"Effective drug treatment enables addicts to turn round their lives and brings benefits not only to themselves but also to their families and society. Treatment gives individuals the opportunity to overcome their dependency and achieve abstinence..."

NTA BUSINESS PLAN 2010-11

EFFECTIVE TREATMENT CHANGING LIVES
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NHS
National Treatment Agency
for Substance Misuse

NTA business plan 2010-2011

Contents

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
W www.nta.nhs.uk

1. INTRODUCTION

THE CHALLENGE

Effective drug treatment enables addicts to turn round their lives and brings benefits not only to themselves but also to their families and society. Treatment gives individuals the opportunity to overcome their dependency and achieve abstinence, while also cutting drug-fuelled crime, improving the health of the individual and reducing the health risks to communities. The NTA promotes a balanced treatment system in which clients move as quickly and safely as possible through treatment to recovery and reintegration into their local community. We intend to take forward the government's ambition for a rapid transformation of the treatment system to promote sustained recovery and get more people off illegal drugs for good.

Drug treatment in England has already come a long way. The number of people successfully completing treatment free of dependency has increased from 9,000 to 25,000 a year; offenders are systematically referred into treatment, preventing millions of crimes each year; and the number of adults accessing treatment has more than doubled. The expansion of the system presents vulnerable people not only with opportunities to overcome their addiction, but also to increase their employability, improve the life-chances of their children, and reduce the risk of drug-related deaths.

However, the NTA recognises that much more should be done. Too often, the opportunities presented by engagement with treatment are squandered by a lack of ambition and a willingness to routinely write off the potential for dependent drug-users to assume full roles as citizens. The government's commitment to reform now provides the spur for the cultural and structural change that is necessary to rebalance the system, and ensure that successful completion and rehabilitation is an achievable aspiration for the majority in treatment. Our challenge is to implement this further transformation as speedily as possible, while continuing to provide the substantial crime reduction and health benefits that treatment currently brings to communities.

The NTA's response

This Business Plan therefore reflects the priorities of the government, the commitments in the coalition agreement, and the financial constraints facing the taxpayer. The NTA expects that during 2010-11 we will be able to reposition the treatment system to focus on sustained recovery, and demonstrate transparent outcomes, while consistently providing more for less.

The key actions identified in the Business Plan are:

- **Improving outcomes**

National and local performance will be judged on outcomes, e.g. abstinence rates, employment, and reduced criminality. We will use the evidence from the Treatment Outcomes Profile to establish clearly what services work to achieve abstinence-focussed outcomes, over what timescale, and how they are best provided on a cost-effective basis. This will be supported by smarter matching of health and criminal justice databases to ensure that individuals are sustaining their recovery after leaving treatment without relapsing into addiction or offending. Extending data-matching across government through the 'data warehouse' project will also enable us to support the delivery of complex, multiple outcomes such as getting people off drugs, off benefits and into work.

- **Better value for money**

The unit cost of treatment has fallen by 16% since 2004-5, according to the National Audit Office. We will continue to drive unit costs down by a combination of matching resource allocation to performance, progressive implementation of payment by results, and the provision of comparative unit cost data to commissioners and providers. We will work with government to ensure that the allocation of central funding is appropriately aligned to need and value, incentivising the achievement of clear outcomes.

- **Championing abstinence-focussed treatment**

No-one should be parked indefinitely on methadone or similar opiate substitutes without the opportunity to get off drugs. New clinical guidance has introduced strict time-limits to end the practice of open-ended substitute prescribing in prisons. This principle will be extended into community settings. New clinical protocols will focus practitioners and clients on abstinence as the desired outcome of treatment, and time-limits on prescribing will prevent unplanned drift into long-term maintenance. Sound evidence-based clinical judgement endorsed by clinical governance will be able to identify cases where the approach would not be appropriate, but the intent is to see a fundamental shift in the balance of treatment for opiate addiction, away from long-term maintenance towards abstinence and long-term recovery.

- **Commissioning a rebalanced treatment system**

Creating a patient-focussed treatment system means offering people the right treatment and support at the right time. It is also good value for money. Patient placement criteria will be developed to maximise access to abstinence-focussed pathways, ensure a consistent and transparent approach to the commissioning of community and residential rehabilitation, and achieve a cost-effective balance between different types of treatment. We will also develop new services and innovative responses to address new problems, ensuring that treatments are available for emerging threats such as misuse of so-called legal highs. In addition we will take steps to improve the patient experience in treatment, for example by ensuring a smooth flow between prison and community treatment, and reducing bureaucracy around multiple assessments.

- **Rehabilitating offenders**

A rebalanced and patient-focussed treatment system should still be challenging for offenders, and focussed on stopping offending. The crime reduction yield of treatment will be further strengthened by integrating drug treatment into the Ministry of Justice's 'rehabilitation revolution'. We will also work with the

Ministry of Justice (MoJ) and Offender Health to develop a model for commissioning abstinence-focussed treatment in a criminal justice setting, and to identify the most effective way to establish secure treatment facilities for drug-misusing offenders.

Each of these strands of activity will be reflected in the development of an explicit recovery-oriented vision for the drug treatment system to replace the current framework, *Models of Care for Treatment of Adult Drug Misusers*, last updated in 2006. This blueprint for change, underpinned by the latest evidence and best practice in provision, will promote an ambition for recovery that meets the needs of all addicts and their families, both those currently in treatment and those yet to be engaged.

The document and accompanying implementation activity will facilitate the transformation of local treatment systems to enshrine that greater ambition, and ensure that achieving sustained recovery from addiction is the basis of all local commissioning and service delivery in both prison and community settings.

This radical change of emphasis will be underpinned by a programme to develop the skills of practitioners. We will support the efforts of employers through the skills consortium, to improve the capability of the treatment workforce so that practitioners provide the right treatment to the right people at the right time in the right settings.

We will also improve our own efforts to engage self-help organisations and mutual aid groups in providing visibility of recovery in the system, and sustaining recovery outcomes after successful treatment.

Our aim throughout is to improve the quality of treatment, both medical and psychosocial, by offering more ambitious and individualised service responses. Building on the evidence of what is both effective and cost-effective, we will ensure that we determine what treatment is most helpful to people, given their needs and circumstances; that support is offered across a care pathway; that services for young people are appropriate; and that services in the community and prison are setting-specific.

This new approach will be delivered within the constraints of resource reductions, both in the core NTA budget and operating income. The NTA will continue to drive down costs and obtain best value for money for its own corporate services and communications, in line with the demands for further efficiency savings among all government bodies.

Looking ahead

Beyond 2012, the government has indicated it considers the key functions of the NTA would best be located within the proposed new Public Health Service to support the local delivery of drug treatment services. Details are yet to be worked out, but it is already clear the PHS would operate in a very different healthcare landscape, featuring an independent NHS commissioning board. Our focus will be firmly on the added value the NTA can bring to drug treatment, and not on our own form or structure. The coalition government has made clear that it wishes to ensure that best value is delivered from the local commissioning arrangements supporting drug and alcohol treatment. As part of the preparations for the establishment of the Public Health Service we will be working with key partners and agencies to ensure that treatment services for both drug and alcohol dependency are coordinated to the fullest extent.

Meanwhile, the NTA will contribute its expertise and experience to the cross-government task of recasting the drug strategy. As a Special Health Authority of the NHS, we will continue to support the Drug Interventions Programme for the Home Office, implement the Integrated Drug Treatment System in prisons for the MOJ, and oversee young people's drug and alcohol interventions for the Department for Education. We will also work with the Department for Work and Pensions to take forward a new approach for helping problem drug users trapped on benefits to find work and overcome related barriers to recovery like housing and mental health.

2. THE NHS CONTEXT

Drug treatment is an aspect of front-line NHS healthcare that does not fall neatly into the traditional NHS model. Many providers of treatment are private or voluntary sector organisations, working alongside GPs and clinicians in NHS hospitals or mental health trusts.

Some of the central funding comes from budgets outside the Department of Health, notably the Home Office and the Ministry of Justice. These two departments retain a key interest in the role of treatment in reducing crime and stopping reoffending. Proposals for directly elected police and crime commissioners and a 'rehabilitation revolution' in prisons will directly impact on drug treatment.

Local funding comes not just from PCTs but also local authorities, criminal justice agencies and voluntary donations to local Third Sector providers. All the local partnerships that commission treatment services include representatives from local authorities, police and probation services as well as the local primary care trust. Some of those working in the sector regard themselves as public health specialists, whose responsibility is to prevent the spread of disease and reduce harm to society as much as to cure sick patients.

Nevertheless the fact that the NTA was set up as a special health authority within the NHS was a recognition that drug treatment cannot be seen in isolation from the general provision of a comprehensive service that is free at the point of use, and based on need, not ability to pay. The new Secretary of State for Health, Andrew Lansley, is committed to the core values of equity and has an ambition to achieve excellence in outcomes as well, within the constraints of efficiency that now affect all public services. He has set out a clear vision for the NHS as patient-centred, clinician-led, evidence-driven, and resource-efficient. This has a number of implications for drug treatment.

