Pathways to Recovery

A Manifesto for Drug and Alcohol Treatment

EATA European Association for the Treatment of Addiction (UK)

the independent voice of the sector

Contents

PART I

Pathways to Recovery

A Manifesto for Drug and Alcohol Treatment

EATA
European Association for the Treatment of Addiction

SUMMARY

1. **EATA is the membership organisation representing the majority of drugs and alcohol treatment providers in the UK who work with many of the 225,000 drug users engaged in treatment.**

2. **EATA works with Drugscope, Adfam and the Alliance to complement each other's remits in the field of drug policy, family and carer and user involvement and representation.**

3. **As the independent voice of the sector, EATA wants to contribute to the greater success of treatment outcomes, not only for the benefit of users, but for their families and the wider society. This manifesto has therefore been produced with a view to publication prior to a General Election in 2010. Consultation on the document was undertaken with the membership through a series of events and written feedback. The resulting document has gained depth and weight from the considerable experience of participants.**

4. **EATA acknowledges that the investment in treatment has been of great benefit to society and that treatment has become more accessible to thousands of users. There have been health gains, including reductions in blood-borne viruses and crime reduction. The next stage of the long term drug strategy must concentrate on the benefits that would come from development of the treatment system with as much focus on fostering independence as on harm reduction.**

5. **Seven principles underpin the manifesto and include developing courageous leadership to improve systems and enhance objectives at all levels in current treatment approaches.**

6. **The manifesto includes alcohol as an equal partner with drugs at the treatment table.**

7. **The manifesto recognises that polydrug use and alcohol problems compromise treatment outcomes. This view is in line with the EMCDDA report on polydrug use 2009[1] which states: "Polydrug use and concomitant alcohol problems are now the defining elements of the European Drug Problem." A recovery approach at the outset of treatment would move current treatment modalities away from substance specific treatment to holistic treatment.**

8. **An outcome-focused approach will benefit individuals by basing outcome funding on factors that include: health improvement and harm reduction[2],**

[1] From EATA's inception we have recognised the need for a European dimension in drug treatment strategy and that countries in Europe should learn from each other. The recent report on Polydrug use by the EMCDDA (Nov 2009) can be found at http://emcdda.europeeu/publications/selected-issues/polydrug-use

[2] **Harm Reduction**

social well-being, abstinence[3], training for work, being in work for six months and coming off benefits.

9. **The manifesto promotes recovery-oriented treatment as the starting point for the treatment journey from initial assessment onward.**

10. **The manifesto proposes the engagement of 'recovery mentors', to be identified in communities. The experience and empathy of mentors are key to carrying an effective message of hope to those in treatment or who are about to embark on treatment.**

11. **Self-help groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Cocaine Anonymous (CA) are already well embedded in communities across the UK, at no cost to the State. There are also other non-state funded self-help groups such as SMART. They encourage lifestyle change and offer support during the day, evening and at weekends. Users can become part of recovering communities that offer support with people who have made a commitment to leading lives free of drugs or alcohol. Formalising a pathway for users to investigate these groups among all professional drug workers can help improve outcomes for the user. Professionals themselves need to better understand what these and other self-help groups have to offer.**

12. **The Personalisation Agenda[4] as part of the recovery approach gives informed choices to the individual service user and to families and carers to use for their needs. Well-managed flexible services should be able to respond better to client needs.**

13. **EATA has designed an outline of an evidence-based local treatment model (Point 5). Recovery plans will be inputted as data.**

14. **We are entering a period of public sector constraints and probable cuts. EATA believes that efficiencies could be found by a review of policy and commissioning practice. Streamlining costly acute medical services could yield savings. Third sector organisations could provide professional services, with GPs to reduce the numbers of those in long term methadone treatment by helping them to abstain and move towards recovery and independence.**

15. **Competitive community care funding for substance misuse treatment (drugs & alcohol) will need review if the tier 4 rehabilitation is to be sustained.**

Harm reduction is a term that defines policies, programmes, services and actions that work to reduce the: health; social; and economic harms to: individuals; communities; and society that are associated with the use of drugs. *(Newcombe,1992)*

[3] **Recovery Abstinence**
To refrain from the usage of chemicals or substances to which a person may have become addicted.(*Treatment Solutions Network, Dictionary)*

[4] The Department of Health describes the Personalisation Agenda as meaning: "every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings."

16. **Current commissioning needs reform – with the PCTs and Local Authorities to prioritise within a framework of a recovery approach.**

17. **Drug and alcohol misusers need choice and motivation to become drug and alcohol free. Harm reduction has a role as does prescribed substitutes such as methadone. However, it is EATA's contention that recovery should be a constant theme from the outset of the treatment journey.**

18. **Drug and alcohol policy needs to be mainstreamed across social care areas but this takes time, political commitment, and legislation. In any transition period, dedicated investment in treatment needs to be protected by being ring- fenced. This is particularly important in the context of the localisation agenda where differing priorities and a lack of understanding of the importance of treatment could result in services surviving in some areas and disappearing in others.**

1 BACKGROUND AND CONTEXT

What do we want from drug and alcohol policy in the UK?

EATA members comprise over 110 UK drug and alcohol treatment organisations and - hundreds of projects or services. Almost all members operate in the not-for-profit 'third sector'. They largely depend on Government funding and contracts that are designed to meet Government's strategic objectives to reduce the harm that drugs cause to individuals and communities.

Over the past two decades, Governments have responded to rising illicit drug use with unprecedented investment and policy built on the three pillars of prevention, enforcement and treatment. The National Drugs Strategy for England and Wales 2008-2018 is driven by a determination to reduce crime. Over time, treatment has gradually become more of an equal partner with the other pillars of strategy in comparison to its marginalised position at the outset of strategy. Much of the treatment delivered by the not-for-profit agencies has been and continues to be either based within the criminal justice system or closely linked to it.

The cost of drug and alcohol misuse is enormous. It affects the criminal justice budgets with approximately 70% of prisoners having drug and alcohol problems which are related to offending. Health resources are affected detrimentally especially in A&E, Acute medical, mental health and primary care. Substance misuse affects thousand of children and social care budgets bear the cost of interventions. Drug and alcohol treatment must now be placed in the mainstream, offer recovery in all polices aimed at reducing offending as well as being introduced into social welfare such as benefit allocation.

