the whole of 2019, and nearly 200 people continue dying in this way every month. So the need to provide opportunities for people to get help has never been more pressing.

Recovery is such a personal thing, and whilst some define it as the renunciation of all psychoactive substances, there are many who have fought to widen the definition to include those who change their lives and stop using street drugs through medical treatments. So it was particularly pleasant to hear several of the presenting peers talk about the help they had received from medication in the course of their own journey.

One effect of the opiate emergency here has been to sharply reduce the arguments and competition around how people get better and just what comprises recovery – we all pitch in together regardless of how we found our path. There's no better way to show this than to read the Opioids Survivors Guide which six of us wrote last year – it covers all the ways for people to stay alive.

Graphic by Hawkfeather Peterson. Opioids Survivors Guide *available at https://www.bccsu.ca/opioids-survivors-guide/*



OBITUARY
GARY SUTTON

Bill Nelles says goodbye to an irreplaceable friend and colleague

I'd like to pay tribute to my dear friend and colleague, Gary Sutton, who passed on earlier in September. Gary was in a league of his own – loved and respected by thousands of people whose lives he touched during his career as an advocate and expert witness.

For so many, he was the heart at Release, the UK charity that provides legal assistance to those charged with drug offences. As head of drug services, he broadened the charity's ability to help users in crisis over treatment as well as the law, and authored countless special reports. Having also found time to gain a master's degree in therapeutic counselling, he regularly lectured as well as providing help to clients at various projects. As a senior member of a leading legal agency, Gary was also a frequent witness for the defence (of course) as well as working alongside leaders in the field.

Gary had a dry sense of humour which made him great fun to be around. Sitting with him after a successful conference was always a warm and happy experience. He was a great listener but also a great raconteur. His cheeky – but more often, earnest – expression, especially when describing a particularly egregious situation, will always be with me, for Gary also had strong principles that he did not compromise.

> 'Gary was in a league of his own – loved and respected by thousands of people whose lives he touched...'

As a founding director on the board of the Alliance in 1998, he always gave me invaluable advice and counsel. For five years, he was my wingman, sharing his perspectives on all manner of things – particularly treatment policy and practice. When I saw him last around 2009 he was happy and fulfilled, with love all around him.

Release always had a special place in my heart, and when Gary joined their staff team I knew he was in the right place at the right time. He packed more into his twenty-plus years there than most people do in a long lifetime. He will be greatly missed for he was, quite simply, irreplaceable.

They said what..?

Spotlight on the national media

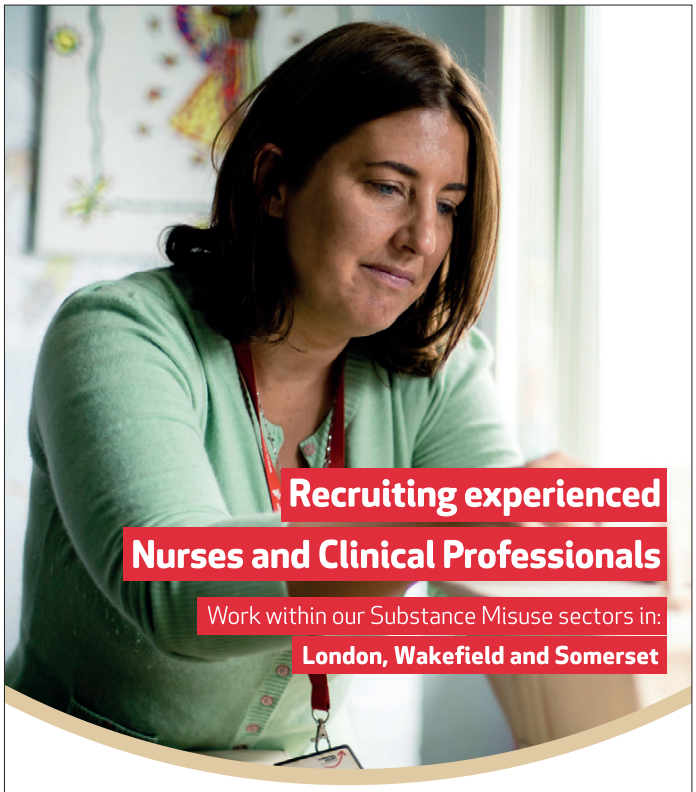
THERE REMAINS CONSIDERABLE STIGMA AROUND DRUG USE, which largely falls into two strands. There's snobbish (and often racist) moralising, where people who use drugs are looked down upon as 'junkies', feckless and irresponsible people to whom we owe no sympathy. There's also a 'punching up' version, which posits recreational drug use as a metropolitan decadence for hedge-fund managers, students at Bristol University and Michael Gove... But the problem here is the law itself and how it's applied, rather than any one demographic fuelling demand... Lambasting privileged people who use drugs plays into the same discourse that justifies criminalisation.
James Grieg, Guardian, 5 September

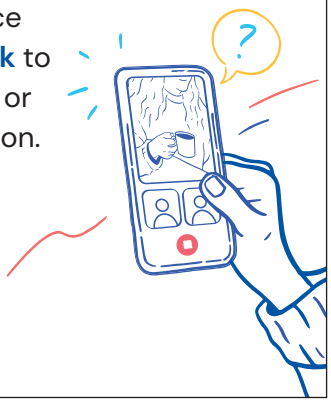
'Lambasting privileged people who use drugs plays into the same discourse that justifies criminalisation.'

THERE IS GREAT CONCERN that what little is left of public health will now be further weakened and marginalised. This fate would be very much in keeping with this government's philosophy that sees individual behaviour as being the source of health problems and believes that the role of the state should be limited to providing information to the public and then leaving them to make their own choices. This completely ignores the fact that major public health problems such as alcohol and substance misuse, sexual health, obesity, and smoking are societal issues where political and policy decision-making dictates, to a very large extent, the degree to which the health of the whole population is damaged or improved. There is no doubt that it is the government's behaviour that needs to change, otherwise all we will experience is serial bouts of victim-blaming where individuals are held responsible for their own ill-health.
Gabriel Scally, Guardian, 9 September

WHILE THE STIGMA AROUND MENTAL HEALTH disorders is thankfully waning, the same cannot be said for people with an alcohol use disorder. The question of 'fault' looms strongly over individuals. People with an addiction are made to feel ashamed and treated as if they simply can't be bothered to stop. Current attitudes mean that pledging to improve their services is not a vote winner and those struggling to cope are forgotten.
Julia Sinclair, Independent, 16 September

COUNTY LINES OPERATIONS exploit young and vulnerable teenagers to act as drug couriers by drug gangs, meaning they take the greatest risks as they are the most visible part of the supply and distribution chain of illicit drugs. In any other setting this abuse of young children would attract the attention and support of the state via social services, who would intervene to ensure they were removed from this activity and adequately protected. But this is about illegal drugs where the state response has a history of illogical action based on ideology not caring pragmatism.
Ian Hamilton, Independent, 26 September





Change Grow Live

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You'll speak to someone from our online team. They'll introduce themselves and ask for your first name. Then they'll ask you some questions to understand more about the situation.

They'll give you any guidance they think will be helpful to you and let you know about the help and services available for the person you are supporting.

Our webchat is available on:
Monday, Tuesday, Thursday, and Friday from 09:00 to 18:00 and on Wednesday from 09:00 to 14:00 and 15:00 to 18:00.