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INSIGHTS

Social reintegration and
employment: evidence and
interventions for drug users
in treatment

13



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and interventions for drug users in treatment

Authors

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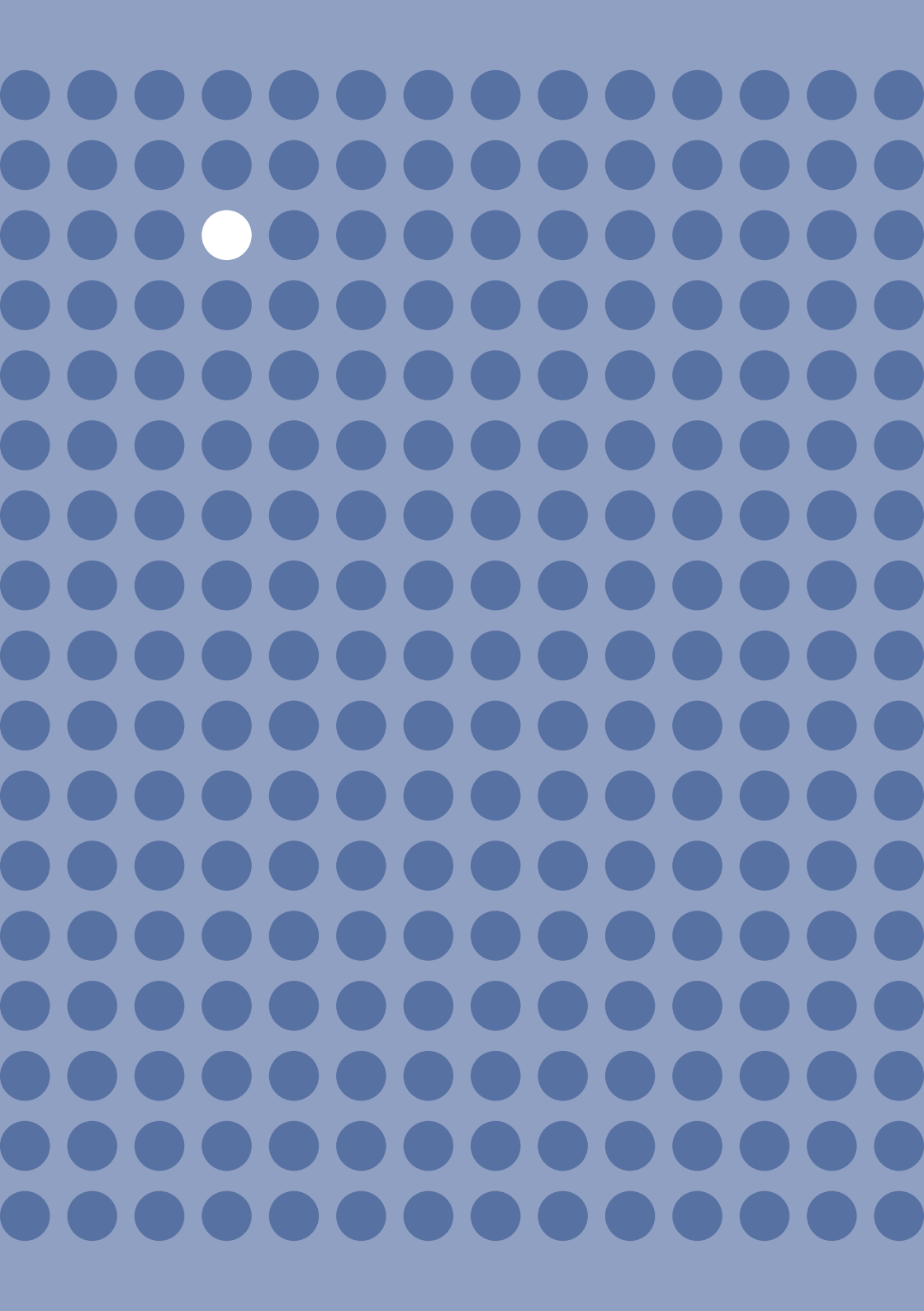
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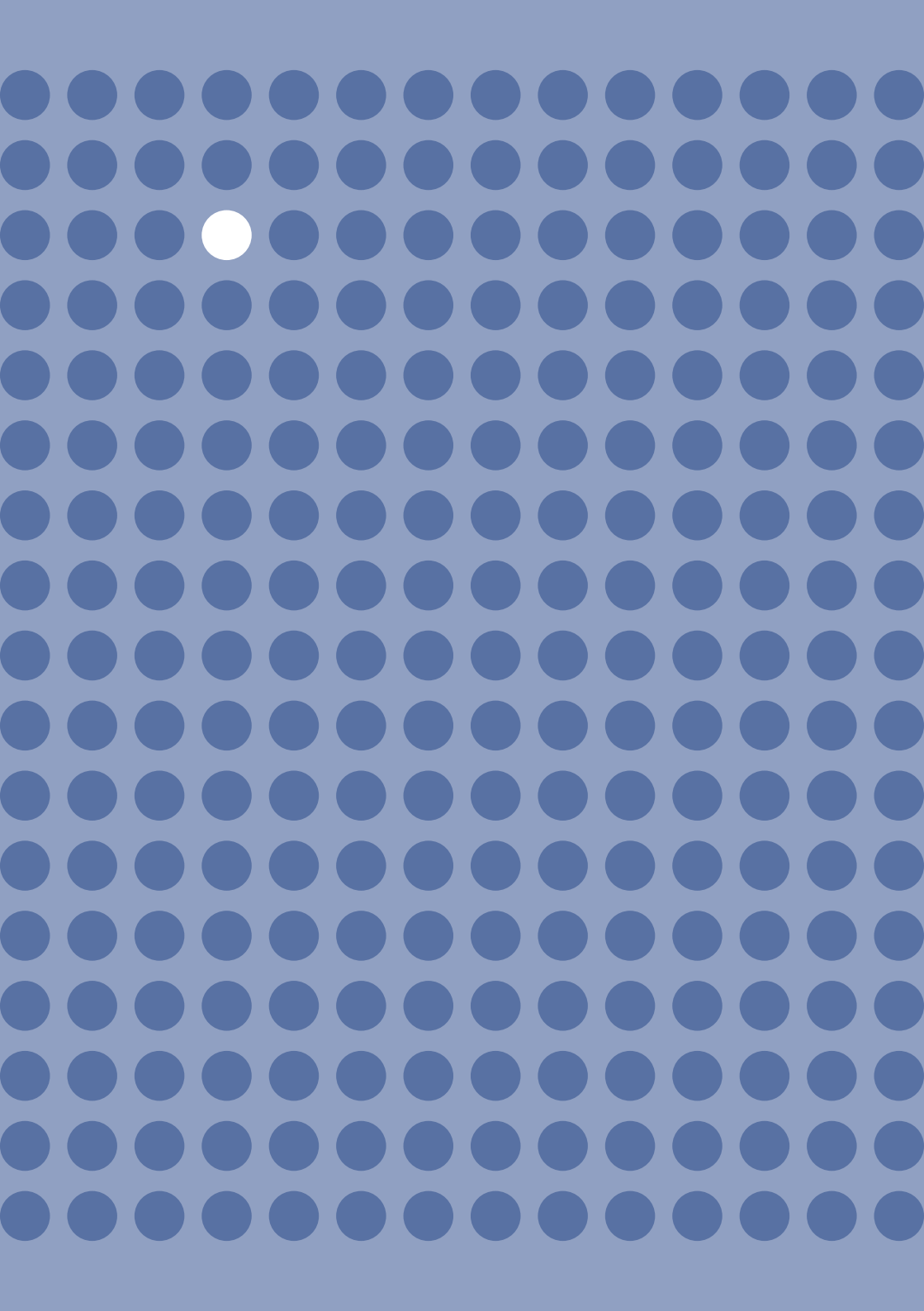
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Foreword

Drug use often develops from being occasional to problematic: ties with close family members and non-using friends are gradually severed, while school and professional performance can be seriously affected and may come to a premature end. As a consequence, the normal process of socialisation, the integration of an individual from adolescence to adulthood as an independent, autonomous member of society, is jeopardised and this often leads to a gradual exclusion into the margins of society. However, this is a two-sided process. At the same time, society is marginalising problem drug users, making their access to education, employment and other social support even more difficult. Also, one should not forget that, in many cases, social exclusion already precedes drug use. Drug use often then exacerbates the already difficult life conditions of excluded individuals, making integration efforts a real challenge for the individual and for those providing support. This aspect is particularly relevant during the current period of economic difficulties in Europe, with high levels of unemployment among young European citizens and their gradual impoverishment.

In order to protect problem drug users or recovering users from further social exclusion and to support them in their integration efforts, it is crucial that we provide individuals with opportunities and tools that are efficient, adequate and acceptable both for them and for their social environment. In this respect, the significant number of problem drug users who have accessed European drug treatment services in recent years reflects an important step towards integration. However, there is general consensus among professionals and researchers that neglecting the social needs of clients can undermine the gains achieved during treatment and that these needs ought to be addressed alongside treatment in order to assure long-term success. Measures addressing the housing, education, vocational and employment needs are therefore crucial reintegration complements.

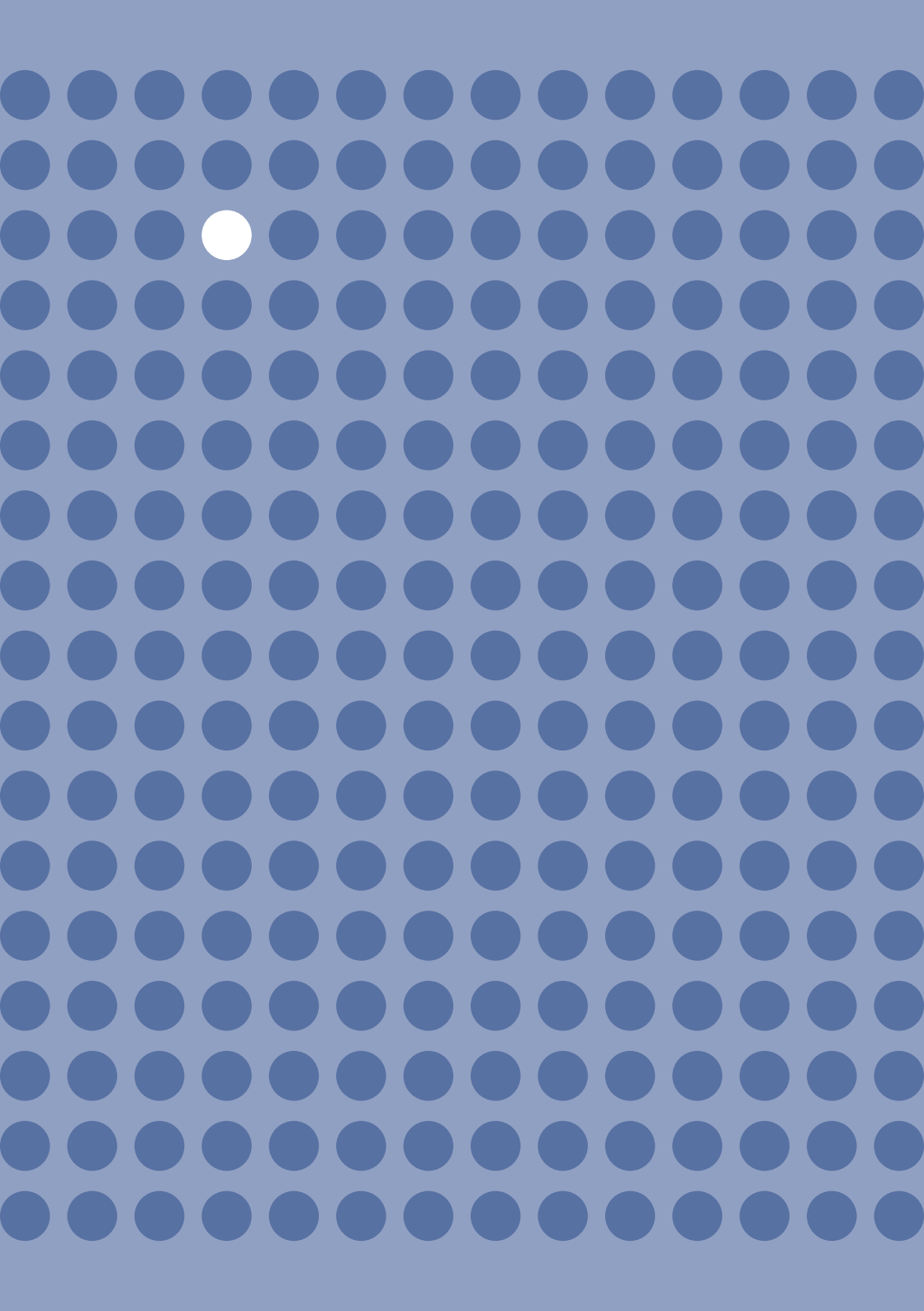
This EMCDDA *Insights* publication brings together the existing evidence of interventions addressing the social reintegration of problem and recovering drug users, with a particular focus on improving their employability. The publication also presents the concepts behind social reintegration and an overview of available approaches in Europe. Here, as elsewhere, the question of ‘what works’ is crucial. Unfortunately, there are few scientifically robust studies available on such an important topic and many findings are based on studies conducted outside Europe

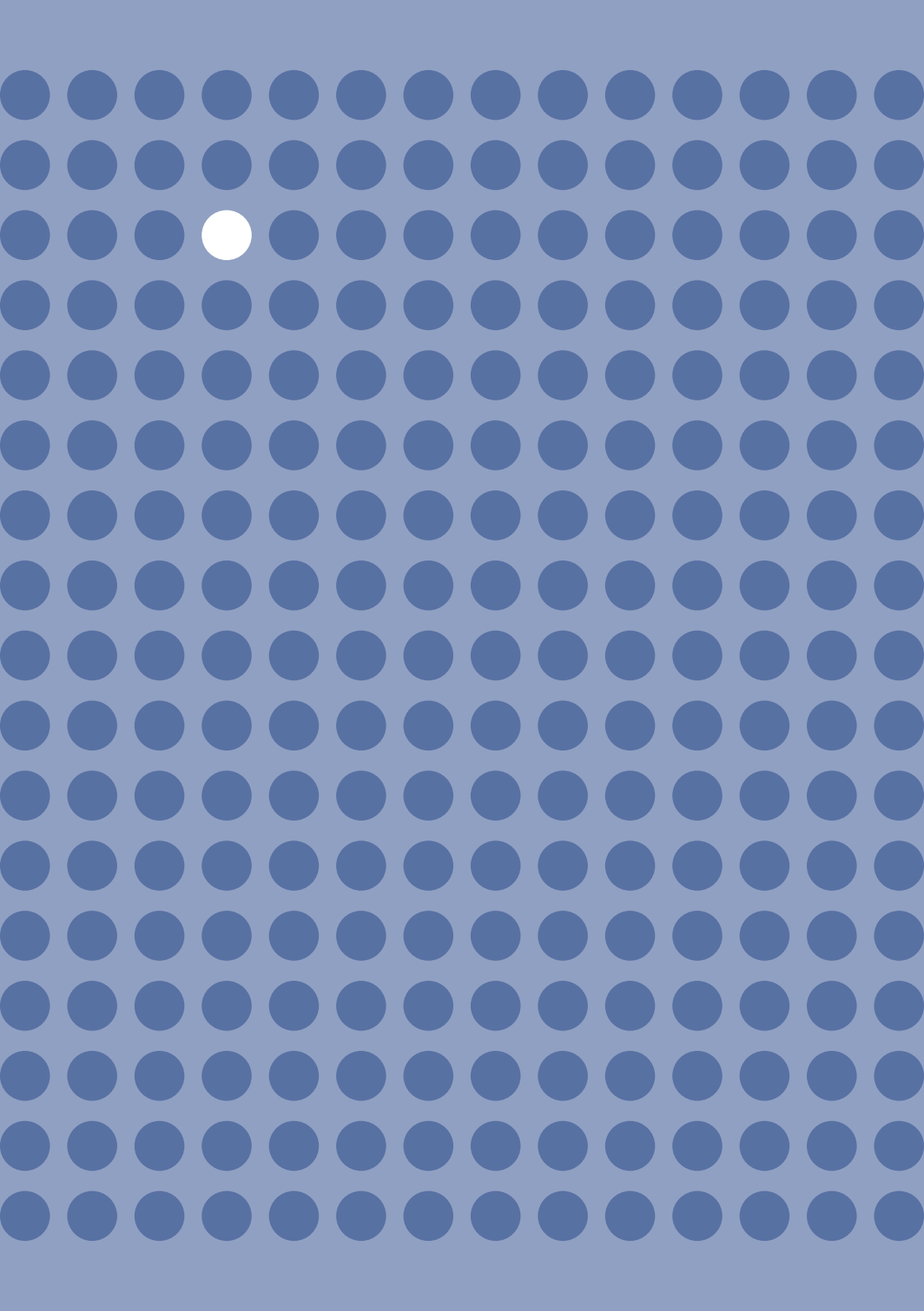
— mostly in the USA. While these studies provide us with a hint of what works in this field, their implementation under European conditions may often require considerable adaptations and even sometimes may not be feasible at all. This finding is a clear indication of the urgent need that exists for more research in this field in Europe in the coming years.

