NHS
National Treatment Agency
for Substance Misuse

nta annual report 2008-09






EFFECTIVE TREATMENT
CHANGING LIVES
www.nta.nhs.uk

The National Treatment Agency for Substance Misuse,
6th Floor, Skipton House,
80 London Road,
London SE1 6LH
T: 020 7972 1999
F: 020 7972 1997
E: nta.enquiries@nta-nhs.org.uk

October 2009

Getting the job done

"Treatment offers an individual the chance to get onto the road to recovery.

www.nta.nhs.uk

Substance misuse is a complex issue. It affects not only individuals but also their families, friends and communities. Not all drug users are addicted or need treatment, but most of those who come into treatment do want to end their dependency.

The job of the National Treatment Agency is to increase the availability of treatment for drug dependency, and to maximise the benefits treatment brings for individuals, their families and communities.

Treatment offers an individual the chance to manage their dependency and get on the road to recovery. It also gives society an immediate respite from the harm caused by drug misuse. Treatment is a gateway through which drug users can rebuild their lives, and reintegrate with their families and communities.

As someone who has been passionately interested in health education and the welfare of children all my career, I was particularly pleased during 2008-09 to help launch the NTA's pioneering report, 'Getting to grips with substance misuse among young people'.

This aimed to promote a better understanding of the work of specialist services dealing with under-18s and substance misuse, mainly cannabis and alcohol. By contrast, the pages that follow highlight the work of the treatment system with adults who are dependent on drugs – chiefly heroin and crack.

In 2008-09, those efforts were about getting people better, so they are able to leave treatment with the prospect of a decent place to live, the means to earn a living, and the ability to look after their own children.

There is as much of a family focus here as in the work with young people, and on the back of this promising start to delivering the new drug strategy, Protecting Families and Communities, I look forward to further progress in the year ahead.

Baroness Massey of Darwen, Chair

Recovery begins here

The NTA has succeeded in getting more drug users into treatment. Now, we're working to ensure that treatment delivers lasting improvements...

"Recovery can best be sustained by interventions that support drug users to assume a role as active citizens.

Drug treatment has come a long way. Record numbers are now getting help to overcome their addiction, the average time to start treatment is less than a week, and most stay in treatment long enough to benefit. The dedication and commitment of staff in drug action teams and providers across England ensured that 207,580 adults were in contact with structured treatment services during 2008-09.

There is no cause for complacency, however. We need to consolidate these achievements and build on them, in the spirit of the new drug strategy, putting as much emphasis on improving quality as maintaining quantity. Hence the twin themes of recovery and reintegration set out in this report.

Having successfully brought drug misusers into treatment, the system focuses on getting them better so they can leave, free of dependency. That process of recovery, in turn, can best be sustained by interventions that support drug users to assume a role as active citizens, take responsibility for their children, earn their own living, and keep a stable home.

We have made a good start by meeting our new Public Service Agreement target two years early. By April there were 163,127 problem drug users in effective treatment; that is, heroin or crack users who either successfully completed a course of treatment, or were retained long enough to benefit from being in treatment.

This is well over the 3% increase required by the government to justify the investment in treatment. As long as the momentum is maintained, drug action teams now have the opportunity to focus on local aspirations for improving services. More than 100 have committed to improving access for clients to employment, and over 80 to improving access to accommodation.

Research says being in treatment provides benefits: for individuals in terms of better health, reduced drug-use, and improved social functioning; and for society in terms of fewer public health risks, less crime and greater social inclusion. Judged by this standard, treatment is effective; nine out of ten clients are effectively engaged, and fewer than 10% of those who come into contact with structured treatment services drop out early.

However, increasingly – and perhaps inevitably, in an economic climate where resources are limited – politicians and the public alike demand further evidence of positive outcomes.

We are well placed to meet this challenge. The latest official statistics show a steady rise in the numbers of people successfully completing treatment, free of dependency – 24,656 adults last year. Initial findings from the Treatment Outcomes Profile (TOP) confirm that treatment is effective: a study reported in the medical journal *The Lancet* demonstrated dramatic falls in drug-use, with more than a third of heroin users, and over half of crack users, abstinent during the first six months of treatment.

"Treatment provides benefits for individuals in terms of better health and improved social functioning; and for society in terms of less crime and greater social inclusion"

Yet treatment does not provide an instant cure to addiction. It takes time to overcome dependency, or manage it so drug users can lead normal lives, and during that period relapse is a risk to recovery. The dynamics of a treatment system in which drug misusers move in and out over a period, are reflected in the data and developments presented in this report.

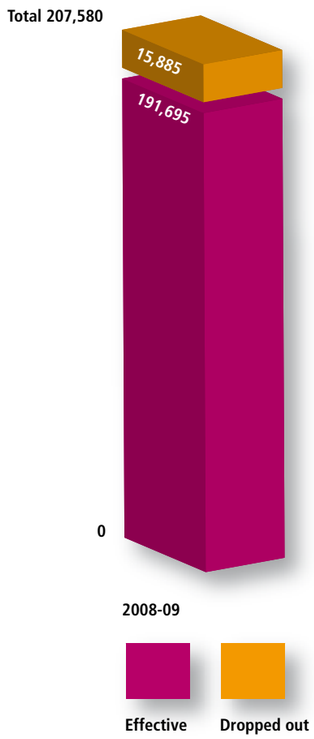
The latest figures also illustrate a significant shift in the nature of the drug-misusing population, as fewer young adults present for heroin and crack dependency, and more present with cocaine problems. This is a gradual change, but one that highlights the contemporary relevance of psychosocial interventions to complement the traditional reliance on substitute prescribing.

Following the launch of our Routes to Recovery materials last year, the NTA will continue to work with providers to ensure practitioners are always ambitious for their clients, promoting recovery and reintegration for the future. Drug treatment has come a long way, but there is some way yet to go.

The year in numbers

The National Drug Treatment Monitoring System (NDTMS) collects information on people in drug treatment in England. This data is the bedrock of effective drug treatment and is used for a range of purposes, from allocating funding to identifying trends in drug use. It also enables us to see how treatment affects people's lives, helping us to push for recovery and reintegration. This is what the data tells us about adults in drug treatment in 2008-09*...

Figure 1: the proportion of over 18s in effective treatment

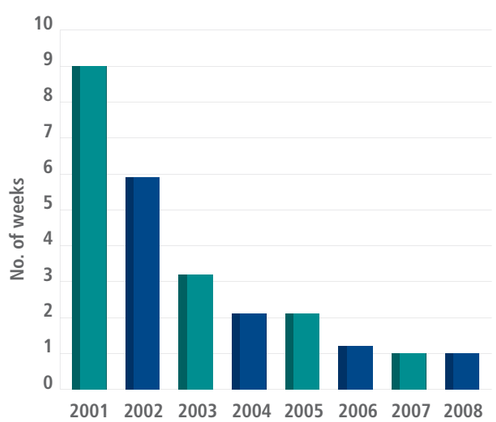


Getting in and staying in

The 2008-09 data shows 207,580 adults were in contact with structured drug treatment (Fig 1). The system now has sufficient capacity, with an average waiting time for treatment of less than one week (Fig 2) – a huge improvement since 2001, when the average wait was nine weeks.

But simply getting people into treatment is not enough. Once they are in, we need to keep them in long enough to benefit. This year's data shows that fewer than 10% dropped out of treatment early – so nine out of ten adults complete or stay in treatment.

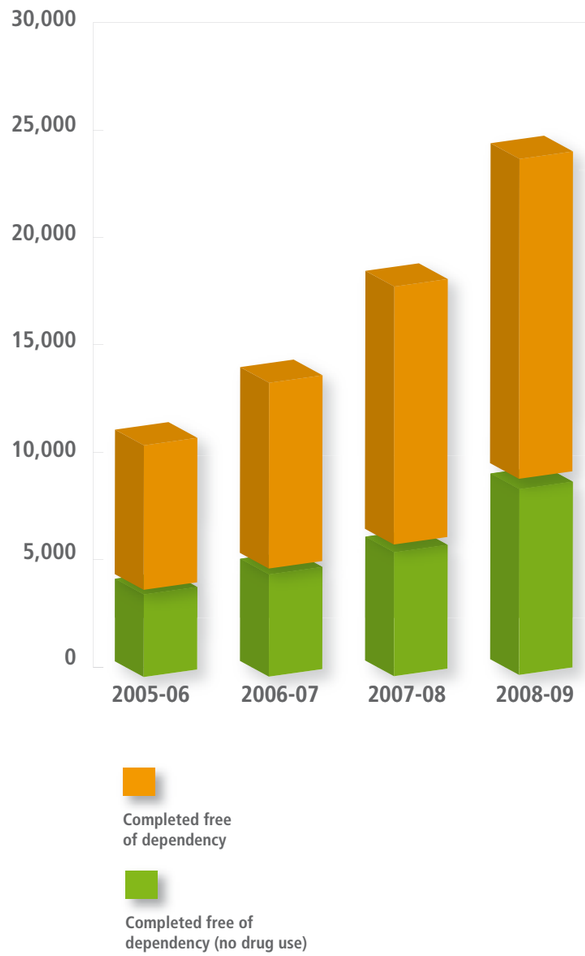
Figure 2: waiting times for first intervention, 2001-2009



Overcoming dependency

Getting people into treatment and holding on to them is the start of the job. The ultimate aim of drug treatment is recovery – helping users to overcome their addiction and regain their place in society. This year 24,656 adults – 12% of the total in treatment – successfully completed treatment free of dependency. This proportion has risen considerably during the past few years, almost doubling since 2005-06.

