



UKDPC

UK DRUG POLICY COMMISSION

Payment by Results co-design group consultation

Draft outcomes for piloting payment by results for drug recovery

Joint response from DrugScope and the UK Drug Policy Commission

Introduction

DrugScope and the UK Drug Policy Commission both welcome this opportunity to comment on the draft outcome document produced by the Drug Recovery Payment by Results (PbR) co-design group (CDG). Both organisations are represented on the CDG (and were members of the initial 'expert group').¹ We have chaired CDG sub-groups on employment outcomes (UKDPC) and health and well-being outcomes (DrugScope). We have appreciated the opportunities that we have had to participate in the co-design process.

As independent organisations, we are responding to this consultation in order to raise particular issues and concerns about the evolving outcomes framework. Our comments are based on consultation and engagement with a range of policy experts, commissioners, service providers and service users. For example, the UKDPC held an expert seminar on 'Utilising payment by results in drug treatment and recovery services' on 15 September 2010 forming the basis of the subsequent report *By their fruits...Applying payment by results to drugs recovery*.² The issue of PbR outcomes was also discussed at a meeting of the DrugScope Chief Executives' Forum for treatment providers on 8 June, which was attended by nearly 30 CEOs and Senior Managers from drug and alcohol treatment services.

General comments

Both DrugScope and UKDPC have welcomed the high level outcomes specified in the 2010 Drug Strategy, and support a focus on outcomes in the commissioning and delivery of drug services. We note that there are different ways of developing 'payment by results' (including the activity-based tariffs that have been introduced in the NHS since 2003 and the 'social bond' approach at HMP Peterborough) and alternative ways to incentivise a focus on recovery outcomes (for example, the NTA is currently providing financial incentives for commissioners to increase the numbers of people successfully completing treatment, which does not constitute 'payment by results' as such but may achieve the same ends).

¹ Although we note that our involvement, and that of other independent members of the co-design group, is not acknowledged in the list of 'Co-design Group Members' listed in Annex A of this document.

² UK Drug Policy Commission (2011), *By their fruits ... Applying payment by results to drugs recovery*, available on the UKDPC website at www.ukpdc.org.uk

Developing PbR for drug recovery in a way that incentivises outcomes for treatment and recovery creates significant practical challenges for those managing the system and delivering services. The challenge of moving to a new system in the pilot areas is compounded by the fact that the introduction of Drug Recovery PbR would overlap (for example) with radical health service reforms, a new system for prison commissioning, the introduction of elected police commissioners and restricted budgets for local councils. In particular, there is a need to properly integrate a number of different PbR initiatives that will be dealing with overlapping client groups, including Drug Recovery PbR, the Work Programme, PbR for alcohol problems within the NHS and PbR in the criminal justice system.

Both DrugScope and UKDPC have expressed concerns about the practical challenges of developing Drug Recovery PbR pilots, particularly given the time constraints on the co-design process. In other areas of health and social care, PbR models have been developed over a period of several years (for example, PbR for mental health services has been in development for around seven years, with implementation of currencies for mental health PbR now expected in 2012-13). By contrast, the design of the Drug Recovery PbR pilots – which are arguably even more ambitious – is being attempted in under 12 months. The co-design period began in April 2011, with the intention of launching the pilots in September/October 2011. We are concerned that the planned timetable will result in PBR systems being introduced in the pilot areas before they have been properly developed – in our view, considerably more time is needed if we are to get this right.

As discussed in the UKDPC *By their Fruits* report, the challenges include:

- Developing a framework that incentivises collaboration between the range of services and sectors that can contribute to the individual's recovery journey;
- Taking proper account of the impact of local conditions at a particular point in time (for example, local availability of housing or employment);
- Avoiding perverse incentives, particularly for services to focus on service users who they believe are most likely to achieve outcomes, and neglect some of those with the greatest needs;
- Ensuring a balance between interim and final payments that is realistic about the nature of recovery;
- Developing a payment structure that makes it financially viable for voluntary and community sector organisations to participate in payment by results (particularly smaller, local organisations).

The co-design group has made progress in the last four months to begin to develop outcome measures and eligibility criteria for a Drug Recovery PbR approach and to address some of these issues. We know that hundreds of hours of time by officials and others have been invested in developing a PbR model which is appropriate and effective for services supporting people with drug and alcohol problems.

However, the draft outcomes document suggests that limited progress has been made towards a robust and detailed framework that can: incentivise effective delivery of the recovery outcomes in the 2010 Drug Strategy; ensure sufficient consistency to enable meaningful evaluation of the programme; provide a viable business model for service providers (particularly from the voluntary and community sector); and avoid

the ‘perverse incentives’ that can exclude people from accessing the support they need for recovery or leave them ‘parked’ within services.

The extensive and considerable work on developing a PbR framework has highlighted and evidenced the challenges and complexities inherent in applying it to services delivering or supporting treatment and recovery services. We are concerned, for example, that the consultation document:

- includes no proposed approach to employment related outcomes at this late stage;
- is unclear about the role of substitute prescribing in PbR despite debate on this issue;
- lacks detail on the approach to relapse; and
- does not address the potential tensions arising from using tools like the TOP that have a clinical and diagnostic function for assessing and rewarding the performance of service providers.

There is also the considerable challenge of developing fair and effective ‘tariff structures’. It is still unclear what general principles and criteria will be applied to determine the appropriate payments, or how the LASAR services will work in practice.

We would urge the Government to allow the co-design group the flexibility to explore different forms of PbR and outcome-based commissioning in light of some of these theoretical and practical challenges. Given this is largely uncharted territory, we favour a cautious and staged approach (for example, phased introduction of outcome-based payments and flexibility within the pilots to recalibrate the outcome frameworks during the pilot period if there is evidence of a negative impact on service users). We therefore welcome the commitment to pilot Drug Recovery PbR. We are concerned by reports that commissioners outside the pilot areas are being encouraged to develop PbR approaches that may be guided by frameworks being developed by the CDG prematurely, and before an evidence base for effective PbR approaches is developed by the pilot areas.

Comments on recommended options

Outcome Domain 1: Free from drug(s) of dependence

DrugScope and the UKDPC believe that abstinence from drug(s) of dependence will be the ultimate ambition for most clients of drug treatment services, while recognising that this is not a realistic short-term goal for many clients entering services. The evidence shows that for many people entrenched drug dependency is a ‘chronic, relapsing condition’ and for these service users long-term stable recovery will take time. This is partly because a high proportion of clients first present to services with multiple needs linked to their dependency problems, including experience of abuse and neglect, family breakdown, mental and physical health problems, homelessness, little or no experience of employment and involvement in the criminal justice system.

It is critically important that the outcome measures in this domain, which are concerned with treatment delivery, are designed to incentivise those interventions and approaches that are demonstrated by the best available research to be effective in treating drug dependency and supporting recovery. This must include the provision of prescribing services that can be important in the early stages of recovery as well as the throughcare and aftercare services that can help to sustain it.

While we recognise the Government's concern about over-dependence on methadone prescribing there is consistent evidence that substitute prescribing can play an important role in supporting clients entering drug services to stabilise their lives and to begin a recovery journey. This is recognised in the 2010 Drug Strategy, and discussed at length in the recent interim report from an expert group chaired by Professor John Strang looking at 'Recovery-Oriented Drug Treatment' (NTA, 2011).

Option 1.1 Initial Outcome

- In order to incentivise services to work with users in the early stages of recovery it is to be hoped that a client on a substitute prescription would attract an interim payment if they were no longer using the illegal drugs for which they sought treatment (e.g., opiates such as heroin). However, this is not clear in the current definition. This will often represent an important step in an individual's recovery and is consistent with good clinical practice and NICE guidelines. Services should attract an interim payment for appropriate and proportionate use of substitute drugs in support of recovery. Given the controversy around substitute prescribing, it is important that the outcomes framework is clear and explicit on this issue.
- There is an inconsistency between the description of the interim measure and the accompanying comments. The description requires the client to be 'abstinent from all ... presenting substances' but the 'comment box' says that 'this option would allow the early success of cessation, or a significant reduction, in the use of the drug(s) of dependence to be reflected'. How does the 'Measure' that is specified for the interim payment (abstinence) 'allow the early success of ... a significant reduction ... to be reflected'. The Treatment Outcomes Profile (or TOP) does allow the identification of change so such a measure would be feasible but this is not included in the description of the measure. This requires clarification as does exactly what is meant by 'presenting substances'. Both DrugScope and the UKDPC believe that the interim measure for this outcome domain should incentivise and reward progress in moving to less harmful patterns of drug use.
- The interim outcome is assessed depending on responses to the previous two TOP reviews. We would suggest that it would be advisable to specify the minimum time lapse between the first and second review. We also note that the TOPs process records use of drugs and alcohol in the past four weeks as self-reported by the service user. This is one area in which there is a potential tension between the use of TOPs as a clinical and diagnostic tool in working with service users and as an independent measure being used to assess and reward the performance of service providers. For example, from a therapeutic perspective a clinician conducting a TOPs assessment will want to encourage a client to reveal the full extent of their drug and alcohol use, but use of the measure for outcome assessment for payment will introduce an incentive for services not to press clients pro-actively where they do not disclose drug use.
- The potential use of biological testing organised by the LASAR service as a possible additional verification also raises some concerns. First, there are practical issues about the use of testing. Most forms of testing can only provide information about drug use in the previous two or three days. Hair testing could potentially be used to indicate drug use over a longer period but there are issues about reliability and the accuracy of time periods covered and the lack of ability to detect alcohol use or recent use. Secondly, there are issues of medical ethics. We would have concerns about any requirement that service users submit to testing for purposes extraneous to their treatment, and which imply a lack of confidence in their responses to TOP

reviews, particularly without independent grounds for concern. We would question whether a requirement to submit to drug testing is consistent with building the kind of trusting and positive therapeutic relationship that is known to be one of the critical factors for recovery.

Option 1.2 Final Outcome

- We support approaches to outcome-based commissioning that reward services for successful completions, and therefore the identification of successful discharge from treatment as the final outcome for this domain.
- Service providers – including smaller local organisations – have expressed concerns to DrugScope and UKDPC about their ability to absorb the costs of delivering services and manage the financial risks associated with outcome payments, particularly where payment is postponed. We note that it is proposed that the final outcome in this domain would be measured by non-representation to treatment services in the 12 months following discharge. We would suggest that options are considered for payment systems that could release payment in instalments (monthly or quarterly) to ease cash flow - so some payment could be made, for example, at 3 months, 6 months and 9 months. This would be analogous to the way employment service providers will be rewarded for sustained employment outcomes under the Work Programme.
- It would be helpful to clarify what will happen in the event of relapse. For example, if someone relapses in the 12 months following discharge and re-enters drug or alcohol treatment could they attract a further interim payment? If they relapse after the 12 months following discharge could they qualify for a second interim and final payment?
- We would note that there may be a number of reasons why an individual does not show up in NDTMS or on the DIP prison case load in the 12 months following successful completion of treatment. These could include a change of name or mortality (including a drug-related death). There is also the risk that this measure could create a perverse incentive not to proactively re-engage former service users who develop drug or alcohol problems in the 12 months after discharge.
- Given alcohol's status as a legal drug and the options for people to address alcohol dependency problems without becoming fully abstinent from alcohol, there is a particular issue about the suitability of an exclusively abstinence-based measure for alcohol.

Outcome Domain 2: Employment

- Our understanding is that the inability to propose outcome measures for this domain, despite detailed and productive discussions within the co-design group, reflects an ongoing discussion between the Department for Work and Pensions and HM Treasury on how outcome payments in this domain will be funded. It has not been made clear what outstanding issues are preventing inclusion of any proposed outcomes at this stage.
- A key issue is how the Drug Recovery PbR pilots interact with the DWP's Work Programme. If service users in the Drug Recovery PbR programme have access to the Work Programme then who will receive the payment if they are successfully moved into employment? Alternatively, if service users are denied access to the Work Programme will they therefore miss out on the sort of specialist support available through it?

- A related issue is the need for concordance between the Drug Recovery PbR pilots and the expectations of the welfare system. Many drug and alcohol treatment service users will be receiving Employment and Support Allowance, with the expectation that they will participate in 'work-related activity' (assuming they are not in the ESA 'support group'), and not move into employment directly. The 2010 Drug Strategy states that 'where people are taking steps to address their dependence, they will be supported, and the requirements placed upon them will be appropriate to their personal circumstances and will provide them with the necessary time and space to focus on their recovery'. This recognises that for clients in the early stages of recovery a premature focus on employment could be unrealistic and destabilising. Incentivising services to move these clients directly into employment through Drug Recovery PbR would not be helpful, or consistent with the welfare system.
- A further consideration is that drug and alcohol services will have a significant but restricted impact on employment outcomes for their clients, which will depend on a range of other factors, including local availability of employment.
- DrugScope and the UKDPC would not object in principle to the final employment outcome of moving people into work being 'owned' by the Work Programme (as long as recovery service providers are rewarded for any contribution they make). However, we have concerns that this client group could be neglected by Work Programme providers. We would strongly support the inclusion of interim outcomes within the Drug Recovery PbR pilots, incentivising treatment providers to work with service users to facilitate entry or re-entry into work in the longer term. These could include evidence of progress in building social skills and self esteem, participation in training and education, involvement in volunteering and/or work placement - and perhaps entry into the Work Programme, so long as this doesn't incentivise services to push people towards full-time employment prematurely.
- One option would be for responsibility for employment outcomes to transfer to the Work Programme after an initial 12 month period, providing the flexibility for benefit claimants entering drug treatment that was proposed in the 2010 Drug Strategy. Of course, some drug treatment service users will wish to enter employment during this 'initial' period. We would suggest that this process is best managed through adaptation of the welfare system and not the Drug Recovery PbR process. Rewarding services for moving clients into employment in this early phase of treatment engagement would create perverse incentives to push people into mainstream jobs prematurely. In addition, the extent to which access to employment is dependent on factors over which drug and alcohol treatment services have limited (if any) control raises questions about the fairness of payments for employment outcomes.
- We would add that we also have some concerns about the current state of readiness of the Work Programme to provide specialist support for people with drug and alcohol problems, following the decision to decommission Progress2Work and to discontinue Drug Co-ordinator roles within JobCentre Plus. DrugScope members report little or no contact with 'prime providers' of the Work Programme – even, in some cases, where members have been explicitly identified in the 'supply chains' set out by the prime providers in their tender applications to the DWP.

Outcome Domain 3: Offending

- DrugScope and the UKDPC support the inclusion of this outcome domain. There is clear evidence that a minority of problem drug users are responsible for a high volume of often low level acquisitive crime to support their dependency, and that this

has a negative impact on families, neighbourhoods and communities. If local communities are to support investment in drug services they will want to see an impact on offending, and there is strong evidence that drug treatment does reduce offending.

- While individual measures of offending are more in keeping with the personalised nature of recovery-oriented service provision there are a host of issues with the use of an individual measure, including the perverse incentive for a provider to cease working with an individual who has been charged with an offence (noted in footnote 2) and the fact that people may be charged with offences that occurred some time previously.
- As noted in the 'Comment' section, evidence suggests that engaging with a treatment provider will in itself produce a reduction in offending behaviour (particularly given that clients will tend to engage with services at a crisis point when they are motivated to change and/or through the criminal justice system). There is a risk of paying for outcomes that would occur anyway.
- Neither is it clear how this problem could be satisfactorily resolved by 'starting the clock at different times in the offending domain', as suggested in the 'Comments'. One option might be to measure changes in offending and re-offending beginning after a period of time has elapsed to allow for the initial impact of treatment engagement. But how would the time period be determined? And what would be the approach, for example, if there was some increase in offending following this initial period of contact (where motivation might be at its highest), but it remains substantially below the rate of offending before entry into treatment?
- We understand that it was originally intended to include payments for 'continued non-offending' in this domain, to incentivise work with service users with no history of offending. We agree that this would result in a significant volume of 'deadweight' payment. However, there is a concern that there will be less incentive for providers to engage with clients where there is no prospect of an outcome payment around offending.
- Footnote 1 suggests that there could be incremental payments for improvements above the threshold level for triggering an initial payment, but that a cap would need to be applied 'determined by local affordability'. There is a question about the incentive to continue to work on this outcome once this cap has been reached (although, presumably, the service provider would have limited awareness of this). There is also the possibility that the cap will vary significantly between localities.
- Footnote 3 states that the intention is that all 'proven offences' will be relevant for this domain, and not only drug or alcohol-related offences. We would question the legitimacy of making payment to treatment providers partially dependent on behaviour that is recognised to be unrelated to drug or alcohol issues (for example, many motoring offences). An alternative would be to focus on drug and alcohol-related offences, perhaps basing these on the list of 'trigger offences' identified as part of the Drug Interventions Programme (DIP).
- We agree that it would be helpful to make provision for 'resetting the clock' where offence(s) are committed which disqualify providers from any payment within this domain. This will help address the problem of perverse incentive (as there will continue to be an incentive to work with someone who have offended if the clock is

subsequently reset), and could apply equally to the interim measure (which appears to comprise the first half of the relevant time period for the final outcome measure³).

- As previously noted, service providers are concerned about their capacity to absorb the costs of delivering services and manage the financial risks associated with outcome payments, particularly where payment is postponed. We note that the minimum data lag for the final offending measure would be 34 months with a 'cohort' approach and 22 months with an individual approach. It is helpful that footnote 9 suggests that there are options to shorten the 'follow up' period in the time lag, with a 'minimum lag of 10 months to allow for court convictions and data updates'. Again, we would suggest that options are considered for payment systems that could release payment in instalments (monthly or quarterly) to ease cash flow - so some payment could be made, for example, at 3 months, 6 months and 9 months.
- It is clear that, although apparently robust offending measures can be constructed for use in the payment by results process, we know almost nothing about how they will operate in this context and there is significant potential for perverse incentives and gaming so caution is required in loading too much payment onto this domain.

Outcome Domain 4: Health and Wellbeing

- DrugScope and the UKDPC strongly support the inclusion of a Health and Well-Being domain.
- We welcome the recognition of the importance of public health interventions that can save lives (cessation of injecting and Hepatitis B vaccination). We would, however, urge consideration of how health improvement measures could be expanded and developed to apply to a wider cohort of users of drug and alcohol services. Currently, they are primarily concerned with injecting drug users, although recent statistics suggest falls in injecting and significant increases in people entering treatment with other patterns of drug use (for example, growing numbers of young adults using cocaine). It is important that a payment by results approach incentivises appropriate health promotion work with these service users.
- We welcome the inclusion of a housing outcome, which is in our view essential given the importance of appropriate accommodation for the process of recovery. However, in view of its critical importance for recovery, we were disappointed that access to housing does not comprise a separate domain in its own right, as we understand was originally proposed and intended. The 2010 Drug Strategy stated that 'failure to provide housing for those with drug or alcohol dependence can have a range of negative consequences for local communities', and 'it is therefore vital that communities recognise the importance of providing accommodation'. The issue of accommodation and housing has recently been discussed at the Inter-Ministerial Group on Drugs which considered a paper from the Recovery Partnership.
- We are concerned, however, that the proposed housing measure should not allow a payment where drug and alcohol service clients are inappropriately or inadequately housed. This could create an incentive to move service users into poor

³ The initial outcome for offending is based on offending over a 6 month period from the point a commencing a recovery intervention from a provider. The final outcome is based on a 12 month period from the point of commencing a recovery intervention from a provider. This suggests that the first six month period qualifies the provider for the interim outcome payment and (conditional upon what happens in the second six month period) half of the final outcome payment. It might be clearer to specify the final outcome as dependent on offending behaviour in 'the six months following the initial period'. Where an offence is committed in the first six months, this could result in 'resetting the clock' for the interim outcome.

accommodation, and even contribute to the problems of 'hidden homelessness'. The TOPs form asks whether the client has an 'acute housing problem' or is 'at risk of eviction'. The TOP definition of an 'acute housing problem' would exclude, for example, people in 'temporary accommodation (up to six months) *including* staying with friends or family as a guest...' [emphasis added]. The definition also excludes people as being in housing need if they are squatting (we note that the Government is proposing to make squatting a criminal offence). We would like to see an outcome measure for housing that was consistent with the aim of supporting and sustaining recovery, with a focus on access to safe, secure and appropriate accommodation. While recognising there would be practical difficulties in operationalising such a measure, we do not see why these need be insurmountable, particularly given that housing is critical for other recovery outcomes (including employment).

- As with employment, we would note that the ability of drug and alcohol services to access suitable housing depends on a range of local factors that are largely outside their control. In a recent on-line survey conducted by DrugScope on behalf of the Recovery Partnership, 47 per cent of respondents said that 'safe, secure and appropriate accommodation' was 'difficult to access' for their clients in their local area, and a further 42 per cent that it was 'very difficult to access'. Sixty two per cent of respondents expected appropriate accommodation to be less accessible over the next 12 months.
- DrugScope and the UKDPC are broadly supportive of the inclusion of a general health and well-being measure, while appreciating some of the difficulties that are highlighted in the 'comments' section. It is not obvious, however, why the co-design group believes it would be necessary to establish 'a functional norm ... that would indicate a client has reached a "happy" outcome' or that 'a threshold would need to be identified'. An alternative would be a comparative measure of improvement over time with the baseline established by the TOP scores of the individual service user on entry into treatment (or at some other initial point) – which could legitimately vary between individuals. Payments could then be triggered depending on improvements from this baseline. We would note that it has never been suggested that the usefulness of this measure within the existing TOP process requires the identification of 'a functional norm for ... a "happy" outcome'.
- The fact that service users progressing through treatment may feel worse before they feel better as noted in the Comments is a problem for this kind of measure. It is not clear how this could be resolved, but it is perhaps no different in principle from the similar issues around offending outcomes, where initial contact with treatment services produces a fall in offending. Further consideration could be given to alternative ways of 'setting the clock' and establishing a sufficiently robust deadline to enable a general health and well-being measure to be operationalised.
- We would also acknowledge – again – the potential tension between the use of TOP as a clinical and diagnostic tool in working with service users and as an independent measure being used to assess and reward the performance of service providers.
- One merit of a general measure of this kind is that it incentivises service providers to work on a range of health and wellbeing issues that are not captured by the other indicators, but are known to be profoundly important for recovery, such as rebuilding family relationships and access to community resources (e.g., opportunities to participate in local recovery communities).

Comments on options that were considered but not recommended

Outcome Domain 1: Free from drug(s) of dependence

- This proposed option would have allowed an initial (but lesser) payment for service users who significantly reduced their drug or alcohol consumption without achieving abstinence from 'all presenting substances'. We would be supportive of this approach in principle, and there is no indication or discussion in the consultation document of the grounds on which it was rejected by the co-design group.
- Again, we would note that alcohol is a special case, given it is a legal substance, and there is no general requirement or expectation that people should abstain from using it. While we recognise that abstinence might be the most effective approach for many people with serious alcohol dependency, it is not the only approach for everyone seeking treatment for an alcohol problem. Setting up the outcome payments in this way effectively privileges abstinence-based treatment for all service users with an alcohol problem.

Outcome Domain 2: Employment

- We support the rejection of this option. It is unclear why abstinence from drugs and alcohol would even be proposed as a measure for the employment outcome.
- We would urge the development of an interim employment outcome with a focus on 'work related activities'. These could include building soft skills and self-esteem, addressing barriers to employment (such as health problems and access to housing) and training, volunteering and work placement.

Outcome Domain 4: Health and well-being - We have no comment on this proposal.

Some general points

- The current outcome domains will disproportionately reward successful engagement with drug and alcohol treatment service users with a particular profile – for example, there will be less potential to receive payments for clients with no history of offending or who are not injecting drug users. There would, for example, be limited incentives to work with a client with an alcohol, cannabis or cocaine problem who had no history of offending, was in employment or education and had adequate housing. It would be useful to 'proof' the proposed outcome framework to ensure that it will incentivise a balanced engagement with the range of people who can benefit from drug and alcohol treatment. There is a particular concern about the appropriateness of the outcome framework for alcohol treatment (for example, must alcohol treatment invariably be abstinence-based?)
- Conversely, it is not clear that this outcome framework fully addresses the well-known concerns about 'perverse incentives' that could lead services to focus on working with clients who are most likely to achieve the outcomes, potentially neglecting some of those with the most serious dependency problems. We welcome the recognition of this issue in the discussion of the offending measures for outcome domain 3 and the inclusion of health improvement measures in domain 4 that will incentivise and reward services for working effectively with clients who may not be ready to move towards abstinence in the shorter term. However, there still appears to be only limited incentive to engage with many clients who may (for example) be unlikely to achieve abstinence in the shorter term or to move into work.
- We have highlighted a general concern about balancing the use of tools like the TOP for clinical and therapeutic purposes and as a tool for measuring and verifying

outcomes that will release financial payments to services. This is an issue that merits further consideration.

- The case for payment by results has appealed to the role of a market in driving improvements in service delivery and outcomes. There is a concern that the time lags before some of the payments for these outcomes are received will discourage many independent providers from the voluntary and community sector from entering these markets. We would welcome further thought on how incremental payment schedules could be developed given the time scales for verification of these outcomes to help smaller organisations to manage cash flow and business risks. There is growing evidence from other sectors that in this period of austerity there is a move to more joint commissioning resulting in fewer, bigger contracts which also perhaps favour bigger private sector contractors as prime providers, which if it also occurs in the drug sector will add to the pressures on smaller local providers.
- There is little indication of what role service users could play in determining outcomes for Drug Recovery PbR. The 2010 Drug Strategy described 'recovery' as an 'individual person-centered journey' with 'the individual at the heart of any recovery system' - and the creation of a more market orientated approach depends on empowering the 'customers' of services. The PbR outcomes are being determined independently of a process of recovery planning involving individual service users (and potentially family, carers and partners). It would be helpful to specify how these will interact in practice. What will incentivise services to take proper account of the outcomes that are identified by service users in recovery plans, and may be critical to engaging them and motivating recovery?
- It is a concern that there are no outcomes that will support and incentivise services to work more effectively to support families and to work with other local services to support children (including child protection and safeguarding). We support the case made by Adfam in their response to this consultation.

Whatever outcome definitions are chosen it is essential that consideration is given to any potential negative unintended consequences that could arise from their adoption (e.g., creaming, parking, over-performance in some areas, skewed provision, increased death rates and other adverse health outcomes) and diagnostic measures identified that will pick these up at as early a stage as possible. While this will probably form part of the evaluation, commissioners should also have tools in place to identify serious problems early and plans in place for dealing with these.

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