NHS

National Treatment Agency
for Substance Misuse

Effective Treatment, Changing Lives

Annual report
2007/08

National Treatment Agency
for Substance Misuse

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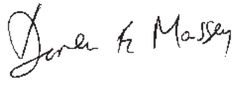
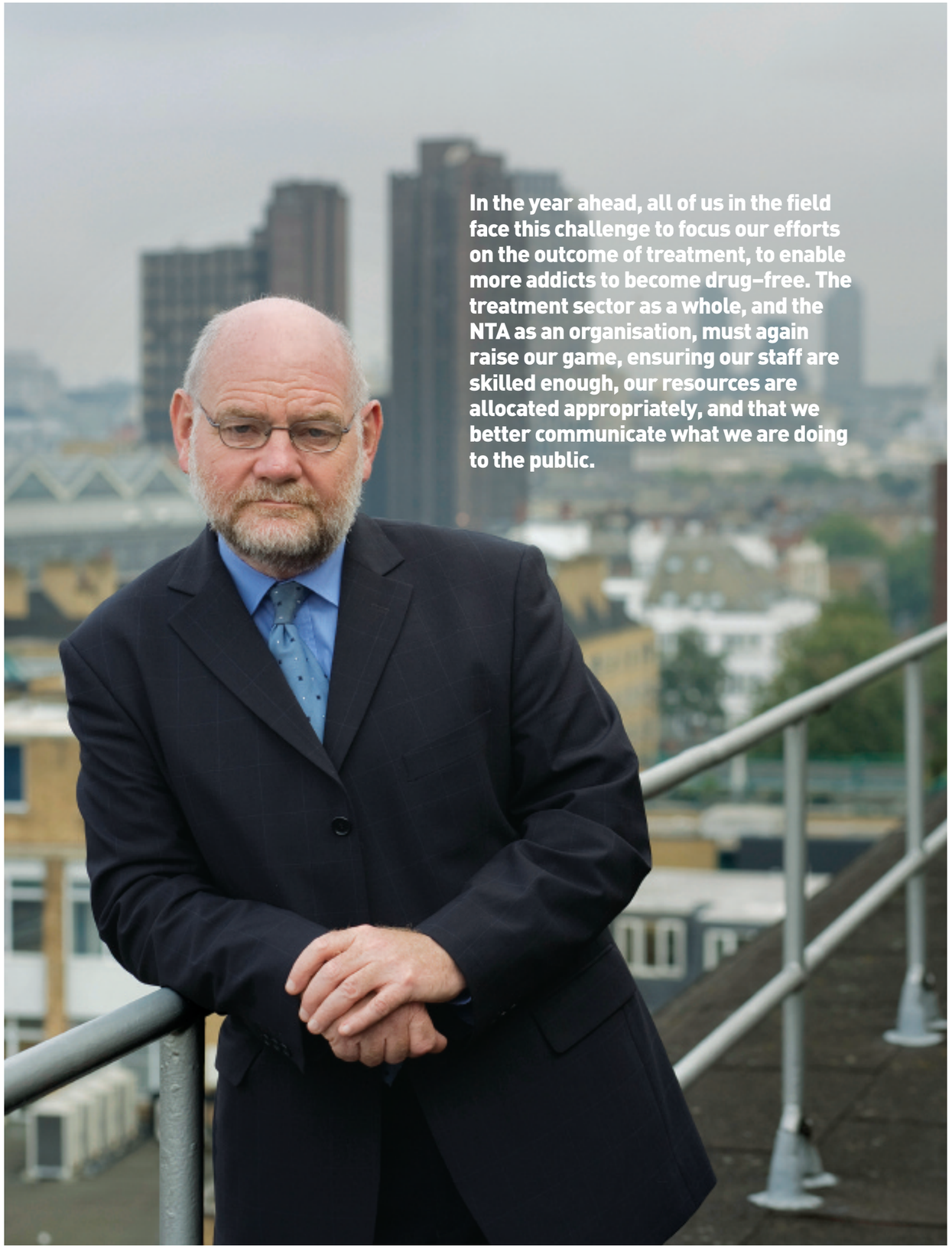
Foreword

Most individuals come into drug treatment wanting to end their dependency on drugs. For some, this can be achieved in a relatively short time. For others, particularly those with entrenched heroin and crack cocaine problems, treatment can take many years. For all, the success of treatment is judged on its impact on the quality of people's lives.

This annual report details the work the National Treatment Agency has undertaken during the past year to increase the availability of effective treatment, and maximise the benefits it brings to individuals and communities.

Baroness Massey of Darwen
Chair





Introduction

Effective treatment, changing lives

This report and the year it covers mark a watershed in drug treatment. Barely did we have time to celebrate the successful completion of the tasks set out in the last Drug Strategy, than we were set a new challenge, to do even better over the next ten years. This coincided with a point in the political cycle when the achievements of the treatment system came under unprecedented scrutiny in the media and Parliament.

With our record of achievement in the past, we welcome the prospect of greater scrutiny in future. The treatment system did what it said on the tin; the numbers in treatment more than doubled, waiting times fell dramatically, and progressively more drug users were successfully retained in treatment programmes.

The latest official statistics confirm that there were more than 202,000 people in treatment in 2007/08 – 138 per cent of our original target – and treatment worked for more than three–quarters of our clients.

Treatment success

In total, more than 190,000 people either completed treatment successfully or stayed in treatment long enough for them and the community to benefit.

The old Drug Strategy gave birth to the NTA on the back of the Government's commitment to cut drug–related crime. The new one again puts drug treatment at its heart, but with an even wider social purpose, as the key to reintegrating drug–users into society, particularly through work but also through a new emphasis on families.

Of these, over 34,000 individuals successfully completed a treatment programme, up from 27,000 the previous year.

Unfortunately, for others there was little benefit – they dropped out early. The evidence shows that drug users need to stay in treatment for at least 12 weeks to gain lasting benefit, and on this measure we acknowledge a failure rate of six per cent.

However, those 12,323 failures were fewer in number than previous years, and should be compared with the 190,343 successes that did stay in treatment for 12 weeks or more and derived benefit from it.

New Drug Strategy, new target

The Government has shown its continuing commitment to improving drug treatment by setting a new target in the new Drug Strategy: to achieve a three per cent increase in the numbers of problem drug users in effective treatment, over the next three years.

Most users, and the community, benefit from them being in treatment. The support provided by drug treatment services stabilises their lives, resulting in fewer crimes and reduced health risk to themselves and others.

I am confident we will achieve this, taking as our benchmark the 156,387 opiate or crack addicts on our books in April. Nevertheless, the numbers game must not obscure the purpose of the new strategy: to herald a shift from quantity to quality.

