Radio 4 junkies

Two significant events in the UK drug field happened on 18 October this year. The second was a highly positive conference about day services, run by KCA, which gave the opportunity for a number of providers and researchers to demonstrate that, although this is a modality which needs considerable further work, there is strong evidence that it is of significant benefit to thousands of people with dependency related problems.

The first, and the one which has been the subject of much discussion since, was the Radio 4 *Today* programme's assault on the record of drug treatment over the life of the current drug strategy. Using the springboard of contingency management and sensationalising a report on the apparent presence of manipulated forms of it in current UK practice, the reporter went on to heap criticism on the perceived lack of success of treatment in England.

The contrast between these two events couldn't have been greater. For instance the reporter on the *Today* programme said that there was 'no evidence whatsoever' for the efficacy of structured day programmes. Less than two hours later at the conference I listened to Dr David Best explaining the research that demonstrates the opposite.

Like thousands of others, I have great pride in the leaps forward that we have made in drug treatment over the last ten years. A less selective view of the figures available shows a vastly increased number of people receiving a service and, even more significant, an improvement in retention and completion figures.

The problem seems to be that, when drug treatment is anything other than rehab for celebs, we haven't explained to the public what it is and what realistic expectations would be. In addition we haven't sufficiently tackled prejudices surrounding our client group. What better example of this than a reporter's use of the word 'junkies' on BBC Radio's flagship news programme.

We have to face some unpalatable facts. The new NICE guidelines on psychosocial interventions have taken many of us by surprise and we need to regroup to demonstrate the efficacy of some of the work that we do. We still do not have good data on the success of much treatment; the recently commenced collection of the Treatment Outcome Profile (TOP) is late but much better than never. Most worrying: we still do not have enough options for service users seeking treatment exits.

To suggest that we have not made progress, however, is plain daft. We can see increases in retention and increases in participation in treatment. Where there are gaps in the system, residential rehabilitation for example, providers continue to offer excellent and proven treatment to service users from all backgrounds. This progress receives little attention from the media, for whom pulling at the thread of pockets of bad practice is much more rewarding than examining the diverse tapestry that is UK drug treatment.

We can fully expect the new drug strategy to make changes in the way in which we deal with drug use in the UK. There is no risk, however, that the well-proven maxim 'treatment works' will not be as firmly reflected in the plans for the next ten years as it has been for the last.

Bill Puddicombe, chair of EATA (European Association for the Treatment of Addiction) and independent consultant.

Incompetent times

Some DDN readers may well have read the extensive coverage of 'safe' drinking limits that appeared in the *Times* of 20 October. This formed not only the front page headline, but also a feature on pages 6 and 7.

Those less familiar with the history of the safe drinking debate may well have been left with a completely false impression of how the current government guidelines on safe drinking were arrived at.

These were, not as the *Times* says, based on the Royal College of Physicians (RCP) 1987 report, they were based on the 'Interdepartmental Report on Sensible Drinking' published by the Department of Health in December 1995.

This report established the current 'official' government recommendations of daily limits of two to three units for women and three to four for men. These are now printed on the containers of most UK produced alcoholic drinks.

It is coincidental that the RCP report chose two units a day for women and three for men. I was a member of the working group that produced the DoH report and daily units were deliberately chosen in order to dissuade drinkers from saving up their units for a weekly binge.

It is true that the conclusions of the Royal College of Physicians (RCP) 1987 report were not scientifically based. This was one of the main reasons for the 1995 committee being formed.

In contrast, our report was extremely well researched. Over 150 submissions of written evidence from concerned parties were considered and several oral 'interrogations' of expert witnesses took place, one involving the great Sir Richard Doll himself.

The vast majority of the report's conclusions, including those linking 'moderate' drinking with reduced heart disease, remain fully valid and consistent with subsequent research. It is salutary that Dr Richard Smith has now admitted that the RCP limits 'were not based on any firm evidence'. It is unfortunate that certain members of the medical profession, and several others, continue to insist on using the old ill-researched limits of the 1987 RCP report.

Furthermore, it may be of interest that I wrote a letter to the *Times* informing them of the deficiencies in their reporting, but they chose not to publish it.

