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Portsmouth CITY COUNCIL

Agenda item:

Title of meeting:	Health and Wellbeing Board
Date of meeting:	17 June 2015
Subject:	Impact of funding reductions on substance misuse
Report by:	Director of Public Health
Wards affected:	All

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1. Purpose of the report:

To inform the Health & Wellbeing Board of the proposed funding reductions for substance misuse prevention and treatment services in the coming 3 years, what is necessary to achieve these and the likely impact for Portsmouth residents.

2. Recommendation:

The Health & Wellbeing Board notes this paper and agrees to discuss the impact of funding reductions to substance misuse provision in Portsmouth.

3. Background

Portsmouth City Council has a responsibility, as part of its Public Health function, to provide drug and alcohol prevention and treatment services. As an area with above average deprivation, Portsmouth has a higher than average incidence of drug and alcohol misuse, and associated problems.

Why invest in alcohol and drug treatment services?

3.1 Life Expectancy and health

- **At least 2 Portsmouth residents die each week from alcohol related causes**, a higher rate than the national average. Recent data from Public Health England[1] showed that Portsmouth had the 4th highest rate of alcohol-specific deaths[2] in England, behind only Blackpool, Liverpool and Manchester. Our residents are also more likely to die younger and of chronic liver disease than the England average.
- Nationally alcohol related deaths rose 30% between 2001 and 2010.
- Approximately 40,000 Portsmouth residents drink at levels that are harmful to their health.
- Of these around 7,000 will be alcohol dependent.
- Around 4,000 Portsmouth residents are admitted to hospital with an alcohol related condition annually. This used to be the highest rate in the South East and

[1] www.lape.org.uk

[2] These are preventable deaths that are wholly attributable to alcohol and could not have occurred without alcohol. Most of these deaths are due to long term heavy drinking.

significantly higher than the England average. For the past 2 years, following significant investment in prevention and treatment services the Portsmouth rate is now lower than the England average and 4th highest in the South East.

- 17% of road deaths involve alcohol
- Drug use is widespread, but addiction is concentrated, there are an estimated 1,500 heroin and crack cocaine users in Portsmouth.
- Death rates among heroin users are 10 times the rate of the general population
- The use of NPS ("legal highs") is increasing with a corresponding increase in associated health risks.

3.2 Crime and community Safety

- Alcohol is linked to 50% of violent crime, including domestic abuse
- Nationally 40% of prisoners report having used heroin
- A typical heroin user spends £1,400 per month on heroin
- On average any heroin or crack user not in treatment commits crime costing £26, 074 per year
- In 2014/15 the drug arrest referral service provided advice, information and support to 467 people detained in police custody; this led to 98 referrals for drug treatment;
- 831 people were assessed by the alcohol arrest referral paramedic, with 153 referred on for ongoing support;
- 114 people received a "conditional caution" for alcohol related offences, of whom 100 fulfilled the requirement of their condition;
- Between June 2014 and April 2015 the service delivered drug treatment support to 51 people subject to court Drug Rehabilitation Requirements, with 63% of these successfully completing their orders;
- For the 6 months from October 2014 to April 2015, 34 people engaged with support for substance misuse from the through-care worker on release from prison.

3.3 Families and communities

- Nationally 1,200,000 people are effected by drug use in their families, mostly in poorer communities
- Nationally 29% of serious case reviews involve parental drug misuse and 27% mention alcohol
- 13% of our 'troubled families' have substance misuse identified upon referral, although drug and alcohol issues were identified in more cases once families had engaged in the programme.
- The Recovery Hub works with approximately 300 parents, with a total of over 600 children; of these 11 are documented as being subject to Children in Need plans and 27 Child Protection plans - any reduction in drug and alcohol support for these families is likely to increase the immediate and longer-term risks to the children concerned.

4. Cost benefit analysis

Public Health England has undertaken analysis of the costs and benefits of drug treatment, looking at the costs listed above. They have found that:

- **For every £1 spent on young people's drug and alcohol treatment there is a lifetime benefit of £5- £8.**
- **For every £1 spent on adult treatment £2.50 is saved in crime and NHS costs.**

These costs are an average across the whole treatment population. The benefits are greater with more targeted services, for example those targeted at offenders.

In addition PHE found that:

- 1 alcohol nurse in hospital can prevent on average 97 A&E visits and 57 hospital admissions; however our local Alcohol Specialist Nurse Service at QA hospital found an additional weekend nurse prevented 114 admissions and saved 375 overnight stays by engaging patients into treatment and enabling earlier discharge.
- For every 100 alcohol dependent people receiving alcohol treatment 18 A&E visits and 22 hospital admissions are avoided
- The Portsmouth High Impact Patients project works with a small number of alcohol misusing patients who frequently attend A&E or are admitted to hospital. The project has achieved up to a 50% reduction in admissions amongst this group, saving significant sums of money.