Patient-centred

First, we need to match the aspirations of service users to overcome addiction with appropriate local treatment systems that are focussed on achieving safe and sustainable recovery. In this respect service users are no different from most NHS patients: they want to get better. We need to listen to the voices of service users and their families and carers, and ensure they are heard not only as the beneficiaries of treatment, but also as participants in the design of its delivery.

Clinician-led

Second, clinicians are crucial too. Their skills and knowledge, along with their ambition, on behalf of their patients, should shape treatment systems. We need to empower them to deliver, exercising their clinical judgement to the best of their ability and on the basis of evidence. Doctors are directly accountable to their patients for achieving demonstrably better outcomes; and those clinicians who best respond to the needs of service users will achieve the best outcomes for them. The NTA has recently boosted its in-house clinical team to offer specialist advice to the field, and we remain committed to full consultation with practitioners and providers in implementing the changes ahead.

Evidence-driven

Third, interventions and systems should be rooted in the existing evidence of effectiveness, while also seeking to innovate to further improve outcomes. The evidence-base for effective drug treatment is robust, as enshrined in NICE recommendations and the UK Clinical Guidelines. However the NHS has been criticised for being slow to adopt successful ideas and new practices. The coalition government wants to actively encourage innovation and improvement in healthcare, so that if emerging evidence says something new works, then clinicians and managers should feel free to get on and do it.

Resource-efficient

Finally, payment needs to be explicitly linked to desired outcomes if the best value is to be derived from the available resources. Everyone in the NHS understands that the decision to protect health spending does not make services immune from pressure to use the money more wisely. Increasing demand from an ageing population with ever-rising public expectations of quality will easily absorb any inflation-proofed funding. Efficiency savings will be about more than cutting management costs to reinvest in front-line services. All medical and therapeutic disciplines will have to demonstrate value for money, and adapt to a commissioning regime that pays by results.

The coalition government set out its priorities in the programme published after the general election. Some of these commitments have immediate implications for drug treatment, but other aspects of drugs policy may not become clear until ministers have had further cross-departmental discussions on strategy. Meanwhile, we already know we are entering a period of fundamental change in health and care, framed by the principles set out in white papers on the NHS and Public Health.

For example, Mr Lansley has signalled that his personal priority is to improve public health and get to grips with the drivers of NHS demand – including alcohol and drug misuse – through the development of a new Public Health Service. This would be nationally led, but locally delivered. A national strategy will set clear outcomes and measures to judge progress, but be led locally by directors of public health, working with local authorities and public health partners. As well as a ring-fenced public health budget, there would be local public health budgets and a health premium to support local strategies that deliver measureable results. The focus would be preventative interventions to improve the health of communities, based firmly on the evidence of what works, and reducing alcohol and drug misuse is likely to be one of the objectives.

The government has proposed that from April 2012, the NTA should be abolished as a separate organisation and critical

functions to support the local delivery of drug treatment systems should be integrated into the Public Health Service. While the details of this transformation are being worked out, the NTA has a responsibility to demonstrate leadership to the drug treatment field. It will play its part in moving towards a health service which puts patients at the heart of decision-making, focuses on quality and outcomes, and devolves responsibilities to make treatment available to all those who need it.

3. IMPROVING OUTCOMES

The purpose of treatment is to enable individuals to overcome addiction. This is fully achieved when someone has completed treatment and been rehabilitated back into their community as an economically active contributing citizen.

Treatment is not an instant cure: it takes time to overcome addiction, and relapse is an ever-present risk to recovery. The length of time an individual needs in treatment will vary according to their circumstances, and some entrenched users may go in and out of treatment over a number of years before they are able to sustain long-term recovery.

However the benefits of treatment to individuals and communities not only accrue on successful completion, but begin to impact on treatment commencement. Compared to those outside treatment, those in treatment are less likely to die, less likely to contract or spread blood-borne viruses, and less likely to offend.

Treatment also brings other progressive benefits, such as reduced drug use or periods of abstinence. As well as helping addicts become free of dependency, drug workers support them to be active citizens, take responsibility for their children, earn their own living and keep a stable home.

So the gains from treatment can be measured at several levels, recording the positive benefits achieved by individuals at stages of their progression through a treatment journey, leading to the ultimate goals of abstinence and long-term recovery.

Lower drug use

Treatment contributes to society's efforts to reduce overall drug use by increasing the numbers of successful completions, improving long-term rates of recovery, and inhibiting inter-generational transmission by successfully engaging parents in treatment.

The overall level of drug use in society is tracked by the British Crime Survey (BCS), supplemented by schools surveys. Levels of heroin and crack use are too low to be accurately identified by the BCS so the Home Office has for some years commissioned the University of Glasgow to undertake specific prevalence estimates for heroin and crack in England.

Successive sweeps for the years 2004-05, 2005-06 and 2006-07 showed a broadly stable position with an estimated 330,000 users of opiates and/or crack cocaine in England across the period. A follow-up estimate for 2008-09 is due to be published in October.

A more up-to-date indication of shifts in the patterns of use and addiction is available from the National Drug Treatment Monitoring System (NDTMS) data. As treatment has become readily accessible, treatment presentations have become a more reliable indicator of underlying need, enabling us to track the significant changes in patterns of use emerging over the past two years.

For example, we will continue to assess treatment capacity to ensure that the treatment needs of powder cocaine users are met. There has been a steady increase in the numbers seeking treatment over the last few years and the most recent figures show powder cocaine users now amount to 6% of the total treatment population.

Our activity will be informed by the stocktake being undertaken by the Home Office into the nature of the increase in powder cocaine use. This includes the relationship between cocaine, alcohol use and other synthetic drug use (particularly in the context of the night-time economy), the health risks of cocaine use, and the availability of common cutting agents.

The trends in the NDTMS data are encouraging. New presentations to treatment are falling, with this being particularly marked in the under 30s group. The NTA's view is that the high-water mark of the heroin epidemic which began in the 1980s has now passed, with relatively few presentations for opiate misuse among the under 25s, and a decline in presentations for heroin use generally – particularly in those parts of the country where the heroin epidemic took hold earlier.

The most recent NDTMS data, allied to data from other sources, suggests that alongside the longer-term reduction in presentations for heroin addiction, the number of crack and powder cocaine presentations is also falling. More worrying is a significant steady increase in the number of presentations for cannabis dependency particularly in the 18-24 year group. Drug markets appear to be in a state of flux. During 2010-11 we will develop the responsiveness of NDTMS to identify emerging trends as quickly as possible. This will be particularly valuable in responding to treatment need arising from 'legal highs'.

In addition to our work on illegal drugs we will also work with the Department of Health to determine the scale and implications of the use of addictive medicine, following the recommendations of the all party parliamentary group inquiry into prescription and over-the-counter medicines in June 2009.

Actions

- Publish the University of Glasgow prevalence estimates for 2008-09 – quarter 3
- Identify any emerging trends over time, and act upon these accordingly – quarter 3 and ongoing
- Assess the potential for existing data sets (e.g. NDTMS, DIP testing data) to provide real-time prevalence data – quarter 2
- Review the potential for NDTMS to alert local communities to trends in the misuse of designer drugs and 'legal highs'
- Review the scale and implications of the use of addictive medicine – quarter 4
- Review the range and availability of services to support people to withdraw from prescribed and over-the-counter medicines – quarter 4.

Improving treatment effectiveness

The Treatment Outcomes Profile (TOP) is a clinically-validated outcome monitoring tool that tracks the progress of individuals through their treatment journey. It measures drug use, the means of administration, health, social functioning and self-reported criminal activity.

The majority of treatment providers in England have now adopted TOP into routine clinical practice and a majority of services have sufficient compliance to allow local clinicians, service managers, commissioners and service users to reap the benefits.

During 2009-10 two reports on the effectiveness of community treatment, using data from TOP, were published demonstrating significant reductions in heroin/crack and powder cocaine use six months after treatment commencement.

	Abstinent	Reduced drug use	Statistically insufficient improvement	Deteriorated
Heroin[1] (13,542)	37%	31%	29%	3%
Crack cocaine[1] (7,636)	52%	12%	33%	3%
Cocaine powder[2] (5,511)	61%	11%	27%	1%

[1]Effectiveness of Community Treatments, *The Lancet* no 9697 Oct 2009
[2] Powder cocaine: how the treatment system is responding to a growing problem, NTA March 2010

During 2010-11 abstinence rates six months after commencing treatment for heroin, crack and powder cocaine users will be released quarterly (where local compliance allows), providing commissioners, providers and national stakeholders with valuable insights into the effectiveness of local systems.

Service users with TOP review after six months	Drug of misuse (service users may present with more than one)	Service users treated for problems with each drug	Service users either abstinent or with statistically significant reduced drug use	Successful impact
22,955	Opiates	20,716	13,139	63%
	Crack	7,479	4,390	59%
	Cocaine	1,835	1,240	68%

Based on NTA monthly delivery assurance report April 2010

TOP was developed as an outcome measurement to supplement the activity data collected by the NDTMS. The two data sets are being merged and joint data for 2009-10 will be published in October 2010.

