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UK DRUG POLICY COMMISSION

Commissioning for Increased Recovery: Lessons from a UKDPC Seminar

This briefing highlights key issues facing those commissioning drug services at the local level as they seek to increase the numbers of people with drug problems who achieve recovery through overcoming addiction, building new lives and relationships, and participating in society. It draws on the experiences of attendees at a one-day seminar held in November 2011 as part of a wider project undertaken by the UK Drug Policy Commission looking at the impact of the many policy changes currently underway which seek to achieve greater localism in a period of financial constraint.[1] As these changes are still in progress it is not possible to evaluate their impact but instead the project aims to highlight risks, opportunities and emerging lessons to assist those who are seeking to provide and improve services while the structures are shifting around them.

One issue that came through very clearly that should be noted at the outset is the enormous variability in the situation and experience in different areas. Local areas had different starting points, both in terms of structural arrangements and the level of investment and organisation of treatment services. On top of this the financial situation has affected some areas more than others, while some are adapting to the changes faster than others. This means there are a wide variety of answers to the question of how to go about commissioning for improved recovery in the current context. The findings highlighted here are potential opportunities and promising ideas for improving services in the current context alongside possible risks and barriers that may need to be monitored and addressed.

THE CURRENT CONTEXT

The 2010 Drug Strategy[2] increased the developing focus on improving recovery outcomes for people with drug problems. It identified the need, not only for a range of treatment options with a greater emphasis on helping people overcome their drug problems, but also for support in areas such as employment and housing to help them integrate into society. The strategy calls for a step change in delivery of recovery outcomes and commissioners of drug services clearly have a key role to play in this. The Payment by

[1] The summary of the findings and full report of this project is available: http://www.ukdpc.org.uk/publication/charting-new-waters/

[2] Home Office (2010) Drug Strategy 2010 'Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life,' London: HM Government.

Results for Drug and Alcohol Recovery pilots were identified as one possible approach to incentivising this.[3]

However, this drive to increase recovery outcomes is taking place in a time of financial austerity when all government services are required to deliver savings. At the same time the government has embarked on a series of reforms which seek to devolve decision-making and accountability for service provision to the local level. Due to the cross-cutting nature of drug issues, many of these will have a major impact on commissioning of drug services.

The reforms to the NHS will have the most direct impact, although the extent of change will depend on current arrangements which vary from area to area. The key issues are:

- Responsibility for commissioning drug treatment services, which will be part of a wider population-focused public health service, will shift to Directors of Public Health who will be local authority-based.
- Directors of Public Health will be accountable to Health and Well-Being Boards who will set the strategic direction for Public Health in their area.
- Commissioning of other services that may be important providers of services for people with drug problems will be the responsibility of other groups. For example, from April 2013 mental health services will be the responsibility of Clinical Commissioning Groups (CCGs) and prison health services the overall responsibility of the NHS Commissioning Board (NHS CB) although this will be devolved to local areas.

The appointment of Police and Crime Commissioners (PCCs) may also have an impact, since the police are key members of the current partnerships. They will also control some of the Drug Interventions Programme (DIP) budget.

AIMS OF COMMISSIONING IN THE CURRENT CONTEXT

As mentioned above, the main aim arising from the 2010 Drug Strategy is for **improved recovery outcomes** or, as one of the seminar participants put it, *"the ultimate aim is to improve the life outcomes of the people that walk through the door"*.

However, a number of other goals were highlighted by participants, which are implicit or explicit within the policy drive for greater localism or arise from the current financial constraints. These were a push for **greater efficiency** within the system: to do more with less. There was also a desire to encourage **greater diversity in the market** and **more involvement of the voluntary sector**. A strong desire for **innovation** was also manifest.

Alongside this, some participants highlighted the need to deliver services that are able to **respond to the greater diversity in treatment needs** that arise from changing patterns of drug use.

[3] A UKDPC briefing outlines how payment by results works, examines how it has been used elsewhere, and discusses the issues and challenges that will affect its introduction for drug treatment. Available: www.ukdpc.org.uk/publication/by-their-fruits-applying-payment-by-results-to-drugs-recovery

However, for participants from some areas an important aim was simply to **keep the system going**, *"keeping the boat afloat"* in a time of massive change. There is a risk that, amidst the change and uncertainties, the services to a very vulnerable group of individuals may be reduced or reconfigured in such a way that the gains from the last two decades are lost. This would be damaging not just to the service users, the individuals with drug problems and their families, but also to their communities and wider society who would also suffer the consequences, such as increased health care costs, increased crime, higher benefit bills and loss of productivity.

COMMISSIONING STRATEGIES TO IMPROVE RECOVERY OUTCOMES

The seminar heard presentations from three different areas about the approaches they had taken to try and improve recovery outcomes and then there was a discussion session where other approaches being adopted were shared. There were also presentations from two service providers that highlighted some of the issues they were experiencing.

Every area is different but four broad approaches to improving recovery outcomes, which were often overlapping, were apparent:

1. **Working with current providers to improve recovery focus.**
   The increased focus on recovery over the last few years has led to many areas using the commissioning process to work with their current providers to improve recovery outcomes. As a starting point this may involve simply closer monitoring of outcomes and using this as a focus of commissioning discussions, but may also involve recovery events with provider staff, more detailed work around referral protocols and pathways etc., and can lead to agreement on more extensive changes. This can successfully improve collaboration between providers and encourage culture change within services and improve links to groups such as Narcotics Anonymous and Alcoholics Anonymous. This closer look at outcomes is likely to be a necessary starting point, whatever changes are desired in the longer term, since a good understanding of current outcomes is important in deciding where and what change may be needed.
2. **Commissioning additional services, often quite small-scale and innovative.**
   There were many examples of this approach described by participants. These ranged from commissioning groups such as SMART recovery[4] or peer mentoring to work alongside traditional treatment providers, through setting up recovery cafes or other drop in facilities, to schemes that included one where people can earn credits by volunteering which could be put towards activities to assist recovery such as courses, a laptop or gym membership (more information is below).
3. **Re-commissioning the drug treatment system.**
   Many areas are putting all, or large parts, of their drug services out to tender, incorporating into their specifications the requirement for a greater recovery focus. They are also often incorporating some payment for outcomes or quality element into the contracts. This approach was seen as appropriate where incumbent service providers have seemed unable to become more recovery-focused. For instance one

[4] A four point programme using motivational, behavioural and cognitive methods.

participant commented *"providers are proving resistant to changing to a recovery-based model of service delivery as they are still wedded to a medical model of understanding of substance dependency"*.

4. **A user-focused approach.**
   In West Sussex the RSA has undertaken a service user-led project, the Whole Person Recovery Project, which was presented to the seminar.[5] This had identified a range of issues from the service user perspective that facilitated or impeded recovery and, in collaboration with local service providers, had identified a number of ways of overcoming these. Another area that attended the seminar noted that they were working on a personalised approach to service provision. The individual nature of recovery means that a focus on the individual is central to improving recovery outcomes.

KEY ISSUES IDENTIFIED

There are perceived opportunities from the changes

A key opportunity recognised within all the changes at the local level was for greater integration of services. The broad nature of recovery and the support needed to achieve it means that the establishment of pathways between services and greater integration is essential.

Integration was mentioned in a wide range of ways:

- Integrating commissioning of prison and community drug services;
- Integrating treatment and recovery services;
- Developing integrated drug and alcohol services;
- Involving wider services, eg integrating sexual health and drug services for young people; linking with dental health; or having Domestic Violence workers in drug treatment service.

Seeking these types of integration were seen as opportunities for providing better services to meet the needs of the individual clients, more of a 'one-stop shop'. However, it may also provide efficiency savings. This can also be seen as building on the pre-existing partnerships that have been a feature of drug service delivery at the local level for some time. Taking advantage of and learning from some of the pilot programmes, such as Drug Systems Change and Integrated Offender Management, that have taken this approach was highlighted as a good opportunity.[6]

The value of service user involvement

The importance and value of involving service users throughout the commissioning process came up again and again throughout the seminar. As one participant described,

[5] More information available: www.thersa.org/projects/connected-communities/whole-person-recovery

[6] For more information on these programmes see: www.nta.nhs.uk/who-healthcare-scp.aspx and www.homeoffice.gov.uk/crime/reducing-reoffending/iom/

"the service-users council have got involved with providers and are building those relationships with staff and doing events, like World Hepatitis day and a whole range of things and speakers, and they organised it. You could kind of see that people were getting a bit more inspired by working with each other a bit more, and actually, it's kind of been a bit of a catalyst and they've developed recovery socials and gained the trust of each other."

Some areas reported extensive peer involvement in the commissioning process, including taking a co-design approach to re-commissioning. This was seen as being very valuable in redesigning systems to better meet users' needs. However, it was also pointed out that it was important to ensure that those involved needed support in these roles and should not be used as a free resource.

In many services people in recovery are widely involved as peer mentors and volunteers but they also provided valuable input in providing ideas for changes or new services, often very small, that can make a big difference. An example of the latter was a credit scheme for individuals working towards recovery:

"One of the new things we have just done in the last year is a service user said one of the barriers to getting into recovery and employment was that they had no CVs. They had no education because a lot of them fall out of school at fourteen or fifteen. So we have come up with a 'Give Yourself Credit' scheme where if they are a peer mentor or they are a volunteer on our services they can earn credits at minimum wage and we then put those credits towards courses or towards driving lessons or towards buying a bike or something like that which will enable them to get into employment, into full time education, and that has really gone down a storm."

A recurrent theme at the seminar was the importance of having service users as champions and making recovery visible to people with drug problems as well as to services and the wider community. Several areas were organising or supporting recovery conferences, recovery cafes and other similar initiatives. It was suggested that it is important for each area to identify what is suitable and needed in their own area, which fitted well with the asset-mapping that formed part of the RSA whole person recovery approach.

Other examples of service user involvement mentioned by participants included:

- The organisation of a recovery conference by service users with key speakers talking about their recovery.
- Creation of a prison-based peer mentoring system.
- Organisation of a fashion workshop and a fashion show, models wore t-shirts designed by service users that included a recovery message.
- The refurbishment of bikes by service users, reclaimed from the police, to use for transport to services and to keep fit.
- The regeneration and tidying of a strip of waste land around a church by service users in a visibly prominent part of the local community.

Workforce development and the challenge of culture change

Both the recovery agenda and the wider changes resulting from the NHS and other reforms have significant implications for the drug service workforce. As well as mentioning the need for workforce development in terms of developing new skills, many participants described the need for culture change or mentioned cultural differences between groups causing difficulties.

For the commissioners themselves some cultural differences were noted with respect to their move into local authority Public Health departments. It was suggested that people within Public Health took a more theoretical approach based very much on a medical model, rather than the more practically-orientated drug and alcohol sector and the recovery agenda. There were also issues raised about working through LA procurement departments who are not familiar with commissioning clinical services.

It was felt that some drug service providers, especially those that have provided services in a particular area for some time, were resistant to change or lacking in some knowledge around the recovery agenda, for example *"some of these mental health specialist services are still lagging behind really in sort of taking the baton. And the culture shift...we've set targets as well, but we seem to be spending an awful long time discussing are they the right targets, rather than getting on."*

Good dialogue and relationships with provider organisations was understood as key to working through these issues and building consensus around change. One participant observed *"it's about how we can change that mindset because that one-to-one contact that frontline staff has with the service user is paramount. Without them on side it's almost impossible to make the necessary changes."*

Contractual and legal issues and barriers

Legal issues surrounding the commissioning and re-commissioning of drug treatment and recovery services in a local authority context were an important consideration. For instance, due to the lack of central guidance, there is variation between localities in legal interpretations of arrangements relating to the commissioning of drug treatment and recovery systems. Different areas access different sources of legal advice, which vary in their interpretation due to different understandings of contract law: "*I work in the local authority and I haven't got a procurement team, it's me, so as well as the commissioning and doing everything else I've also got to go out and do the procurement and the tendering, and to try and have to do that and keep up with contract law every couple of years, it's a nightmare."*

One area was experiencing problems in re-commissioning a contract for a prescribing service. Due to the imminent move to a new public health system, the local authority would in future need to hold this contract. Yet there were significant questions as to the legality of this as the contract does not include support elements in addition to the health element. National clarification on the issue was being pursued.

