

**Improving the value of drug treatment systems
CONSULTATION (13 October 2008 – 5 January 2009)
Stakeholder Comments**

Please use this form for submitting your comments to the NTA.

1. Please put each new comment in a new row.
2. Please do not paste other tables into this table, as your comments could get lost – type directly into this table.
3. For comments that do not directly answer the questions, please insert the **section number** in the first column (see examples). If your comment relates to the document as a whole, please put **'general'** in this column. **Please refer to section numbers and not page numbers.**
4. Please provide supporting evidence for your comments.
5. If you are happy for us to contact you, please provide us with your contact details in case we need to seek clarification.

Your completed form MUST be returned to model@nta-nhs.org.uk by 5 January 2009.

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ANSWER TO SPECIFIC QUESTIONS

No.	Question	Your response
3.1 Opioid & crack cocaine user community treatment pathways		
3.1.1 Tier 2 and harm reduction interventions		
1	<p>It is assumed that seventy per cent of injecting drug users will access pharmacy based needle exchange on average and thirty per cent will access one-to-one needle exchange, on average, in a specialist drug treatment setting such as an open access service</p> <p>Is this a reasonable assumption?</p>	<p>EATA believes that the 70% figure is an underestimate. Some of our members feel that this figure may be more realistic as 80%. Meanwhile the 30% figure may be reasonable, although this may be too high in some areas.</p> <p>It should also be noted that in some areas there is a lack of an adequate number of participating pharmacies, which alongside limited out-of-hours access may mean great variation in access figures.</p>
2	<p>It is assumed that pharmacy clients make 26 needle exchange contacts a year on average</p> <p>Is this a reasonable assumption?</p>	<p>Members who commented on this assumption highlighted their concerns that the figure given (26) was considered to be an underestimate. For example, one member explained that their figures revealed an average of 44 (between 36 and 54) needle exchange contacts a year on average. EATA is calling on the NTA to consider its assumption to reflect a higher average.</p>
3	<p>It is assumed that one-to-one needle exchange clients make 26 needle exchange contacts per year on average</p> <p>Is this a reasonable assumption?</p>	<p>Again, the figure given in this assumption was highlighted by members as an underestimate. EATA recommends that the NTA considers the figure average in this assumption.</p>
4	<p>It is assumed that all opioid and crack cocaine users receive two harm reduction interventions on average, excluding needle exchange, when they first make contact with the treatment system.</p> <p>Is this a reasonable assumption?</p>	<p>EATA agreed that this is a reasonable assumption.</p>
5	<p>All opioid users in contact with the treatment system at risk of hepatitis C infection should be offered access to screening tests and tests to confirm hepatitis C infection.</p> <p>How much do these tests cost in your experience, including pay, non pay and overhead costs?</p>	<p>Many of our members refer such clients on for testing and therefore have no direct figures for costings. But EATA would like to stress that early screening, detection and prevention will save much greater costs further down the line.</p>

No.	Question	Your response
6	<p>It is assumed that 75 per cent of those offered the tests will receive them, as some will already have received the tests and others will refuse them.</p> <p>Is this a reasonable assumption?</p>	<p>This figure of 75% was felt to be an overestimate. This figure will vary widely as it depends on the method of testing which is offered and accessibility to screening within each area.</p>
7	<p>All opioid users in contact with the treatment system will be offered vaccination and other will refuse it.</p> <p>It is assumed that 75 per cent of those offered the vaccination will receive the full course, as some will already have received the vaccination and others will refuse it.</p> <p>Is this a reasonable assumption?</p>	<p>Again this was felt to be an overestimate for the same reasons as in the box above (6).</p>
8	<p>A full course of vaccination costs £219 on average.</p> <p>Is this a reasonable assumption?</p>	<p>EATA's members who commented explained that their organisation refers clients on for this procedure so they are unable to comment on direct costings.</p>
<p>3.1.2 Opioid users - (including opioid users who use crack cocaine) - in structured treatment (Tier 3 and Tier 4)</p>		
9	<p>It is assumed that a comprehensive assessment takes place on average over the course of three hours, which may be conducted over several sessions.</p> <p>Is this a reasonable assumption?</p>	<p>EATA believes that this assumption is a reasonable one. However comments were raised by members that this assessment is an ongoing process and very patient-dependent. The three hour point should not become a cut-off point beyond which no further assessment can take place.</p>
10	<p>It is assumed that a comprehensive assessment costs £140 on average. This includes the costs of drug testing as well as a doctor's involvement in the assessment.</p> <p>Is this a reasonable assumption?</p>	<p>EATA has concerns that the average £140 figure may be too low. As the "average" three hour-long comprehensive assessments includes the doctor's time, drug testing and the assessor's time. These costs are considerable.</p> <p>Costs could also increase if the client has complex needs and the care plan involves interaction with multiple agencies.</p>