Measuring real outcomes

This is a journey the NTA has anticipated through the preparatory work we have done on the Treatment Outcome Profile (TOP). The TOP is the yardstick by which drug treatment should be measured. It goes beyond the traditional benefits of being in treatment to work with others to ensure that users can also get a job, look after their families and integrate back into society.

The treatment system needs to be ambitious for those using services, and we need to foster that ambition in them. Most users do not want to be in treatment for the rest of their lives. They see treatment as a means to help them overcome addiction and gain control of their lives.

This may not be achievable quickly, and for some it may not be achievable for many years, if at all. However, enabling users to leave treatment safely, free of dependency, is the challenge to which the treatment system must now rise. The NTA's role is to help services and users get there.

Paul Hayes
Chief executive

The NTA and drug treatment

Our ambition is for a balanced drug treatment system where all drug users can get effective treatment according to their needs and eventually live their lives free of dependency.

Drug treatment in England

Drug treatment in England is complex. It is provided by networks of services, rather than by individual organisations. These networks, or "local drug partnerships", follow local authority boundaries so there are 149 of them in England. They bring together representatives of local organisations involved in the delivery of drug treatment, such as primary care trusts, drug treatment services, voluntary sector organisations and charities, local authorities, the police and the probation service.

About the NTA

The National Treatment Agency for Substance Misuse is part of the NHS, tasked with increasing the number of drug users in effective treatment in England. We have a central office in London, and nine regional offices, one in each of the government regions.

The central office is responsible for developing national policy and programmes, working with national organisations involved in healthcare and the harms that drug use causes. These include government departments such as the Department of Health, the Home Office, the Ministry of Justice, the Department for Work and Pensions, the Department for Children, Schools and Families, as well as royal colleges, training organisations, academic institutions and researchers.

The regional offices are responsible for implementing the NTA's work programme through the local drug partnerships. The teams review and provide guidance on commissioning and treatment planning processes, overseeing the development of local treatment systems. They monitor performance in key areas, such as how many people are in treatment, whether they stay in treatment, how long they have to wait for treatment and the involvement of drug users and their families in treatment. The NTA does not provide drug treatment services itself.

Tackling drug dependency often requires a total change in lifestyle, and involves support to help people do this as much as medical care.

About dependency and treatment

Drug dependency can be a chronic relapsing condition, which can take years for some users to overcome. Different types of treatment are appropriate for different people at different times on the road to recovery. They include detoxification, medication, talking therapy, advice on harm reduction, vaccination against disease, and help with housing, education, employment and offending behaviour.

A sound investment

A wealth of international and domestic evidence shows that drug treatment works. It provides measurable and sustainable benefit to individuals and society. Drug treatment is also a sound investment. Research shows that, for every £1 spent on drug treatment, there is a saving of £9.50 to society – through better health and less crime.

The new Drug Strategy sets a bold and challenging course for the next ten years. It provides a strong impetus for the reintegration of drug users into society, in particular consolidating the benefits of treatment by improving access to housing and employment.

People in treatment are less likely to commit crime, are less likely to harm the health of themselves or others, and will use significantly fewer drugs. They are also more likely to gain employment, more likely to meet their responsibilities as parents, and be better integrated into their communities.

"Having a job is key to keeping drug users off drugs, but most organisations are understandably wary of employing an ex-user. We can help by employing people ourselves, helping to identify the skills they have to offer, giving them the confidence to believe that they can hold down a job – and giving them something positive for their CV."

Vince Carroll
Manager,
Bridge Substance Misuse Services

Caroline Page
Service manager
Community Drugs Outreach Team (CDOT)
Rochdale MBC

"We know that the needs of the client must come first and, whether the client is in the community or in prison, we try to make it as easy as possible for them to get the treatment they need."

Vince Carroll

Manager,
Bridge Substance Misuse Services, Northamptonshire

“What we do is effective: in the three years we’ve existed, only two of our volunteers did not get into paid employment or education. Most choose to work or study within drug treatment or related areas, so we also help train the next generation of the workforce.

We insist that our volunteers have been clean for at least 18 months before they start working with drug users, but no-one who comes to us goes away empty handed. Even if they haven’t reached 18 months or are still using, we encourage them to join in and help with the activities we offer, such as football and boxing. Drugs can be a full time occupation, and when users stop using they need to fill their time. We can help them fill that time usefully.”

From quantity to quality:
the story so far

The Government spent £800 million on drug treatment in 2007/08. In order that this money is spent where it is most effective, we need to know what treatment activity is taking place, and where. That information is provided for the NTA by the National Drug Treatment Monitoring System (NDTMS), and is also used by several Government departments.

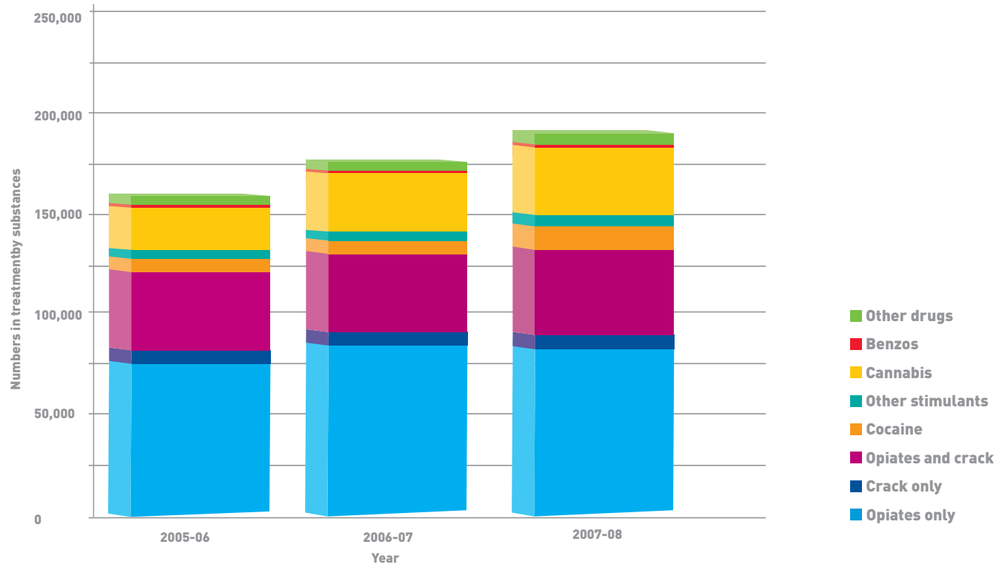
Every year the data is validated by the National Drug Evidence Centre at the University of Manchester and published in a separate official return as National Statistics. In 2007/08, for the first time, the NTA annual report is being published alongside the figures for the year, and acts as a commentary on them.

