The investment and regenerative value of addiction treatment

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The author is immensely grateful to the staff and service users at the residential centre at which the research was based. At all times, the author was provided with candid insights into people's lives, made to feel very welcome, and was privileged to be invited back to their leavers' graduation day. The author is also grateful to the former residents and those in the Community Drug Team who were similarly helpful.

Abstract

Purpose – *The purpose of this paper is to show that despite welfare retrenchment and political rhetoric towards welfare, spending on residential addiction treatment should be protected.*

Design/methodology/approach – *Examining benefits in context of costs, the research used social return on investment to monetise benefits and compare with costs. Based at a residential addiction centre, the research used questionnaires and focus groups with residents and former residents.*

Findings – *The centre created almost £4 of benefit for every £1 of cost. Whilst the bulk of savings came from health, housing and criminal justice, there was also a regenerative impact for the local economy.*

Research limitations/implications – *Sampling in sensitive themes is always problematic, however, the research had contact with many respondents, achieved data saturation and used the centre's success rate as a guide to weight the findings.*

Practical implications – *The benefits of addiction treatment go beyond health outcomes and raise questions about how this should be reflected in cost distribution. Consequently, this has implications for the ways in which addiction services should be measuring their successes beyond solely health outcomes.*

Social implications – *Existing research has largely overlooked the benefit of addiction treatment to the local economy and the fact that, as an investment, this benefit will continue to grow as more people enter the labour market over time.*

Originality/value – *The research recognises the political context of funding and measures success beyond solely health outcomes. Furthermore, the research recognises the regenerative impact of addiction treatment, which is often overlooked in similar research.*

Keywords *Substance abuse, Public spending, Neo-liberalism, Political economy, Regeneration, Social return on investment*

Paper type *Research paper*

Introduction and context

Based on research carried out during 2013 and 2014 at a residential drug treatment centre in a major British city, this paper argues that spending public money on treating addiction represents not only considerable benefits to other service providers, but also a regenerative benefit to local economies. As such, this starts to broaden debates within addiction treatment beyond health and personal definitions of success. Importantly, by recognising such services as having both social and economic regenerative impacts, it further strengthens the argument to protect funding during what could be politically and financially turbulent times ahead within health provision.

Increasingly, current trends in government welfare spending and provision are being shaped by ongoing austerity and a politically motivated reduced support for welfare (Slay and Penny, 2013; Reeves *et al.*, 2013; MacLeavy, 2011). This is especially true for those viewed in policy-making circles as "undeserving" welfare recipients as we move towards an increasingly neo-liberal model of welfare provision. To this end, Patrick (2011, p. 16) references David Cameron's implication "that there are some claimants (notably those with drug and alcohol addictions, as

well as the morbidly obese) whose impairment is their own fault, and whose deservingness of state support should thus be called into question". Undermining the universalist model of UK welfare, Daguerre and Etherington (2014, p. 45) identify "a resurrection of the moral underclass discourse which portrays poverty and unemployment as being caused by individual behaviour such as alcohol and drug addiction". However, it is possible that the political expediency of blaming drug users (among others) for increased welfare demand belies any evidence that this approach will work (Bauld *et al.*, 2012) let alone implications for social justice.

Amidst this politically led redefining and repositioning of problem drug users and welfare along increasingly moral lines (Duke, 2013), the Conservative-led coalition government has faced uncomfortable trends and headlines regarding A&E resources, hospital waiting times and insufficient resources for GPs and primary care (Kings Fund, 2013a, b; House of Commons Health Committee, 2013; Foundation Trust Network, 2013).

Whilst current welfare spending debates have been dominated mainly by the effects of government funding cuts, there exists a more nuanced change in welfare and prioritisation of funding. Despite David Cameron's 2014 conference pledge to protect NHS funding, stating that "The next Conservative Government will protect the NHS budget and continue to invest more" (Goodman, 2014), there could still be a reprioritisation of funding and resources away from areas such as addiction services and towards more vote-winning areas such as GPs and A&E. To this end, Monaghan (2012, p. 35) points out that whilst the Conservative-aligned Centre for Social Justice initially recommended the use of residential centres rather than methadone "madness", "it costs around £26,000 per person per year to undergo residential rehabilitation treatment in comparison to the £2,020 it costs to run a methadone maintenance programme over the same duration. In times of austerity, how the roll-out of residential rehabilitation places will be funded remains unclear".