No.	Question	Your response
11	<p>Keyworking is defined as a basic delivery mechanism for a range of key components including the review of care plans and goals, provision of drug-related advice and information, harm reduction interventions, and interventions to increase motivation and relapse. Help to address social problems, for example housing and employment, is also important. The keyworker may be a doctor, a nurse, a voluntary sector drugs worker, etc. The clinician in most regular contact with the patient is normally the key worker. Keyworking helps to ensure the delivery and ongoing review of the care or treatment plan. This would normally involve regular sessions or consultations with the patient in which progress against the care plan would be discussed and goals revised as appropriate.</p> <p>As a result it is assumed that all opioid users will receive keyworking all year</p> <p>Is this a reasonable assumption?</p>	<p>EATA considers this to be a reasonable assumption.</p>
12	<p>It is assumed that keyworking takes place once a month on average for an hour on average, with two sessions on average in the first month. High dependency clients will probably require more than this in general and low dependency clients will probably require less.</p> <p>Is this a reasonable assumption?</p>	<p>EATA does not consider this to be a reasonable assumption as different areas have adopted different approaches which work for them. For example some of our members explained that for them, fortnightly sessions are the norm.</p>
13	<p>It is assumed that keyworking costs £40 per hour on average, which is the total cost of one hour of a Band 6 drug worker's time.</p> <p>Is this a reasonable assumption?</p>	<p>EATA does consider this to be a reasonable assumption, but there needs to be scope for manoeuvre because costs could increase if the client has complex needs and the care plan involves interaction with multiple agencies, or the key worker is a psychologist or doctor.</p>
14	<p>It is assumed that for each hour of keyworking, there is an additional half hour for non contact activity, for example completing case notes.</p> <p>Is this a reasonable assumption?</p>	<p>While this is also considered to be a reasonable assumption, travel time needs to be considered if workers are assessing off site. Especially if offering services in rural areas.</p>
15	<p>It is assumed that keyworking costs £780 per year on average (13 hours + 13 half hours at £40 per hour).</p> <p>Is this a reasonable assumption?</p>	<p>This figure is not a reasonable assumption, as highlighted above, if the norm is fortnightly sessions this would increase the annual costs.</p>

No.	Question	Your response
16	<p>Following the initial harm reduction interventions and comprehensive assessment (including screening, triage and brief initial assessment), heroin users are assumed to opt for either:</p> <ul style="list-style-type: none"> • Stabilisation, detoxification and support to enable them to become abstinent, leave the treatment system altogether, or • A treatment path that provides a substitute opioid maintenance programme. <p>Is this a reasonable assumption?</p>	<p>EATA considers this to be a reasonable assumption.</p>
3.1.2.1 Opioid Detoxification		
17	<p>It is assumed that 15 per cent of all opioid users (including those who use crack cocaine) in the treatment system in a given year opt for opiate detoxification.</p> <p>Is this a reasonable assumption?</p>	<p>There were concerns that this assumption overestimated the percentage of those who make this choice. It is a small percentage that opts for opiate detoxification and EATA recommends that this assumption is changed to “up to 15 per cent”.</p>
18	<p>The opiate substitution stabilisation phase takes two to four weeks (2007 Clinical Guidelines). It is assumed therefore that stabilisation will take three weeks on average.</p> <p>Is this a reasonable assumption?</p>	<p>EATA believes that this is not a reasonable assumption. Comments from our members highlight that it would take longer than two to four weeks to stabilise, unless the client is seen more often, for example, seen daily in a titration clinic.</p>
19	<p>It is assumed that opiate substitution stabilisation is more intensive than substitute opioid maintenance and requires greater clinical input, and costs £76 per week on average. So it is assumed that the total cost of stabilisation is £228 on average.</p> <p>Is this a reasonable assumption?</p>	<p>EATA is calling for further clarification on how these costs and assumptions were reached. For example, how is stabilisation more time consuming than maintenance and at what point? We have concerns that this set of assumptions only serve to “box up” service users and fail to understand that it is possible for patients to move between different service options as needs and desires change.</p>
20	<p>It is assumed that an inpatient opiate detoxification lasts for 21 days on average.</p> <p>Is this a reasonable assumption?</p>	<p>EATA agree that this is a reasonable assumption, although this may need to be extended depending on the complexity of clients’ needs.</p>
21	<p>It is assumed that a community opiate detoxification lasts for a maximum of 12 weeks.</p> <p>Is this a reasonable assumption?</p>	<p>This is not a reasonable assumption because of the rate of relapse that exist within the community setting, very few opiate dependant client successfully complete their detoxification within the maximum 12 weeks.</p>

