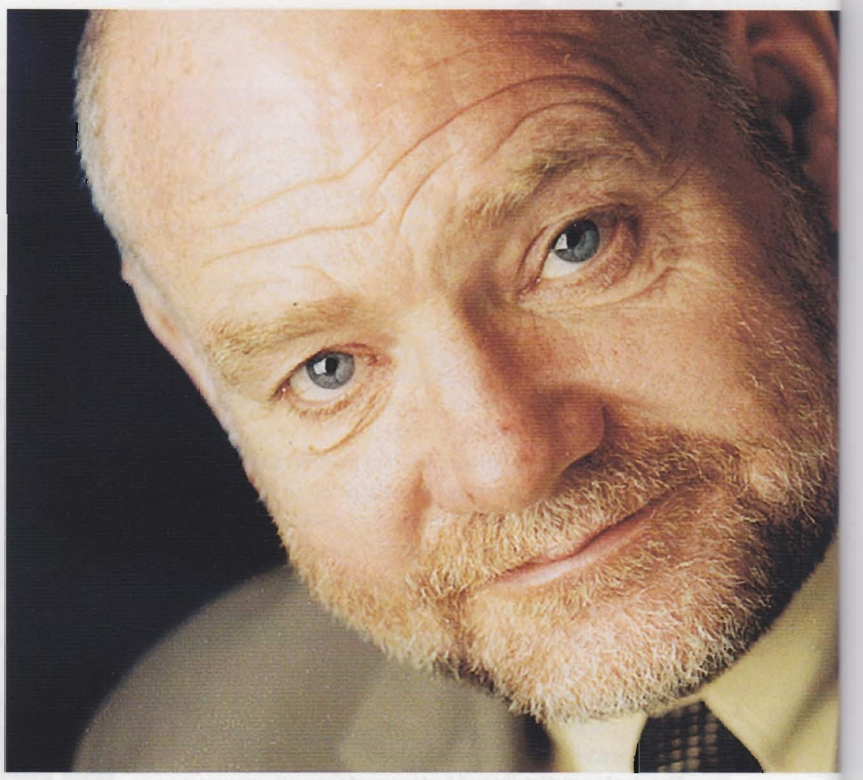
Staying the course

When the National Treatment Agency was set up in 2001 it heralded a brave new world of drug treatment. **Paul Hayes**, chief executive of the NTA, on how the organisation intends to stick around to ensure drug users stay in treatment



Keep-on keeping on: Paul Hayes, chief executive of the NTA

I SAID some brave words in *Druglink* back in August 2001 when I was appointed chief executive of the National Treatment Agency – and I still stand by them. I boldly claimed that, "if neither the ordinary drug user nor local communities notice improvements to their lives, then the NTA will not have been successful". I am confident that we have been even more successful than we could have anticipated three years ago.

There is little value in disentangling the impact of increased funding and the hard work of drug action teams and treatment agencies, from the input of the NTA. We can, however, show what our contribution has been to recent improvements

Drug misusers are more likely to be in treatment now than three years ago, as services expand and commissioning improves. They are likely to have entered treatment more quickly, as waiting times fall. And, as we challenge poor practice, they are more likely to have appropriate care such as preventing under-prescribing.

BIG ISSUES

The Audit Commission report, *Changing habits* (2002), identified the priority issues that needed to be tackled to improve drug treatment: limited treatment options, lengthy delays and poor care management. These priorities were universally welcomed and set out our agenda at that time.

One of the direct consequences of prioritising certain topics is that others get less attention. So we have not made the same level of progress on all issues. For example, work still needs to be done to ensure that appropriate treatment is available to more marginalized groups. As such, we have our critics – but we're not here to be popular – we're here to improve a weak system. So I make no apology for focusing on top priorities when the net gain is that we have tackled inexcusably long waiting times and enabled more people to get into treatment. Of course the NTA hasn't done this single-handed. The nature of drug misuse and treatment means that many partners have been involved in moving forward. But we have led and monitored progress on these key issues.

