

QUESTIONS THE NTA DECLINES TO ANSWER

1. WHERE ARE THE 65,000-70,000 PATIENTS NOT IN REHAB NOR ON SUBSTITUTE MEDICATION?

NDTMS figures, given in a 2008 parliamentary question, confirmed that 131,468 people in the last year received methadone or buprenorphine. But only about 2% (about 4,000 patients) are referred to rehab, and there are even fewer psychosocial daycare programmes -- which means that 65,000-70,000 patients are unaccounted for. What percentage of the 65,000 are people seeking help forced to wait 12 weeks between an initial appointment and a second one, who are then labelled as being in "12 weeks retention"? An independent audit could perhaps shed light.

NTA response. The only clients unaccounted for are those in the one-third of residential rehabilitation providers who do not report figures to the National Drug Treatment Monitoring System (NDTMS). Annual statistics for 2008/9 provided a detailed analysis of treatment journeys, many of which overlap since individuals receive different types of treatment over time – though individuals are counted only once. The NTA annual report illustrated the balance of a system in which under half of all interventions are substitute prescribing, one fifth are psychosocial, and one in thirty residential (inpatient and rehab).

The figures show nine out of ten clients waited less than three weeks to get into treatment. For any client to be counted in the statistics, they must have a treatment start date recorded, so there is no question of anyone waiting weeks between an initial appointment and treatment and still being counted as 'in treatment' or 'retained'.

The figures are validated by the National Drug Evidence Centre at Manchester University under the auspices of National Statistics.

2. WHY HAVE DRUG DEATHS RISEN?

The titles of these reports are self-explanatory: *Male drug poisoning deaths highest in five years: Health Statistics Quarterly autumn 2008* published by the Office for National Statistics and *Drug-Related Deaths in the UK - Annual Report 2008: Increase in the number of Drug-Related Deaths*, published by the International Centre for Drug Policy at St George's University of London. Widespread prescribing was justified as avoiding such results as are listed in these reports; furthermore, 20% involved methadone.

NTA response. According to the Office for National Statistics, the number of drug-related deaths in England reached a new high in 2008 of 1,607. The NTA is responsible for drug treatment services in England and cannot comment on the

situation in Wales, Scotland or Northern Ireland, which together contribute to higher overall figures for the UK.

Nevertheless, the increase of 138 drug-related deaths in England is worrying. We suspect those individuals with a long history of drug dependency and injecting drug use are engaging in more dangerous behaviour, and therefore at greater risk of dying from overdose.

The NTA in conjunction with the Department of Health is committed to delivering an Action Plan to reduce drug-related harm, and has boosted the national campaign by targeting those most at risk of overdose with additional support, including a programme of training in use of the life-saving drug naloxone which reverses the effect of heroin overdose.

3. WHY DID THE NTA DENY THE EXISTENCE OF ITS OWN TIER-4 NEEDS ASSESSMENT?

Addiction Today wrote to the NTA saying that "Another success story we would be happy to feature in an article is: What activities, and with what results, did the NTA undertake to implement the actions and recommendations from its own commissioned piece of work on Tier 4 needs, researched by David Best". We also offered to feature similar research by Ed Day on detoxification provision. NTA communications director Jon Hibbs responded about "the mysterious non-existence of any substantive piece of work from either Ed Day or David Best on the subjects you mention. We can't publish what we don't have".

Addiction Today managed to track down the research, which belongs in the public domain:

[Download National needs assessment for Tier 4 drug services](#) (1.07Mb)

[Download Tier 4 drug treatment-inpatient provision and needs assessment](#)

NTA response. The NTA originally thought *Addiction Today* was accusing us of suppressing publication of some research we had commissioned. It is now apparent that *Addiction Today* was referring to NTA research we published in June 2005. Both the needs assessment, and companion survey of inpatient treatment services, were commissioned to further our understanding of the Tier 4 sector, and are available on our website. The findings informed the NTA's Treatment Effectiveness Strategy launched in 2005, and underpinned much of our work since, including recent Tier 4 commissioning guidance.

4. WHY IS THE NTA DENYING THAT REHABS HAVE CLOSED?

About 19 rehabs in the UK closed and others made counsellors redundant. Most depend on the state for clients – but it refers only 2% of drug abusers to drug-free treatment, creating a crisis of empty beds and waiting lists of people desperate to fill them.