No.	Question	Your response
3.1.2.2 Post detoxification treatment and support		
22	<p>Following detoxification, it is estimated that 20 per cent of clients need structured psychosocial interventions (usually one-to one) in addition to ongoing keyworking.</p> <p>Is this a reasonable assumption?</p>	<p>EATA agrees that this is a reasonable assumption. However members highlighted the need for structured interventions before and during detox – not just afterwards.</p>
23	<p>It is assumed that these psychosocial slots last for 12 weeks on average.</p> <p>Is this a reasonable assumption?</p>	<p>This is a reasonable assumption.</p>
24	<p>A 12-week psychosocial slot costs £480 on average.</p> <p>Is this a reasonable assumption?</p>	<p>This is a reasonable assumption</p>
25	<p>It is estimated that forty per cent of those who have completed detoxification will require residential rehabilitation.</p> <p>Is this a reasonable assumption?</p>	<p>EATA does not agree with this assumption. We strongly believe that the figure of 40 per cent is an underestimate.</p>
26	<p>It is assumed that residential rehabilitation lasts for three months on average, often purchased in six-week blocks.</p> <p>Is this a reasonable assumption?</p>	<p>EATA does not agree with this assumption. Our members commented that residential rehabilitation is purchased in 12 week blocks, with average stays of six months. This is double the figure highlighted by this assumption.</p>
27	<p>It is assumed that the remaining forty per cent of those who have completed detoxification will attend intensive day programmes.</p> <p>Is this a reasonable assumption?</p>	<p>EATA considers this assumption to be an overestimate.</p>
28	<p>Intensive day programmes (structured day programmes) last for 12 weeks on average.</p> <p>Is this a reasonable assumption?</p>	<p>While EATA considers this to be a reasonable assumption, further clarification is required on what intensive day programmes fall into this category.</p>
3.1.2.3 Substitute opioid maintenance		
29	<p>It is assumed that 85 per cent of opioid users (including those who use crack) will opt for treatment that provides substitute opioid maintenance in the first instance.</p> <p>Is this a reasonable assumption?</p>	<p>EATA considers this assumption to be a reasonable assumption.</p>

No.	Question	Your response
30	<p>It is assumed that the opioid users who opt for maintenance will receive substitute opioid maintenance all year.</p> <p>Is this a reasonable assumption?</p>	<p>This is a reasonable assumption, but there are concerns that many opioid users will remain effectively “parked” on substitute opioid maintenance for several years.</p>
31	<p>It is assumed that eighty per cent of people on substitute opioid maintenance will require a formal 12-week structured psychosocial intervention during the year to address either persistent crack use, alcohol misuse, underlying anxiety or depression, persistent injecting or other issues. For example, those in a methadone programme who continued to use crack would receive a 12-week additional psychosocial programme to address crack dependency.</p> <p>Is this a reasonable assumption?</p>	<p>EATA considers this on the whole to be a reasonable assumption, although there were concerns from members that this might be a slight underestimate.</p>
32	<p>It is assumed that ten per cent of opioid users who are receiving substitute opioid maintenance medication attend intensive day programmes.</p> <p>Is this a reasonable assumption?</p>	<p>EATA has concerns that this assumption is an overestimate because in rural areas these programmes are far less available or accessible.</p>
33	<p>It is assumed that fifty per cent of clients will continue to require harm reduction services. This may include needle exchange or testing and referral for treatment of blood-borne viruses.</p> <p>Is this a reasonable assumption?</p>	<p>EATA considers this assumption to underestimate the percentage of clients that will require access to harm reduction services.</p>
34	<p>It is assumed that four of these harm reduction interventions will be required on average by each client each year.</p> <p>Is this a reasonable assumption?</p>	<p>EATA considers that much more than four such interventions will be required on average by clients each year. For example, taking just needle exchange alone, more than four interventions will be required each year and should be actively encouraged by agencies so as to promote safe injecting practices and prevent the spread of BBVs.</p>

3.1.3 Crack cocaine users in structured treatment (Tier 3 and 4)

No.	Question	Your response
35	<p>As with opioid users, crack users requiring structured drug treatment interventions all receive a comprehensive assessment and keyworking throughout structured treatment</p> <p>As a result it is assumed that crack cocaine users will receive keyworking all year.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>
36	<p>It is assumed that 80 per cent of primary crack cocaine users will receive 12 weeks structured psychosocial interventions in addition to keyworking.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption, although it may increase depending on clients' needs.</p>
37	<p>It is assumed that 30 per cent of primary crack cocaine users attend intensive day programmes.</p> <p>Is this a reasonable assumption?</p>	<p>EATA considers this figure to be an overestimate.</p>
38	<p>It is assumed that 20 per cent of primary crack cocaine users will require residential rehabilitation.</p> <p>Is this a reasonable assumption?</p>	<p>EATA considers this figure to be an underestimate. More than 20 per cent of primary crack cocaine users will require residential rehabilitation.</p>
39	<p>As with opioid users, it is assumed that residential rehabilitation for primary crack cocaine users lasts for three months on average.</p> <p>Is this a reasonable assumption?</p>	<p>EATA does not agree with this assumption. Our members commented that residential rehabilitation is purchased in 12 week blocks, with average stays of six months. This is double the figure highlighted by this assumption.</p>
3.1.4 Aftercare		
40	<p>It is assumed that aftercare lasts for twelve months with intensity tapering off after six months.</p> <p>Is this a reasonable assumption?</p>	<p>While EATA considers this to be a reasonable assumption, there are concerns among our members that the provision of aftercare doesn't always match up to this assumption.</p>
3.2 Prison treatment pathways		
3.2.1 General assumptions		