The data that NDTMS collects from the providers of structured treatment, through the regional and public health observatory network, is constantly evolving. We know there are some gaps, for example because not all independent or voluntary sector providers of residential services supply returns. There are also issues about consistency in using statistical terms.

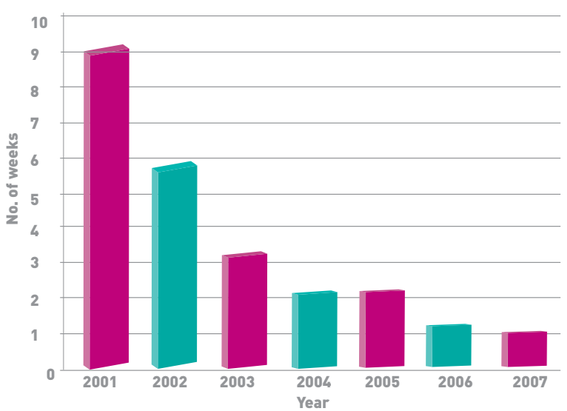
Nevertheless, the NDTMS is one of the most comprehensive data sets in daily use in the National Health Service. It provides a wealth of knowledge at local level about drug treatment in the community, and provides practitioners in the field with the tools they need for planning, commissioning and delivering services to users.

In future, additional information from the Treatment Outcomes Profile will be grafted on to NDTMS to give an even richer picture of effective drug treatment. Meanwhile, the raw numbers have told their own success story of growth and development over recent years, as these charts illustrate.

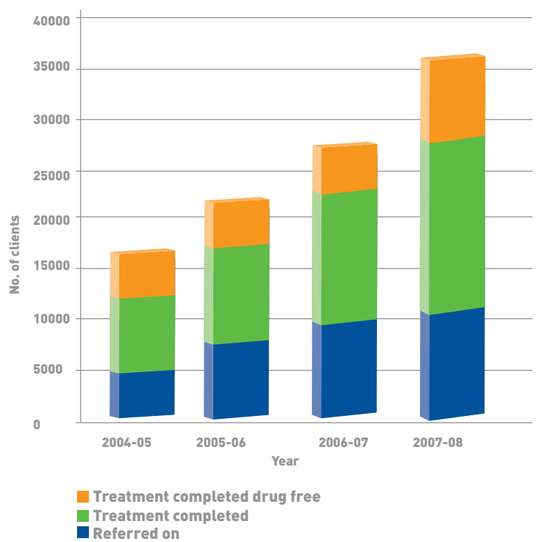
Numbers in treatment by substances



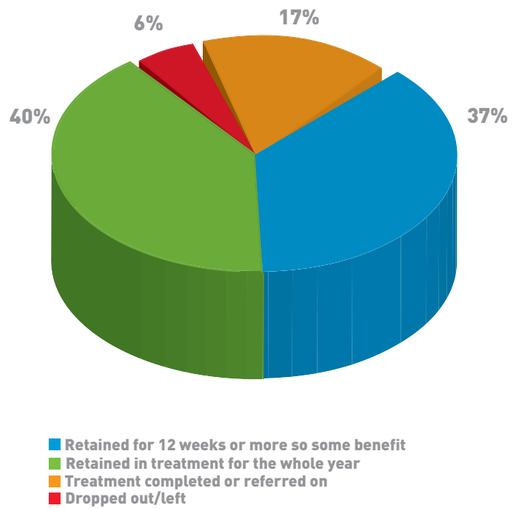
Average wait in weeks to start treatment December 2001– December 2007



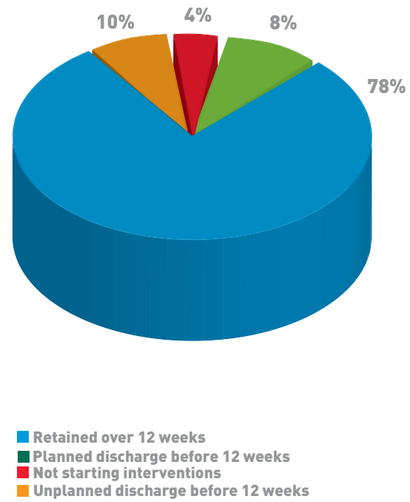
Number of clients successfully completing their course of treatment



What happened to all those in treatment 2007/08



What happened to the drug users coming in to treatment 2007/08



Quality:

the key to effectiveness

As the focus for drug treatment moves from simply getting more people into treatment to getting more people into effective treatment, we need to improve the quality of treatment. Quality treatment is treatment that suits the needs of the individual, helping them to rebuild their lives and confidence so that they can eventually leave the treatment system and get on with their lives.

Improving quality has been a thread running through all our work programmes this year.

A year of partnerships

This year we have worked closely with key partners such as the National Institute for Health and Clinical Excellence (NICE), the Department of Health, the Scottish Government, the Northern Ireland Executive and the Welsh Assembly Government on a suite of clinical guidance for drug treatment.

The suite comprised several publications, including:

Drug Misuse: Opioid Detoxification provides information about the support and the treatment people can expect if they have a problem with opioids, such as heroin.

Drug Misuse: Psychosocial Interventions recommends introducing incentive programmes for some drug-users in order to reduce illicit drug use, encourage engagement with harm reduction services, and promote physical health.

These are both "clinical guidelines", which means that the NHS needs to review its current provision and modernise services to deliver treatment in line with these guidelines. The guideline on psychosocial interventions, in particular, will present a challenge to the sector, as some of the treatments it recommends, for example, behavioural couples therapy, are not widely provided and will require extra training for the workforce.

Updating the Orange Book

The overarching guidance for drug treatment, not only in England but across the United Kingdom, is Drug Misuse and Dependence: UK Guidelines on Clinical Management, often called the Orange Book. It provides guidance on how to treat drug users, based on current evidence and professional consensus. It is aimed at all clinicians, especially those providing pharmacological treatments, such as methadone, as part of a drug treatment programme.

The Orange Book was last published in 1999. In 2007 it was updated to reflect the considerable changes and developments in the evidence for drug treatment and clinical practice that have occurred since then. Professor John Strang, Director of the National Addiction Centre, chaired the independent working group of key stakeholders undertaking this major work. The NTA provided a secretariat for the working group and the separate user and carer advisory groups.

Supporting implementation

Introducing new treatments and redesigning services to deliver more effective treatment quickly and with the least disruption and cost can be challenging. The NTA therefore organised a series of regional events with NICE on the guidance and the updated Orange Book across England in the winter of 2007/08.