Our waiting times programme, delivered in partnership with the National Institute for Mental Health in England (NIMHE), has contributed to a 71 per cent decrease in the average waiting times from over nine weeks in December 2001 to just over two and a half weeks in September 2004. I am not claiming that every client gets into treatment within this time – there are still significant problems out there. But progress is impressive. It is recognised in the Audit Commission report, *Drug misuse 2004: Reducing the local impact*, based on independent and extensive fieldwork. The report said: "There has been impressive progress since 2002 ... The capacity of local drug treatment services has grown. Local agencies are working more effectively in partnership and services are more integrated. As a consequence waiting times are down and 20 per cent more users are now starting treatment."

WAITING TIMES

Our waiting times targets were established to improve service users' experience of treatment. Areas with historic problems such as Birmingham may not be neatly hitting the targets that we set – but is it fair to criticise when waiting times for inpatient services and specialist prescribing fell from 24 weeks in December 2001 to four and seven weeks respectively in September 2004. In my book, that's a huge success.

One of our regional teams' key roles has been to oversee the commissioning of services to meet local needs. Increased funding means that the role of the commissioner is even more important. Our teams have

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worked with DATs to ensure that there is a joint commissioner in every area and that service level agreements are drawn up with providers. In 2001, seven per cent of DATs had dedicated commissioners – now over 99 per cent of them do. *Models of care*, which we published back in 2002, set out the framework for commissioning a co-ordinated system of care. While we recognise that 15 per cent of DATs are failing to make adequate progress on implementation, overall progress has been good. We put a lot of pressure on DATs to deliver in a short period of time – the majority of them have risen to that challenge. As a result there are now more services available throughout the country. We're now consulting the sector on what worked and what should change in the revised version of *Models of care for drug misusers*, due to be published later this year.

Crucially, the Government has decided to continue to increase investment in drug treatment – an additional £219 million was announced in September 2004. If the commissioning of services had not improved and treatment was ineffective, it is highly unlikely that this investment would have continued – I think it's fair for the NTA to claim some credit for that continuation.

STICKING AROUND

Rumours of our demise are grossly exaggerated. The review of all special health authorities clearly identified the NTA as one of the agencies to remain in existence "for the long term". But let's be realistic. The drug treatment sector has changed beyond recognition in the last three years so it is inevitable and appropriate to review the structures and agencies that co-ordinate the sector. The Audit Commission has raised concerns about the complex performance management arrangements within the drug misuse field (2004). We welcome the opportunity of a review and it has been recognised by government that it would be pointless to re-examine the role of just one partner (e.g. the NTA) without re-examining the whole partnership.

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We will work with the Department of Health, Home Office and other key stakeholders to identify the most appropriate arrangements to support delivery of drug treatment and the wider drugs strategy. One of our objectives will be to ensure that the benefits of having a national lead on drug treatment are not lost, should funding and performance management become increasingly mainstreamed. It is to no-one's benefit to return to the days when drug treatment was a Cinderella service on the margins of the health and social care systems – that would undo the significant progress made in recent years.

It is also vital that the delivery of drug treatment is taken forward at regional level. Interestingly, the Audit Commission also reports that stakeholders recognise the positive impact of our regional teams in monitoring and leading local improvement – and in particular, balancing the health and criminal justice agendas. This echoes the findings of our own stakeholders' audit published last year where, once again, they felt strongly that our role in balancing these agendas was crucial. New arrangements will need to demonstrate that they can maintain this equilibrium as effectively as the NTA has done.

BETTER SERVICE

The Audit Commission has, once again, put its finger on the next set of priorities to be tackled: retaining clients in treatment, sustaining recovery with better follow-on services and making better use of user and carer expertise. For us, that's all about improving the quality of the whole system. Effective, well-managed treatment, targeted to meet the clients' needs, will retain people in treatment, and retention is key to achieving clients' goals. In order to maintain the continuing development of effective treatment, we are expanding our support to commissioners, providers and service users including: clearer, evidence-based guidance and research; more reliable performance data indicating what's working where; joint reviews of services and systems alongside the Healthcare Commission; increased support to user and carer involvement; a genuine understanding of diverse needs; and increased emphasis on co-ordinating through care and aftercare.

In conclusion, if someone told me in 2001 that within three years we would have seen such a dramatic decrease in waiting times and an equally dramatic increase in numbers in treatment, I'd have said "right, okay, I'll settle for that". What I'd settle for in 2008, is to have seen the same improvements in treatment quality and outcomes over the next three years, as those that have been made in access to treatment over the last three years. ■

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