No.	Question	Your response
41	<p>It is assumed that adult drug users who do not use opioids and/or crack cocaine are not provided with treatment in prison.</p> <p>Is it reasonable to assume that adult drug users who do not use opioids and/or crack are not provided with drug treatment in prison?</p>	<p>This is considered to be a reasonable assumption.</p>
42	<p>It is assumed that 100 per cent of those who self-report that they have used of opioids, crack cocaine or are injecting drugs in the past seven days have a general medical assessment on entry to prison.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>
43	<p>It is assumed that this general medical assessment costs £63.40 on average, including medical and nursing costs.</p> <p>Is this a reasonable assumption?</p>	<p>EATA is unable to comment on this assumption.</p>
44	<p>It is assumed that following this assessment, it is assumed that 100 per cent of those who have had the general medical assessment have a triage and comprehensive substance misuse assessment.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>
45	<p>It is assumed that the first half of this assessment is clinical and is conducted by a nurse and lasts for 1.5 hours.</p> <p>Is this a reasonable assumption?</p>	<p>EATA is unable to comment on this assumption.</p>
46	<p>It is assumed that this clinical assessment costs £37.50 per person on average.</p> <p>Is this a reasonable assumption?</p>	<p>EATA is unable to comment on this assumption.</p>
47	<p>It is assumed that on entry into prison, all opioid and crack cocaine users, both remand and sentenced, who are in prison for 90 days or more receive 90 days of treatment on average provided by the Integrated Drug Treatment System.</p> <p>Is this a reasonable assumption?</p>	<p>EATA is unable to comment on this assumption.</p>
48	<p>It is assumed that 90 days of treatment costs £531 on average plus the fixed cost allocation of £40-120K per prison. This excludes the cost of CARAT.</p> <p>Is this a reasonable assumption?</p>	<p>EATA is unable to comment on this assumption.</p>

No.	Question	Your response
3.2.2 Opioid users (including opioid users who use crack cocaine)		
49	<p>It is assumed that on entering prison, opioid users are stabilised on substitute opioid medication for an average of five days, excluding assessment.</p> <p>Is this a reasonable assumption?</p>	EATA is unable to comment on this assumption.
50	<p>It is assumed that opioid stabilisation costs £45 on average per person.</p> <p>Is this a reasonable assumption?</p>	EATA is unable to comment on this assumption.
51	<p>It is assumed that 100 per cent of clients who use opioids will be provided with either detoxification or substitute opioid maintenance.</p> <p>Is this a reasonable assumption?</p>	This is considered to be a reasonable assumption.
52	<p>It is assumed that 50 per cent will have a detoxification from opiates (including clinical monitoring and support for stimulant dependence) with some also receiving naltrexone treatment and 50 per cent will have substitute opioid maintenance.</p> <p>Is this a reasonable assumption?</p>	EATA is unable to comment on this assumption. (Members who responded were unaware of Naltrexone use).
53	<p>It is assumed that prison detoxification lasts for 19 days on average.</p> <p>Is this a reasonable assumption?</p>	This is considered to be a reasonable assumption.
54	<p>It is assumed that detoxification costs £372 on average.</p> <p>Is this a reasonable assumption?</p>	EATA is unable to comment on this assumption.
55	<p>It is assumed that there is a 25 per cent relapse rate in prison among opioid users who have been detoxified and are in prison for more than 90 days.</p> <p>Is this a reasonable assumption?</p>	EATA considers this is to be an unreasonable assumption as the relapse rate in prison is believed to be higher than 25 per cent.
56	<p>It is assumed that those who relapse receive another 90 days of prison treatment.</p> <p>Is this a reasonable assumption?</p>	EATA considers it unreasonable to assume that those who relapse receive another 90 days of prison treatment.

No.	Question	Your response
57	<p>It is assumed that 50 per cent of clients who use opioids will opt for substitute opioid maintenance. The average length of stay for those requiring treatment is six months, however the average duration of prescribing is 3 months.</p> <p>Is this a reasonable assumption?</p>	<p>EATA considers that more than 50 per cent are likely to opt for maintenance.</p>
58	<p>It is assumed that substitute opioid maintenance costs £41 per week on average. So the average total cost per person is £535.</p> <p>Is this a reasonable assumption?</p>	<p>EATA is unable to comment on this assumption.</p>
3.2.3 Crack cocaine users		
59	<p>It is assumed that there is an observation period for crack cocaine-using clients when they arrive, consisting of two daily observations for three days – this is to check that they are free from harm.</p> <p>Is this a reasonable assumption?</p>	<p>EATA is unable to comment on this assumption.</p>
60	<p>It is assumed that this observation period costs £20 on average. This is calculated from eight minutes per patient, twice a day for three days, equalling 0.72 hours of a nurse's time at £25 per hour.</p> <p>Is this a reasonable assumption?</p>	<p>EATA is unable to comment on this assumption.</p>
3.3 Other drug user community treatment pathways		
3.3.1 Adults		
61	<p>It is assumed that two harm reduction interventions will be provided per person on average.</p> <p>Is this a reasonable assumption?</p>	<p>EATA considers this assumption to be an underestimate, with members commenting that they would provide more than two harm reduction interventions per person on average. Some members commented that they provided four such interventions per person on average.</p> <p>EATA is calling on the NTA to increase this assumption to a minimum of four harm reduction interventions per person on average.</p>
62	<p>It is assumed that 50 per cent of the 'other' group will receive only Tier 2 interventions.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>

No.	Question	Your response
63	<p>It is assumed that they will receive 8 weeks of structured psychosocial interventions on average in addition to keyworking.</p> <p>Is this a reasonable assumption?</p>	<p>This is not considered to be a reasonable assumption. There may be a need for further sessions beyond 8 weeks. Members have commented that they usually deliver 12 weeks of structured interventions, subject to an assessment.</p>
64	<p>It is assumed that an eight-week psychosocial slot costs £320 on average.</p> <p>Is this a reasonable assumption?</p>	<p>While an 8 week slot would cost £320, the costs may be higher because members have pointed out that they usually deliver 12 weeks of structured interviews, subject to an assessment.</p> <p>If the 8 weeks slot costs £320, then EATA would expect 12 weeks slot to cost £480.</p>
65	<p>It is assumed that this keyworking will occur once a week for an hour, for eight weeks on average, as this is the average length of time for which 'other' drug users will be in treatment.</p> <p>Is this a reasonable assumption?</p>	<p>One hour, once a week is reasonable but as highlighted in Q63 and Q64, further sessions may be required, especially if they are carried out over a 12 week slot.</p>
66	<p>It is assumed that keyworking costs £320 on average for eight weeks.</p> <p>Is this a reasonable assumption?</p>	<p>Again, note that that the costs will be higher because providers usually deliver 12 weeks of structured interviews, subject to an assessment.</p> <p>If 8 weeks costs £320, then EATA would expect 12 weeks to cost £480.</p>

3.3.2 Young People under 18

3.3.2.1 Treatment pathway 1a

67	<p>It is assumed that 15 per cent of young people who engage with a treatment service will have low-severity drug or alcohol use, a low risk of harm and high protective factors.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>
68	<p>It is assumed that this group is mainly comprised of alcohol, cannabis and stimulant users.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>
69	<p>It is assumed that these clients will access four one-hour keyworking sessions, which will take place with a drugs worker.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>

No.	Question	Your response
70	<p>It is assumed that for each young person's treatment pathway that for each hour of keyworking, there is an additional half hour for outreach, travel and family working.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption, but it should be borne in mind that the amount of travel in large rural areas will be greater.</p>
71	<p>It is assumed that the cost of keyworking will be six hours of a drug worker's time at £40 per hour on average (4 hours of keyworking plus the half an hour extra per hour). The total cost then will be £240 per person on average.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>
3.3.2.2 Treatment pathway 1b		
72	<p>It is assumed that 15 per cent of young people have extremely chaotic behaviour and their drug use is secondary to other problems. Their characteristics are that of low-severity drug use, but very high risk of harm and very low protective factors.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>
73	<p>It is assumed that this group will also access the same treatment pathway as that described above, but will access the pathway on average twice a year.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>
74	<p>It is assumed that the cost of keyworking will be 12 hours of a drug worker's time at £40 per hour on average (eight hours of key working plus half an hour extra per hour). The total cost then will be £480 per person on average.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>
3.3.2.3 Treatment pathway 2		
75	<p>It is assumed that 45 per cent of young people who engage with a treatment service will have medium severity drug or alcohol use, low risk of harm and medium protective factors.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>