This publication will provide the reader with a comprehensive overview on different intervention types and the status quo of social reintegration measures for problem drug users. It informs us of both the developments in this area and the current practices in the EU Member States and provides indications of promising interventions that could inspire future research investments. Finally, this publication should provide decision-makers, professionals, researchers and the general public with the latest information available on an area that, despite its relevance for a large number of our citizens, has been neglected in recent years. I hope and believe that this Insight publication will in this way fill a real gap and provide these groups with the information needed to take decisions and make informed choices.

Although an individual life can follow very different patterns and paths, societies should be able to integrate as many of these patterns as possible and avoid marginalisation with all its negative consequences. Interventions described here can facilitate the process of (re)integrating recovering drug users and even active drug users in need into our societies. I certainly do hope that this publication can contribute to this process.

Wolfgang Götz
Director, EMCDDA





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This publication was authored by Harry Sumnall and Angelina Brotherhood, of the Centre for Public Health, Liverpool John Moores University, United Kingdom.

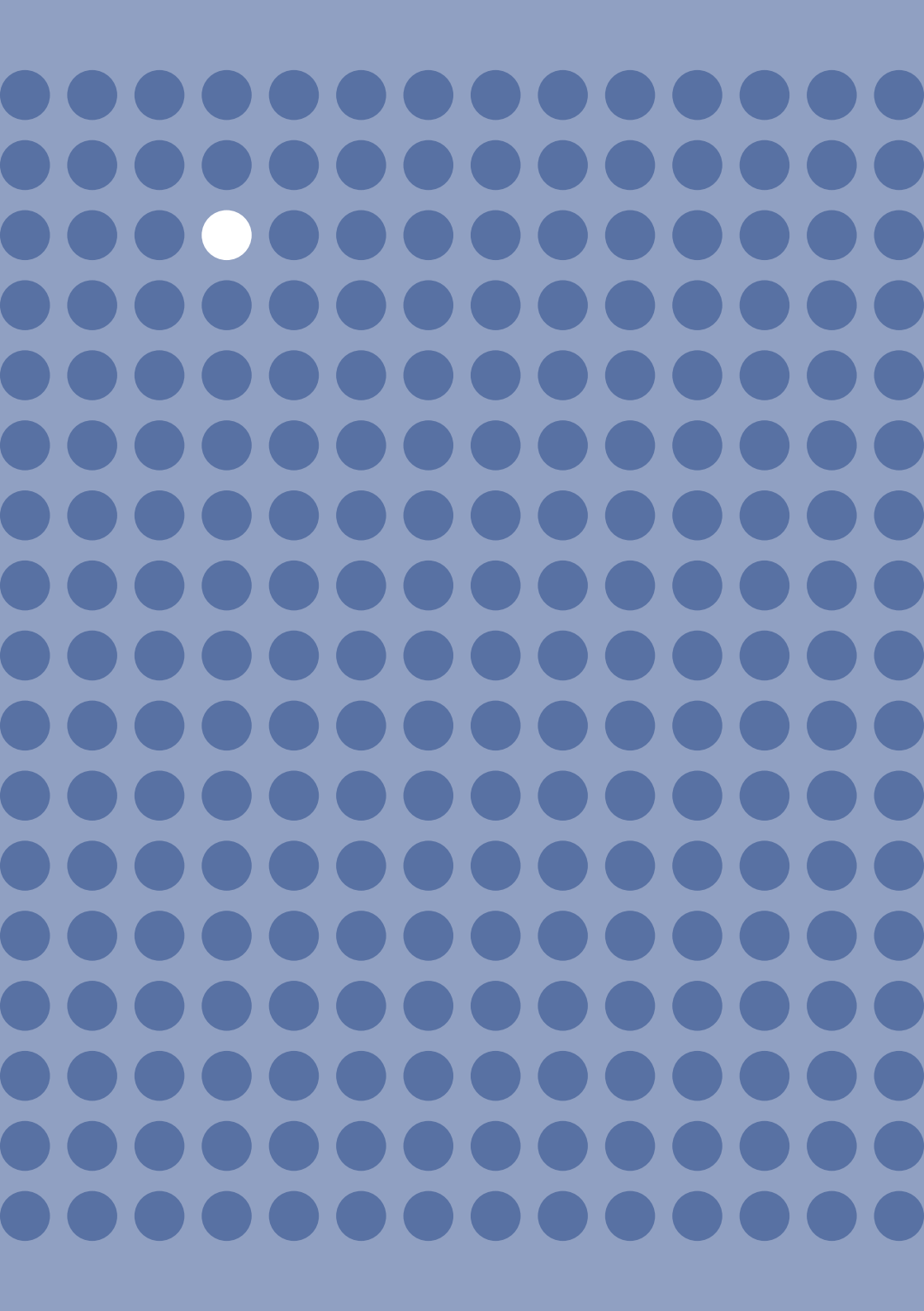
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Additionally, the EMCDDA would like to thank the Reitox network of national focal points for providing information and data on social reintegration measures in the European Member States, Norway, Croatia and Turkey.

EMCDDA project group

Alessandro Pirona, Alessandra Bo, Teodora Groshkova and Roland Simon.



Executive summary

Aims of this Insights publication

Although the quality and provision of drug treatment has improved significantly in the European Union (EU) over the last two decades, most activities are currently predominantly oriented towards the management and cessation of substance use. This has led to concerns that support aimed at the psychosocial and other needs of problem drug users is lacking. This apparent gap recently received increased attention in many Member States, where drug policies have focused attention on 'recovery' and social reintegration. This report aims to review recent discussions and developments concerning the social reintegration of problem drug users and examines the evidence for the effectiveness of interventions that aim to increase their employability. To this end, the report draws upon a review of scientific papers and grey literature, national reports submitted by the focal points of the EMCDDA Reitox network, and EMCDDA standard data collection. Although evidence is sparse, it is possible to integrate this information and to present in this report a logic model to assist policymakers and drug practitioners in developing coherent and inclusive strategies to promote social reintegration.

Problem drug use and social exclusion

As well as experiencing physical and social harms as a result of their substance use, many problem drug users in Europe have unmet housing, educational, employment and other social needs. In many cases these needs were evident before drug use commenced. Across Europe, this group is overall more likely than the general population to be vulnerably housed, to report fewer years of education and fewer educational qualifications, and to be unemployed. Their social and family networks may be less well developed than in the general population, thus adding to their exclusion. Ongoing treatment contact and long-term secondary illnesses mean that they often have to attend daytime prescribing, support and aftercare services, causing disrupted working weeks, which can be difficult to reconcile with regular employment. Further challenges await those individuals who successfully complete drug treatment. The stigma associated with being a (former) problem drug user and the increased likelihood of having a criminal record mean that obtaining and maintaining employment is more difficult. These problems are particularly acute for

those individuals who have recently left prison and who face further difficulties after the loss of rented accommodation while incarcerated. Some employers perceive (former) problem drug users as being 'problem people', and because they have disengaged from education and training at an early age many of them do not have the qualifications, personal capital and other life skills needed to succeed in an increasingly competitive and demanding employment market.

What is social reintegration?

'Social reintegration' is not a term that is used or defined consistently across EU Member States but it is a key aspect of full recovery from drug dependence. Its scope is wider than the traditional treatment focus on pharmacological and psychosocial outcomes. The EMCDDA defines it as: 'any social intervention with the aim of integrating former or current problem drug users into the community'. The three 'pillars' of social reintegration are (1) housing, (2) education and (3) employment (including vocational training). Other measures, such as counselling and leisure activities, may also be used. More recently the EMCDDA has introduced the concept of employability to account for the complexity of the issue (e.g. interlinkage between interventions, contextual factors, distinguishing between different needs). Furthermore, as employment is acknowledged in the EU Member States and beyond as important for social integration, supportive measures to overcome personal and structural-level barriers to obtain employment and to increase personal employability are seen as a key to social reintegration.

Whereas recovery from drug use and rehabilitation of problem drug users (particularly in the traditional abstinence-oriented sense) often emphasises the relationship between an individual and drug use, social reintegration is also concerned with the position of the individual in wider society. Although this report focuses on employment outcomes, simply being employed is not equivalent to being socially integrated and so employment should not be considered as the only goal of social reintegration. Non-work-related spheres of life, such as supportive networks and relationships with significant others, are equally important, including the ability to lead a life that is free from stigma and discrimination.

Social reintegration is seen as a foundation for drug treatment and as such it also includes all those activities that aim to develop human, social, economic and institutional capital. Activities that promote social reintegration are ethical and should be integral to drug treatment.

National, European and international policy directives

The overall aim of the EU drugs action plan (2009–12) is to ‘significantly reduce the prevalence of drug use among the population and to reduce the social and health damage caused by the use of and trade in illicit drugs’. Social reintegration contributes to achieving this aim and is specifically included in the national drug strategies of 22 Member States. In March 2006, the European Council also adopted a framework for social protection and social inclusion that was designed to promote social cohesion and social inclusion policies. The United Nations 1961 Single Convention also makes specific reference to the need for social reintegration measures, where paragraph 1 of Article 38 states: ‘The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends.’

Interventions and approaches to improve the social reintegration of problem drug users

The review identified a range of research and discussion papers that either discussed evidence of effectiveness or presented good practice in social reintegration of problem drug users. Strategies included in the review were specific to problem drug users and so must be considered alongside other general population and targeted programmes to promote stability, employability and economic prosperity (e.g. employment services, welfare to work, benefits, job creation schemes for unemployed populations in general).

Different approaches to social reintegration can be broadly arranged according to eight categories: (1) general vocational rehabilitation, (2) drug treatment, (3) criminal justice interventions, (4) housing support, (5) education and (vocational) training, (6) employment support, (7) general policy and (8) advocacy.

Overall, there was little evidence internationally — and almost none from EU Member States — to clearly suggest ‘what works’ with regard to social reintegration interventions, although it became clear that contextual factors (e.g. social attitudes to drug users, local and national economic prosperity, standards of living in the general population, professional training, stability in problem drug users’ lives, etc.) were extremely important moderators of success. The findings from the review can be summarised as follows:

- In general, providing drug treatment alone (e.g. substitute prescribing) without additional support or services had only limited and inconsistent effects on employment outcomes.
- Vocational training, which aims to improve job-seeking skills and improve motivation for work, shows promise, but no particular intervention models were identified as producing consistently positive outcomes.
- Contingency management approaches, whereby rewards (e.g. monetary vouchers) are contingent on successfully performing a particular activity (e.g. getting a job, providing a negative urine toxicology sample), showed some promise, but these types of interventions were mainly developed and researched in the USA. Their application might raise particular ethical concerns in the EU, and they have largely been developed to motivate drug abstinence rather than social reintegration.
- Court-mandated treatment is used increasingly in some EU Member States, and research has shown that such (quasi-)compulsory treatment produces similar outcomes to 'voluntary' drug treatment. Drug courts specialising in drug-related offences and drug-dependent offenders have also shown promising results in well-designed studies in the USA and Australia. Evidence from the former country shows that this may be an effective way of improving employment outcomes.
- Anti-discrimination legislation may be useful to ensure that former problem drug users are not disadvantaged in the workplace. Anti-disability discrimination legislation such as that developed in the USA may be one policy model to consider, but findings from the USA suggest that discrimination against problem drug users still occurs in the workplace. Furthermore, classifying former problem substance users as 'disabled' assumes, first, a medical model of dependence and, second, that substance use dependence is extremely difficult to overcome and that full recovery can never occur. Such an interpretation may be at odds with current EU Member State national drugs policies and the views and experiences of treatment professionals and drug users themselves.

Conclusions for practice and policy

There was not enough evidence of effectiveness to be able to make direct recommendations about which specialist types of interventions should be promoted in the EU, although responses to a structured questionnaire indicated that Member

States reported delivery of most of these already. However, there was little coherence between the approaches described in the literature and the way in which these activities were delivered within the EU. Most examples of EU implementation have not been evaluated and overall coverage appears to be poor. It was also difficult to identify the best ways in which the identified approaches should be delivered alongside traditional drug treatment as part of an individualised care plan. In the absence of specific recommendations on intervention models, for example for vocational training, the recommendations below present general considerations on activities promoting social reintegration. These are based upon the synthesis of the implications of primary studies, reports from expert groups (including existing good practice guidelines) and wider discussions of social exclusion and associated factors. The lack of a consistent set of research findings and the paucity of EU research into this topic means that these recommendations should be considered only as the first steps in promoting social reintegration activities and it is essential that this work be expanded in the coming years. Given the crucial role of social reintegration in limiting and overcoming drug-related problems in the long term, a better understanding of these interventions in Europe is greatly needed.

- There is a need for social reintegration interventions. This should also be acknowledged in funding provision and national drug policies. Drug treatment alone cannot address the complex needs of problem drug users. Treatment alone is also not sufficient to prevent social exclusion of marginalised individuals, particularly as many problem drug users were already marginalised before they started using drugs. Without social reintegration interventions, there is a serious danger that the gains made during treatment will be undermined.
- There is an urgent need to increase the availability of and access to social reintegration interventions for problem drug users in the EU. The availability and coverage of social reintegration measures currently delivered in EU Member States are overall limited and interventions are often subject to particular conditions that may exclude those most in need of support (e.g. drug-free status, stable housing). Additionally, policymakers should encourage the expansion of intermediate labour market interventions and the role of social enterprises within their economies, as these have been shown to be profitable for the wider society and to provide a bridge back to the world of work for disadvantaged, long-term unemployed individuals.
- It is important that definitions of social reintegration use a broad understanding of social reintegration that, besides *economic* integration, should also prioritise

components related to human, social, economic and institutional capital. This also allows a better understanding of the level of social reintegration that individuals can achieve. The logic model presented in this report promotes a comprehensive approach to social reintegration that systematically addresses the multiple barriers faced by problem drug users. It is also important to recognise that many individuals were already socially excluded prior to their drug use, and thus the term 'social (re)integration' may be more appropriate in some cases.

- Social reintegration measures can, and should, be embedded into drug treatment at an early stage. Depending on individual client needs, the provision of supportive structures, such as stable housing in the short term and vocational training in the medium term, may lead to improved treatment outcomes. Drug use abstinence should not necessarily be a condition of social reintegration support.
- Treatment providers should consider social reintegration outcomes as part of individual care planning and make use of multisectoral working to address these. Although stabilising and reducing drug use and associated harms is a primary outcome of drug treatment, outcomes related to social reintegration should also be considered important. Therefore, it is recommended that the monitoring of effectiveness of drug treatment must include data on social reintegration.
- Research funders should provide sufficient resources to allow high-quality outcome evaluations and cost-effectiveness studies of existing interventions in the EU or consider commissioning work that aims to adapt promising models of social reintegration developed elsewhere for delivery in the EU. Once sufficient evidence is available on 'what works', evidence-based guidelines should be developed.
- Problem drug users are not a homogeneous population and consist of many different subgroups with different needs. Social reintegration services need to be oriented accordingly. For example, most EU services target opioid users, which means that users of other drugs such as psychostimulants or cannabis may have even less access to social reintegration provision.



Part I: The need for social reintegration



Chapter 1: Setting the scope

Chapter 1: Setting the scope

In response to the high levels of drug use and associated problems witnessed in the European Union (EU) during the last decades, Member States significantly increased the availability, accessibility and diversity of drug treatment options. As a result, there has been a significant increase in the number of drug users in contact with drug treatment providers during this period. The latest available data show that at least 1.1 million drug users received any type of drug treatment in the EU in 2010 (EMCDDA, 2011a). Although provision of psychosocial interventions and detoxification is reported by all Member States, opioid substitution therapy (OST) remains the predominant treatment modality, with an estimated 700 000 opioid users in OST (EMCDDA, 2011a).

