HOTTER THAN JULY – JOBS, NEWS AND VIEWS

DDN
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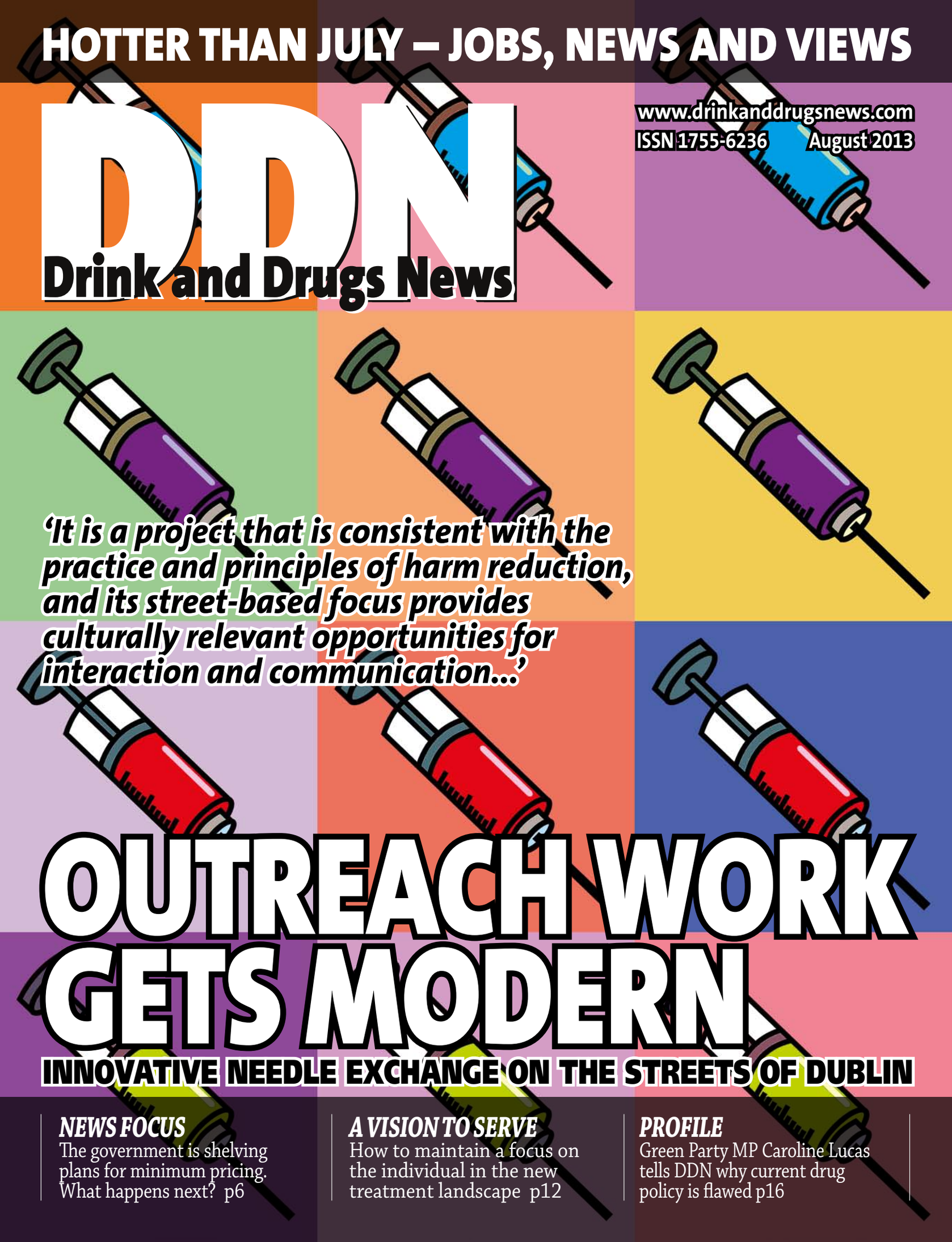

'It is a project that is consistent with the practice and principles of harm reduction, and its street-based focus provides culturally relevant opportunities for interaction and communication...'

OUTREACH WORK GETS MODERN

INNOVATIVE NEEDLE EXCHANGE ON THE STREETS OF DUBLIN

UK RECOVERY WALK
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Keep innovating

We want to share your good ideas

This month's cover story (page 8) documents a logical approach to something that should be straightforward, but so often isn't. How often do services wait for clients to come knocking when they're hardly likely to? True outreach means seeking out the people most in need of services and literally reaching out to them, while being mindful of every aspect of their dignity. Seeing evidence of the Ana Liffey Project's work on the streets of Dublin impressed Stephen Parkin enough to find out more, and to think about how such logical, street-based harm reduction initiatives could be transplanted elsewhere. 'All our staff are very client focused – we're constantly seeking new ways to reach marginalised clients,' says the project's director, Tony Duffin, and it's this constant quest for innovation that's so relevant.

With this in mind, we'd like to invite your contributions to our new 'good practice exchange', to be featured in the magazine and on our website. Do you have a successful initiative that you'd like to share with other readers – maybe a familiar area of practice that you've approached a little differently or with a certain flair, or an innovative twist that's worked particularly well for you? We all spend too long reinventing the wheel – please share your ideas with us. You might just spark a new initiative elsewhere in the country.

This issue

FEATURES

REGULARS

NEWS IN BRIEF

NOT FOILED AGAIN

The government has accepted the ACMD's advice to allow for the provision of foil by treatment providers 'subject to the strict condition that it is part of structured efforts to get people into treatment and off drugs', home secretary Theresa May has announced. The government would also introduce mechanisms to monitor take-up and adherence to conditions, she said. 'The provision of foil in needle exchange and drug treatment services can contribute to a reduction in drug injecting and associated health risks, such as exposure to blood born viruses, vein collapse and overdose,' said DrugScope chief executive Martin Barnes. 'Support that enables heroin and other drug users to reduce the risks to themselves and others can be the catalyst for engaging with treatment and support for recovery.'

HEP C HELP

A free, confidential helpline for prisoners has been launched by the Hepatitis C Trust. The helpline, which will be open five days a week on 0800 999 2052, allows the trust to 'reach out to a highly affected population', said head of patient support services, Samantha May. 'What we offer is the facility for prisoners to speak with their peers who can empathise with the stigmatisation that someone can face when they have the virus,' she said. 'We can answer their questions and tell it like it is.' The trust has also produced a new briefing for London's health and wellbeing boards which urges local authorities to improve commissioning, promote testing and encourage training. Councils had an 'unprecedented opportunity', said trust chief executive Charles Gore. 'If we diagnose and treat those infected, we could virtually eradicate the virus within a generation.' *Reducing health inequalities in London by addressing hepatitis C at www.hepctrust.org.uk*

GET NETWORKING

A new website has been launched by the Alcohol Health Network to help reduce alcohol-related harm in workplaces and the community. Founded by former Alcohol Concern chief executive Don Shenker, the network works with companies and public health teams to help drinkers understand and reduce their drinking levels via online self-assessment tools, training and advice. *www.alcoholhealthnetwork.org.uk*

Minimum pricing 'will not be taken forward'

Minimum unit pricing will 'not be taken forward at this moment', the government has announced in a statement on the outcome of its alcohol strategy consultation. There will also be no ban on multi-buy promotions.

There was not enough 'concrete evidence' that minimum pricing would help reduce alcohol harm without penalising responsible drinkers, crime prevention minister Jeremy Browne told MPs. However alcohol sales below the level of alcohol duty plus VAT would be banned from next spring, meaning it would no longer be legal to sell a can of lager 'for less than about 40 pence'.

There was also 'a lack of convincing evidence' that a ban on multi-buy promotions would have a significant effect on reducing consumption, he said, adding that its introduction would be unreasonable 'at a time when responsible families are trying hard to balance their household budgets'.

The government would tackle irresponsible promotions by making mandatory licensing conditions more effective, he stated, and promote responsible drinking by 'raising customer awareness of the availability of small servings'. It would also work with 'high harm local alcohol action areas' to improve enforcement, strengthen partnerships and 'increase good practice of what works locally'.

The alcohol industry now had 'an opportunity to demonstrate what more it can do to reduce harms associated with problem drinking', he continued. 'We want fair and effective policies,' he said. 'We are not in the business of making laws that do not work.'

The statement was instantly welcomed by industry bodies. British Beer and Pub Association chief executive Brigid Simmonds said that the decision not to ban multi-buy promotions recognised 'the lack of evidence that this encourages over-consumption, rather than providing value and convenience for shoppers', while Portman Group chief executive Henry Ashworth said that 'through a series of voluntary pledges aimed at improving public health, the industry has proven itself to be committed and willing partners and welcomes the opportunity to continue this successful approach going forward.'

The industry's win, however, was a 'grave loss for the public health of the nation', said Alcohol Concern chief executive Eric Appleby. 'The alcohol industry must be congratulating themselves on their success at lobbying government to bin minimum unit pricing.'

Abandoning the plans amounted to a public health 'catastrophe', he said. 'In the government's own alcohol strategy it committed to tackling alcohol misuse by making tough decisions, including introducing minimum unit pricing, a policy proven to cut crime and save lives. Sadly, with this announcement, cheap alcohol will continue to be sold at pocket money prices.'

The government's decision also led to an announcement by Cancer Research UK, the Faculty of Public Health and the UK Health Forum that they were pulling out of the government's public health responsibility deal alcohol network, along with network co-chair Dr Nick Sheron, head of clinical hepatology at the University of Southampton. 'Talk of "punishing the hard worker" who can afford few other pleasures than a pint of mild is a red herring,' said a joint statement. 'It is our most deprived communities who pay the highest price for cheap alcohol through the consequences of street crime, violence and younger people developing alcohol-related health problems.'

Organisations including Alcohol Concern, the British Medical Association, the Royal College of Physicians and the British Liver Trust refused to sign up to the controversial deal in 2011 (*DDN*, April 2011, page 4), accusing the government of allowing the drinks industry to dictate health policy.

See news focus, page 6

'Not enough concrete evidence that minimum pricing would help reduce alcohol harm without penalising responsible drinkers.'
Jeremy Browne, MP

Government consults on proposals for new drug-driving offences

The government has published plans to make it easier to prosecute people who drive under the influence of drugs. A new offence of 'driving with a specified controlled drug in the body above the specified limit for that drug' is to be introduced, designed to 'reduce the wasted time, effort and expense' of failed prosecutions.

The proposals are contained in a consultation document, which also looks at penalties for driving when impaired by certain prescribed drugs, although the government has stressed that drivers who had taken 'properly prescribed' medicines would not be penalised.

