The long view

The NTA is shifting its focus from getting people into treatment to long-term recovery, as chief executive Paul Hayes tells **DDN**

Paul Hayes is used to being quizzed about treatment. As chief executive of the National Treatment Agency, his sights have been set firmly on getting people into treatment, reducing huge waiting lists, looking at how to stop people from dropping out before they feel the benefits – and defending the NTA's direction of travel to both the treatment field and the outside world.

It is now 18 years since the Audit Commission's report laid the foundations for this agenda and Hayes is determined not to 'allow waiting times to balloon back up again'. But he is also readjusting the NTA's lens to focus on 'the recovery agenda – people getting better and leaving treatment' and 'the reintegration agenda – people having a decent place to live, having a job, looking after their own kids, having a stake in society'.

Catching a trend? No, Hayes insists. This is part of the new drug strategy – 'and if you go back to the previous government and *Tackling drugs together*, all the various green papers and white papers going back over the last 20 years, there's a strong thread of continuity going through all this,' he says. The point is that the time is right, he emphasises. 'The new drug strategy can focus more on recovery and reintegration because the basic building blocks around the size of the treatment system, and access to it, are in place.'

Because accountability underpins the NTA, Hayes is quick to mention the added value for the taxpayer in making communities safer and diverting people from crime. He is also keen to justify the investment in TOPS – the treatment outcomes performance system – which will 'tell us about the real impact of treatment on real people, rather than having to use proxies like waiting times and retention that we've relied on up to now'.

With the revised agenda comes an acknowledgment – for which Hayes credits 'the doctors who are always very keen to remind us' – that there will be a certain proportion of people who will probably never leave the system. 'So we need to be working with the people who *can* leave, who *can* get out at a sensible pace,' he says.

He sees this as 'a much more complex system, a much more difficult system to manage than a system where we just get as many people in as we can, get them scripted, get them stable, less likely to offend, less likely to die using drugs, job done'. 'That's not job done,' he adds. 'That's job started.'

Acknowledging that drug problems are themselves complex, will the focus still be on funding treatment for heroin and crack – particularly as alcohol plays such a major devastating role?

'The reason we focus on heroin and crack is that they cause most problems for most people,' says Hayes. 'But we've always said that the treatment system should be available for anyone who has a problem with their drug use.'

But surely the weighting of payments for treatment doesn't reflect this? 'I think they do,' he counters. 'Because what we had was a situation previously where resources were allocated on the basis of a formula that was built around indices of social deprivation, and what became apparent was that that was over-rewarding some areas and under-rewarding others.

'Ideally of course we would have a good enough understanding of prevalence in each area to allocate resources based on prevalence. Unfortunately, because this is a hidden, stigmatised, illegal activity, our information about prevalence at a local level isn't robust enough to do that... so the next best thing is to build it around activity, because activity does to some extent map onto need. So we're entirely comfortable we've got the allocation process right.'

Allocating twice as much money to treat some drug problems as others 'is entirely legitimate, because the average length of time in treatment for heroin and crack is twice as long as for cannabis or amphetamines'. But he emphasises that these are the resources allocated by the NTA to local partnerships – and it is up to them to decide how they commission and purchase services from their local providers.

While NTA reports show burgeoning alcohol problems among young people, Hayes backs off from suggestion that adult drug treatment should attempt to incorporate alcohol addiction. The NTA's brief on alcohol is confined solely to under-18s and there is no crossing the line to the Department of Health's responsibility for the adult alcohol agenda.

'The alcohol agenda is much broader than treatment for dependency... it's driven by concern about the impact on the health of people who are drinking too much, but are nowhere near being dependent,' he says. 'The view that's taken at the moment is it's more appropriate for the different strands of the alcohol agenda to be together – prevention, binge drinking and the disorder associated with it.'

So clients should expect their problems to be divided up to be treated? No, he says, that's not the point. 'Their problems don't have to be divided up to be treated and they shouldn't be. What we're talking about is funding streams, we shouldn't be talking about clients' experiences. We've always said if someone's genuinely got an alcohol and drug problem, we're happy to pay for it through the pooled treatment budget.'

But Hayes is fiercely protective of the money ring-fenced for drug treatment: 'The pooled treatment budget was created to put money into drug treatment, to meet individual health need and public health need, and also to address the drugs-crime link.' It is the Department of Health's job to invest in alcohol, he points out, and down to primary care trusts to weigh up spend on alcohol and tobacco, alongside allocating resources for hip replacements, mental health, cancer, heart disease and everything else. Sure, there's a strong argument that the NHS should be investing more in alcohol treatment, he says, but that's not his remit.