Dr Rob Tunbridge, independent alcohol & drug impairment consultant, Rayleigh, Essex

Treatment and recovery

Congratulations to the Addictions Working Group, for their exposure of the distortions by some agencies of the Tory proposed strategy on drug abuse and addiction (*DDN*, 22 October, page 9).

The reported views of those agencies were remarkably similar, differing only to the extent they sought to distort the well-researched empirical evidence contained in the report. It is also notable that none of the agencies whose views were sought or reported, have recovery writ large in their activities or objectives. In fact it would be reasonable to suggest that recovery is not part of their strategy.

While acknowledging that the article was 'a round-up of reactions to Breakthrough Britain' and given that the majority of treatment agencies periodically listed in *DDN* are recovery-focused and use 12-step facilitation, the absence of any counter-balancing views in the report is puzzling. It may be a case that there weren't any, but in the interests of balanced reporting, one assumes that they were sought.

On the subject of recovery, I must thank Professor David Clark and Lucie James for their hard-hitting, no nonsense letter regarding the *Today* programme. One would be hard-pressed to find an equal of the latter, in terms of rhetorical rubbish. What it did expose was that both Paul Hayes and Dawn Primarolo are unaware of what is going on in their own backyards – or that they are, but seek to deny it. One thing we can be sure of as Professor Clark and Lucie James clearly highlight, is that the amount of time devoted to effective counselling is abysmal.

The failure of the current drug strategy, insofar as recovery and rehabilitation is concerned, can be attributed to the inexplicable refusal to utilise the worldwide evidence of 'what works', again as highlighted by the excellent articles from Professor Clark, describing the principles of effective treatment, and recovery. Such wilful dismissal of authoritative research and evidence, combined with 'treatment' involving the ongoing administration of addictive drugs, even where the addicted has expressed a desire to become drug free, serves only to increase the severity of an individual's addiction.

Peter O'Loughlin,
The Eden Lodge Practice

No secret anymore

So the NDTMS data is flawed – 'NTA dodges fire to announce more clients in treatment' (*DDN*, 22 October, page 4). This comes as no surprise to those of us who have been in many a meeting where service providers have been encouraged to take a liberal interpretation of what constitutes retention in treatment, planned discharges and positive treatment outcomes.

The real shocker behind the headlines must surely be the impact that striving to meet these government targets is having on treatment.

I understand and support the need for the harm minimisation and criminal justice agenda, but they have taken undue precedence because they are seen to have the political impact that this government seems to need. Some Drug Intervention Programmes (DIP), in their endeavour to keep offenders engaged, are ignoring re-offending behaviour, failures to turn up, non-engagement in programmes and illicit drug use. There needs to be a more balanced and realistic approach to treatment.

It saddens me that we seem to have come to accept the lowest common

Obituary – Roger Duncan

Swansea Drugs Project, 25 next year, has been marking the sad news of the death of one of its founder members and its first director, Roger Duncan. Roger, aged 58, died peacefully on 14 October, after a short illness.

Roger Duncan was without doubt one of the most knowledgeable and experienced workers in the drugs and alcohol field in South Wales, and had made an immense contribution to the development of substance misuse services across the region.

Ifor Glyn, current manager of Swansea Drugs Project, said: 'The death of Roger leaves a massive gap in the substance misuse field in Wales and beyond. He was a unique individual, passionate and compassionate, who was vociferous in demanding better services for those affected by drugs and alcohol. His work touched upon and improved the lives of thousands of individuals and families over the years, and it was due to his commitment and passion that Swansea Drugs Project continues in its work of offering services to users and their families.'

Before coming to Wales, Roger had worked for several social care services in London, including Release, Blenheim Project and Riverpoint. He was then appointed the first director of Swansea Drugs Project, and oversaw its development from a small voluntary group to a professional organisation with more than 25 staff. His passion and main focus was always the care and treatment of those affected by substance misuse, and he would always challenge discrimination and prejudice, and stand up against any inequality.

Under his management, Swansea Drugs Project opened the first needle exchange in Wales in an attempt to reduce the spread of HIV/Aids, and less than five years ago he developed the first specialist service for young people in Wales. He was an innovative and creative individual who believed that drug users had the same rights to services and help as other members of the community.