Research shows that drug treatment contact impacts positively on clients' physical and psychological health, reduces drug use and criminal activity, reduces injection and lowers the risk of non-fatal overdose (e.g. Gossop et al., 2000a,b; Prendergast et al., 2002; Stewart et al., 2002; WHO, 2009). Thus, accessing and adhering to drug treatment is a significant step towards recovery from drug dependence, but additional social support is often required. Indeed, drug use affects many spheres of life, including family and relationships, housing, education and employment, and it is also associated with social and economic exclusion. This can undermine the gains people have made while in treatment. It is therefore increasingly recognised that, in order to improve treatment outcomes, prevent relapse and ensure successful integration into society, drug dependence must not be treated in isolation; instead, the wider context in which drug use and recovery take place must also be considered and addressed (UNODC, 2008; Neale and Kemp, 2010). The United Nations Office on Drugs and Crime (2008a, p. 18) describes this approach as 'sustained recovery management', as a positive alternative to the current common approach of 'admit, treat, and discharge', often resulting in revolving-door cycles of high dropout rates, post-treatment relapse and readmission rates.

Consequently, the aim of social reintegration measures is to prevent or reverse the social exclusion of current and former drug users (including those who are already socially excluded and those who are at risk of social exclusion), but also to facilitate the recovery process and help sustain the outcomes achieved during treatment.

In this context, it is important to first clarify what is meant by 'social exclusion'. Thus, although there are different definitions of social exclusion, two common aspects are

relevant to this report (see, for example, Duffy, 1995; Walker and Walker, 1997; Khan, 2010):

- Social exclusion describes the inability of an individual or group to participate fully in mainstream society, economically, politically, socially and/or culturally.
- Social exclusion is a process in which society plays an active role; it is produced by discrimination against individuals or groups and denying them access to relevant resources based upon a certain characteristic.

Drug use is an important factor that increases the likelihood of concurrent social exclusion (EMCDDA, 2003a). However, there is no clear causality between drug use and social exclusion, as either may lead to the other, and both may be preceded and caused by (unknown) third factors. Many problem drug users already experienced problems in other spheres of life, including social exclusion, prior to their drug use. In this sense, problem drug users can also belong to other vulnerable groups, such as homeless people or people with mental health problems. Likewise, it is important to note that not all drug users are socially excluded (and vice versa). However, this report focuses on social reintegration of problem drug users, who are at greater risk of social exclusion than non-problem drug users (EMCDDA, 2003a).

Thus it becomes evident that problem drug users are not a distinct and exclusive population. As a consequence, overlaps exist between social reintegration activities targeted specifically at problem drug users and social reintegration activities for other vulnerable groups. This is reflected in the fact that many social reintegration programmes in the EU target not only problem drug users but a wider population at risk of social exclusion, including, for example, former prisoners and homeless people. Finally, European countries have set up a wide range of generic policies and structures that allow their citizens to maintain a minimum standard of life, to strengthen their abilities to be self-dependent and to protect them from the risk of social exclusion. Such generic structures or policies are generally referred to as welfare states. They are expected to provide social security, education and healthcare. European welfare policies generally include a commitment to full employment, social protection for all citizens and social inclusion (see Europe 2020 ⁽¹⁾).

It is, however, beyond the scope of the present report to address the wide range of available generic (re)integration policies and interventions from which drug users

⁽¹⁾ http://ec.europa.eu/europe2020/index_en.htm

may potentially benefit. Instead, this publication focuses on specific interventions that aim at improving the employability and employment opportunities of problem drug users, when possible, within the context of drug treatment. There are two reasons for these restrictions in scope.

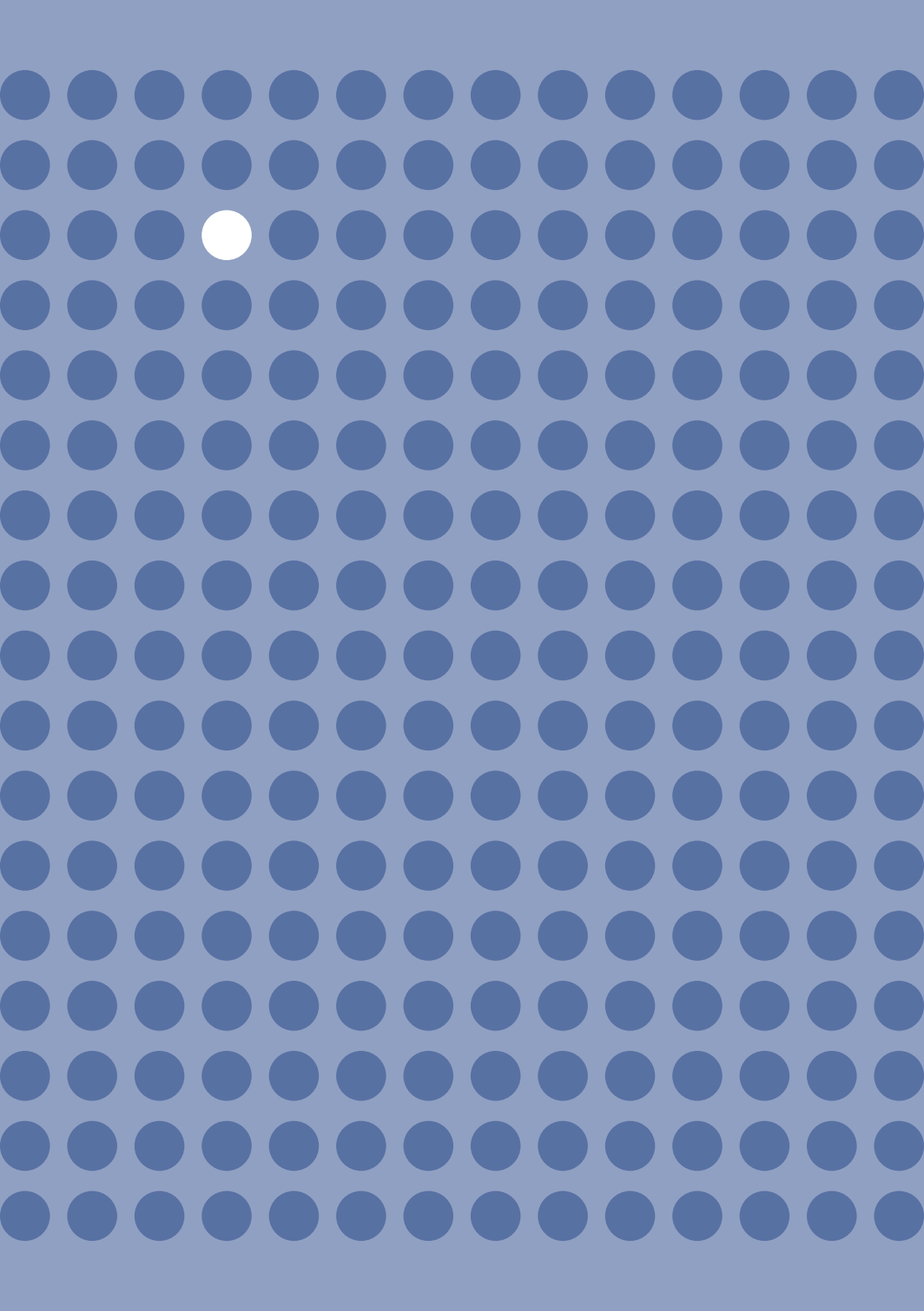
The first is that employment is a key protective factor against social exclusion, as it can provide financial means, increase social networks, be associated with certain rights (e.g. access to free healthcare), and so on. ⁽²⁾. Studies on the general population as well as specific populations (such as ill and disabled people) also indicate that employment is a key factor for physical and mental health and wellbeing, whereas worklessness is associated with negative outcomes (Waddell and Burton, 2006). Moreover, employment can help drug users to recover from their dependence and reduce the risk of relapse after drug treatment (e.g. Effective Interventions Unit, 2001); the positive value of employment is also recognised by many drug users themselves (UKDPC, 2008a; Neale and Kemp, 2010). The potential benefits of being in (paid) work can include a sense of responsibility and contribution to society; a sense of self-worth and confidence; a new source of identity; a new social network of non-drug users; and a daily routine that is not focused on the procurement of drugs.

Second, a focus on employability and employment of problem drug users, when possible in the context of drug treatment, allows a defined and outcome-oriented framework to be fitted around the wide area that is social exclusion and reintegration. It should be noted that 'employability' refers to a person's capability of gaining initial employment, maintaining employment and obtaining new employment if required (Hillage and Pollard, 1998). For individuals, employability depends on the knowledge, skills and attitudes they possess, the way they use those assets and present them to employers, and the context (e.g. personal circumstances and labour market environment) within which they seek work. Crucially, the ability to realise or actualise 'employability' assets depends on the individual's personal and external circumstances and the inter-relationship between the two. Personal circumstances include caring responsibilities, disabilities and household status, which can all affect one's ability to seek different opportunities and will vary during an individual's life cycle.

⁽²⁾ Some types of employment (e.g. below nationally agreed 'minimum' wages) and in some populations (e.g. young people), however, are considered to reinforce social exclusion (e.g. Pavis et al., 2000).

Thus, a focus on employability allows us to report simultaneously on a range of policies and interventions that are directly relevant to improving the employment opportunities of problem drug users, such as access to treatment, housing, education, training, welfare and other aspects of social integration.

Part I of this report discusses the meaning and importance of social reintegration. Then, a model of potential approaches to promote social reintegration through employment is presented, developed through literature review and information provided by the Reitox national focal points (Part II). Finally, conclusions are drawn that are of relevance to policymakers, practitioners (e.g. treatment providers) and researchers working in the drugs field (Part III). The Annexes contain a glossary of key terms, further information on and examples of social reintegration measures in EU Member States, and key employment indicators used in employability research.





Chapter 2: Defining social reintegration for problem drug users

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Chapter 2: Defining social reintegration for problem drug users

The term 'social reintegration' in reference to problem drug users is not used or defined consistently across EU Member States (EMCDDA, 2003b) and each Member State may hold different priorities with regard to the objectives of drug treatment, overall drugs policy and how social reintegration might be achieved.

The EMCDDA uses the following definition of social reintegration:

Social reintegration is defined as 'any social intervention with the aim of integrating former or current problem drug users into the community'. The three 'pillars' of social reintegration are (1) housing, (2) education, and (3) employment (including vocational training). Other measures, such as counselling and leisure activities, may also be used.

This definition was developed in 2004 following earlier work conducted by the EMCDDA to estimate the nature and level of social reintegration efforts in the EU (EMCDDA, 2002, 2003a, b; Verster and Solberg, 2003). The second sentence of this definition emphasises employment as one of three key indicators for problem drug users' level of integration into the community; in this context, housing and education can be understood as facilitators increasing the employability of problem drug users. The term 'social reintegration' is also used internationally. The United Nations Single Convention on Narcotic Drugs of 1961 makes a specific reference to the need for social reintegration of drug users. The term is also currently used by United Nations organisations, such as the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC). However, the term is not defined in the WHO *Lexicon of alcohol and drug terms* (WHO, 1994), the WHO *Health promotion glossary* (WHO, 1998) or the UNODC's *Demand reduction glossary* (UNODCCP, 2000).

As the following sections will show, social reintegration aims to support treatment and prevent relapse by taking a holistic view of the client with the ultimate goal of social inclusion. Moreover, social reintegration is a key aspect of full recovery from drug dependence and its scope is wider than the traditional treatment focus on pharmacological and (more recently) psychosocial outcomes.

2.1 Social reintegration and drug treatment

The relationship between social reintegration and drug treatment is largely dependent on the understanding of ‘drug addiction’, ‘treatment’ and the desired outcomes of treatment. Ideally, social integration should be seen as an integral part of the treatment process (UNODC, 2008). In such a broad understanding of treatment, the question about the relationship between treatment and social reintegration may appear redundant. However, if the aim of treatment is seen only as being drug free, then social reintegration is a separate task to be tackled. In this case, the limits of drug treatment described at the beginning of this report must be taken into consideration. Moreover, it could be argued from a harm reduction perspective that social reintegration is possible and desirable even without necessarily achieving abstinence. Hence, the relationship between social reintegration and treatment is worthy of further exploration.

Key issues concern the timing, purpose, target population, intervention content and provision of services:

- *Timing:* Traditionally, social reintegration has been regarded as a phase that *follows* treatment after being drug free. This is evident in an earlier report published by the EMCDDA (2002, p. 5), which defined social reintegration as ‘Any integrative efforts made to the community as a *last step* in the treatment process’ (emphasis added). Similarly, the definition of rehabilitation in the WHO *Lexicon of alcohol and drug terms* (1994, p. 55) (see section 2.2) implies that social reintegration ‘follows the initial phase of treatment’ as an aspect of rehabilitation. However, more recent thinking has proposed that social reintegration and drug treatment should be seen as integrative elements (e.g. UNODC, 2008; EMCDDA, 2010a).
- *Purpose:* Whereas treatment is typically aimed at stabilisation, reduction or cessation of drug use, social reintegration can serve a multitude of purposes. For example, it may support the initial treatment process; prevent relapse following treatment; facilitate recovery without formal treatment; or prevent or reverse adverse consequences of drug use. More importantly, social reintegration seeks improvements on non-drug-related outcomes.
- *Target population:* Although treatment is usually targeted only at current drug users, social reintegration efforts can be directed towards current and former drug

users, as well as socially excluded or vulnerable groups more generally (Verster and Solberg, 2003), although, as mentioned earlier, this report focuses on interventions that are specific to problem drug users, when possible, in the context of drug treatment.

- *Intervention content:* Social reintegration interventions differ from most treatment interventions also in that psychosocial or medical components are not essential, for example where the intervention consists of vocational training only.
- *Service provision:* Depending on the type of approach, social reintegration approaches can be implemented by a range of different providers. Interventions such as job skills training may be delivered by existing treatment services (e.g. by providing additional services) or by non-specialist teams/agencies such as job centres. Other interventions, particularly those targeted at removing structural barriers (e.g. changes in legislation, advocacy work), require a separate approach altogether, such as environmental, often national policy-level, interventions.

These are important considerations, particularly in countries where the availability of and access to drug treatment services are not well developed (see EMCDDA, 2011a). In such countries, there may be concerns that social reintegration measures can be implemented only once a threshold of minimum quality of treatment provision and target population coverage has been achieved. However, this report demonstrates that social reintegration measures can be implemented independently of treatment in other fields and through other providers; that for drug users in treatment it should be an integral part of their treatment plan; and that social reintegration measures need not be targeted at drug users exclusively (allowing the use of a variety of funding streams).

2.2 Social reintegration and recovery/rehabilitation

Whereas the EMCDDA defines social reintegration as described, use by other organisations suggests an overlap between ‘social reintegration’ and other relevant terms such as ‘recovery’ and ‘rehabilitation’: terms that are often difficult to define and are typically not used by the EMCDDA ⁽³⁾.

⁽³⁾ The decision to use the term ‘reintegration’ rather than ‘rehabilitation’ was made in an earlier report (EMCDDA, 2002), based on the observation that the term ‘rehabilitation’ was more ambiguous.

The WHO *Lexicon of alcohol and drug terms* (1994, p. 55) defines 'recovery' as:

Maintenance of abstinence from alcohol and/or other drug use by any means. The term is particularly associated with mutual-help groups, and in Alcoholics Anonymous (AA) and other twelve-step groups refers to the process of attaining and maintaining sobriety. Since recovery is viewed as a lifelong process, an AA member is always viewed internally as a 'recovering' alcoholic, although 'recovered' alcoholic may be used as a description to the outside world;

whereas 'rehabilitation' is defined as:

The process by which an individual with a substance use disorder achieves an optimal state of health, psychological functioning, and social well-being. Rehabilitation follows the initial phase of treatment (which may involve detoxification and medical and psychiatric treatment) [...] There is an expectation of *social reintegration* into the wider community. (emphasis added)

According to these definitions there is a clear overlap between social reintegration and rehabilitation, whereby social reintegration forms an aspect of, but is not synonymous with, rehabilitation. Recovery, according to the WHO glossary, appears to be relatively unrelated to the term. However, since the publication of the WHO glossary in 1994, the understanding of the term 'recovery' has developed further and today it is much closer to the meaning of the term 'rehabilitation' as quoted above. As Best and colleagues (2010, p. 275) note: 'The target of recovery is about quality of life rather than abstinence, although abstinence may be a long-term goal for clients.'

This development is particularly evident in the ongoing political debate about 'recovery' and the desired outcomes of treatment, which has taken place in the UK and other countries over the past few years. In response to this debate, the UK Drug Policy Commission Recovery Consensus Group (2008, p. 6) issued a 'vision' ⁽⁴⁾ of recovery, which is meant to be applicable to all individuals with drug-related needs regardless of the type of treatment they receive. It states:

⁽⁴⁾ The term 'vision' was deliberately chosen over the term 'definition' to emphasise that recovery has different meanings to different individuals. Rather than limiting the meaning of the term by defining it, the aim of the group was to develop a vision that could inspire drug services and individuals, not to specify evaluation indicators of successful recovery. Similarly, the recently formed UK Recovery Federation (UKRF) does not provide a definition of recovery on its website, arguing that it is up to clients to define recovery as individual experiences of recovery differ (UK Recovery Foundation, 2011).