This is not an issue of harm reduction / abstinence - it is about bad practice versus good practice.

The disproportionately low 2% of referrals also signifies denial of patient choice. According to researcher Dr David Best, a new phenomenon has arisen: people who want to get off drugs are now afraid to approach agencies because they fear substitute drugs will be pushed onto them instead.

In the hope of raising awareness and working together for solutions, *Addiction Today* started posing questions to the National Treatment Agency for Substance Misuse in October 2008. Disappointingly - given this charity's seven years of unswerving support for the NTA - the NTA instead communicated to organisations in the field that "On *Addiction Today*,... the magazine/website could not be trusted as an impartial source because it misrepresented the NTA's position on a variety of issues, not least residential rehab... it would be worth checking out the status of *AT*'s claims about closures with the organisations themselves".

Not getting through on telephone or website for the defunct organisations is an answer in itself. The list of closures is on the home page at www.addictiontoday.org.

NTA response. The NTA has never denied some rehabs closed in recent years. The substance misuse treatment sector is dynamic and changing, and closures (as well as openings) of treatment services are to be expected. However it is inappropriate to speculate about the possible commercial or confidential factors behind the failure of independent charities or private businesses. Residential rehabs operate in a marketplace where services compete with other similar agencies for clients across the country. Local commissioners and care managers decide which providers best meet the needs of their clients, depending on the services and standards on offer. As a consequence some enterprises close, and others open, according to demand. The NTA has reviewed the reasons behind the *Addiction Today* list of closed rehabs, and are confident that there are multiple reasons for these closures not necessarily related to low levels of referrals.

While some providers have empty beds, interviews with the highest-performing services from the recent Healthcare Commission review of Tier 4 showed many services with waiting lists for entry. There is also evidence that the availability of improved community treatment options, including abstinence-based services, means in some areas fewer people want to move away from home for an extended period in order to recover from their addiction.

Nevertheless, the NTA recognises that the commissioning process has not always worked well. We encourage local drug partnerships to make more use of Tier 4 treatment, and are talking to commissioners and providers about how to

overcome obstacles to this. The NTA is also committed to expanding and improving the Tier 4 sector as a whole, through the Government's £54m capital investment programme.

5. WHY DOES THE NTA DENY EMPIRICAL RESEARCH THAT REHAB WORKS?

Professor David Clarke of Wired has written of “a local commissioner who was telling drugs workers that research showed that residential rehab did not work. Therefore, local commissioners were not going to send people to residential. Very worrying was the fact that the drugs workers believed what he was telling them! No wonder residential centres are struggling to fill their beds, with this disgraceful misinformation”.

The same adjective could be applied to the NTA head-office staff member who unjustifiably told BBC home editor Mark Easton, when researching a programme, that “there is no evidence that rehab works”.

The £90,000⁺ annual-salaried NTA communications director Jon Hibbs also posted comments on this website denying empirical research - click [here](#). And NTA board member Peter McDermott stated in *The Observer* last November that "Residential rehab doesn't actually work very well" alongside other negative comments.

The NTA has a stated aim of getting people off drugs – but this must surely be mere lip service when millions of pounds in each of its seven years have not been utilised to give its own staff accurate, life-saving information. Incidentally, the NTA was given £8million to spend on staff and over £3million to spend on consultancy, according to its latest annual report.

NTA response. The NTA does not deny the existence of research that suggests rehabs work for many people. However, this has to be weighed alongside other research that is less supportive. The balance of all the evidence is not conclusive. Hence we say (following the advice of NICE and clinicians) that residential rehabilitation is right for some drug misusers in some circumstances, but not necessarily for everybody.

Mark Easton has never reported anyone at the NTA claiming that rehab doesn't work, and *Addiction Today* misrepresents the comments Jon Hibbs made. Peter McDermott defended his own position as spokesman for The Alliance on the NTA website.

The expert group which developed the NICE clinical guideline on psychosocial interventions concluded: “*There have been some studies comparing residential treatment with community-based treatment. However these studies are often based on small sample sizes, lack methodological quality, and have produced inconsistent results. Residential treatment requires significantly more resources*

than community-based treatment, so it is important to assess whether residential treatment is more effective.”