Actions

- NTA to provide additional support to areas not achieving 80% TOP compliance through performance improvement plans – quarter 1 and ongoing
- Support partnerships and providers to systematically integrate TOP reports to improve local outcomes – quarter 1 and ongoing.
- Review TOP reports to ensure maximum utility – quarter 3
- Roll out TOP Tracker Tool which allows services to generate individual reports for each service user – quarter 1 and ongoing
- Provide partnerships and services with data which benchmarks TOP outcomes against others with a similar case-mix – quarter 4.
- Publish in a peer-reviewed academic journal a paper on the proposed methodology for measuring reliable change through TOP – quarter 3.

Reducing crime

Most drug-addicted offenders committed crimes on a regular basis before their drug use escalated into addiction. Generally, addiction increases the frequency of offending rather than precipitating first involvement in crime. Accessing treatment does not eliminate criminal activity but it does reduce frequency with an almost immediate impact, and this has been consistently demonstrated in studies in the UK and abroad.

There is strong evidence in relation to the effectiveness of substitute prescribing in achieving significant reductions in offending. However most of this is based on self-report.

To ensure that the crime reduction yield from treatment engagement is supported by more robust evidence, the NTA undertook a study through the University of Manchester in 2008 to match data from the Police National Computer (PNC) with NDTMS database. This took a sample of 1,476 opiate and crack users who had recently offended but had not been jailed and had started treatment in the community. The number of offences they committed almost halved the year following the start of prescribing treatment.

Offence group	Charges year before treatment	Charges year after treatment	% difference
Drugs	505	149	-70
Motoring	509	185	-63
Violence	455	215	-53
Theft (inc shoplifting)	1,252	635	-49
Total	4,372	2,253	-48

From *Changes in offending following prescribing treatment for drug misuse* NTA 2008

As part of its work to track long term outcomes, the NTA intends to undertake similar data-matching exercises on an annual basis, utilising information from progressively more clients over a longer time-frame.

Action

- Seek agreement to publish 2009-10 PNC/NDTMS data – quarter 3.

Increasing treatment completion

The key indicator for tracking progress towards improving the recovery focus of treatment systems during 2010-11 will be the numbers of adult completing treatment, having successfully overcome addiction. This has been increasing year on year since 2004-05 as has the number of adults leaving treatment free of all drugs.

	2006-07	2006-07	2006-07	2007-08	2008-09
Total number of adults leaving treatment free of dependency	8,992	11,208	13,717	18,274	24,970
Adults leaving treatment free of dependency and with no drug use at all	3,281	3,953	4,862	6,347	9,148

NDTMS annual statistics

An important focus of our activity during the current year will be to improve the performance of those local partnerships which have struggled to make as much progress as others. Areas will be supported to improve the number of service users completing treatment successfully while ensuring that this does not result in individuals being 'rushed' out of treatment before it is clinically appropriate.

Actions

- Provide 28 poorly performing partnerships with NTA support to improve successful treatment completions – quarter 1 and ongoing
- Identify a means of incentivising systems and providers to improve recorded successful completions of treatment which minimises the potential to discharge clients before it is clinically appropriate – quarter 2 and quarter 4, subject to cross-government agreement.

Sustaining long term recovery

The Treatment Outcome Profile (TOP) tracks improvement while individuals are in treatment. Tracking long term recovery systematically is difficult as cohort studies struggle to retain contact with individuals who have left treatment. To overcome this, the NTA is working with the Home Office and MoJ to anonymously match NDTMS to other government data sets to track the subsequent treatment and offending careers of those who left treatment since 2005-06. We anticipate the drugs data warehouse project will provide new insights that will enable the treatment system to target support and enable more people to recover in future.

A separate but similar piece of work using DIP and drug testing data currently under way will look at those successfully completing treatment (having overcome addiction) in 2005-06, to identify how many subsequently resume drug use and/or offending and how many do not come to the notice of police or return to treatment over the intervening years.

The chronic relapsing nature of addiction would suggest that a significant proportion of those who initially 'succeed' may eventually relapse. The medical consensus is that heroin and crack addicts take several years to overcome addiction, and spend repeated attempts in treatment before they do.

The work will also explore whether people who have been through treatment sustain their recovery and whether those who do reappear in treatment or the criminal justice system do so in the first few months after leaving treatment.

The work will provide robust evidence to add to what practitioners have argued for many years: that although drop out is usually signalled by relapse, a significant proportion of those in treatment simply walk away once it has met their clinical needs, without engaging with the formal administrative discharge process required by NDTMS.

During 2010-11 we will explore the possibility of working with other government departments, particularly DWP, to extend the data matching capacity of the warehouse to track the journeys of service users away from welfare dependency towards work.

Actions

- Seek agreement from Home Office to publish study on long-term recovery – quarter 3
- Examine the long-term recovery outcomes of clients who have left the system since 2005-06, profiling the characteristics of those clients who have not returned to treatment. Use this information to further optimise the recovery focus of the drug treatment system – quarter 2, subject to cross-government agreement
- Anonymously compare the data held on PNC for a cohort of individuals for the year before and the year after they accessed drug treatment – quarter 2, subject to cross-government agreement
- Seek agreement with other government departments to extend the scope of the data warehouse methodology – quarter 3, subject to cross-government agreement.

4. BETTER VALUE FOR MONEY

The National Audit Office's two-year investigation into tackling problem drug use concluded in March 2010 that treatment delivers value for money for the taxpayer. It cited the Drug Treatment Outcomes Research Study, finding that the benefit cost ratio for treatment was 2.5 to 1, meaning that every pound spent on treatment delivered £2.50 worth of benefits to society, mostly by cutting crime.

At the same time, the NAO found that investment was used more efficiently. The cost of funding for every adult in effective treatment has fallen by 16% in real terms over the last five years to £3,000. In a challenging economic climate, this is a healthy base upon which to build the further efficiency savings required across the public sector.

As resources tighten, the NTA will work with partnerships and providers to continue the improvements in outcomes, volume and productivity that have been apparent since 2004-05.

Matching resource allocation to performance

The pooled treatment budget for substance misuse (PTB) for 2010-11 is £406.7 million. This comprises £25.4 million for young people's specialist interventions and £381.3 million for the adult drug treatment system.

For adult treatment, 2009-10 was the third and final year of a process to introduce a new funding formula where all local drugs partnerships received funds according to the number of clients engaging in effective treatment during the preceding 12 months.

Matching resources to activity has resulted in a distribution of resources between partnerships that incentivised efficiency. During 2010-11 we will seek to identify ways to build on this to incentivise partnerships and providers to improve the number satisfactorily completing treatment without creating perverse incentives to push service users out of treatment earlier than it is clinically appropriate.

Actions

- Develop proposals to incentivise successful completions whilst avoiding perverse incentives – quarter 2
- Continue work with local drugs partnerships to ensure that the resources received are channelled to deliver best value – quarter 1 and ongoing
- Work with commissioners to improve the transparency of local investment plans to promote local accountability – quarter 3
- Seek agreement to publish an analysis of the value-for-money of drug treatment since 2001 in crime, health, re-integration and safeguarding – quarter 4.

Payment by results

Payment by results demands a radical re-conceptualisation of drug treatment commissioning. Drawing on best practice from across government, particularly the Department of Health, the Home Office, the Ministry of Justice and the Department of Work and Pensions, the NTA will work with commissioners and providers to identify workable models of commissioning which will deliver improved outcomes at lower unit costs.

Actions

- Identify best-practice across government and elsewhere – quarter 3
- Undertake a sector-wide consultation – quarter 3/4
- Develop models of practice – quarter 4.

Value improvement programme

Since 2007-08 local areas have been able to benchmark their unit costs of treatment against national unit cost data and costs in comparable areas. This has enabled areas and individual providers to reduce their costs. A value improvement tool is now being developed which links unit costs to outcomes as demonstrated through TOP, providing local areas with a value for money measure for their whole system and for each of the most common treatment pathways.

Actions

- Complete an evaluation of the value improvement tool piloting work that has been performed with a number of pathfinders across the country during 2009-10 – quarter 2
- Subject to evaluation, implement nationally – quarter 3.

Systems change pilots

As part of a commitment to improve outcomes and maximise the value for money of drug treatment, the NTA will continue to support the systems change pilots, which were launched in April 2009. The pilots were designed to test the premise that local partnerships can achieve better outcomes if they are allowed flexibility in using a range of funding streams, giving them the freedom to innovate, to tailor services in response to local needs and to allow partners to align their efforts between shared priorities and targets.

Actions

- Provide national support for project management, including the process for progress reports to the cross departmental management board – quarter 1 and ongoing
- Provide input to the national evaluation study as required, including facilitating access to relevant national data sources – quarter 1 and ongoing.

5. CHAMPIONING ABSTINENCE-FOCUSSED TREATMENT

The best available evidence suggests that tackling addiction to drugs such as heroin and crack cocaine is a therapeutic process tailored to each individual's needs and delivered by an integrated, evidence-based drug treatment system including community and residential treatment approaches.