The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.

This understanding of 'recovery', which encompasses more aspects than 'being drug free' or in which references to abstinence may be missing completely, is in line with other recent international literature (e.g. Betty Ford Institute Consensus Panel, 2007).

Similarly, the UNODC publication *Drug dependence treatment: sustained recovery management* (2008, p. 17) uses a wide understanding of recovery. The publication does not provide its own definition of the term; however, it proposes eight domains of 'recovery capital':

1. Physical and mental health;
2. Family, social supports and leisure activities;
3. Safe housing and healthy environments;
4. Peer-based support;
5. Employment and resolution of legal issues;
6. Vocational skills and educational development;
7. Community integration and cultural support; and
8. (Re)discovering meaning and purpose in life.

It is noteworthy that three of these domains, namely safe housing and healthy environments, employment and resolution of legal issues, and vocational skills and educational development, are equivalent to the three main areas identified in the EMCDDA definition of social reintegration.

Finally and most recently, the US government Substance Abuse & Mental Health Services Administration (SAMHSA) offered the following working definition of recovery (SAMHSA, 2011):

Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential.

The distinction between social reintegration and recovery therefore clearly depends on the understanding of the term 'recovery'. In its traditional sense, which emphasises abstinence, recovery can be almost understood as a separate process from social reintegration. However, in its recent use, the term 'recovery' includes

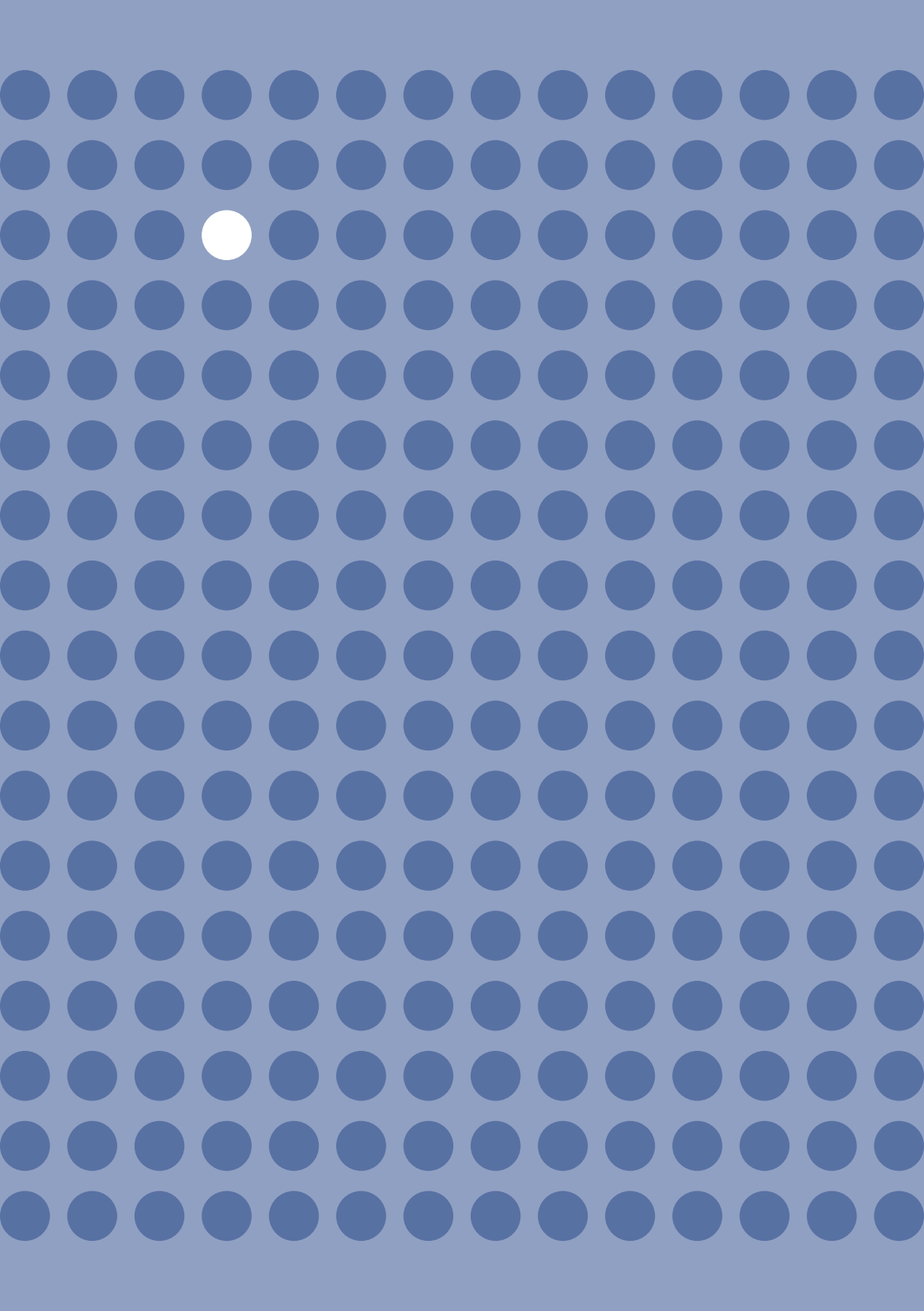
other aspects, some of which typically refer to social reintegration; and it may also refer to medically assisted treatment (White and Mojer-Torres, 2010). It can therefore be concluded that social reintegration is an essential aspect of recovery and rehabilitation. Nevertheless, recovery and rehabilitation have a wider scope, which can include areas such as abstinence/stabilisation of drug use, physical and mental health, and personal relationships.

The implications of this for the EMCDDA definition of 'social reintegration' are discussed in the conclusions of this report. Given the wide variation in definitions used for 'recovery', this report is focusing on 'social reintegration': a term that seems to be understood by many different stakeholders in a similar way. Furthermore, it should be noted that, in this report, being drug free is not seen as a precondition for social reintegration (see also the box below).

What comes first – being drug free or being socially integrated?

In some social reintegration interventions, there can be an expectation that drug users must become drug free before they can, for example, take up employment or receive welfare support. Many of the interventions that have been evaluated for effectiveness and published in the scientific literature originate in the USA, where this is often a requirement for participation. The analysis of EMCDDA Structured Questionnaire 28 showed that being drug free was also an entry criterion for some interventions in Europe, such as supported housing, vocational training and intermediate labour market interventions. Although current receipt of methadone maintenance prescription was sometimes acceptable, complete abstinence was required in some circumstances. There is also some evidence to suggest that even drug users themselves may prefer to successfully complete drug treatment before going on to secure work (Neale and Kemp, 2010).

However, if social reintegration measures are conditional upon being ready for change or being drug free then this limits the support to those who are not (UKDPC, 2008a). Moreover, social reintegration may actually facilitate the treatment and recovery process. For example, employment may support formal drug treatment through its potential benefits, such as providing a new daily routine and contacts with non-drug users. It may consequently be argued that the social reintegration of drug users should be understood not only as a consequence of (or a reward for) being drug free, but indeed as a possible condition for becoming or staying drug free.





Chapter 3: Problem drug use and social exclusion

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Chapter 3: Problem drug use and social exclusion

3.1 The nature of problem drug use in the European Union

As indicated by the UNODC (2011), there is no established definition of problem drug use, although countries usually refer to regular use of illicit substances, drug dependence and injecting drug use in their definitions. A subgroup of ‘problem drug users (PDU)’ is defined by the EMCDDA for monitoring purposes with respect to ‘Injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines’. ‘Problem drug users’ include problem users of other substances. In some Member States the definition may also include aspects of outcomes of drug use (i.e. social, psychological, physical or legal problems associated with use, including dependence). Differences in definitions may be due to differences of substances that are considered problems in a country (e.g. problem drug use estimates from the Czech Republic, Slovakia and Finland include problem amphetamine users, whereas the UK excludes these). These differences in definition of which drugs are considered problems reflect not only geographical variation in the availability and prevalence of drugs, but also the priorities of national drug policy and the relative acceptability of use of different drugs. In acknowledgement of these differences, this report uses the term ‘problem drug users’ as a proxy for all individuals who experience significant negative health and social consequences from their drug use, regardless of the type of drug used and the way it is administered.

Differences in definition and drugs/behaviour included also mean that problem drug use is difficult to estimate at a European level and consequently it is hard to monitor trends over time. However, EMCDDA data available for 2002–09 suggest relative stability in problem drug use (see EMCDDA annual reports). Injecting drug use and opioids are the main features of problem drug use across most of Europe, with problem amphetamine and cocaine use also reported by a few countries. In 2009, it was estimated that there were 1.4 million problem opioid users in Europe and Norway (around 0.4 % of the population aged 15–64) ⁽⁵⁾.

⁽⁵⁾ See Table PDU-1 in the EMCDDA *Statistical bulletin*, 2011 for further information on the size of problem drug use, injecting drug use and problem opiate use in the Member States, Norway, Croatia and Turkey (<http://www.emcdda.europa.eu/stats11/pdu>).

3.2 The links between substance use, housing, education and employment

Supporting problem drug users to access secure housing, education (including vocational training) and long-term employment are crucial elements of preventing social exclusion and promoting social reintegration. Abstaining from or reducing drug use, engaging with and completing education, as well as securing and sustaining employment can all be great challenges if an individual has no access to supportive structures such as stable accommodation. Eight per cent of all outpatient clients in the EU starting a new treatment episode in 2009 were living in unstable accommodation (see Figure 1 on p. 45). This ranged from 2 % in Estonia to 20 % in France, 21 % in the Czech Republic and 33 % in Luxembourg. Within this population of drug users there are those subgroups that may be vulnerable or face additional barriers obtaining appropriate accommodation, such as women and young people, or those with enduring mental health problems (Shaw and McVeigh, 2008). There are many reasons why drug users may develop severe accommodation needs (whether they are defined as homeless or inappropriately accommodated), or why homeless people may start using drugs, and such progressions are rarely due to a single factor alone (Pleace, 2008). Typical reasons for homelessness may include a combination of mental health problems, unemployment, financial difficulties, criminal behaviour, relationship problems, family breakdown and difficulties in progressing into independent living after release from an institution (e.g. prison) (UKDPC, 2008a). Conversely, high-risk behaviours such as injecting drug use are reported to be prevalent among homeless people (EMCDDA, 2003a).

Education is a key factor in the development of social and economic wellbeing. Across the countries of Europe, there is a considerable disparity in educational attainment, whether measured by completion of formal education or level of education achieved, number of years of schooling or the measurement of skills or competences such as literacy (Rodríguez-Pose and Tselios, 2007). In addition to variations between Member States, within countries educational attainment amongst problem drug users is consistently lower than in the general population, with 37 % of clients entering outpatient treatment in 2009 having completed only primary education and 2 % not even achieving this level (see Figure 1 on page 45). There is also strong evidence linking school attendance and engagement with education to protection against (problem) drug use (e.g. Edmonds et al., 2005).

Although there is a large body of evidence describing the association between problem drug use and unemployment, the exact mechanisms and direction of influence are under-researched and not fully understood (reviewed by Henkel, 2011). Employment is generally regarded as being protective against substance use (i.e. regular employment is a statistical predictor of reduced drug use; see for example Atkinson et al., 2001; Brown and Montoya, 2009). Additionally, unemployment (long-term unemployment or becoming newly unemployed) significantly increases the risk of relapse after drug treatment. For example, lack of (or poor self-)identity, boredom, frustration and the psychosocial stress associated with being or becoming unemployed, especially during times of economic prosperity, may lead to (increased) drug use (Neale and Kemp, 2010). Furthermore, a drug-using lifestyle shared with peers who are unemployed or economically underactive may be associated with alternative routines focused on acquiring and using drugs, separating those engaged in such activities from the labour market. However, under some circumstances, unemployment will lead to reduced substance use, particularly as a result of decreased income and the removal of workplace stresses that may have originally predicated use. Conversely, involvement with drugs may mean that a user is less likely to gain or maintain employment. It may be concluded that the relationship between drugs and unemployment differs between people as well as within individuals at different times and social contexts (South et al., 2001).

However, it is clear that problem drug use is associated with employment difficulties; 56 % of those entering outpatient and 75 % of those entering inpatient treatment in 2009 reported being either unemployed or economically inactive (see Table 1 and EMCDDA *Statistical bulletin*, 2011), which are much higher rates than in the general European population (for example, Eurostat reported 9.3 % unemployment in April 2011 and 35.8 % economic inactivity in 2010 in 15- to 64-year-olds). A recent German study compared unemployment rates of drug treatment clients with those of the general population between 2000 and 2007. The study's findings showed that the unemployment rate of the drug treatment clients, including that of young cannabis clients, more than doubled during the period, from 18 % to more than 40 % (Kipke et al., 2011). On the other hand, the unemployment rate in the German general population decreased from 10 % to 8 % over the same period.

In a comprehensive review, Henkel (2011) examined over 130 studies that had investigated the impact of problem drug use (defined therein as 'substance abuse')

on unemployment (and vice versa), and the effect of unemployment on treatment outcomes. It was shown that, overall, problem drug use negatively affected employment outcomes, and problem drug users were more likely to lose their job and subsequently less likely to find paid employment later on. Few studies have examined the *causes* of such findings, but the limited data available suggest that health consequences, rather than use per se, might be the most likely explanation (unless the employer imposed prohibitive workplace substance use policies, e.g. random drug testing). Participation in criminal activity is also an important negative factor, especially with regard to convictions (including loss of driving licence) and imprisonment, and the negative effects that this has on future employment opportunities. Even former problem drug users face problems, as one US study suggested increased job loss (15–23 % higher) due to stigma from employers, despite the passing of the Americans with Disabilities Act in 1990, which aimed to prohibit discrimination against disabled populations; that is defined to include individuals with diagnosed drug dependence or those who have been or are currently in treatment (Americans with Disabilities Act of 1990 – ADA – 42 U.S. Code Chapter 126) (see also section 11.2 Disability Discrimination Acts).

Storti and colleagues (2011) examined whether the ‘payoff’ for entering treatment increases when the unemployed drug user has a greater probability of finding a job after treatment. Using EU datasets and employing mathematical modelling they found that the structural component of unemployment has a stronger impact on the number of treatment clients, i.e. when the number of structural unemployed declines (increases) the number of drug treatment clients increases (declines). However, when unemployment declines temporarily, it is likely to have a weaker impact on the decision of drug users to seek treatment than when unemployment declines structurally. These findings were thus thought to result, in part, from the incentivising effects of treatment, that successful completion would lead to employment, but only when jobs were available (i.e. when national rates of unemployment were low). Empirical confirmation was achieved using a German dataset and it was found that a one percentage point decline in the unemployment rate lead to an increase in the number of persons seeking treatment by 2.5–5.3 %. Thus, the creation of job prospects adds significantly to the willingness of unemployed drug users to seek treatment and lends support to the idea that employment programmes need to be integral to drug treatment interventions.

Table 1: Education, labour and accommodation status of all clients entering outpatient treatment (EU average, %) in 2009 or most recent year available

Education status	
Primary level not completed	1.6
Primary level of education	36.8
Secondary level of education	54.3
Higher level of education	7.2
<i>Status known (n)</i>	221 345
<i>Status not known</i>	33 756
Labour status	
Regular employment	29.9
Pupil/student	7.6
Economically inactive	10.7
Unemployed	45.2
Other	6.5
<i>Status known (n)</i>	319 733
<i>Status not known</i>	57 305
Accommodation status	
Stable accommodation	83.9
Unstable accommodation	8.4
In institutions (prisons, clinic, etc.)	7.7
<i>Status known (n)</i>	224 978
<i>Status not known</i>	36 241

Source: EMCDDA 2011d (*Statistical bulletin*).

3.3 Barriers to social inclusion for problem drug users

Although, as shall be discussed in subsequent sections, there is some (limited) evidence to suggest that the completion of employment-related programmes can increase employability (and indirectly improve drug treatment outcomes), simply completing such activities does not guarantee that work can be obtained or

sustained. Although there are usually no legal obstacles (i.e. legislation does not discriminate against problem drug users), several barriers to the social inclusion of problem drug users, and their employment in particular, have been outlined in numerous studies and reviews (e.g. Effective Interventions Unit, 2001; Klee et al., 2002; Baum et al., 2003; Hasluck and Green, 2007; UKDPC, 2008a, 2008b; Lloyd, 2010; EMCDDA, 2010a; Neale and Kemp, 2010; Monaghan, 2010). These barriers can broadly be categorised as either personal or structural ⁽⁶⁾:

- i) *Personal-level barriers*: limited or no qualifications, including low levels of literacy and numeracy; poor employment histories; criminal records precluding certain careers (e.g. police, teaching, working with children, financial institutions); chronic mental and physical ill health; insecure housing circumstances; limited interpersonal skills; complex personal needs; lack of confidence; chaotic lifestyles (e.g. poor timekeeping); family problems; low expectations of themselves and of life in general.
- ii) *Structural-level barriers*: requirement to attend treatment on a daily basis; inadequate opening hours of treatment services (e.g. pharmacies) that are incompatible with working hours (see the box on p. 71 on 'Making treatment services work-friendly'); lack of interagency coordination; etc. Some structural barriers affecting problem drug users are common to other socially excluded groups, for example stigmatising and discriminative views, actions and procedures among the general public. Other authors have discussed evidence about whether economic recession negatively affects the public (including employers and co-workers) and professional workers (e.g. job centre staff); inability to open a bank account to receive wages; increased likelihood of temporary or insecure work; shortage of suitable employment opportunities; perceived 'benefit trap' whereby an (incorrect) belief is held that the loss of welfare benefits due to employment will result in a reduction of income which is not compensated by the salary; criminal record checks required by employers. Like other applicants, they might face problems through limited public transport in rural areas and lack of childcare services.

