Collective Voice

BUDGET REPRESENTATION from COLLECTIVE VOICE, SEPTEMBER 2018

About Collective Voice

1. Collective Voice is a group of eight voluntary sector organisations providing drug and alcohol treatment and other associated services who have come together to ensure that the interests of the drug and alcohol treatment sector and those who use our services are represented effectively. Together we support more than 200,000 vulnerable people annually.

Drugs and alcohol

2. Government policy recognises the huge harms to individuals, families and society caused by the use of drugs and alcohol, as well as the economic impact. According to Government publications:

    - The social and economic costs of alcohol related harm amount to an estimated £21.5bn, while harm from illicit drug use costs £10.7bn. These include costs associated with deaths, the NHS, crime and lost productivity.
    - 2,503 people died from illegal drugs in 2017 and about ten times that number from alcohol use (using the broader definition of causation).
    - About 45% of acquisitive crime (excluding fraud) can be attributed to heroin and crack use.
    - There are over 1 million alcohol-related hospital admissions every year, including 339,000 where an alcohol-related condition was the primary reason for admission.
    - More working years are lost due to alcohol than the 10 most frequent cancer types combined. In 2015 there were an estimated 167,000 working years lost due to alcohol, 16% of all working years lost in England.
    - Parental drug or alcohol use features in a quarter of the cases on the child protection register; and drug and alcohol use are involved in 38% and 37% of serious case review respectively.

Drug and alcohol treatment is vital to the delivery of the Government's policies

3. Drug and alcohol treatment is rightly one of the pillars around which delivery of the Drug Strategy is built.

4. We are encouraged by the discussions that have taken place so far regards the Government's alcohol strategy which will be published in 2019. We believe treatment should be a central theme of that strategy too.

5. Treatment also has a key role to play in contributing to the successful delivery of the Modern Crime Prevention Strategy and Serious Crime Strategy which recognise drugs and alcohol as significant drivers of crime. It is also an essential component of the diversion and rehabilitation of offenders and hence to the successful rejuvenation of probation services, Community Rehabilitation Companies and Transforming Rehabilitation.

Why invest in drug and alcohol treatment?

6. Drug and alcohol treatment provide huge savings to public services. The case for investment is well established. According to the Government (Public Health England):

- Providing well-funded drug and alcohol services is good value for money because it keeps people alive, cuts crime, improves health, and can support individuals and families on the road to recovery.
- 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.
- Specialist interventions for young people potentially save £5-£8 for every £1 invested, mainly in health and crime benefits.
- Drug and alcohol treatment resulted in 4.4 million fewer crimes in 2016/17.
- Needle and syringe programmes reduce the spread of blood borne viruses such as HIV and Hepatitis C infections, saving £10-42,000 per year for each case.

Funding levels

7. Much greater potential financial benefit could be accrued through the treatment system. For example, 40% of opiate users remain outside the system and more than 80% of people estimated to need specialist alcohol treatment are not accessing it.

8. Yet, under austerity and localism, local authority funding[1] for community based treatment has already reduced by 18% in cash terms from £828million in 2013/14 to £682million in 2018/19 and is expected to fall further. We estimate that funding for prison based treatment has fallen even faster, by over a third in the same period. If comparison is made with the situation in 2012/13 before public health moved to local authority control, we estimate that funding for drug and alcohol treatment overall has fallen by around 30% in real terms.

9. If central government is not to lose further capacity to deliver on related strategies, it must find a funding mechanism that stabilises and protects this funding.

10. Collective Voice supports a renewed focus on alcohol treatment within the wider treatment system. Whereas funding for drug treatment increased greatly in the early years of this century, funding for alcohol treatment has been roughly stable at around £200m annually. This is despite the fact that alcohol harms to the self and others combined are judged to be higher than any other drug (Nutt, King & Phillips, 2010). The use of 1% of alcohol duty to fund £100m+ of new alcohol treatment would make significant inroads into the 80% of people whose needs are not being met.

Funding mechanisms

11. The rapidly reducing funding for treatment can happen because the Public Health Grant ring-fence offers only very limited protection in the context of austerity and localism. Drug treatment is not a natural priority for Directors of Public Health or Health and Wellbeing Boards as the impact of dependent drug use on population health is limited and the service user population is politically unpopular. This contrasts sharply with the benefits of treatment accrued against central government objectives.

[1] This refers to local authorities' planned expenditure, as analysed by Collective Voice using MHCLG's datasets.

12. The revised conditions on Public Health Grant (PHG) requiring local authorities to improve drug and alcohol services have had little impact on stemming the flow of funding away from these services, which are becoming progressively depleted. In our view, even if a ring-fenced PHG were to be retained and the provision of treatment services were to be made mandatory under revised local authority prescribed functions for public health, this would not guarantee the necessary levels of funding for the reasons given above.

13. Moreover, it is hard to see how any of the mechanisms so far proposed under the local government *Fair Funding Review* would not lead to treatment's further demise, as its funding is likely to be subsumed in an even larger funding block, where it cannot compete with more politically acceptable populations.

14. If central government is not to lose further capacity to deliver on its strategies, it must find a funding mechanism that stabilises and protects this funding, even if it is then distributed via local authorities or devolution deal areas. This mechanism should require local authorities, Police and Crime Commissioners and heads of probation services to co-operate on the planning of this.

15. Protection of the funding will become doubly important if some form of alcohol levy is adopted. Politically, local authorities will be tempted to reduce funding for treatment even faster, judging that services will be supported by the levy, even if it is not like-for-like funding or is distributed through a separate mechanism. Protection of funding for drug and alcohol treatment should therefore be introduced before any such levy is introduced, to remove the incentive to reduce existing local authority funding and 'backfill' it with levy monies.