1.1 The Value of Drug and Alcohol Treatment

EATA acknowledges that the investment over ten years in drugs treatment has enabled the rapid expansion of services and treatment has become more accessible to thousands of users. There have been health gains, for example in the year-on- year reductions in HIV infection and progress with Hepatitis C and also in crime reduction. These are great policy successes. But, while harm reduction is vitally important, it is only part of the recovery process. Harm reduction is not an end in itself when many users want to move on to full recovery and play a more constructive role in society. The next stage of the long term drug strategy must concentrate on the benefits that would come from the development of the treatment system with as much focus on fostering independence as on harm reduction.

1.2 The Role of EATA

EATA as a representative body of treatment agencies has a natural remit to help develop a manifesto for drugs and alcohol treatment and ensure Government hears the voice of the treatment sector. Consultation took place among members through a series

of events and written submissions. The resulting document has gained depth and weight from the considerable experience of those who have contributed.

The manifesto intends to inspire and make a truly constructive contribution to treatment policy. While it believes savings can be made in costs, it avoids being simply a platform that calls for immunity from public sector cuts. There are other forums in which that case must be made more fully. The manifesto outlines seven unifying principles upon which a redirection of policy could be based.

The seven principles included in the manifesto attempt to define the values needed for a developmental policy based on recovery. They frame a reinvigorated vision for treatment, one in which the path individuals take towards leading drug-free lives is measured and where outcomes are evaluated.

1.3 A focus on recovery

For many years, treatment has seen an imbalance of investment in favour of acute medical services. At a rough approximation, upwards of fifty eight per cent of the drug treatment budget within the NHS is spent on acute medical treatment.[5] Methadone has benefits for some who need stabilisation and/or detoxification, yet, there is good evidence that over half of all users want to stop using drugs altogether[6]. Worryingly, many drug users who are assessed as needing abstinence treatment placements can not secure funding. Currently, detoxification and rehabilitation centres are struggling with funding and several have closed. Abandoning this sector to market forces along with a failure to address the causes and consequences could lead to problems in the delivery of effective treatment responses in the future, and ultimately in increased costs.

1.4. Alcohol - the 'elephant' in the treatment room

Alcohol misuse affects many more individuals and communities than drugs in the UK, yet there is no comparable treatment policy response to dealing with it. There are various economic, cultural and historic reasons for this outlined in consultation responses to the Government's Alcohol Harm Reduction strategy[7]. Additionally, alcohol plays a part in undermining the effectiveness of drugs treatment among individuals. We will suggest where savings can be made in processes and non-essential areas of drug policy to arrive at a joined up substance misuse policy. We want to make the case for including alcohol misuse as an equal partner to drugs misuse in policy. This is not only a necessary development for effective substance misuse treatment as a whole but it would also bring real benefits to the wider UK society.

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[5] In 2001, the methadone prescribing budget alone cost £67 per person per week or £3,484 per annum for 100 mls daily for stabilising chaotic users and for maintenance. (Variability in dosage is accepted). But this amounts to an approximate £156million per annum for the 45,000 methadone dependent users then known. The figure has increased since that time. This figure does not include the resource infrastructure for delivering methadone. Quoted in Phase I Birt Report to Government's Strategy Unit, 2003 based on NHS and NCIS data. In 2002, mainstream health spending on treatment was £180m and the pooled budget for treatment was £190m.

[6] Addaction, collecting the evidence, Jones et al, 2004 and R Yates University of Stirling, Interim Evaluation , & Project Match

[7] i.e. Addaction response to Government's alcohol consultation and the subsequent Alcohol Strategy, 2004

1.5 Enhanced Objectives

It is axiomatic to say that how we measure 'What Works' in drugs treatment depends entirely on the objectives. If the major objective as stated in policy is to reduce social harms and harm to individuals, policy has had beneficial effect, particularly as far as the spread of HIV is concerned. However, outcomes have disappointed and failed to meet the expectations of the public and the politicians. Despite numerous interventions to improve pathways out of the criminal justice system into treatment, the circular path back into custody is still a crowded one. Now is the time, as the next stage of the drug and alcohol strategy, to enhance objectives and meet expectations of users, their families and the wider society.

1.6 Environment

Rehabilitation centres are closing at a worrying rate. In response to the public debt, a programme of public sector cuts will be shared by major government departments including the Department of Health, and will adversely affect delivery of drug and alcohol treatment in community settings. PCT budgets are likely to become a soft target. A squeeze on local government is likely to see Community Care budgets reduced. The drugs strategy to date has relied on a commitment backed by funding from central government and driven by the Home Office. In the future we could see an undermining of services in what has been dubbed 'localisation' as people in communities are forced to make hard choices.

A large proportion of current drugs spend, is absorbed in administration and process, and some is even spent on projects that have nothing to do with drugs. In this environment it becomes even more imperative to seek accountability and transparency on real costs, and to promote savings in non-essential processes and sustain frontline delivery.

2 THE CONSULTATION DOCUMENT

2.1

A consultation document was produced, aimed at the EATA membership and was circulated to chief executives of member organisations prior to discussion events held in Autumn 2009 and subsequently at two regional events. It is proposed to publish and publicise the document in 2010. It will be used to try to influence decision makers and to argue for secure funding tied to improved outcomes for sustained recovery. It will call for an immediate review of process and the way funding is administered in order to produce efficiencies. The manifesto will be underpinned by our own analysis and projections of costs and savings to be made by a change of direction towards a policy based on recovery to enable those in recovery to become a positive force in their communities.

To summarise the context, EATA believes that individual drug and alcohol users seeking help must be placed at the centre of treatment, rehabilitation and recovery. The gains to be had from such a policy are potentially enormous, not only in crime reduction but in health improvement. The goal

is nothing less than to transform dependent individuals who possess minimal expectations, to become healthy, working, taxpaying contributors to society.

3 SEVEN PRINCIPLES

i. **foster independence*** in the individual from the outset of treatment towards social well-being and away from social management. Our aim is to integrate treatment for the individual as part of community reintegration and family life. (*independence from drugs, alcohol and state benefits).

Ii **instil absolute integrity & accountability** in researching and disseminating the evidence base for programmes, methods and models.

iii **have courage** – we accept that courage is needed to promote a policy of recovery in a climate that can be hostile to drug users, and is often polarised and protectionist. We applaud courage in leadership among the recovery champions who include supportive politicians and professionals, as well as recognising the courage required by those individuals who choose recovery goals, has to become part of our ethos.

iv **value people**. We will recognise the value of service users who find recovery and engage them to help others through mentoring support programmes, testimonials and appropriate publicity. The role of the family will be understood and nurtured and those in recovery will be enabled to support themselves and their families in a sustained way. Professionals should challenge stigma and ignorance whilst recognising those in recovery and service users can fill a valuable role in society.

v **be open to transformational change**. The culture of substance misuse treatment requires a deeper understanding of what is possible for the user. We must also promote best practice in commissioning and service delivery to meet new recovery and reintegration objectives.[8]

vi **place success for people above successful process**. Funding must be linked to outcomes not processes (such as the completion of assessment reports).

vii **inspire and motivate the workforce**. Encourage the development of professional workers. People who work in the field are our strongest asset.