These events reached an audience of over 1,100 drug treatment providers, commissioners and service users. They were briefed on the guidance and workshops were held to help plan how they could review and update services in line with the new guidance. The NTA regional teams then worked with local drug partnerships, holding review meetings and treatment planning to take forward action plans.

Taken together, these publications add up to a sound evidence base for effective drug treatment and endorsement of the need for a balanced drug treatment system that addresses the needs of all drug users, from harm reduction services to methadone maintenance and abstinence–based inpatient and residential treatments.

"The regional launch event hosted by the NTA and NICE was very useful, and it was good to see so many colleagues and partners there, from community based and prison treatment backgrounds.

What differentiates the 2007 Orange Book from the 1999 version is the breadth of different treatments it covers. The earlier version had a strong medical focus, while the update includes psychosocial treatments and harm reduction measures. Taken with the NICE guidelines, this is a strong evidence base for such therapies and has given us a firm foundation to promote them. It has enabled us to work with our providers to re-engineer the service. For example, we now have dedicated psychosocial interventions workers.

The full suite of guidance gives clarity. In the past, ideology sometimes got in the way, and treatment was delivered according to what an individual believed. The new guidance leaves less room for that and strengthens my hand as joint commissioning manager in ensuring that the treatment we provide is based on the national consensus as to what works best."

Mark Harrison
Joint commissioning manager
County Durham Drugs and Alcohol Action Team

“ We are applying the tried and tested principles of a basic behavioural reward system. In the case of drug users, encouraging a very small change can have life–saving consequences. This new approach is a way of kick–starting change, and helping people regain control over their chaotic lives, thus reducing the harm done by their drug–use to families, neighbours and communities.”

Dr John Dunn
Consultant psychiatrist and NTA clinical advisor

The service review doesn’t just identify partnerships which need to improve. By seeing how the top performers work, it also identifies good practice. This good practice can then be highlighted to all partnerships, who can adapt it for their service, and improve the quality and effectiveness of drug treatment.

These events also supported the implementation of the NICE technology appraisals on naltrexone, methadone and buprenorphine, published in January 2007. These publications recommend how these medicines should be used within drug treatment.

Partnering for quality: the Healthcare Commission

Since 2005, we have worked in partnership with the Healthcare Commission on a programme of annual service reviews. We speak to each of the 149 local drug partnerships and assess how well they perform on specific themes within drug treatment.

Partnerships are scored “excellent”, “good”, “fair” or “weak”. The bottom 15 per cent are then targeted and requested to develop improvement plans, supported by their NTA regional office.

Each year the service review focuses on two themes. The themes for 2007/08, the final year of the programme, are diversity and inpatient and residential services. The review of inpatient and residential services will be supported by the Commission for Social Care Inspection, as it will assess the provision of residential services and social care. The final results will be released to partnerships in November 2008, enabling them to start planning all necessary improvements.
Last year the themes were how drug treatment systems are commissioned, and harm reduction services such as needle exchanges and vaccination services. The results of the review, published this year, showed the vast majority of partnerships performing acceptably. Thirty–four per cent had an overall score of “excellent”, forty–five percent were “good” and twenty–one per cent were “fair”. No partnership had an overall score of “weak”.

However, there is room for improvement, with the majority of partnerships showing some deficits. Since the review the Healthcare Commission and the NTA have issued guidance and supported action plans to address these.

Looking at new approaches

Improving the quality of drug treatment requires us to look at new approaches as well as ones which have been applied elsewhere, and assess whether they would be effective in England.

Treatment incentives

One of these approaches involves offering incentives to encourage drug users to change their behaviour – known as “treatment incentives”.

These incentives can come in the form of credits towards evening classes, children’s clothes and other recovery–appropriate goods and services, and they can be earned, for instance, when a drug user in treatment routinely returns consecutive negative urine tests for heroin over a period of 12 weeks.
Both of the NICE clinical guidelines mentioned above recommended that treatment incentives be introduced to drug services as part of an NTA–led implementation programme.

The evidence base for the effectiveness of treatment incentives is substantial, but drawn mostly from America. To evaluate how best it would work in England, the NTA has developed a demonstration programme involving 15 sites around England, where treatment incentives are being offered to drug users, under rigorously controlled conditions. The programme began in the spring of 2008 and initial results will be published in spring 2009.

The International Treatment Effectiveness Project

Another new approach we have been looking at is the International Treatment Effectiveness Project (ITEP). Two years ago, the NTA and the Institute of Behavioural Research at the Texas Christian University began working together on this project. This is a programme of treatment interventions which takes a structured approach to psychosocial “talking therapies”, using manuals which help keyworkers to deliver the intervention effectively and which also help clients to view their drug problem and treatment holistically.

The ITEP model was successfully implemented across Manchester and, as a result, a further roll–out was carried out in the West Midlands this year. A revised set of manuals was developed for this programme and, as with Manchester, the intervention was very well received, not least because it has encouraged positive organisational change.
The NTA now has a rich experience of ITEP–related interventions and will soon be publishing a suite of ITEP reports and manuals.

Engaging hard to treat users

Although injectable opioid treatment (injectable heroin and injectable methadone) has been available for decades, it is not currently available in all drug treatment services. Working with several partners, the NTA has this year contract managed the Randomised Injectable Opiates Treatment Trial, the first study to evaluate the effectiveness of this treatment within the English treatment system. The treatment is included in the updated Orange Book for consideration for hard to treat drug users for whom more established oral maintenance treatment has not been successful.

A decision on the wider implementation of this type of treatment will be taken by Government when the results of the study have been assessed.

Users and families:
listening to those who know

Involving service users and carers – usually family members – in planning, delivering and improving services has long been at the heart of the NTA's work and now sits firmly with our nine regional teams.

Harnessing expert opinion:
service users

Mechanisms for local user involvement are well–established across the country, backed up by results from three years of our national user satisfaction survey. Information from the surveys informs the joint NTA and Healthcare Commission service improvement reviews so, in 2007, we carried out two user satisfaction surveys – of Tier 2 and 3 service users, and Tier 4 service users – to support the themes of the reviews. A record 13,500 questionnaires were returned.

A positive difference

The vast majority of respondents to both surveys said that they were generally satisfied with their treatment and agreed that it had made a positive difference to their lives. They also found that service users who had care plans which were regularly reviewed were much more likely to be happy with their treatment. However, both surveys also identified areas where improvement is needed: support for families; and aftercare services, such as help with access to employment and housing. This information reiterates findings from the previous surveys and shows that, while good progress is being made, there is still room for improvement.