The consultation sets out a 'zero tolerance' approach to driving under the influence of cannabis, MDMA, cocaine, ketamine, LSD, methamphetamine, benzoylecgonine, heroin and diamorphine, with limits set at the 'lowest level at which a valid and reliable analytical level can be obtained' but designed to rule out 'passive consumption' or 'accidental exposure'.

There will also be a limit for amphetamine, as yet to be confirmed, along with limits for eight controlled drugs that 'have recognised and widespread medical uses' but which can also affect the ability to drive, including methadone, morphine, temazepam and diazepam. Penalties will include an automatic driving ban of at least a year, as well as a maximum fine of £5,000 and potential custodial sentences.

Although police will not be able to conduct random tests, they will have the power to administer a preliminary drug test if someone has been in an accident, committed a traffic offence, or if the officer 'suspects that a driver has a drug in his body or is under the influence of some drug'. Police will be allowed to administer up to three preliminary saliva tests, to be followed by arrest and the requirement for a blood test if positive.

'Drug driving is a menace which devastates families and ruins lives,' said roads minister Stephen Hammond. 'That is why we are proposing to take a zero tolerance approach with those who drive under the influence of illegal drugs and sending a clear message that this behaviour will not be tolerated.'

The government has also launched a consultation on the prescription drug tramadol, saying that it wants to make it a class C drug while ensuring it remains 'available to those who need it as a prescription medicine'. The announcement follows a recommendation by the Advisory Council on the Misuse of Drugs (ACMD) that the painkiller should be placed in Schedule 3 of the Misuse of Drugs Regulations, which allows controlled substances to be prescribed and legally possessed.

The ACMD had expressed concern at the misuse of tramadol, with the number of deaths involving the drug nearly doubling – from 83 to 154 – between 2008 and 2011.

Drug driving consultation at www.gov.uk/government/consultations/drug-driving-proposed-regulations, until 17 September.

Tramadol consultation at www.gov.uk/government/consultations/scheduling-of-tramadol-and-exemptions-for-temazepam-prescriptions, until 11 October.

PMA in ecstasy tablets warning

Drugs agencies have reacted with concern to the number of recent deaths thought to involve PMA, which can be present in ecstasy tablets or pills being sold as ecstasy. Deaths have been reported in England, Scotland and Northern Ireland in recent weeks.

PMA can take longer to have an effect than ecstasy, with the risk that people take repeat doses in the belief that the drugs are not working. The Department of Health has issued a health alert to NHS and public health networks about 'reports across regions in the UK of cases of hospitalisations and sudden deaths linked to the use of ecstasy-like pills. It has been reported that pills taken by those affected have contained, either alone or in combination, para-methoxyamphetamine (PMA), MDMA (the usual active ingredient expected in "ecstasy" pills), or other ecstasy-like stimulants.'

The pills reported in recent cases have 'been described with a variety of colours and with a variety of different logos stamped on them', says the document, with warnings issued about 'pink ecstasy' tablets and, in Scotland and Northern Ireland, 'green Rolexes'.

'With the festival season under way, those who are using ecstasy need to be extra vigilant,' said DrugScope chief executive Martin Barnes. 'There is no way of knowing whether or not a pill contains PMA.'

Meanwhile, new figures from the Home Office have led the government to claim that drug use in England and Wales is at its 'lowest level since records began'. Just over 8 per cent of adults are estimated to have used an illicit drug in the last year, compared to more than 11 per cent in 1996, according to *Drug misuse: findings from the 2012/13 crime survey for England and Wales*. In 2012-2013, 2.8 per cent of 16 to 59-year-olds were defined as frequent drug users – based on having taken any illicit drug more than once a month on average – down from 3.3 per cent in 2011-12.

The statistics are based on *Crime survey* interviews with around 21,000 adults aged 16 to 59. Questions on use of the legal drugs salvia and nitrous oxide were added for the first time and revealed that more than 6 per cent of 16 to 24-year-olds had taken nitrous oxide in the last year and more than 1 per cent had taken salvia.

'It is worrying that the report shows there is a disproportionate number of people aged between 16 and 24 taking these types of drugs, compared to the overall number of 16 to 59-year-olds using legal highs,' said regional development manager at Swanswell, Jo Woods. 'We welcome this report and are pleased to see the Home Office recognising the developing problem.'

Report at www.gov.uk

NEWS IN BRIEF

MARIJUANA MOVE

As *DDN* went to press, it was announced that Uruguay's House of Representatives had passed a bill to legalise marijuana. If approved by the Senate, Uruguay will be the first country to regulate the sale, production and distribution of marijuana.

HIV WARNING

A 'significant' increase in injecting rates among gay men could lead to sharp rises in HIV levels, according to a report from the National Aids Trust (NAT). Earlier this year NAT wrote to London councils warning of the 'rapid rise' in the use of drugs like crystal meth and mephedrone in parts of London's gay scene, coupled with high rates of needle-sharing and lack of appropriate services (*DDN*, April, page 6). 'We need drugs and sexual health services to work together to meet the needs of gay men,' said NAT director of policy and campaigns, Yusef Azad. *HIV and injecting drug use at www.nat.org.uk*

SEPARATE LIVES

The Netherlands' approach to drug policy helped to keep cannabis users separate from 'hard drug dealers', according to a report from the Open Society Foundations (OSF). Just 14 per cent of Dutch cannabis users reported being able to obtain other drugs from their suppliers, compared to more than 50 per cent in Sweden, says *Coffee shops and compromise: separated illicit drug markets in the Netherlands*. 'As other countries and local jurisdictions consider reforming their laws, it's possible that the Netherlands' past offers a guide for the future,' said director of the OSF's global drug policy programme, Kasia Malinowska-Sempruch. *Report at www.opensocietyfoundations.org*

WHAT IS RECOVERY?

Birmingham-based UK Recovery Radio (*DDN*, March, page 17) has released its second 'Purple Bull' podcast – What is recovery? – which focuses on the role of harm reduction. *Listen at recoveryradio.blogspot.co.uk*

ALL CHANGE AT CRI

CRI's deputy chief executive David Biddle will take the top job at the charity on 1 October, following David Royce's decision to pursue a part-time role in the voluntary sector.

IS MINIMUM PRICING DEAD IN THE WATER?

Last month saw yet another chapter in the 'will they, won't they?' saga of minimum unit pricing for alcohol, when the government announced it was shelving plans for its introduction. *DDN* considers what might happen next

WHEN THE GOVERNMENT PUBLISHED ITS ALCOHOL STRATEGY LAST YEAR, many people were surprised to find that it contained a commitment to introducing minimum unit pricing (MUP) (*DDN*, April 2012, page 4). But now, almost 18 months later, MUP is once again seemingly off the agenda.

Although it remains 'a policy under consideration,' according to crime prevention minister Jeremy Browne's carefully worded statement to the House of Commons, it will 'not be taken forward at this time' (see news story, page 4). While lack of evidence has been cited as the reason, even the government's own Public Health England body has expressed disappointment and pledged to 'take forward a comprehensive and scientific review of all the available evidence' to inform any final decision.

The University of Sheffield has also published research claiming that the government's alternative measure – a ban on selling alcohol below the level of the tax payable on it – would have a 'small impact', as just 1.3 per cent of units sold would fall below the threshold.

When the rumours started earlier this year that the government was planning to abandon MUP, much of the talk was about the rise of Nigel Farage – often photographed with a pint in his hand – and UKIP, and the desire to not be seen as 'anti-booze' or out of touch with ordinary people. But now the discussion has turned back to a far more long-standing and intractable obstacle – the sheer might of the drinks industry – with a joint statement from Cancer Research UK, the Faculty of Public Health and others saying that it was 'perfectly clear that MUP has fallen victim to a concerted and shameful campaign of lobbying' by sections of the industry happy to put profits 'before health and public safety'.

'One thing is undoubtedly the power and influence of the industry,' Alcohol Concern chief executive Eric Appleby tells *DDN*. 'We know they've put massive resources into lobbying. But it also appears that MUP is a bit of a victim of internal divisions in the Conservative party, with certain ministers in favour and then against. When the news first came out that they were thinking of dropping it, it coincided with a bit of caballing between various people like Theresa May, Andrew Lansley and Micheal Gove, so there's internal politics in this as well. But what it all boils down to, again, is that public health is way down at the bottom of the agenda when it comes to what's important to them.'

What does his organisation make of the commitments the government has made, such as banning the sale of alcohol below the level of duty plus VAT, or 'facilitating local action'? 'Banning sales below duty has absolutely no impact whatsoever,' he states. 'It will just do nothing. I think the reckoning [from researchers at the University of Sheffield] was that it would save 15 lives a year, instead of the 3,000 you'd get with MUP. It's just a very flimsy fig leaf.'

Local action, meanwhile, relies on 'good local people', he points out. 'There are some good examples around, obviously, but not everywhere are there people with the understanding and resources. We know that the whole thing with alcohol – and why it's different to drugs – is that it's about whole-population approaches, and you don't get that just from local action. You can't knock it, but on its own it's not the answer.'

A vital function of minimum pricing has been to provide a focal point for campaigners and a means of unifying the message. Can it still do that now? 'I think it can – almost even more so,' he says. 'The dropping of it has been done in such a way that it's almost become a cause célèbre. The government's arguments that there's not enough evidence are plainly just wrong. The fact that the government have said they're not doing it doesn't lessen the arguments for it in any way, and the very obvious sense that they've just bowed down to the alcohol industry is only going to fire people up more.'

He told *DDN* in June (page 16) that minimum pricing was 'not going to go away'. Is that something he still believes? 'Absolutely,' he says. 'And I can tell you that we're not going to go away either, and other members of the Alcohol Health Alliance are not going to go away. We're gearing up to take it on even more strongly.'

So what happens now? 'Obviously we're going to do some planning over the next few weeks about what we do next, but at the moment we're looking at things like party manifestos for the next election,' he says. 'The Coalition haven't actually ditched it – they've backed off a bit and said that they're just not doing it right now – so if that's the case they can at least put it back in their manifestos for the next election.

'We know those aren't necessarily worth that much, but nonetheless it's one way of keeping the discussion going, keeping it in the forefront of debate. And just making sure that – every step of the way – they're confronted by the fact that there's evidence that it works, and that none of the alternatives can do the same job.'

Modelled income group-specific impacts of alcohol minimum unit pricing in England 2014/15 at www.shef.ac.uk/news/nr/below-cost-selling-ban-1.294086

'The government's arguments that there's not enough evidence are plainly just wrong.'

ERIC APPLEBY, ALCOHOL CONCERN

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

Have you been stopped and searched by the police recently? If you are a white, middle-class resident of, say, Tenterden or Totnes, then almost certainly not. If you are a hoodie-wearing black teenager, often to be found out on the streets after midnight in Tottenham, then the chances are pretty high that you have. So, is this a function of ethnicity or of relative crime rates? Common sense would suggest the latter.
Philip Johnston, *Telegraph*, 1 July

Azelle Rodney was a violent drug dealer on his way to rob a rival gang at gunpoint when he was shot dead by police. Oh dear, how sad, never mind. ...Naturally, the usual suspects are lining up to turn this vile little gangster into the latest cause célèbre to bash the Old Bill. BBC London, Channel 4 and the Guardianistas are filling their boots... In his line of work, getting shot is an occupational hazard. If it hadn't been the Old Bill, it may well have been a Colombian hitman. Or one of his closest associates, off his face on heroin.
Richard Littlejohn, *Mail*, 8 July

Why Theresa [May] takes advice on drugs at all is a mystery. I suppose it's nice to get out and have some meetings with experts, even if their input is superfluous.
Grace Dent, *Independent*, 3 July

While tabloid coverage of the mephedrone craze focused mainly on the risk of death, the less extreme side of the story – that people who wouldn't have touched illicit chemicals began hoovering up legal ones with gusto – went largely unreported... Perhaps legalisation remains the best solution for society as a whole – but, at least through my anecdotal periscope, it won't result in nirvana. British people like to boogie, and aren't too good at stopping.
Memphis Barker, *Independent*, 1 July

In a complete inversion of morality, modern welfare punishes the diligent and rewards the feckless. That profound unfairness is why the coalition has been so right to embark on a major programme of welfare reform under the combative Iain Duncan Smith, through sanctions on the workshy, limits to housing benefit claims and the withdrawal of subsidies for spare bedrooms.
Leo McKinstry, *Express*, 18 July

Criminals will not stop their crimes, change course and become honest tax-paying citizens if drugs were legalised. Although there may be freedom of choice to use dangerous substances there can be no freedom from the consequences. International drug control is working; fewer than 6 per cent of people globally use drugs regularly and legalisation is not the answer.
Ian Oliver, *Herald Scotland*, 16 July

How many times do we keep trying to save people who don't want to be saved? How many times do we bring them back from the brink to show them what a decent life is, only for them to vomit all over it after yet another bottle of gin?
Carole Malone, *Mirror*, 14 July

Post-its from Practice

'Some do, some don't...'

All GPs should see involvement in drug and alcohol treatment as the norm, says **Dr Steve Brinksman**

I became interested in working with people who develop problems due to their drug and alcohol use very early in my GP career.

However a significant number of GPs do not work with people who use drugs and alcohol.

On the one hand there are practices like ours, in which all of us regard this work as a priority and where a few years ago our list was closed, unless the person had a drug problem! This compares with others where, from the outset, it is clear that 'your sort' isn't wanted. Why the difference?

Medical education plays a significant part in attitudes – as undergraduates we receive very little teaching on drug and alcohol problems. Although this has improved a little over the past few years, there is still a great deal more that could be delivered, as evidence suggests that young doctors are quite happy to engage in this role.

At a postgraduate level it is fairly hit and miss. I was fortunate to have a GP postgraduate tutor, Dr Ian Fletcher, who passionately believed in primary care 'substance misuse services' as we called it then. He arranged a session for the West Midland GP registrars and one of his patients agreed to come along and share his experiences with us. This was a real eye opener to me, allowing me to see drug use not as a self-inflicted problem but as an attempt by some individuals to try and deal with the trauma they face or experience as they go through life.

Dr Clare Gerada, the current chair of the RCGP council, has been a leading light in encouraging primary care to provide good quality care around substance use. She is also keen to increase the length of GP postgraduate training from three to four or even to five years. This would provide an ideal opportunity for the RCGP drug dependence and alcohol training – currently optional for both GP registrars and established GPs – to be a part of the core curriculum.

Another problem relates to GP contracts. The vast majority of GP practices have either GMS (General Medical Services) contracts which apply across the country and do not include or specify providing treatment for drug or alcohol problems; or PMS (Personal Medical Services) contracts which are locally agreed for a range of other services above and beyond GMS – but again, many would not have a specific substance misuse category. This doesn't mean GPs can ignore the physical or mental health problems of people with drug and alcohol problems but they are not obliged to offer OST, community alcohol detoxifications etc unless they have signed up to specific local contracts.

There also remains a cohort of (often older) GPs in practice who trained at a time when GPs were actively discouraged from getting involved in this field. I hope that as time goes by they are being replaced by more receptive GPs and that it will become as normal to work with those with drug and alcohol problems, as it is to treat someone with diabetes or hypertension.

For this to occur the training needs to be right, the support structures from commissioners, drug workers, and the more experienced GPs need to be in place and the current investment in services needs to be maintained. Given this, my aspiration is that in time, the maverick GPs will be those that are not involved in working with drug and alcohol patients. Until then, I will continue to educate and inform all GPs about providing primary care treatment to this interesting group of patients, giving them the chance to recover from problematic drug and alcohol use in their own communities.

For more information about the RCGP Substance Misuse and Allied Health certificate courses in the management of drug and alcohol misuse, see http://www.smmgp.org.uk/html/rcgp.php

Steve Brinksman is a GP in Birmingham, clinical lead of SMMGP, www.smmgp.org.uk, and RCGP regional lead in substance misuse for the West Midlands.

Getting STREETS

Stephen Parkin was so impressed by The Ana Liffey Project's innovative street-based outreach work in Dublin that he contacted director Tony Duffin to find out more

If you've visited Dublin recently, you may have noticed that something innovative is afoot on the streets of Ireland's capital city – quite literally. The Ana Liffey Drug Project has recently expanded its peripatetic needle and syringe programme (NSP) as part of a progressive form of innovative outreach work. The 2013 version of the project, which was originally launched in June 2010, combines old-fashioned footwork with telecommunications, emerging technologies and high-visibility promotional material on the streets.

The project was brought to my attention during a recent visit to the Republic of Ireland and I was fascinated by the initiative because of its relevance to topics that I have spent almost six years researching in various towns and cities throughout the UK – namely street-based injecting and drug-related litter. I was so impressed by the project that, on my return to England, I contacted the director of the Ana Liffey Drug Project, Tony Duffin, to find out more about this potentially groundbreaking venture.

Ana Liffey Drug Project is a national addiction service with a low threshold harm reduction ethos. The organisation receives funding from a number of sources, including the Health Service Executive, drug and alcohol task forces, the Probation Service of Ireland, other local authorities and government departments. One of the ways Ana Liffey engages with drug users and other stakeholders is in the reduction of drug-related harm associated with episodes of street-based injecting, which often takes place in public places throughout Dublin city. As an indicator of the frequency of public injecting in the city centre, a recent report (*Re-establishing contact: A profile of clients attending the health promotion unit – needle exchange at Merchants Quay Ireland*) highlighted that 14 per cent of the 388 injecting drug users attending a fixed-site city centre NSP reported regular injecting in public places 'in the last month'. This translates to approximately 55 individuals of the cohort regularly involved in episodes of street-based injecting in concealed alleyways and side streets throughout the city.

Furthermore, as there are few public conveniences in Dublin city, street-based injecting sites are located in what I have termed category B and category C settings, such as alleyways, doorways and secluded settings hidden from public view, or in 'opportunistic' settings concealed within business premises. These are places that are among the most harmful environments for street-based injecting drug use. For these reasons, Tony Duffin made the case for introducing medically supervised injecting centres to Dublin at a recent *safer city for all* seminar (http://www.aldp.ie/resources/video).

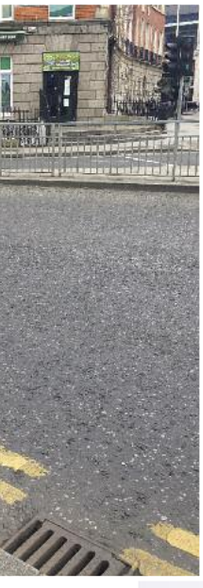
In the meantime, the Ana Liffey Drug Project is continuing to provide a proactive outreach service as part of an ongoing harm reduction response to street-based injecting drug use. This involves two outreach workers walking the streets of central Dublin equipped with, among other things, a pink vanity case for carrying-out street-based interventions. The case makes it easy for clients to locate the staff, who often deliver the service in busy city centre locations. Within it is a range of injecting equipment and other paraphernalia that would be available from a more orthodox (static) NSP. As

'All our staff are very client focused, we're constantly seeking new ways to reach marginalised clients, or to improve accessibility to existing services...'

VISE

such, water-amps, swabs, filters, steri-cups and a range of needles (including Exchange Supplies' 'NeverShare' variety) and barrels can be provided, along with harm reduction brief interventions. Each NSP pack given out also has an adhesive label on it that promotes safer disposal with the peer-designed slogan, 'If You Bang it, Bin It!' – itself an illustration of dynamic, creative and innovative outreach work that challenges many drug-related outreach projects' reluctance to walk the streets with injecting equipment for wider distribution.

Dotted around the city centre on many of the public litter bins are dedicated advertising slots that have been provided by Dublin City Council at no cost to the Ana Liffey Drug Project. Duffin explained that these prime advertising sites provide the ideal opportunity to publicise and promote the project's outreach work, and its 1800-78-68-28 Freephone line gives callers information and signposting to services.



Staff at Ana Liffey have combined the telephone service with the outreach service to create a genuinely innovative and rapid response NSP throughout the city centre. As Duffin says, 'All our staff are very client focused – we're constantly seeking new ways to reach marginalised clients, or to improve accessibility to existing services.' In the case of the NSP, individuals may call the 1800 number free of charge and be transferred to an outreach worker's mobile phone. The client and workers arrange a mutually convenient time and location to meet, giving an opportunity to discuss injecting paraphernalia and how the client can obtain new equipment and return used paraphernalia. They are also offered sharps boxes in an attempt to minimise drug-related littering. As with conventional NSP, this meeting also provides opportunities to conduct some form of limited intervention, such as checking an individual's physical injecting sites and inspecting any related injuries, and providing a referral to the blood borne virus nurse at Ana Liffey's medical surgery.

Provision of equipment takes place in a discrete manner and does not involve the open distribution of injecting equipment for all to see. As with conventional NSP, activity data is collected by the outreach team, including documenting the interaction and what items may have been distributed and returned. In the first five months of this year, 381 NSP interventions were done under this system of outreach, including telephone referrals.

Further developments in this street-based project are to pilot the use of a tablet, or other portable device, that can be linked to a centralised system for recording similar data within static sites of NSP and have the ability to show harm reduction videos relating to safer injecting. This would help to feed live data to a master-monitoring system and provide immediate up-to-date information regarding process, performance and outcome of all relevant activity. Ana Liffey also intends to promote its Freephone number across the 12 counties of Ireland where they currently provide direct client services through a telecommunications hub, linking Freephone callers throughout Ireland to satellite Ana Liffey outreach teams that can best respond to the caller's needs.

This street-based form of NSP is innovative because, as far as I am aware, it is the only service where the caller is directed by internal transfer within the offices of a central location to an outreach team's mobile phone. However, what struck me most about Ana Liffey's outreach project is the pioneering and inventive application of old and new methods – combining peer-based outreach with portable telecommunications that in turn are advertised by traditional methods using street-based furnishings (litter bins). As the latter are positioned in street settings they are more likely to be noticed by the target population of this particular project – people who are homeless and/or those participating in street-based injecting.

Simplicity and technology underpin the initiative to provide a method of actively engaging with street-involved individuals who may not necessarily be in contact with mainstream drug services. I am further impressed by how the project genuinely reflects the original street-based ethos that defined harm reduction throughout the UK during the 1980s.

In terms of drug-related outreach work, however, the project ticks all the required boxes. In addition to engaging with hard-to-reach populations, it also involves participation, intervention, advice and information, and creates opportunities for referral to other services while complying with the need for confidentiality. In short, it is a project that is consistent with the practice and principles of harm reduction, and its street-based focus provides culturally relevant and environmentally significant opportunities for interaction and communication.

Indeed, this is a project that should be given some consideration in other settings and could very easily be emulated throughout the UK and beyond, made easier by Ana Liffey's culture of sharing their resources, knowledge and expertise as much as possible. **DDN**

Stephen Parkin is a research fellow at the University of Huddersfield and is the author of Habitus and drug using environments (published by Ashgate Sociology, 2013). Email: s.parkin@hud.ac.uk

Tony Duffin is director of the Ana Liffey Drug Project. Further details of the street work described above are available from tony.duffin@aldp.ie

LETTERS

'The proportion of drug users contacting a methadone prescribing clinic increased massively from 30.2 per cent in the weeks in advance of the operations to 84.3 per cent in the weeks following... police operations.'

FALSE DICHOTOMY

In her open letter to Anna Soubry MP (DDN, July, page 8) Dr Chris Ford draws an erroneous and largely unhelpful distinction between treating drug misuse as a health issue and treating it as a criminal justice issue.

In peer-reviewed research evaluating the impact of major drug enforcement operations on street-level drug markets it was found that the proportion of drug users contacting a methadone prescribing clinic increased massively from 30.2 per cent in the weeks in advance of the operations to 84.3 per cent in the weeks following the police operations (McGallagly and McKeganey 2012).

This research shows that drug enforcement operations can have a welcome positive impact on encouraging drug users into drug treatment. Instead of claiming that drug use is either a health or a criminal justice issue we need effective joint working between health and criminal justice agencies and a recognition that both domains have an equally important contribution to make in tackling drug misuse.

Ref: McGallagly, J., McKeganey, N. (2013) Does robust drug enforcement lead to an increase in drug users? Drugs: Education, Prevention, and Policy, 2013, Vol. 20, No. 1: Pages 1-4.

Neil McKeganey Ph.D, director, Centre for Drug Misuse Research, Glasgow

SELF-HELP SALVATION

It is ridiculous for Ford and Soubry to be battling it out over whether addiction is a criminal or a health issue. It is the failure of the law and of medicine to understand and cure addiction that gives neither of them the right to even have an opinion.

Addiction is simply a current condition initiated by an individual making the mistake of choosing to use an addictive substance in an attempt to solve a 'personal' problem. It is straightforwardly a personal decision, made alone or in agreement with advice, which proves to be a mistake, and for which medical 'treatment' has never been an answer. Nor, as history shows, can criminal punishment resolve the country's addiction problems.

When the coalition chose as the first strand of their 2010 drug strategy 'reducing demand', they knew what they were doing, because they were focusing on the source of our addiction problems – the individual addict. As they move towards 'localism' they are again focusing on the individual addicts that all inevitably exist in their local community.

It follows that reducing demand is achieved solely and only by curing individual addicts, and this is just not occurring other than sporadically as a result of medical treatment or criminal labelling or trying to restrict supply.

But it can be achieved by recognising that life is a do-it-for-yourself activity, that deciding to use drugs is also a do-it-for-yourself activity and that quitting addiction is most often achieved on a self-help basis.

Seventy to 75 per cent of addicts who have used for three days, three weeks, three months, three years or 30 years have tried, often daily, to quit and have failed – but still want to quit.

All they lack is the knowledge of how to attain lasting relaxed abstinence, and we know from the results of addiction recovery training delivered since 1966, and now at 169 centres (including prison units) in 49 countries, that 70-plus per cent can cure themselves.

So lets give addicts and the drug strategy a chance – by training drunks and addicts to cure themselves.

Kenneth Eckersley, CEO, Addiction Recovery Training Services (ARTS)

35 YEARS STRONG

Norwich charity NORCAS are celebrating 35 years of working in the region with a huge birthday party – all welcome!

Since 1978 when NORCAS opened its first alcohol service in Norwich they have gone on to provide drug, gambling and welfare rights services for many thousands of people across East Anglia. Now working in partnership with national substance misuse charity Phoenix Futures under the name Phoenix + NORCAS, the party will be an opportunity to hear inspirational stories of recovery, meet staff, volunteers and service users, past and present and to learn more about the plans for the future.

The party to be held on 22 August at OPEN, 20 Bank Plain, Norwich NR2

We welcome your letters...

Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity – please limit submissions to 350 words.

4SF, between 10.30am and 3.00pm, is open to all who want to drop in. Lunch and (of course birthday cake!) will be provided.

As Paul Hammond, Phoenix and NORCAS service manager says, 'Over the last year alone NORCAS has worked with 8,342 adult and youth clients across Norfolk and Suffolk, and positively impacted the lives of many more through educational events. We want to thank the local community for the support they've provided us to help so many local people make positive changes in their lives.'

For more information go to www.phoenix-futures.org.uk/phoenix-norcas/ or contact me on bob.campbell@phoenix-futures.org.uk

Bob Campbell, special projects officer, Phoenix Futures

HELP THE AGED

I have been trying to raise the profile of alcohol misuse in older people for some years, particularly as my own clinical service covers a population that has a rate of alcohol-related deaths in the 75-plus age group that is more than twice the national average.

Older people with alcohol problems remain caught between services. Luckily for me, I managed to gain additional skills in substance misuse and integrate these into a mainstream mental health of older adults service.

I would be interested to know whether practitioners see this as a growing clinical and public health problem and what is being done to tackle this problem in their local area or region.

Dr Tony Rao, consultant old age psychiatrist and chair of Royal College of Psychiatrists Substance Misuse Working Group

HOW LUCKY WE ARE

Reading the coverage of the International Harm Reduction Conference really brought it home how lucky we are in the UK (*DDN*, July issue).

Sadly I was unable to attend in person but by reading the *DDN Daily updates* and the special issue I was able to get a real sense of the genuinely life-threatening situations that users in many countries face. It once again reinforced the indisputable fact that harm reduction saves lives.

To have the luxury of debating the individual nature of recovery and patient choice is something that many of the speakers at the conference must dream about, and we would do well to remember that. While the stories of the ongoing battle to have their drug use recognised as a health issue, and the ongoing human rights abuses were as harrowing as ever, there did seem some cause for cautious optimism.

The, albeit slowly, changing political acceptance that harm reduction works, the increasing high-profile support and, most importantly, the untiring work of the activists working across the world do give you hope that things will get better. I would like to thank both Harm Reduction International for having the courage to hold this unique event, and *DDN* for providing coverage to everyone unable to attend.

J Spence, by email

DDN provided daily magazines for the International Harm Reduction Conference 2013 in Vilnius. These and the August DDN coverage can be read at www.drinkanddrugsnews.com.

IN PRINT, ONLINE, VIA EMAIL AND SOCIAL MEDIA

We have been working extremely hard over the last few weeks on www.drinkanddrugsnews.com.

The website has always reflected the publication, with every issue of *DDN* available to read free-of-charge in both PDF and mobile formats, as well as up-to-date news, jobs and tenders. The website also provides links to other sites, training and rehab directories and all back issues of *DDN* available as a searchable archive. In addition, updates and breaking news are available on our Facebook page and through our Twitter feed. We have always provided a weekly *DDN* email letter but this is now in an improved format and easily readable on computers, tablets and smartphones. Subscribing couldn't be easier – simply enter your email on the *DDN* home page and you'll get the latest issue straight to your inbox!

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REVIEW

SKILLS UPDATE

What's the latest on professional training? Nadine Singh **explains the DANOS review**

Skills for Health is undertaking a review of the National Occupational Standards (NOS) for specialist workers who work with adult substance users.

The NOS, first developed with stakeholders in 2005, are being reviewed by a working group consisting of service user organisations and stakeholders who work in substance use services. A steering group is overseeing the project, consisting of members from the four UK nation government departments and chaired by Carole Sharma, chief executive of the Federation of Drug and Alcohol Professionals (FDAP). 'Stakeholders will welcome the review of the NOS for the substance misuse sector as it is vital that the standards reflect what workers are currently doing as part of their practice,' she says.

This review is to ensure that the NOS reflect up-to-date practice in the field of substance use and that workers who wish to use the NOS are working to a set of defined standards. The project working group includes members from the four UK nations, and the revised NOS will reflect common practice right across them.

The drug and alcohol NOS, commonly known as DANOS are widely used across the health, care and justice sectors. NOS can be used for a variety of purposes, all of which lead to the development of a particular workforce. The DANOS have been used to underpin nationally accredited qualifications, such as:

- ***the level 3 diploma in health and social care and level 3 SVQ in health and social care, which assess competence against the NOS***
- ***the level 3 and level 4 awards and certificates in working with substance misuse.***

They are also used:

- ***to develop new roles for the sector***
- ***in frameworks for staff development***
- ***to improve standards of practice across the sector by organisations such as FDAP***
- ***to develop a variety of bespoke training and education programmes.***

The working group, chaired by John Jolly of Blenheim CDP, has been working to update the standards and they will be available for consultation until 30 September 2013. A consultation for service users will also be available and their responses will inform the final content of the updated NOS. This consultation will run until 12 September 2013.

Once final versions of the NOS have been approved by the UK Commission for Employment and Skills, they will be accessible via the Skills for Health competence tools.

For further information about both the service user and NOS consultations and the Skills for Health tools, visit the Skills for Health website www.skillsforhealth.org.uk or email danos@skillsforhealth.org.uk

Skills for Health is the sector skills council for all health employers – NHS, independent and third sector – and acts as the voice for employers working in the healthcare sector.