Figure 3: number of users successfully completing their course of treatment, 2004-05 to 2008-09



DRUG TREATMENT IN ENGLAND 2008-09

THERE WERE

207,580

adults in structured treatment

OF THESE

191,695 (92%)

were in treatment for 12 weeks or more, or exited treatment free of dependency before 12 weeks

93%

of all clients waited less than three weeks to start treatment

OF ALL ADULTS IN DRUG TREATMENT

172,624

were in treatment for opiates and/or crack cocaine (ie, problem drug users, or PDUs)

OF THESE

162,302 (94%)

were in treatment for 12 weeks or more, or exited treatment free of dependency before 12 weeks

85%

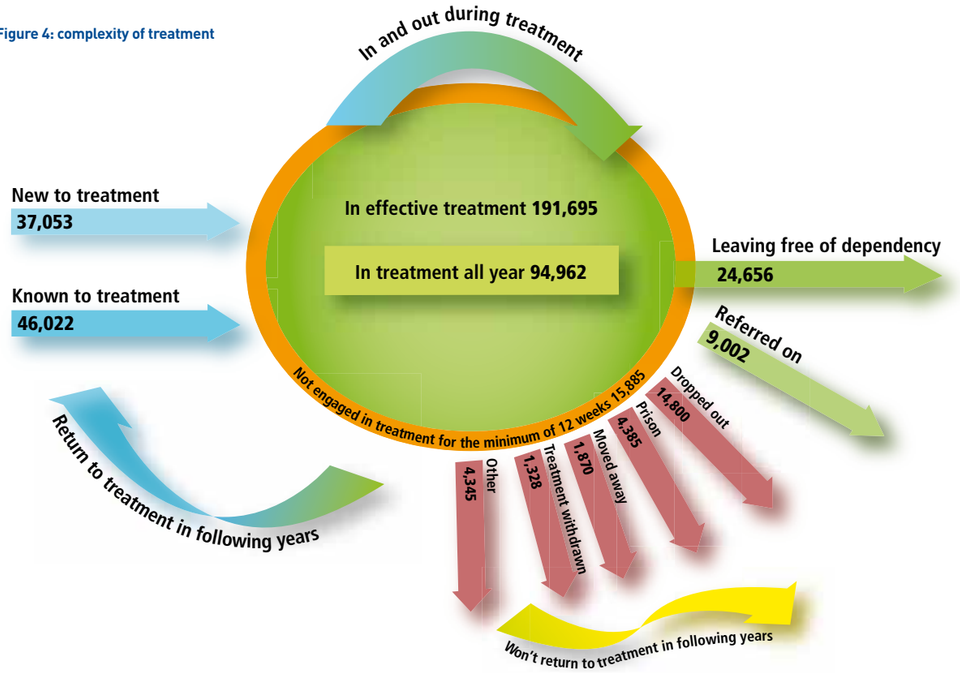
of users starting new treatment journeys were in treatment for 12 weeks or more, or exited treatment free of dependency before 12 weeks

* The numbers do not include people in treatment in Bristol because of concerns over the quality of data supplied to the Safer Bristol partnership. The partnership is now addressing these concerns.

The complexity of treatment

The data reveals a system in which users flow in and out of treatment over a period, illustrating the complexity of treating drug addiction. Many problem drug users need more than one cycle of treatment before they are abstinent. Our figures indicate they need to spend several years in treatment before they are discharged free of dependency.

Figure 4: complexity of treatment

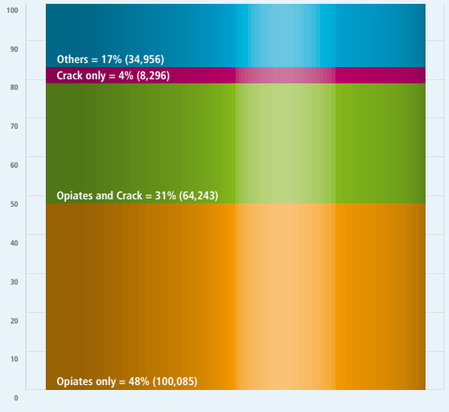


Treating problem drug use

Drug treatment in England is available to anyone who needs it, regardless of their drug of use. However, the target set by government for the NTA and the treatment field is to get specific users – those who use heroin and crack, often referred to as problem drug users (PDUs) – into effective treatment. Effective treatment means that a user successfully completes their treatment or is in for long enough to benefit.

In 2008-09, there were 163,127 problem drug users in effective treatment, an increase of 4% on the previous year. This figure represents around half the estimated 330,000 heroin and crack addicts in England.

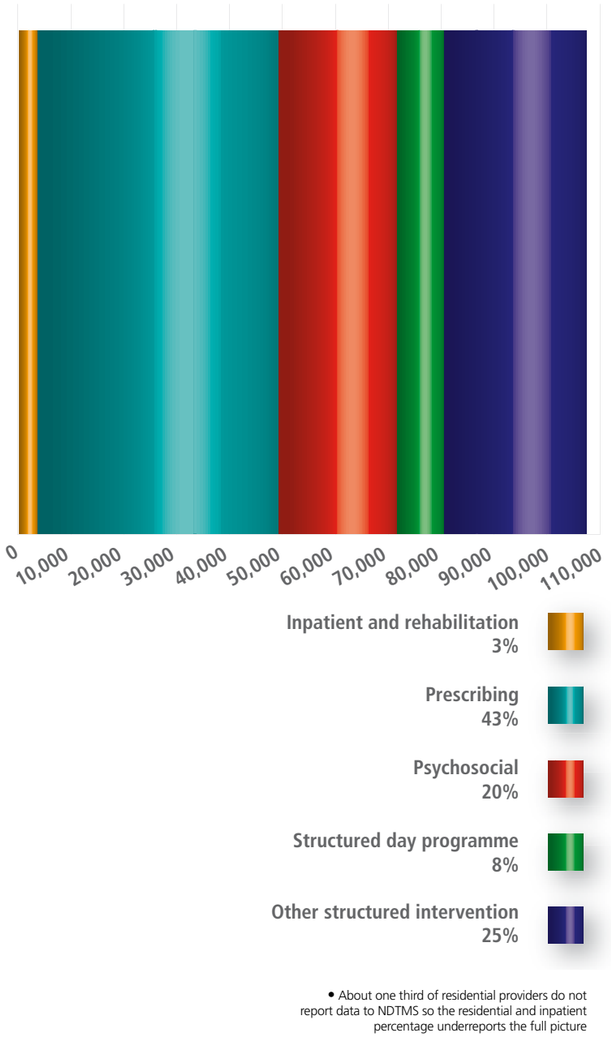
Figure 5: primary and adjunctive drug use of over 18s, by drug group, 2008-09



Individual treatment

Drug treatment must be tailored to the needs of the individual – one size does not fit all. There are a range of treatments available: some meet the needs presented by particular drugs, others confront users' attitudes and behaviour. All treatment should include a psychosocial component, and we expect local systems to offer a range of treatment options.

Figure 6: breakdown of new treatment journeys by type, 2008-09



• About one third of residential providers do not report data to NDTMS so the residential and inpatient percentage underreports the full picture

DRUG TREATMENT IN ENGLAND 2008-09

83%
users in contact with treatment were using opiates and/or crack cocaine

6%
of users in contact with treatment were using powder cocaine or cannabis

49%
of users starting treatment reported having injected illicit drugs at some point. Some 23% reported injecting at the time of starting treatment

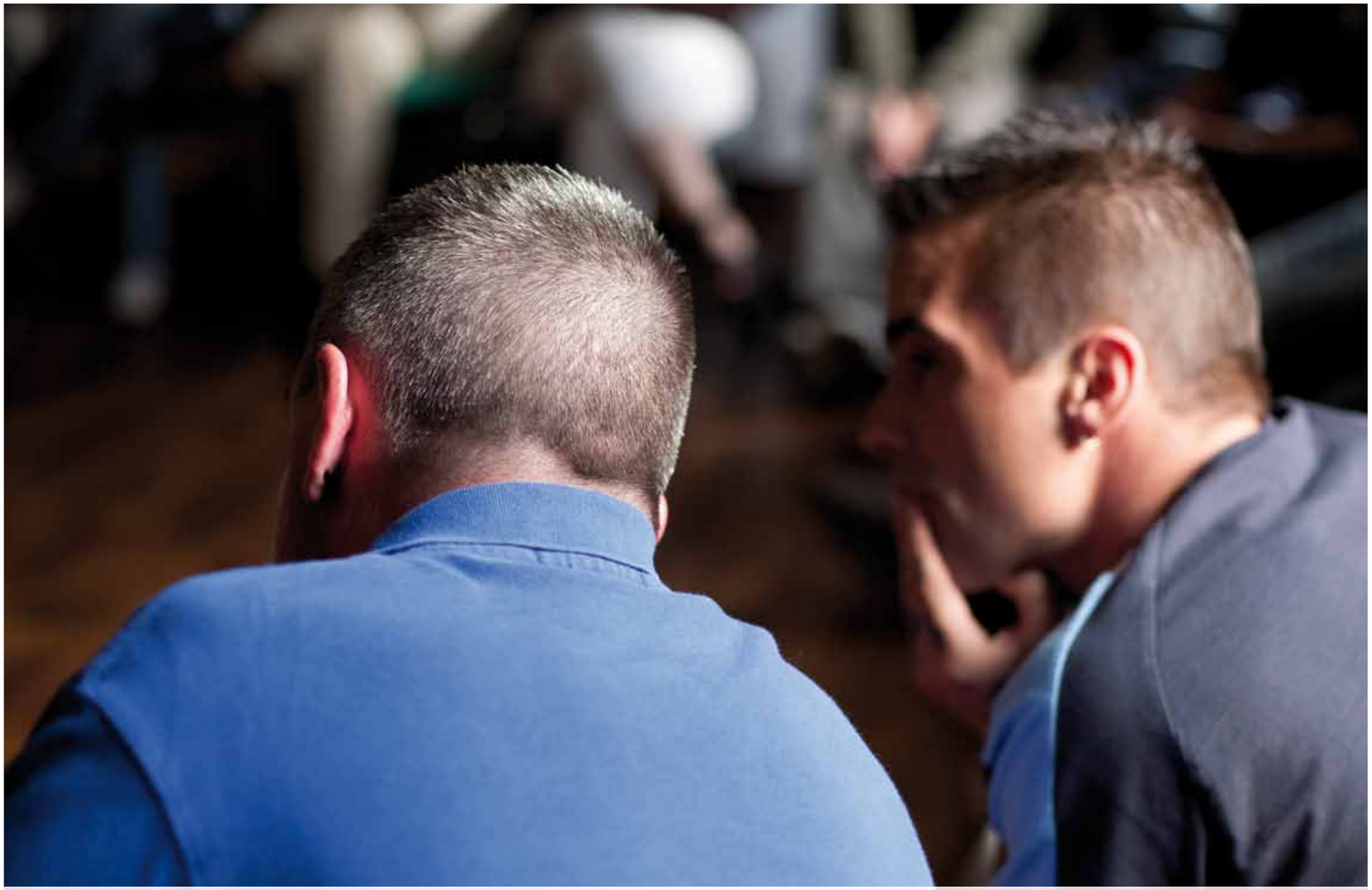
8,603
the number of under 25s who started treatment for the most problematic substances of opiates or crack cocaine. This has fallen significantly since 2005-06, when it was 12,320

Sustaining recovery

The NTA remains ambitious for drug treatment services in England. Having got more people into treatment quickly, we now need to actively move them through treatment safely as they get better...

Treatment is the first step on the road to recovery for drug misusers. What constitutes recovery is a subject of some debate within the field and amongst service users. For some, recovery may simply be the process of being in treatment. For others, it may be a specific setting, such as residential rehabilitation. For some, recovery is the end state, equivalent to being abstinent from the drug of dependency that brought them into treatment. For others, being "in recovery" is an outcome that carries the ever-present threat of relapse.

Our national conference in June 2008 provided a platform to debate the efforts to achieve a consensus on recovery. Discussion was passionate, demonstrating that all perspectives have their advocates, yet none are exclusive. In this context, the job of the NTA is to promote the package of services and support that actively helps drug users in structured treatment to get better and overcome their addiction.



"Nobody is opposed to recovery and reintegration. Opinions differ as to how we get there, but we need to remain fixed on getting drug misusers off benefits and into work.

Spreading the news on recovery

The Recovery Academy is an idea that sprung from discussions in the North West, as Mark Gilman, the NTA's regional manager, explains.

"The Recovery Academy emerged as a way for individuals and organisations to share research on recovery from addiction. Planned as a small group, the first meeting in Manchester blossomed into a major event. We now want to open it wider and get more people working together on this issue.

"A key success has been engaging local authority chief executives. They recognise that the idea of 'recovery' offers genuine attempts to address unemployment, looked-after children, and other deep-seated social problems that go hand-in-hand with addiction. But I still think the biggest challenge is convincing people beyond the rhetoric – showing them that this is about getting people back on track.

"For the user I think the idea of recovery brings a sense of hope, that they don't have to be dependent for the rest of their lives on illegal drugs from street dealers or legal drugs from doctors. The Recovery Academy definition of recovery is 'independence'. In other words, going back to work, looking after your children, and paying taxes. This is why it is potentially so interesting to the government and local authorities.

"I hope that this time next year the academy will have good representation from across the country. Nobody is opposed to recovery and reintegration. Opinions differ as to how we get there, but we need to remain fixed on getting drug misusers off benefits and into work. The focus has to be on individuals, and helping them live a life we would consider normal. That's far more important than whether they do it with or without methadone."

Reducing harm

'Harm Reduction Works' is a communications campaign targeting those users most at risk of drug-related deaths and blood-borne viruses (hepatitis and HIV). It is also aimed at their families, treatment service providers and commissioners. The campaign resources include a website, films, leaflets and cards, posters, online briefings and a magazine. Reaching the most difficult to engage drug users was a key criterion for the campaign, and the strong design and informal style of the materials designed for drug users have proved popular. The website (www.harmreductionworks.org.uk) gets about 800 unique visitors a month, who order around 6,000 items.

Engaging users

Recovery is the ultimate goal of treatment. But first, we have to get users into treatment that works for them. It's also about improving their lives as they move towards abstinence.

Understanding what factors get people into treatment and keep them there is crucial: this year saw the third NTA user survey. While most who took part felt treatment had a good effect, a third said family members needed more support.

Information from our user surveys also helped identify themes for our joint service reviews with the Healthcare Commission: this year, diversity, and inpatient and residential services. Eighty-seven percent of local drug treatment partnerships scored 'excellent' or 'good'. While this is encouraging, it also identified weaknesses in minimising the risk of overdose for those discharged from rehab. Our regional teams are now addressing this with individual partnerships and services.

Encouraging change

Launched at the NTA national conference, our treatment incentives project is a new trial to get users to complete treatment and stay off drugs for good.

Users who stay off illegal drugs are given vouchers for approved goods and services, such as evening classes or courses to prepare for going back to work. The trial has evaluated which methods are most effective in reducing drug use and promoting abstinence. Preliminary results are expected later this year.

Funding residential and inpatient services

For some drug misusers residential and inpatient treatment – often called rehab – is the setting that makes the difference and enables recovery. To increase capacity, some £54m of extra funding was made available in 2006 for capital projects. NTA chief executive Paul Hayes opened one of the first of these facilities to be completed, BAC in Newcastle-under-Lyme, in November 2008. This is a new 21-bed residential rehabilitation unit that can treat 140 people a year, including day care and residential, with 80% of families and carers attending the family programme.

"We provide rehab in the real world. We treat people close to where they live, to enable them to cope when they leave. After 12 years of delivering rehabilitation in east Staffordshire, we opened a new 21-bed unit in north Staffordshire.

"Resettlement training – paying the bills, nutrition and cookery, learning to be responsible – is available to all our clients. By working with Staffordshire County Council we can also provide a wide range of work placements, when clients are ready.

"Providing a balanced service has enabled us to build a strong and successful organisation – it's strong because it's a good service, providing what's needed, using resources well and getting full value for money."

Noreen Oliver MBE, chief executive, BAC

Changing behaviour

Psychosocial interventions, or 'talking therapies', are a cornerstone of drug treatment. These techniques, such as cognitive behavioural therapy, help users to change their attitudes towards drugs...

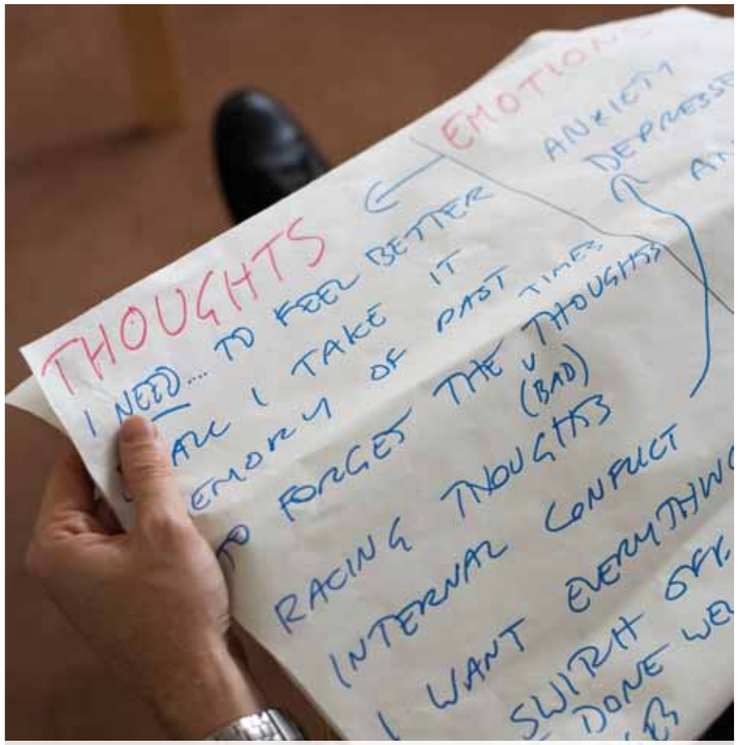
Clinical guidelines say that any treatment for drug misuse must include a psychosocial component. In some cases they are used alongside clinical approaches such as pharmacological stabilisation and detoxification, while for some drugs they are used on their own.

One of the benefits of psychosocial interventions is their flexibility. They can help users achieve abstinence or harm reduction goals, have a vital role to play at different stages during recovery, and are effective in short or long-term treatment.

As drug treatment continues to evolve, there is a growing emphasis on psychosocial interventions. This past year the NTA has responded by producing a range of resources geared towards helping drug workers improve their skills and abilities. Collectively, these resources are called 'Routes to Recovery'. They aim to empower drug workers and so improve the quality and outcomes of treatment.

Mapping techniques

This year, the NTA also published a series of manuals based on the International Treatment Effectiveness Project (ITEP) and the Birmingham Treatment Effectiveness Initiative (BTEI), following successful pilot studies. The manuals pull proven psychosocial techniques into a collection of user-friendly 'maps'. Drug workers use the maps to build a visual representation of a drug misuser's thinking, and then to develop strategies for breaking free from that mindset.



"Psychosocial interventions can address the issues that created the problem in the first place.

The maps establish clear links between ideas and practical problem-solving tasks, but allow users, supported by drug workers, the freedom to work in a way that suits them best – helping to improve the relationship between the two. The maps also provide easy reference points for all their discussions, and offer a range of simple self-help techniques for misusers to use during their recovery.

Toolkit for workers

The NTA also published a toolkit ('Psychosocial interventions in drug misuse: a framework and toolkit for implementing NICE-recommended treatment interventions') aimed at helping drug workers make best use of talking therapies in helping misusers recover from drug dependency.

The NTA produced the guide along with the British Psychological Society (BPS) as a way of improving the level of skills and supervision among a rapidly expanding drug treatment workforce.

It looks at the core skills and competencies drug workers require in terms of therapeutic knowledge and understanding of treatment processes. In practical terms it provides assessments of core abilities, and competency checklists for completing careplans.

The toolkit also sets out the skills that drug workers need to deliver formalised interventions and programmes, such as motivational interviewing, relapse prevention, and the motivational and cognitive elements of the ITEP/BTEI manuals.

Sharing skills

The NTA also took the first steps this year towards establishing a National Skills Consortium when it launched a partnership of practitioners, providers and others aimed at improving drug treatment delivery.

The idea is to build on good practice and to ensure that drug workers are equipped with the skills and expertise they need to adapt to a balanced and aspirational treatment system that puts more emphasis on helping as many drug misusers as possible to recover and reintegrate. We hope the partnership will include NHS trusts, the voluntary sector, the royal colleges and related bodies, the BPS, relevant government departments and other stakeholders.

A psychologist's view: Luke Mitcheson

"The emphasis on psychosocial treatments has come with the shift to thinking more about recovery, social inclusion and reintegration.

"The talking-based approach is focused on achieving goals beyond substance misuse. It can be about helping users to develop new skills, for example. Pharmacological interventions can help people stop using heroin, but psychosocial interventions can address the issues that created the problem in the first place – helping to maximise the value of being in treatment.

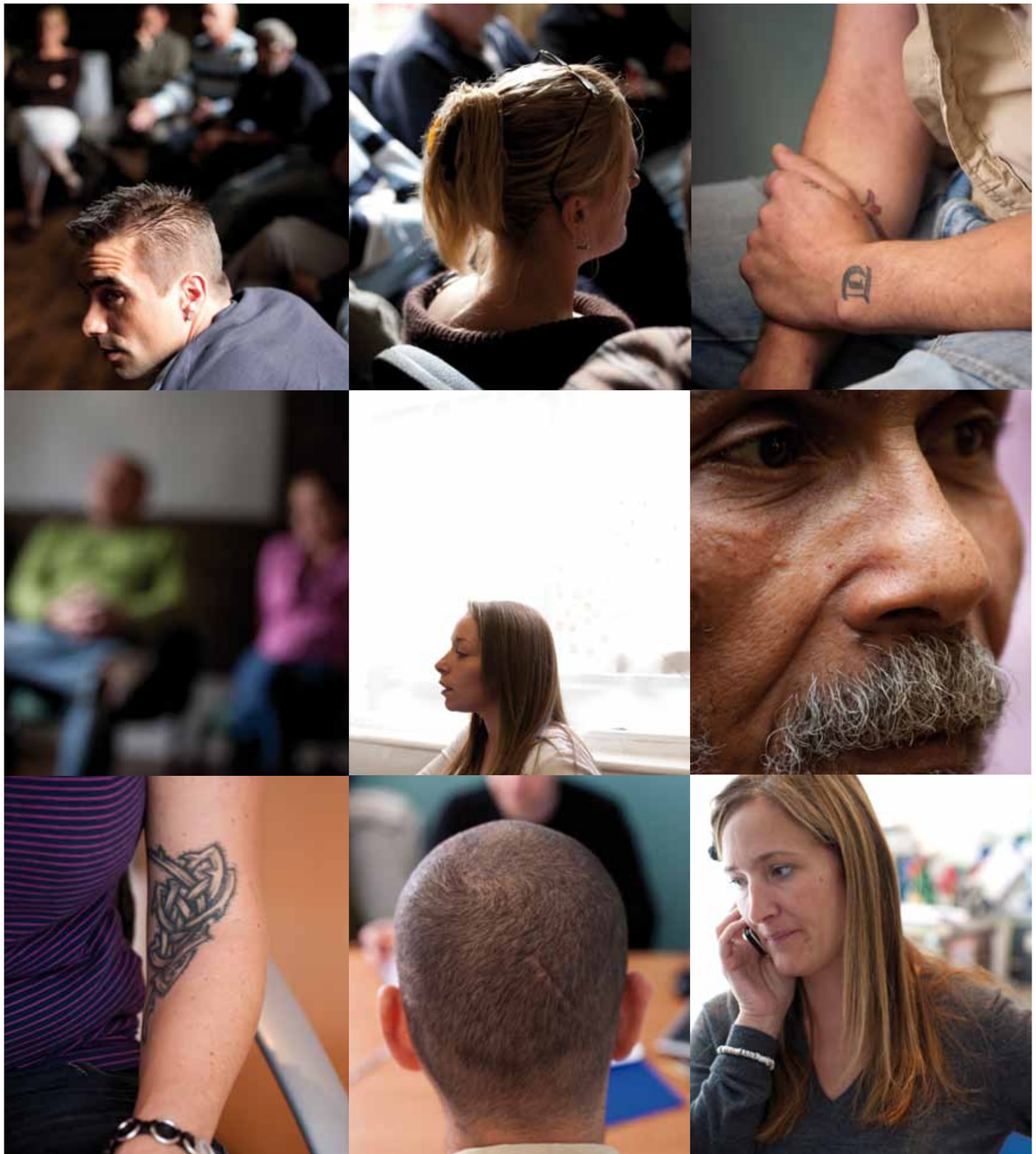
"From the drug worker's perspective, 'psychosocial interventions' is a broad term that encompasses a lot, starting with the initial assessment of a user and continuing with the careplan and the TOP.

"The ITEP mapping tools are incredibly useful for workers in structuring and focusing conversations, and in giving a sense of momentum and direction for users.

"Many psychosocial techniques, including motivational interviewing and CBT, are client-centred and give users an active role in the change process. Motivational interviewing is particularly useful when users make first contact with treatment services, in helping to instil a sense of hope and change. CBT is useful for addressing underlying mental health issues.

"This puts a lot of demand on drug workers. But my experience is they want to develop their knowledge. The psychosocial toolkit strips down the treatments into competences, so workers and supervisors can see exactly what's required.

"Looking forward, workforce development will mean we can share best practice, improve workers' skills and ultimately the effectiveness of treatment."



Joined-up thinking for better outcomes

As the reintegration agenda came to the fore in 2008-09, the NTA was working with a range of other agencies to ensure the treatment system helps drug users return to living normal, working lives...

Getting drug users into treatment and putting them on the road to recovery is not 'job done', it is 'job started'. As well as wanting to help drug users to get better and leave treatment, we want them to have a decent place to live, be able to look after their own children, and take a stake in society. Reintegration is therefore not the end of the process, but a stage in the journey that can consolidate personal motivation to recover.

Over the course of the year the NTA forged new relationships at a national and local level with the Department of Work and Pensions (DWP) and JobCentre Plus (JCP). These alliances ensured we could drive forward the elements of the welfare reform agenda that relate to drug users, in close collaboration with the treatment sector.

Benefits

At the time, what attracted a lot of attention was benefit conditionality – the idea that unless drug users took up the offer of treatment, their benefit would be cut. The emphasis for us was the opportunity that closer collaboration brought to get drug-users who are on benefit into treatment, and those in treatment into employment or training in order to make them ready to take up a job.

The Department of Health committed £9m over three years to fund JCP drugs coordinators at a district level across England. These coordinators work in partnership with NTA regional teams to manage the pathways between treatment and employment opportunities. The NTA was instrumental in developing the role of the coordinators, and in providing the training they required, as well as commissioning development resources for all frontline JCP advisors.

Referrals

The voluntary referral pathway for problem drug users within the benefit system was also implemented during 2008-09. The NTA regional teams made significant efforts to ensure that the pathways across 149 local partnerships and 47 JCP districts were robust and working as intended, embedded in the local needs assessment and treatment planning process.

So the building blocks are in place to give drug users access to skills that will benefit them in the labour market. The next challenge is housing. Our statistics show that one in ten drug users coming in for treatment are homeless. However, our experience is that a stable home is a key ingredient of recovery from dependency. Society has struggled for many years to reintegrate people at the margins back into the mainstream. The devolved nature of decision-making in local government means this requires different solutions.

Traditionally, many recovered drug users have found employment within the drug treatment sector. But an innovative programme called Ready for Work, run by Business in the Community's (BITC) Business Action on Homelessness (BAOH) campaign, supports homeless people, or those at risk of homelessness, who face numerous barriers to employment, including a history of drug abuse. It is driven by a group of business leaders from Barclays, Bain and Company, Carillion, Freshfields Bruckhaus Deringer, KPMG, Marks & Spencer and Royal Mail and also receives funding from the Department for Communities and Local Government. Rebecca Ford, Policy and Communications Manager at BAOH, explains how it works:

"BITC mobilises business for good. It has more than 850 member companies and represents one in five of the UK private sector workforce. BAOH is one of BITC's flagship campaigns.

"Essentially, what we do at BAOH is work with businesses to provide work experience placements and job coaches for our clients, which helps them gain and sustain employment. All of our clients are homeless or are at risk of homelessness, and about 13% have had a drug problem. As a general rule, we look for people who haven't used illegal substances for at least six months.

"We have strict criteria – the Ready for Work programme is quite intensive and we are conscious that it may not be right for everyone. We wouldn't want anyone to be put further back along their journey towards employment if it's the wrong thing for them at that time.

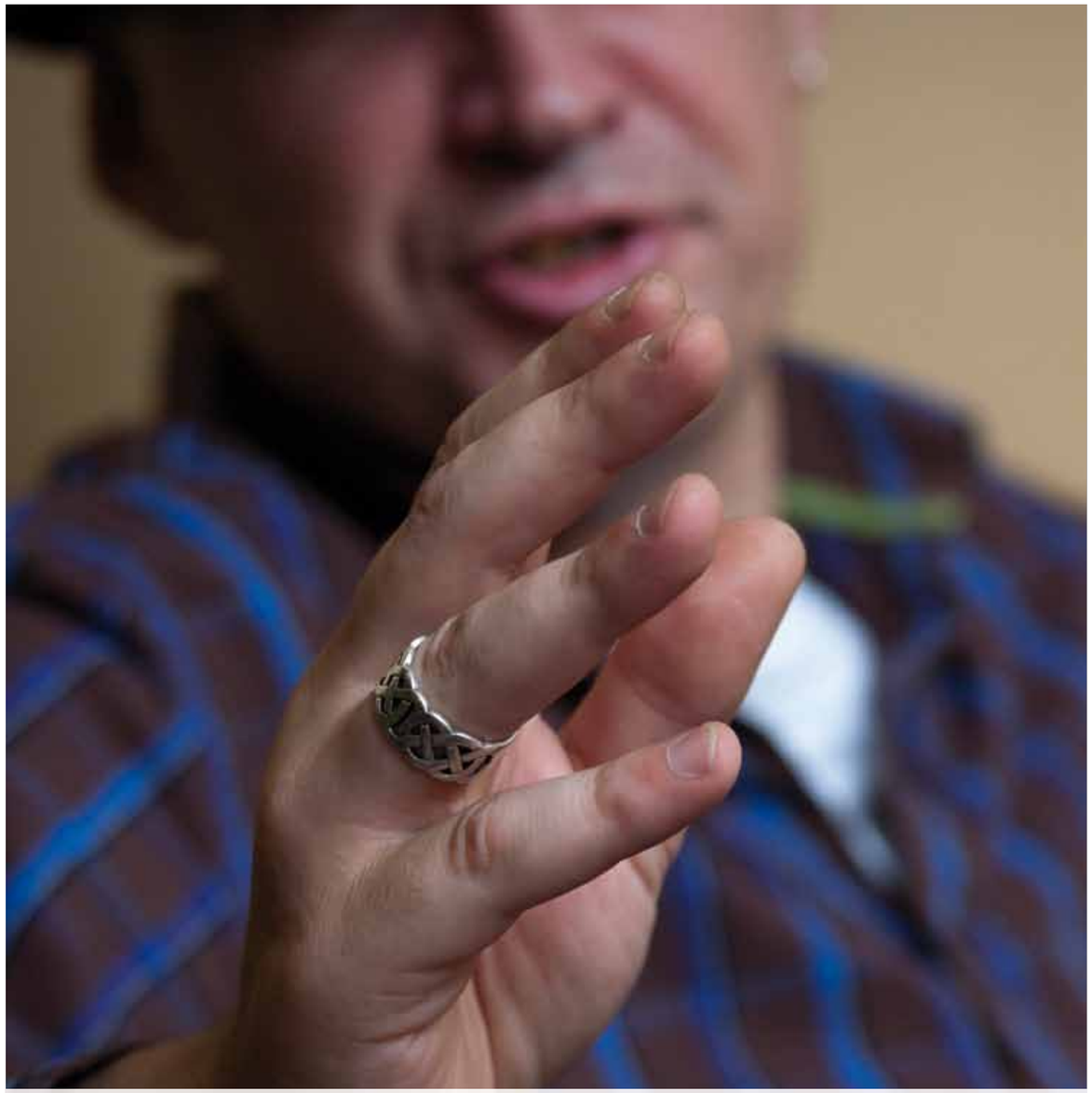
"So, we ask that our clients have been working with their keyworker for at least three months, because it's important that they know the individual and can make a proper assessment as to whether or not they are ready for work.

"It's a popular programme and we are proud of our success – last year we supported nearly 300 people into work. We have a wide range of placements including retail, construction and hospitality. We try to have something for everyone and always carefully match the individual to the placement. We have just had a client come through our London programme who's a really talented illustrator, and we've secured him a placement in a company that designs greetings cards. He will get up-to-date experience in a creative environment using the latest software – that will really suit him and the company.

"People are sometimes surprised that big international companies as well as small local ones take on homeless people. That is what BAOH is all about – smashing preconceptions and raising the aspirations of our clients.

"Our business partners are involved not only because they believe it's the right thing to do – it really benefits their staff, too. For example, employees who work as coaches to our clients get valuable training and experience that is directly relevant to the workplace. It's an attractive opportunity for any business interested in developing the core management competencies their businesses require.

"At the end of a placement, clients are usually on cloud nine. They've had the time of their lives and are desperate to find permanent work. A permanent job doesn't always happen straight away, of course, particularly now, in the current economic climate. So job coaches drawn from our businesses continue to work with our clients, keeping them motivated and focused on their job search." ■



"People are surprised that big international companies as well as small local ones take on homeless people. That is what we're about – smashing preconceptions.

Information value

The NTA is committed to using evidence to help drive up the quality and value of the treatment services for drug users. Embedding the Treatment Outcomes Profile (TOP) into routine clinical practice is a big step towards achieving this aim

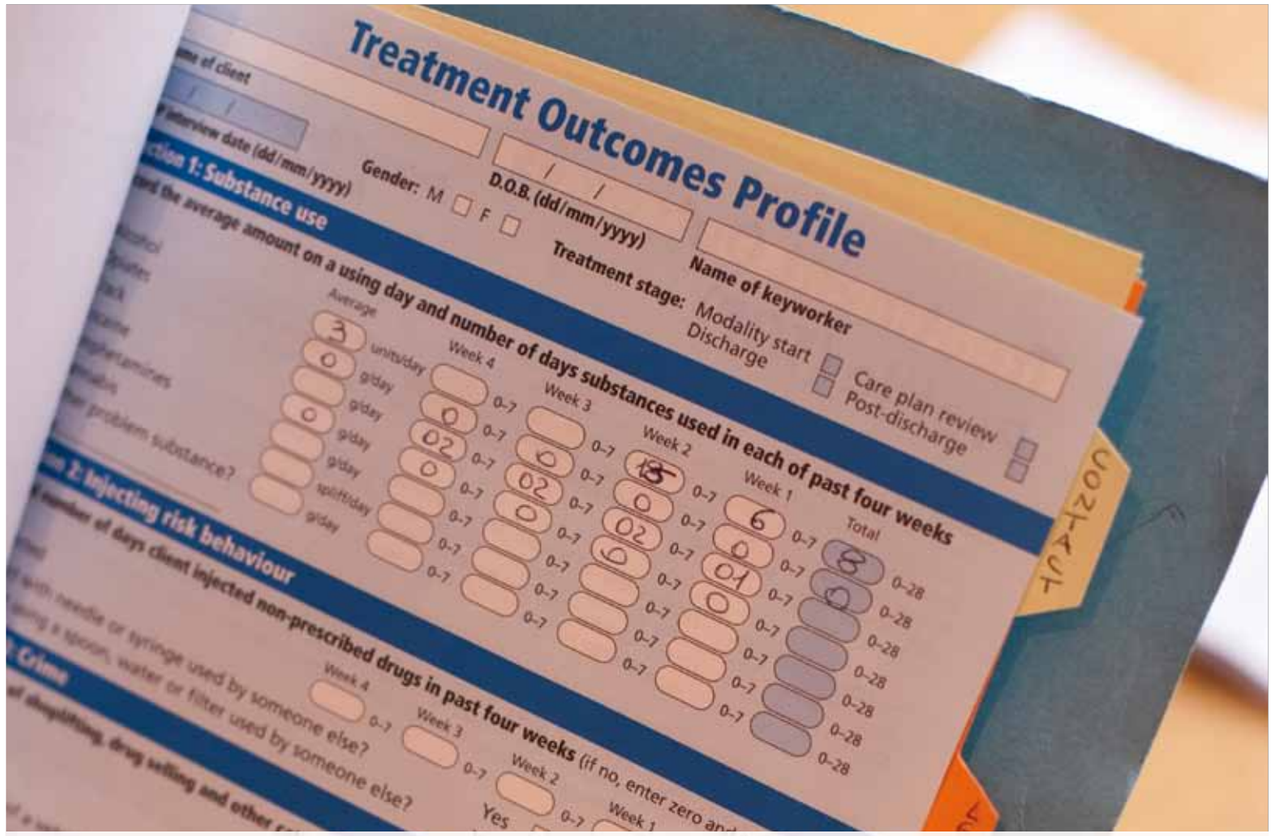
An individual's path through drug treatment is far from predictable. Of the many thousands who enter the system some will successfully complete their treatment, some will drop out only to relapse and return at a later date, some will leave early having made all the progress they need to, some will remain for many years as they confront an entrenched condition. Many take several attempts over several years to beat addiction and make a full recovery.

One of the NTA's jobs is to monitor and understand the workings of the system and to produce as detailed a picture as possible of what happens to users between entering and leaving the system (and beyond). This knowledge helps us to ensure users get the right treatment in the right place and at the right time.

We collect data chiefly via the National Drug Treatment Monitoring System (NDTMS), which supplies figures on demographics, trends and outcomes. This was the first full year of incorporating the TOP, which collects invaluable information on client outcomes, into NDTMS.

The TOP is a short clinical interview that measures a drug user's progress during treatment. The drug worker and user complete it at the start of treatment, the end of treatment, and around every six months in between. It accurately measures changes in substance misuse, health and social functioning, and crime.

This is the first time an outcome monitoring system for drug treatment has been introduced on a national scale, but TOP's simplicity and ability to capture useful clinical information has been reflected in the international requests we have received to translate and use it, from places as diverse as Chile, Taiwan, Australia, Wales, Iran, Finland and the USA.



> "This knowledge helps us to ensure users get the right treatment in the right place and at the right time.

The evidence base

One of the NTA's roles is to supply evidence of treatment effectiveness that can stand up to independent scrutiny. To this end, we produced the first in a planned series of reports using TOP and other NDTMS data to measure the impact of treatment. This report has just been published in *The Lancet*.

The study examined changes in heroin and crack cocaine use among 14,656 addicts in community-based treatment across England during 2008-09. It found that during the first six months of treatment more than two-thirds had stopped or significantly reduced their use. Just over a third had stopped using heroin and/or crack altogether by the six-month point. It also includes the first UK evaluation of psychosocial or 'talking' therapies for crack users – they are proving particularly effective, with over half of all crack users quitting the drug during the first six months of treatment.

For prescribing-based treatment (eg, methadone) the report backs up previous research that shows it can help people reduce and stop their heroin use. For those on a prescription, over one third stopped using heroin by the time of their follow-up and another third had significantly reduced their use from pre-treatment levels.

We plan to produce further reports on the long-term outcomes for people after they leave treatment, and a wider analysis of the impact of treatment, and the subsequent changes in health and injecting behaviour.

Local use

The first stage in implementing TOP has been to ensure the information we receive is properly representative of the treatment population. So we introduced a quality assurance measure: when 80% of local providers have a good TOP completion rate, we can reasonably assume the information is representative.

As providers reach this level they will start receiving TOP reports that show what position users are at when they start treatment, how they progress, and what outcomes providers are achieving for them at the point they leave treatment.

There have been strong improvements in TOP compliance levels during 2008-09 (Fig 1), so that the progress of the great majority of users receiving treatment is tracked at critical points – ensuring that the data is a fair and accurate picture of local results.

Local outcomes

As more and more TOP forms are being completed, a more accurate picture of the effectiveness of local treatment services is beginning to emerge.

Birmingham is the largest treatment system in the country, and in the last year its providers have been at the forefront of TOP data collection – the analysis (Fig 2) clearly shows how they are performing.

Figure 1: TOP completion 2008-09

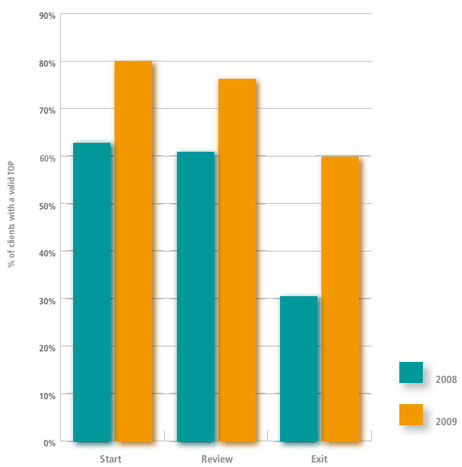
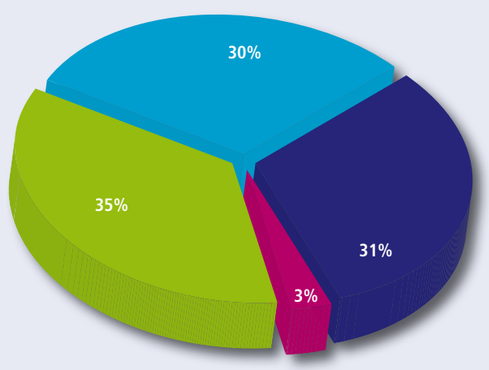
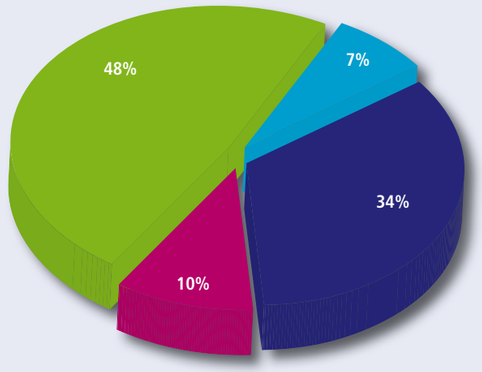


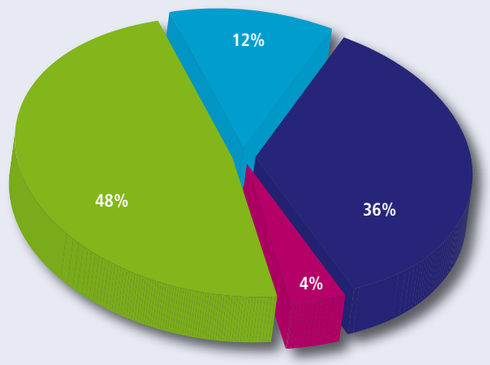
Figure 2: Birmingham TOP analysis 2008-09. Status of users after six months in treatment



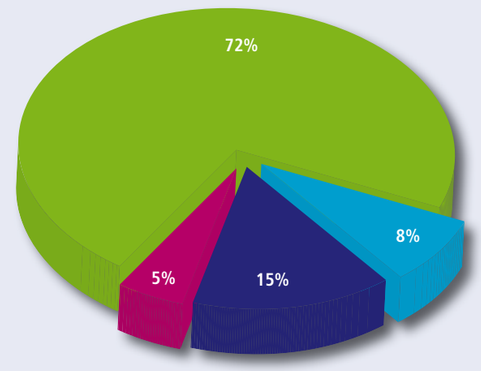
OPIATES (HEROIN ETC): 671 USERS



CANNABIS: 193 USERS



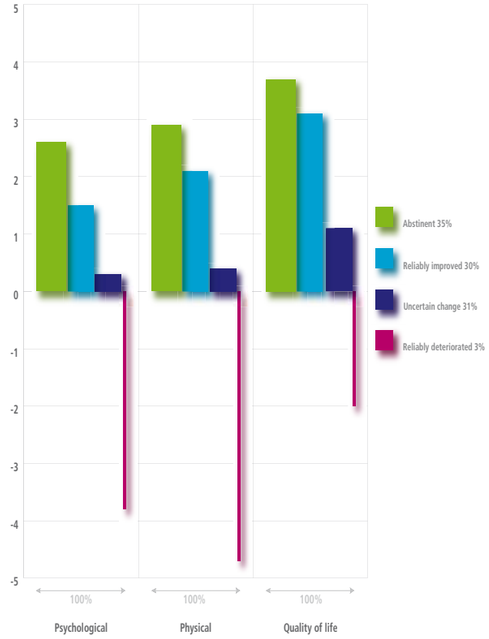
CRACK COCAINE: 254 USERS



COCAINE: 61 USERS

The Reliable Change Methodology is a technique the NTA has developed to be confident that any changes in substance misuse are significant enough to indicate genuine progress rather than simple fluctuations from one month to the next.

Figure 3: Birmingham opiate users' mean change in reported health 2008-09



Using a similar methodology to *The Lancet* study, this data looks at individuals who started treatment in 2008-09 and completed a TOP at their review, around six months later. The results mirror the national findings of *The Lancet* study: two-thirds of heroin and crack users stop or significantly reduce their drug use after around six months in treatment. Other substances show a mixed picture, but information such as this will help local services and providers work on improvements for all their users.

Other data (Fig 3) shows that people who reduce their substance misuse also report significant improvements to their health and wellbeing.

The employment, education and housing outcomes they report are mixed – lending weight to our desire to work with government departments to ensure housing and employment support services give a higher priority to helping drug users during their recovery and reintegration back into society.

Age of change

A notable trend identified by NDTMS data this year is that the drug treatment population is getting older: while one in six of those who started treatment in 2005-06 were over the age of 40, in 2008-09 it was one in five.

This change was reflected among problem drug users (PDUs), where the proportion of over 40s rose from 15% to 21% over the same period. There is a corresponding fall in the proportion of young PDUs: 19% of PDUs starting treatment in 2005-06 were aged 18-24 and 26% 25-29. These figures had fallen to 14% and 24% respectively by 2008-09 (Fig 4). This takes place against the backdrop of a steady increase in the proportion of 18-24 year olds in the general population – from 9.1% in 2005 to 9.5% in 2008.

Change also appears within age groups. In 2005-06, two-thirds of 18-24 year olds were being treated as PDUs (68%). By 2008-09, it was just over half (53%). This is a dramatic fall from 12,320 to 8,603 in four years.

The average age of adults at treatment entry has remained at around 32 years. Given that the national PDU estimates and the overall number of people entering treatment have been broadly stable for some years, this suggests that opiate and crack use among young people has been tailing off.

Among young PDUs who have never been treated before ('treatment naïve'), the time between their first use of those drugs and entry to treatment has also narrowed. Between 2006-07 and 2008-09, the time from first use to

treatment fell by half a year among 18-24 and 30-34 year olds, and by more than that among 25-29 year olds.

This means the treatment system is getting to young PDUs earlier in their drug-using careers – especially treatment-naïve PDUs who use opiates only. In the past three years, the time between their first use and treatment has fallen by 0.7 years for 18-24s, 0.6 years for 25-29s and by 0.8 years for 30-34s.

Young PDUs can be referred to treatment via a number of sources, and here too there are significant differences when looking at the time between first use and treatment.

Criminal justice referrals appear to target 25-29 year old treatment naïve PDUs best – with a reduction in the time between first use and treatment of 0.8 years. However, GP referrals seem most likely to reach people earlier. Over three years, the time between first use and treatment fell from 3.9 to 2.9 years for 18-24s, from 6.7 to 5.9 years for 25-29s, and from 9.4 to 8.5 years for 30-34s.

While this is good news, we cannot be complacent. Although opiate and crack use seems to be falling among young adults and the treatment system is getting to them sooner, the proportion who start treatment for cocaine has been rising.

In 2005-06, 31% of all people starting treatment for cocaine were between 18 and 24. Last year, this figure stood at 35%. Furthermore, within the 18-24 age group the proportion treated for cocaine use has doubled from 9% to 18% (Fig 5).

Figure 4: Number of PDUs starting treatment, by age group

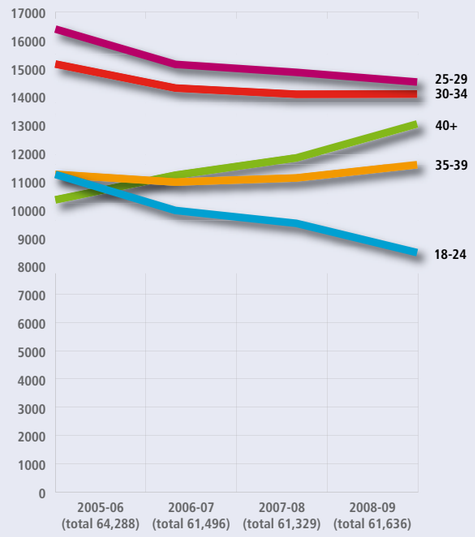
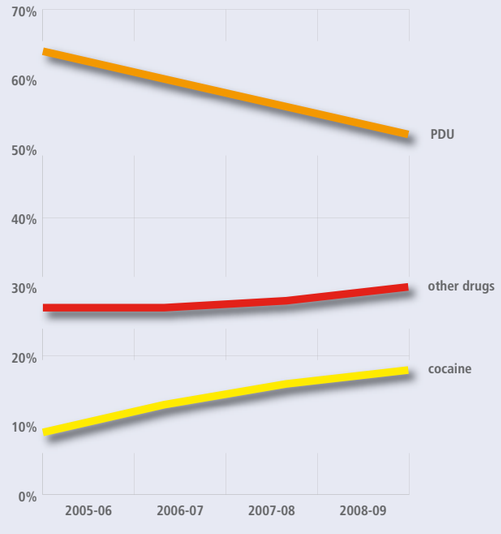


Figure 5: Drug use among among 18-24 year olds starting treatment



Smoking: a hard habit to break

Smoking is legal, but nicotine is addictive. Just like dependency on illicit drugs, smoking causes harm to individuals and society – every year, around 83,000 people are killed by smoking in England, while treating smokers costs the NHS around £2.7bn. What can the drug treatment field learn from efforts to curb smoking?

NHS stop smoking services have been incredibly successful, helping thousands quit and cutting smoking prevalence from 28% to 21%. The challenge is to turn aspiration into reality with the remainder who find it most difficult to overcome addiction and are more likely to relapse.

One in six smokers have their first cigarette within five minutes of waking – and over half say they would find it difficult to go all day without smoking. Yet most of them say they want to give up, just as three-quarters of heroin or crack users tell us they want to stop using drugs.

On average, smokers in the UK make around five attempts to stop. The lessons of tackling nicotine addiction should make us wary of expecting 'instant' results from drug treatment. A government study found that one in seven users of stop smoking services were abstinent at the end of any given year.

Drug misuse is a chronic, relapsing condition, and Professor Robert West, a leading authority on health behaviour, suggests addicts may need even more help than smokers to kick the habit: "The chief difference is probably that smoking is less likely to be connected to other psychological and social problems, so a single treatment episode can result in permanent abstinence in a significant proportion of cases; whereas the wider social and psychological problems of drug dependent patients usually means that chronic or repeated treatment is required."

The grass-roots response

The NTA works through a network of nine regional offices to quality assure the efforts of 149 local partnerships who commission services across England. Here a selection of people involved in drug treatment talk about their experiences on the frontline...

Jerome Peirson, CRI drug worker:
"E was a heavy user of heroin, cocaine and cannabis. He ended up losing his job, falling out with his family and running up debts of £20,000. On his entrance TOP he rated himself poorly: four out of 20 for psychological health, six for physical health and six for quality of life.

"As his drug worker, I oversaw his medical and psychosocial treatment. The aims were to stabilise him, rebuild his family relationships, find him a job, reduce his daily medication, and stay drug free. We worked on relapse prevention. He found the 'cycle of change' useful – identifying where he was and where he wanted to be.

"E set goals for himself and planned his weekends to impose some structure on his life. We worked together on a CV, which resulted in him finding a job. With the security and routine of employment, we could reduce his appointments from twice a week to once a week, and then once a fortnight. After giving drug-free urine and mouth swab tests, he started collecting his medication from a community pharmacy. This helped him to build yet more structure into his life and to avoid other opiate users.

"He steadily reduced his medication. He was working five days a week and continued to submit drug-free tests. He eventually achieved abstinence from illicit and prescribed substances. On his exit TOP form E rated himself 20 out of 20 for psychological health, 18 for physical health and 18 on overall quality of life."

> "The aims were to stabilise him, rebuild his family relationships, find him a job, reduce his daily medication, and stay drug free.

"TOP high performers understand it can help them deliver good results.

Alison Keating, East of England NTA regional manager: "This year the East of England has become one of the best performing regions for TOP. We faced plenty of challenges during the roll out, not least the need to demonstrate to commissioners, drug workers and treatment services that the TOP could benefit them and drug misusers – otherwise it just looked like we were asking them to do extra work.

"The promotional campaign we ran last year was instrumental. It started with a detailed review of one partnership area, where we met providers, data managers and so on to highlight the importance of the TOP. We also asked commissioners and providers for their input on issues that affected TOP completion and on local solutions that were working for them. A regional report was compiled from these reviews.

"The finished report contained a range of recommendations for providers and commissioners. We sent it to every provider in the region, along with positive messages about the importance of TOP. It was well received.

"Now, drug workers who are TOP high performers understand that it can help them deliver good results. This generates real enthusiasm and we encourage them to work with us and demonstrate the benefits to others in the field."

"We are managing our performance for outcomes rather than output.

Ben Hughes, Essex Drug and Alcohol Action Team: "We are getting feedback from providers that they are finding TOPs very useful. We as commissioners are also finding it a useful process as we are now able to set more effective outcome-based targets, we are starting to manage our performance with regard to outcomes rather than pure output targets.

"The commissioned providers are engaged with our performance management framework and they are working well with the development of the treatment system. We have regular meetings between our performance and information department and the providers themselves to restate the importance of collecting and reporting data and information on performance. We are constantly reviewing the structure and functions of the DAAT to ensure providers and service users are fully engaged with our treatment planning processes.

"We are continuing to develop our performance management framework so that we are hands-on and supportive with the development of individual providers in the treatment system.

"We are developing ownership of the system so it is not seen as DAAT-imposed but has been developed with the input of all providers and users. There is a willingness to accept the need for change and this change was driven by all of us as partners rather than purely imposed."

"We need to be focused on what we deliver and how we deliver it.

Lesley Andrews, Kent Drug and Alcohol Action Team: "Already as a DAAT we have got quite a spectrum of different treatments in place such as harm reduction, structured psychosocial interventions and we've also got eight day-programmes across the county. These are starting to evolve in some areas towards group work and reintegration.

"We are looking at day programmes in their current form and how we can evolve those programmes into group work provision but group work with a view of reintegrating people back in to the community so we are looking at working with providers, colleges, and employers to try and give people an experience outside of the treatment sector. We were first in the region to go live, to have our whole process with Jobcentre Plus set up. We have a specific lead on our team for housing.

"We are in leaner times and need to be much more focused in terms of what we deliver and how we deliver it. We will have to see how we can deliver the system more effectively in order to respond to future budget changes. Because obviously many DAATs have a lot of historical growth so we may need to refocus in order to make sure we maximise on the investment we put in. There is a lot of work ahead."

"Next year we open our new inpatient detox and residential rehab unit.

Tony Mercer, Birmingham Drug and Alcohol Action Team: "Because our area is so big, we are addressing ways to work effectively at a local level by aligning with local authority Local Delivery Groups. We now have DAAT officers sitting on those groups so we are better plugged in to local decision making.

"The diversity of communities across Birmingham remains a challenge. We need to be able to work effectively in all those different contexts.

"To ensure services are inclusive and reflect the views and concerns of users, we commission a service called DATUS (Drug and Treatment User Service). They do advocacy, peer-led research, and build up the user infrastructure across the city. We have a city-wide user forum that meets monthly, bringing together users from different services across the city and I am invited to discuss treatment services, DAAT policies, etc.

"Early next year we will open our new Tier 4 centre of excellence, an inpatient detox and residential rehab unit. It will be part of our local treatment system whereas at the moment we send people miles away for residential services.

"Right now, we're up there in terms of numbers in effective treatment but I'd like to be in the top quarter for successful completions in 2010-11."

NTA BOARD

The **NTA Board** comprises the chair, eight non–executive members, six ex–officio members and four executive members, including the chief executive.

The chair was appointed by the Secretary of State for Health. The non–executive and ex–officio members were appointed by the Parliamentary Under–Secretary of State for Health. The chief executive was appointed by the Board.

The **NTA's Audit and Risk Committee** provides an independent and objective view of arrangements for internal control within the agency.

The **HR Committee** is responsible for ensuring that policies and processes for performance review and remuneration of the chief executive, executive directors and senior managers are in place and agreed by the full Board.

The **ex–officio members** were appointed because of their current position within their organisations; therefore, their term of appointment is not fixed.

Baroness Massey of Darwen

Chair of NTA board and member of HR Committee
Appointed Jan 2002 to Apr 2011. Born 1938, white female. Occupation: Labour working peer. Membership: co–chair of the All–Party Parliamentary Group for Children, member of the Advisory Council for Alcohol and Drug Education, the Trust for the Study of Adolescence, and all–parliamentary groups on alcohol, drugs and HIV/AIDS, and member of Lady Taverners.

Andy Buck

Non–executive director and member of Audit and Risk Committee
Appointed Feb 2004 to Dec 2010. Born 1959, white male. Occupation: chief executive, Rotherham Primary Care Trust Membership: board member, Rotherham Primary Care Trust; board member, Burngreave New Deal for Communities; chair, Sheffield Drug Action Team.

Mandie Campbell

Ex–officio member
White female. Occupation: director of Drugs & Alcohol Directorate, Home Office.

David Chater

Ex–officio member (attends on behalf of Ian Whitehouse)
White male. Occupation: Substance Misuse Team, Department of Children, Schools and Families.

Lori Chilton

Ex–officio member
White female. Occupation: head of National Drug Programme Delivery Unit (NDPDU), Ministry of Justice.

Alison Comley

Non–executive director
Appointed Aug 2006 to Jul 2010. White female. Occupation: head of community safety and drugs strategy, Bristol.

Tony Cooke

Non-executive director
Appointed Jun 2009 to May 2013. Born 1949, white male. Occupation: assistant director, Commissioning and Strategic Development, Drugs, NHS Kirklees.

Kate Davies

Non–executive director and member of HR Committee and Audit and Risk Committee
Appointed Jul 2001 to Jul 2011. Born 1962, white female. Occupation: director of the Nottinghamshire County Drug and Alcohol Action Team; director of Community Engagement, University of Central Lancashire. Membership: NDTMS Project Board, Home Office DIP and the Diversity Scrutiny Board.

Adrian Evans

Non-executive director
Appointed Aug 2009 to May 2013. Born 1950, white male. Occupation: retired. Membership: board member, Derbyshire Probation Service.

Brendan Finegan

Ex–officio member
White male. Occupation: director of Strategy, Youth Justice Board.

Grantley Haynes

Non–executive director and member of HR committee and Audit and Risk Committee
Appointed Jul 2001 to Jun 2009. Born 1959, African/Caribbean male. Occupation: development manager, Birmingham Crack Strategy, Birmingham Drug Action Team Membership: COCA (Conference on Crack and Cocaine).

Gill Laver

Non-executive director and chair of the Audit and Risk Committee
Appointed Jun 2009 to May 2013. Born 1949, white female. Occupation: retired. Membership: non-executive director, Chair of audit and risk committee, West Midlands SHA.

Martin Lee

Ex–officio member (to May 2009)
White, male. Occupation: head of Custodial Drug Strategy Team, Interventions and Substance Abuse Unit, Ministry of Justice.

Peter McDermott

Non–executive director and member of Audit and Risk Committee
Appointed Feb 2004 to Dec 2010. Born 1955, white male. Occupation: freelance consultant, Liverpool. Membership: UK Harm Reduction Alliance.

Vanessa Nicholls

Ex–officio member (until December 2008)
White female. Occupation: director of Crime and Drug Strategy, Home Office.

Professor Lord Kamlesh Patel OBE

Non–executive director, Chair of Audit and Risk committee, member of HR Committee
Appointed Jul 2001 to Oct 2008. Born 1960, Indian male. Occupation: director, Centre for Ethnicity and Health, University of Central Lancashire, Labour Peer, House of Lords. Membership: chairman, Mental Health Act Commission; patron, National Men's Health Forum; Patron, Sharing Voices; patron, the Bridge Project; Trustee and Commissioner of the UK Drug Policy Commission; UK member of UNICEF's Global Task Force on Water, Sanitation and Hygiene; vice chair of All Parliamentary Group on Men's Health.

Gabriel Scally

Non–executive director
Appointed Feb 2004 to Dec 2010.Born 1954, Irish male.Occupation: regional director of public health for the South West

Ian Whitehouse

Ex–officio member
White male. Occupation: deputy director, Youth inclusion, Young People at Risk, Supporting Children and Young People Group, Department for Children, Schools and Families.

Paul Hayes

Executive director
Appointed Jul 2001 (permanent). Born 1951, white male. Occupation: Chief executive, NTA.

Annette Dale–Perera

Executive director (until June 2009)
Appointed Oct 2001 (permanent). Born 1961, white female. Occupation: director of quality, NTA.

Jon Hibbs

Executive director
Appointed May 2008 (permanent, from April 2009). Born 1956, white male. Occupation: director of communications, NTA

Stephen Hodges

Executive director
Appointed Nov 2004 (permanent). Born 1957, white male. Occupation: director of corporate services, NTA.

Rosanna O'Connor

Executive director
Date of appointment April 2003 (permanent).Born 1950, white female. Occupation: director of delivery, NTA. Membership: board member, Youth Justice Board.

NTA HEAD OFFICE STAFF

Paul Hayes

Chief executive
paul.hayes@nta–nhs.org.uk

Stephen Hodges

Director of corporate services
stephen.hodges@nta–nhs.org.uk

Rosanna O'Connor

Director of delivery
rosanna.o'connor@nta–nhs.org.uk

Jon Hibbs

Director of communications
jon.hibbs@nta–nhs.org.uk

Tom Aldridge

Young people's national programme lead
tom.aldridge@nta–nhs.org.uk

Oswin Baker

National programme lead – research
oswin.baker@nta–nhs.org.uk

Colin Bradbury

Treatment delivery manager colin.bradbury@nta–nhs.org.uk

Pete Burkinshaw

National programme lead – standards and inspection manager
pete.burkinshaw@nta–nhs.org.uk

John Dunn

Clinical lead
john.dunn@nta–nhs.org.uk

Jane Eccles

Corporate communications manager
jane.eccles@nta–nhs.org.uk

Claire Ainsley

Public affairs manager
claire.ainsley@nta-nhs.org.uk

Linda Grant

Human resources manager
linda.grant@nta–nhs.org.uk

Nino Maddalena

Criminal justice national programme lead
nino.maddalena@nta–nhs.org.uk

Allan McKay

Business and finance manager
allan.mckay@nta–nhs.org.uk

Malcolm Roxburgh

Information manager
malcolm.roxburgh@nta–nhs.org.uk

NTA REGIONAL MANAGERS

Lynn Bransby

NTA regional manager–London
Government Office London
4th Floor, Riverwalk House
157–161 Millbank, London SW1P 4RR
lynn.bransby@nta–nhs.org.uk
020 7217 3660

Beverley Oliver (from April 2009)
Mark Gillyon (until March 2009)

NTA regional manager–North East
Government Office North East
11th Floor, Wellbar House, Gallowgate
Newcastle upon Tyne NE1 4TD
Beverley.oliver@nta–nhs.org.uk
01912 022245

Mark Gilman

NTA regional manager–North West
Government Office North West, City Tower,
Piccadilly Plaza, Manchester M1 4BE
mark.gilman@nta–nhs.org.uk
0161 952 4476

Tony Goss

NTA regional manager–South West
Government Office South West, 2 Rivergate,
Temple Quay, Bristol BS1 6ED
tony.goss@nta–nhs.org.uk
01179 003532

Fintan Hayes

NTA regional manager–South East
Government Office South East
Bridge House, 1 Walnut Tree Close
Guildford, Surrey GU1 4GA
fintan.hayes@nta–nhs.org.uk
01483 882427

Sally Hughes

NTA regional manager–East Midlands
Government Office East Midlands
The Belgrave Centre, Talbot Street
Nottingham NG1 5GG
sally.hughes@nta–nhs.org.uk
01159 712738

Alison Keating

NTA regional manager–Eastern England
Government Office East Eastbrook
Shaftesbury Road, Cambridge CB2 2DF
alison.keating@nta–nhs.org.uk
01223 372778

David Skidmore

NTA regional manager–West Midlands
Government Office West Midlands
5 St Philip's Place, Colmore Row
Birmingham B3 2PW
david.skidmore@nta–nhs.org.uk
01213 525075

Mark Gillyon (from April 2009)
Glennis Whyte (until March 2009)

NTA regional manager–Yorkshire & Humber
The Lateral, 8 City Walk, Leeds LS11 9AT
Mark.gillyon@nta–nhs.org.uk
0113 3412880