

THE NTA: UNZIPPING TREATMENT FACTS

A dozen rehabs in the UK have 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. Taxes were spent on a redefinition of “recovery” excluding drug/alcohol-free goals. Deirdre Boyd feels the seven-year itch for change.

REHABS CLOSING – LATEST COUNT.

The UK has lost the following life-saving addiction-treatment centres in the past year or so:

- Thurston House, London, is scheduled to close in December (men only, extended care)
- Pierpoint Women's Unit, Lancashire
- Two Saints, Hampshire
- Phoenix Futures London Residential Service
- Priory Farm Place, Surrey
- Priory Coach House (extended care)
- Barley Wood, Somerset
- Murray Lodge, Coventry
- Hebron House Women & Baby Unit (women's unit still here)
- Phoenix Bexhill
- Isham House no longer treats addiction patients
- Diana Princess of Wales Hospital, Norfolk, is in administration
- One treatment centre liquidated a counselling company but does not wish to be named.

Addiction Today, and the Addiction Recovery Foundation charity which publishes the journal, supported the National Treatment Agency for Substance Misuse since it came on the scene in 2001. But the long honeymoon is over. There is a seven-year itch for something much better – something on the lines urged at the start.

Of prime importance in the disillusion with the NTA is that over a dozen abstinence-based treatment centres have closed, the inevitable result of the pathetically tiny percentage – 2% according to NTA delivery manager Colin Bradbury – of people with drug problems being referred them, regardless of how clinically necessary rehab is.

The paucity of referrals has occurred under the stewardship of the NTA which is responsible for implementing drug policy in the UK, via 149 Drug Action Teams. Sadly, I have heard stories of DAT commissioners jeering the very idea of drug-free treatment. 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 that “there is no evidence that rehab works”.

Senior NTA directors have 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. Anyone truly interested and impartial can access the research free at the *Addiction Today* website.

WISE ADVICE WAS IGNORED.

So what has gone wrong? Let's look at the recommendations we publicised in March 2001.

Pursuant to a meeting with treatment providers and Neil Townley, then head of the NTA team in the Department of Health, plus his colleagues, *Addiction Today* (vol2, no69) publicised the key finding: that delivering funds/infrastructure through DATs was the key barrier to effective implementation of government strategy.

“The NTA is depending on DATs for its plan to work – but the unanimous view was that, while a tiny minority of DATs were good, the vast majority were not trusted. There was agreement that DATs need guidance; there is a high level of unawareness. The NTA needs a carrot-and-stick approach, the stick to include sanctions if performance is not satisfactory.”

Townley wanted an increase in the numbers of clients in treatment, and the effectiveness of their treatment raised. We urged another guiding principle: that the latter be extended to include “starting from accurate, accessible assessment”.

“Assessment is key but it is hugely volatile across the country,” we wrote. “There needs to be a defined continuum of care from assessment onward up to/including resettlement.

“Departments can be driven by individuals prejudiced for or against certain treatments and

this can be more powerful than any formal system. Can this be addressed? We also need transparency and perhaps ring-fencing in pooled budgets.”

If these goodwill recommendations had been respected, the issues they addressed would not now be NTA crises. Sadly, ignoring them was an indication of problematic attitudes to come.

CURRENT CRISES: GOOD POINTS FIRST.

These have now reached such a peak that the NTA has been publicly panned by the BBC, *Times* and *Observer* among other media, and by the Centre for Policy Studies think tank, which develops policies to limit the role of the state and enable families and voluntary organisations to flourish.

Let's start with what the NTA did right. It has drawn up some excellent models of care describing how organisations across the treatment and related fields should collaborate for the ultimate benefit of people seeking help. The first problem is in implementing these models of care. The second major problem is lack of transparency surrounding the consequences.

It is to the NTA's credit that, even though it devoted 3-4 hours of its annual conference last June to the highly-funded UKDPC redefinition of recovery which excludes goals of becoming drug free, and printed a taxpayer-funded booklet on that, four of its senior people confirmed to me in October (two in writing, two verbally) that they will not link the NTA Top outcomes measure form to it. In other words, Top will still indicate whether people have managed to become drug free, rather than blurring the numbers with those who maintain “control over substance use”.