Nothing About Us, Without Us

May 2007 saw a group of 11 service user representatives – sponsored by the NTA – attend the International Harm Reduction Association (IHRA) conference in Warsaw. The intention was to collect information on new evidence–based initiatives to bring home and use to improve harm reduction in England.

The visit was very productive, and details were published in Nothing About Us, Without Us. This and evidence from a follow–up visit to the IHRA conference in Barcelona in May 2008 will help inform a harm reduction campaign in 2008.

An NTA first

Models of Care for Adult Drug Misusers: Update 2006 is one of the bedrocks of drug treatment, and vital guidance for health professionals, commissioners and service providers. The information it contains is also important for service users, and, to ensure that the information is more easily accessible, we produced Getting Help for a Drug Problem: a Guide to Treatment, which is a plain English summary of the key messages from Models of Care. This was our first publication written specifically for the service user and has proved very popular, with over 30,000 copies ordered or downloaded by the end of March 2008.

Harnessing expert opinion:
families and carers

The vital contribution of families and carers to effective treatment is well evidenced and has long been acknowledged. But they have separate and specific needs of their own – and that is less acknowledged. The NTA is addressing those needs.

The new Drug Strategy identifies families as a priority. Involving and supporting families is, of necessity, a cross–government project, and the Department for Children, Schools and Families (DCSF) will lead a group including the NTA to co–ordinate and improve support for family members, including the children of drug users, kinship carers and drug–using parents.

Our own work on families this year included commissioning Professor Richard Velleman, expert on how drug use affects the family, to help produce draft guidance for commissioning support for families and carers and involving them in treatment services. This guidance will be launched at the House of Lords in October 2008.

Rewarding user and carer representatives

In line with the Department of Health's Reward and Recognition, the NTA consulted on a policy to pay users and carers for their time when doing specific pieces of skilled work for the NTA. The policy went live in March 2008. The contribution of users and carers in helping the organisation achieve its objectives has long been recognised, and this new payments system reflects the value we place on specialist user and carer input.

"It is really important to involve and provide help to family members and carers. Involving family members in their users' treatment helps the users to be much more successful. And providing help to family members in their own right is necessary to help them cope.

So working with the NTA and with a really committed and very able group of people to develop and produce national guidance for commissioning support for families and carers, and involving them in existing treatment services, has been really exciting. We all feel that there is a chance for the NTA, working with commissioners, to make a real difference to both family members' and users' lives."

Professor Richard Velleman
Professor of Mental Health Research, Department of Psychology, University of Bath and Consultant Clinical Psychologist, Avon and Wiltshire Mental Health Partnership NHS Trust

Sue Hall

Co-ordinator,
Family Drug Support, Herefordshire

"I see our role as two-fold. We can offer support and practical help to families who are suffering because of a loved one's drug problem, but we can also help improve treatment for drug users by sharing our extensive knowledge and experience with commissioners and service providers.

We need to be professional in order to achieve both of these objectives. FDS volunteers are trained in drugs awareness to level 3, and are also trained in understanding co-dependency and in communications and listening skills.

Organisations like Family Drug Support can make a difference.

Over the last two years, we have noticed an increase in grandparents worried about the effects of their children's drug misuse on their grandchildren. In response, we are developing links to appropriate local agencies to highlight these concerns. We are also offering more practical help to grandparents who have taken on the role of parenting their grandchildren.

Everyone involved in treatment must focus on outcomes. At the end of the day, what families want is for their relatives to be happy and productive members of society."

Measuring effective treatment

Having delivered our initial task – improving the availability of drug treatment and access to it – the new Drug Strategy tasks the NTA with increasing the number of drug users in *effective* treatment. The Treatment Outcomes Profile (TOP) will be key in helping us to do this.

Treatment works. It improves the health and social functioning of our clients, minimises public health risks, and reduces criminality. All the evidence proves this. We have now introduced a tool that will better measure these improvements for every individual in treatment.
The TOP measures improvements in drug users' lives in four key areas: drug and alcohol use, health, social functioning and offending – in other words, the things that make a real difference to drug users, their families and their communities. The TOP is a set of 20 questions which can be fitted on a single sheet of A4 paper, designed – and proven – to be quick to complete but effective in measuring change. It's carried out when a drug user enters treatment, then every three months and when the client completes treatment, allowing both drug user and clinician to track progress.

The TOP is a hugely ambitious project. There has never before been one single quick, simple and effective tool which works across the treatment sector.

Developing the TOP

Following extensive development work, piloting, testing and retesting, we launched the TOP at the Queen Elizabeth Conference Centre in London in May 2007 and were proud to welcome Caroline Flint MP, then Minister of State for Public Health.

Rigorous validation

Leading experts in outcomes monitoring, Dr John Marsden and Dr Michael Farrell, carried out rigorous academic validation of the TOP. Over 1,000 clients in structured drug treatment in over 70 locations in England took part in the process, which included independent, international peer review. Details of the validation process appeared in the journal Addiction in September 2008. Measuring the outcomes of drug treatment is a subject of international interest, and we have so far received enquiries about the TOP from Scotland, Wales, Australia, Chile, Iran, China and Italy.

We have so far received around 200,000 completed TOP forms and have been sending data on clients entering treatment back to all partnerships since summer 2008. From the autumn of 2008, partnerships whose data complies with rigorous quality control will also begin to receive data on clients during their treatment and when they complete treatment.

A major milestone for the project was achieved on 1 October 2007, the date on which the TOP was launched for use with all clients accessing structured treatment in England.