4 DRUG AND ALCOHOL TREATMENT, REHABILITATION AND RECOVERY

[8] NTA Drug Partnership Action Plans, to be introduced April 2010

4.1 **Alcohol** is one of the most serious health hazards we face in the UK. Since the 1990s we have witnessed unprecedented levels of early-onset liver disease and other alcohol-related illness. The Government's Alcohol Harm Reduction strategy[9] offers little investment in treatment intervention and at best produces health education campaigns which have had a marginal impact on behaviours and harms. Alcohol is a factor in the drug treatment outcomes as it is a major secondary drug of choice.

Alcohol and drugs need to be addressed together and not separated by diverse strategies and different funding streams. Mutual aid groups should not be seen or used as an optional extra but placed at the very heart of the treatment system.

4.2 **Separate the drug from the person**. Too much attention is spent on what drug the individual takes and too little on what underlies the drug use. It is much more helpful in planning effective treatment responses to have knowledge of an individual's background, the culture and the triggers that lead to first use and subsequent patterns of use. There is an abundance of opiate replacement services. We offer little for the stimulant or cocaine user, the alcohol dependent person, or, indeed, the cannabis user, so they do not get offered the chance for recovery. The manifesto recognises that polydrug use and alcohol problems compromise treatment outcomes. This is in line with the EMCDDA report on polydrug use 2009[10] which states: "polydrug use and concomitant alcohol problems are now the defining elements of the European Drug Problem."

A recovery approach at the outset of treatment would move current treatment modalities away from substance specific treatment to universal holistic treatment. Proposals in our manifesto promote treatment that focuses on the user not the drug. There should be a single point of access for treatment whatever the drug used.

4.3 **Addiction Fingerprint.** Users will often display common characteristics such as low self-worth, a lack of direction and anxiety. But the manifesting symptoms of addiction will be different with each individual. Each will have a unique profile based on family history, physical make up and length and depth of drug and alcohol misuse. When people find recovery and abstain, this is when their full potential can emerge. We must also recognise that today's investment in recovery can interrupt and stop the generational cycle of substance misuse. There is much to learn from the recovery movement in the mental health field.

4.3 **Recovering Communities.** Excellent work has been done in the UK where it has been demonstrated that recovery mentors can form the basis of recovering communities. Mentors who have successfully sustained abstinence or are recovering, find that sharing their experiences and helping others, keeps them firmly on the path to recovery. The 'new' recovering client respects the

[9] Strategy Unit (SU) 2004

[10] From EATA's inception it has recognised the need for a European dimension in drug treatment strategy and that countries in Europe should learn from each other. The recent report on Polydrug use by the EMCDDA (Nov 2009) can be found at http://emcdda.europeeu/publications/selected-issues/polydrug-use

experience of a mentor, is inspired by a mentor's successes and feels understood.

Across the UK courageous leadership could harness those in recovery to help build communities of recovery and to challenge stigma that exists in the workplace and in communities.

4.4 **Self-help Groups**. Professional drug and alcohol workers rarely refer clients to self-help groups. Work and education is needed to address the lack of understanding by professionals of how the self-help programmes work. The most well known are Alcoholics Anonymous (AA) Narcotics Anonymous (NA) and Cocaine Anonymous (CA), but there are many different groups, including Adfam, and SMART as well as Al-anon for partners and children of users. Utilisation of self-help groups will benefit those new to treatment at the triage stage of assessment in the very heart of treatment engagement especially within the NHS.

Providers should support these groups by making premises available for meetings in their treatment settings and by encouraging their clients to participate.

4.6 **Individualism and Personalisation**

Client choice can be helped by a planned Personalisation Agenda where clients will be given access and choice to buy treatment and care to best suit their needs.

Models are being developed to help service users make the best decisions for themselves through informed choice.

4.7 **Quality Improvement**

The Care Quality Commission (CQC) is currently proposing to regulate segments of the treatment system beyond the traditional regulation of the NHS and registered care homes. While EATA welcomes this development, it is as yet unclear as to how this will work in practice. However, treatment effectiveness is not within the CQC remit. EATA manages an accreditation scheme where criteria will consider effectiveness of treatment. This will complement the CQC's work.

Between EATA's accreditation scheme and the CQC, we believe treatment effectiveness can be optimised and therefore advocate a policy of adopting EATA accreditation as a kitemark of quality and effectiveness for providers.

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5 ELEMENTS IN AN OUTLINE RECOVERY MODEL FOR TREATMENT

To present just one model as an example:

5.1 Each locality will require access to three treatment and recovery elements. Each of these programmes will operate to a high standard and be accredited to an evidence base.
Models of Care - Tiers should be a series of doorways with users able to access the system at any point.

5.2 First Point of Contact (Element 1)

- A well-publicised point of entry from the outset encompassing rapid response assessment and harm reduction within the ethos of recovery.
- Street agencies or community drug and alcohol teams assess, inspire, motivate and help the client through the early planning stages.
- 'Engagement' in this context, translates as a personal relationship-building exercise and not mere form-filling.
- 'Recovery Plans' will be inputted as data.
- 'Peer Mentors' will be available to inspire the individual and reduce anxiety.
- Detoxification or short term-prescribing may be required.
- Providing an integrated care and recovery plan for users once they enter the system

5.3 Detoxification and recovery oriented residential treatment (Element 2)

EATA has seen some extremely encouraging models of best practice – which can be integrated into the community and supported with funding locally. (Examples upon request)

5.4 Community recovery-oriented day programmes (Element 3)

Day programmes can be used as an alternative to residential services for those who already have a supportive living environment, including children.

They can also be used as stepping stones when people leave residential programmes.

Relapse prevention would be delivered along with employment training and job seeking support. The benefit of aftercare will yield much reward.
Recovery is long term and sustainable. Commitment from those many people who have found recovery will support the changes required for diminishing crime, reducing criminal justice costs, rebuilding families and communities, and increasing independence and for productive use of precious resources. The next stage of this strategy will be to model and cost programmes and to support current programmes with the changes required to build recovering communities across the UK.