⁽⁶⁾ However, (some) personal-level barriers can be caused or at least reinforced by (some) structural-level barriers, and vice versa. This distinction is therefore made from a theoretical point of view; in practice a comprehensive approach to social reintegration must address personal- and structural-level barriers together.

Also, high levels of unemployment in general and an increasingly competitive job market leave few job opportunities for workers with low levels of qualifications and skills. The most recent global recession (European Commission, 2009), which is disproportionately affecting some EU countries, may mean that many current and former drug users will be placed in an even more marginalised position in the competitive employment market when trying to secure employment, as they are easily outperformed by those with better qualifications and skills. However, as suggested by Henkel (2011), during an economic recession, already employed problem drug users would not necessarily be at greater risk of losing their jobs, as the greatest proportion of layoffs are the result of large-scale closure of organisations and departments rather than individual job losses. In fact, there is no evidence to suggest that in times of high general unemployment substance users are more likely to lose their jobs than non-users (NB lack of evidence does not imply lack of effects). Other authors have discussed evidence of whether or not economic recession affects substance use behaviour and prevalence (see the box below).

It should also be noted that, although there are some barriers that are specifically faced by problem drug users, many barriers are the same for problem drug users as they are for other vulnerable and disadvantaged groups (7). In this regard, it is also worth noting that the situation is worsened if an individual has multiple disadvantages, for example if a problem drug user is also diagnosed with a serious mental illness.

The relationship between economic recession and substance use

Henkel (2011) failed to identify any studies in the general adult population (who constitute the greatest proportion of the workforce) that had examined the relationship between economic recession, employment levels and substance use. However, the jobs typically offered by employability services to client groups (including problem drug users) are in the construction and service industries, which are particularly sensitive to economic changes. One study from the USA indicated countercyclical variations in substance use in young people, i.e. drug use prevalence and drug selling increased in times of economic

(7) The review by Hasluck and Green (2007) defined 'the most disadvantaged' as including people with serious drug or alcohol dependence, current or former offenders, homeless people, people with basic skill needs, people with learning difficulties, non-native language speakers, refugees and people with mental health conditions, as well as those with multiple disadvantages.

downturn (Arkes, 2007). One explanation offered for this was that, as there are ordinarily fewer legal paid jobs for adolescents, and these opportunities become fewer during recession, they may be more likely to start selling drugs instead. Hypothesising about the current recession, Bretteville-Jensen (2011) argued that global recession may lead to a reduction in law enforcement expenditure, and therefore the 'cost' of risk incorporated into the street prices of drugs would also decrease. Loss of legitimate jobs may also lead to an increase in individuals wishing to take on the risks of becoming a drug dealer; increased competition would therefore lead to a decrease in consumer prices. Price elasticity has been shown for a variety of drugs (e.g. Petry and Bickel, 1998; Carroll, 1999; Sumnall et al., 2004; Van Ours and Williams, 2007; Brunt et al., 2009; Chalmers et al., 2010) and so it would be expected that, independent of personal income, reduced drug prices would lead to increased consumption. Prevalence would be maintained by increased drug initiation rates and decreased cessation rates, use behaviours that are price sensitive.

3.4 Social reintegration activities to address barriers

Research carried out on unemployed people in general (not only drug users) suggests that programmes addressing a wide range of issues are more effective than those that address employment alone (Meadows, 2008). This is reflected in the approaches presented in this report, which address many of the barriers described above directly and indirectly ⁽⁸⁾:


- Drug treatment aims to address physical and mental ill health and can also meet other needs by providing additional services such as vocational training. Compatibility with the demands of working life can be achieved by giving special consideration to opening hours and other practical challenges that working or job-seeking problem drug users may face.

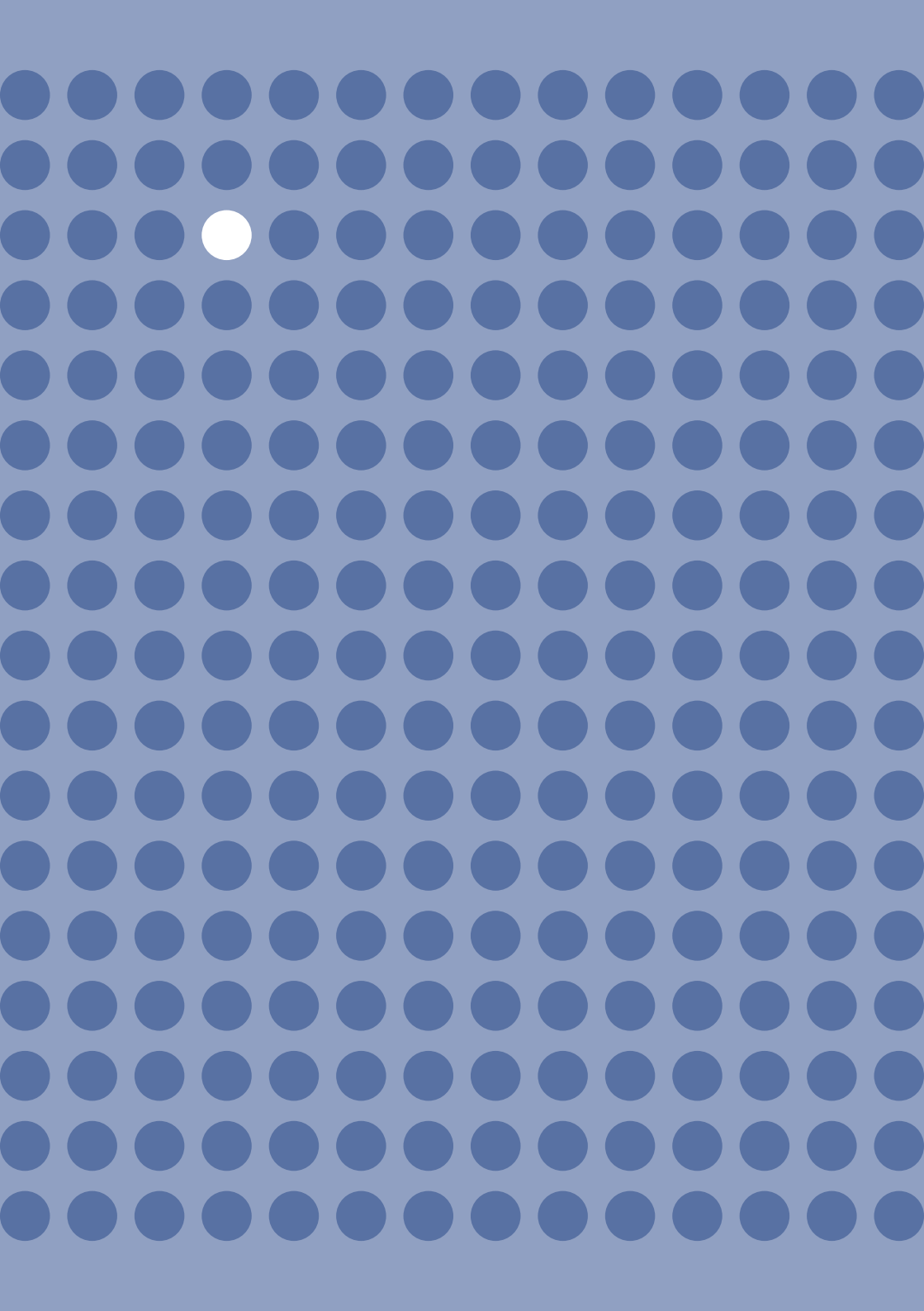
⁽⁸⁾ Other activities, such as interventions to strengthen clients' social networks (e.g. personal relationships with family and friends, integration in residential community), can also help reduce barriers to social reintegration. However, the evidence review in this report focused on employment-related outcomes, and the presentation of social reintegration approaches is limited to those most relevant to increasing the employability of problem drug users. Consequently, interventions targeted at improving physical health or social networks and relationships are not presented in Part II of this report and are not included in this overview. This issue is reflected upon in the conclusions (Part III of this report).

- Interventions in the criminal justice system can help to reduce reoffending, and thus indirectly increase the employability of individuals. In particular, activities that aim to divert offenders from prison into treatment allow greater opportunity to address the complex needs of clients. By avoiding or reducing prison sentences these interventions can also prevent loss of accommodation and disruption of families and other social networks.
- Housing support services provide short- or long-term accommodation as well as access to other services such as medical care, drug treatment, social activities, education and training.
- Education and (vocational) training can be offered in different settings and help improve the individual resources required to achieve social reintegration.
- Employment interventions can provide support for those who have found a job as well as employment opportunities for those who are struggling to secure work in the open labour market; thereby they also address other potential barriers such as low confidence.
- General policy is needed to address structural barriers, for example by improving interagency coordination (see the box on this topic, p. 54), addressing practical difficulties that job-seeking problem drug users may face and ensuring that benefit recipients are well informed about conditions of benefit receipt. Legislation can also be put in place to prevent discrimination against problem drug users and to prevent misuse of workplace drug testing and criminal records checks by employers.
- Advocacy aims to improve the general perception of problem drug users in society and to impact positively on how problem drug users are treated by professional staff (e.g. employment centre staff, healthcare professionals) and the general public (e.g. landlords, employers, co-workers); this contributes to the removal of other barriers identified in this section.

The evidence underpinning these approaches, as well as general vocational rehabilitation, will be described further in Part II.

Figure 1: Overview of barriers faced by problem drug users and activities to remove barriers

Barriers to social reintegration		Activities to address barriers (as presented in Part II of this report)
Access to treatment not compatible with employment Physical and mental ill health Complex personal needs, low expectations towards self and others Criminal records		Drug treatment Criminal justice interventions
Insecure housing circumstances		Housing support (short- and long-term solutions)
Limited skills, limited or no qualifications		Education and (vocational) training (including life skills training, work placements)
Poor employment histories, shortage of suitable employment opportunities		Employment support (on the intermediate and open job market; as part of treatment)
Perceived 'benefit trap' Practical difficulties (e.g. lack of childcare, lack of driving licence) Criminal record checks		General policy (e.g. antidiscrimination acts, benefit system, welfare-to-work programmes)
Stigma and discrimination		Advocacy (targeted at the general public and professionals)





Chapter 4: Social reintegration as a policy objective

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Chapter 4: Social reintegration as a policy objective

4.1 Social reintegration in international and EU policy

Policies and measures to support social reintegration form essential components of a comprehensive drugs strategy, and this is also reflected in international and EU policy.

The United Nations Single Convention on Narcotic Drugs (1961) also makes specific reference to the need for social reintegration measures, where paragraph 1 of Article 38 states: 'The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and *social reintegration* of the persons involved and shall co-ordinate their efforts to these ends' (emphasis added).

Responding to the health and social risks and consequences of problem drug use, including through social reintegration measures, is also recognised as an important responsibility of EU Member States. The overall aim of the EU drugs action plan (2009–12) ⁽⁹⁾ is to 'significantly reduce the prevalence of drug use among the population and to reduce the social and health damage caused by the use of and trade in illicit drugs'. More specifically, objective 7 of the plan is 'Enhance the effectiveness of drug treatment and rehabilitation by improving the availability, accessibility and quality of services'. In relation to this objective, action 14 is 'To deliver existing and develop innovative rehabilitation and social re-integration programmes that have measurable outcomes', and the indicator associated with this action is 'Increased availability and effectiveness, when possible, of rehabilitation and reintegration programmes in M[ember] S[tates]'

Also of policy relevance, in response to the European Commission Communication *Working together, working better: a new framework for the open coordination of social protection and inclusion policies in the European Union* (COM/2005/706), the European Council adopted a new framework for social protection and social inclusion processes ⁽¹⁰⁾. The overarching objectives are to encourage and coordinate national governments in implementing policies and activities that promote social

⁽⁹⁾ Available at <http://www.emcdda.europa.eu/policy-and-law/eu-activities>

⁽¹⁰⁾ See <http://ec.europa.eu/social/main.jsp?catId=750&langId=en>

cohesion through adequate, accessible, financially sustainable, adaptable and efficient social protection systems and social inclusion policies; besides good governance, transparency and the involvement of stakeholders in the design, implementation and monitoring of policy.

Although these are not drug-user-specific objectives, they are important because they provide guiding principles within which to develop and deliver actions that aim to improve the wellbeing and social cohesion of all members of society. Improved levels of social functioning in the general population should also improve the quality of life of members of subgroups within that population. However, an important objective of such policies is the amelioration, not maintenance or (unintended) worsening, of social inequalities.

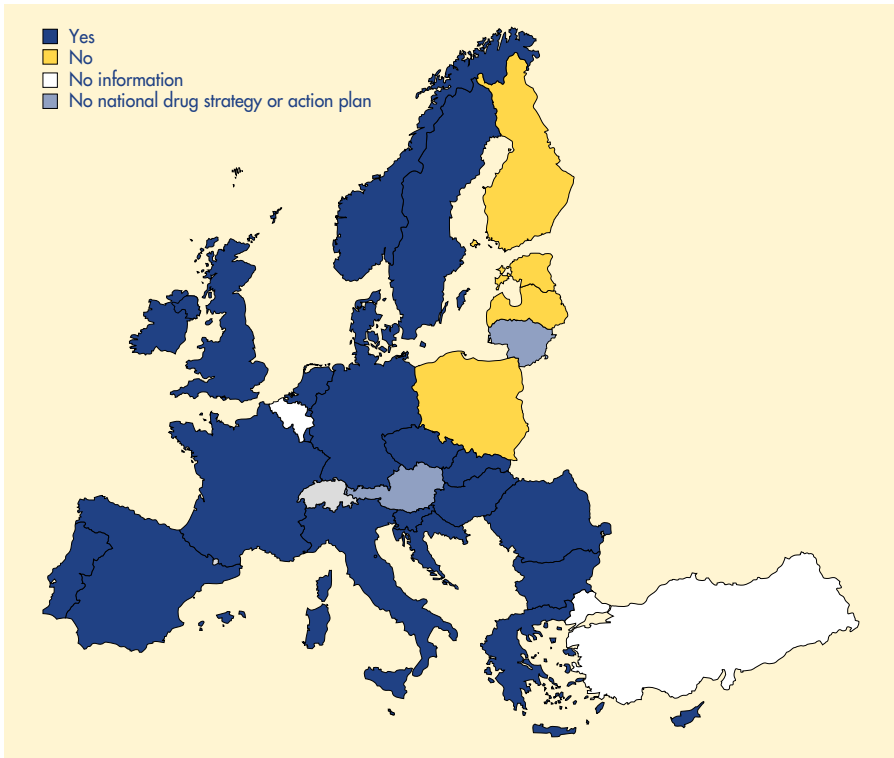
4.2 Social reintegration in EU Member State policies

According to the EMCDDA Structured Questionnaire 28, 22 (79 %; $n = 28$) countries reported that their national drug strategy or action plan included specific social reintegration components, four that it did not (Figure on page 50). Austria (regional strategies only) and Lithuania (national strategy draft not formally approved by government) do not at present have national drug strategies.

Focal points provided information on inclusion in policy of health, housing, education, and employment objectives. This information is presented in Annex 2. Focal points were also asked to provide information on other main social reintegration-related objectives and actions that were included in their national drug strategies or action plans. Fourteen countries provided additional information. For example, the Czech Republic's strategy provides guidelines on the systematic referral of drug users from treatment and prison settings to aftercare/reintegration programmes. Croatia's objectives include educational programmes for specific groups of unemployed persons, including those clients who have completed drug treatment. These aim to increase their employability and competitiveness in the open labour market. The objectives of Cyprus include the development of cooperative actions between social integration programmes and other organised groups in order to deliver financial assistance, vocational training and job rehabilitation. Slovenia aims for social reintegration by developing a network of therapeutic communities and a network of social reintegration programmes, employing drug users, improving housing provision and improving the framework of basic, specialised and in-service training of professionals providing medical, psychological and social care to problem drug users. Romania's objectives include the

development of the necessary legal framework and resources for the development and strengthening of outpatient medical services in order to guarantee access to health and social care for problem drug users, as well as the development of legislative and institutional frameworks to ensure the provision of integrated support programmes.

Figure 2: Structured Questionnaire 28 analysis — inclusion of sections on social reintegration in national drug strategies or action plans (data collected 2009–11)



4.3 A logic model for policy development

The previous sections have demonstrated that social reintegration measures are needed in Europe to support problem drug users in achieving recovery from dependence and attaining full participation in society. The report has also indicated how drug users are socially excluded within a range of dimensions, including

housing, education and employment, and described some of the barriers that problem drug users may face when trying to access these areas and other support structures. These barriers cannot be addressed by (traditional) drug treatment alone but require a range of additional activities (summarised in Figure 1, p. 45). The need for social reintegration activities is acknowledged in international and national governmental policy objectives. Identification of effective social reintegration approaches is critical to the achievement of these policy objectives, and this report contributes to achieving this aim through this and the following sections.

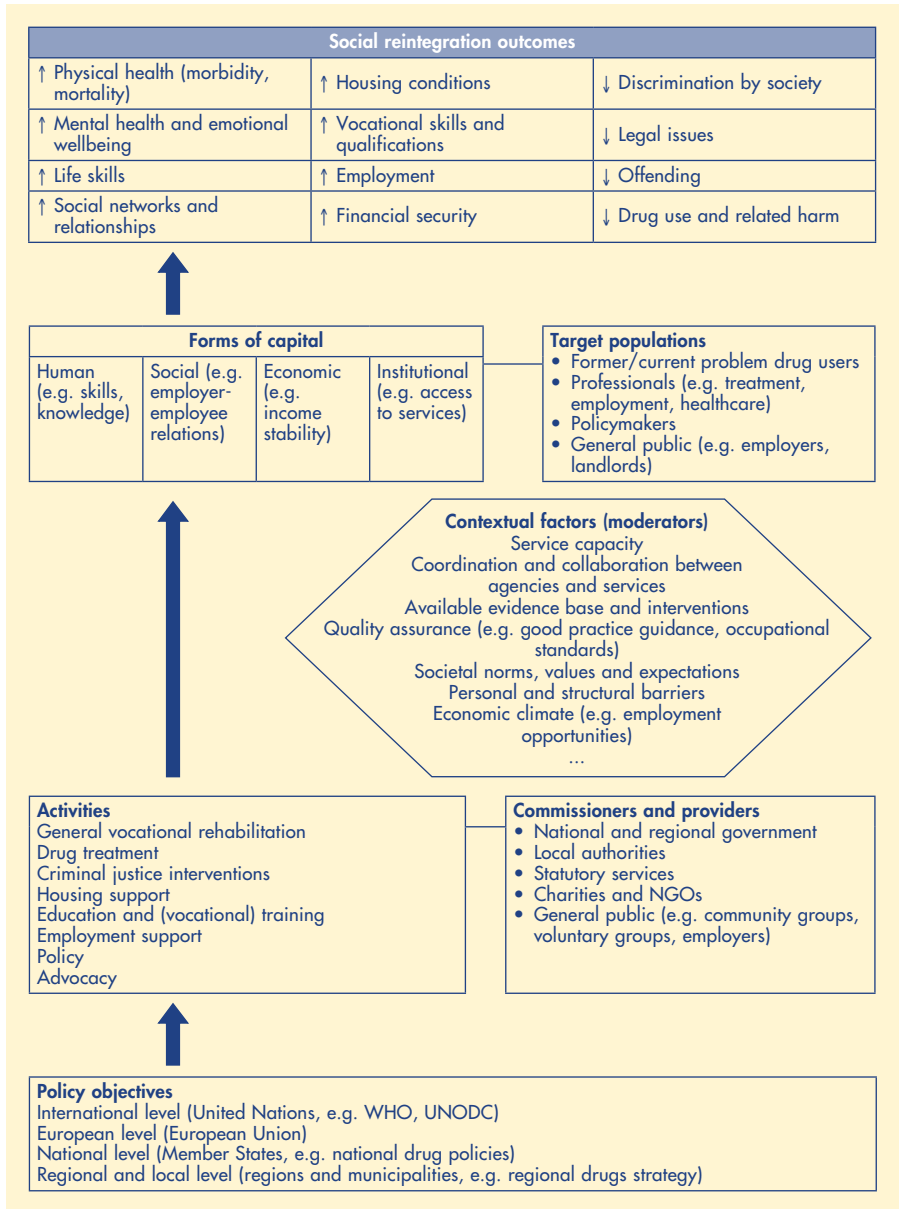
The final section of Part I builds upon these considerations to present a logic model for policy development (see Figure 3, p. 53). This logic model facilitates an understanding of how social reintegration ‘works’ in practice from the formulation of international policies to the positive changes achieved at an individual level; hence it also highlights the different aspects of implementation that need to be considered.

- According to the model, relevant policy at international, national, regional and local levels constitutes the foundation of any social reintegration activity. This includes the legislative and policy frameworks highlighted earlier, such as the EU drugs action plan and the United Nations 1961 Single Convention. At national, regional and local levels, where available, drugs strategies and corresponding government papers outline relevant objectives.
- At the next level, the model highlights how policy objectives are translated into a range of specific activities, including policy actions, strategies, programmes or interventions carried out in different settings. The model categorises these activities according to the eight approaches presented in Part II of this report.
- A variety of commissioners and providers will be involved in the delivery of social reintegration, including statutory as well as non-statutory services, professionals and the general public. ‘Providers’, in this sense, does not refer only to formal service providers (e.g. treatment providers), but can also refer to informal providers of activities such as community groups and employers, as well as families and supportive peers who may be, for example, at the forefront of (uncommissioned) advocacy activities. Consequently, commissioning and funding structures as well as implementation procedures may vary according to the type of social reintegration activities and the underlying ‘drivers’.
- All activities will aim to increase different forms of capital in problem drug users: human capital as the personal resources that an individual can draw upon (e.g.

skills, knowledge); social capital as benefits arising from existing networks and relations (e.g. within the local community; relations between employer and employee, job adviser and client); economic capital as financial and material assets (e.g. income stability); and institutional capital as resources available through relations with services and other support structures (e.g. defined by access to services).

- The model also emphasises that, while former/current problem drug users are the main target population of social reintegration, some activities are directed (also) at other target populations who determine the availability of capital (such as professionals, policymakers and the general public). This is particularly relevant in removing some of the more subtle barriers (e.g. stigma) to social reintegration.
- The ultimate aim of social reintegration should be to improve a range of social reintegration outcomes. The indicators presented in the figure have been developed using the literature review as well as other existing models of recovery and social reintegration (e.g. Burns et al., 2006; UNODC, 2008). Social reintegration covers many different areas of life, and this is reflected in the variety of social reintegration outcomes in the model.
- The model also highlights the importance of considering contextual factors or moderators that define different aspects of delivery and may affect the effectiveness of social reintegration efforts. For example, an intervention may have been evidence-based and well delivered, and the client may be highly motivated; however, an unfavourable economic climate will decrease the number of job opportunities, thus decreasing the effectiveness of the activity. Such intervention may have been effective in times of economic prosperity. Contextual factors may also increase the effectiveness of activities, for example where measures such as standards and guidelines are in place to ensure a consistently high quality of delivery. Ethics can also play an important role, as they define what goals and activities are acceptable. The report discusses some of these contextual factors in designated 'boxes' (interspersed in the report where appropriate) and in the conclusions (Part III).

Figure 3: A policy model for social reintegration



The need for interagency collaboration and integrated services

The success of social reintegration measures often relies on the effective collaboration between different services. Such collaboration can occur for a variety of reasons and in different ways. Often, it is required to address multiple needs of clients or to ensure continuity of services as no one organisation can address all the needs a client may have (Meadows, 2008). For example, interagency collaboration is essential in prison release programmes to ensure that former prisoners can continue treatment outside the prison setting and that they have access to housing and social support services (EMCDDA, 2010a). Collaboration is also essential to ensure appropriate referrals for clients as well as a sufficient number of referrals (Effective Interventions Unit, 2001). Monaghan (2010) reports on programmes carried out in Scotland in which staff members from different agencies (e.g. employability service provider, job centre, criminal justice service) work-shadowed each other, including during appointments with clients. The goal of these programmes was to increase staff members' awareness of available services as well as their knowledge of everyday processes and targets in different fields.

Findings from a 2009 EMCDDA survey revealed that 16 out of 28 reporting countries have some form of partnership agreements between drug treatment agencies and social services (e.g. employment and housing services). In six countries (France, the Netherlands, Portugal, Romania, the United Kingdom, Croatia), structured protocols are the most commonly used mechanisms for interagency coordination; in the remaining 10 countries, partnerships rely mainly on informal networks. Further details on mechanisms for coordination between relevant agencies can be found in Annex 2.

Also, reforms in labour or social laws can trigger new opportunities for multiagency collaborations. For example, a labour and social law passed in 2004 in Germany to reduce long-term unemployment required clients to agree to a contract in order to receive unemployment benefits. This contract outlines what they are obliged to do to improve their job situation, and non-compliance may result in a reduction or even complete suspension of the appropriate payment. This law provided job centres with new options for the support of unemployed people with addictions and led to new cooperation needs between treatment centres and job centres (Henke et al., 2010).



Part II: Approaches to promote social reintegration

Part II: Approaches to promote social reintegration

Introduction

This section of the report summarises the approaches categorised in the logic model for policy development (see Part I) and that have been used to promote labour market participation as a component of social reintegration for problem drug users. Each approach presents, where possible, evidence on their effectiveness. European example projects are included to illustrate the diversity of work taking place in the EU. Selection of these projects is on the basis of geographic representation rather than endorsement of the approach and it must be noted that few have been evaluated for effectiveness. It is recognised that other drug treatment modalities and interventions are offered in the EU, but this list includes only those that explicitly include promotion of employment outcomes or have been subject to research regarding such outcomes ⁽¹¹⁾. It is also worth noting that, although the approaches are presented as distinct activities and in different sections, in practice there can be a great level of overlap.

Methodological remarks regarding the review of the scientific evidence

A brief survey of the published literature showed that the field of social reintegration research is underdeveloped in the EU and, as there are difficulties in transferring US interventions and policies, it was decided not to conduct a systematic review ⁽¹²⁾ of effectiveness. Instead of synthesising heterogeneous outcome and evidence types, the report aims to provide a descriptive overview of the current state of the social

⁽¹¹⁾ Intervention definitions were obtained from a variety of published sources, including the EMCDDA website/annual reports; the UK NTA (2011) *Business definition for adult drug treatment providers*; the WHO (1994) *Lexicon of alcohol and drug terms* and (1998) *Health promotion glossary*; and the UNODCCP (2000) *Demand reduction: a glossary of terms*.

⁽¹²⁾ A systematic review attempts to identify, appraise and synthesise all the empirical evidence that meets pre-specified eligibility criteria to answer a given research question. Study inclusion criteria differ between review groups. Organisations such as the Cochrane Collaboration, for example, included only randomised controlled trials (RCTs) of effectiveness in their reviews, whereas reviews supporting the development of NICE (National Institute for Health and Clinical Excellence) public health guidance in the United Kingdom include those studies without an RCT design. See <http://www.thecochranelibrary.com/view/0/AboutCochraneSystematicReviews.html>

reintegration field and typical intervention approaches. The findings of grey literature and other contextual documents have also been reviewed and summarised, although a data extraction process was not undertaken. By discussing contextual and practice considerations, these type of documents were particularly useful in establishing a foundation from which to discuss limited evidence findings. Although existing reviews were preferred, primary studies have been included where no reviews exist or where they supplemented or added contemporaneous details or a European perspective to review findings. Overall, although a number of studies were identified, because of differences in approach (e.g. types of intervention delivered, setting, study design), study population investigated (e.g. community methadone-maintained clients, army veterans with multiple co-morbid mental health problems) and outcomes assessed, and a lack of replication, it was difficult to draw conclusions about the effectiveness of any of these approaches. Additionally, most research findings on this topic emanate from US studies. This may limit the direct transferability of the interventions because of possible differences in legal, structural and ideological environments in regard to, for example, drug treatment systems and welfare systems between the USA and Europe. It should also be noted that, despite greater harmonization, such differences also exist between European Member States. A discussion of US data of relevance to EU policy and practice is provided when possible in the respective sections.

A list of social reintegration search terms and search strategies was developed. Search terms incorporated substance use and (likely) intervention- and outcome-related keywords and were supplemented by the use of thesaurus terms. Sources searched included academic databases (e.g. Medline, EMBASE, Psychinfo), grey literature libraries (e.g. OpenSIGLE) and websites of organisations working in the field (e.g. EMCDDA, UNODC, the Joseph Rowntree Foundation). General Internet searches, expert consultation and cross-referencing of publication reference lists were also undertaken to complement these findings. Inclusion criteria were reviews and primary studies, published since 1990, written in the English language (no translation facilities were available), that described interventions with social reintegration outcomes in drug users. The research tender specifically referred to interventions that examined employability and employment acquisition. Titles and abstracts of identified studies were screened according to inclusion criteria, and relevant studies retrieved. Data were extracted into a bespoke database and findings synthesised. Research undertaking secondary analysis of high-quality data sources (e.g. representative surveys, comprehensive treatment service monitoring systems) was also included.

Although these studies did not have an experimental design they were useful in identifying factors associated with particular outcomes (e.g. employment). Similarly, high-quality cross-sectional research was included, although findings from these types of studies cannot be applied to the general population of problem drug users because the study population might not be considered representative. Evidence tables were prepared for those selected studies that described employment specific interventions. These are presented in the online Annex ⁽¹³⁾ and referred to throughout the text. Systematic reviews and large-scale studies were used to derive evidence on employment outcomes associated with drug treatment interventions that did not have employment specific components (e.g. maintenance prescribing).

Methodological remarks regarding the availability and coverage of social reintegration interventions in the EU

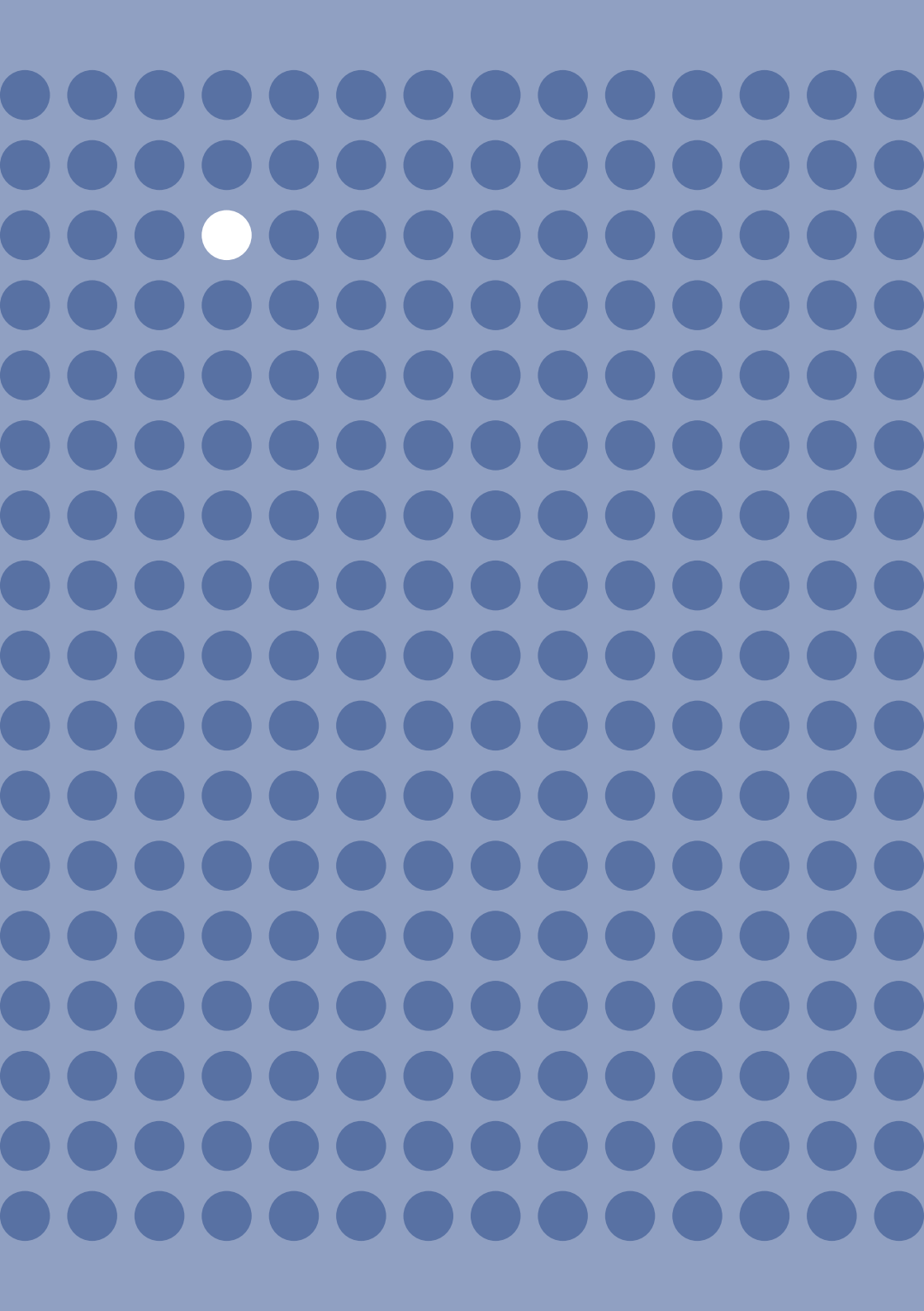
In order to assess the current situation with regard to the availability, accessibility and diversity of social reintegration measures, in 2009 the EMCDDA launched Structured Questionnaire 28 on 'Social reintegration and reduction of social exclusion of drug users' ⁽¹⁴⁾. The questionnaire was sent by the EMCDDA to the national focal points of Reitox, the European Information Network on Drugs and Drug Addiction, in the 27 EU Member States plus Croatia, Turkey and Norway (30 countries in total). Two countries (Belgium and Turkey) were not able to provide information and were consequently excluded from the data analysis. The questionnaire requested information on the policies that EU Member States have put in place to improve social reintegration and reducing social exclusion of drug users and information on interventions to improve the employability of people in drug treatment. Brief summaries of the questionnaire analysis are interspersed throughout the report where relevant to a particular report section or social reintegration intervention type, with further detail provided in Annex 2. It should be noted that the responses may have changed slightly since completion of the questionnaires by national focal points, because of government changes, the economic recession and other developments. Results from Structured Questionnaire 28 are referred to as '2009 EMCDDA survey' throughout the text.