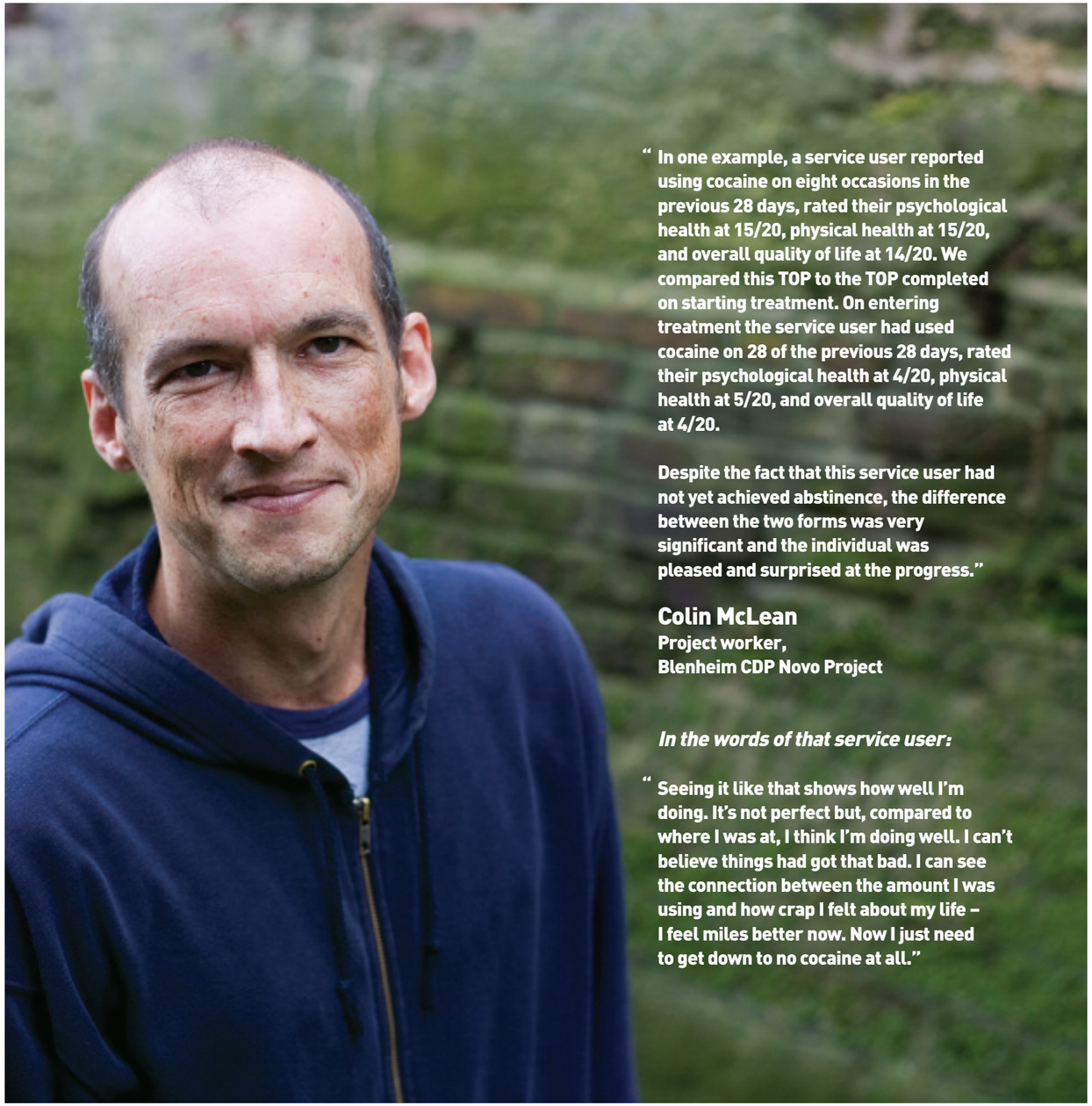
Seeking feedback

Incorporating the views of the field is vital to the effectiveness of a major project such as the TOP. In March 2008 we held a major event to consult a wide range of stakeholders, including representatives from Royal Colleges, the Department of Health, data analysts, managers, keyworkers, and user and carer representatives. The event proved very useful, and the views expressed will help shape how we use the TOP. The comprehensive training and guidance materials for keyworkers, managers and service users, produced at the time of the launch event, will also be updated, and a further consultation event will take place in October 2008.

Real outcomes, effective treatment

Once fully embedded in drug treatment services, the TOP will enable us to measure the success of drug treatment by real outcomes, not the proxy measures (such as numbers in treatment and how long drug users stay in treatment) that we have had to use so far. Being able to prove what works will help the field drive up the quality and effectiveness of treatment. The TOP will also highlight where things are going wrong, enabling corrective action to be taken.

Implementing and rolling out a new national dataset of this size is a huge task. The speed with which the TOP was developed and brought into service is a significant achievement for the NTA, its partners and the drug treatment sector.



"In one example, a service user reported using cocaine on eight occasions in the previous 28 days, rated their psychological health at 15/20, physical health at 15/20, and overall quality of life at 14/20. We compared this TOP to the TOP completed on starting treatment. On entering treatment the service user had used cocaine on 28 of the previous 28 days, rated their psychological health at 4/20, physical health at 5/20, and overall quality of life at 4/20.

Despite the fact that this service user had not yet achieved abstinence, the difference between the two forms was very significant and the individual was pleased and surprised at the progress."

Colin McLean
Project worker,
Blenheim CDP Novo Project

In the words of that service user:

"Seeing it like that shows how well I'm doing. It's not perfect but, compared to where I was at, I think I'm doing well. I can't believe things had got that bad. I can see the connection between the amount I was using and how crap I felt about my life – I feel miles better now. Now I just need to get down to no cocaine at all."

Colin McLean

Project worker,
Blenheim CDP Novo Project

"The TOP is a valuable tool for reviewing service users' progress. Change is a process that can take time, and goals often take several months or even years to achieve. The TOP form highlights the progress made towards achieving the longer term goals of reduction, abstinence, improved social functioning and healthier living.

With many service users, abstinence from class A drugs is the eventual goal, and frustration can set in when this is not achieved immediately.

In many cases the TOP review is the first time the service user sees written evidence of their drug use over a period of 28 days, and the reductions they have achieved in both quantity and regularity of use. This can be a powerful moment, and provides encouragement to continue in treatment and work towards longer term goals and lasting change."

Improving
treatment for young people

Tackling substance misuse among young people is a key priority in the new Drug Strategy, which puts a fresh emphasis on preventing harm to children and helping families at risk. The treatment activity commissioned through the NTA supports both the Children's Plan and the Youth Alcohol Action plan drawn up by the Department of Children, Schools and Families.

The NTA has agreed a Memorandum of Understanding with the Department for Children, Schools and Families (DCSF) that gives us a clear responsibility for delivering the young people's treatment system. Working with our Government partners, we have made good progress in doing just that.

The nature of the challenge

Young people represent about seven per cent of all the clients of substance misuse services, and the numbers have grown in successive years. Yet the British Crime Survey and the Schools Survey on Smoking, Drinking and Drugs show a downward trend in drug and alcohol use by young people.

The increase in the numbers in treatment reflects both the historic growth in appropriate treatment services, and our success in getting more young people into them, rather than any increase in the actual incidence of substance misuse.

About three–quarters of the under–18s in treatment use cannabis as their main drug, and almost half are being treated for alcohol abuse. However, drugs and alcohol are only part of the problem affecting these young people. They may also be truanting from school, committing crime, or being looked after in care. Their treatment will include a care package that tackles these related problems. For all these reasons, it is quite different from adult drug treatment.

Treatment for young people is about reducing the harm associated with substance abuse in general, including problem drug use, and ensuring it does not escalate to addiction in adulthood.