Issues relating to TUPE were raised.[7] A clear understanding of potential TUPE liabilities is a key part of good quality commissioning, together with the capacity within providers to take on these liabilities. This had not been the case in some areas, one participant commented that the market in their area had been effectively closed to smaller providers: *"voluntary and community sector providers need more support to take on the liabilities associated with contracting to deliver drug and alcohol services, particularly in relation to TUPE issues. There is little understanding of TUPE issues among local authority procurement departments as they are used to contracting with very large service providers."*

Another area had committed funding towards TUPE costs to enable a range of providers to participate in the re-commissioning of services: *"I had to agree to pay 75% of the TUPE to enable third sector providers to actually come forward to say we're going to go for some tenders, because they just couldn't afford it because it was all statutory services going out to tender, with pensions and everything."*

The trend towards single provider contracts

As noted earlier, many areas were in the process of re-commissioning their drug treatment services and this was seen as providing an opportunity to extend the provider market. However in almost all cases the tenders led to a single contract with a smaller number of providers.

In many cases this was due to the need to achieve savings via the creation of economies of scale, especially as the capacity to manage multiple contracts was becoming increasingly stretched. It was recognised, and this links to the issues relating to TUPE, that larger providers are comparatively more able to bid for contracts in the current environment of increasing austerity. It was seen that encouraging coalitions of provider organisations can bring benefits in terms of the range of services that can be provided. *"Encouraging the larger providers to go into partnership with a local provider, the smaller providers, particularly local, ensures that you still have that kind of mix when that provider brings somebody else in that maybe has a particular skill in a particular area, like in one of our cases, their skill was in the young people's side of things."*

Concerns about de-prioritisation of drug services

There were important concerns raised around the future de-prioritisation of drug services due to drug treatment either not being seen as an issue locally or because of resistance from elected members or local community members due to the stigma surrounding drug services and those using them. For example: "*Councillors in our area just want tourism, tourism, tourism, so therefore, anything to do with drugs and alcohol affects their tourism, because it's not nice for people to see that. I was told this week by a councillor if I shut all your services I'll save a six and a half million pounds, which can go into tourism, and, therefore, we won't get all these drug addicts on the streets."*

[7] TUPE is an acronym for Transfer of Undertakings (Protection of Employment) Regulations. These apply if services are transferred from one provider to another and are aimed at protecting employees if the organisation in which they are employed changes hands.

It was suggested that, with the move into a new local authority public health system, although the drug sector was providing a large proportion of the new public health budgets, this was not necessarily recognised and they were seen as very different from the rest of public health because they were commissioners of treatment services. This could cause difficulties and links to the issue around evidence discussed below. One participant noted *"And it's getting on to their agenda, because as you rightly point out, we are a big fish, but they don't see us as that. They think we're these funny little uneducated creatures, and so many of their agendas touch ours, but they're not particularly too keen on it."*

The importance of evidence to make the case for investment

Collecting the right data and evidence and using this to make the case for continued investment in drug services is of critical importance in moving forward: *"We've always done needs assessment and we were very evidence based, but now it's even more pressure to be that way, with a very good, strong, cost-benefit analysis and health economics involved in anything you present"*. Commissioner participants talked of a 'new world' in which they must be more proactive in arguing the value of particular interventions and in assessing that services are achieving their outcomes. The arrival of elected Police and Crime Commissioners adds further impetus to prove and evidence the value of DIP spend.

However, frustration was expressed around the quality of existing data, and the infancy of the current evidence base on the value of recovery-oriented services. For instance: "*I'm not a value for money expert, but there's a difference between cashable savings…the only real cashable savings are in the Work Programme and employment stuff, and it's difficult to calculate the cashable savings from drug treatment and housing and all sorts of things. No one's ever really done it."* Unless these issues are addressed this is a clear threat to both the future priority and funding of drug interventions.

The difficulty of measuring benefits, and the timescales involved, was highlighted: *"we've been trying to develop a business case around efficiencies and our argument is you're not going to see these efficiencies in the next 24 months, you're talking at least ten years…we're talking about long-term health, we're talking about employment, crime, it's those kinds of things"*.

The value of shared learning

The pace of change, together with a lack of certainty about the future shape and delivery of services, was of concern for seminar participants. The lack of time to plan and reflect was a barrier to the continuing development of good quality services: "*Difficult for commissioners to actually find any space to reflect on what they wanted to achieve because we were just kind of overwhelmed with bureaucracy and with kind of like competing interests.*"

The ability to learn from what others are doing in other areas was highlighted as essential, particularly in the current environment of extensive change. It was felt that there was a role for the national collection and co-ordination of evidence: *"The NTA was a*

pain at times, but at the same time it gave a very good profile to commissioning, to the accountability of money, the Part 4s which we used to do, and debate with the finance directors not siphon the money somewhere else, and all that. Localism is great, but I think those are some of the challenges which commissioning is facing."

There was a clear appetite amongst participants for the continuation of regional, or area networks to share knowledge, ideas, good practice and provide peer support. Again, a role for central government in stimulating, or supporting, these linkages was seen to be important.

CONCLUSIONS

This briefing highlights the experiences of those currently commissioning drug services at the local level. It is one element of a wider UKDPC project, *Charting New Waters,* which further develops the issues that are explored above. This seminar identified opportunities in the new context to build quality, recovery-oriented drug treatment services. People highlighted the establishment of greater integration between different services and the critical importance of service user engagement and involvement in the delivery of services. However, it also revealed a number of key issues and areas for action that need to be addressed if the vision of increased recovery identified in the 2010 Drug Strategy is to be realised in this period of rapid change and financial austerity. These can be summarised as follows:

Supporting commissioners

There is enormous variability in the way local areas are responding to the changes underway so local drug service commissioners need networks and links with other commissioners to share knowledge and examples of good practice, as well as about the new procurement, operational and contracting arrangements that the movement to a new public health system will entail. In this era of localism there remains a role for central government and/or national organisations in facilitating and supporting these.

Commissioning treatment services requires particular skills which differ from those traditionally needed within public health departments. It is important that these are recognised and developed further. Bodies such as the Substance Misuse Skills Consortium[8] can have a role to play here.

Promoting and developing the evidence base

Local drug service commissioners need to be proactive in promoting the current efficacy and value for money of treatment interventions as there may be a risk of considerable disinvestment from drug treatment services within the new public health funding arrangements.

At the same time, there is already considerable change in the services being commissioned and how that is being done. The rapid adoption of Payment by Results (PbR) for recovery services is the most high-profile example of this but it needs to be

[8] See http://www.skillsconsortium.org.uk/

recognised that this approach has yet to be shown to be effective and the evidence underpinning the use of PbR more generally is limited. However, the seminar also highlighted the fact that there are many other ways in which commissioners are seeking to improve recovery outcomes, which may be just as effective. It is therefore important that there is investment in evaluation of these different approaches to ensure that quality and value for money is maintained and service users benefit from the changes.

Service user involvement

The importance of service user involvement throughout the commissioning process as well as within service provision was a key theme throughout the seminar. It is important that this is continued and increased within the new arrangements developing at the local level and does not get lost. A number of commissioners were concerned about the potential for the stigma associated with drug users to negatively impact on services in the future and Directors of Public Health as well as drug treatment commissioners need to promote their inclusion.

Overall, the seminar showed that commissioners of drug treatment services have a real commitment to improving services to increase recovery. However, they face considerable challenges within the on-going extensive financial change and policy reform in meeting these recovery ambitions.

We are grateful to Barclays and the Esmée Fairbairn Foundation for their support for this research.