Adfam Submission: Piloting Payment by Results for Drugs Recovery – Draft Outcome Definitions

About Adfam

Adfam is the national umbrella organisation working to improve the quality of life for families affected by drug and alcohol use. We do this by working with a network of organisations, practitioners and individuals who come into contact with the families, friends and carers affected by someone else's drug or alcohol use. We provide direct support to families and practitioners through publications, training, consultancy, prison visitors' centres and signposting to local services, and work extensively with professionals and Government to improve and expand the support available to families.

Throughout this response, the term 'families' is used to refer to relatives or close friends affected by someone else's drug use. This includes parents and carers; spouses and partners; children and siblings; grandparents; extended family members and close friends with respect to those supporting current drug users, recovering users and those that have been bereaved by drug use.

Overall points

As part of a new recovery-orientated system, Payment by Results represents a huge opportunity to reform what, in the past, has been criticised as too focused on substance use rather than the reasons behind and related to it. However, it is disappointing that, despite an increasing wealth of knowledge, research and acknowledgment in strategies and guidance (for example NICE guidelines, NTA publications such as *Supporting and Involving Carers* and the 2010 national Drug Strategy), family and relationship measures are not included in the draft outcome definitions for this new way of commissioning.

Evidence shows that improved family relationships are a key component of recovery, and that treatment is more effective when families are involved –this is explicitly recognised in the 2010 Drug Strategy. Whilst treatment agencies may recognise this independently and therefore improve family involvement in order to boost results, it remains crucial that family work receives the attention and leadership it needs from national and statutory bodies tasked with driving forward innovation and effective work – such as the National Treatment Agency and Department of Health. Strategic leadership and sponsorship is important in order to ensure that family work does not fall behind as services concentrate on new ways of working in which there are more explicit financial stakes.

To not mention children, parents and families in the draft outcomes risks these important elements of recovery losing focus and resources, as services work towards the new more explicit paid-for outcomes at the expense of other contributors to successful, sustained recovery journeys.

How well the proposed outcomes avoid the risk of perverse incentives, including 'cherry picking' service users

It is difficult for a treatment service to take the entirety of credit for a simple drug-free measure when so many other factors play into someone's life and behaviour changes. The recovery agenda is predicated on 'more than substance use' – that the reasons behind drug and alcohol use need to be tackled alongside any medical interventions so that life changes 'stick' and efforts are not simply put into achieving short-term abstinence that is not sustainable, but would reward services for the outcome nonetheless. Adfam is pleased to see this recognised by the inclusion of a final outcome after 12 months, encouraging services to continue their work with clients after the substance has been removed. Adfam would hope that this offers an opportunity for services to support the individual with the other important recovery elements, including the development of positive and sustained relationships.

In terms of families, relationships and psychological measures, 'cherry picking' is largely ameliorated by allowing for 'distance travelled' as well as rewarding a final outcome in the measurement system – that is, rewarding behavioural change and recognising recovery as a process, rather than looking only at a single end results. In fact if this were the case, there would be *more* incentive to work with those with the most entrenched problems rather than less, and services would be encouraged to continue working with more challenging clients. Of course there is the accompanying risk of manipulation of data where people's starting point is played down, therefore giving an illusion of progress at the end of the work even if their situation has remained static; that said, the act of dishonesty on the part of a service would be a much more serious – and, one hopes, unlikely – occurrence than lawful manipulation of the system due to inherent flaws within it.

Collecting information about family relationships can help to ensure that a system is properly focused on whole family recovery, rather than focused only on the individual – for example by comparing outcomes from users and their families on the status of relationships. Relationships are not a one-way street, so comparing the scores from drug/alcohol users and their families would not only recognise this, but also provide a useful check against 'optimistic' reporting of psychological measures by the agencies involved.

Providing an incentive that leads to innovative and effective activity to support more drug and alcohol users towards full recovery

It is Adfam's view that the drug strategy and its implementation plan must be as ambitious and innovative for families as they strive to be for users. The 2010 Drug Strategy makes explicit mention of social capital and the importance of the family, even listing 'improved relationships with family members, partners and friends' and 'the capacity to be an effective and caring parent' as best practice outcomes key to successful deliver in a recovery-orientated system. Although we appreciate that improvements in these relationships would obviously contribute to the overall 'Wellbeing' outcome domain, Adfam would argue that these relationships are crucial to real recovery and therefore should be acknowledged more clearly.

Family relationships can be huge motivating factors and catalysts for change, and are often a primary reason that people want to change their behaviour – especially for parents. Preliminary work on the ONS National Wellbeing survey showed that relationships with family and friends were highlighted by people of all ages as a key determinant in wellbeing[1]: this is no different for people struggling with drug and alcohol problems and if they are to truly recover, then family relationships must be looked at as a key issue.

Many of our supporters are concerned that the levers for improved work with families affected by drugs are not set by these new draft outcomes. The 2010 Drug Strategy promises to 'encourage local areas to promote a whole family approach to the delivery of recovery services, and to consider the provision of support services for families and carers in their own right' – but without strategic recognition and incentive to drive this forward there is a risk it may be diluted. It is Adfam's view that the draft outcomes do not provide sufficient incentive for services to expand and improve their work with families and relationships, which are key elements of recovery.

One could argue that 'the market will regulate itself' and that, if family involvement really does improve outcomes, more services will implement it as a way of achieving these better outcomes and therefore reap the financial reward. This may be problematic, however, as it assumes that treatment agencies know how to identify when families are and are not appropriate for involvement in treatment; have sufficient knowledge to involve them effectively and safely; and do not view families simply as a 'recovery resource' who require no ongoing support in their own right. As mentioned previously, there is a need for strategic leadership to help promote family work and ensure that it is implemented appropriately, safely and effectively, as well as spread knowledge of 'what works' in an area with little or no standardisation in terms of practice.

In order to identify the positive outcomes stated in the document, there is a clear need for cross-departmental statistical analysis, for example looking at the benefits system to help measure employment outcomes, or utilising DIRweb to support the offending outcome. This partnership plan should be extended to other services: in particular, records from drug treatment agencies should be cross-referenced with the children at risk register. As well as helping to identify families in which substance use is an issue, it would also help to provide a baseline and ongoing statistics for the Drug Strategy's key best practice outcome of 'the capacity to be an effective and caring parent'. Though parenting skills are obviously not as simple as having a child who is on/off the 'at risk' register, there is a clear opportunity for substance use agencies and social services to work in partnership to identify the children of substance users earlier and more effectively; assess parenting capacity; and work towards the key recovery outcome of being an effective and caring parent. Successive Governments have published guidance on joint protocols for safeguarding and family services and drug and alcohol treatment agencies, and this work should be built upon.

[1] Office for National Statistics (2011), *Findings from the National Well-being Debate*

The extent to which the proposed outcomes strike the balance between being sufficiently challenging yet achievable

The draft outcomes are not challenging enough in terms of work to address the needs of families and better involve them in recovery services. Whilst the potential difficulties in measures of quality of life and health and wellbeing factors are well known and establishing normative thresholds does present difficulties, this is not to say that they are insurmountable barriers to action, especially in a truly recovery-focused system which looks at the whole of someone's life circumstances.

The statement that 'all outcomes should ideally be measured by *national*, independently verifiable data sources with *robust historical baseline data'* makes a positive point, but has the unfortunate consequence of ruling out any system of measurement which does not already exist and is not already operational on a nationwide scale – an impression which is compounded by the heavy reliance on the existing NDTMS and TOPs tools.

Expanding NDTMS and TOPs to better reflect family outcomes and researching suitable systems from other fields should not be out of the question. It would be a shame if, during a move to reorientate the system towards recovery, new methods and options for data collection were not considered or investigated further. TOPs already recognises the value of family relationships, stating 'gets on well with family and partner' as a contributing factor to a client's rating of overall quality of life: this should be built upon to form a data collection system on relationships and families which is more fit for purpose in a Payment by Results system, for example using learning from the Carers Support Outcomes Profile tool.

At the very least, a new system of data collection and outcome definitions must place more emphasis on the needs of families and their relationships with the user. For example, data fields on children form part of NDTMS but the NTA does not regularly release the statistics, and underreporting is common – figures from the North West (the only region for which they are available) show that no parental status is recorded on 18.6% of forms, which must be improved. Similarly, there should be improved data collection on the living circumstances of people accessing any treatment services, and the level of support provided by families – for example accommodation, living expenses and childcare. There should be a fuller, whole family picture of people with drug and alcohol problems.

There should also be an opportunity for family support services to contribute to data collection. Tools do exist for the measurement of psychological indicators for families – CSOP (Carers Support Outcomes Profile), for example – and recent work by the Office for National Statistics showed that people of all ages rate family relationships as a key factor in wellbeing, showing that they are central to conceptions of 'quality of life'[2] and cannot be ignored. Though the draft outcomes make reference to problems with thresholds and norms for health and wellbeing measures, tools should take into account distance travelled by service users as well as their endpoint - which CSOP does. This way services can be recognised for their contribution to improvement rather than reaching a goal of disputed certainty.

[2] Office for National Statistics (2011), *Findings from the National Well-being Debate*

The draft outcomes also reference a high starting score in health and wellbeing measure as a negative in terms of service provision: 'there would be nowhere for them to progress to'. This misses a clear opportunity in terms of the recovery capital families can provide – those people who rate their family relationships positively are more likely to desire family involvement in their treatment, and a high 'starting score' for this measure should ideally trigger further investigation into how families can contribute positively to recovery. Though this particular measurement may not lend itself to Payment by Results when a starting score is high, this does not mean the information gathered is rendered useless – services should be gaining a complete picture of someone's circumstances.

The likely effects of the proposed outcomes on providers, in particular smaller organisations and the third sector

There is a real opportunity – in line with Big Society principles – to increase the involvement of small organisations in the third sector through a greater recognition of the services they provide, and there is a risk that the new proposed outcomes do not take advantage of this.

There is a likelihood that this new system of data collection and Payment by Results will diminish the role of smaller organisations: they have less access to capital to cover running costs in order to manage the transition between advance funding for services provided and future reward for outcomes secured. Small community organisations should not be penalised for their previous ways of working - that is, those typical of small voluntary groups, which often do not have robust monitoring systems in place and are not used to complex data recording and analysis. Phasing in and capacity building to manage the transition to the new system is crucial, and without this there is a risk the system will shrink constitute to a small number of large providers, rather than become a competitive and accessible system which recognises the role of smaller community organisations, in line with Big Society ideas. Small organisations may struggle to find a place in the system which leans heavily towards existing modes of data collection, and it is no surprise that larger organisations with greater institutional security and capacity are ahead in this respect – smaller providers should have every opportunity to catch up.

It is vital to work alongside organisations which do not have a robust history of outcome measurement in order to phase it in effectively, without allowing good quality work to be excluded because it can't catch up to new ways of working and data collection quickly enough. Larger organisations will be more able to secure Payment by Results contracts in the first place, and by the time that these contracts are up for renewal or evaluation results begin to take shape, other services may have dissolved, leaving no alternative to the current providers.

Family support services are often founded by family members affected by substance use themselves, and run and staffed by volunteers on a relatively small scale. They have historically survived on shoestring budgets and their staff are invariably dedicated to a very specific cause which is very meaningful to them. Family support services should be fairly compensated for the service they provide: even if they are not robust enough to be officially recognised in subcontracting

arrangements under the new system, their valuable contribution to whole family recovery should still be recognised. All that many ask is the opportunity to provide a service that they never received to local, vulnerable families.

Small organisations need the opportunity to access subcontracting relationships or there is a risk that a two-tier or duplicated system will develop, in which large organisations receive the lion's share of contract money whilst smaller organisations unsuited to strict subcontracting arrangements may falter and be forced outside the mainstream system. Payment by Results has great potential in terms of ensuring accountability and effectiveness; however, if it is the only way for services to access any statutory funds, this risks alienating valuable community resources which cannot immediately justify their work with figures and statistics.

There will always be drug and alcohol users, and they will always have families – so there will always be a need to support them. Family support organisations, which are often set up by families themselves and always led by local need, will continue to develop from within the community where they need to – but without support for existing organisations and those just getting on their feet, there is a real risk of 'churn' and the loss of years of learning, where small voluntary groups cannot afford to continue and do not survive to participate in the future when their expertise would be called upon.

As mentioned previously, it is difficult for one service to take full financial credit for outcomes that have been secured with the input of other services. Though subcontracting agreements are designed to recognise and illustrate this (for example a family support service being compensated for its work by the holder of a larger tender), these agreements must properly recognise the full range of outcomes and improvements that family support contributes to – for example family functioning and relationships, the service user's wellbeing, secure accommodation and childcare during treatment.

Conclusions

Any new system of payment by results should:

- Focus on health and wellbeing measures as the distinguishing features of a truly recovery-orientated system, and not one based purely on offending and dependency measures;
- Work alongside the voluntary and community sector to find an outcome monitoring system that is fit for purpose in measuring quality of life and wellbeing factors – current systems such as NDTMS and TOPs are currently not appropriate for outcomes relating to families;
- Recognise the key role of families and family relationships in recovery, from acting as a motivating factor in drug/alcohol users accessing services through to helping maintain recovery and positive lifestyles after treatment;
- Support the role of dedicated family support in helping families address their own psychological needs.

It is also worth noting that Adfam's Manifesto for Families (pdf), published in Spring 2010 and distributed widely in the drug and alcohol sector, approached the issue of monitoring effectiveness clearly. It is not too late for work on outcomes for families.

Contact

For further discussion of Adfam's work, responses and how we can continue to contribute to new approaches to tackling drug and alcohol use, please contact **Vivienne Evans OBE, Chief Executive,** at 25 Corsham Street, London N1 6DR**.**

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