Working in partnership

The NTA fully realises that delivering effective treatment for young people will require sustained effort, investment and commitment from all the agencies involved. Upcoming projects include:

- Working with three Royal Colleges – of Psychiatry, Paediatrics and General Practice – to produce a workforce plan for those professions.
- Working with DCSF, the Department of Health, the Youth Justice Board and the Ministry of Justice to develop guidance to support effective and consistent treatment across the community, and between the community and young people in care.

"It's absolutely vital to recognise that young drug users need different treatment from adults. The evidence shows that most adults need at least 12 weeks in treatment, but that is not the case for all young people – many need shorter treatment periods. Providing treatment to young people and then being vigilant in ensuring engagement does not go on longer than is required to meet need is better for them – as well as freeing up treatment for others who need it."

Dave Schwartz
Young person's lead, drugs and alcohol
Plymouth Children's Trust

All effective drug treatment requires cross–government working. Arguably, it's even more important for young people's treatment, as many more agencies need to be involved.

A regional approach

While policy is set centrally, delivery takes place locally. In summer 2007 we produced guidance on specialist needs assessment for young people*. This ensures a needs assessment process is built into the existing local framework for planning young people's treatment. Evidence that this approach was effective came in January 2008, when local partnerships submitted their plans for the next year. The quality of the plans was extremely encouraging.

This approach is now being refined and developed with DCSF for future years, including further guidance to address not just the needs of young people, but also effective treatment for drug–using parents.

This year our regional teams have also worked closely with local commissioners to ensure a smoother transition for clients moving from young people's services to adult treatment, and have developed relationships with regional partnerships' directorates for children and learning.

*Young People's Specialist Substance Misuse Treatment: Needs Assessment Guidance.

"Historically, we had quite a few 18 and 19 year olds in our service. We have been able to add value to the contract by developing a transitional work role to identify what clients need as they approach 18, whether it's specialist treatment in an adult service or more general social care, and help them access it."

Shirley Sinclair
Young people's service manager
Harbour Drug and Alcohol Services

Dave Schwartz
Young person's lead, drugs and alcohol
Plymouth Children's Trust

"Knowing your treatment population is vital. In Plymouth, we developed our own model to identify need, then reviewed our contract with Harbour. We wanted a service with a very clear focus on young people, which could work within an integrated young people's system that provides support before, during and after treatment – as well as providing value for money.

Our ambition?
Even greater integration – to ensure support and management of risk of young people is shared."

Shirley Sinclair
Young people's service manager
Harbour Drug and Alcohol Services

"Recognising that some young people do not need to be with us too long has been challenging but the staff have responded fantastically and this has been helped by increasingly closer working relationships with other children's services. We try hard to work with referrers from the point of the referral so that any supportive relationship is maintained.

Having confidence in our relationship with commissioners from Plymouth Children's Trust really helps. I know that I can pick up the phone and talk through any concerns and get clarification quickly.

Our ambition?
To prevent young drug users from becoming adult drug users."

Quality treatment
inside and outside

Drug use drives crime – a wealth of evidence proves it. Drug users in prison should be easier to treat than those outside – common sense suggests it. Yet treatment in prisons has been generally patchy, and an opportunity to break the link between drug use and crime is often missed.

The good news is that this scenario is changing and the NTA is driving the change.

Treatment in prisons: IDTS

2007/08 was a significant year for the development of treatment in prisons, with the implementation of the Integrated Drug Treatment System (IDTS) continuing apace.

The IDTS programme, a partnership between the Ministry of Justice and Department of Health, supported by the NTA, aims to develop drug treatment in prisons and ensure it matches Models of Care guidelines. By March 2008 IDTS was well advanced, and fully operational in 11 of the 12 first wave prisons. Our ambition is for IDTS to be implemented in all prisons by 2011.

The new Drug Strategy gives a clear commitment to IDTS and to minimum clinical standards for drug treatment in prisons. This chimes with the NTA's on–going work around treatment for offenders and our ambition for a seamless treatment service, whether in the community or in prison.

Funding prison treatment

In July 2007 consultants PricewaterhouseCoopers were commissioned by the Department of Health and the Ministry of Justice to undertake a comprehensive review of the funding of prison treatment. Their report was submitted in December. As a result, the Prison Drug Treatment Strategy Review Group, chaired by NTA Board member and chair of the Mental Health Act Commission, Professor Lord Kamlesh Patel, was set up to take forward the recommendations of the review. These include:

- Agreeing key outcomes for offenders, both in prison and on release
- Establishing national minimum standards for drug treatment in prisons
- Improving information sharing to support better performance and case management
- Developing the commissioning model at national, regional and local level.

Crucially, Department of Health funding for IDTS was confirmed for the next three years: £13 million for 2007/08, rising to £24 million in 2008/09, £39 million in 2009/10 and £43 million for 2010/11.

Regional delivery

Delivering IDTS across the country is managed by the NTA's regional teams, and this year saw a dedicated IDTS development manager in post in each regional office. The regional teams also managed the roll–out of an IDTS needs assessment framework and treatment planning process specifically for use in prisons from 2008/09. Once this is up and running, treatment planning in prisons will mirror treatment planning in community–based services.

Drug Interventions Programme

The Drug Interventions Programme (DIP) is a key part of the Government's strategy for reducing crime. And it's working. Home Office figures show that drug–related crime has fallen by around a fifth since the police started testing those arrested for a range of crimes often linked to drug use.

DIP aims to get adult drug users out of crime and into treatment and other support quickly. DIP is now well–established and is part of the day to day business of the NTA's regional teams. Home Office research* indicates that offending levels following DIP contact are lower than prior to DIP contact.

Tough Choices

DIP was introduced in 2003 and has consistently achieved its key aim of reducing offending. New elements have been added each year. Last year, a new programme was phased in to bring forward the point at which a drug test for Class A substances is carried out. Under the Tough Choices programme, individuals are now tested on arrest, rather than after they have been charged. This means that up to three times as many people are tested at some point of their detention, giving a better opportunity for prompt referral to treatment.

The highlight of 2007/08 for the DIP came in January 2008, when we achieved our target to get 1,000 offenders per week into treatment by 31 March 2008 two months early. In March 2004 just 438 offenders were entering treatment each week.

Earlier intervention

The research also shows that Tough Choices results in a greater proportion of individuals with few or no proven previous offences being tested. In other words, more drug–using offenders are being identified before they become serious offenders, presenting a better opportunity to get them into treatment and help break the link between drug use and crime.