Nadine Singh is manager of NOS, qualifications, apprenticeships, products and services at Skills for Health

The challenge of not losing sight of the individual in the new public health landscape was one of the themes discussed at a recent event organised by the London Drug and Alcohol Policy Forum. **DDN** reports

'We were created as a response to what was a frankly appalling drug and alcohol treatment system in Sunderland,' CEO of Counted 4, John Devitt, told delegates at the London Drug and Alcohol Policy Forum's recent *Our friends in the north* event. 'There were six- to nine-month waiting lists and very rigid prescribing regimes. We were set up to serve the people of Sunderland – it's about treating people in the community in the normal way, without ghettoising them.'

A clinically led organisation and community interest company (CIC), Counted 4 employed doctors, nurses and drug workers, and provided a range of services in the home. It also tried to work in partnership with key providers, such as pharmacies, he said, and aimed to be client-focused, non-judgmental, accessible and community-based.

'We're living in a very interesting world – it's a time of huge social change,' he said, with welfare reform, funding cuts and the move to Public Health England all having an impact. While there had been positive changes – such as the focus on recovery – the poor were now being widely demonised, he stressed, which was having a profound effect on vulnerable people.

Treatment staff were also worried about their job security, he said. 'But the real question is who's worrying about the clients? It's also a unique situation in that the main political parties seem to agree on pretty much everything when it comes to these changes, and many charities are just toeing the line. Everybody talks about working in partnership, but partnership is about sharing an ethos, sharing working practices, sharing the good and bad times. Everyone's going to have to move much more in that direction because we're going to have to make the most of the resources we've got in the community.

'The key thing is to stop bringing people into services,' said the organisation's recovery and tier 4 lead, Brian Hindmarch. 'Take the services into the community.'

One of the biggest problems facing treatment was translating its founding vision across the workforce and to partner organisations, said Counted 4's medical director, Dr Martin Weatherhead. 'We can often say, "for this group of people we provide a fabulous service", but I've not really come across a system that provides that across the board.'

While there had been no major change in the evidence base, there had been changes in the interpretation of that evidence base, he continued. 'What we're guilty of is extrapolation – there have been changes in emphasis, but no huge changes in fact.'

Keyworking was vital, he told the event. 'Prescribing is just a little bit of oil in the engine of treatment – you can't build everything around that. The medication hasn't changed, the facts haven't changed, but everyone's now terrified of being seen as "parking" people on methadone. But there are people who need those higher doses. We're moving back into a more regimented treatment world, and that does concern me.'

One problem that treatment needed to overcome was that NICE guidelines were constantly employed as obstacles, said one delegate. 'If they don't want to do something, or if they do, then you hear, "ah, it's the guidelines".'

'As an industry, our customers aren't our first priority,' said another participant. 'The drug treatment system has been awash with money for years, but no one ever says that everything's working well.' However it was impossible to commission 'perfectly individualised' services for everyone, replied another. 'It's a pipe dream. What you can do is get what's best for that individual at that time, because it changes over time – people change, systems change, money flows change. You need flexible services that are responsive. A lot of it is about relationship management and being human – it's a patchwork.'

While the recovery agenda contained a great deal of pros and cons, 'one positive thing to come out of it is to try to get the best for your clients,' commented another delegate. 'But changing the ethos of an organisation can be like turning a tanker.'

'Get to know the client,' stressed one participant. 'On paper they may look like one thing, but you need to get to know them. And continuity is vital.' Having the right people with the correct skills set was vital, added another. 'The right person for the right role.'

An obvious problem facing the sector was that budgets were no longer ring-fenced, a delegate stressed. 'So we need to show that the things we commission

SERVE

‘The key thing is to stop bringing people into services... Take the services into the community.’

BRIAN HINDMARCH

are meeting what they’re supposed to. Ultimately it comes down to whether we’ll continue to be funded – and if the service is cut, that doesn’t meet anyone’s needs’, while others commented that disinvestment was already happening.

There were also significant problems around recruiting specialist GPs, Martin Weatherhead told the event. ‘The areas where you have the most problems recruiting doctors are deprived areas. Doctors are herd animals – they’ll go where the herd is grazing. There’s a huge recruitment crisis in general practice – the GPs who are working are overwhelmed and the last thing they want to do is make their lives even more difficult by working with people with substance problems.’

Risk was often used as an excuse not to act, commented one delegate. ‘Senior politicians need to have the ability to trust people to deliver, so they can prove the impact. You’ve got to protect your funding streams, but there’s no trust that things will actually be delivered. There’s got to be a better way than just telling us to tick boxes.’

‘You have to bring hope and aspiration into it,’ said John Devitt. ‘If you can’t do that – because you’ve had a crap day or whatever – then you’re messing with people’s lives and you shouldn’t be in this profession. We’re defining people by their symptoms, so you’re not designing the system for individuals. The key is personalisation – you’re providing a service here. It’s a privilege to be looking after these clients, and if you really believe that you’ll get the results.’ **DDN**

ENTERPRISE CORNER

A TALE OF TWO ENTREPRENEURS

Nola and Jackie are living proof that you can turn life’s adversities into business opportunities, says **Amar Lodhia**

OUR VISION STATEMENT GUIDES OUR WORK: ‘Our vision is to create an enterprising and entrepreneurial society that does not hold people back from becoming successful.’

When you hear from people like Nola and Jackie you feel that we all can bridge the gap between aspiration and inspiration and you reiterate the fact that we all can make an impact and a difference in people’s lives. Lest I bore you with my motivational talk, let me delve more into the real stars of this tale, Nola and Jackie – two of the participants from our City of London E=MC^2 programme.

When Nola left prison, she came back home and looked for a job to no avail, but since she joined the TSBC programme she has started her own business, an initiative to get ex-offenders into work, called ‘Wanna work’.

When Nola completed her prison sentence, she came back home and looked for a job to no avail. She believed she was being stereotyped by employers because of her past criminal history, then thought: ‘I have served my time and I am a better person but why does society want to hold me back?’

In her new life chapter, TSBC’s E=MC^2 programme has inspired her to start her own community interest initiative for those who have left prison and are searching for work. ‘I think the course is excellent, well delivered and practical learning models were used,’ she said. ‘I have been able to put my ideas into practice and make steps towards starting my own business.’

We see a serial entrepreneur in the making, as Nola has several other start-ups in the pipeline, including an organic food catering business.

Jackie had been unemployed for years after she had finished serving her probation and was on benefits. However unhappy, she continued teaching drama classes to children, although she knew she had more to offer society.

She was invited to the TSBC E=MC^2 programme by a friend and it created a world of hope and opportunities for her. She has started her baby clothing business and has stopped collecting benefits. ‘I enjoyed the fact that E=MC^2 helped me to push myself a lot and gain more business skills,’ she said.

Jackie’s future is filled with aspiration and hope. She now feels independent and in control of her future, and is not dependent on government benefits or even employment anymore. She is very excited about her baby clothing manufacturing business. She has her business plan, design prototype and the support of her TSBC mentor, and is ready to take on the world.

To enquire more about our work please contact me at ceo@tsbccic.org.uk and follow me on Twitter @amarlodhia or @tsbclondon – don’t forget to use the #tag DDNews when tweeting!

Amar Lodhia is chief executive of The Small Business Consultancy CIC (TSBC), thesmallbusinessconsultancy.co.uk

A CASE F

If electronic cigarettes can save lives, why are we jeopardising this public health breakthrough, **asks** Professor Gerry Stimson

Until recently, an end to cigarette smoking looked like a long and slow business. Year on year only small reductions have been made in reducing smoking prevalence in developed countries.

The arrival of electronic cigarettes (e-cigarettes) and other new nicotine delivery devices changes that. These new devices are a disruptive technology, just as the invention of the cigarette-making machine was in the 1880s. There are now real prospects of helping smokers shift from smoking tobacco to using nicotine by less harmful routes.

The Medicines and Healthcare Products Regulatory Agency (MHRA) and the European Commission (EC) now want to regulate e-cigarettes as medicines. Will this advance the sale of e-cigarettes, or push back the progress that has been made?

First introduced to the UK in 2006, uptake of e-cigarettes has been a relatively quiet consumer-led revolution. There has been no public health input or encouragement, and no spending of NHS resources – no taxpayers have been harmed in this process. There has been little expenditure on marketing. The growth in popularity has come about by word of mouth and internet advertising. Unlike many public health measures, there is a population ready and eager to change – most smokers want to stop smoking. Until e-cigarettes there was no viable option but to quit smoking altogether or to use nicotine replacement therapy (NRT).

The MHRA estimates that 1.3m people are using e-cigarettes in 2013. The proportion of smokers using them rose from 3 per cent in 2010 to 11 per cent in 2013. The European market is estimated at around EUR 400-500m, and sales of e-cigarettes now equal those of NRT. The market has been dominated by mainly small and medium-sized distributors, but this will change as most major tobacco companies are already selling or investing in the development of new nicotine delivery devices.

Most anti-smoking organisations aim for an end of the tobacco industry. Ironically – for many public health experts – an end to tobacco smoking may be hastened not though the end of the tobacco industry but through its transformation. In the next couple of decades, tobacco companies, under pressure from anti-tobacco legislation, will move towards becoming nicotine companies. Wells Fargo stock analysts predict that revenue from e-cigarettes will overtake ordinary cigarettes by 2021.

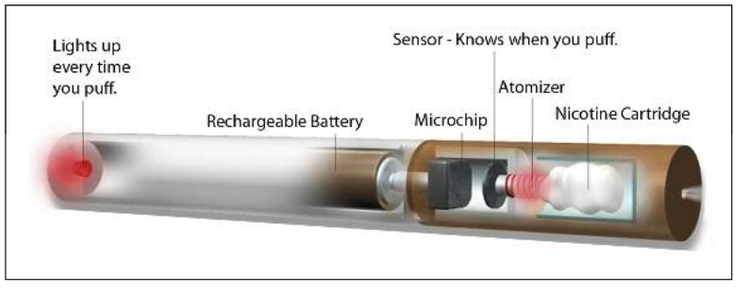
E-cigarettes v smoking tobacco

E-cigarettes have major advantages over smoking tobacco. More than 4,000 chemical compounds are found in tobacco smoke, and it's the products of the burnt organic material that are so harmful to health. Around 80,000 people in England die every year from smoking-related disease. Smoking is the single most common cause of preventable illness and death. As Mike Russell noted long ago, people smoke cigarettes for the nicotine but die from the tars.

E-cigarettes contain nicotine, propylene glycol (a carrier that creates the vapour when heated) and flavourings. They deliver nicotine but without the dangerous toxins found when tobacco is burnt. They are used by people who want to stop smoking but who do not want to or cannot stop using nicotine.

