Evaluation of the Drugs and Alcohol Recovery Payment by Results Pilot Programme

Interim Summary Report

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Preface

The Drugs and Alcohol Recovery Payment by Results Evaluation is a 42-month project commissioned by the Department of Health Policy Research Programme, which commenced in October 2011. The reporting arrangements for the evaluation include a requirement for annual interim reports from year two onwards. This report is a summary of the first interim report.

We have sought to provide an integrated overview of this multi-strand project, each of which is led by different partners within the consortium. Findings in this report from the process evaluation have been subject to RAND Europe’s interim quality assurance review.

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Disclaimer

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Introduction

In April 2011 the Department of Health (DH) announced that eight local areas had been selected to pilot a new approach to commissioning and delivering drug and alcohol misuse treatment. Under these ‘payment by results drug and alcohol recovery pilots’, a proportion of provider payments are linked to achievement of specified outcomes representing recovery from problems relating to drug and alcohol misuse by service users. The pilots started in April 2012. The purpose of the PbR pilots is to both develop and test out this new approach to the commissioning and delivery of drug and alcohol services.

Alongside the pilots programme, the DH, in partnership with other government departments, commissioned an independent evaluation. This evaluation will support future policy-making by providing a rigorous and independent, formative and summative, evaluation of the pilots programme. The aims of the evaluation are to: robustly assess the effectiveness of the PbR pilots on the provision of treatment; undertake an economic evaluation of the PbR pilots programme; and disseminate lessons for ensuring the quality, effectiveness and efficiency of drug and alcohol recovery PbR models in the future. To meet these aims, the evaluation includes process, impact and economic components to be carried out in all eight pilot sites. The evaluation involves undertaking in-depth interviews with a range of stakeholders, and analysis of administrative data on costs, outcomes and impact.

The reporting arrangements for the evaluation include a requirement for annual interim reports from year two onwards. This report is a summary of the first interim report from the evaluation team. It follows the publication of a comprehensive Scoping and Feasibility Report in November 2012,¹ which refined the scope of the evaluation and listed the extended set of agreed research questions to be addressed in the evaluation.

For this interim report, we have focused on four themes:

(i) the Local Area Single Assessment and Referral System (LASARS);
(ii) variations in funding models;
(iii) implementation and delivery of recovery-orientated treatment systems under PbR; and
(iv) exit strategies.

The first three themes were selected because they were prominent issues raised during the course of interviews. The fourth theme, exit strategies, has been included to provide DH with an overview of the interviewees’ experience of operating as a PbR pilot and an indication of their future intentions. All four are important issues for the DH and other government departments at this key stage in the PbR policy development.

The findings in this report are based on 142 one-to-one stakeholder interviews, 109 service users in 18 focus groups and 19 carers in one-to-one interviews. These interviews were conducted between March 2012 and August 2013. The findings also draw on the monthly, followed by quarterly, update

¹ Available at: http://www.population-health.manchester.ac.uk/epidemiology/NDFC/newsandevents/news/PbR_Report.pdf
reports provided by the pilot sites to the DH and on data recorded in NDTMS between April 2012 and March 2013.

(i) The Local Area Single Assessment and Referral System (LASARS)

The existence of the Local Area Single Assessment and Referral System (LASARS) primarily reflects the desire to have an independent system in place to prevent gaming in assigning complexity scores and tariffs to service users. There are notable differences in how the LASARS operates and performs across the eight pilot areas. Its success or failure is very dependent on how it has been established and the different contextual factors in each pilot site.

Concerns have been raised that LASARS divert resources from the provision of treatment. The evidence collected and analysed so far suggests that interviewees in pilot sites who opted for arrangements without a LASARS have not seen increased incidence of gaming.

The need to attend an appointment with LASARS represents an additional step in a user’s treatment journey, which may reduce the likelihood of users entering treatment. At the same time, some pilots reported positive impacts as a result of LASARS, such as shorter waiting times for treatment. Early analysis of NDTMS substantiates these reports, albeit with considerable variation between sites.

It is important to clearly define the role and responsibilities of the LASARS function, as a lack of clarity in this area can adversely affect the performance of the entire treatment system. According to some interviewees, LASARS offers a range of benefits to pilot areas. However, it is unclear whether these depend on the existence of LASARS or could be achieved via other means.

Main findings in summary:

- The LASARS function may contribute to improved data collection
- LASARS may enhance the integration of drug and alcohol treatment services
- LASARS can fulfil an important user advocacy role
- LASARS may increase the likelihood of drop out, but may reduce waiting times
- LASARS may deter people with relatively low needs from accessing or staying in treatment
- Referral by the LASARS assessors of users needing Tier 2 (Open Access Service)\(^2\) may distort data on caseloads and performance
- NDTMS data for Year 1 broadly correspond to the qualitative findings above
- Pilot sites have developed strategies to mitigate possible negative effects of a LASARS
- LASARS may limit opportunities for early practitioner-client relationship building
- It is important that all information gathered by the LASARS assessors is passed on in a timely manner.
- Opinions vary on whether a LASARS diminishes the workload of treatment services
- The performance of the LASARS can impact services’ ability to achieve outcomes
- The roles and responsibilities of LASARS were not immediately clear to all stakeholders and varied across pilot sites
- Treatment services often questioned the skills of LASARS assessors

\(^2\) Open Access Services: Advice & Information, Drop-in Service, Harm Reduction Services
(ii) Variations in funding models

Respondents reported a range of considerations when developing their funding models:

- a desire to improve recovery outcomes for their clients;
- providing sufficient incentives to providers to contribute towards delivering these outcomes;
- bringing new providers and services into the market; and
- minimising any destabilising effects on local treatment systems brought about by the introduction of a PbR model for treatment services.

When asked to identify the most effective aspects of the PbR funding models, interviewees tended to emphasise how these had helped to ensure a greater focus by commissioners and providers on the nature and complexity of the needs of local treatment populations, innovation in service provision, and sharpening the focus on particular issues, such as throughcare and aftercare.

The main challenges encountered across the eight pilot sites when seeking to develop and implement PbR funding models were problems that have arisen under previous pay-for-performance (P4P) schemes (MacDonald et al. 2013). They include:

- risk aversion shown by (both statutory and non-statutory) providers within the market;
- lack of engagement and dialogue with providers prior to design and implementation;
- greater than anticipated data requirements and related costs for modelling and evidencing outcomes;
- local design of payment models and indicators; and
- concerns about the accuracy of estimates being produced for the complexity of treatment caseloads and the impact of this on the potential funding available to providers via PbR.

However, whilst such challenges have arisen, other aspects of the design of PbR have adhered to best practice guidelines for P4P schemes, including design of indicators with a long-term focus, benchmarking and setting of achievable targets, and consideration of mechanisms to mitigate uncertainty of provider revenues.

Main findings in summary:

- Funding models with a smaller PbR component reflect the desire not to destabilise existing treatment systems
- PbR funding models were seen as one way to incentivise providers towards achieving recovery outcomes
- PbR funding models may have helped bring about a sharper focus on better identifying the needs of local treatment populations
- PbR contracts may fail to attract some prospective providers
- Large organisations are better placed to manage and respond to the risks associated with some PbR contracts
- Contracts with large PbR components may lead to cash-flow challenges for treatment providers
- Large organisations may be less affected by cash flow challenges presented by PbR
- Contracts with large PbR components can increase budgeting uncertainties
• Treatment services at times expressed concerns that funding models were not consistent with their understanding of the nature of dependency
• Interviewees expressed concerns about the complexity levels used as the basis for PbR payments

(iii) Implementation and delivery of recovery-orientated treatment systems under PbR

Early indications of the progress being made in two of the three recovery outcome domains under PbR (‘freedom from drugs of dependence’ and health and well-being) appear mixed and varied between the sites. The focus on delivering recovery-orientated outcomes by commissioners and treatment providers typically predated the emphasis placed on this by both the 2010 Drug Strategy and the introduction of PbR. A number of sites described a greater emphasis now being placed on promoting the staged reduction of opioid substitution dosage to both new and existing service users under PbR. This was often coupled with a desire to deliver more holistic interventions which address broader needs and issues extending beyond substance use and misuse.