At the same time, health funding and commissioning is entering a period of potentially greater diversity in priorities and practices characterised as a "more complex and fragmented resource allocation process" (Buck and Dixon, 2013, p. 1) and increasing belief in payment by results; the latter of which further emphasising the need to recognise a full range of service provider and economic regenerative results.

However, despite such political drivers, this research shows that spending on treating addiction should not only be protected, but possibly even expanded in a time of post-recession to reduce long-term welfare demand and boost local economies.

A pervasive theme within current drugs discourse is how addiction perpetuates problems such as domestic violence, crime, homelessness and demand for health care as well as an inordinate impact on budgets of organisations providing these services (Galvani, 2010; Galvani and Humphries, 2007; House of Commons, 2010; Department for Communities and Local Government (DCLG), 2012). This research contributes to such debates by highlighting the investment and return value of treating addiction not only in its savings to other service providers, but also its benefit to the local economy; the latter being a factor that is frequently overlooked. Whilst various forms of cost-benefit analysis have been used in American studies of the value of addiction services that include impacts on productivity (US Department of Justice National Drug Intelligence Center, 2011; Mark *et al.*, 2001; US Department of Health and Human Services, 2008; Uggen and Shannon, 2014), it is only now becoming increasingly popular in the UK (SROI Network, 2013; Cabinet Office, 2009; Arvidson *et al.*, 2013; Jardine and White, 2013; Jones, 2012; Marsh Farm Outreach, 2009; Millar and Hall, 2012), though there remains little awareness of the economic regenerative impact of addiction treatment amidst a focus on benefits to the budgets of other service providers.

With political rhetoric increasingly understanding welfare in individualistic terms and as being determined by personal life choices, this is leading to a judgemental basis for welfare allocation. As such, this overlooks broader social and economic benefits that should be recognised to understand accurately the impacts of welfare. Current government goals of reducing welfare spending as part of an overarching deficit reduction programme. (HM Treasure, 2010; Reeves, 2010), whilst partly based on economic logic, are strongly influenced by aspirations towards small government and encouraging greater personal responsibility for welfare (HM Government,

2010; Wiggan, 2012; Department for Work and Pensions, 2010; Centre for Social Justice, 2013). This moves welfare away from a universal model of addressing social problems and begins to diminish the role of government intervention.

Consequently, this paper should be of interest to those involved in welfare provision and addiction services as the core of research and debate regarding such provision is carried out by health professionals with the definition of success being framed within health outcomes. However, there is a danger that this approach will create a sense of false confidence that comes from having robust data without taking into account the influence of political logic and objectives. As will be mentioned later, the residential centre defines its own success through health checks and supporting people to address their addictions, yet these inward-facing targets fail to place the centre in a broader outward-facing economic context that will help define success in a battle against political factors.

Methods

Mindful of the social and economic impact of welfare spending, this research used social return on investment (SROI) to monetise benefits (Cabinet Office, 2009; Arvidson *et al.*, 2013; Jardine and White, 2013; Jones, 2012; Marsh Farm Outreach, 2009; Millar and Hall, 2012) and evaluate the impact of the residential centre in relation to other services, such as housing, health and criminal justice. The advantage of this approach is that in addition to the usual health-based measurements of the centre's success in relation to targets determined by the funders, the centre's impact can also be assessed in relation to broader issues such as welfare demand and economic benefits that can be generalised to other similar situations.

With SROI recognising benefits in monetary terms, allowing them to be directly compared with the monetary value of costs, the government has recommended that SROI should include and monetise all benefits (Cabinet Office, 2009). For the treatment of addiction problems, this would normally include personal qualitative benefits such as: quality of life, engagement with families, aspirations and feelings of wellbeing. However, this research specifically sought to recognise more quantitative social and economic benefits of reducing welfare demand as well as benefits to the local economy. This does not mean that personal outcomes are less important, instead it is a recognition that different aspects of SROI have different influences and that the more quantitative and less subjective aspect of SROI was appropriate in this context in order to relate to funders, commissioners and service providers.

Fundamental to researching the centre's benefits was an examination of the experiences of service users prior to their stay at the residential centre and to compare this with the experiences of those who had left the centre.

The centre treats, on average, over 240 residents per year and has a good success rate for former service users being drink and drug-free six months after leaving the centre and not being flagged as accessing substance abuse treatment elsewhere. Following discussions with staff at the residential centre, it was recognised that the centre's measurements of success or otherwise were determined by the funder's outcomes. With funding for the project coming from health budgets, success was consequently defined by targets such as numbers of people becoming abstinent, detox programmes and hepatitis testing. Problematically, this only enabled a focus on work carried out within the centre and did not fully take into account broader external benefits for the city and other service providers. Significantly, substance abuse has implications not just for addicts and their families, but also for hospital admissions, the criminal justice system, housing providers and, importantly though overlooked, the local economy. By only measuring their core funder-determined outcomes measured through individual contacts with addicts, the centre was in fact under-assessing the full range of its impacts.

Discussions with residential centre staff highlighted that whilst SROI presented a valid method of gathering results and contextualising the findings (Arvidson *et al.*, 2013), staff members were put off by what seemed a complex process requiring expensive external support. Aware of these potential barriers, it was decided that instead of seeing SROI as an "all or nothing" methodology, an SROI framework was developed that met their evaluation needs and was workable. It also

became clear that by developing a workable and applied model of SROI, the evaluation is something that can be repeated in the future.

Using information from focus groups and questionnaires, the research started with quantitative data regarding the financial cost of substance abuse as a context for measuring the impact of the residential centre. Subsequently, focus groups were conducted with current residents at the centre to discover their experiences before entering the centre and gather feedback of their experiences of both rehabilitation and engagement with areas such as health, criminal justice and housing prior to admission. Further focus groups were conducted with previous residents to recognise what had changed in terms of their engagement with various service providers such as the police and health services, as well as their experiences of homelessness, work (paid or voluntary) and training.

Questionnaires were also distributed to gather further quantitative data; the first being a "before" questionnaire to establish service users' experiences prior to intervention. The second was a follow-up questionnaire, which sought to identify service users' experiences before, during and after residential treatment.

The "before" questionnaire was conducted with a sample of current service users at the residential centre and service users who were due to become residents. This group was asked about their experiences during the year before admission to the centre in order to gather information on their circumstances and experiences of crime, housing, health and other services. Service users from the Community Drugs Team (CDT), who were due to enter the centre as residents, were also asked to report their current circumstances, and that of the last year.

Overall, sampling for the research was challenging, with the manager of the centre recognising the difficulties of maintaining contact with previous residents. He typified the problem as being that those who were successful with their treatment got rid of their phone so that "old friends" could not contact them, and those that had not been successful with their treatment sold their phone to raise funds. Through the focus groups at the residential centre, questionnaires with CDT service users prior to admission and focus groups with former residents, the research was able to engage with nearly 70 individual people at various stages of addiction treatment. Clearly, the research had to rely on an element of self-selection and convenience in the sampling process, which is common in many areas of research examining such sensitive issues. However, being aware of the potential for sampling bias, two key factors maintain validity within the research. First, the coding and analysis of the research recognised a high degree of data saturation in terms of experiences and outcomes from the respondents. Second, the final results were weighted to offset sampling bias, this meant that the samples' results could be multiplied to account for the total number of residents in a year and then reduced to 65 per cent of that total to reflect the centre's success rate.

Findings

Prior to admission, 60 per cent of residents had been arrested at least once per year, many being arrested multiple times, with there being approximately 145 arrests per year and 235 court appearances. After treatment, the research showed this had reduced to only 31 arrests with subsequent court appearances. Not only does this have cost implications for police, courts, CPS, legal aid and a host of other agencies, there are clear personal and unrecovered/unidentified costs entailed. It is estimated by the NHS that one year's involvement in crime has a cost implication of £26,074 (NHS, 2011, 2012; Attorney General Dominic Grieve QC MP, Speech to the Institute of Legal Executives, May 2011); this is particularly relevant for those with addiction problems where acquisitive crime is significant in order to cover the cost of drugs and/or alcohol (National Treatment Agency, 2009, 2012). Placing this in context, with nearly all of the centre's residents having been on out-of-work benefits prior to admission, it is worth noting that the NTA estimates that the average heroin user spends approximately £1,400 per month on drugs.

In terms of health, the centre's work led to over 4,300 fewer GP appointments, making a total saving of over £250,000 to local GP surgeries (National Audit Office, 2009; PSSRU, 2009).

Furthermore, the research identified that 40 per cent of residents had been admitted to hospital in the 12 months prior to entering the residential centre with an average of 2.2 admissions each. This equalled approximately 213 hospital admissions in the 12 months prior to admission at the centre, with the NHS Institute for Innovation and Improvement estimating that one night in hospital costs a minimum of £255. After treatment at the centre, this had reduced by 87 fewer hospital admissions, with the number continuing to decrease as former service users gained improved health with time. Added to this are 71 fewer visits to A&E at £100 per visit and 74 fewer ambulance call outs at £250 per call out. The total saving in terms of health is in excess of £300,000 to local health providers.

Another key saving is in the field of homelessness, where the cost of a person being homeless for a year is approximately £25,000 due to the costs of emergency accommodation, lost rent and other interventions (New Policy Institute, 2003; National Audit Office, 2005; DCLG, 2012; New Economics Foundation, 2008; Making Every Adult Matter, 2009; Homelesswatch, 2013). From the research, it was found that 20 per cent were homeless during the 12 months prior to entering the centre, equating to nearly 50 people and thereby costing approximately £1.25 m per year. Following treatment, fewer than ten people were homeless, which equates to a saving of approximately £1 m from local housing budgets.

Reflecting a greater stability and management of their lives, the unemployment rate also fell from in excess of 80 to 61 per cent and is showing signs of further reduction as 20 per cent are involved in voluntary work and 35 per cent are taking part in education and training. Of the reduction in unemployment, which will continue over time, they are spending their income in local shops and benefitting the local economy and the national economy in terms of VAT to a figure in excess of £240k. This is an important point as existing literature has recognised the benefits of addiction treatment to other service providers, but little recognition of the benefit to local economies. Following double-dip recessions and austerity, this has benefitted the local economy, especially those neighbourhoods that have the highest concentration of former residents. For a city that has a problem with unemployment and poverty rates, this local regenerative impact is important and will grow as the employment rate amongst former residents increases each year that they remain drug-free.

Overall, it was found that whilst the residential centre cost £1.4 m per year to fund, there was a return on this investment of just over £5.5 m. This means that for every £1 spent on the centre, there is a £3.92 benefit to other service users and the local economy.

Discussion and implications

Not only does addiction treatment produce life-changing results on a personal level, the research demonstrates that it also represents an investment as money spent on addiction services has an almost fourfold benefit to other services and also to the local and national economies. Furthermore, continued success of the centre means benefits will continue to accrue from each year's investment. As such, instead of seeing addiction treatment as a potential target for funding cuts based on moral judgements or neo-liberal welfare ideologies, the service needs to be viewed as a saving in public spending such as health and the criminal justice system as well as more people leaving benefits and paying tax and national insurance.

Additionally, successful treatment of people with substance abuse problems means that their entry into the labour market creates more money being spent in the economy. However, as debates regarding welfare are increasingly framed by personal choices and individualism, the broader social and economic benefits risk being overlooked. Whilst this is most pronounced within the easy target of social security, it can be seen to be increasingly prevalent in other areas of welfare, and could increasingly frame debate regarding resources in health.

