Title of meeting:	Cabinet Member for Health, Wellbeing and Social Care
Date of meeting:	6th February 2020
Subject:	Funding for residential rehabilitation (social impact bond)
Report by:	Director of Public Health
Wards affected:	All
Key decision:	No
Full Council decision:	No

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1. Purpose of report

1.1 To seek approval from the Cabinet member for Health, Wellbeing and Social Care to commit funding towards a pilot social impact bond (SIB) which will deliver drug and alcohol residential rehabilitation.

2. Recommendations

2.1 It is recommended that the Cabinet Member:

a. Approve a funding contribution towards the social impact bond of no more than £100,000.

b. Approve that the funding source proposed for this pilot would be the Public Health reserve. At the end of this pilot a longer term funding source would need to be identified if the service is to be maintained.

3. Background

3.1 The rationale for investing in residential rehabilitation services

The misuse of alcohol is widely recognised as a driver for anti-social behaviour and crime. Alcohol misuse is also linked to a number of poor outcomes for adults and young people, in particular, poor health and social problems such as unemployment, homelessness and poverty.

There are an estimated 3,075 adults in Portsmouth who are dependent on alcohol, this is a rate of 1.86 per 100, the second highest rate in the South East and higher than the England average 1.39 per 100. There are however only around 292 people in alcohol treatment at any one time in the city, a significant amount of unmet need.

The cost of drug misuse is far reaching, including not only financial costs, but also the costs of drug related crime, health issues and impact on families and communities. The Government defines drug related harms as:

> "far reaching and affect our lives at every level. It includes crime committed to fuel drug dependence; organised criminality, violence and exploitation which goes hand in hand with production and supply; and the irreparable damage and loss to the families and individuals whose lives it destroys"[1].

There are an estimated 1,541 adults dependent on illicit opiates and / or crack cocaine in the city. Although this headline number is relatively low, the impact of harm is high to the individual and the wider community. Portsmouth has one of the highest rates of drug related deaths in England, a rate of 8.8 per 100,000 population, compared to an England average of 4.3 per 100,000. There are currently 759 opiate users in treatment, around half of the prevalence in the city.

Around 45% of acquisitive crimes (theft, burglaries etc.) are committed by heroin and crack users. Nationally 40% of prisoners report having used heroin. A typical heroin user spends £1,400 per month on heroin and on average any heroin or crack user not in treatment commits crime costing £26,074 per year.

Public Health England (PHE) estimate that the economic and social benefit of drug treatment in 2016/17 in Portsmouth was £6,066,519 in terms of improvements in crime, health and social care. They estimate 16,033 crimes were prevented due to participation in drug treatment.

Further PHE research[2] suggests the following benefits to the public sector from investment in treatment (including health, criminal justice and social care costs):

- Alcohol treatment reflects a return on investment of £3 for every £1 invested, which increases to £26 over 10 years.
- Drug treatment reflects a return on investment of £4 for every £1 invested, which increases to £21 over 10 years

3.2 **Residential Rehabilitation**

Residential rehabilitation is a 24-hour setting providing intensive, structured psychosocial interventions for people who have an abstinence goal in the main. Residential programmes in England vary in duration and intensity of care, but common elements include communal living with other people in recovery; addressing cognitive and emotional symptoms of dependence; improved skills for activities of daily living, and referral for continuing/aftercare support.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628148/Drug_strategy_2017.PDF

[2] https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest

Two systematic reviews[3, 4]have examined the effects of therapeutic community (TC) residential programmes following a NICE review. Treatment comparisons suggest that longer TC programmes may have better rates of completion than shorter TC programmes. However, the evidence quality for the effectiveness of residential rehabilitation is low due to the lack of comparison groups in the evaluation designs. Nevertheless, NICE endorses residential treatment for people seeking abstinence who have significant comorbid physical, mental health or social problems, and particularly emphasises this setting of treatment for people who have not benefited from previous community-based interventions.

The treatment provided usually starts with detoxification for a period of 1 - 4 weeks depending on the substance and level of addiction. This involves medical provision overseeing a physical withdrawal from the substance. Following on from this, a period up to 6 months is typically spent addressing the psychological aspects of addiction and preparing the person to return to their home, or resettling them into unsupported accommodation. There are a range of different models and timescales offered by different providers. Providers of residential rehabilitation are usually in the private or voluntary sector.

Employment support within a residential rehabilitation setting shows benefit according to PHE. The addition of employment related support to a residential drug rehabilitation facility has been shown to increase the likelihood of employment post-treatment.