⁽¹³⁾ Available on the EMCDDA's publications website at: <http://www.emcdda.europa.eu/publications>

⁽¹⁴⁾ The full Structured Questionnaire 28 is available at: <http://www.emcdda.europa.eu/html.cfm/index1573EN.html>

Methodological remarks about national examples of social reintegration interventions

Example policies and projects were identified through the 2010 annual reports from national focal points of the EMCDDA Reitox network and through analysis of textual comments in EMCDDA Structured Questionnaire 28 and the European Exchange on Drug Demand Reduction Action (EDDRA) database coordinated by the EMCDDA. Examples from different countries are given in the report and its Annexes to illustrate certain mentioned approaches. However, the report does not intend to provide a full picture of interventions provided in the EU.





Chapter 5: General vocational rehabilitation

5.1 General approaches

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Chapter 5: General vocational rehabilitation

‘Vocational rehabilitation’ refers to all those processes, ideas or interventions that enable people with functional, psychological, developmental, cognitive and/or emotional impairments or health conditions to overcome barriers to accessing, maintaining or returning to employment or other useful occupation (Scottish Executive, 2007). Thus, all employment-promoting strategies for problem drug users fall under this general category, and, although this client group often requires specialist intervention, these general vocational rehabilitation approaches provide an important framework within which to provide both targeted activities and broader social reintegration work. For example, all clients in contact with drug treatment services will benefit from broad strategies to promote employment-seeking and retention skills, whereas those with additional needs (e.g. long-term worklessness, lack of skills, co-morbidities, housing problems) benefit most from targeted activities.

In general, individually targeted vocational interventions seek to improve both *human* and *social* capital (Koo et al., 2007). ‘Human capital’ refers to those activities that ‘influence future monetary ... income by increasing the resources in people’ (Becker, 1964: 1; cited in Koo et al., 2007, p. 1036). The ability of individuals to increase their human capital through education, training and work experience is influenced by stable housing circumstances, the community where they live and the opportunities available for them. Social capital is related to these latter features and most often, although not exclusively, refers to participation in cooperative social networks and attachment to and endorsement of positive and productive social norms. In Europe, employment, and belief in its positive value to both the individual and the community, is considered an accepted societal norm. Possessing social capital can help create and sustain ties to conventional society by instilling a greater stake and social obligation to others. Successful employment is dependent upon the stability of these factors and a good overall capital resource.

5.1 General approaches

Work in the general healthcare field suggests that for employees wishing to return to work, there is strong evidence that proactive employer approaches to ‘sickness’, together with the temporary provision of modified work duties and accommodation, are

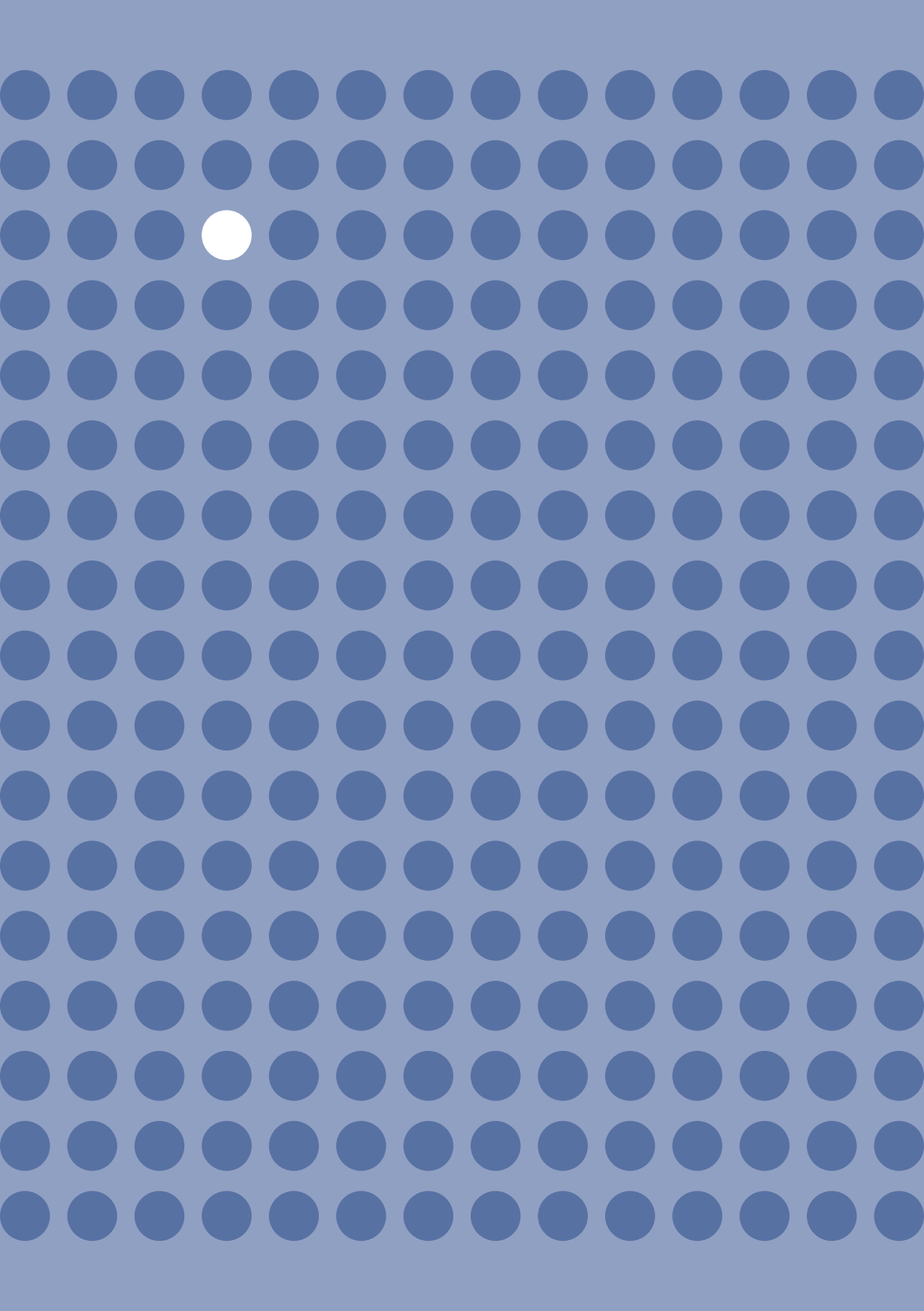
effective and cost-effective ⁽¹⁵⁾. Approaches are more efficacious if they are linked to company policies for health and safety, occupational health, sickness absence management and disability management. However, most evidence underpinning these recommendations was obtained from research conducted with large employers. The evidence for vocational rehabilitation interventions in medium and small enterprises (which may not have well-developed health and safety and occupational health policies) was less strong, but similar strategies are still encouraged.

A key determinant of success is early intervention, as long-term worklessness makes vocational rehabilitation more difficult. A staged reintroduction should begin with simple, low-intensity and low-cost interventions, as these are believed to be adequate for most. More intensive and structured interventions are subsequently provided for those who need additional help. This approach allocates finite resources most appropriately and efficiently to meet individual needs. Effective vocational rehabilitation depends on communication and coordination between all key stakeholders including the individual, healthcare and other services (including drug treatment services), and the workplace.

Specific evidence gained through systematic reviews exists for some client and patient groups, although these have not reported on outcomes for problem drug users. Whilst the needs of such groups may differ from those of drug users, some of the evidence-based principles applied may be useful when formulating responses for the latter. In individuals with severe illnesses, for example, supported employment (see below) was significantly more effective than extended training schemes in promoting employment outcomes (Crowther et al., 2001). People who had received supported employment interventions were more likely to be employed, earn more, and be working more hours. In a systematic review of employment enhancing interventions for cancer patients (De Boer et al., 2011), it was concluded that there was ‘moderate quality evidence’ ⁽¹⁶⁾ that multidisciplinary interventions involving physical (i.e. interventions that included any kind of physical training), psychological and vocational (person and work-directed) components led to higher return-to-work rates than usual care.

⁽¹⁵⁾ Comprehensively reviewed by Waddell and colleagues (2008), from whom these evidence statements are taken.

⁽¹⁶⁾ Cochrane Collaboration grading of evidence. High quality evidence refers to evidence whereby 75 % of the randomised controlled trials reviewed have no limitations on study design, have consistent findings, direct and precise data, and no known or suspected publication biases. Moderate quality evidence refers to evidence where one of these criteria is not met.





Chapter 6: Drug treatment

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Chapter 6: Drug treatment

As mentioned earlier (Part I), 'employability' describes the combination of factors and processes that enable people to progress towards or get into employment, to stay in employment and to move on in the workplace (Keane, 2007). However, employability programmes can engage realistically only with those clients who have achieved a consistent state of stabilisation and are in good health and secure accommodation (Kemp and Neale, 2005). In this respect, the primary function of drug treatment is the stabilisation of problem drug use, and thereby it contributes indirectly to enhancing the employability capital of recovering drug users.

In the EU, drug treatment can be broadly categorised according to its setting (outpatient, inpatient, residential and prison treatment units) and/or the intervention type (detoxification, substitution/maintenance treatment and psychosocial interventions). (For an overview of drug treatment availability in Europe, see EMCDDA, 2011a.) For the purposes of this report, this section includes only approaches for which research has reported employment outcomes but the intervention itself does not necessarily include specific employment-promoting components (e.g. vocational training). Employment outcomes are generally secondary outcomes (in contrast to levels of drug use, mortality, etc.) and are generally included in studies of treatment approaches in order to ascertain the cost-effectiveness of drug treatment, and the quantification of economic and social benefits of drug treatment. Approaches are also considered in this report if they directly target employability-related factors or have been subject to scrutiny by expert groups with respect to potential implications for employability. It is recognised that other treatment modalities (e.g. detoxification/assisted withdrawal, residential programmes for specialised target groups, peer support and mutual-help groups) exist that make important contributions to treatment outcomes, but these have not been investigated or discussed with respect to employability outcomes, and so are not described in detail here.

The Drug Treatment Outcomes Research Study (DTORS) was one example of European research with encouraging results regarding employment (Jones et al., 2009). This study investigated drug use, health and psychosocial outcomes in 1 796 English drug users attending a range of different types of treatment service. Follow-up interviews were conducted between 3 and 13 months after baseline (soon after initial treatment entry). Regardless of the type of treatment received or drug

use outcomes, employment levels increased from 9 % at baseline to 16 % at follow-up. This was accompanied by a corresponding increase in the amount of legitimate income earned per week. The proportion reporting being unemployed but actively looking for work decreased slightly from 27 % to 24 %, reflecting the increase in employment and a 5 percentage point increase in those reporting being unable to work (because of long-term sickness or disability). The proportion of participants classed as unemployed and not looking for work also fell from 24 % to 11 %. Treatment attendance was also associated with changes in housing status; the proportion staying in stable accommodation increased from 60 % to 77 % at follow-up. It should be noted that the findings of this study were weakened by use of a non-experimental design, failure to separate outcomes according to client type and treatment modality, and insufficient detail on the nature of the employment obtained.

The Drug Outcome Research in Scotland (DORIS) study of treatment in Scotland reported that, 33 months after entry, only around 10 % of the sample ($n = 1007$) were currently legally employed, although around 20 % of the sample had reported work in the previous 18 months (McIntosh et al., 2008). Factors such as receiving assistance to enter training or education were the best predictors of employment. Age, dependence severity and criminality inversely predicted employment. Treatment modality (prison-based treatment, residential rehabilitation or methadone prescription) did not appear to be related to outcomes but, interestingly, although participants in residential rehabilitation were more likely to access vocational services, they were not more likely to gain employment.

In a recent secondary analysis of a national US survey of clients conducted in the early 1990s (National Treatment Improvement Evaluation Study), researchers tried to identify which types of treatment modality (methadone-substitute prescribing, methadone-assisted detoxification, outpatient detoxification, short-term residential, long-term residential or criminal justice focused) and treatment characteristics (e.g. length of treatment) were associated with better employment outcomes (Dunlap et al., 2007). Overall, the treatment modality received and the characteristics of that treatment (such as length of stay or number of sessions completed) were not significantly associated with employment outcomes. The strongest predictor of employment was pre-treatment employments. The authors hypothesised that receipt of treatment services per se was less important than the quality of services received, although this was not tested.

6.1 Substitute prescribing

Substitute prescribing is the controlled prescribing of medication (usually opioids) to illicit drug users, usually heroin users, as part of an overall care plan. The aim of substitute prescribing is to reduce or eliminate illegal drug use and/or to reduce negative health and social consequences of use. Opioid substitution treatment is an effective intervention for the treatment of heroin dependence, as it retains patients in treatment and decreases heroin use better than treatments that do not utilise OST (e.g. Mattick et al., 2009).

Opioid substitution is the most common type of treatment for opioid dependence in Europe, typically integrated with psychosocial care and provided at specialist outpatient centres. Fourteen countries report that it is also provided by general practitioners (EMCDDA, 2011a). In some countries, general practitioners provide this treatment in a shared-care arrangement with specialist treatment centres. The total number of opioid users receiving substitution treatment in the European Union, Croatia, Turkey and Norway is estimated at 700 000 in 2009 (EMCDDA, 2011a). Methadone is the most commonly prescribed opioid substitute, received by up to three-quarters of substitution clients. Buprenorphine-based substitutes are prescribed to up to one-quarter of European substitution clients, and is the principal substitution drug in the Czech Republic, France, Cyprus, Finland, Sweden and Croatia (17). Treatments with slow-release morphine (Bulgaria, Austria, Slovenia), codeine (Germany, Cyprus) and diacetylmorphine (Belgium, Denmark, Germany, Spain, the Netherlands, the United Kingdom) represent a small proportion of all treatments.

Unfortunately, no systematic review on the effectiveness of OST has included employment-related outcomes in its meta-analysis. Individual studies, however, have also shown that the likelihood of gaining and retaining employment is increased for clients in OST (e.g. Bilban et al., 2008; Skinner et al., 2011), but evidence is generally inconsistent. For example, the Predictors, Moderators and Outcome of Substitution Treatments (PREMOS) study in Germany showed promising results regarding employment (Wittchen et al., 2011a,b). The naturalistic prospective longitudinal study followed a sample of initially 2 694 eligible substitution patients, recruited from a nationwide representative sample of institutions, over a time period of up to 7 years. The aim of the study was to track changes concerning clients'

(17) See Table HSR-3 in the EMCDDA 2012 *Statistical bulletin* at www.emcdda.europa.eu/stats12/hsr

mortality, morbidity, treatment retention, drug use, psychosocial status and delinquency, as well as to determine predictors and moderators of retention and treatment success. Follow-up assessments were made at 12 months and six years after baseline (final sample size 1 624 clients). The authors found a significant improvement regarding clients' employment rates. The proportion of employed clients increased from 24 % at baseline to 34 % at six-year follow-up, and the proportion of those receiving education, training or vocational rehabilitation increased from 8 % to 19 % in the same time period. Conversely, the proportion of unemployed clients decreased from 52 % to 42 %. Improvements were also visible on all dimensions of the Addiction Severity Index (ASI), including a slight improvement in the mean scores from 3.88 to 3.01 on the employment/support dimension. However, the significance of these findings is weakened by methodological issues, including the lack of a control group; hence, it is not possible to attribute these improvements to the receipt of (substitution) treatment.