No.	Question	Your response
76	<p>It is assumed that this group is mainly comprised of alcohol, cannabis and stimulant users.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>
77	<p>It is assumed that these clients will access nine one-hour sessions of keyworking on average; possibly two sessions a week to start off with.</p> <p>Is this a reasonable assumption?</p>	<p>Again, this will very much depend upon location of client and the issues relating to rurality and the size of the county within which services are provided.</p>
78	<p>It is assumed that the cost of keyworking will be 13.5 hours of a drug worker's time at £40 per hour on average (nine hours keyworking plus half an hour extra per hour). The total cost then will be £540 per person on average.</p> <p>Is this a reasonable assumption?</p>	<p>As raised in several of the questions above, the size of an area/county will have an impact on the costs of providing services, particularly those areas/counties that are difficult to travel around.</p>
3.3.2.4 Treatment pathway 3		
79	<p>It is assumed that approximately ten per cent of young people who engage with a treatment service will have medium severity drug use, medium risk of harm and low protective factors and will require long-term contact with services.</p> <p>Is this a reasonable assumption?</p>	<p>EATA recommends that this assumption also includes alcohol use.</p>
80	<p>It is assumed that those presenting will be using any type of drug.</p> <p>Is this a reasonable assumption?</p>	<p>EATA recommends that this assumption also includes alcohol use.</p>
81	<p>It is assumed that on average clients will access 20 one-hour keyworking sessions (which will take place over the course of 4–6 months) and three one-hour multi-agency interventions (during the early part of the treatment journey), which will be attended by the keyworker.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>
82	<p>It is assumed that for each hour of a multi-agency intervention, the keyworker will need to do an additional three hours of preparation.</p> <p>Is this a reasonable assumption?</p>	

No.	Question	Your response
83	<p>It is assumed that the cost of keyworking and multi-agency interventions will then be 42 hours of a drug worker's time at £40 per hour on average (20 hours of keyworking, plus the half an hour extra per hour plus twelve hours for the multi-agency interventions). The total average cost then will be £1,680 per person.</p> <p>Is this a reasonable assumption?</p>	<p>Again, this assumption needs to factor in the amount of costs and time spent on travelling, particularly in large or rural areas.</p>
3.3.2.5 Treatment pathway 4		
84	<p>It is assumed that approximately 15 per cent of young people who engage with a treatment service will have high-severity drug use (which means that they are dependent on drugs), high risk of harm and low protective factors and will require more intensive long-term contact with services.</p> <p>Is this a reasonable assumption?</p>	<p>This is considered to be a reasonable assumption.</p>
85	<p>It is assumed that those presenting will be predominantly using heroin, alcohol, cannabis and cocaine in that order.</p> <p>Is this a reasonable assumption?</p>	<p>This is not a reasonable assumption because there are concerns that crack cocaine has been omitted from this list.</p>
86	<p>It is assumed that on average, this will consist of 20 one-hour keyworking sessions (which will take place over the course of six months) and six one-hour multi-agency interventions which will be attended by the keyworker.</p> <p>Is this a reasonable assumption?</p>	<p>While this appears to be a reasonable assumption, it should be borne in mind that the 20 hour figure is dependent upon the needs of the young person. In cases where chaotic use is evident, there will be a need for more intervention.</p>
87	<p>It is assumed that for each multi-agency intervention the keyworker will need to do an additional three hours of preparation.</p> <p>Is this a reasonable assumption?</p>	<p>This is not a reasonable assumption because as members have commented, YP substance misuse services are often left dealing with complex and chaotic cases because generic services are unable or unwilling to engage with these YP until they are stabilised in respect of their drug/alcohol use.</p>
88	<p>It is assumed that the cost of keyworking and multi-agency interventions will then be 54 hours of a drug worker's time at £40 per hour on average (twenty hours of keyworking, plus the half an hour extra per hour plus twenty four hours for the multi-agency interventions). The total cost then will be £2,160 on average.</p> <p>Is this a reasonable assumption?</p>	<p>Again, EATA stresses that the size and individual characteristics of different areas will have an impact on this cost. This should be reflected within the assumption rather than "one size fits all".</p>

No.	Question	Your response
89	<p>It is assumed that of this group, 95 per cent of those using heroin will opt for detoxification and five per cent will opt for substitute opioid maintenance.</p> <p>Is this a reasonable assumption?</p>	<p>This is a reasonable assumption because this group rarely opt for residential/In-patient and rarely opt for maintenance.</p>
90	<p>The assumptions from the adult treatment system apply to the young heroin users described above who opt for detoxification or substitute opioid maintenance.</p> <p>Is this a reasonable assumption?</p>	<p>This is not a reasonable assumption because assumptions made in respect of service provision to adults should never be transposed onto YP treatment. A completely independent view of need and provision is required as the issues in relation to YP treatment are so different to those in the adult world. There needs to be a greater degree of thought given to what is an extremely complex and very different area of service provision.</p> <p>For example, this group rarely require residential services and rely on good quality assessment of need and Mental Health services (CAMHS) that will prescribe.</p>
3.4 General assumptions		
91	<p>Throughout the treatment pathways described in the previous section, users will drop out of treatment altogether.</p> <p>How can we reflect this attrition in the model?</p>	<p>EATA has several concerns about this assumption.</p> <ol style="list-style-type: none"> 1. Rather than trying to reflect this attrition in the model, the focus should be on ensuring and prioritising re-engagement when commissioning and planning services provision and local treatment pathways (for both adults and YP). 2. According to our members who provide treatment services to YP, those young people who do drop out of treatment are in most cases re-engaged at a later stage. 3. No model is actually proposed for YP except an adult-focussed model which fails to cater or provide a unique YP approach. 4. Model also fails to consider transitional arrangements (16-25 age group) and need for joined-up working for patients in adult and YP services.

No.	Question	Your response
92	<p>It is assumed that all interventions provided by drug treatment systems have been included.</p> <p>Have any interventions been excluded?</p>	<p>This assumption is not reasonable because EATA considers that a very narrow approach to treatment has been dealt with by this document. Some of our concerns include:</p> <ol style="list-style-type: none"> 1. Addressing the client's employment, training and education, healthcare (non drug treatment), mental health care and housing needs is essential for facilitating the recovery journey, preventing relapse and helping the individual to reintegrate into the community. These vital areas should be run and provided concurrently to treatment services, and not, as EATA members described it, "tacked on at the end". 2. This assumption has also continued to automatically split detox from residential rehabilitation. EATA is keen to stress that the two can be provide together in an extremely effective fashion and for the benefit of the client. 3. Finally, the whole document fails to deal adequately with the issue of Dual Diagnosis, and the interventions and costs implications this area presents for drug treatment.
93	<p>It is assumed that the model will have a positive impact on drug treatment systems planning.</p> <p>Are there any possible unintended consequences of developing the model or are there any other issues which should be taken into account during the development of the model?</p>	<p>There are concerns that the model as shown in the document is too linear and rigid, which will limit choice for the client at different stages in their treatment. This could also have a major detrimental impact on the way in which treatment services are commissioned.</p> <p>Specific comments we have received from EATA members include:</p> <ul style="list-style-type: none"> • DIP/Custody should be included within the treatment system (or at least overlapped) as the provision of Harm Reduction should be starting as soon as possible for this client group. • Referral routes in are Self, Third Party, Primary Care/Health professional and Criminal Justice. • Lack of mention of General Medical Service provision. • The model diagram indicates that Harm Reduction happens before treatment, but not during and after. Harm Reduction, as per the NTA planning guidance, should be integrated into the whole treatment approach.

No.	Question	Your response
4.1 Clinical governance costs		

No.	Question	Your response
94	<p>The NTA will be providing guidance on clinical governance in 2008. This is a key element of drug treatment provision, is a legitimate draw upon the adult pooled treatment budget and will need to be costed. The key components of clinical governance are:</p> <ul style="list-style-type: none"> • Lines of responsibility and accountability • Quality improvement activities • Policies aimed at managing risks • Procedures for identifying and remedying poor performance. <p>However, these do not identify the activities that are likely to result in costs to the treatment system. There are very many of these and it is not feasible to be comprehensive here but some of the key activities that will need to be covered include:</p> <ul style="list-style-type: none"> • Risk assessment and management • Clinical supervision • Clinical audit • Service user involvement in service monitoring, planning, design, etc • Service information management • Contingencies for investigating and responding to serious untoward incidents and poor performance <p>Costing these is likely to be difficult as it will depend on the nature and sector of individual services. For example, NHS trusts have statutory clinical governance responsibilities but also the infrastructure to manage them. Commissioned voluntary sector services may have the same responsibilities but may not be able to call on a broader infrastructure to provide resources.</p> <p>More detailed guidance on costing the different elements will be included in the next phase of the development of the model. For now, an “all-inclusive” cost is included in the system management cost suggested below in section 4.4.</p> <p>Are there substantial elements of clinical governance that need to be costed separately?</p>	<p>EATA considers clinical audit to be a vital and costly element of the agenda, which needs to be given greater attention. Firstly, we feel that Clinical Audit needs to be extended to include Clinical and Quality Audit because the two naturally complement each other.</p> <p>Particular areas that require addressing within the overall costs of effective systems of treatment include:</p> <ul style="list-style-type: none"> • Safeguarding issues in relation to vulnerable adults • Costs related to developing and implementing the safeguarding children agenda. • Up to date IT systems and finances to manage them at a high level within clinical services.

No.	Question	Your response
4.2 Commissioning costs		
95	<p>The NTA will be publishing draft new commissioning guidance in late 2008 after which further attempts will be made to break down these costs. However, as with clinical governance, key activities need to be reflected in system management costs and these include:</p> <ul style="list-style-type: none"> • Needs assessment • Training and other activities to ensure that commissioners are competent • Procurement • Performance management. <p>In addition to local commissioning costs, there may be additional costs associated with local involvement in cross-area or regional commissioning. And where a lead commissioning arrangement is used, the costs may all arise in one area or PCT but need to be met by multiple partners.</p> <p>Are there substantial elements of commissioning that need to be costed separately?</p>	<p>Comments from our members who provide and commission services called for a move away from the focus on “Unitary” setting. Many areas are multi-tiered authorities, multi-PCTs which have different needs and priorities, and fail to fit into the Unitary setting.</p>
4.3 Workforce strategy costs		
96	<p>The individual interventions costs described in section 3 include the current, direct costs of training and supervision for staff to ensure they are competent. However, at a partnership level there are workforce strategies that may entail additional costs. This is especially true with the expectations of new clinical guidance and the new drug strategy.</p> <p>Should workforce strategy costs be dealt with in the model: for instance as part of intervention costs; as a system cost; or with a calculated allocation to each?</p>	<p>EATA recommends that the calculated allocation should be identified as a separate element.</p>