3.3 **The potential client cohort that would be suitable/benefit from such services**

There are currently over 1000 service users within our treatment system. Many would benefit from residential rehabilitation, however the reality is access has been restricted to manage costs. In 2013/14 before significant funding reductions in treatment spend, the annual spend on residential rehabilitation was £371,000 (this did not include detoxification which was another £710,000). In 2019/20 the combined budget for residential rehabilitation and detoxification is £135,000. In 2018, 20 people benefited from residential rehabilitation; however stays have been much shorter than previously, typically only 8 weeks are funded.

The substance misuse service has stated they would have no difficulty identifying at least 2 suitable service users per month. Therefore the 12 placements would be made within 6 months. The clients who would be referred would be those that have the greatest need and also are particularly high cost to the public sector. This will be in line with the NICE recommendation that this type of treatment should be available to people with significant comorbid physical, mental health or social problems and for who have not benefitted from community based treatment. We would also be particularly considering people who have a history of homelessness and offending behaviour.

[3] Malivert M, Fatséas M, Denis C, Langlois E, Auriacombe M. Effectiveness of therapeutic communities: a systematic review. Eur Addict Res. 2012;18(1):1–11.
[4] Vanderplasschen W, Colpaert K, Autrique M, Rapp RC, Pearce S, Broekaert E, et al. Therapeutic communities for addictions: a review of their effectiveness from a recovery-oriented perspective. ScientificWorldJournal. 2013;2013:427817.

3.4 Details of expected drop-out rates/successful completions - based on national/local data

Although now 20 years old the large National Treatment Outcome Research Study (NTORS)[5] was one of the largest studies of the effectiveness of residential rehabilitation in England. It was a prospective cohort study of 408 drug users attending 23 different residential units. It found that rate of abstinence from all drugs during the 3 months prior to follow-up had increased from 2.5 to 37%. Just over half of the sample was abstinent from illicit opiates at 1 year follow-up. The high rates of crime committed by service users prior to treatment, also dropped by half.

There were 20 rehab placements in 2018 funded in Portsmouth, 9 are thought to still be abstinent[6]. This is not a direct comparison with the model proposed in the SIB as in many cases the service has only placed service users for around 8 weeks of rehab, rather than the longer stay in the SIB. The assumptions made in the SIB business case that 1 in 6 service users will progress through the whole treatment programme and in to work, based on Yeldall Manor data, seem reasonable to the Public Health directorate. Based on the evidence and local data, we could expect 6 of the 12 placements to stay in treatment up to one year.

4. Social Impact Bond

4.1 A cost comparison based on the above data of commissioning the service directly v's SIB

Using data from the rehab providers we currently commission, considering best value for money, the costs of a similar programme on offer through the SIB would cost £26,780 per person, detailed below:
Stage 1: 14 days detox: £1250 + 11 weeks rehab: £6875 = £8,125
Stage 2: £625 p.w. x 13 weeks = £8,125
Stage 3: £405 p.w. x 26 weeks = £10,530
Total: £26,780

In 2018 there were 20 clients who received residential rehabilitation, the following was observed:

9 (45%) completed residential treatment and remain abstinent
8 (40%) completed residential treatment (average 8 weeks), but relapsed after leaving
3 (15%) left treatment early (average after 2 weeks)

Modelling these costs into what we might expect in terms of length of stay and cost for 12 placements (to compare to that available with the SIB), the details are in the table below:

[5] Gossop M et al Treatment retention and 1 year outcomes for residential programmes in England, Drug and Alcohol Dependence 57 (1999) 89–98
[6] this is not an exact figure as the service is no longer in contact with some of the service users

Length of stay in residential treatment	Number of service users (total= 12)	Estimated Cost
Complete detox, but then drop out	2	£2,500
Complete at least 8 weeks, but relapse after treatment	4	£20,000[7]
Complete full treatment and remain abstinent	6[8]	£160,680
Total		£183,180

Therefore based on this model the equivalent cost of providing the level of treatment available in the SIB, through our current commissioning arrangements for 12 service users, would be: £183,180.

4.2 Rationale for using the Social Impact Bond, as opposed to PCC investing directly itself.

The SIB has pulled in funding from the Department for Culture, Media and Sport's (DCMS) Life Chances Fund, to off-set some of our outcome payment, which would be £50,000 per outcome for Portsmouth City Council. For every £1 Portsmouth City Council pays the DCMS will contribute and additional 35p towards the bond.

We have negotiated with the SIB provider that we will have 12 people go through treatment, but will pay for only 2 outcomes (people in employment), even if the provider has a higher number of outcomes. Therefore our total liability will be £100,000 if these 2 outcomes are achieved. If the provider fails to achieve an outcome, then Portsmouth City Council would pay nothing, the liability sits with the social investor who will pay the costs up front.