6 COMMISSIONING

6.1 The Government has developed a central infrastructure to develop policy which is then delivered locally by 149 DATs, DAATs or Drug Partnerships. In addition, CDRPs (Crime and Disorder Reduction Partnerships) have been formed within local Boroughs. CDRPs join up disparate agencies to develop publicity programmes and other community initiatives, often responding to drugs and alcohol issues within the community.

It is important that all commissioning bodies, and CDRPs with their information and publicity remit, should be involved in the development of policy that focuses on recovery and gain a full understanding of it.

6.2 Local authorities fund residential treatment under Community Care where substance misuse clients are often competing for limited resource with the elderly and disabled. This is quite apart from the systems that pertain within prisons. The administrative and care management resource required to manage these systems is often viewed suspiciously by some as soaking up too much precious money which could be better used on the front line.

EATA advocates a total but rapid root and branch review of systems to make funding simpler and less costly. Savings could be made there instead of on the front line.

6.3 Far more emphasis must now be placed on "outcome focused" funding where payment is made on the basis of results (PBR). We know that currently outcome data exists that is heavily aligned in favour of medical treatment and is not recovery orientated.

We must address positive recovery outcomes for the benefit of individuals, families and communities. In line with PBR, EATA is examining the potential for tariffs for specific outcome-based activities.

7 WORKFORCE DEVELOPMENT

7.1 Over the last ten years the head count within drug and alcohol rehabilitation and treatment has expanded significantly in line with much needed Government investment. While many organisations have dedicated training and development resources to meet the needs of the service users and comply with National Standards there are still training requirements.

7.2 Individual workers should be accredited with, for instance an agency such as FDAP (Federation of Drug and Alcohol Professionals) on an annual basis with the minimum entry requirement being at NVQ levels 3. Recovery champions (those in recovery) will be ideally placed to work in the field with an equal status.

7.3 Management development in clinical disciplines and business skills are required for those managing people and services.

7.4 All workers should be competent to inform service users about treatment pathways and options including both harm reduction and abstinence orientation.

Qualifications and awards will need to be reviewed to reflect this. There may be a requirement to review or develop new national occupational standards to fully define the competencies required. All qualifications should be based on the National Qualification framework to ensure parity with the wider health, social care and criminal justice sector.

7.5 Practitioners will need to demonstrate appropriate continued professional development to continue to be accredited. This will improve quality and continue to advance practice.

8 TIER 3

8.1 Serious blockages to access exist in the Tier 3 methadone programmes which are mainly run by NHS Mental Health trusts. It is therefore worth noting some good evidence of the effect of recovery orientation on methadone maintained patients. George de Leon's Passages Programme[11] describes 1100 long term methadone maintained patients who were offered a recovery orientation – the outcomes showed that a third of the cohort stayed the same, a third dramatically reduced their prescriptions, and a third became abstinent and recovered.

8.2 Recovery partners should be contracted to work in these programmes to motivate change where the NHS staff offering acute medical services are not encouraging recovery or don't understand the process.

8.3 Prescribing methadone should be used as a tool for stabilisation and harm reduction but providers should prioritise work on an individual's recovery. All providers should either provide this or be partnered with a recovery agency especially within the NHS. Needle exchanges provide a good opportunity to access users who haven't accessed treatment in the past and to help to prevent the spread of blood borne viruses (bbv) such as Hepatitis C.

9 RECOVERY MENTORS

9.1 Recovery mentors who have experienced drug/alcohol addictions or both, and have moved on to recovery can be superlative advocates for those who are still addicted and also sources of inspiration. Good policy and practice will be augmented by their experience which carries substantial credibility underpinned by empathy, hope and a solution not often available in all treatment settings.

10 CRIMINAL JUSTICE

[11] Passages: a Modified Therapeutic Community Model for Methadone-Maintained Clients. George De Leon 'Community as Method' 1997, pp225-239

Intensive recovery oriented treatment programmes, which are backed by evidence and underpinned by the use of self-help groups, provide a genuine opportunity to build on the effectiveness of coercive rehabilitation and treatment, which we accept can be a useful tool in reducing crime.

11 THIRD SECTOR

The third sector has much to offer in terms on increased value through efficiency and its ability to respond rapidly to a changing environment. It can maintain contact effectively with other sectors such as housing and employment. The sector needs to be sustained.

The Home Office Compact for Voluntary Sector Services needs to be a mandatory commissioner requirement

12 THE NEXT STAGES

In two stages, the manifesto will be subject to cost-benefit analysis, factoring in social returns on investment, and suggesting projected savings to be made in implementing a new vision towards recovery-based treatment. **This economic cost benefit analysis can be found in Part II of this document**

Secondly, we will be presenting the case to individuals and organisations who may be persuaded to support and help implement this new approach.

PART II

The economic and social benefits of implementing the *Pathways to Recovery* Manifesto

Landman Economics

The economic and social benefits of implementing the *Pathways to Recovery* manifesto

A research paper for EATA by Howard Reed, Landman Economics

January 2010

Introduction

This paper is designed to be read in conjunction with the EATA manifesto document *Pathways to Recovery: A manifesto for Drug and Alcohol Treatment* (henceforth referred to as 'The Manifesto'). As the Manifesto explains, current levels of drug and alcohol abuse in the UK impose substantial costs on the public finances and on society as a whole. The paper uses cost-benefit analysis techniques to provide some estimates of how large the costs of drug and alcohol misuse are, and what the benefits from implementing the kinds of policies detailed in the Manifesto might be.

Summary of economic and social benefits

The table overleaf summarises our estimates of the benefits arising from implementing the policies in *Pathways to Recovery*. Note that the figures for the public finance benefits of extending the treatment model to drug and alcohol users not currently in treatment should be viewed as an upper bound on the possible savings, as they do not include the NHS costs of extending treatment services but only the reductions in costs to other parts of the NHS from a lower incidence of drug and alcohol misuse in the population. All the figures refer to England and Wales and are annual estimates in current prices.

The calculations in this paper suggest that implementation of the Manifesto could produce public finance savings of around £1.1 billion (based on applying the model to drug and alcohol users already in treatment), plus up to £2.5 billion from applying the model to drug and alcohol users not currently in treatment. In addition to this there are additional social benefits (mainly in terms of reduced costs resulting from crime) of £1.2bn (based on applying the model to existing treatment cases) and £3.7 billion (based on applying the model to users not currently in treatment.