No single form of drug treatment is effective for all people – there is no 'one size fits all' solution, no 'magic bullets' and access to a wide range of treatment options is required to respond to the varying needs of problem drug users.

This balanced approach to treatment has been endorsed by successive UK and European governments as well as the UN Offices of Drug Control (UNODC) and of AIDS (UNAIDS); the World Health Organisation (WHO) and the USA's National Institute on Drug Abuse (NIDA).

In England it is enshrined in the recommendations of the National Institute for Health and Clinical Excellence (NICE), and the Department of Health's own *Drug Misuse and Dependence – UK Guidelines on Clinical Management*.

These make clear that while substitute prescribing can be a first step in managing addiction to heroin, and should always be accompanied by psychosocial interventions, its purpose is to allow addicts to embark on the process of recovery without the pressures of procuring illicit drugs and the money to buy them; without the fear of withdrawal and the dangers of using street drugs.

Nevertheless, too many people in treatment find themselves unquestioningly maintained for a long time on opiate substitutes. While for a minority, long-term prescribing may continue to be appropriate, it should be clear to the majority at the outset of their treatment that substitute prescribing is planned to be a time-limited intervention that stabilises them as part of a process of recovery, not as an end in itself.

Those who need substitute prescribing beyond an initial time limit should, in turn, be reassured that it is only on the basis of a rigorous, multidisciplinary review of their ongoing needs.

This principle has already been applied in prisons in England following concern that the continuation of some prescriptions may be clinically inappropriate. Guidance was updated in April 2010 to limit the circumstances in which prisoners are prescribed opiate substitutes, for example to users on remand, those on short sentences, or in cases where clinicians judged there was a risk of relapse on release.

The revised guidance made clear that prisoners serving sentences of more than six months should be expected to work towards becoming drug-free. To facilitate this, any prescription regime must be reviewed every three months, at which point alternative options for treatment should be considered, and a written record kept of the decision.

Adapting this approach to community settings will be a radical reform of the treatment system and needs to be undertaken with the full support of clinicians if it is to be successful. The NTA will consult widely with clinicians, service users, academics, commissioners and others on how these reforms can be implemented and will convene an expert group of clinicians and other interested parties to develop the guidance.

The objective is to make the system more dynamic. We do not want to allow service users to drift into long-term maintenance prescribing without effort being made to promote beneficial change in their lives. This is not about pushing people out of treatment too early, with the associated risk of relapse and a return to a life of addiction and crime and for some the risk of overdose and death, but ensuring that long-term maintenance prescribing is not the default position.

Service users come into treatment wanting help to beat their addiction and get on with their lives. We need to respond to this ambition by creating pathways through and out of treatment into recovery that are safe, evidence based, clinically effective and sustainable.

Actions

- Expert Group to be convened – quarter 2
- Interim report – quarter 4.

6. COMMISSIONING A REBALANCED TREATMENT SYSTEM

The goal of all treatment is for drug users to become free of addiction and fully recover. While the treatment system in England has improved dramatically in terms of penetration, prompt access, low drop-out and successful discharges, further work is now required to ensure that recovery from dependency is the bedrock of all commissioning and provision.

In particular, improvements to the foundation of good quality, personalised, care-planned treatment that takes account of the whole family are required to enable the ambitions of service users and their families to be met and the welfare of the children of drug misusing parents safeguarded. In order to maximise the impact of treatment this should include reintegration interventions and mutual aid approaches.

The NTA has been working informally with the field to develop an explicit recovery-oriented vision for the drug treatment system to replace the current framework, *Models of Care for Treatment of Adult Drug Users*. This was last updated in 2006 and therefore does not take account of significant recent developments such as the development of NICE guidance, the NTA's own emphasis on moving clients safely through the system, and the increased aspirations and expectations for recovery and reintegration among users. Many local partnerships are already reconfiguring their local systems to put more emphasis on outcomes in anticipation of a public consultation on the new approach.

The proposed new framework will also give the treatment system the flexibility to reflect changing patterns in drug misuse, as the traditional predominance of heroin and crack users in the treatment population is challenged by users of other drugs. According to the United Nations Office on Drugs and Crime, the UK is now the largest cocaine market in Europe, accounting for almost a quarter of the cocaine user population on the continent. The World Drug Report 2010 observed that this prevalence level is higher than the United States, and while cocaine consumption in the US and other major European countries is declining, it is increasing in the UK. Since substitute prescribing is not an option for treating cocaine addiction, the NTA believes these developments underline the importance of ensuring that local systems in England are able to commission sufficient access to the psychosocial interventions recommended by NICE.

Supporting local systems

The NTA currently has responsibility for overseeing a system in which drug treatment services in England are commissioned locally by 149 partnerships containing representatives from the primary care trust, local authorities, the police and probation service. The NTA's role is to ensure that these partnerships accurately assess the local need for drug treatment and commission an appropriate balance of quality provision, in line with national clinical guidelines for evidence-based treatment and the government's drugs policy.

In the past this role has been discharged through a performance-management framework in order to meet specific national targets. In addition the central drug treatment budget has been ring-fenced in order to minimise the risk of disinvestment at local level. In future, the coalition government has signalled it wants to move towards a decentralised system which emphasises local autonomy and local accountability.

The information captured in the TOP tool comes from the relationship formed between user and clinician. In the future, those relationships and associated information become the critical building block for treatment systems. They, along with the information provided by the NDTMS database and the TOP tool provides the means by which services can be held to account by local partnerships and communities. Alongside this vital local management information, the NTA's role is to ensure comparability and consistency in the data, along with supplying advice and guidance to partnerships so they can adapt to their local circumstances, enabling them to rise to the challenge of creating and operating a devolved treatment system.

Actions

- Publish a new recovery-oriented framework moving drug treatment on from the *Models of Care* approach to a modern decentralised system which meets the hopes and ambitions of service users and their families to recover from their drug, or drugs, of addiction – quarter 1 and ongoing.
- Work with local drugs partnerships to implement the guidance document *Commissioning for Recovery* to refocus treatment systems towards recovery and reintegration principles – quarter 4.

Innovation in the community and residential treatment system

The debate about recovery and reintegration is hampered by the fact there is currently no consensus as to how treatment should distinguish between those requiring long-term treatment and those who could be safely and quickly moved to abstinence. Similarly we do not have a consensus about who will benefit from residential treatment. While local needs assessments enable local areas to understand the pattern of misuse among their drug-using populations, they don't tell us which individual drug users would benefit best from which service models.

In recent years the NTA has sought to make the most of international best practice, and in particular worked closely with Professor Dwayne Simpson of the Texas Christian University in the US on developing talking therapy interventions through the International Treatment Effectiveness Project, now being rolled out in England after successful trials in Manchester and Birmingham.

Since then, the NTA has been studying a model developed by the American Society of Addiction Medicine to match individual clinical need as closely as possible to the location, intensity and duration of the treatment that is most likely to be effective. 'Segmenting' the English treatment population in this way would enable commissioners and providers to signpost clients towards the right package of care-planned treatment to promote their recovery.

A respected independent addictions researcher, Dr David Best of the University of the West of Scotland, has been contracted to undertake the first phase of this work, and an expert group convened to oversee it, with the intention that segmentation will be incorporated in the proposed new recovery framework to replace Models of Care.

The next stage is to convene a wider steering group to develop a clinical consensus around new patient placement criteria, taking into account positive aspects of the individual's potential to recover, rather than focussing solely on their limitations and problems. Starting with residential options, the project would eventually cover all aspects of treatment, including currently under-utilised options such as the supervised consumption of Naltrexone for those wanting support in remaining abstinent.

Patient placement criteria have the potential to maximise access to abstinence-focused pathways, ensuring a consistent and transparent approach to the commissioning of community and residential rehabilitation, and achieving a cost-effective balance between different types of treatment. Meanwhile, NTA locally based staff are working with partnerships to recast the nature of existing local structured day services so they offer more counselling and abstinence-focused support in a therapeutic setting, thus emulating the successful model pioneered by community rehabs.

The NTA will also monitor the emergence of new threats and problems, such as the prospect of increasing dependency on so-called legal highs or manufactured alternatives to conventional illegal drugs, with a view to develop new services to address the problems they cause.

We will also learn lessons from what works in the wider public health field, where smarter incentives have shown to be an effective way of encouraging people to adopt healthier lifestyles, particularly among disadvantaged groups. For example, the NTA tested how different forms of treatment incentives might be implemented in England. The demonstration sites are currently sharing their experiences with a major independent research project being undertaken by the National Addiction Centre into the application of contingency management principles.

Actions

- Convene an expert advisory group to develop patient placement criteria for national consultation – quarter 3
- Pilot the approach in selected parts of the country to refine the effectiveness of the criteria – quarter 4
- Ensure adequate integration of community care assessment and associated funding processes with drugs partnership commissioning of Tier 4 to facilitate improved recovery pathways – quarter 2 to quarter 4
- Continue to work with providers of residential rehabilitation services to support improvements in access, relationships with commissioners and service quality – quarter 1 and ongoing
- NTA local staff to support partnerships to enhance responsiveness to changing patterns of use (e.g. legal highs) – quarter 3.

