Response to Payment by Results Consultation
Stockton DAAT – Adult Commissioning Group

General Comments

DAATs have strived to ensure that differing organisations and partners involved in the treatment system work in an integrated way. Most areas have achieved this. Therefore, how will it be clear which provider is the one that made the change to receive the reward?

We understand that in the current alcohol PbR pilot there is no requirement to be fully abstinent from alcohol in order for a provider to be paid. Why would abstinence from alcohol therefore be a key indicator in the drug pilot?

How will Harm Minimisation/needle exchange services be funded if payment is only structured around abstinence?

How will services for carers/families be funded payment is structured around the individual drug user and their abstinence?

Budget

Where will the budget for PbR be held? Is it to be held within the local Public Health budget or centrally? What proportion of the drugs budget will be for PbR? Is there to be a portion of core funding not linked to PbR? How will the first year of PbR be managed? Will the first year's payment be based on historical data?

Despite much effort expended by agencies collectively, all DAAT areas will have a core group of individuals who do not respond positively to intervention – what will the approach be to such individuals in a PbR system? Providers should not have a disincentive to work with those individuals who are most resistant to change.

Hidden Harm

The Hidden Harm agenda is not reflected in the current payment system. There should be rewards for assessments relating to children/family, potentially rewards for clients who attend accredited parenting courses etc.

Free from drugs of dependence

1.1 – By using the current TOP form this will not allow for emerging drug trends to be on the list. The 2010 drug strategy states that over the counter medications should now be dealt with – what if an individual's problematic drug included benzos? Is it acceptable to state that someone should be abstinent from alcohol? Alcohol is not an illegal substance and an individual may opt for controlled drinking rather than abstinence.
Biological testing as a possible verification method - how enforceable would this be? Would we be refused payment if a client refused to be tested (even though this is their legal right)?

The requirement for two review TOPs to be completed and showing abstinence on all measures:

- Would services lose out if a client had maintained their abstinence but had not received a second review TOP?
- What about a client with less entrenched drug use? If they only require one review TOP and are then discharged in a planned way, what would happen? The decision to offer someone a second review TOP should be a clinical decision; we cannot enforce a second TOP if it is not deemed necessary. Similarly if the client is deemed to have 'no ongoing treatment need' then the treatment agency could appropriately discharge the client at this stage, prior to the second review TOP being completed
- If a client shows abstinence on their first review TOP but then relapses, would this model provide a disincentive to the treatment agency to give a second review TOP to the client until they are showing abstinence again? If so, does this jeopardise the client's treatment, given that TOP is marketed as a clinical review tool?

1.2 – 12 months is a long time to wait for payment. Which payment will be the highest 1.1 or 1.2?

This is unfairly weighted against intensive DIP areas. Should a client reappear through Arrest Referral and test positive for crack and/or opiates an intensive DIP would enforce a follow-up assessment, whereas a non-intensive DIP does not necessarily have to do this. That being the case, it would be more likely for a client to reappear in treatment in an intensive DIP area and therefore a non-intensive DIP would be favourably weighted towards within this PbR measure. From a national perspective we would have expected to see this PbR model incentivising DAAT areas into becoming intensive DIP partnerships; this does not appear to be the case.

1.3 – identified as being discounted but there should be rewards for progress made.

Employment

Which provider would receive this payment? If this is aimed at treatment providers, the measure should be based on making a positive contribution. It should not be the responsibility of a treatment provider to gain employment for an individual or get them 'off benefits.' The current labour market is poor for people who are recovering from drug addiction.

Treatment providers could be financially rewarded for their clients who take part in voluntary work/peer mentoring/training/education/social enterprise or community engagement activities. They could also be rewarded for appropriate referrals made to employment agencies.

All such activities contribute to a client being more enabled to engage in employment. In addition, individuals can take part in such activities whilst still being on prescribed medication so would not need to be abstinent.

Offending

3.1 The payment system with a time lag of what appears to be 28 months or 34 months is unacceptable. There should be rewards for reductions in offending rather than no proven offending for individuals. Rewards should also be based on a reduction in gravity of offences. It would need to be very clear what is meant by offences recorded on PNC because such things as 'dangerous dogs' are included on the PNC list and a treatment provider should not be penalised for this. Rewards should be based on an individual's progress rather than a cohort. NI38 data indicated that a small number of individuals who were resistant to change 'skewed' the whole data set as a small number of individuals could be responsible for a high volume of crimes. Also, what about those who have offended but not been caught? Good keyworking might identify offending via TOP. The key worker could work with them on this and a reduction could occur, although the individual may never have been arrested for an offence.

3.2 The 'reset the clock' idea appears to be a linear process. A linear process does not reflect the proven cyclical nature of addiction (Prochaska & DiClemente).

Injecting

Agree with.

No Fixed Abode

'Housing Problem' is too vague. Access to housing for this client group is going to be impacted upon by the changes to the Local Housing Allowance from January 2012. Again, why should a treatment provider be held responsible for an individual's housing circumstance? Such external factors as availability of housing in a local area and the type of housing available are outside of a treatment provider's control. An individual may not be 'no fixed abode' but could still live in poor accommodation.

Hep B

Agree with
Query: why not reward for Hep C testing?

Health and Well Being

Reduced hospital admissions could be included in this.
Would have to be clear what the 'normative score' was based on.

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