Summary table: economic and social benefits of implementing *Pathways to Recovery*

	Drug/alcohol users in existing treatment		Drug/alcohol users not in existing treatment	
Benefits (reduction in existing drug & alcohol treatment population)	**Public finances**	**Wider social benefit**	**Public finances**	**Wider social benefit**
	£m	**£m**	**£m**	**£m**
Drug-related costs:				
Reduction in NHS spending on methadone and other substitute drugs	116			
Reduction in drug-related crime	361	1,116	885*	2,732
Reduction in benefit expenditure	192		470	
increased income tax and national insurance receipts	49		120	
Reduced number of children in care	144		353	
Reduction in NHS spending on diseases linked to drug use	170		416	
Other NHS costs	30		74	
Alcohol-related costs:	12	54	212*	957
TOTAL	**1,075**	**1,170**	**2,530***	**3,689**

* upper bound estimate.

Methodology

In order to estimate the reductions in costs of drug and alcohol misuse that arise from implementing the Manifesto, it is necessary to make an assumption about **how successful** the treatment techniques introduced by the Manifesto will be. This section outlines the assumptions we have made.

Number of existing addicts successfully treated

For **drug users**, this analysis assumes that the policies recommended in the manifesto will deliver a 25% reduction in the methadone (or substitute) caseload, through successful treatment of addicts. Given that a similar package of recovery orientation for methadone addicts implemented in the US in the 1990s delivered caseload reductions of around one-third[12], we believe that 25% is a realistic conservative estimate of programme effectiveness.

Currently there are approximately 350,000 Problem Drugs Misusers (PDU's) in England and Wales, of whom around 225,000 are undergoing treatment for addiction. Of this 225,000, around 60% (i.e. 143,000) are being prescribed methadone or other substitute drugs[13]. So the calculations here assume that the successful implementation of the manifesto reduces the total number of addicts in England and Wales by (25% × 143,000) = 35,750.

For **alcohol users**, a recent report by the NHS Confederation and the Royal College of Physicians[14] suggests that around 11.1 million people in England and Wales regularly drink above sensible limits[15], of whom 1.1 million are classified as alcohol addicts (i.e. chronic drinkers or alcoholics). The figures in this report relate to England and Wales, so we have made an upward adjustment based on population size. The Alcohol Needs Assessment Research Project (ANARP) study in 2005 produced figures showing that only 5.6% of alcohol addicts were in NHS treatment. This suggests a current treatment population of around 65,200.

As with the methadone calculations, we assume that 25% of the treatment caseload make a recovery and exit addiction as a result of the manifesto strategy (i.e. 16,300 people.)

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[12] De Leon, G. (1997), 'Passages: a Modified Therapeutic Community Model for Methadone-Maintained Clients' in *Community as Method*, pp 225-239.
[13] NTA National Drug Treatment Monitoring System Annual Report 2009
[14] NHS Confederation/Royal College of Physicians (2010), 'Too much of the hard stuff: what alcohol costs the NHS', January, Issue 193.
[15] The figures actually given in the report relate to England only. We have made an upward adjustment size based on the population size of England and Wales compared with England (from the most recent ONS estimates at http://www.statistics.gov.uk/pdfdir/pop0809.pdf) to make the figures geographically consistent with the rest of the report.

This is a relatively small proportion of the number of addicts in England (0.6%) and an even smaller proportion of the total number of people drinking above sensible limits.

Number of addicts not currently in treatment who are successfully treated

This paper also presents estimates for the benefits from treating drug users and those chronically dependent on alcohol who are **not currently in treatment**. Using the figures for the treatment caseload above and subtracting them from the overall number of people with drug or alcohol problems respectively, this implies non-treatment populations of:

350,000 – 225,000 = **125,000** PDUs not in treatment

1.1 million – 65,200 = **1.03 million** alcohol dependent people not in treatment (to the nearest 10,000)

This report produces separate figures for the reduction in costs relating to drug and alcohol misuse which would arise from getting a proportion of both these groups into successful treatment. We assume that 25% of drug users and alcoholics not in treatment can be successfully treated if the treatment programmes are expanded under the Manifesto.

How the cost savings are measured

The savings from implementing the Manifesto are estimated by using estimates from the most up-to-date and reliable academic and policy sources on what the current costs of drug misuse and alcohol addiction are, and then what effect a reduction in the drug user (or alcoholic) population would have on those costs. The sources are fully referenced throughout the report.

The report distinguishes between impacts of the Manifesto on the **public finances** (e.g. reductions in public spending costs relating to drug use and methadone treatment) and wider **social benefit** (e.g. reductions in the amount that drug-related crime costs individuals). From a public spending perspective, the former is most important. But from a cost-benefit analysis perspective the latter is equally important.

Cost-benefit analysis conventionally calculates the impact of policy over an extended time period (50 years is often used), discounting future benefits and costs using a social discount rate (the 'Green Book' which UK Government departments use for evaluations recommends a discount rate of 3.5% per year). This approach involves additional complexity because the time path of each

impact of interventions has to be modelled. Hence in this analysis we have used a simpler methodology to derive the 'long run' effects. We assume that the policies recommended by the Manifesto have been implemented and given enough time to be fully effective, and work out what reduction in the drug and alcohol user population we could expect once this is the case. We then work out the reduction in costs based on this long-run reduction in the number of drug users and alcoholics. Hence all the figures presented here are in annual terms and represent the annual benefit to the public finances and society of implementing the Manifesto policies in the 'long run' – say, ten years from when they are first introduced.

Drug and alcohol intervention programme budgets

The basic proposal outlined in the manifesto is that the budget for drug and alcohol support services will be refocused to new treatment methods (e.g. recovery services, recovering communities, detoxification and rehabilitation, supporting self-help groups, and so on) rather than reduced. Hence, our calculations do not factor in any savings for the cost of treating alcohol misusers and drug users, *except* for the savings resulting from not prescribing methadone, other substitute drugs and related costs.

For the groups who are *not* currently in treatment, there will be some additional cost of expanding the treatment programmes to reach those groups. We do not attempt to estimate this cost as there are simply too many unknowns (for example, how much of the cost will be borne by detoxification, rehabilitation and recovering communities and groups who cost the state nothing.) Thus the figures for the potential savings from extending the treatment programmes to those currently not in treatment are *gross* rather than *net* savings. They represent an upper bound on what the cost savings might be.

Calculations: Drug-related costs and benefits

This report models savings resulting from reductions in several different types of cost relating to drugs:

- The cost to the NHS of **treatment using methadone and substitute drugs**
- **Drug-related crime** (both to the NHS and to society at large)
- **Benefit payments** to drug users who are unable to work
- **Increased income tax and National Insurance Contribution receipts** from ex-drug users who are able to move into paid work
- **Care costs for children of drug users** who have to be taken into residential or foster care
- NHS costs from the **spread of blood-borne infections** through needle-based drug use (HIV and hepatitis C.)
- **Other NHS costs** (mental health services, GP visits, additional neonatal costs arising from mothers who are drug users)

We discuss the cost calculations and the calculations of savings resulting from the reduction in the drug user caseload for each one of these categories below.

Total Costs to NHS of treatment using methadone and substitute drugs

The overall budget for NHS treatment of drug users in England and Wales is approximately £800m[16]. This breaks down into £55m from mainstream NHS spending, plus £745m from the pooled treatment budget.

Estimates suggest that 58% of this treatment budget is spent on methadone or similar programmes. This equates to £464m, of which approximately 64% is spent on methadone, 21% on brupronorphene and 15% on diamorphine respectively.

A 25% reduction in the treatment caseload would mean savings of **£116m.**

This figure relates only to the drug user population in treatment at the moment (because the non-treatment population are not currently in treatment).

[16] DH/National Treatment Agency figures for 2009/10

Costs of drug-related crime

a) Costs to the public purse

The Home Office estimates that in 2003-04, the overall cost of drug-related crime to the public purse (through increased costs to the criminal justice system) in England and Wales was £3.16 billion[17]. This breaks down as follows:

Type of cost	Cost to CJS (£m)
Fraud	877
Burglary	1,419
Robbery	822
Shoplifting	383
Drug-related arrests	535
TOTAL	3,159

For the purposes of this report we have up rated the figure for inflation, giving an estimate of approximately £3.54 billion for 2009-10.

For **drug-users currently in treatment**, a reduction of 25% in the methadone (or substitute) caseload, with successful treatment of the people leaving the methadone programme, would imply a reduction of (35,750/350,000) = 10.2% in the total stock of problematic drug users.

If this leads to a proportionate reduction in the costs of drug-related crime we can expect savings of (£3.54 bn × 10.2%)

= **£361m** in total.

For **drug-users currently not in treatment,** we assume an additional reduction of 25% in the total stock of PDUs. This leads to additional savings of (£3.54bn × 25%)
= **£884m** in total.

b) Social costs

The equivalent Home Office estimates for the *social costs* of crime (for example harms to the victims and costs imposed on the rest of society through higher insurance premiums, and so on) was that in 2003-04, the overall cost of drug-

[17] N Singleton, R Murray and L Tinsley (2006), *Measuring different aspects of problem drug use: methodological developments* (2nd edition), Home Office Online Report 16/06.

related crime to the public purse (through increased costs to the criminal justice system) in England and Wales was £9.76 billion. This breaks down as follows:

Type of cost	Cost to CJS (£m)
Fraud	3,989
Burglary	2,651
Robbery	1,585
Shoplifting	1,533
TOTAL	9,758

Uprating this figure for inflation gives an estimate of approximately £10.93 billion for 2009-10.

Using the same methodology as for the public purse costs of crime, we can expect savings of **£1.12bn** arising from applying the Manifesto to drug users currently in treatment, and **£2.73bn** for those not currently in treatment.

Costs of benefits paid to those incapacitated by drugs

80% of the total drug user population are on at least one of the following benefits:

- Incapacity Benefit (IB)
- Income Support (IS) for disabled people[18]
- the new Employment and Support Allowance (ESA), which replaced IB for new claimants in October 2008
- Disability Living Allowance (DLA)
- Severe Disablement Allowance (SDA).

This report uses figures from the Department for Work and Pensions' online tabulation tool (which is based on its administrative statistics on benefit receipt) for the total working age caseload for these benefits. These are used to estimate the percentages of drug users claiming we have used figures from DWP on total working age caseload for these benefits to derive the percentages claiming them. To simplify the calculations we treat IB, ESA, IS and SDA as one benefit and calculate the average expenditure for the caseload of these benefits taken together. The results are as follows:

IB/ESA/IS/SDA only: 39% of claimants
DLA only: 14% of claimants
IB/ESA/IS/SDA and DLA: 47% of claimants

[18] Alternatively known as 'IS with IB credits'. Benefit claimants falling into this category would be eligible for IB based on their state of health, but have not paid sufficient previous National Insurance Contributions to qualify. Hence they are paid IS (with additional disability premia) instead of IB.

Because DWP don't produce separate figures for the breakdown of benefit caseload for the drug user population, the calculations here are based on the assumption that these percentages apply to the drug user population (in the absence of any better alternative hypothesis).

Each of these benefits is paid at several different rates. DWP figures show that the average *weekly* value of these benefits is approximately:
£100 per week for IB, SDA, IS or ESA
£70 per week for DLA

Taking these figures and the percentage estimates for receipt of different combinations of benefits above and applying them to the estimated 270,000 drug users on benefits, we estimate that total benefit expenditure on this group is £1.88bn.

For the **drug-user population currently in** treatment, we use the calculation made earlier of how many people would be taken off the caseload by the implementation of the Manifesto (i.e. a reduction of 10.2% in the number of users). Proportionately, this reduces benefit expenditure by **£192m.**

For the **drug user population currently not in treatment,** a reduction of 25% in the number of users produces benefit savings of **£470m.**

Public finance benefits of ex-drug users being able to work

To calculate these savings it is necessary to work out the additional tax that would be paid by an ex-drug user who is able to enter work. Even assuming that his or her salary is relatively low, he or she would pay income tax and National Insurance Contributions (NICs), if working. Therefore, gain to the Exchequer from increased tax receipts. Turning this around, it is clear that the existence of drug user population imposes a social cost via foregone tax receipts as well as additional benefit payments.

For these calculations we assume that:

- 80% of drug users currently undergoing methadone treatment (or substitutes) are not currently in work. (the obverse of the statistic that 20% of them are employed)
- The employment rate for drug users who successfully go through treatment will be 70% (just below the national average, reflecting the fact that many of them will, at least initially, be low skilled, and the employment rate for low-skilled people is lower than the employment rate for people with higher levels of skill).
- Each ex-drug user entering a job works 38 hours per week (approximate national average excluding overtime)

- Their hourly wage rate is £6 per hour (a conservative assumption reflecting the fact that many of this group will be low-skilled).

Given these assumptions, each ex-drug user moving into work pays £1,083 of Income Tax and £677 of employee NICs per year. In addition, their employer pays £698 per year of employee NICs.

Thus, the total increase in tax and NICs receipts from each ex-drug user is around £2,458 per year.

Given our previous calculations on the number of people who move into work for the drug-user population currently in treatment, the total increase in tax/NI receipts arising from the implementation of the Manifesto is around **£49m.**

For the drug-user population currently not in treatment, the corresponding figure is **£120m.**

Costs of children in care

Approximately 62% of children currently in local authority care placements are children of a drug-using parent or parents[19].

The total number of children in residential and foster care[20] in England and Wales is approximately:

- 9,200 in residential care;
- 46,800 in foster care

Estimates suggest that the cost of residential care is around £2,200 per week[21] and the cost of foster care around £500 per week[22].

Therefore the total cost of children in care in 2009 was around £2.2bn.

For drug-users currently in treatment, based on earlier calculations we assume that the manifesto policies reduce the number of children in care by 10.2% (the reduction in the total number of addicts resulting from the implementation of the

[19] Advisory Council on the Misuse of Drugs (2003), *Hidden Harm: Responding to the needs of children of problem drug users*.
[20] DCSF (2009), 'Statistical First Release: Children looked after in England (including adoption and care leavers), year ending 31 March 2009. London: Department for Children, Schools and Families.Again, estimates have been adjusted to take account of the population of England and Wales compared with the population of England.
[21] Cost figures for England from Northern Ireland Department of Health, Social Services and Public Safety (2000) online at http://www.dhsspsni.gov.uk/he-chapter_1.pdf uprated to 2009-10 levels.
[22] Cost figures from R. Tapsfield and F. Collier (2005) *The Cost of Foster Care: Investing in our childrens' future*, The Fostering Network/ BAAF. Uprated to 2009-10 levels.

manifesto) × 50% (the proportion of children in care who have drug-using parents.

Therefore, the reduction in children's care costs arising from the manifesto is estimated at approximately **£144m.**

For drug-users currently not in treatment, using the same methodology a reduction of 25% in the total number of drug users produces savings in children's care costs of **£353m.**

Costs of spread of blood-borne infections: HIV and Hepatitis C

Cost of treatment

For HIV, the HPA estimates that HAART treatment (combination of antiretroviral drugs) costs approx £16,000 per year[23].

For hepatitis C, NICE[24] recommend treatment via a combination of peginterferon and ribavirn. The dosage and length (and therefore the cost) varies according to the virus genotype:

Genotypes 2&3: Cost = £5,000 per person p.a.
Genotypes 1,4,5 & 6: Cost = £11,000 per person p.a.

As the HPA's publication *Hepatitis in the UK* (2009) quotes evidence that the breakdown of these sets of genotypes among sufferers in the UK is approximately 50/50 we have used a cost estimate of £8,000 per year for hepatitis C treatment.

Number of people infected

HPA (2008) reports that 152 people were diagnosed with HIV through injecting drug use.

HPA (2009)[25] reports that in 2008, the number of new hepatitis C cases was 8,196 in England (figures also available for rest of UK). Around 93% of new infections are thought to be due to injecting drugs.

Calculation

[23] Health Protection Agency (2008) *HIV in the UK: 2008 Report*
[24] NICE (2006) 'Peginterferon alfa and ribavirin for the treatment of mild chronic hepatitis C'
[25] Health Protection Agency (2009): *Hepatitis in the UK: 2009 Report*

Because the manifesto recommendations would not change the existing stock of people with each disease, but would instead reduce the number of new infections, this report calculates the cost savings which we could expect 10 years from now. This is a sufficiently long time period for substantial benefits to have accrued, while being short enough to be relevant in public finance terms.

For drug users currently in treatment, in line with our previous calculations about the reduction in the stock of drug users, we have assumed that the number of new diagnoses of HIV and hepatitis C falls by 10.2% each year as a result of the Manifesto. Therefore, in ten years' time the savings in treatment costs of these diseases are as follows:

HIV: **£6m**
Hepatitis C: **£164m.**

For drug users not currently in treatment, based on a 25% reduction in the drug user population the equivalent figures for savings in treatment costs are:

HIV: **£15m**
Hepatitis C: **£401m.**

Additional NHS costs of drug use

The Home Office estimates that in 2003-04 the NHS incurred the following additional costs (not related directly to methadone treatment) as a result of drug use in the population:

Type of cost	Cost (£m)
A&E services	81
Inpatient mental health	88
Community mental health	61
Primary care – GP visits	32
Neonatal effects	3
TOTAL	265

Uprating to 2009/10 prices this equates to just under £300m. Using the assumption that the stock of drug users reduces by 10.2% as a result of applying the manifesto policies to those currently in treatment, the savings in these additional NHS costs for this group amounts to **£30m.** The savings for the group not currently in treatment amount to **£74m.**

Alcohol-related cost calculations

The overall cost of alcohol

A recent report from the NHS Confederation/Royal College of Physicians[26] estimates that alcohol costs the NHS in England about £2.7bn per year (original source: DH, 2008). These figures have been adjusted for the additional population in Wales here to give an overall figure of around £2.85bn.

The NHS Confederation RCP paper estimates that these NHS costs break down as follows:

- Acute hospital costs: 78.3%
- Ambulances: 13.77%
- General practices: 4.12%
- Prescribed drugs: 0.07%
- Specialist services: 2.04%
- Other: 2.01%

In 2004 the Cabinet Office estimated that the other social costs of alcohol misuse in the UK were:
£7.3bn – crime and anti social behaviour
£6.4bn – lost productivity and profitability
£4.7bn – harms to family and society
We have corrected these figures for the difference in population size between the UK and England and Wales, and up rated them to the 2009-10 price level, for the calculations in this report. The two corrections roughly balance each other out, meaning that the figures used in the calculations are very similar to those given above.

Number of people suffering from alcohol addiction (and the numbers in treatment)

NHS Confederation/RCP suggest that around 10.5 million people in England regularly drink above sensible limits, of whom 1.1 million are classified as alcohol addicts (i.e. chronic drinkers or alcoholics). Adjusting these figures to include the Welsh population produces estimates of 11.1 million for the number of people regularly drinking above sensible limits, and 1.16 million alcoholics.

The Alcohol Needs Assessment Research Project (ANARP) study in 2005 produced figures showing that only 5.6% of alcohol addicts were in NHS treatment[27]. This suggests a current treatment population of around 65,200.

[26] NHS Confederation/RCP (2010), *Too much of the hard stuff.*
[27] Department of Health (2005) *The Alcohol Needs Assessment Research Project*

Cost savings for existing treatment group

As with the methadone calculations, the central assumption here is that 25% of the treatment caseload make a recovery and exit addiction as a result of the manifesto strategy (i.e. 16,300 people.)

