

**EATA's Spring 08 regional meetings:** Key points from discussions into the implications of implementing the National Drug Strategy for drug treatment providers and the drug treatment sector.

Diversity and equality	<p>Always an issue for the sector and members questioned what can be done in practical terms. More guidance is needed at a service level and criticism was expressed about using the drive for diversity within staff teams as a way of leading to greater understanding of cultural issues. Concerns were also raised about passing responsibility to staff teams to address diversity, weak recruitment policies and ticking the boxes.</p> <p>EATA members want to share best practice on diversity but more guidance is needed on what it is, where it is “stored”, and accessing and sharing it.</p> <p>Visible and invisible populations make it difficult to achieve the best outcomes for members of all communities. The approach should always be client-centred.</p>
Reduce politicisation and division	<p>Treatment still viewed in the strategy as a “linear” process. There is too much top down focus on targets, which members believes stifle innovation. The strategy was deliberately ambiguous about abstinence and harm reduction approaches to treatment, but a call was made to end the polarisation of these approaches by political influences to rebalance and stabilise funding. Instead, better defined evidence on different treatment is required.</p> <p>Strategy’s new approach goal is for drug misusers to “achieve abstinence as soon as possible”. However, the close association of treatment with crime reduction subjects the sector to the bottlenecks of the political agenda and could prevent the new approach goal being achieved. E.g. huge mass of people on methadone scripts plays role in bringing down crime rate but this could create reluctance to refer them on to other treatment.</p> <p>Abstinence vs Harm Reduction was again branded an unhelpful debate, diverting attention away from the more important concept of recovery. Comparisons were made with the Mental Health review’s bigger focus on recovery.</p>
Funding	<p>Despite the new strategy, the sector still faces same financial pressures as well as new ones. But it is positive that the strategy takes advantage of “charitable status” which enables funds to be raised elsewhere by providers that hold this status. Concerns raised include:</p> <ul style="list-style-type: none"> <li>• Funding systems not in place to achieve its goals, particularly for families.</li> <li>• How will treatment providers cover the costs of redeveloping current services to meet goals?</li> <li>• Fragmentation of different boxes and streams of funding.</li> <li>• Funding still affected by the post-code lottery.</li> <li>• Funding for training is fragmented and makes it difficult for providers to build relationships with local colleges. Education providers should work together in partnerships to deal with this.</li> <li>• Funding needs to cross boundaries, in the same way as people.</li> </ul>
Administration and ensuring quality	<p>There’s a lack of consistency in standards, practice and treatment, which the NTA should lead on implementing. The competence of local delivery also varies across different treatment services in a local area. DATs must speak out when a treatment service is not delivering.</p>

	<p>Accreditation of services or similar, i.e. through EATA's Accreditation Scheme, needs to be taken up by both providers <b>and</b> DATs.</p> <p>Concerns were raised about funding following desires of regional commissioners or the strongest force in PCTs. A central directive to balance local motivations behind decisions is needed, particularly for Tier 4 services where there is less understanding from commissioners about the needs and pressures. A key pressure for Tier 4 is the NTA driving more people into treatment, but as people accessing treatment at an increased rate there is less money per capita available. But as Tier 4 is more expensive, it is experiencing a decline in the number of services being commissioned.</p>
<p>Buying what works</p>	<p>Need for agreements to be made at local and regional levels as difficult for providers to deal with multiple "national" agencies.</p> <p>Commissioners must take longer-term view on treatment. Members also warned that expansion in commissioners' bureaucracy eats into treatment funds.</p> <p>Concerns about care management funding were raised, as members feel DATs are inconsistent in putting a care management system in place, e.g. providers in Liverpool co-ordinate the care plan.</p>
<p>Developing the workforce</p>	<p>Members were concerned that the workforce section was relegated to the Strategy's appendix, which makes the issue appear unimportant.</p> <p>Not enough examination into what workforce development is required to implement the Strategy has been carried out. Improving access to quality treatment goes hand in hand with an effective, competent, trained workforce.</p>
<p>Personalised care – a new approach</p>	<p>Members recognised that personalised/individual budgets are a positive development but raised a number of concerns.</p> <ul style="list-style-type: none"> <li>• Treatment providers should look beyond the treatment budget and take advantage of Local Area Authorities' funding sources.</li> <li>• Personalised budgets must work alongside the NHS Improvement Plan, which has a number of implications. E.g. the Plan requires use of Tier 4 which local DATs increasingly avoid due to high costs involved.</li> <li>• Improvements need to be monitored to encourage informed spending and an effective drug treatment system for the benefit of the client. Current monitoring through the National Drug Treatment Monitoring System is voluntary and as a result could lead to a false picture, misinformed commissioners and mal-distributed resources.</li> <li>• Consistent practice and ensuring quality services is essential with personal budgets. How will the workforce in this and partner sectors cope with understanding and incorporating these new practices? More multi-disciplinary training and development are required.</li> <li>• With introduction of personalised care, the need for external co-ordination will affect costs, taking money away from treatment. Who will hold ultimate responsibility for the money in the client's budget if housing, employment, etc are based in different departments?</li> <li>• To make this workable on a local commissioning scale, needs must be translated into a language which DATs can understand.</li> </ul>

## Key recommendations

- There needs to be more effective ownership of the diversity and equality agenda by the treatment sector and the NTA.
- Guidance is needed at a service level (not a staff level) on tackling diversity issues, but treatment should always be client-centred.
- Sharing best practice on diversity issues (or any issues) is only possible if those who need to find this information know where to go. More communication and co-ordination is required whether on a regional or national level to facilitate this.
- End the polarisation of abstinence and harm reduction by political influences to help rebalance the funding.
- Reassessment of competence required in the workforce – and what is really required.
- The NTA needs to be more transparent and facilitative, as it is currently target driven.
- There needs to be a shift of balance towards public health.
- The NTA/DH and HO need to help interpret the “personalisation” agenda.
- The NTA/DH and HO need to tell people precisely what they must do to achieve goals.

Three recommendations were also made to EATA members as well.

- Get accredited to ensure they stand out to commissioners and clients.
- Get to regional meetings to hear the information on offer and to find out how to access information.
- Use NDTMs and TOPs to facilitate monitoring of services and standards.