Importantly, in recognising that the benefits of addiction treatment are spread across a variety of service providers and even the local and national economies, one way of maintaining long-term funding for residential treatment could be to look at the way in which costs are borne. In attempting to match costs with benefits, and looking in more detail at this link, there exists a

clear disparity between funders and beneficiaries of addiction services. To this end, the research shows that whilst the cost of the centre is borne by health budgets, the benefits of the investment are far more widely spread. Without local capacity for strategic or even pooled use of funding, there exists a continuing imbalance between the division of costs and benefits. Problematically, the political climate of small government is making this harder as fewer officers and reduced formal communication structures between agencies and sectors present barriers.

Currently, the neo-liberal discourse in welfare is becoming increasingly dominant, leading to the concept of blame as an important concept in shaping welfare resource allocation. Amidst predictions of there being a £20 bn shortfall in NHS funding within a decade (Crawford and Emmerson, 2012) and a limited appetite among politicians for tax rises, it seems likely that "blame" might be a useful way of realigning health funding in a populist manner. However, this research counters this political logic by reasserting the social and economic benefits of spending on addiction treatment that eclipse debates around the potentially "undeserving" nature of recipients.

Clear from the evidence is that investment in addiction treatment has resource benefits for other service areas, particularly criminal justice, housing and health. But going beyond this, evidence also shows that the investment in addiction services has a notable benefit to the local economy. In the wake of double-dip recessions and the impact of austerity on many inner-city areas, benefit to ailing local economies and deprived neighbourhoods that have a higher-than-average concentration of those with addiction problems is clearly attractive. To date, there has been some recognition of benefits of addiction to other service providers, and even an identification of benefits to the exchequer, however, there has been little recognition of the benefit to local economies. This was an important theme within this research, with the residential centre being based in a low-income area of the city and many residents similarly moving on to low-income areas and jobs. For a city that has a problem with unemployment and poverty rates, it has been shown that the investment in the residential centre has a regenerative impact of injecting over £240k into the local economy. With employment rates amongst the cohort likely to increase, this figure will continue to grow each year that the cohort remains drug-free – a factor that seems likely given the centre's past record.

Conclusions

In conclusion, this paper started by arguing that resources allocated to addiction services should be protected despite any political pressures that may arise in the future due to resource pressure from elsewhere. Not only does addiction treatment produce excellent and life-changing results on a personal level, but the money allocated represents an investment. In making this claim, the research has evidenced the way in which money spent on addiction services has an almost fourfold benefit to other services and also to the local economy. Furthermore, the high success rate of the centre researched means that benefits will continue to accrue from this investment. As such, first, instead of seeing addiction treatment as a potential target for funding cuts, the service needs to be viewed as a way of saving money in other areas of public spending such as health and the criminal justice system. Second, the service produces beneficial results for central government as more people are consequently leaving benefits and are getting into a position of paying tax and national insurance. Third, and finally, a factor often overlooked is that the successful treatment of people with substance abuse problems means that their entry into the labour market means more money being spent in the economy, with approximately £240k being spent in the local economy per year if the unemployment rate can be reduced to 70 per cent amongst the whole cohort and they are earning £18,000 per year. These are clearly conservative figures and represent calculated estimates bearing in mind that an unemployment rate of 70 per cent is still very high and that £18,000 per year, whilst not low, is below the national average and represents an achievable wage. Consequently, it is not beyond reason that the £240k figure could be exceeded.

However, health research needs to avoid a false sense of confidence that comes from having robust data without fully appreciating the political context of decision making. Whilst addiction

services may never gain public sympathy amidst a time of policy making based on personal responsibilities and small-state politics, and whilst there may also be increasing pressures within health funding, this research has conclusively shown that addiction treatment represents excellent value for money, sustainable results and clear socio-economic benefits.

In summary, the research has implications for policy, which are to maintain funding levels whilst also recognising that contemporary neo-liberal ideology within welfare poses a long-term threat. In addressing this threat, areas such as addiction treatment should reflect on how they measure success in order to include indicators beyond health outcomes. Furthermore this research recognises that costs and benefits are not evenly matched and that there could be a more strategic fit between beneficiaries and funders of addiction services in terms of both money and other resources. Finally, addiction treatment also benefits the economy in a way that will continue to grow with each cohort over time as unemployment levels continue to decline. As such, funding addiction treatment is an investment and should be valued accordingly.

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