This is a relatively small proportion of the number of addicts in England and Wales (0.6%) and an even smaller proportion of the total number of people drinking above sensible limits.

Our calculations apportion the NHS and social costs across everyone in England and Wales drinking above sensible limits, but we allocate *disproportionately high* costs to alcoholics (including the treatment group) compared with other heavy drinkers. Specifically, we assume that alcoholics are responsible for three times their population share of NHS costs (except for ambulance costs where we use a multiplier is two rather than three because 'binge drinkers' – not all of whom are alcoholics are particularly likely to present in A&E compared with other categories.) We ascribe 100% of the prescribed alcohol drugs budget to alcoholics who are in treatment.

We also use a social costs multiplier of 2 for alcoholics – in other words, assuming that they are responsible for twice their share of wider social costs compared with other heavy drinkers.

Our calculations assume that there is no reduction in the NHS costs of specialist services for alcohol misuse but rather that this budget is diverted into other types of recovery programme as a result of the EATA manifesto recommendations.

Using this methodology we calculate that implementation of the EATA recommendations – *given the current number of alcohol addicts undergoing treatment* - reduces NHS costs by around **£12m**, and wider social costs by **£54m**. At first glance these figures seem small compared with the figures for drugs given the sheer scale of the alcohol abuse problem in the UK. However, the size of the results can be explained by the relatively small number of alcohol dependent people in treatment. If treatment were expanded and treatment rates increased then much bigger social benefits and reductions in NHS costs could be realised.

Cost savings from extending the treatment model to alcoholics currently not in treatment

If the Manifesto treatment model for alcohol misuse could be extended to an additional 25 per cent of the alcohol-dependent population over the next ten

years (i.e. 25% ×1.11 million = 277,000 people), we can expect much greater savings from the implementation of the manifesto:

- An additional *gross* reduction in NHS costs of **£212m**
- Additional reductions in the social costs of alcohol abuse of £**957m.**

For the NHS costs, the figure of £212 million represents an upper bound estimate on the overall savings, because there would be costs involved in extending alcohol dependency treatment to an additional 277,000 people. It is hard to estimate the precise costs involve because this depends on the precise mix of alcohol recovery treatments on offer including detoxification, prescription drugs to help alcoholics initially, GP services, 'one-stop shops', recovery mentoring, treatment communities and self-help groups. Some of these services will involve additional NHS costs whereas others (e.g. self-help groups) can be funded by the voluntary sector at no cost to the State. These issues do not affect the calculations for reductions in *social* cost for this group, which are all-inclusive.

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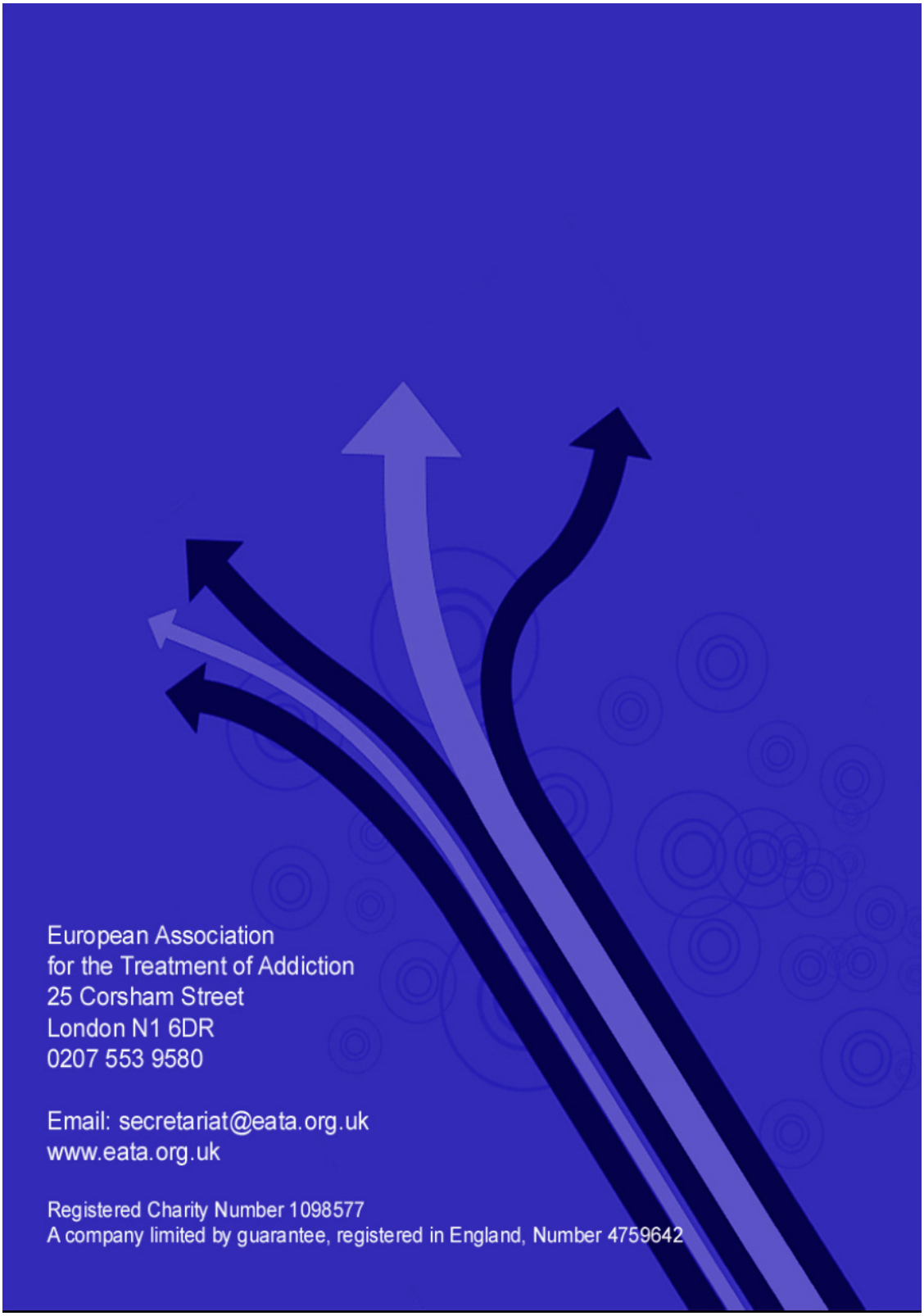
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