In Portsmouth annually we provide:

- Drug treatment to around 900 people per year, 60% of our problematic drug using population.
- Alcohol treatment to around 1000 people per year, just short of 15% of our alcohol dependent population.

We have seen significant reductions in alcohol related violent crime and acquisitive crime in the past 5 years, following a period of gradually increasing resources for prevention and treatment.

5. How much are we planning to dis-invest in drug and alcohol services in the coming years?

Due to the budget setting process and the requirement on public health to redistribute current spend to other parts of the Council there is a requirement to reduce spending on treatment and prevention services.

Drug and alcohol treatment funding is primarily from the Public Health Grant, although there are smaller contributions from Adult Social Care and the Police and Crime Commissioner (currently £220K and £69k per annum respectively). Both of these sources are also anticipated to cease or reduce over the next three years. The table below shows total funding for substance misuse services. This demonstrates the

savings achieved since the transfer of responsibility from the old PCTs to Public Health, primarily through greater efficiencies introduced with the previous re-modelling, as well as the projected further cuts:

Year	total drug/alcohol budgeted spend	Saving achieved or required	
2012/13	£4,829,889	Baseline	*cumulative*
2013/14	£4,330,145	£498,744	*£498,744*
2104/15	£3,884,800	£445,345	*£944,089*
2015/16	£3,404,498	£480,302	*£1,424,391*
2016/17	£3,130,973	£273,525	*£1,697,916*
2017/18	£2,797,178	£333,795	*£2,031,711*

Projections include the proposed cuts to drug and alcohol budgets to facilitate re-distribution of the public health grant and removal of the Social Care funding. From October 2015 some of the Alcohol specific funding will be moved as the Alcohol Interventions Team move into the new Integrated Wellbeing Service. It is anticipated that approximately £105,000 will be reduced from that budget over the course of 2015/6 - 2016/7 which is additional to the totals stated above.

6. How will we manage this reduction in funding and what will the impact be?

The Recovery Hub, hosted in Adult Social Care, currently provides assessment and care coordination for people with drug and alcohol problems. A range of providers including the NHS and voluntary sector deliver medical, counselling and group-work to provide the range of interventions indicated in NICE guidance for drug and alcohol treatment.

The current model has been in place since July 2013, having been designed following consultation with service users to ensure more consistent access to treatment and recovery. Recent evaluation of the model recognised that improvements have been made since its introduction and the latest available performance reports from Public Health England demonstrate marked improvement in the numbers of drug users successfully completing treatment.

In order to further reduce expenditure on the scale set out above we will need to re-tender all these different aspects of provision into a single contract from July 2016, with a reduced amount of provision. A single contract should bring about some economies of scale and management efficiencies which may offset some of the impact of the reduced funding.

One of the most significant areas of expenditure, which has proved very difficult to reduce, is the cost of substitute opiate prescribing. Whilst we hope that the procurement process can provide a more cost effective means of delivering medical interventions, it should be noted that when we re-tendered in 2013, no more cost-effective options were offered. It is also likely that there may be considerable on-off set up costs associated with re-tendering, due to probable reduction in staff numbers and associated redundancy costs.

The reduced management costs alone will not achieve the level of savings required; hence, we do expect that the reduced funding will lead to reduced capacity. Currently there are approximately 51 whole time equivalent clinical and recovery support staff employed across the agencies, supporting approximately 1800 people (drug and alcohol) to address their substance misuse problems. The further reductions proposed would be likely to result in a reduction to 35 wte staff, lowering capacity proportionately would mean approximately 500 fewer people able to be supported per annum. If half of these people are heroin/crack cocaine users, then based on national modelling of drug related offending costing £26,074 per dependent user, this could mean an additional £6.5m in crime and justice costs per annum for the City.