Despite the separate funding streams, he is keen on joint operating structures with the DH, particularly around the families agenda, as 'it doesn't make a lot of sense to have two different sets of structures, one applying to drugs and one applying to alcohol'.

Another major strand of joint working is the welfare to work agenda with the Department of Work and Pensions – the 'back to work' schemes that have been greeted warily. It was inevitable, says Hayes, that all the headlines on this focused on benefits conditionality – that unless you're referred to treatment your benefit will be reduced. 'But what we're focused on much more is the opportunity that this closer collaboration gives us to route the 20,000 people who are already in treatment into training and employment, to make them job ready.'

NTA regional staff have been very impressed with the DH's network of job centre coordinators and their willingness to engage, he says, adding: 'We need to make sure they're fully trained up and able to deliver the service. What we'd like ideally is for those services to be commissioned alongside all other local services, so access to employment support becomes as integrated to the rest of the treatment system as DIP is, for example.' Progress to Work initiatives are currently commissioned separately and 'there are all sorts of bureaucratic hurdles that have to be cleared'.

But even if these services can't be commissioned together, they work in tandem as far as service users are concerned, says Hayes, 'so it's clear to them that the local drug treatment system is working with the local job centre to get them back into work.'

All fine in principle – but how can this work in a climate where there are no jobs? 'Well there are two ways of looking at that,' says Hayes. 'You could argue that it would've been worse if it had started 18 months ago – this will not start with huge numbers of people 'job ready' and able to get jobs in the current labour market. A lot of people will be talking about being job ready and able to get jobs in 18 months, two years, three years time, when the economy will hopefully be turning around.

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'In the last recession in the '80s we decided to write off generations of people, and it can then be very difficult to re-engage those people in the labour market. Many of those people and communities are still dependent on welfare, and their children have grown up in an environment where nobody works.

'So I think everybody recognises it's not sensible to say there's no chance of getting drug misusers into employment because non drug misusers can't find work. We have to try and maximise everyone's opportunities.

'Once this is in place it will be available long term,' he adds. 'This presents a real opportunity to put reintegration and employment at the heart of everything we do, and we need to grab it with both hands.'

While working with DWP has given the impetus of operating with a national government structure, improving housing provision has presented a different set of challenges for the NTA, in working with 149 local partnerships and encouraging them to engage with services in their area.

'Inevitably there's a patchwork quilt of provision,' says Hayes. 'We're dealing with a population that are stigmatised and that many local decision takers actually see as being at the end of the queue.'

He reflects that it's often easier to persuade central government of the long-term benefits of providing stable housing and employment for marginalised, unpopular groups than it is to persuade people locally.

'We need to win those arguments,' he emphasises. 'We need to persuade people locally that this isn't providing goodies for baddies.' Working with the NTA teams, two thirds of local partnerships have now signed up to improving employment for their service users and more than half have committed to increasing access to accommodation.

'We'll be holding them to that promise on behalf of their community and their service users,' he says.

A further strand of NTA support is for employers, particularly in making it easier for them to train their staff and keep their skills refreshed. The newly set up National Skills Consortium met for the first time in July, 'to collectively own mechanisms by which best practice is spread'.

'Everyone's very keen, everyone's very supportive... all we've got to do now is make it work,' he says. 'One of the things we need to bottom out, all of us collectively, is what does keyworking mean? How do you help someone through the system, guide them and motivate them, accompany them through their journey? How that's best done is a key component of practice, particularly if we're going to be focused on recovery and reintegration. We haven't got that right yet.'

The reality for many clients, in being stuck in treatment regimes they neither want nor can move on from, is why Hayes believes wholeheartedly in the recovery agenda as 'not just a new buzz word', 'because what we do need to do is challenge services to make sure they are focused on recovery all the time and aren't just taking the easy route of leaving people in treatment when they don't need to be'.

'It's all part of our motivation for the skills agenda,' he adds. 'It's all about balance and finely tuned professional judgement. It's not hard to get people into treatment, to script them and then forget about them.

'But it's hard to work with them on an ongoing basis and judge how you support them in the long term – that calls for high levels of professional skill. What's been very encouraging is that staff and employers are very keen to make sure their staff are sufficiently skilled to rise to that challenge.' **DDN**