Public Health believes that the risk borne between the parties is clear, reasonable and appropriate. Using local and national data it is estimated that the SIB should provide £183,180 worth of treatment. The maximum cost of this to Portsmouth City Council would be £100,000. If the provider fails to achieve any employment outcomes, then the liability would be zero for the Council.

[7] This cost is likely to be higher compared to the SIB model as this group of people completed the treatment that was paid for (average 8 weeks). If they were provided with longer they would likely stay longer and may have been less likely to relapse. Each additional person that stays engaged for 1 year, would cost an additional £21,780.

[8] It is reasonable to expect that 6 would achieve this with an enhanced stay in residential rehabilitation, as the current average if 45% of clients abstinent after a shorter period of treatment. 50% would be in line with the findings of the UKATT trail detailed above.

4.3 **The outcomes against which any payment would be made are clearly defined and measurable.**

Outcomes would only be paid if someone was in a sustainable job (not zero hours contract or short term contract) for more than 3 months after a full year of treatment. The job must be with an employer independent of the SIB. This must be validated by the commissioner speaking to the employee and proof supplied (i.e. contract of employment and wage slips). It is in the interest of the SIB provider to maximise outcomes as they are looking to use the Portsmouth clients as evidence that their model of treatment, with an extended treatment stay, is effective in getting service users into sustainable employment. They will use this evidence to market the SIB to other areas for investment.

4.4 **The plans at the end of the SIB period**

It is anticipated that the initial time period of the SIB will be 15-24 months as service users go through treatment, become job ready, seek employment and spend 3 months in a job. During this period each client will be tracked to record their progress. The end of this initial period will coincide with the retender of our main substance misuse contract, due for completion by November 2021. The success or otherwise of the SIB will allow us to consider the balance of residential rehabilitation funding within this contract, especially if it is successful with the challenging cohort we are looking to consider as part of the SIB.

In addition, if the SIB is effective and outcomes good, then the funding approach is something that the City Council, along with NHS and police colleagues may want to consider investment in. As stated earlier in this paper, the clients that would be eligible for this scheme would be those that have significant comorbid physical, and mental health problems. We would also be particularly considering people who have a history of homelessness and offending behaviour. These are high-cost individuals across the public sector and could warrant additional investment from partners and a co-ordinated funding approach.

4.5 **Funding**

Should the outcomes be achieved, then the funding source proposed for this pilot would be the Public Health reserve. At the end of this pilot a longer term funding source would need to be identified if the service is to be maintained. A review and retender of the main substance misuse contract is due to be completed by November 2021.

5. Conclusion

The social impact bond provides an opportunity to provide long term residential rehabilitation to individuals impacted by addiction who have a history of homelessness and offending. It provides good value for money compared to current funding models and the risk is borne by the SIB investor. Portsmouth City Council will only be liable to pay if any of the service users achieve sustainable employment.

6. Integrated impact assessment

The integrated impact assessment was completed. The service will enhance access to support for people coming from vulnerable disadvantaged groups. The service does not have any other negative or positive impact.

7. Legal implications

The terms, conditions and specification for the proposed contract between the Council and the SIB provider will need to be reviewed and agreed to ensure that they are suitable to deliver the desired outcomes as described in this report, including the particular allocation of financial risks and liabilities as between the Council and the provider which forms the basis of the SIB.

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8. Finance comments

As set out above, this is a pilot opportunity to trial residential rehabilitation services for cohort of 12 people for a maximum 15-24 month treatment period. This pilot opportunity will be provided through a Social Impact Bond (SIB) arrangement, which will operate on a payment by results arrangement, rather than tradition commissioning arrangement. The payments made by the City Council under the SIB arrangement, would be triggered after evidence of successful completion of the full treatment and 3 months post-treatment employment is provided; as explained in sections 5 and 6 above.

The contractual agreement between the City Council and SIB provider have yet to be agreed. Based on the initial financial modelling, the estimated costs via traditional commissioning model could be in range of £23-27k per person; for each person who completed the treatment programme. Based on estimated completion rates for each treatment stages, the total cost under traditional commissioning model would be in the region of £160k-£180k, and would be dependent on the number of individuals completing the various stages of the programme.

As explained within section 5 above, the City Council's maximum liability for this trial period would be limited to £100,000; and will be dependent on the outcomes being achieved. If the outcomes are not achieved, then the City Council would not be required to make a payment. Under the SIB arrangement, the SIB provider will fund the costs of providing these services during the pilot period. Should the outcomes be achieved, then the funding source proposed for this pilot would be the Public Health reserve. At the end of this pilot a longer term funding source would need to be identified if the service is to be maintained. A review of the main substance misuse contract is due in the future as referenced in section 4.4.

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Signed by:

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

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Signed by: