

NTA has misled on stats

Your readers may have read (*DDN*, 29 Nov) Paul Hayes' 'disappointment' about 'claims' in Druglink critiquing statements from the NTA, but not seen the documents being referred to. The *Druglink* report included evidence of pressure to distort treatment statistics to meet government targets, which readers will either believe or not. But the so-called 'claims' about misleading presentation of statistics can be verified from material available through the NTA itself. What is truly 'disappointing' is that these mistakes are not owned up to in a way that gives confidence that they will not continue to occur. These were the NTA statements being questioned and the reasons why.

1. 'An estimated 154,000 people are calculated as being in contact with treatment services in 2003/04.'

We know (and so should the NTA) that this statement from their September national media release is false; the 154,000 deliberately included people known *not* to have been in contact during 2003/04. To make it comparable with the previous year, it included at least 14,000 'virtual' people thought to have been double-counted or never actually heard of during 2003/04. This is clear from Manchester University's report *Bridging exercise comparing drug misuse treatment data 2002/03 and 2003/04* available through the NTA web site.

2. '54 per cent more drug misusers were in contact with drug treatment services in 2003/04 by comparison to 1998/99.'

This further statement from the media release (comfortably close to the 55 per cent target) is based on a comparison of the 154,000 figure with a 1998/99 baseline of 100,000. In fact, the only defensible statement would have been something like, 'We're pretty sure we've got more people in treatment but we don't know how many.' The problem is that the 154,000 was never intended to be comparable with the baseline. It included the deliberate errors noted above which would almost certainly not have been replicated in 1998/99. The effect was to artificially boost the percentage increase. But the baseline itself was a questionable estimate. The NTA seems now to have recognised the hopelessness of this exercise. From here on they will be using as their baseline the estimate of 125,900 individuals in contact with structured treatment in 2003/04 (NTA, *Briefing for drug treatment stakeholders*, 8 November 2004) – but not before they

have used questionable data to establish that progress in the second half of the 10-year strategy will build on an 'on-target' first half.

3. As *Druglink* pointed out, the NTA has previously presented convenient but questionable statistics as if they were facts. Last December, an NTA media briefing said, 'There has been a four-fold increase in the length of time clients stay in treatment from 57 days in September 2001, to 203 days in June 2003.' It said this was based on a

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15 per cent sample but otherwise the statement was entirely unqualified – no ifs, buts, or maybes. Now we are being told (NTA, *Briefing for drug treatment stakeholders*, 8 November 2004) that these figures 'were never intended to be seen as official national performance data.' But at the time, that is exactly how they were presented, as the second point under the heading 'Progress against targets'. And they continued to be presented in that way after the NTA was told that this supposed increase conflicted with national drug treatment monitoring data, after the responsible person at the NTA said 'there was no effort made to ensure that data would be comparable across different time periods', and after its chief executive acknowledged the need to understand the conflict with the other figures (emails between the NTA and myself and/or *Druglink*). Still there is no

apology or admission that for months the NTA allowed this misleading claim to be presented and no sense that anyone at the top of the organisation feels they did anything wrong.

4. The first point in the briefing referred to above said, '141,000 people accessed drug treatment in 2002/03. This represents a 41 per cent increase since 1998.' As *Druglink* pointed out, from the *Bridging exercise* we now know how pumped up this figure was. It included two different sources of double-counting, people never heard of during the year, people not accessing treatment at all but tier two support and harm reduction services, and in the 'vast majority of areas' incomplete records meant an estimate had to be made of how many people *should* have been reported. Together these added tens of thousands to the figure. That's why they were considered 'provisional' yet they have never publicly been revised.

Unfortunately, the obfuscation continues. In *Drink and Drugs News* Paul Hayes compares the data now available to the NTA to that produced by the National Treatment Outcome Research Study, implying that the NTA's sources are vastly superior because NTORS drew its data from 'approximately 540 individuals, the NTA is now able to draw on data from over 125,000 individuals.' Actually NTORS drew its data from 1075 individuals and the richness and reliability of the dataset available to the researchers from directly talking to clients bears no comparison to that available from national monitoring. The key difference is NTORS measured post-treatment *outcomes*, so was in a position to assess quality, not just quantity. Above all, when the NTORS researchers present their figures, we may query interpretations, but we can believe what they tell us.

Mike Ashton

Substitute for abstinence?