A visit to e-cigarettes and vaping websites indicates extraordinary testimony of their successful use by long-term smokers. E-cigarettes contain some potentially harmful constituents but at traces very much lower than found in regular cigarettes, within the safe limits for consumer products, and indeed at similar levels to potentially harmful constituents found in NRT. And their attraction for many users is precisely that they are not medicines.

FOR E-CIGARETTES



Where to with tobacco policy?

Harm reduction is central to current tobacco policy in England. This will be welcome news to those in the drugs field who feel rather beleaguered and browbeaten by the drugs recovery agenda.

The history of tobacco harm reduction is tied in with the development of NRT. In 1990 there were only three NRT products, all prescription-only. Pharmacy sales started in 1991, expanded to all products by 2000, and since 2009 all NRT products have been on general sale. Initially NRT was only indicated for abrupt quitting, and later extended for people who wanted to cut down more gradually before stopping. But in 2009/2010 the MHRA agreed it could be used for harm reduction, including temporary abstinence and a reduction in smoking with no intention to quit.

The Department of Health's 2011 tobacco control plan committed to encouraging tobacco users who cannot quit to switch to safer sources of nicotine and to encourage manufacturers of safer sources of nicotine to develop new types of nicotine products. In 2012 the Cabinet Office's behavioural insights team – the so-called 'nudge unit' – urged the use of e-cigarettes.

The most recent piece of the story is the work of the National Institute for Health and Clinical Excellence (NICE) which gives a strong endorsement for tobacco harm reduction for people who do not wish to quit smoking altogether, and for people who want to quit smoking but are unable or unwilling to quit using nicotine. The NICE group concluded that nicotine does not pose a significant health risk.

Enter MHRA and the European Tobacco Products Directive. The MHRA has decided to regulate all electronic cigarettes as medicinal products by 2016, and the European Tobacco Products Directive – currently going through the European legislative process – proposes that all e-cigarettes should be regulated under medicines legislation.

'Smoking cessation' or 'smoking sensation'?

Those in favour of medical regulation argue that electronic cigarettes are currently unregulated products, that they are accessible to children, that there is no control over advertising, that they contain potentially dangerous constituents, and that the devices themselves, including the batteries, pose a threat to user safety.

Medicines regulation, they argue, will improve safety, quality and efficacy, and make them work better as a smoking cessation product.

There is another thread going through the political argument however, which is that electronic cigarettes are just another way to feed addiction to nicotine, and that they send the wrong message and undermine attempts to drive down tobacco use. Some claim that electronic cigarettes are contrary to efforts to 'de-normalise' smoking. There are already scaremongering stories about schoolchildren using them. Certainly they might be a short-term fad amongst some children who wish to challenge authority, but the e-cigarettes market is made up of long-term smokers and surveys by Action on Smoking and Health (ASH) show minimal use by non-smokers and by young people.

Consumers do not want medical regulation. There has been extensive comment on the proposals on social media sites, Twitter, and letters to members of the European Parliament – current users insist that these are consumer products, a safe way of enjoying nicotine, rather than a therapy. These products are popular precisely because they are not medicines. As one user put it – these are not 'smoking cessation products', they are 'smoking sensation products'.

Getting the balance right

The problem is the trade-off between making the product safe enough, but also sufficiently attractive to achieve widespread uptake. On balance more weight should be given to attractiveness, given their relatively low risks and the huge consequences of continued smoking.

The argument that these products are currently unregulated is false. The Electronic Cigarette Industry Trade Association has shown that they are covered by the General Product Safety Directive and various other EC directives covering electrical safety, chemical safety, weights and measures, packaging and labelling, commercial selling practice and data protection.

Applications to MHRA are costly, including the licence fee and the required studies, analyses, documentation. There are fears that few companies will be able to afford this, that the process will favour big players and drive many products off the market. There are further problems with medical regulation in that e-cigarettes include a big range of products and product combinations. Not all of them are simple pre-packaged cigarette lookalikes, but many are customisable, where the user can vary the delivery device and the nicotine strength and flavourings. It is likely that medical regulation will prematurely limit the range of products and stifle innovation.

Even the announcement of future medical regulation has created uncertainty among retailers, current and potential e-cigarettes users.

How this will play out is uncertain. Given that MHRA has put the deadline as 2016, by then there will be a much larger market and it will be harder to limit and control products. Already there have been four successful legal challenges against classing these products as medical products (two in Germany, and one each in Estonia and the Netherlands).

At the end of the day the potential public health gains from e-cigarettes will be determined by the decisions about how to regulate these devices. There is right thinking about tobacco harm reduction, but a risk of making significant mistakes in the way this is played out in regulatory frameworks.

The danger is a classic regulatory trap: making safer products harder to obtain than their unsafe counterparts. The regulatory proposals are tougher on e-cigarettes than on tobacco cigarettes. The framing of electronic cigarettes within a regulatory context misses the point that the public health drive must be to promote, endorse and facilitate their use. **DDN**

Prof Gerry Stimson is visiting professor, London School of Hygiene and Tropical Medicine and director of Knowledge-Action-Change.

Green ZONE

Green Party MP for Brighton Pavilion Caroline Lucas tells David Gilliver **why she wants the government to acknowledge that 'current policy is flawed'**

'As an MP for a city with such high levels of drug-related harm, it would be negligent of me not to ask whether we could be doing things differently,' says Caroline Lucas. 'As well as identifying the national policies that get in the way.'

A member of the Green Party since 1986, she became one of the party's first MEPs in 1999 and was made party leader in 2008, before being elected the UK's first ever Green MP – 'a privilege', she says – for the constituency of Brighton Pavilion in 2010.

She's currently enthused about a Private Members' Bill she's about to present calling for the railways to brought back into public hands as franchises expire – 'potentially saving the Treasury more than a billion pounds a year', she says – but she's long been interested in drug policy as well, sparked by a sense of injustice at seeing people 'pointlessly criminalised' and by frustration at what she considers to be doomed policies. 'On an intellectual level it's clear that current policies are failing,' she says. 'But I've also seen first-hand the terrible effects that's having.'

Brighton is famous for many things, but the grimmest was always the number of drug-related fatalities in the city, earning it an unenviable reputation as 'drug-death capital of the UK'. Recent signs are encouraging, however. From 50 drug-related deaths in 2009, the number fell to 35 the following year, and, according to the *Independent drugs commission for Brighton & Hove* report from earlier this year (*DDN*, May, page 5), the indications are that 'the trend is being continued through 2011 and 2012'.

Problem drug use is still clearly a major issue in the city, but does she think it's fair to say that the situation is improving? 'Levels of drug-related harm and deaths in Brighton and Hove are still worryingly high, but good progress is being made,' she says. 'In the last few years we've seen, for example, a 17 per cent increase in numbers of people leaving treatment successfully, compared to the 7 per cent national average.'

Some of these improvements can be attributed to 'different approaches being taken locally, in particular through intelligent commissioning,' she says. 'And we are saving more lives thanks to initiatives like making naloxone more widely available.'

In terms of different approaches taken locally, while the Brighton and Hove drug commission's report included 20 recommendations – among them increased training in naloxone administration, better data collection on drug use trends and improving services for those with a dual diagnosis – the one the national media inevitably seized on was the call to establish consumption rooms. Or rather, to quote the actual wording of the document, to 'convene a working group to explore the feasibility of implementing a form of consumption room, targeting those who are hard to reach and not engaged in treatment, as part of the range of drug services in the city'.

Does she find that a frustration – are the press dictating the terms of the debate? 'It would have been great for all of the drugs commission's recommendations to have received the attention they deserved, but the press stories were always going to be about drug consumption rooms, and that at least put the report in the public eye,' she states. 'But I do think some of the popular press make it very difficult to have a nuanced debate about drugs policy. It's clear that mainstream politicians won't go near certain solutions – no matter how evidence-based they are – because they're worried about the headlines in the *Daily Mail*.'

Nonetheless, decriminalisation is an increasingly mainstream topic of discussion in the media these days, something that was unthinkable a few years ago. 'We're not there yet – the immediate goal is the impact assessment,' she says, referring to the call for a comprehensive review of the 1971 Misuse of Drugs Act (*DDN*, June 2011, page 5). According to the petition she's created on the government's e-petition website, 'nobody is checking whether Britain's current approach is value for money or money wasted'.

It's primarily about 'getting the government to at least acknowledge that current policy is flawed,' she stresses. 'However, I don't think decriminalisation in the future is out of the question, by any means. Some societies that you might think of as socially conservative – Portugal and Switzerland, for example – have introduced decriminalisation, or other policies based on health not crime, and seen positive results. If you believe in evidence-based policy-making and want to reduce drug-related harm, this is the logical first step.'

*****

She recently coordinated an open letter to the *Times* which, along with urging the government to agree to an independent review of the Act, exhorted the coalition to join 'the global effort towards an alternative strategy based on evidence'. How confident is she that messages like that are going to be taken on board?

'I'd like to think that there's a point at which ministers have to change course, just because the evidence is so compelling,' she states. 'But it's difficult to say when. Certainly we're making the case very strongly, and in terms that should appeal to ministers – our arguments are all about reducing the harms caused by drug addiction and using taxpayers' money more effectively.'

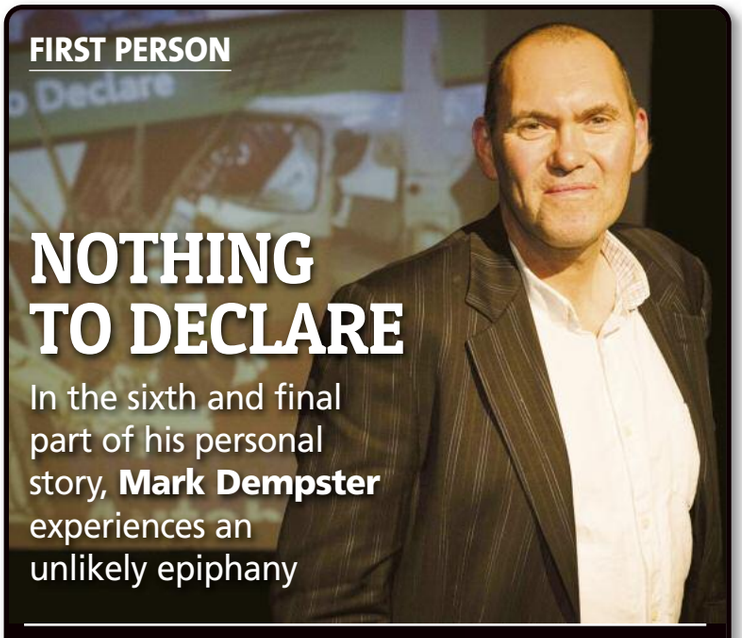
On that note, does she feel that moving drug and alcohol treatment to local authorities, overseen by Public Health England, was the right thing to do? 'It's vital that everyone gets the drug and alcohol treatment they need,' she says. 'I think this is undermined by the fragmentation of the NHS, and there's a risk that services will be poorly integrated and people will fall between the gaps. I just hope that – as in Brighton and Hove – local authorities will continue to make drug and health services a priority.'