In terms of service delivery reduced capacity will mean reducing the number of people engaging in treatment services and/or reduced accessibility and intensity - e.g. moving from 5 or 7 day per week provision to 3 days per week in some areas of service. The impact is likely to include:

6.1 Reduced Access and Increased Waiting times

Currently we work in a very open preventative way, proactively seeking drug and alcohol misusers (e.g. in hospital or in police cells) to encourage them to access treatment. In order to manage a reduction in capacity the new service may have to:

- Prioritise clients and introduce tighter eligibility criteria. Prioritisation may be on the basis of assessed risk of harm to self or others, or on an assessment of motivation, as focusing on people with higher motivation to change rather than trying to motivate change yields more positive outcomes. Either approach would result in more people continuing to misuse substances with all the negative impacts as noted above.
- People would have to wait longer before being able to access expensive residential detoxification and rehabilitation programmes. Past experience has shown that excessive delays in accessing detoxification, leads to more people "dropping out" of treatment, increased number of relapses and less long term recovery.
- Reduced expenditure on the Alcohol Specialist Nurse Service. The service is very effective at engaging patients into treatment and successfully detoxifying them. However the longer-term effectiveness of these interventions is dependent on sufficient capacity in the community services to support ongoing recovery. This would lead to a reduction in the number of patients receiving alcohol treatment with subsequent increased A&E attendances and increased hospital admissions.
- Reducing the amount of time people spend in treatment, particularly substitute prescribing is already one of the main aims of the services. At present this involves targeting more intensive interventions and attempting to engage longer-term service users with volunteers from the recovery community. However, reduced staff capacity would potentially threaten this work which could lead to increased costs due to more people remaining on long-term prescribing; or, alternatively the introduction of more rigid time-limited prescribing, which is counter to good practice guidance and also potentially ineffective if people discharged when not ready relapse, resulting in increased societal costs and re-presentation for treatment.

6.2 Reduced specialist Criminal Justice provision:

We may have to remove or significantly curtail our criminal justice specialist provision. Within the recovery hub we currently provide specific services for offenders, this includes:

- Arrest Referral - workers visiting police cells to engage drug and alcohol misusing offenders into treatment;
- Through-care engagement and support with offenders in custody to enable more of them to engage with drug and alcohol treatment upon release;
- Support for Community Orders - Drug Rehabilitation Requirements, Alcohol Treatment Requirements and Alcohol Specified Activity Orders;
- Specific criminal justice groups, peer support and accommodation as part of the Integrated Offender Management (IOM) programme.

This additional focused work with offenders enables them to access drug treatment and helps to prevent re-offending. However, it requires more intensive worker input to build motivation and maintain engagement.

Reducing the recovery workforce, would lead to a reduction in the number of offenders able to be maintained in drug and alcohol treatment. There is a well evidenced close link between substance misuse and offending. It is likely that crime, particularly acquisitive and violent crime, and repeat offending will increase if fewer offenders are supported to access and complete treatment.

6.3 Reduced capacity for "Think Family" and Community Focused Working:

Substance misuse services have been at the forefront of developments in more whole-family approaches to working with people who misuse drugs and alcohol. This contributes to the effectiveness of programmes such as the troubled family initiatives and parenting programmes which are crucial to the more preventative approach to health and wellbeing the City is pursuing. Whilst this approach will, in time lead to reduced demand for treatment services, the rapid removal of funding planned for treatment services will make it difficult to sustain staffing resources to contribute fully to inter-agency working as they do now. This would have a negative impact on their ability to support partnership work with initiatives such as positive family futures, mental health services to manage complex dual diagnosis patients, domestic violence interventions; all of which would result in poorer outcomes for the most vulnerable members of our community and increased costs to other areas of the health, social care and justice systems.

7. Summary Considerations:

Whilst expenditure on drug and alcohol services currently represents a relatively high proportion of Public Health spend for the council, this should be viewed in the context of the extent and far reaching impact of problematic alcohol and drug use for the City, in health, criminal justice and community harms. The proposed re-tendering to a single contract service will enable the required savings to be achieved; however, the board

should be aware that the extent, timing and pace of savings required will result in a reduction in scope and quality of service as highlighted in this paper and this is likely to have a negative impact for health, families and communities.

Appendix A Performance Summary

Substance Misuse Key Performance Indicator Trends:

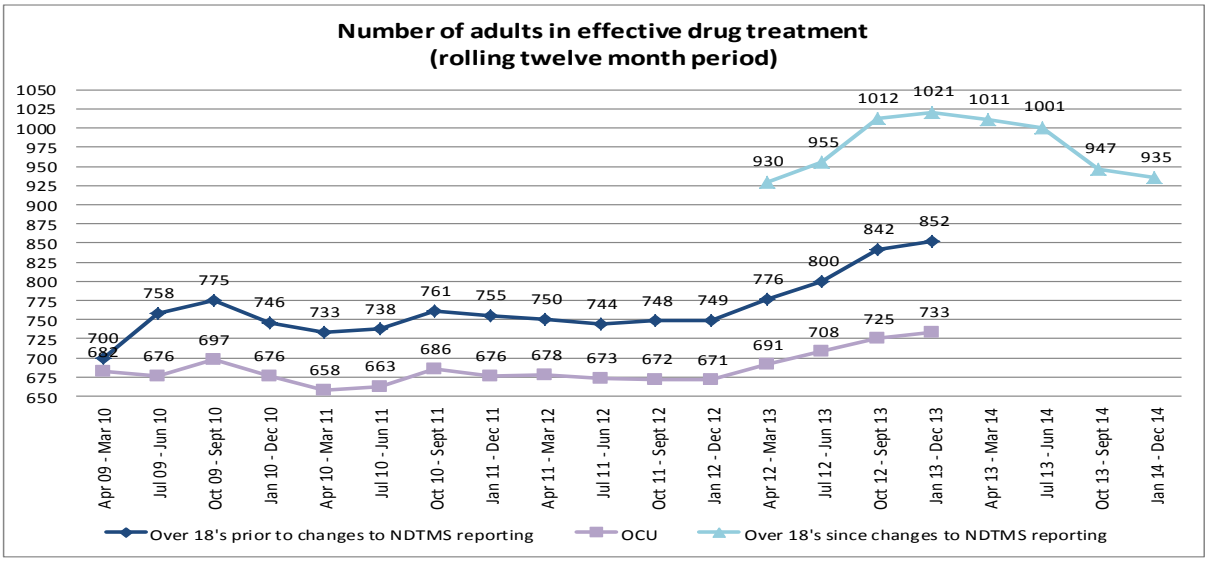
The overarching aim of drug treatment services following the 2010 Drug Strategy is to increase the number of people achieving and sustaining recovery from drug and alcohol problems. The principle performance measure to indicate achievement of this aim is the number of people completing treatment drug free (successful completions) as a proportion of the total number in treatment. Alongside this, supporting key indicators are a reduction in the number of people re-presenting for treatment within six months of completion and sustaining the overall number of people in treatment.

Completions & Re-presentations:

The latest data shows a significant improvement in the proportion of successful completions in Portsmouth. In 2014/15, 11.0% (n82) of those in treatment for opiate use completed successfully and 43.3% (n39) of non-opiate users completed successfully. This is an improvement compared to the previous year when 7.7% (n61) of opiate users and 24.0% (n29) of non-opiate users successfully completed treatment. This builds on gradual improvement over the past year, following a dip in performance prior to and immediately following the re-modelling. Whilst this is an area where Portsmouth was previously performing badly, Portsmouth now ranks 1st out of 8 in the SPP most similar group (MSG), where 8th is the worst, for both opiate and non-opiate successful completions.
Similarly, substantial improvements have been seen in the re-presentation rates for those who have successfully completed treatment. For this purpose, a re-presentation is defined by NDTMS as an individual who successfully completed treatment within a given period and then subsequently represented to treatment within six months. It does not include any clients who re-presented to treatment within 21 days of a successful completion and this is instead counted as one continuous period of treatment.

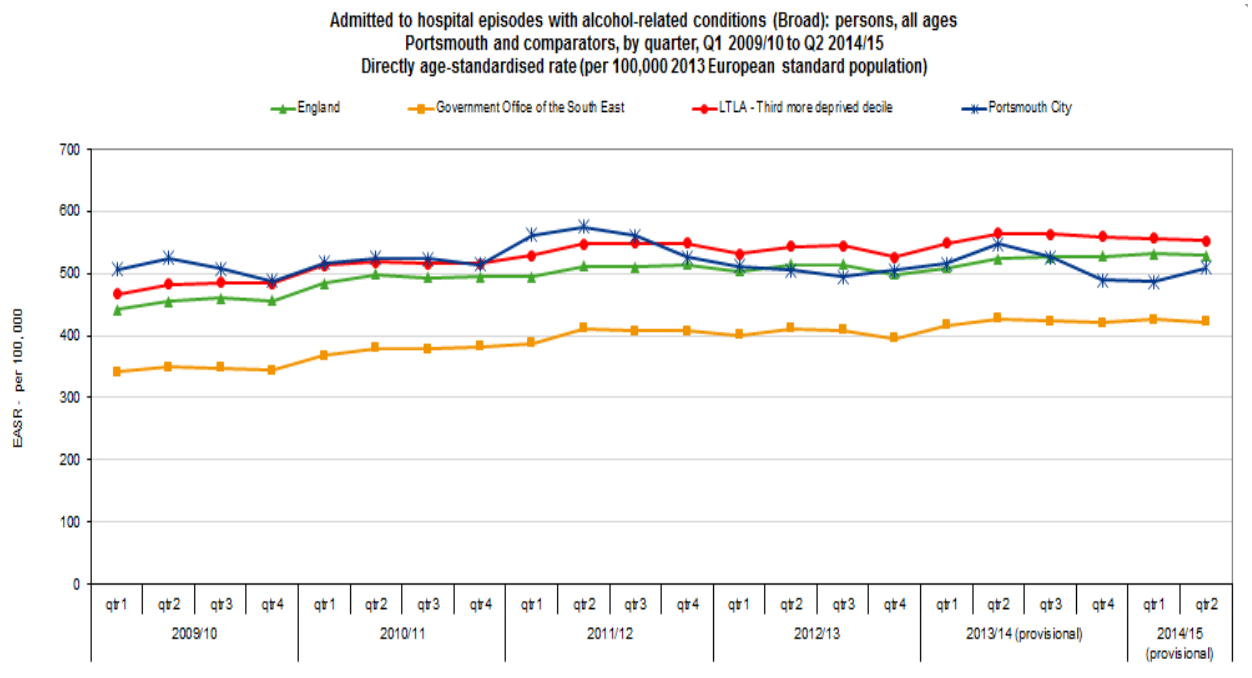
Number in Effective Treatment:

The table below shows the number recorded as being in effective treatment over a rolling 12 month period since 2010. Although the national data method changed in 2013, the period of duplicate reporting shows that Portsmouth initially improved its numbers and has subsequently sustained these since implementation of the new recovery model.



Alcohol Harm Reduction:
The key performance indicators used to gauge performance in reducing alcohol related harm are: the number of alcohol related hospital admissions; numbers of people in treatment for alcohol problems, and; proportion of alcohol users successfully completing treatment and not re-presenting within 6 months of discharge.

Alcohol related hospital admissions:
This has been the main performance indicator since it became a national indicator in 2007/8 and locally in the Portsmouth Alcohol Strategy in 2009. The aim was to reduce admissions if possible, but also to be no higher than the England average rate.
Alcohol related hospital admissions are a combination of conditions which are wholly attributable to alcohol or partly attributable to alcohol. A wholly attributable condition can only occur due to alcohol use, such as alcohol liver disease or alcohol poisoning. A partly attributable condition could be linked to alcohol, for example national evidence highlights that 30% of admissions to hospital due to assault are linked to alcohol, therefore 30% of cases locally count towards our data. Other conditions included as partly attributable include strokes, hypertension, some cancers (i.e. oesophagus) etc.
In Portsmouth our rate of admissions per 100,000 population, the national measure has stabilised, increasing from a rate of 2,025 in 2009/10 to 2,079 by 2013/14, a 2.7% increase. There is a lag on data for 2014/15, but the first 6 months shows a reduction in admissions compared to the previous year. During the same time period the England average rate per 100,000 increased from 1,813 to 2,087. The chart below highlights how the Portsmouth rate is now lover than the England rate and that for comparator areas.



Number in Alcohol Treatment:
In the Portsmouth Alcohol Strategy 2009 a target was set to increase the numbers receiving alcohol treatment to 15% of our dependent drinker population per year. We had an estimated problem drinker population of 7,000, so the target was to have 1,050

annually. At the time around 550-600 people were in treatment annually. Following significant new investment from Portsmouth City PCT in 2010, by 2012/13 this had increased to 1038, just short of the target. In 2013/14 there were 1032 in treatment. We currently only have treatment data for the first 6 months of 2014/15 due to problems with the NDTMS system, however this data is showing a small fall (5%) in the numbers in treatment, which is likely to be reflective of the savings taken to date. These numbers will fall further in 2015/16 with the additional savings and changes to the Alcohol Interventions Team. From October 2015 the Alcohol Interventions Team will no longer exist, merging in to the integrated Wellbeing service. They will no longer report to the NDTMS, removing around 290 clients from the system. Specialist alcohol treatment will be managed through the Recovery Hub.

Completions & representations:
For alcohol treatment (NDTMS data), Portsmouth has a higher number of unsuccessful completions and a higher number re-resenting within 6 months. Analysis of re-presentations highlights that this is almost exclusively due to the existence of our Alcohol Specialist Nurse Service at QA. The service is not a conventional community treatment service, which is more suited to NDTMS reporting, therefore there ia a data anomaly. In addition the service provides alcohol treatment to patients admitted to hospital who have not volunteered to enter treatment, this has happened due to their admission and subsequent withdrawal from alcohol. It would therefore be expected that a higher proportion with not complete treatment and will re-lapse. We are undertaking further analysis of cases to understand better the data anomalies.