National Treatment Agency for Substance Misuse

Annual Report 2002/03
The National Treatment Agency for Substance Misuse (NTA) is a special health authority, established by Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

The overall purpose of the NTA is to:
- double the number of people in effective, well-managed treatment from 100,000 in 1998 to 200,000 in 2008
- increase the percentage of those successfully completing or appropriately continuing treatment, year on year.

In order to fulfil our purpose, the NTA works in partnership with a range of national, regional and local agencies to:
- improve the commissioning of drug treatment by providing guidance and support to drug action teams and their commissioning groups, monitoring expenditure on treatment and implementing performance management systems
- promote evidence-based and co-ordinated practice by distilling and disseminating best practice drawn from research
- improve performance by developing standards for treatment, promoting user and carer involvement, and expanding and developing the drug treatment workforce.

NTA priorities
The NTA will focus on the following nine priorities:
- Integrated care: To develop a co-ordinated system of treatment in all areas of the country, incorporating a range of treatment options as outlined in the service framework, Models of care.
- Access to treatment: To double the number of people accessing treatment between 1998 and 2008.
- Effectiveness: To increase the proportion of people completing or appropriately continuing treatment.
- Efficiency: To increase the efficiency of the treatment system – indicated by reduced waiting times.
- Information management: To develop effective local information systems that will meet both local business planning and national performance monitoring needs.
- Diversity: To ensure that the diverse needs of the whole population are reflected in the planning and provision of treatment.
- Service user and carer involvement: To ensure that service users and carers are involved in the planning of services and development of policy.
- Treatment for offenders: To ensure that drug misusing offenders have access to treatment and that treatment agencies and criminal justice agencies appropriately share information.
- Capacity: To recruit an additional 3,000 practitioners to the drug treatment workforce, and retain and develop those currently in the sector.

The NTA would like to thank all the individuals and agencies who agreed to be interviewed and photographed for this annual report.

Cover photo - Dean, service user, Essex Young People’s Drug and Alcohol Service
Welcome to the National Treatment Agency’s annual report for 2002/03. This was our first full year of operation, and one that has seen a dramatic increase in our activity and productivity.

Having set out our priorities in 2001, we have been making steady progress, with more drug misusers able to access treatment, more staff joining the drug treatment workforce and continued reductions in waiting times.

As chair and chief executive of the NTA, we have personally spent time visiting drug action teams, treatment services, Government office staff and directors of public health. Meeting staff, service users and carers, and learning about their experiences has been a real privilege and an education. We recognise that much still needs to be done to improve the availability and quality of treatment in England, but signs are that the additional Government funding and support being provided through the NTA is having a positive impact.

Models of care – the national framework that we launched last year – is providing a clear picture of the integrated system of care to be developed across the country. Our Opening doors programme to reduce waiting times has helped to halve average waits and, along with our other programmes, has initiated and benefited from effective service user and carer involvement. By announcing funding for a three year period, we have enabled DATs to develop longer-term plans to expand services.

In order to develop more effective regional and local partnerships, we have restructured and expanded the NTA. We have strengthened our regional teams which now provide additional support to DATs and service providers. In particular, our teams now offer guidance on developing effective monitoring systems and treatment for offenders, working closely with the Government office drug teams, criminal justice agencies, directors of public health and user and carer groups. At a national level we have established a directorate of finance and planning to improve our own business management, and we are currently appointing a clinical team and support network to provide advice to both the NTA and service providers. We are also holding a series of discussion groups with MPs this autumn to develop mutual understanding.

We would like to express our thanks to the staff, Board members and partners of the NTA for their energy and commitment over the last year. We were particularly pleased to welcome user and carer representatives from our advisory group to Board meetings. They bring a crucial and refreshing perspective to our work and we look forward to formalising their position this year, and expanding Board membership to include representatives from the NHS. We are also grateful for the ongoing support and guidance provided by the Department of Health and the Home Office.

We look forward to another positive and productive year, working with our partners to deliver effective, appropriate treatment for drug misusers.

Paul Hayes,
Chief executive

Baroness Massey of Darwen, Chair
Integrating drug treatment systems

Models of care – the new framework for developing an integrated drug treatment system – forms the basis of the NTA’s work programme. In many ways it is the NTA project.

Commissioning
“Changing Habits (2002)”, the Audit Commission’s critique of the treatment system, focused on its lack of coherence and consistency. In recognition of this the Department of Health and NTA published Models of care in 2002, as a proxy National Service Framework for the Drug Treatment system.

Models of care provides a coherent evidence-based national framework for the commissioning and delivery of drug treatment. It details: the system of drug treatment services that should be available in all areas of the country; the individualised integrated care pathways that should be available to clients; and how these services should be linked to mainstream health and social care services.

Models of care was launched in 2002 and will be fully operational across England by April 2005. By then each DAT area will have:

- Locally agreed common screening and assessment processes. (November 2003)
- Care planning and care co-ordination systems integrated with treatment provision to maximise retention and facilitate access to support services after treatment completion. (March 2003)
- Locally agreed integrated care pathways to manage people through the different components of the treatment system. (March 2004)
- Services providing:
  - advice and information for the whole population
  - low threshold services for at risk groups
  - community based treatment services
  - residential treatment services (March 2005)
- The population of each area will have access to the following modalities of treatment:
  - inpatient detoxification
  - residential rehabilitation
  - prescribing in primary care
  - prescribing in a specialist drug treatment service
  - structured counselling
  - day care treatment (March 2005)
- Each drug treatment service will have a detailed service level agreement with its commissioners conforming to the NTA standard. (March 2004)
Integrating care in Northamptonshire

Northamptonshire is a mainly rural area, with varying degrees of drug misuse across the county. For example, the west of the county has had a heroin problem for a number of years, but in the last year, crack has started to appear in the area. This is also reflected in Corby where virtually all new crack users are existing heroin users.

Last year the local DAT started to introduce Models of care – the NTA’s framework for developing an integrated system of care. Models of care emphasises the importance of assessing local needs, and integrating services to ensure that they meet those needs as efficiently and effectively as possible. The aim is to create a system of care with services complementing rather than competing with each other.

As part of the implementation of Models of care, Northamptonshire DAT carried out a local needs assessment that revealed a need for additional services for homeless drug misusers, sex workers and people with both mental health and drug misuse problems. They then mapped out the range of services available in the area to identify any unnecessary duplication. These exercises indicated a need to rationalise drop-in services. Five agencies were offering the same service, but all closed in the evenings and weekends. The agencies now operate a rota system, opening at different times of the week to maximise the availability of this type of service.