The UN's International Day against Drug Abuse and Illicit Trafficking on 26 June saw her donning a Richard Nixon mask outside the Houses of Parliament (*DDN*, July, page 4), as one of those protesting to 'reclaim' the date as part of the *Support. Don't Punish* day of action. What made her decide to back the campaign?

'Because the whole "war on drugs" approach is colossally damaging,' she says. 'It has meant the mass imprisonment of people who use drugs. It has allowed the international trade in illegal drugs to thrive. And, after decades, it has completely failed to reduce drug-related harm. Governments need to adopt approaches based on evidence, which deal with addiction as a health issue.' **DDN**

'I'd like to think that there's a point at which ministers have to change course, just because the evidence is so compelling.'

FIRST PERSON



NOTHING TO DECLARE

In the sixth and final part of his personal story, **Mark Dempster** experiences an unlikely epiphany

IT HAD BEEN A CHOICE BETWEEN PRISON OR DETOX AND TREATMENT. I took detox and treatment. After a while prison began to seem like the choice I should have made: I had a drug counsellor who was constantly getting in my face and I had to sit in circles with idiots talking about 'feelings'. I hadn't had a feeling much other than sick or numb for years, let alone have a discussion about them. The only thing that kept me there was that my drug counsellor was like me; Scottish, feisty and had been a junkie and criminal.

They made me go to 12-step meetings. I had been detoxed from alcohol and drugs and four months later I was at one of these 12-step conventions. There were hundreds of addicts like me, but they looked happy – I couldn't understand what they had to be happy about. Then I heard a woman talking on stage. It was the same as all the others – took drugs, got bad, got clean. I was zoning out.

Then she said something that woke me up: 'In recovery, I got tested and was diagnosed with HIV'. She stopped what she was saying and started crying. She broke down on the stage, in front of everyone. I was embarrassed for her. Then somebody behind me shouted 'we love you'. Then another, and another – until the entire hall of addicts were shouting and whooping and clapping.

That's when it hit me. This is where I am meant to be. All those years, all those scams, all those drugs – all I wanted was this. I wanted to belong.

It wasn't all plain sailing after that. Detoxing was the easy part. I was 32 and had no idea how to live like normal people. Everything, from making a cup of tea to getting a part-time job, was a first without drugs. Slowly, one day at a time, I learnt how to live without a drink or a drug. I was able to make amends to the people I had hurt. I was able to look my dad in the eye and make peace with him before he died. I was able to be a son to my mum again.

Seven years after getting on my knees and begging for help in St Thomas's toilet, I found myself in the same cubicle after the birth of my son. I looked at my reflection in the mirror and compared my happiness and joy with the despair and dereliction of myself seven years before. I started to cry. This time they were tears of gratitude. I was alive and I was happy.

It's been 16 years since I went into that detox. In that time I've made some mistakes, but I've never picked up a drink or a drug. I've got two beautiful children, a loving girlfriend and my own counselling practice in Harley Street.

Most of all I have a peace of mind that I never thought possible.

Mark Dempster is author of Nothing to Declare: Confessions of an Unsuccessful Drug Smuggler, Dealer and Addict, available now on Amazon.

Mark runs a Harley Street counselling practice and is an expert consultant and trainer in addiction, www.markdempstercounselling.com

Prescription for ACTION

Through a recent parliamentary debate, ADS brought together experts to tackle the pervasive problem of addiction to prescription drugs. Tom Whiting reports

Last month Addiction Dependency Solutions (ADS) held a seminal event in parliament, *Addiction to prescription drugs*, with the Labour shadow health secretary, Andy Burnham.

The event was a *Question Time* style debate on this topical issue and consisted of a panel of clinicians, service users and experts in their respective fields, with direct experience of addiction to prescription drugs and treatment services.

It was the first time an event on this issue had been held in parliament and marked a momentous day for many people in the room who had been campaigning for many years for increased awareness of the debilitating effects of addiction to prescription drugs such as benzodiazepines. Addiction to these drugs has devastating and lasting effects on individuals and their families, and the event highlighted the need for increased provision of direct and targeted treatment services for those who are addicted.

Currently, there is little treatment available for those who suffer from prescription drug addiction, with only a handful of services dedicated to this issue in the UK. As a progressive charity, ADS aims to represent those who need help the most. Working with Oldham PCT and Barry Haslam of Oldham Tranx (a voluntary support group for those suffering from addiction to prescription drugs) ADS started providing an addiction to prescription drug service in Oldham in 2004, and – by working with dynamic commissioners – now provides another service in Derby that was recognised as a model of best practice at the Westminster event.

The event was chaired by Andy Burnham MP and consisted of a panel with Lady Rhona Bradley, chief executive of ADS; Dr James Davies, lecturer in social anthropology and psychotherapy at Roehampton University; Dr Jack Leach, consultant in substance misuse; Dr Richard Martin, assistant director of Public Health for Derby Council; James Sutherland, lead commissioner for public health for Derby Council; Barry Haslam, chair of Oldham Tranx and John, service member of Oldham Tranx. Each panellist had time to outline their own background, experience and views on addiction to prescription drugs before the debate was widened, and questions taken from the floor.

All the panellists were of the opinion that addiction to prescription drugs was an issue that had been buried under the carpet for too long and agreed that centralised action was needed on a national scale to offer guidance and results. Barry Haslam drew on his own experience of addiction to prescription drugs, describing the lack of help he received and the resultant health problems he had suffered. This had spurred him on to campaign vociferously on the issue for the past 20 years.

One of the most striking comments of the day came from Dr James Davies. In discussing how people were often 'placed' on prescription drugs without getting to the root of the problem – often as a result of anxiety and stress – he said: 'Fifteen per cent of the British public at one time are on some form of prescription medication as a result of mental health issues.' This statistic highlighted the scale of the problem, with many of these drugs addictive within four weeks and resulting in dependence in as little as six weeks.

> 'Fifteen per cent of the British public at one time are on some form of prescription medication as a result of mental health issues.'
>
> DR JAMES DAVIES

The panel's consensus was shared by the audience, with questions reflecting the need for increased political awareness and action. One audience member, Dr Malcolm Lader, drew on years of experience to highlight the divisive role prescription drugs were playing in our society, and called for direct treatment to curb their long-term ill-effects.

With a member of Public Health England in attendance, it was left to Andy Burnham to ask why current guidelines and protocols for services for prescription drug addiction were so weak. The PHE response was, 'It is up to local authorities to take action on the issue following guidance from Public Health England.' Andy Burnham responded: 'That doesn't answer the question. Clearly more needs to be done.'

As panellists drew on their expertise and personal stories from the audience mirrored their views, there was little doubt about the scale of the problem. Summarising, Burnham said it was time to take action on an issue that had been too long ignored in parliament. As Labour shadow health secretary, he would aim to realign health and social care as part of the NHS.

Lady Rhona Bradley said ADS would continue to 'champion a cause that has clearly affected many in this country, and an issue that should be acted upon without haste.'

Tom Whiting is development and grants officer at ADS

MAKING RECOVERY VISIBLE

On 22 September, thousands of people will be gathering in Birmingham for the fifth UK recovery walk, as **Richard Maunders** explains

IN RECENT YEARS I'VE LEARNED THAT RECOVERY BECOMES CONTAGIOUS WITHIN COMMUNITIES WHEN IT'S VISIBLE, when it's seen and felt, and hope and inspiration are passed on to those still struggling, still trying to define what recovery means to them. This is most apparent at the UK recovery walks. Anyone who attended last year's walk in Brighton will have seen and felt how powerful the walk, a mobilisation of hope and optimism, can be. Looking down the hill in the centre of Brighton last year I saw a crowd packed with happy faces, faces filled with love and hope, faces once etched with pain and misery, now beaming with gratitude in the September sun. Three thousand people marching up from the beach joined in a desire to celebrate recovery in all its diversity.

Whatever your view, or definition of recovery, it is hard to deny the transformative effect of the recovery walks. While communicating a living message of transformation and inclusion they have quite literally been 'tipping points' for lots of people. As one Birmingham walker said to me, 'I really needed today. I love the feeling of belonging to something. I love knowing that all around the country there are people like me, with the same struggles and fears, and knowing that there is a way through this and I'm not alone.'

He wasn't alone. I know of many people from the Midlands, where I live, who came back inspired and determined to take control of their recovery. The Brighton walk planning group passed on the baton (or, more accurately, a stick of Brighton rock) to Birmingham. They've continued to build recovery in Brighton as 'creative cascade recovery', and now it's Birmingham's turn to host the UK's biggest public recovery event.

As the day comes ever nearer I've learnt many things about our recovery community in Birmingham. We've come a long way together. We've had our highs and lows. But what's overwhelmed me as chair of the planning group is how passionate, determined and enthusiastic our community is. We've discovered skills and attributes we didn't know existed. We've learnt to ask different questions – 'what are our strengths, our passions?' – and unearthed a community bubbling with strengths and assets. We've learnt that we need to look at what we've got and not at what's missing, and find the abundance within our own communities. We've learnt that it's not about what can be done for us but what we can do for ourselves. Together we've become powerful and we're really looking forward to making new friends when we walk together on 22 September.

The walk is a powerful articulation of visible recovery, but we believe we can do more. The UK recovery walk charity, established in April this year, will be supporting walks from 2014 onwards. After the Birmingham walk I'll be focusing, in my role as a director with the UKRF, on the promotion and support of a UK recovery month. Inspired by the recovery movement in the US, we want to see September established as a month that makes recovery visible in every city, town and village, speaking to everyone, offering hope to all.

This year we've taken some small steps in preparation for 2014 when UK recovery month will launch. We have some learning to do along the way and we've decided to start the mini 2013 recovery month on top of a mountain.

On 1 September, groups from all over the UK will gather at the top of Snowdon in Wales for a cuppa and a chat. We'll plant a purple flag (the colour of recovery) at the top and we'll reflect on what we've gained and what we've lost. People will make their way to the summit in different ways, symbolising the many different paths they have taken on their recovery journeys.