Operational issues

16. With regard to the current shortage of supply of buprenorphine and consequent rise in price, Collective Voice has recently written to the Secretary of State for Health and Social Care expressing its concern. The letter highlights the inadequacy of existing arrangements for supporting specialist drug services and the need for alternative methods to prevent financial and clinical instability and avoid the negative impact on clients during such times. The letter is attached for reference as an Appendix.

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SOURCES

Home Office (2016). *Modern Crime Prevention Strategy.* Available at: https://www.gov.uk/government/publications/modern-crime-prevention-strategy

ONS (2018). *Drugs related to drug poisoning in England and Wales: 2017 registrations.* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2017registrations

Public Health England (updated 2018). *Alcohol: applying All Our Health.* Available at: https://www.gov.uk/government/publications/alcohol-applying-all-our-health/alcohol-applying-all-our-health

Public Health England (accessed 25 September 2018). *Alcohol and drugs: prevention, treatment and recover - why invest?* Available at: https://app.box.com/s/p52mrjh78yryshd9smogm350s7ougg1l

Nutt, D., King, L. & Phillips, L. (2010) on behalf of the Independent Scientific Committee on Drugs. *Drug harms in the UK: a multicriteria decision analysis*. Lancet 376: 1558–6. Retrieved 28 September 2018 from: http://www.ias.org.uk/uploads/pdf/News%20stories/dnutt-lancet-011110.pdf

APPENDIX

Follows on next page.

SUBMISSION

This response was sent by email to budget.representations@hmtreasury.gov.uk on 28 September 2018.

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APPENDIX – TEXT OF LETTER to the SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE

To The Rt. Hon Matt Hancock MP
Secretary of State for Health and Social Care
39 Victoria St
London SW1H 0EU

27 September 2018

Dear Secretary of State

Collective Voice is an alliance of eight voluntary sector substance misuse treatment providers who have come together to ensure that the voices of the drug and alcohol treatment sector and those who use our services are represented effectively. We offer a range of services to over 200,000 vulnerable adults and young people across the country.

We would like to bring to your attention an issue of real importance to those vulnerable adults and young people: the recent shortage and subsequent extreme price rises of buprenorphine, a widely used and essential medicine.

Buprenorphine is a key pharmacological component of Opioid Substitute Therapy (OST), one of the most powerful tools we have at our disposal in the delivery of a recovery focused treatment system. OST is the most widely evaluated of all our drug misuse interventions and has been proven to decrease heroin use, sharing of needles, the spread of bloodborne viruses, overdose, drug related deaths and increase retention in treatment.

National guidance stipulates that clients in receipt of OST are 'empowered to make their own decision' regarding which form of medication they receive, and the presence of a 'pre-existing preference' for buprenorphine must be taken into account.

For parents engaged in OST buprenorphine is recommended by NICE as its tablet formulation poses less risk of accidental overdose to children than the liquid formulation of methadone. Any lack of buprenorphine could therefore have additional safeguarding repercussions.

Due to a shortage of generic buprenorphine on 18 May it was placed by the Department for Health and Social Care (DHSC) on the concessionary price list. The price we paid as treatment providers rose by as much as 800%.

There is some concern that the current approach will last into October. The additional costs have been calculated to be between one and two million pounds per month. This means the pricing crisis will cost the sector at least six to 12 million pounds and potentially considerably more if it continues into winter. The reduction in funding for treatment services that has occurred in recent years, with many local areas losing around a third of their budget, has left providers unable to bear this kind of strain.

Buprenorphine is an essential part of our formulary and any threat to its regular usage is deeply worrying. We work with a narrow selection of drugs and are therefore hit particularly hard by price rises, there being few fluctuations in the other direction to neutralise additional costs.

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If buprenorphine were to become unavailable; either due to supply shortage or costs so prohibitive they directly impacted on other systems essential in delivering safe care, then transfer to methadone would need to be considered. However I anticipate this could generate significant anxiety for service users, who would rightly be worried about the impact on their safety, stability, and recovery.

It would also likely have a deleterious effect on their care; the risk of disengagement from prescribed treatment would probably increase, with all the implications of increased risk of mortality for people with opioid dependence who are not engaged in treatment. For many, this could harm the trust and therapeutic relationships previously developed with treatment services, thus impacting on future engagement.

Any further continuation of the pricing crisis may impact on the routine use of buprenorphine as part of the recovery services we offer clients. Any such development would impact on the choice and overall continuity of care our clients experience and therefore risk sub-optimal delivery of OST as laid out in our national clinical guidelines.

This is not a problem unique to the voluntary sector. Although the size of the trusts they are part of may protect the NHS substance misuse providers from the extremes of market fluctuations, conversations with colleagues in the NHS indicate they are also alarmed by the situation.

We welcome the commitments made in the 2017 Drug Strategy to 'improving both treatment quality and outcomes for different user groups' and 'grounding our approach in the latest available evidence'. OST is a key tool for us as a sector in delivering an ambitious and recovery focused system that is both high quality and evidence driven.

Consequently we remain deeply concerned that the unexpected and unplanned impacts on substance misuse treatment provision of the concessionary price mechanism employed by the DHSC, and impacts on client health and wellbeing, have not been taken into account. We therefore request DHSC, supported by PHE, urgently consider alternative methods to support specialist drug services to prevent instability and subsequent negative impact on our clients during this time of challenge. We would welcome a chance to meet at your earliest convenience to discuss this.

Yours sincerely,

Karen Biggs
Collective Voice Chair