The most effective aspects of provision under PbR were considered to include:
• a clearer framework which encourages both service users and providers to consider recovery-orientated goals;
• clearer expectations of service users around issues like continued use of illicit substances whilst in receipt of opioid substitution treatment (OST);
• a stronger emphasis on engaging with psycho-social forms of support to enhance the benefits of OST and aid recovery; and
• a renewed focus on reviewing progress towards meeting client goals.

By contrast, problems that had been encountered tended to focus on:
• abstinence not being considered an outcome sought by or achievable for the majority of treatment seekers in the short to medium-term (e.g. in relation to alcohol use or OST);
• the introduction of PbR being accompanied by anxiety and uncertainty for service users and practitioners alike (with service users reportedly experiencing pressure to reduce their prescribed opioid substitution medication too rapidly as a consequence of PbR);
• the chronic, relapsing nature of dependency being at odds with the notion of a PbR outcome focused on re-presentation; and
• some established barriers to recovery, including access to appropriate forms of accommodation and offending behaviour, being beyond the influence or control of providers.

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3 Issues arising from the use of complexity tools and the tariffing of service users will be examined in greater detail as part of the final evaluation report.
Main findings in summary:

- In many sites a recovery focus predates the piloting of PbR
- Pilot sites share common features despite varying treatment structures
- Throughcare, aftercare and peer support are seen as particularly important for promoting and sustaining recovery achievements
- PbR now provides a clearer framework which encourages both service users and providers to consider recovery-orientated goals
- The increased recovery focus has led to some services developing new approaches and/or improving areas that were historically lacking
- Some practitioners insisted that PbR had no impact whatsoever on their work
- Some service users reported experiencing pressure to reduce their prescribed opioid substitute medication at a pace they were uncomfortable with as a consequence of PbR
- Commissioners and treatment providers commented that the achievement of some PbR outcomes were often dependent on factors beyond their control

(iv) Exit strategies

Some interviewees reported that involvement in PbR had created opportunities for increased creativity and flexibility around aspects of service design and delivery. It had also encouraged services and practitioners to place a greater emphasis on monitoring and reviewing the progress of those in treatment. However, the emphasis on measuring progress towards the achievement of designated outcomes under PbR, and the administrative burden associated with this, had the potential to alter and distort aspects of practice and risked undermining the responsiveness of services.

The experience from one of the pilots in particular, illustrates how performance deteriorations caused by the system change required for PbR can significantly erode trust and destabilised the relationship between commissioners and providers. The lessons from the pilots reinforce the need for subsequent iterations of PbR to be afforded an appropriate period prior to systems ‘going live’ to allow related processes and procedures sufficient time to ‘bed-in’.

There was something of a division of opinion regarding the extent to which gaming within the treatment system might necessitate the need for a LASARS function – with its associated costs and bureaucracy - to continue as a feature of future PbR models.

Many interviewees questioned the feasibility of PbR models where contract payments are based entirely on outcomes achieved. Others described how they intended to be more selective around the outcomes that would be sought and incentivised in future, and which could be more readily measured using existing systems.

Despite the many difficulties encountered, interviewees generally expressed a desire to continue with PbR as a feature of their commissioning and provider arrangements, subject to some adaptations, drawing upon the lessons learned from the piloting process. This was despite concerns being raised in the latter stages of the pilot about the degree of random variation (or ‘noise’)
apparent within the treatment and offending outcomes used in this model. This will provide limited opportunity to measure treatment outcomes within more fully developed PbR schemes.

Main findings in summary:

- PbR encouraged greater emphasis on monitoring and progress review
- System changes required for PbR necessitates a relationship between commissioners and providers characterised by good communication, transparency and trust
- Division of opinion regarding the extent to which gaming within the treatment system might necessitate the need for a LASARS function
- Interviewees generally expressed their interest in continuing with PbR
- Some interviewees expressed reservations about the feasibility of 100% PbR models

Future reports

The next interim report is due to be submitted to the Department of Health in October 2014. This will contain findings on all research questions and will incorporate results from all phases of interviews and preliminary analysis of impact on outcomes measured in the NDTMS. The final report is due to be submitted to the Department of Health in March 2015.