No.	Question	Your response
4.4 Other infrastructure costs		
97	<p>In addition to clinical governance costs and commissioning costs there are additional drug treatment system infrastructure costs such as local information management, research and training.</p> <p>Are there other infrastructure costs, apart from clinical governance and commissioning costs that need to be costed separately?</p>	<p>Other costs include:</p> <ul style="list-style-type: none"> • Implementing, managing and monitoring the Safeguarding (adults and children) agenda. • Rental, buildings, overheads, training budgets. • Clinical supervision, new ways of working and the need to incorporate doctors into teams.
4.5 Overall drug treatment system management cost		
98	<p>Pending a detailed analysis of drug system costs, we have taken a rudimentary overview of the adult treatment plans submitted annually to the NTA. Based on this it is suggested that an additional seven per cent of the total cost of the interventions provided in section 3 of the consultation document will be used to calculate drug treatment system management costs.</p> <p>Is this a reasonable assumption?</p>	<p>EATA does consider this to be a reasonable assumption.</p>

OTHER COMMENTS

Section number Give section number or 'general' if your comment relates to the whole document	Your comments (Please insert each new comment in a new row)
<i>general</i>	<p><i>The document highlights gaps in the practice of clinical governance. Although these areas are in the main text of the document, it would be helpful if there could be an additional section at the end of each chapter with areas where further research would be helpful. This would support the research agenda and maximise resources. ... example comment.</i></p>
3.1.1 (1)	<p><i>While we agree in principle with ... example comment.</i></p>
General	<p>The European Association for the Treatment of Addiction (UK) is the main representative body for the voluntary and independent drug and alcohol treatment and aftercare sector, working to ensure that people affected by substance dependencies get the treatment they need.</p> <p>The Association contributes to the debate on policy that relate to drug and alcohol treatment. In this role we respond to consultations and reports from government departments and agencies and other bodies. In this official submission, EATA is representing both the views of our members and the organisation as a whole. Our members' views were assembled from responses received to a consultation questionnaire emailed to all members.</p> <p>While we welcome this document's detailed focus on drug treatment to provide greater understanding of how funding is spent and assumptions of what needs to provide the greatest value and most effective treatment, we felt that the nature of this document and the accompanying questionnaire was extremely counter-productive. Expecting busy professionals to wade through 90-plus questions can be considered as unrealistic and frustrating, especially when so many of the questions appear to be similar and could have been dealt with together.</p>
General	<p>EATA is also highly concerned that this document's focus is predominantly on harm reduction, community-based services, prison services and other forms of treatment. In comparison, very little few of the questions dealt with Tier 4 – residential rehabilitation – and the costs of treatment within this tier. From the attention it received within this document, it could be concluded that Tier 4 is not as high up on the agenda as the other tiers, despite the NTA's position that "improving Tier 4 provision is a key part of the National Treatment Agency's (NTA) Treatment Effectiveness strategy" [<i>Improving the quality and provision of Tier 4 interventions as part of client treatment journeys. A best practice guide</i>, NTA, September 2008]. This is not a fair representation of the service and does not present a level playing field.</p>
Section 3. Fig 1	<p>EATA is concerned that the diagram is too linear by failing to incorporate the Aftercare box into Throughcare. Both need to be run concurrently in order to provide a holistic structured treatment programme where wraparound and non-specialist services are not included as an afterthought.</p>
General	<p>There were many concerns from our members that a particular type of setting was used when considering the costs associated with treatment provision – urban conurbations and small unitary authorities. These assumptions need to take into account the fact that costs of provision within urban areas will differ from those in rural areas.</p>

	Accessibility, both for the client and for services, could have a major impact on sustaining treatment. As one of our members highlighted, one of the major costs incurred within rural shire DAAT areas is that of travel when ensuring the provision of satellite and outreach provision.
General.	There are concerns that this document is still separating in-patient detoxification and Residential rehabilitation. The two can and are provided extremely effectively provided by a number of the most highly respected treatment centres in the country.
General	EATA is also concerned that this document has not kept firmly in mind that much of today's drug treatment provision necessitate the use of multi-agency and multi-tiered input. Therefore, the costs for any particular care plan are bound to be multi-faceted as well.

Please add extra rows as needed

When complete, return by email to: model@nta-nhs.org.uk by 5 January 2009.