The reported findings by Professor McKeganey are of great interest. (*DDN*, 15 Nov) However, as a practitioner within the substitute prescribing, at an agency operating under the harm reduction umbrella and an ex-service user, such findings are of little surprise. In my experience, the majority of individuals presenting for treatment, especially substitute prescribing, when asked of their treatment goals at both initial and follow-up assessments, indicate such goals to be that of abstinence from the drug to which dependence has developed, and rarely harm reduction intervention or

abstinence from all psychoactive drugs.

Although for many individuals abstinence is the desired treatment goal, employing such a rigid goal may have great negative impact upon those presenting to services that are not ready to make such commitments, and therefore prevent such individuals' presentation for needle exchange, advice and information, and substitute prescribing services. As demonstrated long-term, substitute prescribing to individuals not yet ready to commit to achieving abstinence can aid the reduction of harms both to the individual and society at large, by reducing drug intake and crime. For such individuals, short-term methadone reduction goals are likely to be unrealistic and promote poor outcomes.

The harm reduction model, when implemented to its greatest capacity, can be highly effective, simply due to its ability to work with individuals 'where they are at' and thus neither condemning nor condoning drug use. Abstinence is always an optimal treatment goal, as what better treatment goals could be employed to elevate drug related harms? The harm reduction model allows flexible and collaborative working between the practitioner and client in order to reach commonly negotiated treatment goals, which may greatly differ between clients.

In my experience, it is unrealistic for all individuals dependent on a particular substance to achieve abstinence, and some do not wish to do so. Furthermore I believe it unrealistic for all individuals to reach contentment with maintenance on substitute medication. Clients may wish to work towards goals perceived by a practitioner to be unrealistic or a little too ambitious, even after being presented with the practitioner's argument. Through collaborative working, it is important to be experiential and to facilitate the clients treatment direction – we may learn something new, or the client is able to learn for themselves that their aims were a little ambitious and maybe scaling down to smaller goals will be more effective.

An operational structure of abstinence may, rightly or wrongly, promote discrimination, feelings of being judged, and reinforce low self esteem, when goals are not met – all of which are likely to have great impact upon the therapeutic relationship and treatment retention/outcomes. Therefore is it a question of abstinence or harm reduction, or is it a question of making sure service providers hear the voice of their clients, to ensure the harm reduction models are fully utilised?

Paul Hammond, by email

Harm reduction is more than just a substitute

As I read the article about abstinence versus harm reduction (*DDN, 15 Nov*), I got really angry because harm reduction was minimised to just a methadone script.

Harm reduction means a lot more than this! It gives a completely wrong picture of it, which has to do with your view of tackling drug use in the UK. Your system is only focused onto treatment, there is very little that has been done in the direction of harm reduction. Only in the last year have needle exchanges started giving out ascorbin and water as well, and even some filters instead of just syringes and swabs.

You do not have any safe environments for drug users like shooting galleries, and we don't even want to start discussing drug-checking for consumers. So what do you know about harm reduction? A methadone script can be so difficult to get with waiting lists of five to six months. What are the users going to do, meanwhile? What type of harm reduction is offered to them? I worked for about five years in a shooting gallery in Germany and we had about 500 people coming in every day. There was another drop-in which the government wanted to feature more, because it was abstinence based and not in the centre of the city – they had a shuttle bus getting users over there – and they were lucky when they had seen three people a day. How does that fit into your calculation that users only want to go for treatment? Then the needle exchange in Germany changed into proper buses, cafes where you go inside instead of being seen on the outside of a van. Drug users are marked from society everyday in the papers, which is ridiculous because all of us drink or take drugs if we are honest! We had people coming into the needle-exchange bus on Saturdays or evenings who were working their butts off – nobody knew that they were taking drugs (they were normal people not offending and working every day), but nobody talks about them. Then the whole drug-deaths number was reduced so much via harm reduction as they had suddenly a safe place to go where they were not chased by the police, and they were looked after if anything happens. In their own flats they are scared to call the ambulance because they might get arrested.

There are a lot of people in the city who are homeless, lonely with nobody to understand them. Harm reduction places have done so much for them, accepting them in the way they are, but showing them that somebody cares and making them care about themselves.

They will never get discharged from a harm reduction place. I had so many clients over here who went through residential treatment, then ended up on the street again.

This is such a chilly way to react to people who are different, and which do not fit into society like they 'should'. One day you are going to be like the States, if you cannot accept the ways of minorities. Think about it!