The NTA does not treat drug-misusers, but does ensure that public money is properly spent on high-quality and accessible drug treatment that ultimately aims to get people off drugs and reintegrated back into society.

6. When is £54million not £54million?

When the NTA recycles a two-year old press release with an unusual juxtaposition of words and figures. Click [here](#) for details.

NTA response. There is a legitimate difference between announcing the allocation of a sum of money by Government, and announcing the details of how it has been spent. The breakdown of what projects had been funded in which areas was information *Addiction Today* requested, and the Editor complained when it was not immediately forthcoming. When the allocation process was complete, and we were able to identify the 42 residential treatment units and supported housing centres benefiting from the investment, the Editor complained we had recycled old news!

7. Why is the NTA funding an organisation - one of whose directors is a NTA director - without inviting tenders?

This is a more recent question, posed by Peter O'Loughlin of Eden Lodge. "Why is the NTA 'part funding' a study commissioned by the UKDPC to examine employers' attitudes to recruiting ex-drug users, rather than inviting tenders? Has the Confederation for British Industry or the Small Business Organisations been approached for advice?".

NTA response. The NTA funds a number of external projects in addition to its own direct delivery and follows Government procurement rules for determining when and how to invite tenders for the work.

We are working closely with JobCentrePlus to implement Government plans to get more problem drug users on benefit into treatment, and those in treatment into work. The plans set out by the Department of Work and Pensions prompted the UK Drug Policy Commission to undertake independent research into employer attitudes. In view of the potential importance of this work to delivering the policy and informing the subsequent legislation, the NTA made a small contribution towards the cost of the research. This was well below the limit at which a tender process is required by Government rules.

Annette Dale-Perera, the NTA's Director of Quality from 2001-9, was appointed a Commissioner when the UKDPC was set up in 2007 in recognition of her career expertise in drug treatment research and practice. She received no remuneration for this role.

8. ARE FIGURES AUDITED? HOW?

Minutes from a NTA board meeting show that its senior managers' salaries, including its CEO's, are directly linked to outcome targets. So there is a keen interest in the figures being presented to show that targets have been met – but this can act against getting both the right figures and the right kinds of figures. The figures rely on the Top 'validating' paper which independent researchers describe as measuring only reliability of crime – ie, consistency of self-report, not validity.

So, clients underreporting drug use and off ending at structured interview, due to stigma and fear of consequences... combined with workers not asking relevant questions... will lead to... targets appearing to have been met. *Addiction Research & Theory* plans to publish a peer-reviewed paper on this in Spring.

NTA response. The NTA is held to account by Government for delivering on one indicator of the Public Service Agreement targets, the numbers of problem drug users in effective treatment. This is measured through NDTMS, which in turn is audited by the National Audit Office, and inspected by the UK Statistics Authority. The 2008/9 NDTMS statistics show the target for 2011 has been met.

The PSA does not rely on the Treatment Outcomes Profile, which records questions that keyworkers ask their clients as part of care plan delivery. Early results from TOP are demonstrating the impact of treatment on reducing drug use.

In order to counter criticism that research into the impact of treatment on crime is based on self-reporting by offenders, the NTA last year published an anonymised study into Police National Computer records that showed significant reductions in offending after starting drug treatment. We are currently in discussion with Government about the possibility of further anonymised matching of records to further our understanding of the links between treatment and crime reduction.

9. If the NTA can do nothing about residential rehab, why is it doing so little about community rehab?

NTA response. The NTA is committed to a balanced treatment system in which people in all areas of England have access to the full range of treatment services. We are committed to expanding the capacity of Tier 4 services, including residential rehabilitation, although local commissioners decide which providers best meet the needs of clients. Local drug partnerships have traditionally commissioned the provision of structured day programmes and other medical and structured psychosocial interventions to help clients achieve abstinence, and increasingly are also commissioning innovative services from community providers. One of the themes of our good practice guide to Tier 4 services was the growth in local rehabilitation services, which take clients only from their area, and are heavily focused on aftercare and reintegration. Some have plans to

establish local “recovery communities” around the rehabs and the NTA is monitoring these developments with interest.