Local management information

NDTMS provides management information which is fundamental to the local delivery of effective drug treatment and high quality outcomes. NDTMS underpins local needs assessment, commissioning, resource allocation, local performance management, value for money, and accountability.

To further increase the utility of the data, the NTA has commissioned Manchester University to provide an interactive website (Viewit) where stakeholders can use data to produce local geographic maps and tools to enhance the transparency of the data. It will also contain a function that allows partnerships to benchmark themselves against areas with similar characteristics.

Compliance with NDTMS from locally commissioned community services is excellent, underpinned through local contracts.

Much residential provision is purchased outside the commissioned drug treatment system and some providers do not routinely comply with NDTMS which greatly inhibits local planning and the ability to track outcomes. The bodies representing most residential providers have agreed to work with the NTA to improve NDTMS returns.

Actions

- To release a fully functioning prototype of Viewit for use by stakeholders – quarter 2
- Working with the representative bodies of residential providers NDTMS regional teams will seek to improve the accuracy and reliability of data from the residential sector – quarter 2 and ongoing.

The role of mutual aid

Mutual aid groups have a long history in helping service users achieve recovery, providing hope, creating ambition and supporting each other to remain drug free and integrate into society.

There are many pathways to recovery; some people may be able to overcome their problems without the need for formal structured treatment whereas other will need more intensive packages of care. In order to meet the diverse needs of our client group, the treatment system needs to become better integrated with the wider supportive services that already exist within the local community. Mutual aid organisations have a prominent and supportive role in helping people overcome their substance misuse problems, reintegrate into the community and sustain their recovery for the longer term.

The NTA has sought to embed the service user voice within the system, to help shape local systems and services. However, there is significant scope to enhance the influence of the mutual aid movement in this dialogue.

Clients who engage with mutual aid organisations in combination with structured treatment often have a better treatment experience, are in treatment for a shorter period, become less dependent on professional services for support and visibly model the potential for recovery to their peers. They offer a

practical demonstration of how social psychology can achieve improvements in public health, giving positive expression to recent research that suggests public policy can harness the potential for people to be deeply influenced by the behavior of those around them – the so-called social domino effect.

During the coming year the NTA will work with the field to facilitate better access to community resources and mutual aid support groups/organisations through greater publicity, supporting the continued development of local peer support groups and increasing the quality of the interface between drug treatment and community based services.

NTA local teams will promote the potential for mutual aid contribution to recovery to be incorporated into local systems.

Actions

- Regular consultation with mutual aid groups to inform NTA national policy – quarter 1 and ongoing
- Facilitate better communication and joint working between professional treatment services and mutual aid organisations – quarter 1 and ongoing
- Support the development of a mutual-aid directory, to be published in *Drink and Drug News* (DDN). This aims to publicise both local and national peer support based organisations and encourage participation and further developments of such groups – quarter 3
- Support service users and mutual aid groups to develop a national voice to enable their perspective to shape service delivery – quarter 3.

7. RECOVERY AND REINTEGRATION

Recovery is much more likely to be sustained if individuals are supported by their families and communities, are in work and have stable accommodation. The NTA is keen to unlock the potential for families and significant others to play an important supportive role in the recovery of individuals, through their greater involvement in treatment where this is appropriate. Additionally, the NTA encourages effective support services for family and carer groups in their own right.

The coalition has signalled it recognises the centrality of ending welfare dependency and giving service users a stake in society, and the Department for Work and Pensions (DWP) will be leading on this. However, in a locally-led system, the political argument (that supporting drug misusers into employment and stable accommodation is to the benefit of the whole community, even if it is unpopular) has to be won in each community, not just in Whitehall. The NTA can support local partnerships, commissioners and providers in their engagement with their communities.

The DWP is currently revising its strategy for working with substance misusers to support them into employment. Building on the closer working arrangements between the NTA and DWP, the treatment sector and Jobcentre Plus, the NTA will continue to work closely with any new departmental initiatives, most likely to be implemented from April 2011.

There will be an increased focus in any new approach on supporting substance misusers into employment and in engaging with employers to break down barriers towards employing stable and recovered drug users.

The NTA's focus in addressing housing need will be through local partnerships via the local teams. The NTA will work over the course of the next year to develop stronger links between each of the local authorities with responsibility for providing accommodation services and drug partnerships to promote the case for ongoing prioritisation of need through key levers such as the joint strategic needs assessment and other local strategies. We will seek to demonstrate that the provision of adequate housing support for those overcoming their addiction is likely to benefit the whole community in terms of reducing crime, anti-social behaviour and providing a better family environment for the children of service users.

Although the focus of activity will be on influencing central and local government partners, communities, employers, social landlords and the private rented sector, the measure of success will be an increase in the proportion of service users who are in work, education or training and a decrease of those in inappropriate accommodation. This will be tracked and reported through TOP and through anonymised central data matching between NDTMS and DWP data.

Actions

- Work with DWP to develop and implement a new employment strategy in line with the government's wider plans for welfare reform – quarters 2 to 4.
- Work with DWP in segmenting the treatment population and providing tailored support for drug users at differing distances from the labour market – quarter 3.
- Agree joint working protocols with Jobcentre Plus for the treatment sector and Jobcentre Plus to work more closely in order to support drug users in treatment into employment – quarter 3
- Work with Jobcentre Plus, DWP and other stakeholders to agree a strategy for engaging employers and breaking down barriers in the labour market faced by stable and recovered drug users – quarter 3
- Formalise data sharing requirements with DWP and agree a set of outcome-focused reintegration indicators – quarter 3, subject to DWP agreement
- Publish clinical reintegration guidance for treatment keyworkers which aims to raise the treatment sector's employment aspirations of service users – quarter 4
- Agree a programme of housing-related work with local authorities via NTA local teams, supported by the Local Government Association – quarter 3.

8. SKILLS AND PRACTICE DEVELOPMENT

The NTA is committed to harnessing the ideas, energy and talents of the field to develop community and residential rehabilitation and treatment services. The workforce needs to be able to respond to the recovery ambitions of service users and continually develop the competencies needed to deliver appropriate psychosocial and medical interventions. As part of the NTA's commitment to supporting front-line expertise, in 2009 we convened a National Skills Consortium to take ownership of a workforce strategy and a national programme to deliver the recovery agenda. In 2010-11, the NTA will support the consortium to develop a national skills framework, describing the competences needed to deliver treatment throughout a drug user's journey to recovery. The framework will form the basis for a new online gateway to practical tools that drive successful outcomes, improving the quality and impact of drug treatment. This resource will be owned by the consortium and the sector and will give the field the opportunity to share good practice and work together to develop new recovery orientated interventions.

The NTA's new skills and practice development team will work with the consortium and other stakeholders to develop tools that improve the quality and impact of clinical practice, particularly the psychological and social components of treatment, which we see as central to recovery. The work will also focus on improving the interface between treatment services and community based recovery networks. This work will be a priority for the NTA in 2010-11.

Our work on patient placement criteria (page 13) has important implications for the drug treatment workforce. Segmenting the treatment-seeking population on the basis of clinical need will give a clearer picture of the blend of qualifications and skills required at a local level. This has the potential to recast the role of local commissioners, moving them away from a 'shopping list' approach (ensuring they have one of each service type available) to ensuring there is an appropriate skills mix within their locality.

Actions

- Support the national skills consortium to develop a national drug treatment skills framework which contributes to the recovery agenda and underpins a new operating framework – quarter 2 and ongoing
- Support stakeholders to review and update guidance on the roles and responsibilities of clinical staff – quarter 4
- Develop a range of toolkits, manuals and protocols to support better practice and improved interventions – quarter 4
- Continue to support professional networks, including the Specialist Clinical Addiction Network (SCAN) and Substance Misuse Management in General Practice (SMMGP) – quarter 1 and ongoing
- Positively engage with the relevant professional bodies to appropriately engage them with the skills and recovery agenda – quarter 1 and ongoing.
- Ensure the patient placement criteria take account of implications for workforce development – quarter 3 and ongoing.

9. REHABILITATING OFFENDERS

Drugs and crime are inextricably linked. The cost to society of problem drug use is about £15 billion a year, 90% of which is attributed to drug-related offences, mainly acquisitive crimes such as shoplifting, theft and burglary committed by heroin and crack addicts. Estimates suggest that drug addicts commit between one third and a half of all acquisitive crime in this country, and some also support their addiction through low-level dealing or prostitution.

The drug-crime link is so well-established that it is often assumed that it works simply by law-abiding individuals becoming drug dependent and turning to crime to support their habit. In reality, many individuals will already have an established offending lifestyle through which they are exposed to drug use. They then become dependent, and the addiction leads to them committing higher volumes of acquisitive crime.

Successful treatment will help these people overcome addiction, and therefore reduce their offending, but it will not necessarily make them crime-free. Instead they will often revert to their pre-dependency level of offending. Making a further step towards an offending-free lifestyle will often hinge on addressing their offending behaviour through Criminal Justice System interventions and wider reintegration issues such as housing, employment, alcohol use and other behavioural factors.

Research has consistently shown that drug treatment leads to significant reductions in offending. The most recent Home Office study, the Drug Treatment Outcomes Research Study published in December 2009, recorded a 40% reduction in offending on entering treatment, and even bigger reductions in illegal drug-use. The scale of these benefits fell after leaving treatment, but remained significant. The findings and associated economic analysis of the cost-effectiveness of treatment were endorsed by the National Audit Office inquiry in March 2010. The NAO acknowledged that the savings made from reductions in offending exceeded the cost of treatment received by a ratio of 2.5:1.

For heroin and heroin/crack users the most immediate impact on offending is delivered through access to substitute prescribing and this reduction tends to be sustained while the individual remains in treatment.

As the treatment system moves towards a greater focus on treatment completion and abstinence it is important that we balance the community benefit of crime reduction with the moral obligation to enable as many addicts as possible to overcome their addiction and become drug free.

Every time an individual leaves treatment successfully there is an opportunity to leave their offending and drug-using career behind them, but also a risk of relapse and a return to the level of offending that preceded treatment entry. This should never mean that individuals are held in treatment to prevent re-offending but it does demand that we do not push people to leave treatment before it is clinically appropriate for them to do so, in the same way the Secretary of State for Health has recently highlighted the rise in emergency readmissions to hospital because of pressure to cut the length of patient stays.

The NTA believes that this balance is most effectively achieved by using the range of treatment options available to achieve sustainable outcomes both in terms of recovery from drug dependency and long-term reductions in offending. The implementation of the Integrated Drug Treatment System in prisons, the further development of the Drug Interventions Programme, and the introduction of Integrated Offender Management provide a solid basis for achieving the government's aim for a 'rehabilitation revolution' and we will work with the MoJ and other partners to realise this ambition.

Promoting recovery in prisons

Revised clinical guidance in April 2010 limited the open-ended prescribing of methadone in prison and marks a significant step towards placing a greater emphasis on abstinence. There is now a clear expectation that opiate dependent prisoners spending any significant period of time in custody will be stabilised, safely detoxified and released drug free into the community, where their ongoing treatment and reintegration needs can be effectively addressed through offender management.

Sentencing reform

The NTA will work with the Ministry of Justice to develop community sentences with a recovery focus and a greater emphasis on achieving sustainable freedom from dependency. We are particularly keen to develop in community settings the time-limited approach to substitute prescribing in prisons, where open ended maintenance regimes are only used in exceptional circumstances.

Actions

Prison-based treatment

- Complete the implementation of the Integrated Drug Treatment System (IDTS) in all English prisons – quarter 4
- Undertake a quality improvement project to promote good practice in relation to the management of prisoners on substitute prescribing regimes, ensuring that there are regular reviews of methadone prescribing, and that individuals are encouraged to become drug-free whenever this is clinically appropriate – quarter 1 and ongoing
- Complete the prison data quality programme to provide NDTMS compatible data that accurately reflects IDTS activity throughout the course of the prisoner's treatment journey – quarter 2, subject to ministerial agreement
- To use the NTA's involvement in the Prison Drug Treatment Strategy Review Group to promote and encourage the development of an integrated locally commissioned model for delivering evidence-based drug treatment, focused on recovery and reintegration – quarter 2 and ongoing, subject to endorsement of the Patel Review

- To ensure that the effective reintegration and rehabilitation of drug using prisoners as they move between custody and the community is fully integrated into the proposed new national drug strategy, to maximise crime reduction and public health outcomes – quarter 2 and ongoing.

Community-based criminal justice interventions

- Work with local drugs partnerships to implement the new Drug Interventions Programme delivery model to deliver more robust and effective case management processes that will maximise the prospects of drug-misusing offenders successfully reintegrating into the community – quarter 1 and ongoing
- Ensure Routes to Recovery is applicable in criminal justice settings – quarter 4, subject to cross-government agreement
- Work with the Home Office to produce more streamlined and outcome-oriented performance management information to support the Drug Interventions Programme – quarter 4, subject to Home Office agreement
- Contribute to NOMS' delivery review of Drug Rehabilitation Requirements – quarter 1 and ongoing, contributing to the development of new community sentencing to address drug and alcohol misuse.

10. FAMILIES

The coalition agreement contains a commitment to develop "a new approach to families with multiple problems" including substance misuse. Substance misuse by parents (and associated behaviour) is identified as a significant risk factor to children reaching their potential, particularly educational achievement. Adult treatment services and children/family services need to collaborate in order to identify, assess, refer, support and treat adults with the aim of protecting children and improving their outcomes.

Having children is a motivating factor for adults to enter treatment, and having parents in drug treatment is a protective factor for children. Parents enter, are retained and successfully complete treatment at a similar level or better than the whole treatment population. The NTA intends to offer evidence to the Munro review into child protection.

Child protection referrals have increased over the past two years and substance misuse services are one of the most frequent sources of referral. One in three of the treatment population have a child living with them at least some of the time, and therefore working with this group is mainstream activity for treatment providers and commissioners. A cultural shift is in process to orientate services to have a stronger focus on the whole family approach rather than an exclusive focus on the adult service user in front of them. To support this, there is a need to increase the confidence of the drug treatment workforce in this area to ensure the best targeting of resources to both strengthen families and protect children.

Thresholds for referral to children/family services and the range of those services provided are determined at a local level requiring collaboration by frontline staff supported by local strategic agreement. Although substance misuse is a factor in a majority of serious case reviews, often the parents have not accessed treatment, indicating a corresponding need for children's social care staff to be better able to identify need, assess and refer into drug treatment.

The NTA continues to work in partnership with the Department for Education (DfE), with jointly funded posts and shared work programmes. Joint guidance was launched last year on developing local protocols between drug treatment and children/family services, and a recent audit showed that 26% of partnerships had already developed a protocol, with another 44% to be completed by the end of 2010. NTA local teams are working with the remainder to support acceleration of progress, to quality assure existing protocols and identify and spread best practice.

Actions

- During the coming year the NTA will lead work on embedding the whole family approach within treatment systems focussed on recovery and will work with DfE to better understand the referral flows from drug treatment into children's' social care – quarter 2 and ongoing
- NTA to provide evidence to the Munro Review – quarter 3
- Work with the DfE to provide joint strategic leadership in order to encourage and support collaboration between drug treatment and safeguarding provision as a priority by both sectors – quarter 1 and ongoing
- Support drugs partnerships in determining their local priorities for drug misusing parents within their needs assessment, planning and delivery activity and use appropriate opportunities to share effective practice – quarter 3
- Maximise opportunities for appropriate knowledge/skill development for the children/family and drug treatment sectors in order to support local delivery – quarter 4.

11. YOUNG PEOPLE'S INTERVENTIONS

Unlike adult service users, whose lives and identity can be defined by their addiction, very few young people (under 18) develop dependency. Those who use drugs and/or alcohol problematically are likely to be vulnerable, experiencing a range of problems, of which substance misuse is one.

This means that the commissioning and delivery of specialist drug/alcohol interventions for young people should take place within wider children and young people's planning rather than in a drug/alcohol specific silo. The aim is that all needs are met, rather than substance misuse in isolation, before problematic use becomes entrenched.

Issues

The needs of young people, their substance misuse and the services that are provided for them, differ from adults in a number of ways:

- The vast majority (90%) of young people who access specialist drug/alcohol services have problems with alcohol and/or cannabis. They require psychosocial, harm reduction and family interventions rather than the treatment for addiction required by most adults and a small minority of young people. Only 3% of young people in treatment require help with heroin/crack and the aim of treatment for them is abstinence via detoxification and counselling
- Young people's drug misuse contributes to a range of health and social problems including poor educational outcomes, exclusion from school and involvement in crime
- Wider services within schools and youth services aim to address substance misuse before it reaches the point of requiring specialist treatment
- Most young people need to engage with specialist drug/alcohol interventions for a short period of time before continuing with further support from children's services, within an integrated young people's care plan which addresses wider family, health and educational needs.
- Most young people are referred to specialist drug/alcohol interventions by agencies they have contact with (primarily youth justice and children's services) rather than by their families or themselves
- There are widely different numbers in treatment in similar partnerships, owing to varying thresholds for entering treatment, in turn dependent on the local system design and local prioritisation
- The very few young people with complex needs receive a package of care (e.g. foster care, substance misuse treatment, child and adolescent mental health services) close to home, in order to ensure continuity of care rather than substance misuse specific drug/alcohol residential treatment.

While there has been significant progress in improving specialist drug and alcohol interventions for young people since 2007, there is a continuing need to support local areas to understand their individual pattern of need, how to integrate drug and alcohol interventions into wider children's services, and how to deliver value for money.

Actions

- Segment the current treatment population to identify different levels of vulnerability demanding different levels of response – quarter 2
- Collaborate with DfE to review the value for money of current provision – quarter 2
- Improved needs assessment data to be made available to local areas to improve targeting and transition to adult services for 16-20 year-olds – quarter 2.

12. ACCOUNTABILITY

The NTA recognises that explaining what drug treatment does, and how society benefits from it, enables the system to be accountable to the public for spending taxpayers' money on front-line treatment services. Our updated engagement strategy – approved by the NTA Board in March – aims to build the reputation of evidence-based drug treatment, through a programme of positive and pro-active engagement with staff, stakeholders and opinion-formers to promote the benefits of a balanced drug treatment system.

In a decentralised treatment system, accountability is ultimately best delivered at local level. So in the coming year, the NTA will focus its efforts on empowering and enabling those who commission and deliver services to be accountable to their respective stakeholders and public. Local teams will be helped and encouraged to maximise local engagement opportunities, through advice, support and training.

Meanwhile, as people's expectations of public services continue to rise, the integration of a policy and information function within the communications team will enable the organisation to improve transparency by providing accurate information and accessible explanations, including supporting Parliamentary Questions. The new unit will also take over responsibility for cross-cutting projects such as updating for DH the *Dangerousness of Drugs* document.

Utilising research findings on stakeholder attitudes, the NTA will continue to develop new ways of engaging partners in the delivery of a recovery-oriented drug treatment system that enables the reintegration of drug users into society.

At the same time, on the back of research findings into public perceptions, the NTA will refine and disseminate its narrative explaining how drug treatment benefits the whole of society, emphasising that abstinence is the goal of treatment and explaining how users are actively moved through treatment into recovery.

The key delivery outputs of the business plan and other opportunities will be used to promote the effectiveness of drug treatment, and demonstrate to the public how it provides value for money.

Actions

- Build on the success of the intranet (The Hub) as an internal communications tool to further equip regional teams to engage successfully and extensively with stakeholders and public at a local level. Audit of internal communications – quarter 1. Equip regional teams – quarter 2
- Introduce regular Office for National Statistics (ONS) statistical bulletins alongside existing NTA themed reports to further improve the flow and transparency of published information about drug treatment services
- Use the findings of the NTA stakeholder audit to host an ongoing series of policy seminars and regional visits to share insights and intelligence with the field, and inform and influence opinion formers
- Create and maintain a comprehensive electronic library of accurate and accessible policy information and data on drug treatment for use in all external communications.

13. CORPORATE SERVICES

The NTA aims to ensure it makes best use of staff through effective HR, efficient use of finance and resources as well as effective IT and information systems. It continues to improve, develop and embed sound systems and processes across corporate services, and external and internal audit reports reflect this.

During 2009-10 the NTA undertook a number of internal reviews of its operations, including a restructure of the delivery arm of the business, to ensure that resources were used to maximum effect. A review of IT also identified a need for additional staff resources due to the expansion and complexity of the infrastructure and the relative historical low level of staffing.

An external review of the human resources function was undertaken by the auditors RSM Bentley Jennison to ensure the NTA could meet organisational expectations and deliver a good quality of service across the board. The review recommendations are reflected in the delivery outputs for HR in 2010-11.

In 2010-11 corporate services will continue to meet the challenges of budget reductions, and the need to maximise resources and obtain best value for money. The NTA core Grant in Aid (GIA) budget will reduce by approximately 8% in 2010-11 compared to 2009-10.

Some decisions on how the reduction will be implemented have already been agreed, including freezing vacancies in line with government policy, as well as making significant economies across a number of budget heads. Corporate services will continue to ensure that it operates efficiently and effectively in line with expectations on all arms-length bodies (ALBs), for example meeting the challenges of tighter finance and reporting standards, and tighter deadlines in meeting auditing outputs.

Human resources

Considerable demands are made on the relatively small HR team, which is implementing the recommendations of the internal audit. These include some clearer HR processes and policies, improvements in communication and interface with staff, and restructuring the team on a business partnership model. The report also recommended an additional HR advisor post. Responsibilities for payroll transferred to the finance team from April 2010. HR will continue to carry out monitoring and provide performance management information on sickness absences, recruitment including equal opportunity and diversity monitoring.

Actions

- Implementation of the recommendations of the HR review – quarter 1
- Re-evaluation and post-pilot roll-out of the revised appraisal scheme from 1 April 2010 – quarter 1
- Review and update of HR policies and procedures – quarter 1 and ongoing
- Development of performance SLAs with NTA operational departments – quarter 1
- Transfer of the payroll function from HR to finance and development of clear service specifications between the two teams – quarter 1
- Training for key NTA managers will be provided on a range of core HR activities during 2010-11 – quarter 1 and ongoing.

NDTMS programme office, IT team and software development team

A new information management and technology team is now in operation, responsible for managing the NDTMS programme office, supporting and further developing NDTMS systems and providing and supporting IT services for NTA staff.

The NDTMS development function has carried out a fundamental restructuring of the NDTMS software system to enhance and improve the service to users and speed up information flow. Further development will be undertaken in 2010-11 including changes to the core data set.

The IT department will be rolling out new software and hardware to much of the organisation in 2010-11, as well as upgrading the technical infrastructure of the organisation. The IT strategy will be reviewed again in 2010-11 in the light of IT development initiatives and changes.

Actions

- Develop a long term plan for NDTMS – quarter 3
- Implement agreed changes to NDTMS core data set (version G), and agree changes for 2011-12 with partners – quarter 3
- Support migration of regional and national software tools based on legacy NDTMS systems – quarter 4
- Develop Drug and Alcohol Monitoring (DAMS) system to:
  - Extend scope, speed and accuracy of data validation reporting – quarter 1
  - Automate routine reporting, including quarterly performance monitoring and TOP reports (drugs only) – quarter 1
  - Publish and implement XML interface with suppliers – quarter 2
- Develop Data Entry Tool (DET) in collaboration with user group to improve ergonomics and utility to clinical services – quarter 1 and ongoing
- Work with the NHS Information Standards Board (ISB) to align core data-set changes with publication of Data Set Change Notices – quarter 1
- Ensure compliance with United Kingdom Statistical Agency (UKSA) Code of Practice within NDTMS programme – quarter 1 and ongoing
- Ensure NTA compliance with the Cabinet Office Information Governance Assurance Programme (IGAP) – quarter 1 and ongoing
- Agree and implement long term archiving solution for NDTMS data – quarter 3.

Accommodation, estate and facilities

The NTA head office is in Skipton House under a Memorandum of Tenancy Occupation with the Department of Health. The NTA

does not hold any leases or have an estate portfolio. Head office staff at Skipton House occupy on average 7.4 square metres per member of staff, compared to the benchmark target of 10 square metres.

The NTA will review its SLAs with regional government offices for the accommodation occupied by NTA regional teams, some of which may have to relocate as a result of regional government office changes. The NTA will review the cost effectiveness of the arrangements as part of a wider efficiency review.

Actions

- Review of the SLAs with regional government offices with a view to reducing costs through either a reduction in desk space or moves to alternative premises – quarter 3.

Finance, administration and business processes

The NTA resource allocation for 2010-11 is £10,467,000, a reduction of approximately 8% compared to the approved budget in 2009-10, a cash reduction of £700,000. The reduction, together with an increase in some costs over which the NTA has no control, means that this will be a very challenging year.

Economies include evaluating the necessity for posts and the freezing of vacancies as necessary. Running costs are being reduced, including travel, subsistence, and conference expenditure. The size of the reduction is significant for the NTA and measures have been put in place to closely monitor expenditure to ensure that the budget balances at year end.

In addition to the Grant in Aid (GIA) funding, the NTA is anticipating a further £10,609K operating income to cover costs of DIP, Non-Intensive DIP, IDTS, system change pilots and harm reduction there will also be other general income such as secondments. The total budget for 2010-11 (GIA, depreciation, operating income and secondments) is therefore estimated at £21,420K.

Actions

- Ensure that the transfer of the payroll function from HR takes place and operates effectively – quarter 1
- Contribute to the development of service level agreements in conjunction with HR to ensure clear process exist in running payroll system – quarter 1
- Continue to update and review finance systems and processes, making changes as necessary – quarter 2
- Review and update NTA financial regulation documents for submission to the NTA Board – quarter 3
- Ensure that a programme which reflects NTA needs is constructed for internal audit – quarter 1
- Review and monitor all aspects of NTA resourcing and ensure value for money. Completion of phase one – quarter 1. Phase two – quarter 4.

NTA resources - productivity and corporate efficiencies

The NTA continues to ensure that the organisation runs efficiently and effectively. An Operational Efficiency Programme (OEP) exercise in the autumn of 2009 required all public sector organisations employing more than 250 people to provide data on back office operations. Although the NTA has fewer than 250 staff, it contributed towards the exercise providing information on finance, IT, HR, procurement and estates.

Despite being a relatively small organisation, the NTA has a wide range of responsibilities which place a significant burden on time and resources. The scope for further reductions within some corporate services functions, particularly staffing, is limited if the NTA is to meet the demands made on it by its numerous interested parties.

Information technology capacity and efficiency

The NTA IT function has always compared favourably with arms length body targets of an annual cost per internal user of less than £5K. In 2009-10 the total IT spend accounted for 2.1% of total NTA expenditure which equates to spend per NTA user of £2,090.

Shared business services – finance and payroll

NHS/Steria Shared Business Services (SBS), used by the NTA since 2004, provide financial and payroll services. Total costs for the NTA finance team were estimated at 1.6% of total NTA expenditure in 2009-10, higher than the suggested 1% proposed as part of the OEP. This will be reviewed as part of the ongoing finance review in 2010-11.

Business continuity

The NTA reviewed its business continuity plan in the summer of 2009 and undertook a proactive exercise on planning for a potential flu pandemic. The business continuity plan was updated and revised and agreed by the NTA Audit and Risk Committee in July 2009. A further proactive exercise to test the plan will be undertaken during 2010-11.

Human resources

The costs of the HR function in 2009-10 amounted to 1.3% of total NTA expenditure giving a ratio of 46 employees to HR staff. This is higher than the benchmark level of 1:77 proposed within the OEP exercise. This will be reviewed in 2010-11. Increased workloads within HR as a result of organisational restructuring, recruitment, new initiatives and centrally driven projects place considerable pressure on the function. HR has responsibility for the production of a range of key organisational targets including recruitment, staff turnover, training and development and staff appraisal. Sickness absence within the NTA was an average of six days per member of staff in 2009-10.

Governance, risk and controls

The NTA continues to maintain high levels of corporate governance and internal controls. Business performance is measured through a variety of corporate monitoring processes including regular monthly performance management tools and budget reports to staff, the Senior Management Team (SMT), and the NTA Board. The SMT is formally held accountable by DH officials and other Whitehall partners on a quarterly basis, with regular sign-off by ministers and an annual accountability meeting.

Both external and internal audit reports indicate that the NTA is successful in improving performance, and has either substantial or adequate assurances across a range of audited functions, including core financial controls, risk assurance and risk maturity audits and operational functions. The NTA operates software developed by internal audit to monitor risk and strategic high level risks are reviewed regularly by the SMT, Audit and Risk Committee and Board. Ongoing work is continuing to further integrate risk management processes across all teams including further training.

Information governance

During 2009-10 considerable work was undertaken to meet the requirements on information governance and security. Good progress has been made on this, though a recent audit undertaken by NTA internal audit has made a number of recommendations to further improve compliance. These are presently being auctioned.

Sustainable development

During 2009-10 work on the implementation of the NTA sustainability policy began and will be progressed in 2010-11 though the scope for this is limited due to NTA size and due to the fact that it has no estate portfolio.

Gateway

The NTA has agreed with the Department of Health that it will apply to the external Gateway team for approval prior to issuing all national communications, publications and requests for information to an NHS or adult social care audience. The purpose of Gateway is to ensure that the Department of Health and its arms-length bodies spread consistent and deliverable policy which does not impose excessive burdens on front-line services. As such, the criteria covers processes to ensure policies and guidance are impact-assessed (both for equality and economic cost impacts), affordable, outcome-focused, consistent with wider government policy, clear in purpose, and communicated in a targeted and succinct manner.

14. RISK MANAGEMENT

The key strategic risks to the programme of reform set out in this Business Plan, and the action the NTA is taking to mitigate them, are as follows:

Resource constraints

Cause:
• The public sector deficit demands efficiency savings and hard choices about delivery across government, the NHS and local authorities.
Effects:
• Potential rationing of treatment via increased waiting times or focusing available resources on priority populations
• Restricting access to treatment is likely to lead to increased crime, more drug use, higher rates of drug-related death and increased transmission of blood-borne viruses.
Inherent risk priority: high.
Existing controls:
• The dramatic increase in resources over the last ten years has not all been used efficiently, leaving significant scope for savings not to impact on front-line delivery
• The majority of current spend comes from DH or the NHS which will experience less stringent reductions than other government departments
• The coalition has signalled significant commitment to tackle drug addiction as a driver of crime, ill-health and poverty
• The NTA is implementing a series of value-for-money programmes in the treatment sector which have already yielded a 16% increase in efficiency.
Residual risk priority: high.
Additional action required:
• The NTA will work with colleagues across Whitehall during the CSR to mobilise support for investment in treatment being maintained at a level which enables the government's ambition to be achieved.

Managing transition

Causes:
• The commissioning and delivery of drug treatment will change dramatically over the next two years
• A reformed NHS, a more locally accountable police service, the rehabilitation revolution in the justice system and an emphasis on decentralisation and payment by results, will all impact significantly on drug treatment provision.
Effect:
• There is potential for key players at all levels to become preoccupied with designing the new structures, resulting in current delivery being neglected
• Key personnel may leave the sector because of job insecurity
• Much-needed system reform may be inhibited by uncertainty over structures, accountability, resources and staffing.
Inherent risk priority: high
Existing controls:
• The publication of a new drug strategy will provide a clear direction of travel from 2011 onwards
• The NTA through its local teams will maintain its focus on delivery and reform during 2010-11.
Residual risk: high.
Additional actions required:
• The DH arms length body review, the comprehensive spending review and the new drug strategy will set out how the government intends to deliver its aspirations for drug treatment.
• Working with other government departments, the NTA will develop a transition plan in the autumn to ensure that the new landscape can deliver the treatment aspects of the new drug strategy and as smooth a transition as possible to the new arrangements.

Skills deficit

Cause:
• The drug treatment sector has responded well to the demands made of it since 2001. However, delivering the dynamic, outcome-focused systems needed to promote recovery demands that staff acquire new skills to deliver different sorts of intervention, and that systems re-orientate themselves to focus on recovery and reintegration.
Effect:
• Without improving the skills and changing the orientation of providers, treatment systems will fail to enable service users to progress in treatment, resulting in static, silted-up treatment services, increasing waiting times and no improvement in long-term outcomes.
Inherent risk priority: high.
Existing controls:
• The successful launch of the skills consortium provides the sector with an employer-led vehicle to identify the skills required to deliver recovery-focussed treatment and ensure staff competence to practise.
Residual risk priority: high
Additional actions required:
• Support the skills consortium to establish credibility within the sector
• Monitor improvements in outcomes to ensure that skills enhancement is having the desired impact.

Failure consistently to prioritise reintegration in local areas

Causes:
• Competing priorities locally
• Unpopular client group
• Increasing pressure on local budgets.
Effects:
• Individuals inappropriately retained in treatment unable to achieve long-term recovery
• Avoidable relapse
• Benefits accruing from treatment not sustained for individuals, families and communities
• Local systems fail to yield best value from treatment investment.
Inherent risk priority: high.
Existing controls:
• The coalition government has signalled that it will provide clear political leadership to promote reintegration nationally and locally.

• Welfare reform provides the context in which addressing worklessness can become integral to treatment delivery.
Residual risk priority: high.
Additional actions required:
• Working closely with DWP to ensure that reintegration is embedded in the new recovery framework to replace Models of Care
• Through local teams, support areas to recognise the immediate and long-term value-for-money case for reintegration.

15. NTA BUDGET 2010-11

Income and expenditure	**£s**
Revenue Resource Limit (Grant in Aid)	10,811,000
Income	
RIOTT (DH)	1,583,000
System Change Pilots (DH)	1,582,682
Harm Reduction (DH)	421,427
Integrated Drug Treatment System (DH)	1,888,716
DIP (Home Office)	2,042,889
System Change Pilots (Home Office)	1,048,246
NDTMS Dataset Development	417,307
Other departmental income (including secondments)	1,624,473
Sub-total	10,608,740
Total	**21,419,740**
Expenditure	
Non-executive members' remuneration	117,021
Other salaries and wages	10,085,381
Establishment expenses	1,379,961
Transport and moveable plant	60,660
Premises and fixed plant	3,827,073
External contractors	5,531,644
Capital: Depreciation owned/Leased assets	344,000
Auditors' remuneration: Internal Audit fees	40,000
Auditors' remuneration: Audit fees	34,000
Total	**21,419,740**

The NTA is planning to spend its 2010 parliamentary funding and Operating Income against the following programmes and departmental heads:

Delivery	**£s**
Director's Office and Treatment Delivery	548,204
Criminal Justice/IDTS Central	822,136
System Change Pilots	2,434,855
Young People	174,754
Analysis/NDTMS	1,952,205
Regional Teams	4,445,554
Skills and Development	2,520,471
Recovery and Reintegration	133,741
SCAN/SMMGP	406,591
Sub-total	13,438,511
Corporate Services	
NDTMS and IT	3,420,521
Other Central Services	3,638,011
Sub-total	7,058,532
Accountability	922,697
Total	**21,419,740**

16. NTA STAFFING

The NTA proposed staffing profile in 2010-11 is set out below:

Location	**WTE**
East Midlands regional office	11.61
East England regional office	6.00
Head Office – London	97.55
London regional office	14.60
North East regional office – Newcastle	7.67
North West regional office – Manchester	9.5
South East regional office – Guildford	10.0
South West regional office – Bristol	7.2
West Midlands regional office – Birmingham	8.52
Yorkshire and Humber regional office – Leeds	13.24
Total	**185.68**