Martina Jung, Drugswork, USA

It's the combination that counts

I would like to thank all those who read and especially those who responded to my article on drug users' aspirations from treatment (*DDN, 15 Nov*). Most academic work is ignored, some of it is liked, some of it is hated and a small amount is liked and loathed in equal measure. I suspect that the paper 'What are drug users looking for from drug treatment services: abstinence or harm reduction?' recently published in *Drugs Education Prevention and Policy* and covered in *Drink and Drugs News* falls into the latter category.

The responses to the article encompass that range of views. Robert Newman (*DDN, 29 Nov*) is surely right that if you ask most people suffering from a medical condition whether they would like a cure or to have their illness controlled, they would choose the former. The trouble with that question though, is the fact that it is not what we asked our respondents. What we asked them was to tell us what they wanted to get out of treatment. The fact that the overwhelming majority said that they wanted to become drug free and only a small number said they were looking for harm reduction advice is a clear message, no matter how naive we as researchers are alleged to have been. The key question following from this research, however, is to ask whether our drug treatment services are indeed combining abstinence and harm reduction in the way that so many have claimed. This is an easy claim to make, but one where the data is conspicuous by its absence. How many people are indeed moving along the abstinence harm reduction continuum and how many are being warehoused in a state of long-term dependence? We need much better information on the quality of our drug treatment services, whether they have a harm reduction or an abstinence focus.

It is easy for drug treatment professionals to say that they are listening to their clients, but this is not the same as acting in accordance with your client's wishes. The fact remains

though that in many areas, you get what you are given in terms of drug treatment, irrespective of your own preferences. Drug treatment needs to move into the world of client and customer choice. Just because you are a drug user should not exclude you from expressing your preference or from having those preferences influence the treatment offered. Other areas of health and social care have responded to the consumer movement and it is now time that the world of

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drug treatment did the same. If most addicts are looking for abstinence, then we had better ensure that we have services in place that can respond to those wishes and ditch the patronising voice that says 'we know what addicts need, irrespective of what they think they want'.

Neil McKeganey, Professor of Drug Misuse Research, University of Glasgow

State-sponsored insanity

As an alcohol worker in Exeter, Devon, I have watched as this drug phobic parallel universe has been created – not by drug users, but by the government and drug agencies, and even the drug workers themselves who are all responsible for creating and maintaining this drug mania, especially the insane methadone regime. Insane to all except the drug companies and

the government of course.

In the 20 years I have worked, I have never been on more than a year's contract. In fact 60 per cent of the time, it has been six-month contracts. We have had to beg, steal and borrow every single year since I can remember – despite the huge rise in alcohol abuse on every level.

The biggest insult came from my post as an alcohol worker in prison, where I had worked for 12 years. Last year we lost two days' funding in prison, and where did the money go? To buy state of the art kennels for the prison's drug sniffer dogs. Worse was to come: six months after that we lost all our days to fund the post of a new admin worker. You may think we have been doing a bad job, or perhaps we were not busy and that's why they got rid of us. In fact the opposite is true – we were the most respected and hardest working team in the prison, we really were making a difference.

Now no alcohol work goes on apart from AA, when most of the inmates had alcohol problems. Across the board this is totally irrational, and it's impossible to break through it. We just watch our work go up and the funding go down. In fact it's possible we may not survive after April 05 as all the commissioners are denying responsibility regarding alcohol, and the DAAT is so terrified of not producing its targets for drug users, that they are refusing to part with any money for alcohol. Unfortunately the word 'discretion' is the alcohol tragedy, with the government leaving it up to them whether to spend on alcohol and at the same time making it almost impossible for them to do so.

I see on average six clients a day, yet of two fabulously funded drug contracts I know of, one has seen 13 clients in three months, and the other five clients in three months. That's four full-time workers seeing a total of 18 clients over a period of three months. It's the same with our alcohol arrest referral: last year we had 13 per cent drugs-related offenders and 87 per cent alcohol related, and the majority of them violent offences, yet the difference in the funding is huge.

When is this waste going to end? Is there any more we can do? With respect, your magazine is great but we have all been going on about this for years and no-one takes any notice, or palms us off. I'm not that political, but I have plenty of passion and energy, and feel at times we all make nice polite noises but no one takes the least bit of notice. What can I do down here, is there anything we can do to help?

Norrie Mckechnie, alcohol worker, Exeter.