*The Drug Interventions Programme (DIP): Addressing Drug Use and Offending Through Tough Choices

"Addiction is a very cold world. It desensitises you. I saw how it made other people behave and realised that I had to stop, but I'd been using lots of different drugs over the years and it took me a long time to get clean. I wanted my life back, a job, to be back in touch with my family.

With winter coming, being homeless was so bad that I didn't mind going to prison – at least I would be warm. As my release date got nearer, I became genuinely worried and suffered sleepless nights – where would I go when I came out? But there's lots of support in prison if you show you're willing.

I am now living in supported accommodation at Brydon Court, and the help I have received here since my release has been great. It's not a real place of my own yet, but I can shut the door behind me and know that my privacy will be respected. I am planning to learn sign language and train as a mentor for deaf people with drug problems. I would like to use my bad experiences to do some good."

Phil
ex user

Caroline Page
Service manager
Community Drugs Outreach Team (CDOT)
Rochdale MBC

"Sharing information is vital for effective team working, both within the CDOT team and between the team and our partners. The CDOT team is small but we have a wealth of experience and make sure we share it. With offenders, we often find that one of the team has previous knowledge of that individual and can provide valuable insight to the keyworker, ensuring that all the right support is in place on release. We also work closely with the other agencies involved, such as Greater Manchester Police, local prisons and CARAT workers."

Chris Henniker
Drugs outreach worker
Community Drugs Outreach Team (CDOT)
Rochdale MBC

"It really helps that I can come and go within Forest Bank and Buckley Hall prisons as if I were a member of staff. If I am needed, I can be there quickly, without waiting for a prison escort. Our partnership working approach means we know well in advance when clients will leave prison and we can plan accordingly – but, if we do get a last minute panic, I know I will be able to deal with it.

When someone leaves prison, their needs can range from help getting their drug treatment to help with housing and benefits. Knowing your client is so important – having secure housing is crucial, but not all clients are ready for the responsibility. Some will need time in supervised accommodation. It's understanding the level of support required and helping the client to get it that makes the difference."

NTA Board

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

Appointments

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.

Audit and Risk Committee

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

HR Committee

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.

Ex–officio members

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
Occupation Labour working peer
Date of appointment January 2002
Appointed until April 2009
Year of birth 1938
Ethnic background and gender White, female
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

Ian Whitehouse

Ex–officio member (from September 2008)
Occupation Deputy Director, Youth inclusion, Young People at Risk, Supporting Children and Young People Group, Department for Children, Schools and Families
Ethnic background and gender White, male

Andy Buck

Non–executive director and member of Audit and Risk Committee
Occupation Chief executive, Rotherham Primary Care Trust
Date of appointment February 2004
Appointed until December 2010
Year of birth 1959
Ethnic background and gender White, male
Membership Board member, Rotherham Primary Care Trust, board member, Burngreave New Deal for Communities, Chair, Sheffield Drug Action Team

Alison Comley

Non–executive director
Occupation Head of community safety and drugs strategy, Bristol
Date of appointment 1 August 2006
Appointed until July 2010
Ethnic background and gender White, female

Kate Davies

Non–executive director and member of HR Committee and Audit and Risk Committee
Occupation Director of the Nottinghamshire County Drug and Alcohol Action Team, Director of Community Engagement, University of Central Lancashire
Date of appointment July 2001
Appointed until September 2009
Year of birth 1962
Ethnic background and gender White, female
Membership NDTMS Project Board, Home Office DIP and the Diversity Scrutiny Board

Grantley Haynes

Non–executive director and member of HR committee and Audit and Risk Committee
Occupation Development manager, Birmingham Crack Strategy, Birmingham Drug Action Team
Date of appointment July 2001
Appointed until June 2009
Year of birth 1959
Ethnic background and gender African/Caribbean, male
Membership Member, COCA (Conference on Crack and Cocaine)

Martin Lee

Ex–officio member
Occupation Head of Custodial Drug Strategy Team, Interventions and Substance Abuse Unit, Ministry of Justice
Ethnic background and gender White, male

Lori Chilton

Ex–officio member (from September 2008)
Occupation Head of National Drug Programme Delivery Unit (NDPDU), Ministry of Justice
Ethnic background and gender White, female

NTA Board

Peter McDermott

Non–executive director and member of Audit and Risk Committee
Occupation Freelance consultant, Liverpool
Date of appointment February 2004
Appointed until December 2010
Year of birth 1955
Ethnic background and gender White, male
Membership UK Harm Reduction Alliance

Vanessa Nicholls

Ex–officio member
Occupation Director of Crime and Drug Strategy, Home Office
Ethnic background and gender White, female

Professor Lord Kamlesh Patel OBE

Non–executive director, Chair of Audit and Risk committee, member of HR Committee
Occupation Director, Centre for Ethnicity and Health, University of Central Lancashire, Labour Peer, House of Lords
Date of appointment July 2001
Appointed until April 2009
Year of birth 1960
Ethnic background and gender Indian, male
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.

Brendan Finegan

Ex–officio member (from September 2008)
Occupation Director of Strategy, Youth Justice Board
Ethnic background and gender White, male

Gabriel Scally

Non–executive director
Occupation Regional director of public health for the South West
Date of appointment February 2004
Appointed until December 2010
Year of birth 1954
Ethnic background and gender Irish, male
Membership N/A

Tina Williams

Non–executive director and member of HR Committee (until July 2008)
Occupation Project manager
Date of appointment February 2004
Appointed until July 2008
Year of birth 1949
Ethnic background and gender White, female
Membership Parents and Addicts Against Narcotics in the Community (PANIC), vice–chair of FAMFED (National Federation of Families and Carers), chair of North–East Carers' Forum

Paul Hayes

Executive director
Occupation Chief executive, NTA
Date of appointment July 2001
Term of appointment Permanent
Year of birth 1951
Ethnic background and gender White, male
Membership Advisory Council on the Misuse of Drugs

Annette Dale–Perera

Executive director
Occupation Director of quality, NTA
Date of appointment October 2001
Term of appointment Permanent
Year of birth 1961
Ethnic background and gender White, female
Membership N/A

Jon Hibbs

Executive director (from May 2008)
Occupation Director of communications, NTA
Date of appointment May 2008
Term of appointment One year
Year of birth 1956
Ethnic background and gender White, male
Membership N/A

Stephen Hodges

Executive director
Occupation Director of corporate services, NTA
Date of appointment November 2004
Term of appointment Permanent
Year of birth 1957
Ethnic background and gender White, male
Membership N/A

Rosanna O'Connor

Executive director
Occupation Director of regional management, NTA
Date of appointment April 2003
Term of appointment Permanent
Year of birth 1950
Ethnic background and gender White, female
Membership Board member, Youth Justice Board

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