10. Why do NTA figures not differentiate detox and rehab?

Figures are blurred when detoxification and psychosocial treatment are referred to in the same sentence as "abstinence treatment". The two are very different, with very different goals and outcomes, and perhaps with different types of diagnoses. Expenditure and outcomes relating to each should be given discretely.

NTA response. The NDTMS statistics do distinguish between in-patient detoxification and psychosocial interventions. However in practice there is much overlap between the two, and clients may receive more than one type of treatment. For example, many clients go through inpatient detox in hospital before entering residential rehabilitation, as part of an abstinence-focused treatment pathway. Specialist substance misuse hospital inpatient units will have psychosocial programmes running alongside medical treatment in order to help patients work through addiction towards recovery.

NDTMS does not collect information on expenditure. Neither does it collect information on outcomes, which is why the NTA is developing the TOP tool to provide a better picture of the variety of benefits individuals get from the treatment they receive.

11. How many patients are diagnosed with addiction/dependency? How many people are diagnosed as having substance abuse?

Why are we unable to find these two types of patient quantified in the NTA figures? After all, if there is no accurate diagnosis, how can optimal careplans be prepared and implemented?

NTA response. NDTMS records the treatment pathways of people in contact with treatment services, but does not record the diagnoses made by clinicians at assessment. Broadly speaking, the NTA assumes that all adults in treatment have an addiction or dependency problem, while young people receive services for substance misuse. The threshold for accessing services is lower for under-18s than adults, and interventions are typically provided to young people experiencing a range of problems, including school attendance, offending, and family relationships as well as drug or alcohol use.

12. Why are we unable to find numbers of patients with accompanying mental disorders?

NTA response. Providing services for people with mental health problems who also misuse drugs is the responsibility of local mental health services. They work in partnership with drug actions teams, and clinical guidelines stipulate that any

psychological problems identified at assessment should be addressed through care planning. NDTMS collects information about whether clients are in contact with mainstream mental health services and this information is reported back to partnerships as part of delivery assurance and service planning. However, NDTMS does not record confidential information about other medical conditions, and so does not publish information on mental health problems among substance misusers in treatment.

13. Where are the figures demonstrating that more chronic, complex clients go to rehab?

This is clarified in NTORS and other empirical research but not in NTA figures.

NTA response. Normal commissioning practice is to send more chronic clients to residential rehabilitation, in line with NICE guidelines which say: *“Residential treatment may be considered for people who are seeking abstinence and who have significant comorbid physical, mental health or social (for example, housing) problems. The person should have completed a residential or inpatient detoxification programme and have not benefitted from previous community-based psychosocial treatment.”*

NDTMS collects information about residential rehab, but about one-third of providers do not submit any returns so the NDTMS statistics under-estimate the true scale of activity in the sector. The Healthcare Commission called for improved compliance.

Neither NDTMS nor TOP collects data on how complex or chronic an individual's drug problems are. It is the responsibility of clinicians, keyworkers and treatment staff to assess clients and establish the most appropriate services to meet their needs.

14. When will the figures showing drug-free clients actually link them with the treatment they receive?

Only then can anyone know what works.

NTA response. The treatment that clients receive typically covers a number of different interventions and settings over a period of time, so that when they leave the treatment system it will always be difficult to make a simple link with outcomes. We already know that the information received from some settings is less robust than others, with a particular risk in generalising findings when so much data is missing from residential agencies. Nevertheless, the NTA is planning to use TOP data and additional research to determine what types of treatment are most effective.

15. How many of those who have "successfully completed treatment" are now in paid employment?

NTA response. NDTMS records treatment pathways and by definition cannot track clients after discharge unless they relapse and re-present for treatment. We anticipate that TOP will demonstrate improvements in the education, training or employment prospects of clients as a result of sustained periods in treatment.

16. Why have drug offences risen?

Why, if the current treatment protocols are "effective", has violent crime in the Metropolitan Police area for the financial year April-March 2007-8 increased by 22% over 2006-7? Why have drug offences increased by a staggering 73% in the same period?

NTA response. When we say that treatment cuts crime, we are talking about acquisitive crime like theft, not what the police classify as drug-related offences (e.g. crimes of possession and supply). The pattern of drug-related offences reflects many factors over which the NTA has no jurisdiction, including the prevalence of drug use in society, the activity of criminal gangs, and the policies of the police towards suspects. There is no evidence that violent crime is directly linked to drug use. What matters to the NTA is the impact of drug treatment, and all the evidence indicates that both illegal drug-use and acquisitive crime fall by as much as half when drug-misusing individuals are in treatment. This was confirmed by the pioneering research published in November 2008 that matched anonymised data from the Police National Computer with NDTMS records.