Over the years Roger had gained the reputation as the 'drugs guru' in South Wales, with countless numbers of drugs workers, social workers, nurses and teachers being trained by him. Many of his pupils now work across the UK, and share his passion and vision in securing effective and professional services for drug and alcohol users.

Sally Ward, his former partner and co owner of their drugs training business, Abracadabra, said: 'Watching Roger train people working with drug users was such a privilege. Although we often repeated the many successful Abracadabra courses over and over again, it was always fresh and special and everyone learned so much from his encyclopaedic knowledge of pharmaceuticals, and compassionate ways of working with drug users.'

Ifor Glyn added: 'There are so many of us who owe Roger for the inspiration and direction he gave us, many of us who continue to work in the substance misuse field. We could not have hoped for a better mentor, and it was a privilege and honour to have been able to learn from him. In the true sense of the word, he was a great man.'

The Swansea Drugs Project, management committee, staff and service users extend their condolences, and deep appreciation and gratitude for his contribution to his daughter Alice, Sally and his many friends and colleagues.

Swansea Drugs Project

denominator for our sons, daughters, husbands, wives, mothers and fathers! In real terms, there has been a disinvestment in the abstinence models of treatment. Some Tier 2/3 services no longer even mention abstinence or residential treatment to clients anymore because they know there is no point – there is no budget!

Drug agencies have huge pressure to comply with targets that are unrealistic and often, in my opinion, not in the clients' best interest. This translates into keeping or placing people in treatment who clearly are not appropriate, which then negatively affects other people who are trying to be positive about their recovery. I believe this contributes (in part) to the atrocious statistic of only '6 per cent of people on a drug treatment programme emerge free of drugs'! However, I do know of a significant number of agencies that far outperform this statistic with clients emerging and remaining drug free.

We need to raise our expectations of ourselves, and not fail society by expecting and accepting the lowest common denominator for others. We must focus on what works: positive and motivational relationships with our clients; boundaries that are firm, fair and caring; goals that reflect where the client is and where they want to go; protection for the children and young people; access to good quality housing, education, training and work.

The strength of any agency is its vision, philosophy and values and it is through these that we need to challenge the government strategy and not compromise good clinical decision-making to achieve their targets. We need to stand up and be counted for what we believe in and support our managers and workers to do the same.

This is a fantastic opportunity to challenge the drug strategy and improve drug and alcohol treatment in the UK – let's embrace it!

Sean Corbett, director,
Ethos Charity Solutions Ltd

Professional conduct

Kevin Flemen's letter 'Alternative Charlatans' (*DDN*, 10 September, page 8) drew attention to gaps in the regulatory framework for drug and alcohol treatment.

We have already made clear that we share these concerns and I do not propose to go over the same ground again. However, I do want to address the related issue of how we behave when we have concerns about a particular individual or service, and how we respond to any criticism we might receive.

In his original letter, Kevin raised some specific issues about the New Ways Clinic. Antoni Wilk, a 'partner' at the clinic, responded initially by asking that we remove his letter from the *DDN* website and, we understand, threatening Kevin with legal action. He also posted an anonymous article on a website registered under his name entitled 'The truth about KFx and Kevin Fleman (*sic*)'.

The article included a number of comments and claims aimed directly at Kevin and his company, KFx, including:

'Kevin's refusal to embrace all treatments that help with addiction, some say, *demonstrates he is not interested in really helping drug users, only in preserving his position as a self-serving, self-perpetuating and completely useless bureaucrat and any treatments which actually help with addiction are seen as a threat to his job rather than an opportunity to help drug users.*'

If we have real concerns about an individual or organisation offering services to people with drug and alcohol problems, we surely have not only a right to draw attention to them but also an active duty to do so. There are limits here. We must stick to the facts, and refrain from personal attacks, but given the stakes involved we simply can not stand by and remain silent.

Of course, those on the receiving end of a colleague's criticism also have a right to respond if they feel that they have been targeted unfairly. But again there must be limits to any right to reply and personal attacks posted anonymously on the internet seem unlikely to further the interests of the clients to whom we are all ultimately responsible.

Simon Shepherd,
chief executive, FDAP

Editor's note: Antoni Wilk was offered a right to reply to Kevin Flemen's letter in these pages, but he declined to do so. Kevin's original letter can be found at www.drinkanddrugs.net/features/sept1007/letters.pdf

We welcome your letters

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