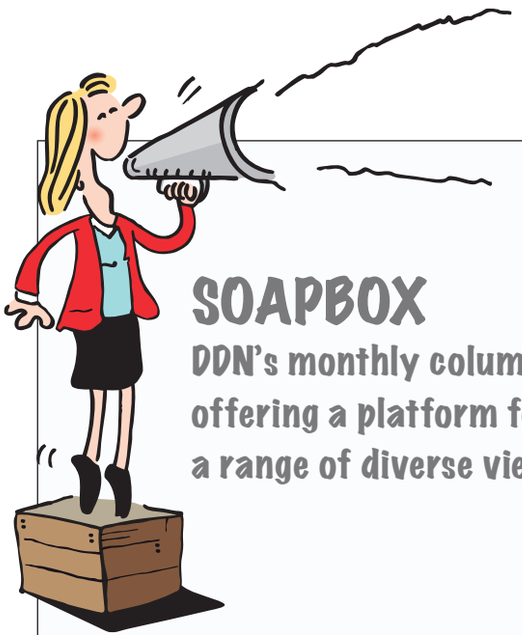
This social gathering, for the UKRF, will mark a new beginning – a shedding of past differences and an embracing of our common humanity. We all have mountains to climb at some point in our lives. In coming together around our similarities as human beings and in recognition of the validity of all paths we hope to support the emerging UK recovery movement. Making the path as we walk it.

There will be other events in 2013 recovery month (that we know of) in Derbyshire, Gloucestershire, Rochdale, Hertfordshire, Birmingham, Norfolk, Lancashire, Kingston, Somerset and Cumbria. It's a beginning and it will grow.

To register for the UK recovery walk in Birmingham: http://www.ukrw2013.co.uk/register

For more info on 2013 Recovery Month: https://www.facebook.com/groups/UKRecoveryFederation/ or contact: alistair@ukrf.org.uk and richard.maunders@ukrf.org.uk

Richard Maunders is chair of the 2013 UK recovery walk Birmingham planning group and UKRF director Alistair SinclairUKRF Director.



SOAPBOX

DDN's monthly column offering a platform for a range of diverse views.

DOWNHILL SLIDE

Our procurement, tendering and commissioning processes are unacceptably poor, says John Jolly

I'VE BEEN SHARING CONCERNS FOR YEARS with other CEOs and senior managers about poor procurement and tendering in the drug and alcohol sector – usually just quietly, over meetings with coffee. When I spoke recently to Martin Barnes, CEO at Drugscope, the umbrella organisation for the field, we shared long-standing worries about the state of commissioning in many areas.

To really address the issue, however, we need evidence of the impact on staff and organisations, and examples of poor practice and waste. How much does it cost service providers to tender? How much money do commissioners spend on consultants? We cannot just complain about the process; we have to demonstrate its impact, unfairness, and consequences for service users and on service provision and quality. It is perfectly legitimate for local authorities to retender work provided to them by contractors, but in the context of Big Society there needs to be a level playing field for the third sector and local third sector providers.

Poor and frequent commissioning has a number of serious consequences, not least of which is the cost. An exercise to quantify the costs of tendering services more than years ago came up with a figure of £300,000 expended by all bidders and the commissioner per tender.

We have to accept that tendering of services is here to stay and that providers will all win and lose contracts. However, I think there is a case to be made to increase from the standard three-year contract to a seven- to- ten-year minimum contract length – or possibly longer.

The contracts are often very one sided and allow cancellation with three or six months notice. Often providers are asked to agree to the contract as a condition of being allowed to tender, which is clearly unfair. Contracts need to be far less easy for local authorities to wriggle out of, with an expectation that any but the most major changes required are done via contract variation rather than retendering, except where there are clear performance issues.

At Blenheim we are concerned about the minimum turnover requirements that are beginning to affect the ability of small providers to tender for contracts they currently hold. This is where to bid for work you have to have a minimum turnover of, say, £5m or £10m. I am aware of many smallish and medium-sized charities that have not been able to bid for their own contracts back in their own right, forcing them into shotgun marriages with other providers as junior partners. This has on occasions included Blenheim, despite us being in the top 750 charities in the UK by income out of 66,000 charities.

Partnerships have a lot to offer and Blenheim is in many great and highly effective partnerships, but they rarely work well when they are marriages of convenience.

Blenheim is concerned that we are starting to see the demise of local third sector organisations operating and attuned to local communities, and their replacement by profit-motivated or organisational-survival-motivated or growth-driven organisations. This I already hear and see impacting detrimentally on service provision.

Blenheim is concerned about minimum standards in the drug and alcohol sector, with the move to local authority commissioning and the demise of the National Treatment Agency. Providers are all being forced to compete on price rather than quality, and this has a direct impact on who is employed or made redundant. The people that service providers employ and their skills and ability is what makes the difference to the mothers, fathers, children, sisters, uncles, neighbours, friends and grandparents with a drug or alcohol problem that we are here to help. These people deserve a quality service, delivered against exacting standards of performance and staff competence, not the cheapest available.

Blenheim is deeply troubled about the many instances of poorly managed tendering processes which create huge wastes of time and effort both at commissioning level and within provider organisations. This is now a regular occurrence and issues have included unfair decisions, lack of transparency about the process, and lack of knowledge about tendering and procurement within tendering teams. A number of tendering processes have to be suspended due to flaws in the process, and there is complete lack of understanding by many commissioners of TUPE rules. There are attempts to dump significant pension liabilities on incoming organisations where the NHS or local authority is the outgoing organisation, and there are sometimes completely ludicrous and unworkable specifications. Local authorities often transfer risk to providers via payment by results with poor data to assess risk – often in relation to performance targets the provider has little control over.

At Blenheim we think its time we should stop talking and start acting, as a provider and a sector, to raise these concerns via DrugScope and other forums.

John Jolly is chief executive of Blenheim CDP

Families First

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This event will showcase latest practice, developments and issues for needle and syringe programmes in England. The day is tailored to the needs of programme workers and service users across the country.

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(Southampton City).

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See the full tender information on

www.drinkanddrugsnews.com

EXPRESSIONS OF INTEREST

Swindon Borough Council

Community Alcohol Treatment and Recovery Services

Swindon Borough Council Drug and Alcohol Action Team (Swindon DAAT) invite expressions of interest from suitably qualified and experienced service providers for the provision of an Adult Community Alcohol Treatment and Recovery Service throughout the Borough of Swindon, serving a population of approximately 210,000 residents.

The Adult Community Alcohol Treatment and Recovery Service is a newly designed, recovery focussed service where a successful provider will ensure seamless and accessible pathways for service users by providing:

- *Intake Team*
- *Hospital Alcohol Liaison*
- *Clinical Service*
- *Recovery, Support and Transition Service*

Full details relating to the four service elements will be provided in the Invitation to Tender (ITT) document.

The resources, range and depth of skills needed to provide the service are such that some organisations may wish to collaborate to form a consortium in order to bid, with a lead organisation becoming the main contracting party with Swindon Borough Council. However, this does not preclude a single provider tendering all the resources and services required by the Invitation to Tender.

The contract will be initially for a period of 3 years commencing 1 April 2014 with an option to extend for a further 12 months subject to satisfactory performance. This is a competitive tender, and a contract will be awarded to the organisation that is deemed to represent the most economically advantageous tender.

Organisations wishing to Register Interest and download ITT documents which will go live on **09 September 2013**, should apply via the South West Portal using the following URL link: *https://www.supplyingthesouthwest.org.uk/procontract/supplier.nsf/frm_home?openForm*

Click on *"Search Latest Opportunities"* and locate Contract ID **SWCE-9A4DZB**
If you have any problems with this link, please email the contact Jennifer Laibach at *JLaibach@swindon.gov.uk* and Kate Daniels *KMDaniels@swindon.gov.uk*

The closing date for the receipt of completed tenders is 12 noon on 09 October 2013

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swanswell

Swanswell is a national alcohol and drug charity that helps people change and be happy. We believe in a society free from problem alcohol and drug use. We are currently recruiting for the following positions:

085 – Accredited Programmes Facilitators (Two vacancies)

Coventry and Stafford. Closing date: 23 August 2013.

Swanswell's Accredited Programmes Facilitators deliver substance misuse accredited programmes to offenders referred by the National Probation Service (NPS). You'll be required to deliver a range of substance misuse programmes, including the Drink Impaired Drivers Programme (DIDP), the Lower Intensity Alcohol Programme (LIAP), the Offender Substance Abuse Programme (OSAP) and the Building Skills for Recovery programme (BSR). You must be accredited in at least one of these programmes and be able to provide evidence of delivering a programme in the last 12 months.

This is a part time post, working approximately 18 hours per week (this is subject to change dependent on the needs of the business, and will be discussed at interview). There may be a possibility of combining this role with another Swanswell role to make a full time position.

086 – Clinical Senior Practitioner

Loughborough. Closing date: 29 August 2013.

Swanswell Senior Practitioners support our Operations managers to deliver quality services. You will supervise a team of workers including our medical team members, motivating them to deliver quality services and go the extra mile for our service users. You will be expected to supervise our nursing teams in the delivery of community detoxifications and ensure that their practice is safe and effective. You will also manage a team of substance misuse workers and will provide supervision, case file audits and observations in order to ensure an excellent level of service delivery.

You must be a registered nurse (RGN, RMN) with a non medical prescribing qualification and a current PIN. This is a full time post.

087 – Community Nurse (Prescriber)

Loughborough. Closing date: 29 August 2013.

Swanswell's Community Nurse Prescriber's support our Operations Managers to deliver quality services and go the extra mile for our service users. You will oversee community drug and alcohol detoxifications and facilitate prescribing clinics across Leicestershire. You will also provide BBV screenings and vaccinations and support substance misuse workers in managing the health needs to our service users.

You must be a registered nurse (RGN, RMN), preferably with a non medical prescribing(NMP) qualification and a current PIN or a willingness to work towards obtaining an NMP qualification. This is a full time post.

088 – Clinical Operations Manager

Loughborough. Closing date: 29 August 2013.

Swanswell Operations Managers are responsible for making sure our services provide effective support. You will manage a team of workers which includes our medical staff and substance misuse workers. A large part of this role will be ensuring that our services are meeting their targets, exceeding expectations and compliant with quality standards. So you'll need to be able to provide effective support to a team of workers, monitoring casework (including service user care plans) and addressing any performance issues. This will include the auditing of caseloads to ensure a high standard of care is being delivered against required standards.

You must be a registered nurse (RGN, RMN) with a non medical prescribing qualification and a current PIN. This is a full time post.

To apply for any of these roles, please visit our website, *www.swanswell.org/current-vacancies*.
If you would like to discuss any of the roles or enquire about our recruitment process, please email us on *jobs@swanswell.org* or call us on *01788 559 400* (HR).