17. What Dat systems support people in abstinent recovery?

How does NDTMS measure this?

NTA response. The NTA view is that the goal of all drug treatment is to achieve abstinence from the drug of dependency. Residential rehabilitation is one treatment option for delivering this, but not the only one. For example, some drug misusers on substitute prescribing will be on a detoxification regime in which their daily dose of methadone is reduced to move towards abstinence. In fact, most drug misusers can make adequate changes to their behaviour whilst in the community, and do not need to go into hospital or residential services at all.

NDTMS records a wealth of information about the numbers of people in contact with a variety of treatment services, but "abstinent recovery" is not a measurable category recognised by the treatment sector. However, TOP data is providing more information about treatment outcomes, including abstinence.

18. If there is a 'third way,' what budgets are spent on training, and in what, to sustain recovery paths?

What is the evidence base for this middle way?

Training budgets are a matter for local partnerships and service providers to determine.

19. Does the TOP measurement tool answer these questions? If not, why not?

If Top and NDTMS do not answer these questions, they should be replaced – was Top sent out to tender? Was its review sent to tender? And was it peer reviewed to answer the questions above?

NDTMS was designed to monitor the delivery of drug treatment, not as a research tool. It enables us to ensure there is enough capacity in the system for clients to get into treatment quickly, receive appropriate care planning and interventions, and stay long enough to sustain benefit.

As an outcome measurement tool, TOP will provide answers to many of the questions raised above. It is being developed by the NTA in partnership with the treatment sector and did not need to be sent out to tender. The principles of TOP were independently validated in a peer-reviewed paper published in *Addiction* vol 103 no 9 (2008) and the first findings published in *The Lancet* vol 374 no 9697 (2009). In time the NTA expects that TOP findings will supplement NDTMS statistics and give us a better picture of how treatment and care impacts on the lives of drug misusers.

20. Who is accountable - the NTA or Local Authorities, PCTs, Dept of Health?

I was among those who regarded the NTA as responsible for only 2% of people getting into drugfree treatment, particularly as it takes credit for “getting 202,000 people into treatment” in its press releases. However, three of its senior people stated the responsibility belongs to PCT/LA commissioners. “They hold the budgets.”

The NTA annual accounts confirm this: last year, it spent £14,517,000, not one penny on treatment.

However, budgets for treatment are not released until the NTA approves them. Despite advocacy, it has not set a target for drug-free treatment admissions, nor people getting drug-free.

But NTA regional manager Mark Gilman achieves outstanding good practice (in comparison; 7% of patients get the drug-free treatment they seek). Why is his paradigm not replicated nationally?

The role of the NTA is to improve and expand the drug treatment system in England, with the goal of getting more drug misusers into treatment, helping them recover from dependency, and reintegrating them into society. It reports to the Department of Health, but is also accountable to the Home Office, the Department for Children Schools and Families, and the Ministry of Justice

The NTA does not itself treat drug misusers, but as part of its remit to promote the quality and quantity of treatment it advises Government on the distribution of the pooled treatment budget, which is currently worth £406m.

In particular it works in partnership with a range of services and agencies on a national, regional and local level, including local drug action teams (or drug partnerships) which have the power to commission a range of appropriate treatment services in their areas. The success of the NTA depends on the performance of these local drug treatment systems. They, in turn, are judged on the range, quality and effectiveness of the treatment they provide to individual drug misusers, and the benefits this brings to society as a whole.

PUBLIC RIGHT TO KNOW

There are many more questions we would like to ask, but 20 is a more realistic target on which to start the new year. Perhaps answers will be forthcoming in 2009, as they were not in 2008.

The NTA is always happy to answer relevant questions about its activity and stewardship of the drug treatment system. We publish a large amount of information about drug treatment on our website, as well as occasional papers and reports, and are held to account by Government, politicians and the media as well as stakeholders within the sector. These arrangements are supplemented at a regional level through ongoing dialogue and relationships with stakeholders, commissioners, providers, service users and carers.