Maple Access Project (MAP) is one of the local agencies involved in developing Models of care in Northamptonshire. Following the identification of gaps in local services, the project now hosts a ‘one-stop-shop’ service for homeless drug misusers, with other local agencies running clinics on MAP’s premises. This co-ordination means that clients can receive a range of services, including welfare advice, psychotherapy, and alternative therapies, without having to travel to different clinics. The project has also developed specialist services for sex workers who misuse drugs, and has appointed a mental health nurse practitioner to work with those who have mental health, as well as drug misuse problems.

Models of care, together with guidance from the NTA, has enabled the DAT to review how they commission and deliver services to meet local needs. Treatment agencies now meet on a regular basis and have recently developed a joint action plan to fill the gaps in services revealed by the mapping exercise.

The implementation of Models of care has been piloted in each region in England and has been supported by briefings, seminars and the establishment of dedicated implementation manager posts in many areas. Progress is monitored by NTA Regional managers as part of their quarterly reviews of each DAT’s implementation of its annual treatment plan.

All drug action teams, with the support of NTA regional teams, are now working towards implementation of the system outlined in the framework. The case study illustrates how the many elements are linked together to provide more, better and fairer treatment to local residents.

“We feel part of a jigsaw where everyone fits in to form a total picture. The Models of care framework enables us to focus on what we do best, and allows others to do the same.”

Dr Catherine Hewitt, Maple Access Project

Photos - Top left: Dr Catherine Hewitt and service user Michael at the Maple Access Project
Right: service users at the Maple Access Project
Long-term funding increases

A record £390 million was spent on drug treatment in 2002/03. This has risen to £450 million in 2003/04. In 2002/03, the NTA announced the allocation of central government funding (known as the pooled treatment budget) for a three-year period. This has enabled drug action teams (DATs) to develop longer-term plans to expand treatment services. In addition, the funding has been distributed according to the NTA’s new formula that takes into consideration factors such as social deprivation – a strong indicator of high levels of problematic drug misuse. While all DATs have received a minimum ten per cent uplift, this year DATs with higher levels of need are receiving increases of up to 33 per cent.

In addition to the pooled treatment budget, DATs also receive funding from the local agencies that form the DAT partnership including local authorities, primary care trusts, probation and police services. The pooled budget constitutes about half the overall spend on drug treatment, and therefore it is vital that the additional local investment by the DAT partnership is maintained to enable the drugs strategy to be delivered at local level.

NTA regional managers work in partnership with other organisations, including strategic health authorities, to monitor spending and to protect levels of local investment. In the past year we have been successful in not only securing current levels of funding, but also additional investment from health and criminal justice agencies. For example, an additional £46 million is being invested in treatment for offenders in high crime areas over the next three years.

Treating more people

There are approximately 250,000 problematic drug misusers in England. 118,500 accessed the treatment system in 2000/01. There has been a steady seven per cent rise in the numbers accessing treatment year on year since 1998. The NTA aims to have 200,000 people in the treatment system by 2008 – the current trend suggests that this will be achieved.

“We constantly review all our services to make sure they meet the ever-changing needs of our clients.”

Geoff Dennis – Service manager, South Gloucestershire Drugs Service
“I am treated as a person, as an equal. My confidence has increased immensely and I've now landed myself a job training other service users about employment and education opportunities.”

Trish Thompson – Chair, Service users forum, South Gloucestershire

**Expanding services – South Gloucestershire**

South Gloucestershire DAT, formed in 1999, has established and developed treatment services in South Gloucestershire. Before this, drug users had to access services in Bristol. Now local services address the needs of 751 clients who live in South Gloucestershire, with a 19 per cent increase in numbers of clients last year alone.

South Gloucestershire Drug and Alcohol Services (SGDAS) provide an innovative partnership in the provision of a variety of services from one main location. Voluntary and statutory sector agencies work alongside each other, providing a prompt, free and easy access to a full range of harm reduction and abstinence-based services. Increased government funding, allocated by the NTA, has helped to develop these services.

Outreach work is fundamental to the work of treatment services within the rural location of many areas in South Gloucestershire. SGDAS offer a local service to residents within the sixteen shared care and five outreach centres throughout the area.

The importance of continued support after treatment is reflected in the development of an aftercare programme providing education, training and employment opportunities, with support from local housing providers and local businesses. The scheme also provides a five-bedded house offering intensive aftercare support for people leaving residential treatment. Following feedback from the local service users’ forum, service opening hours have been extended to enable clients in full-time employment to come to appointments at lunchtime and in the early evening.

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**Improved treatment planning and delivery**

Each year, NTA regional managers assess DAT treatment plans and review progress on a quarterly basis. This year saw a significant improvement in strategic planning at DAT level and clear signs that the planning process is assisting in the steady progress towards targets. Shropshire DAT, for example, has increased access to treatment by improving systems to reduce waiting times, and expanding services provided by GPs. At national level, 23 per cent of GP practices were involved in shared care arrangements compared to 19 per cent in 2001/02.

To support the work of commissioners, we have published a resource pack which includes sample service specifications outlining the standard of service that should be commissioned from drug treatment services. This should result in a consistently higher standard of service being available throughout the country.

From next year, we will have established standards for local treatment systems and will be working with the relevant inspectorates for health, social care and criminal justice services to ensure they are implemented. The actual experiences of service users and their unpaid carers need to underpin this process.
Increasing effectiveness

Getting clients into treatment is important – but it is of little value if that treatment is not effective. In the last year, the NTA has issued new guidance, piloted new approaches and consulted on new standards for drug treatment in order to improve the quality of service available to drug misusers.

Standards for treatment providers

The NTA wants to see a consistently high level of service available to all drug users, regardless of where they live or who provides the service. In order to do that, we are establishing a set of basic standards for the planning, commissioning and delivery of drug treatment, and a system for monitoring compliance. These standards, which link to a range of related standards such as QuADS (Quality in Alcohol and Drugs Services), are currently out for consultation and will be piloted later this year. The system for assessing compliance will build on existing structures and systems and is likely to involve self-assessment, assessment by commissioners and DATs, as well as a degree of external assessment by an independent inspection or review body. We are working closely with the Commission for Health Improvement (CHI) to establish these monitoring systems. We are currently setting up a standards team which will work in partnership with the newly-created Commission for Healthcare Audit and Inspection (CHAI) and other relevant inspectorates, to ensure compliance with the standards.

We also established a QuADS telephone and email support line for treatment providers. The service, operated by DrugScope on our behalf, offers reviews of draft policies to ensure consistency with legislation as well as a general advice service.

Best practice

This year, we published guidance for clinicians on injectable forms of drug treatment for heroin misusers. The guidance, which built on the existing Department of Health guidelines – Drug misuse and dependence: guidelines on clinical management – on the treatment of drug misuse, was developed in consultation with drug treatment providers and service users, and is based on the best available evidence. The report sets out the conditions under which injectable treatment should be considered and delivered. Importantly, it also calls for a significant improvement in oral maintenance treatment and emphasises that medication should only be one element of a drug misuser’s care.

Our evidence-based research programme continued, with briefings on prescribing services and a major review of literature on drug misuse and treatment within black and minority ethnic communities.

Piloting innovative approaches

The NTA encourages innovation in drug treatment and is keen to test new approaches. This year we have developed a new resource pack and training programme to help agencies to respond more effectively to the needs of crack and cocaine misusers. This programme is being piloted in eleven areas across the country. We are also evaluating eight existing crack treatment services. Combined with recent research from City Roads in London and an NTA-led evaluation of drug treatment and testing orders (DTTOs) engagement with crack cocaine misusers, this will constitute the largest evaluation of crack cocaine treatment ever carried out in Europe.

Reducing drug-related deaths

In partnership with the Department of Health, the NTA is developing a range of publications, guidance and training programmes on reducing drug-related deaths. The campaign, which will be launched in autumn 2003, will include:

- guidance for staff in drug treatment agencies, commissioning departments, helplines, A&E and police custody suites
- information for drug misusers on waiting lists, people coming out of care or prison, and homeless drug misusers
- training for parents and carers of drug misusers
- support programme for black and minority ethnic groups on developing appropriate materials for their communities.

“Drug misusers from black and minority ethnic communities often don’t come forward for treatment – it’s seen as a reserve for white people with heroin problems. We’ve started to change that perception.”

Maggie Hanson – Making Things Equal, Kirklees
Piloting crack cocaine treatment – Lifeline Kirklees

Lifeline Kirklees is one of eleven drug treatment services piloting the NTA’s new approach to crack cocaine treatment. The agency, which recognised a growing need to treat clients with crack misuse problems, is expanding its existing services in line with the NTA’s treatment manual. Staff will also be taking part in the NTA’s new training programme designed to improve staff’s skills and knowledge.

Lifeline is piloting the crack service through its structured day care project – Outlook, and an outreach service for black and minority ethnic communities – Making Things Equal. Outlook now provides a drop-in service, where clients can come in without an appointment and receive advice quickly. This rapid access is particularly valuable for drug misusers as they often only seek help when they hit a crisis and require early attention. Outlook, which has received funding to recruit additional crack workers, also provides one-to-one and group counselling and complementary therapies to crack misusers. The Making Things Equal project works with local residents and community leaders to educate black and minority ethnic communities about drug misuse and drug treatment. The project has helped to target hidden populations of crack users and encourage them into treatment.

“Although I’d stopped using other stuff, I’d started smoking crack and didn’t think I could get treatment. Now I can.”

Martin - client, Lifeline Kirklees

Photo - Melanie Carr, service user at Lifeline Kirklees, receives acupuncture from PrisonLink Development worker Afshan Hussain. The treatment is valued by clients in managing cravings and triggers.
Once a drug misuser has made the difficult decision to seek treatment, it is vital for them to get access to that treatment before their motivation evaporates. Reducing waiting times is therefore vital. Furthermore, the length someone waits for treatment is a key indicator of the efficiency of the local treatment system. Average waiting times have been halved, and are continuing to fall, with the support of NTA regional teams and our joint programme with the National Institute for Mental Health in England (NIMHE).

**Opening doors to drug treatment**

Last year we set challenging targets for reducing waiting times for all types of treatment. Since then, NTA regional teams have been working closely with DATs and treatment providers to reduce waiting times across the country. We have teamed up with NIMHE, which is part of the Modernisation Agency, so that the tools and techniques that have worked in other parts of the NHS can be applied to the substance misuse field. Our regional teams are also working with NIMHE’s local development centres to improve services for clients with both drug and mental health problems, through involving users and carers and reducing waiting times.

Our joint programme, *Opening doors*, encourages DATs and treatment providers to work together with other local partners, including service users, carers and referral agencies, in order to identify and overcome blockages along the service user’s journey into and through treatment. Earlier this year, our series of regional events introduced almost 800 participants to simple tools and techniques for improving access to treatment by removing inefficiencies. Some participants were doubtful that the programme would have any significant impact without additional funding or staffing. But many have found that it has.

**Common solutions**

A number of common bottlenecks – and solutions – have emerged over the first stage of the programme. Many treatment agencies reported high DNA (did not attend) rates that block up valuable appointment time. Some areas have now introduced booking systems that invite service users to arrange a convenient appointment time with the service, rather than being told when they should attend. Others now send reminder text messages to clients’
Reducing waiting times in Birmingham

As the largest DAT in the country facing the problems of social dislocation, poverty and crime common in large urban areas, Birmingham faced significant challenges in reducing waiting times. In 2001, some clients had to wait for up to two years for treatment with a community drug team – the longest wait in the country. Following a concentrated effort, supported by the NTA/NIMHE Opening doors programme, the DAT has reduced waits to an average of nine weeks. While the DAT recognises that this is still too long – it is a dramatic and very significant reduction.

The DAT brought together two community drug teams covering the south and east of the city, to review treatment provision from the service users’ point of view. The review highlighted the need for more effective communication with users and an audit of waiting lists to assess the urgency of each case. The teams now proactively telephone users to make appointments and user-friendly information has been produced on referral processes. Services have also been expanded and there are now 33 drug workers supporting primary care specialists and 150 GPs prescribing to over 500 drug misusers. In addition, four user groups now provide feedback on the quality and management of treatment. To reduce waiting times further, new services have been developed, including a quick assessment and detox service and two structured day care services.

“\textbf{We have driven down waiting times and made our workers more satisfied as they are not fighting against a backlog.}”

\textit{Julie Guest, Community drug team leader, Birmingham}

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\includegraphics[width=\textwidth]{waiting_times_graph.png}
\caption{Average waiting times for drug treatment}
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\hline
\textbf{Service} & \textbf{NTA target} & \textbf{Average wait December 2002} & \textbf{Average wait March 2003} \\
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Specialist prescribing & 4 weeks & 4.5 & 4.2 \\
In-patient detox & 6 weeks & 2.6 & 2.9 \\
Structured counselling & 6 weeks & 1.6 & 1.6 \\
Day care programmes & 6 weeks & 3.0 & 3.0 \\
GP prescribing & 6 weeks & 8.3 & 8.3 \\
Residential rehabilitation & 4 weeks & 5.5 & 4.6 \\
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\end{tabular}
\caption{Average waiting times for drug treatment}
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Accurate and timely information is crucial to treating individual clients, planning improvements to services and monitoring the efficient use of public funding. The NTA is developing a co-ordinated approach to data collection and analysis that will provide treatment services, drug action teams and central monitoring agencies with the information they need to carry out their business.

Co-ordinating data collection

There are two main types of information collected about drug treatment. The clinical record of an individual client includes the data that a drug treatment agency needs in order to provide appropriate, safe care. This information should be shared between agencies that may be providing different types of care to the same client.

General performance information, such as number of clients seen and number successfully completing treatment, reveals how well a drug service and, subsequently, a drug action team, is performing. These two forms of information are clearly related.

Following consultation with commissioners and managers of drug treatment services, the NTA is co-ordinating the roll-out of a new electronic health record system that will record information that treatment agencies need to care for clients, and which can then be analysed to show how well

“Our evaluation information helps us to establish clear processes and systems that have a direct impact on the services we provide.”

Philippa Gibson, Joint commissioning manager, West Sussex DAT
the agency is performing as a whole. This information, when combined with all other agencies’ data, shows how well the DAT and region is performing. The system, which will link in to a new electronic version of the national drug treatment monitoring system (NDTMS), is being rolled out across the country. Our target is to have 50 per cent of all data collected electronically by March 2004.

We are currently restructuring the staff mix of the NDTMS to include technical support for treatment agencies’ information systems, and providing funds for additional analytical support for regional public health monitoring.

**Regular reports**

In effect, we will create a single source of data collection that can be analysed to meet local, regional and national reporting requirements. This will ultimately reduce duplication of effort by treatment agencies and DATs. In the meantime, while the electronic version of NDTMS is being introduced, we have brought in quarterly reporting on two key issues: waiting times and numbers of staff. These regular reports will enable agencies and DATs to tackle problems quickly as they develop, and to identify successes.

“**The service user networks review all the performance information. It keeps us in touch with what’s happening and helps us to influence the future.**”

*Tricia Goacher, Service users co-ordinator, West Sussex DAT*

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### Sharing performance information in Sussex

The three DATs covering Sussex use the same system for monitoring and comparing the outcomes of different forms of treatment. This information has been used to identify, share and implement best practice. For example, in West Sussex following the evaluation of performance data, the DAT has developed a triage system whereby the urgency of cases is assessed and clients are referred to the appropriate service for their needs. This has resulted in a significant reduction in waiting times which are monitored on a monthly basis in order to identify and tackle problems quickly.

Service user networks are also actively involved in monitoring performance. They receive regular feedback and verify the data prior to formal approval.

The DATs also jointly monitor the scheme for referring drug misusing offenders in custody suites into treatment. Services are being reshaped as a result of the information revealed, in order to deliver more appropriate treatment across the county.

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### How the NTA monitors performance

The NTA monitors the performance of the drug treatment sector using the following sources:

- **National Drug Treatment Monitoring System (NDTMS):**
  The national database of key data on numbers in treatment, type of treatment available etc. Originally managed by the Department of Health before being transferred to the NTA in 2003.

- **Drug action teams’ annual treatment plans:**
  Reports on DATs’ achievements and plans. The plans are assessed and monitored by NTA regional managers.

- **Quarterly reports to NTA:**
  From April 2003 reports on average waiting times and numbers of staff employed.
Meeting diverse needs

Drug misuse impacts on people from a wide range of backgrounds, but socially-deprived communities are disproportionately affected. Unfortunately these are the groups that are traditionally under-served by the health and drug treatment sector. The NTA aims to ensure that all sections of the community have access to appropriate, effective treatment. Our initial focus has been on services for black and minority ethnic communities, and young people.

NTA policies

All NTA policies, guidance and plans are examined to ensure that their relevance to, and impact on, diverse communities is considered. Our regional staff review drug action teams’ plans to ensure that they are responding appropriately to the full range of needs in their communities.

Diversity reviews

We have commissioned an assessment tool and guidance to enable drug services to review and improve the way in which they address issues of diversity in their organisation and activities. The final product, which will be published later this year, is the first of its kind in the healthcare sector.

Race equality

Our race equality scheme outlines how we plan to meet our duties under the Race Relations Amendment Act. Our approach is to ‘mainstream’ race equality into all our activities. As part of our research programme, we have published a literature review of drug misuse and treatment within England’s black and minority ethnic populations. The review highlighted the value of genuine community engagement, with members of the affected communities actively developing and running services themselves.

We also published guidance for commissioners to enable them to comply with the Race Relations Amendment Act. The guidance suggests that race equality should be integrated into mainstream commissioning; ethnic monitoring arrangements are established to identify who is and is not using

“You can talk about anything here at the centre. People are on your level and they know what you’re about.”

Charlotte, service user, Essex Young People’s Drug and Alcohol Services
Children’s Society, Essex

Essex Young People’s Drug and Alcohol Service provides support, advice and treatment to around 3,000 young people under 19. EYPDAS works across all four tiers of intervention: non-substance misuse services; open access substance misuse services; structured community-based substance misuse services; and residential substance misuse services.

While young people may only require advice and information about drug misuse, rather than treatment, the integrated nature of the service can provide the full range of support from prevention through to treatment. The agency, which is managed by the Children's Society, runs a range of services tailored to meet the diverse needs of different age groups. This includes crisis, assessment and counselling (which responds within 48 hours), structured day programme (including one-to-one, diversionary activities, workshops, streetwork), outreach and services for young offenders involved in the criminal justice system which include one-to-one work and group work. In addition, work with young carers offers support and counselling to young people who are affected by someone who uses drugs or alcohol. Interventions can include practical activities such as the gym or swimming to help promote a positive body image.

“A child of 12 has very different needs to an 18-year-old, and therefore our response to them will vary.”

Sally Hills, Essex Young People’s Drug and Alcohol service
Advisory group and NTA Board membership

Users and carers are now represented at the highest level of the NTA’s management structure. This year, we established a national advisory group comprising representatives from the key user and carer representative organisations. The group provides advice and guidance to the NTA on our policies, plans and procedures, and includes a broad constituency of experiences and viewpoints. At the group’s request, we are actively seeking representatives from black and minority ethnic groups. Crucially, two members of the group now sit alongside government and drug treatment sector leaders on our independent Board that oversees the NTA’s strategy, finance and priorities.

The structure of the national advisory group will change in the coming year as we establish more regional groups that will, in turn, select members to the national group. So far we have commissioned Adfam – a support organisation for relatives and carers of drug misusers – to establish regional groups and provide advice, administration and organisational support to carers. A similar process is under way to establish regional user groups.

National involvement

We routinely consult user and carer organisations in the development of guidance and standards. This year, service users’ contribution to the production of guidance on injectable forms of drug treatment and new materials on drug-related deaths have been particularly helpful.

Regional and local involvement

NTA regional teams are actively encouraging user and carer involvement at regional and local level. We have established regional user and carer advisory groups in all nine areas to provide guidance to our NTA teams.

The NTA exists to serve the needs of drug treatment service users. Their experiences are the driving force behind the need to improve treatment, and as such they must be actively involved in planning and delivering drug treatment.
This year, 60 per cent of DATs actively involved service users, and 46 per cent involved carers, in the development of their treatment plans. Wirral DAT has paid for a full-time service user advocate to work with the local user group. The advocate also sits on the commissioning group that is responsible for deciding how funding is spent on treatment.

We have funded the Alliance – a national user representation organisation – to extend its advocacy services for clients seeking help with complaints about treatment services. In the last year, the service resolved more than 40 cases.

Experts by experience

Service users have played a very active part in our programme to reduce waiting times for treatment (see pages 9 and 10).

"I have been using drugs since the age of 14 and have been in and out of care homes. Thanks to PANIC and a local doctor, I am now on methadone and am starting a course in hair and beauty."

Michelle, service user, PANIC, Stockton-on-Tees

User and carer involvement in the North East

Drug treatment service users and their unpaid carers have played a particularly active role in improving services in the North East.

In Middlesbrough, a service users and carers are full voting members of the DAT board responsible for directing the team’s work. In addition, a user representative was involved in the selection of providers of a new needle exchange service, to ensure that users’ needs were properly represented. The DAT provided additional support to the user to ensure that all technical details of the tendering process were clear and they were able to participate fully. The decision on selection was unanimous.

In Stockton-on-Tees, the local DAT works closely with PANIC (Parents and Addicts Against Narcotics in the Community). PANIC runs a family support centre which provides a drop-in service, counselling, advocacy, buddyng, education, outreach support and a 24 hour helpline. Their ‘reality check group’ keeps DAT officials informed about the reality of drug treatment provision from the users’ point of view. This has proved particularly useful in verifying the waiting times figures that are provided to the DAT. PANIC has also employed two modern apprentices, funded by the DAT, as project workers. Both former users, the apprentices are now working with PANIC to show other young addicts that there is a future beyond heroin and crack.

"Being listened to and taken seriously is such a great feeling – after all, we’re the ones who know firsthand what it’s like for people who need help with drugs."

Martin, service user, Middlesbrough
Getting arrested can be the trigger point for drug-misusing offenders to tackle their problem for the first time, which in turn can reduce their offending. This year saw a strong push on getting offenders into drug treatment.

Integrating care
In the past, an offender could be referred to treatment by different staff at different stages of the criminal justice system – at a police station, at court, in prison, on probation. Lack of co-ordination and ineffective information sharing arrangements result in unnecessary reassessment, disruption to treatment and failure to provide support on release from custody.

In response to this, the Home Office and the NTA have developed the criminal justice interventions programme (CJIP) which is being introduced in 25 high crime DATs. These DATs are now establishing integrated CJIP teams to co-ordinate individual offenders’ care throughout the system – from arrest, through to release and aftercare. In effect, this represents the development of an integrated care pathway, as outlined in Models of care. The government has allocated £46 million over three years, and DATs have indicated that 7,500 additional offenders will be able to access treatment through the new system – well ahead of the 1,800 target set by the Home Office. Our regional teams are working in partnership with Government Office Drug Teams to oversee the effective implementation of this initiative.

Prison treatment and aftercare
Although treatment in prisons is the responsibility of the Prison Service, we have been actively involved in this area. We are, for example, supporting the development of new clinical standards for prison treatment and, once prison treatment becomes the responsibility of primary care trusts, we will monitor its effectiveness via drug action teams.

The NTA recognises that many offenders who begin to tackle their drug problem when in prison, face real difficulties when they are released if they do not have appropriate aftercare arrangements in place.

“Referring offenders into treatment is an effective way of both improving their health, and reducing their criminal activity, but it’s not an easy option. There is no quick-fix to drug misuse, regardless of how someone enters treatment.”

Dr Judy Myles – Senior lecturer and consultant psychiatrist, Head of Education Training Unit, Department of Addictive Behaviour, St George’s Medical School, London
Dr Judy Myles  
St George’s, London

Dr Judy Myles has been working with drug misusers for over 14 years and is senior lecturer and consultant psychiatrist at St George’s Hospital Medical School in London. The training unit delivers a distance learning diploma in addictive behaviour specifically for workers in the criminal justice system and a training programme for the male estate prisons. In the past four years, Dr Myles’ clients have regularly included patients who have been referred for treatment via the criminal justice route, such as court orders to attend treatment (known as drug treatment and testing orders – DTTOs).

To examine whether this route of referral into treatment would produce positive clinical outcomes, Dr Myles carried out comparative research into those referred via criminal justice routes, and those referred via more traditional health systems. Results were encouraging and showed that both referral routes had positive results in terms of health gains and reduction in criminal activity.

"I was given a treatment order as part of my sentence. In the end this was good as I don't really think I would have cleaned up otherwise."

John, former offender

Prisoners serving less that 12 months are a particularly vulnerable group as they do not have the same level of support from probation services as longer-term prisoners. From 2004/05, all DATs will receive Home Office funding to establish aftercare services that will be able to offer dedicated support to all drug misusers on release from prison. Following discussions between the NTA, the Home Office’s drug strategy directorate and the Prison Service, arrangements have been agreed between the new criminal justice drug teams and local prisons to ensure care is provided on release from prison.

The new system will be piloted in August 2003 and will be initially introduced in the high crime areas. The NTA will monitor progress on this work, through the DAT annual reports.

Drug treatment and testing orders

Over 6,000 offenders received drug treatment and testing orders (DTTOs) in 2002/03 in line with Home Office targets. DTTOs are court orders that require offenders to attend treatment and undergo regular drug testing. Failure to comply with these requirements may lead to a prison sentence. Treatment services to support DTTOs are commissioned through DATs. The NTA is working with the National Probation Directorate to review standards for DTTOs to ensure that they reflect the principles promoted by Models of care. We are particularly keen to ensure that treatment under a DTTO is based on the offender’s assessed needs and underpinned by good practice around care planning and care co-ordination.

Young offenders

Young offenders under the age of 18 usually have different drug problems and treatment needs to adult offenders. We are working with the Youth Justice Board to develop new guidance on how young people should be referred.

Drug treatment and testing orders

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Improving skills - increasing capacity

In order to expand the availability of drug treatment, we need to expand the capacity of the drug treatment sector. The NTA aims to recruit 3,000 new practitioners by 2008, and retain and train existing workers. This year we developed new occupational standards, training programmes and recruitment initiatives.

**National Standards**

In order to ensure that drug workers across the country have adequately high levels of skills, we have worked with the national training organisation, Skills for Health, and others, to develop and launch the drug and alcohol national occupational standards (DANOS). The standards, which describe the competencies that staff should have, can be used to write job descriptions, recruit staff, identify training needs and develop vocational qualifications. This is the first time a set of occupational standards has been produced for the substance misuse treatment sector. We are currently developing a qualification framework based on those standards.

**Identifying training needs**

Almost half of all drug workers participated in our analysis of training needs carried out by Cranfield University last year. The review revealed a well-educated workforce with varying training needs. One of the common themes across all roles was the need for training on diversity issues. The NTA has commissioned an assessment tool to review organisations’ response to the diversity agenda. This will enable services to address these issues.

**Leadership programme**

Over 450 drug treatment managers and commissioners have now participated in the leadership programme developed by the NTA and Deloitte and Touche. The course, which also involves ongoing learning sets with colleagues, has received very positive feedback with 60 per cent of participants claiming it directly improved their leadership skills at work. The second stage of this programme is now being developed.

**Attracting apprentices**

The first phase of our modern apprenticeship scheme is now under way in three regions, with apprentices due to start work in treatment agencies this autumn. This initial stage of the scheme focuses on attracting people from black and minority ethnic communities workforce, as they are currently under-represented in the workforce.

**HR toolkits for managers**

This year we published staff development toolkits for managers of drug treatment services. The toolkits, which include a range of sample forms, provide guidance on best practice in recruitment, training and staff development, in line with the relevant standards.

**Numbers working in drug treatment**

The rate of increase in the drug treatment workforce is now tracked quarterly. Currently the workforce is growing significantly faster than the rate needed to achieve the NTA’s target of 9,000 workers by 2008.

Photos - Above: Geoff Hunter with colleague, Rachel Ainsley, GP liaison worker, Salford Drug Service
Right: Geoff at work with his team at Salford DAT
Learning to lead - Salford

Geoff Hunter is a seasoned drug treatment manager with over nine years’ experience. He has worked his way through the ranks from drug worker to managing a team of eight staff within Salford Drug Service. His team is currently responsible for a quarter of the city’s drug services, and the programme of treatment for offenders.

In order to develop his leadership skills further, Geoff took part in the NTA’s leadership programme run by Deloitte and Touche. The course enabled him to assess his leadership style and develop strategies to manage his workload more effectively. His delegation skills have improved, enabling his staff to take on more responsibility, and he manages his time more effectively. Geoff receives ongoing support from his ‘learning set’ – a group of fellow students who meet on a regular basis to share experiences and knowledge.

“I do believe that I am a better manager as a result of taking part in the NTA leadership programme – and I hope my staff think so too! I’ve learned how to give them more freedom and responsibility for their projects.”

Geoff Hunter – Senior drugs worker, Salford Drug Service
Auditors’ opinion

District Audit independently reviewed the NTA’s accounts. The following is their statement on the full accounts.

In my opinion:

• the financial statements give a true and fair view of the state of affairs of the National Treatment Agency as at 31 March 2003 and of its net operating costs for the year then ended, in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Services in England

• in all material respects, the expenditure and income have been applied to the purposes intended by parliament and the financial transactions conform to the authorities which govern them.

The following summary financial statements are consistent with the accounts on which an unqualified opinion has been issued.

Clive Darracott
District Audit
4th Floor, Millbank Tower
Millbank
London
SW1 4QP

July 2003

Statement on internal control

The Board is accountable for internal control.
As accountable officer, and chief executive officer of the NTA, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation’s objectives, and for reviewing its effectiveness. The system of internal control is designed to manage rather than eliminate the risk of failure to achieve these objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing risk management process designed to identify the principal risks to the achievement of the organisation’s objectives. The system of internal control is underpinned by compliance with the requirements of the core controls assurance standards:

• governance
• financial management
• risk management.

As accountable officer, I also have responsibility for reviewing the effectiveness of the system of internal control. This review has taken account of the work of the executive management team within the organisation which has responsibility for the development and maintenance of the internal control framework, and of the internal auditors. I have also taken account of comments made by external auditors and other review bodies in their reports.

The NTA has been in existence for less than two years and therefore a number of the internal controls are in developmental stage.

The assurance framework is still being finalised and will be fully embedded during 2003/04 to provide the necessary evidence of an effective system of internal control.
The actions taken so far include:

- The organisation has undertaken a self-assessment exercise against the core controls assurance standards (governance, financial management and risk management), and implementation has begun to meet any gaps.

- The organisation has undergone a complete restructure, with a finance and planning directorate being established to ensure it has adequate resources dedicated to the processes that support and give assurance of internal control at the highest level.

- The remit of the organisation’s audit committee has been extended to include risk management with the responsibility of providing the Board with a risk management strategy and regular assessments of organisational risk including an overview of the management of identified risks.

In addition to the actions outlined above, in the coming year it is planned to:

- Document and issue organisational vision and values statement to all stakeholders.

- Complete baseline assessment against other relevant controls assurance standards and implement action plans to ensure compliance as agreed by the audit committee.

- Review the provision of financial services and further develop reporting structures across the organisation.

- Establish a central training register to ensure staff training needs are met and to introduce a staff survey to identify risks and evaluate capabilities of employees.

- Formalise the organisation’s risk management strategy to be approved by the Board.

- Identify key risk indicators and establish a risk register to be monitored by the audit committee.

- Review and formalise the complaints policy and procedure and provide training to key staff members.

- Review staff training programme to incorporate specific modules on the risk management process and associated policies.

- Take over responsibility of implementing the National Drug Treatment Monitoring System (NDTMS) from 1 April 2003. An implementation plan will be developed and agreed with the Department of Health in the first quarter of 2003/04. New staff to be appointed in the second quarter.

Paul Hayes
Chief executive, July 2003
Better payment practice code
The Better payment practice code target is to pay non-NHS trade creditors within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed. Of total relevant bills 87.5 per cent of bills, representing 96 per cent by value, were paid within the target. Payments are processed by Chelsea and Westminster Healthcare NHS Trust on the Agency’s behalf.

Diversity
The NTA is committed to action to ensure equal access to relevant and appropriate drug treatment services for the whole population: the eradication of unlawful discrimination and the promotion of equal opportunities with respect to ethnicity, age, culture, gender, sexuality, mental ability, mental health, geographical location, offending background, physical ability, political beliefs, religion, health or status or any other specific factors which result in discrimination.

We have developed a race equality scheme and provided a series of training events for staff to support this.

Directors’ remuneration
The remuneration of non-executive members during the year amounted to £46,648. The salary and pension entitlements of the most senior managers of the Agency were as follows:

<table>
<thead>
<tr>
<th>Position</th>
<th>Age (years)</th>
<th>Salary (£000)</th>
<th>Real increase in pension</th>
<th>Total accrued pension at age 60 at 31.03.03 (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief executive</td>
<td>51</td>
<td>90-100</td>
<td>0-2.5</td>
<td>*30-35</td>
</tr>
<tr>
<td>Director of quality</td>
<td>41</td>
<td>60-65</td>
<td>0-2.5</td>
<td>0-5</td>
</tr>
<tr>
<td>Director of performance</td>
<td>42</td>
<td>45-50</td>
<td>0-2.5</td>
<td>0-5</td>
</tr>
</tbody>
</table>

Staff consultation
A series of team, senior manager and all-staff meetings are held on a regular basis to update and consult with staff. A cross-departmental communications advisory group has also been established to advise on both internal and external communications activities. Amongst the issues considered by these mechanisms were: the restructuring of the organisation, business planning and communications activities.

Restructuring and expansion
Additional staff have been appointed in order to strengthen our regional activities, manage new areas of work and improve our business performance. A new directorate of finance and planning has been established and additional regional staff have been appointed to support our regional managers and strengthen regional partnerships. Following the transfer of responsibilities for the National Drug Treatment Monitoring System services, staff have also transferred across to the NTA and we are in the process of appointing a clinical team to provide policy and practice advice to the NTA and other clinicians.

NTA Expenditure 2002/2003

<table>
<thead>
<tr>
<th>Expenditure breakdown</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NTA staff and board salaries</td>
<td>1,697</td>
</tr>
<tr>
<td>NTA running costs</td>
<td>963</td>
</tr>
<tr>
<td>Programme costs*</td>
<td>3,428</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,088</td>
</tr>
</tbody>
</table>

*Programme costs breakdown

<table>
<thead>
<tr>
<th>Programme costs breakdown</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate business</td>
<td>282</td>
</tr>
<tr>
<td>Ensure equality</td>
<td>48</td>
</tr>
<tr>
<td>Ensure capacity and competence</td>
<td>910</td>
</tr>
<tr>
<td>Increase quality and accountability</td>
<td>142</td>
</tr>
<tr>
<td>Improve availability and accessibility</td>
<td>615</td>
</tr>
<tr>
<td>Increase effectiveness</td>
<td>231</td>
</tr>
<tr>
<td>GP training in substance misuse</td>
<td>1,200</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,428</td>
</tr>
</tbody>
</table>
## Summary accounts

The following is a summary of information in the full accounts which are available on www.nta.nhs.uk or on request from publications@nta.gsi.gov.uk Tel: 020 7972 2214.

### Income and expenditure account

<table>
<thead>
<tr>
<th></th>
<th>2002/03</th>
<th>2001/02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-executive members remuneration</td>
<td>47</td>
<td>37</td>
</tr>
<tr>
<td>Other salaries and wages</td>
<td>1,650</td>
<td>1,697</td>
</tr>
<tr>
<td></td>
<td>547</td>
<td>584</td>
</tr>
<tr>
<td>Auditor's remuneration</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Supplies and services - general</td>
<td>55</td>
<td>86</td>
</tr>
<tr>
<td>Establishment expenses</td>
<td>551</td>
<td>405</td>
</tr>
<tr>
<td>Premises and fixed plant</td>
<td>327</td>
<td>137</td>
</tr>
<tr>
<td>External contractors</td>
<td>3,428</td>
<td>4,361</td>
</tr>
<tr>
<td></td>
<td>871</td>
<td>1,499</td>
</tr>
<tr>
<td>Net cash outflow from operating activities</td>
<td>6,088</td>
<td>2,107</td>
</tr>
<tr>
<td>Adjust for movements in working capital other than cash</td>
<td>129</td>
<td>1,274</td>
</tr>
<tr>
<td>Net cash outflow before financing</td>
<td>6,217</td>
<td>3,381</td>
</tr>
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</table>

### Financing

<table>
<thead>
<tr>
<th></th>
<th>2002/03</th>
<th>2001/02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating income</td>
<td>(243)</td>
<td>0</td>
</tr>
<tr>
<td>Net parliamentary funding</td>
<td>(6,000)</td>
<td>(6,243)</td>
</tr>
<tr>
<td></td>
<td>(3,400)</td>
<td>(3,400)</td>
</tr>
</tbody>
</table>

### (Increase) in cash in the period

<table>
<thead>
<tr>
<th></th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(26)</td>
</tr>
<tr>
<td></td>
<td>(19)</td>
</tr>
</tbody>
</table>

### Balance sheet

<table>
<thead>
<tr>
<th></th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debtors</td>
<td>1,985</td>
<td>1,492</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>45</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>2,030</td>
<td>1,511</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors: amounts falling due within one year</td>
<td>(582)</td>
<td>(218)</td>
</tr>
<tr>
<td></td>
<td>(582)</td>
<td>(218)</td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1,448</td>
<td>1,293</td>
</tr>
<tr>
<td></td>
<td>1,448</td>
<td>1,293</td>
</tr>
<tr>
<td><strong>Taxpayers’ equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General fund</td>
<td>1,448</td>
<td>1,293</td>
</tr>
<tr>
<td></td>
<td>1,448</td>
<td>1,293</td>
</tr>
</tbody>
</table>

**Signatures**

- Paul Hayes
  - Chief executive
- Chandresh Somani
  - Director of finance and planning
NTA Board

The NTA’s Board is made up of a chair, four non-executive members, four ex-officio members and three executive members, including the Chief executive.

Appointments
The Chair was appointed by the Secretary of State for Health. The non-executive and ex-officio members were appointed by the Parliamentary Under-Secretary of State for Health. The Chief executive was appointed by the Board.

Remuneration and terms of service committee
The NTA’s remuneration and terms of service committee is responsible for ensuring that a policy and process for performance review and remuneration of the chief executive, executive directors and senior managers are in place and agreed by the full Board.

Audit committee
The NTA’s audit committee provides an independent and objective view of arrangements for internal control within the agency.

Ex-officio members
The four ex-officio members were appointed because of their current position within their organisations, therefore their term of appointment is not fixed.

Baroness Massey of Darwen
Chair of Board and chair, Remuneration and terms of service committee

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Labour working peer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of appointment</td>
<td>January 2002</td>
</tr>
<tr>
<td>Term of appointment</td>
<td>3 years</td>
</tr>
<tr>
<td>Year of birth</td>
<td>1938</td>
</tr>
<tr>
<td>Ethnic background and gender</td>
<td>White, female</td>
</tr>
</tbody>
</table>

Membership
Co-chair of the All-Party Parliamentary Group for Children; Member of the Advisory Council for Alcohol and Drug Education, the Trust for the Study of Adolescence, and all-parliamentary groups on alcohol, drugs and HIV/AIDS

Dr Berry Beaumont
Non-executive director and member, Remuneration and terms of service committee and Audit committee

<table>
<thead>
<tr>
<th>Occupation</th>
<th>North London general practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of appointment</td>
<td>July 2001</td>
</tr>
<tr>
<td>Term of appointment</td>
<td>2 years</td>
</tr>
<tr>
<td>Year of birth</td>
<td>1947</td>
</tr>
<tr>
<td>Ethnic background and gender</td>
<td>White, female</td>
</tr>
</tbody>
</table>

Membership
Royal College of General Practitioners

Prof Kamlesh Patel OBE
Non-executive director; chair, Audit committee; and member, Remuneration and terms of service committee

<table>
<thead>
<tr>
<th>Career</th>
<th>Director, Centre for Ethnicity and Health, University of Central Lancashire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of appointment</td>
<td>July 2001</td>
</tr>
<tr>
<td>Term of appointment</td>
<td>4 years</td>
</tr>
<tr>
<td>Year of birth</td>
<td>1960</td>
</tr>
<tr>
<td>Ethnic background and gender</td>
<td>Indian, male</td>
</tr>
</tbody>
</table>

Membership
Chair of the Mental Health Act Commission; Board member, Commission for Healthcare Audit and Inspection (CHAI), DrugScope and Lifeline, Patron of the Men’s Health Forum

Grantley Haynes
Non-executive director and member, Remuneration and terms of service committee and Audit committee

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Crack outreach team manager - Northern Birmingham Mental Health NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of appointment</td>
<td>July 2001</td>
</tr>
<tr>
<td>Term of appointment</td>
<td>3 years</td>
</tr>
<tr>
<td>Year of birth</td>
<td>1959</td>
</tr>
<tr>
<td>Ethnic background and gender</td>
<td>African/Caribbean, male</td>
</tr>
</tbody>
</table>

Membership
Board member, COCA (Conference on Crack and Cocaine)
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Occupation</th>
<th>Date of appointment</th>
<th>Term of appointment</th>
<th>Year of birth</th>
<th>Ethnic background and gender</th>
<th>Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kate Davies</td>
<td>Non-executive director and member, Remuneration and terms of service committee and Audit committee</td>
<td>Senior manager, Nottinghamshire County Drug and Alcohol Action Team; Head of operations - Community Engagement (Drugs), Centre for Ethnicity and Health, University of Central Lancashire, (Senior manager, Newark and Sherwood PCT)</td>
<td>July 2001</td>
<td>4 years</td>
<td>1962</td>
<td>White, female</td>
<td>N/A</td>
</tr>
<tr>
<td>Annette Dale-Perera</td>
<td>Executive director</td>
<td>Head of policy, National Probation Service, Home Office</td>
<td>November 2001</td>
<td>Permanent</td>
<td>1956</td>
<td>East African Indian, male</td>
<td>N/A</td>
</tr>
<tr>
<td>Sue Killen</td>
<td>Ex-officio member</td>
<td>Director, Drug Strategy Directorate, Home Office</td>
<td>April 2003</td>
<td>Permanent</td>
<td>1961</td>
<td>White, female</td>
<td>N/A</td>
</tr>
<tr>
<td>Martin Lee</td>
<td>Ex-officio member</td>
<td>Head of Drug Strategy Unit, HM Prison Service</td>
<td>November 2001</td>
<td>3 years</td>
<td>1961</td>
<td>White, male</td>
<td>N/A</td>
</tr>
<tr>
<td>Mark Perfect</td>
<td>Ex-officio member</td>
<td>Chief executive, Youth Justice Board</td>
<td>April 2003</td>
<td>Permanent</td>
<td>1955</td>
<td>White, male</td>
<td>N/A</td>
</tr>
<tr>
<td>Paul Hayes</td>
<td>Executive director</td>
<td>Chief executive, NTA</td>
<td>November 2001</td>
<td>Permanent</td>
<td>1951</td>
<td>White, male</td>
<td>N/A</td>
</tr>
<tr>
<td>Chandresh Somani</td>
<td>Executive director</td>
<td>Deputy chief executive and Director of finance and planning, NTA</td>
<td>April 2003</td>
<td></td>
<td>1949</td>
<td>White, female</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Membership**
- Member, Hetty’s Family and Carer’s of Drug Users Support Service, Nottinghamshire Women and Drugs Forum and SORTED, a support service for current and ex-drug users
- Advisory Council on the Misuse of Drugs
- Chair, European Monitoring Centre on Drugs and Drug Addiction and the Positive Futures Steering Group
- UK Harm Reduction Alliance
- Parents and Addicts Against Narcotics in the Community (PANIC)
National Treatment Agency

More treatment, better treatment, fairer treatment

Head office
National Treatment Agency
Room 522, Hannibal House
Elephant and Castle
London SE1 6TE
Tel: 020 7972 2214
Fax: 020 7972 2248
nta.enquiries@nta.gsi.gov.uk
www.nta.nhs.uk

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All NTA publications are available online at www.nta.nhs.uk
Design: Moore-Wilson www.m-w.co.uk
Photography: Crispin Hughes, Brian Moody and Howard Davies

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