TARGETS WITHOUT AUDIT.

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 under-reporting drug use and offending 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 exposing this in early 2009.

ANSWER THE RIGHT QUESTIONS.

Treatment works – but we must define treatment, prescribe it appropriately, and monitor the results with both accuracy and finesse so that they can truly feedback into improvements.

- Why, after seven years, do most DAT commissioners – or even most psychiatrists and doctors – not understand the distinction between addiction/dependency and misuse? These require different diagnoses and care plans; instead most people are treated in outdated medical-model assumptions of 'physical dependence'. Getting it right is more effective clinically *and* cost-wise.
- Why are we unable to find these two types of patient quantified in the NTA figures?
- Why are we also unable to find numbers of patients with accompanying mental disorders?
- Where are the figures demonstrating that more chronic, complex clients go to rehab?
- When will the figures showing drug-free clients link them with the treatment they receive?
- When will NTA staff stop saying that rehab does not work?
- If the NTA can do nothing about residential rehab, why is it doing so little about community rehab?
- What Dat systems support people in abstinence recovery? How does NDTMS measure this?
- 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?
- 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?

IS IT THE DoH CRUSHING PEOPLE?

I was among those who regarded the NTA as responsible for only 2% of people getting into drug-free 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 (www.addictiontoday.org/addictiontoday/2008/10/nta-annual-accounts-2007-8.html) confirm this: last year, it spent £14,517,000, not one penny on treatment.

However, NTA regional manager Mark Gilman achieves outstanding good practice. Why is his paradigm not replicated nationally?

Also, the £54million to be distributed via the government's *Capital Development programme for inpatient and residential rehabilitation substance misuse (drug and alcohol) services 2007/08 and 2008/09* is not what it seemed. Guidance letters to get the funds were sent by the Department of Health's Nick Lawrence, head of alcohol, drugs and tobacco policy to... PCTs, local authorities and other statutory agencies – no abstinence-based services were classified as recipients.

I was told that residential treatment centres could not qualify for capital funding unless they could prove future financial stability... which rested on DAT/NTA commissioning... but only 2-3.6% of patients are referred... so the centres could not plan for future staff or financial provision... and so the Catch 22 continued, threatening the very existence of these voluntary-sector life-savers.

The Healthcare Commission is reviewing Tier 4 services, with a report due in January. It is a measure of disillusionment that we can even conceive this thought: Will it mark down rehabs for not having the funds to undertake capital renovations, and will it award points to NHS services which were given the funds to meet criteria? Clinical effectiveness is not measured.

A review by the Audit Commission is overdue.

THE RESEARCHER'S EXPERT VIEW

Dr David Best was formerly research manager for the National Treatment Agency, so was uniquely qualified to debate appropriate treatment with the NTA CEO Paul Hayes (more details on page 7). He gives a summary below of his research.

- "Most clients don't want methadone and certainly don't want it for life
- The evidence base for England shows no reductions in alcohol or crack use – and some start both *after* entering methadone 'treatment'.
- Problem drinking exists in up to 40% of methadone maintenance clients.
- Maintenance works but only when it is part of a package – people typically get seen for 1.5 hours a month and receive evidence-based psychological interventions for less than four hours a year.
- Can methadone maintenance work? Not using the NTA model of maximising numbers without delivering meaningful treatment...
- Even the most ardent proponent of maintenance has no idea about an 'evidence-based' model for the transition/exit from maintenance.
- Meanwhile, the client is increasingly coshed by sedating effects of the drug and its long-term impact on decision making and planning – precisely the personal resources required to overcome long-term addiction.
- For all the outcome studies, we have no data on the proportion of clients who are the "models of maintained recovery" that we hear so much about – the golden eggs of the maintenance system who are not readily found and have never been quantified by any brave scientist... and a zero score on Top does not count as reliable evidence!
- NTORS and all major outcome studies suggest that abstinence is a viable goal, achieved by large numbers in spite of the scandalous lack of funding for rehab and recovery journeys (48% abstinence after two years, compared to the NTA 2%).
- Finally, in a time of concern about children of drug-using parents and *Every Child Matters*, is maintenance becoming a heritable curse of stigma, underachievement and decay?