6.2 Psychosocial interventions

Psychosocial interventions may include a range of different interventions, such as structured counselling, motivational enhancement, case management, care coordination, psychotherapy and relapse prevention.

6.2.1 Case management approach

Case management includes those strategies in which a single case manager is responsible for linking patients with multiple relevant services. Basic activities include assessment, planning, linking, monitoring and advocacy. Case management models include brokerage case management (whereby the manager helps the client identify his or her own needs and 'brokers' access to relevant services); generalist/intensive case management; assertive community treatment (which provides assertive outreach and counselling); clinical case management; and strengths-based case management (which focuses on self-direction and the use of informal networks rather than agency resources) (Hesse et al., 2007).

One recent systematic review (Hesse et al., 2007) examined 10 randomised controlled trials (RCTs) that had studied the effectiveness of case-management approaches on a range of outcomes in substance-dependent individuals. The review identified only one study that had been conducted in Europe (German research examining substance use outcomes); the rest had taken place in North America. The

authors concluded that, although this approach was successful in establishing links with other services, there was no evidence that these types of intervention produced positive outcomes in recipients (including employment and income) or led to reduced substance use. However, as employment outcomes were mentioned in only one of the studies reviewed (in a population of 'street' alcohol drinkers; Cox, 1998), further research may show this approach to be effective for other types of problem drug users.

Example of case management approach in reporting countries

Since 2008, the Diagnoses Institute (ISD) has run a programme in Austria for the social reintegration of problem drug users. It includes an addiction-related diagnosing process in which social work as well as medical and psychological services are integrated, with a focus placed on returning to work. If a temporary inability to work is diagnosed, the client may be referred to Standfest, a project run by Dialog, which aims to facilitate employability. For clients who are assessed to be fit for work, the existing services include case management, which is implemented by Berufsbörse (WBB, Vienna Job Exchange).

6.2.2 Residential treatment

Residential treatment and rehabilitation programmes are inpatient services, i.e. whereby participants are required to live in a hostel, home or hospital unit. They usually provide a range of (intensive) psychosocial interventions, group work, practical and vocational activities, and structured programmes of daily activities, which residents are (usually) required to attend. Programme models differ and may be offered on both a short- and long-term basis, and be tailored to specific client groups (e.g. parent and child programmes). Some residential rehabilitation programmes include detoxification. No review-level evidence was found that reported on employment outcomes, but individual studies suggest that residential intervention models have the potential to improve employment outcomes (e.g. Rosenheck and Seibyl, 1997; Slaymaker and Owen, 2006; Smith et al., 2006).

6.2.3 Community Reinforcement Approach and contingency management

The Community Reinforcement Approach (CRA) is a comprehensive behavioural treatment package that focuses on the management of substance-related behaviours and other disrupted life areas. It provides a range of skills training, including

problem solving and assertiveness, family relationships and vocational and employment counselling (e.g. Higgins et al., 1993). A systematic review of the effectiveness of CRA on various drug addictions (alcohol, cocaine, opioids) concluded that there was strong evidence of effectiveness for CRA treatment with contingency management (CM) aimed at cocaine abstinence (Roozen et al., 2004). Contingency management is an intervention model whereby particular client behaviour is reinforced (rewarded or punished) in accordance with a treatment plan. For drug treatment, this may include monetary incentives (in cash or vouchers) for negative urine toxicology. One RCT investigated the effect of CRA plus CM in cocaine-dependent users on employment outcomes and found CRA plus vouchers was significantly better than vouchers alone in terms of improved treatment retention and employment rates (Higgins et al., 2003). Although rarely applied in Europe, CRA and CM have been evaluated both in the Netherlands⁽¹⁸⁾ on methadone-dependent clients with cocaine problems and in Spain on cocaine-dependent clients (e.g. García-Fernández et al., 2011). In both countries, studies have yielded positive results with regard to a number of outcomes, including employment-related outcomes.

Making treatment services work-friendly

It is evident that drug treatment should not constitute a barrier for problem drug users to access or retain employment. However, barriers to employment for drug users in treatment (section 3.3 in Part I) may include the requirement to attend treatment on a daily basis, the inadequate opening hours of treatment services (e.g. pharmacies) or limited geographical coverage of treatment services (EMCDDA, 2010a). Moreover, it has been found that one of the reasons why employers are hesitant to employ drug users in treatment is that they would not want employees to take time off to attend treatment sessions (UKDPC, 2008a). Therefore, one way to increase the employability of drug users in treatment could be to ensure that treatment services offer greater flexibility (e.g. longer opening hours, possibility of appointments outside regular working hours, less stringent regulations for take-home doses of OST).

⁽¹⁸⁾ http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=NL0802&tab=overview

6.3 Summary

Drug treatment is widely available in the EU, especially detoxification, psychosocial interventions and OST, with (outpatient) OST being the predominant treatment modality in most countries. Although there is strong evidence that different types of drug treatment can stabilise (illicit) drug use, reduce some of the associated harms (e.g. BBV ⁽¹⁹⁾ infection), and improve some aspects of social functioning, there is a lack of evidence demonstrating that standard drug treatment improves employment outcomes in recipients. This represents a lack of high-quality research in the area, rather than a conclusion that drug treatment is ineffective in these domains.

⁽¹⁹⁾ A blood-borne virus (BBV) is a virus that is transmitted by blood or body fluids that contain blood.



Chapter 7: Criminal justice

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Chapter 7: Criminal justice

Offenders may come into contact with drug treatment and/or social reintegration measures at different points in time (e.g. upon arrest or being charged, in court, in prison, upon release) and through referral by different professional bodies (e.g. police, court) (UKDPC, 2008b). Available schemes in the criminal justice system are complex and differ between countries, although generally speaking it is possible to distinguish prison-based services (sections 7.1–7.3) from community-based interventions for offenders (sections 7.4–7.5). In responding to an EMCDDA Survey in 2009, the majority of reporting countries indicated the availability of specific social reintegration efforts in the prison setting and upon release (further details can be found in Annex 2).

7.1 Prison treatment

As in the community, drug treatment in custodial settings is an important step towards social integration, especially when linked to prison education and training programmes. A broad range of treatment services that are available in prisons relate to drug use and its associated problems. These include information on drugs and health, healthcare for infectious diseases, treatment for drug dependence, harm-reduction measures and prison release programmes (see below). Prisoners are entitled to the same level of medical care as persons living in the community, and prison health services should be able to provide treatment for problems related to drug use in conditions comparable to those offered outside prison (CPT, 2006; WHO, 2007). This general principle of equivalence is recognised in the EU through the Council recommendation of 18 June 2003 (Council of Europe, 2003) on the prevention and reduction of health-related harm associated with drug dependence, and the EU drugs action plan (2009–12) calls for its implementation.

According to a 2008 review for the Directorate-General for Health and Consumers (DG SANCO) on health and social services for drug users in European prisons, the provision of psychosocial treatment programmes in prison is available in all European countries but the availability varies considerably between and within Member States. Regarding opioid substitution treatment in European prisons, 24 Member States (and Norway) have officially sanctioned this treatment modality in prisons (EMCDDA, 2010a). Here as well, quality and availability of this treatment modality varies greatly between and within Member States.

Given the small number of studies conducted, there is limited evidence of drug treatment interventions in the custodial settings (Paylor et al., 2010; Hedrich et al., 2012). Additionally, the present review identified no studies reporting employment outcomes of prison treatment; most studies of outcomes focused on the effect of drug treatment on recidivism and reincarceration.

7.2 Prison vocational education, training and aftercare programmes

Vocational education and training in prison settings are effective interventions and important components of the range of interventions that enables prisoners, including prisoners with problem drug use, to gain employment after release (Hawley, 2011). In return, securing employment has been shown to be a main factor in preventing reoffending (Skardhammar and Telle, 2009). Vocational education and training in prison settings have benefited, in terms of policy awareness and wide sharing of best practices, from general EU-funded initiatives such as the EU's Lifelong Learning programme (LLP), particularly the Grundtvig programme, as well as the former Community Initiative 'EQUAL' and other European initiatives ⁽²⁰⁾. Although such programmes generally do not target drug users specifically, they are indirectly beneficiaries of these programmes due to their over-representation in custodial settings (Stöver and Michels, 2010). Nonetheless, an EMCDDA 2009 survey indicated that 19 Member States provide specific social reintegration interventions for drug users in prisons (see Annex 2 for further information on the EMCDDA survey and availability of interventions).

However, as in the community, the wide range of problems experienced by problem drug-using offenders cannot be solved by assistance with employment alone. Appropriate tailored 'integrated' approaches need to be developed. Such integrated programmes could involve drug treatment alongside educational and/or vocational training as well as support with securing accommodation and support services on release. Reviews of reintegration programmes suggest that a broader or more integrated approach, going beyond any individual intervention, is most effective in reducing reoffending and enabling participants to secure employment (Lipsey, 1995;

⁽²⁰⁾ http://ec.europa.eu/education/grundtvig/doc/conf11/doc3-esf_en.pdf

Gaes et al., 1999; McGuire, 2002) ⁽²¹⁾. However, it is also important to consider that, regardless of the quality of programmes or the commitment of staff or inmates, programmes have little influence over wider economic factors such as general high unemployment rates (Crow, 2000). In order to maximise effectiveness, integrated approaches should also include aftercare or throughcare activities. These activities aim at linking services that problem drug users have received in prison with those available in the community upon their release and refer ex-prisoners to appropriate drug treatment services and additional services that promote treatment retention and social reintegration such as housing, education, employment advice, advocacy, family liaison and general healthcare services. Overall, data on the availability of throughcare programmes in Europe are scarce. A recent EU-funded project, entitled 'EU Throughcare', investigated effective throughcare for problem drug users and explored the provision of rehabilitation and throughcare programmes for prisoners who are problem drug users in Europe ⁽²²⁾. Although limited, existing information indicated that the capacity of such activities is limited (e.g. the total capacity of social reintegration centres for released prisoners in Greece is 52 places), they are limited geographically to large cities or they fail to address specific needs of ethnic minorities (e.g. problem drug users from Roma communities in Bulgaria).

7.3 Parole management

Parole management consists of specialist activities, often delivered as part of prison release programmes (see point 3.2 above) whereby problem drug users with criminal convictions are paroled into drug treatment services. Assessments and referrals are made by specially trained parole officers, who act as case managers, but usually with a reduced caseload and working in partnership with a range of professionals representing treatment and vocational services.

7.4 Referrals into community-based treatment

This intervention refers to community-based treatment that accompanies or replaces a custodial sentence (diversion from prison) ⁽²³⁾. Referrals may be statutory or non-

⁽²¹⁾ <http://webarchive.nationalarchives.gov.uk/20110218135832/http://rds.homeoffice.gov.uk/rds/pdfs04/hors291.pdf>

⁽²²⁾ <http://www.throughcare.eu/index.html>

⁽²³⁾ Note that, although referrals into community-based treatment are often called 'diversions', not all such activities are truly diversionary as they may take place *in addition* to a prison

statutory and are usually made for drug-related offences or if drug use or dependence appears to be the underlying cause of committing the offence; hence, treatment is assumed to reduce the likelihood of reoffending. In the EU, referral by the criminal justice system is the second most common route to outpatient treatment, surpassed only by self-referral (EMCDDA, 2010a) ⁽²⁴⁾. Referrals can be made at any stage of processing the offence. ‘Alternatives to prosecution’ describes activities that divert the offender from the criminal justice system at an early stage, whereas ‘alternatives to imprisonment’ or ‘custody diversion’ refer to diversionary activities at later stages in the judicial process.

‘Pre-charge diversion’ and ‘arrest referral’ are terms generally used to describe the process of assessing and engaging a (suspected problem drug-using) offender prior to or soon after arrest and, if necessary, facilitating the prisoner’s referral into treatment or other diversionary activity. Studies of such schemes tend to focus on outcomes relating to treatment uptake and retention, whereas employment outcomes are not usually reported (arrest referrals in the UK are reviewed by Mair and Millings, 2010). A UK study of drug treatment and testing orders indicated that those who had completed (or who were near completion of) the corresponding programme reported improvements on a variety of domains, including personal relationships, employment, education and training, confidence and self-respect (Turnbull et al., 2000); however, only few offenders managed to complete the programme and employment outcomes were not independently validated.

Once the offender has been charged, treatment can be made a condition of probation, release on bail or pretrial custody. Treatment can also be court-mandated as part of a community sentence; such measures are often explicitly designed to replace prison sentences (for specialised drug courts see next section). The offender must usually comply with the treatment requirement if he or she wishes to avoid further prosecution and a more severe sentence. Evidence suggests that compulsory (or quasi-compulsory) treatment is at least as effective as voluntary treatment and that legal compulsion can improve treatment retention (reviewed by Schaub et al.,

sentence. Moreover, the term ‘community-based’ is used here to highlight that treatment does not take place in the prison. In this broad meaning, this includes treatment in other settings (e.g. residential) that would not typically be described as ‘community-based’. Referrals into community-based treatment upon release from prison are included under sections 3.2 and 3.3. ⁽²⁴⁾ See EMCDDA (2010b) for an overview of relevant international and EU policy and legislation as well as schemes in EU Member States.

2010). However, such evidence must not be used to justify breaches of ethics and human rights abuse (for a critique of compulsory treatment see, for example, Anokhina et al., 2005). The European quasi-compulsory drug treatment (QCT) study investigated court-mandated treatment in Germany, Italy, Austria, the United Kingdom and Switzerland (Schaub et al., 2010). In this quasi-experimental study the QCT group was defined as participants receiving treatment on court order (in- or outpatient), as an optional alternative to imprisonment or other punishment, in a regular treatment institution. Although treatment modalities, type of order and stage of delivery in the criminal justice process differed between participating countries, overall, QCT produced significant improvements in employment outcomes (mean working days in last month) at 18-month follow-up. Similar improvements were seen in substance use and reported criminality. Furthermore, these improvements were similar to those reported by participants in voluntary treatment (delivered by the same facilities) indicating that (quasi-)compulsory orders are an effective strategy for social reintegration.

Where referrals into community-based treatment are made, special attention must be paid if treatment groups consist of offending problem drug users and non-offending problem drug users, or respectively clients whose attendance is court-mandated and clients who have entered treatment voluntarily. Although many offending problem drug users entering treatment are highly motivated to change their life, there is also some evidence to suggest that the presence of unmotivated individuals (i.e. who attend treatment simply as a measure to avoid prison) can negatively affect (e.g. demotivate) other clients in the group (UKDPC, 2008b).

7.5 Drug (treatment) courts

Drug treatment courts are courts that specialise in dealing with drug-related offences and drug-dependent offenders. Drug courts aim not to 'punish' offenders but to reduce offending behaviour and support integration by referring offenders to drug treatment. In the drug court, specialist judges determine the treatment of offenders and they may also mandate further activities such as vocational training. Adherence is encouraged by use of sanctions and rewards and by seeking to establish a relationship between the offender and the court. For example, continuity of staff is ensured by assigning a judge to the case until its closure. Multidisciplinary collaboration in treatment planning is also a feature of drug courts. Adherence is monitored through a range of activities, which usually include regular status

hearings, drug testing and probation supervision. The fact that drug courts retain supervisory power over the offender during treatment distinguishes this type of 'diversion' from those activities described in the previous section (Freiberg, 2009). Upon successful completion of treatment (and other mandated activities if any), original offences may be discharged or suspended or sentences may be reduced.

Drug courts originated in the USA in the late 1980s to relieve regular courts from an increased caseload dealing with drug-related offences, and have been subject to numerous evaluations ⁽²⁵⁾. Drug courts have also been introduced in several other countries, including Australia and Canada (in both countries the first drug court opened in 1998) ⁽²⁶⁾. In Europe, the first drug courts started in 2001 in Ireland, Scotland, and England and Wales; since then, Belgium and Norway have also introduced them.

The Drug Treatment Court in Dublin, Ireland, deals with non-violent offenders in whom drug dependence is thought to be the underlying cause of offending behaviour. The judge is supported by a multidisciplinary team comprising at least the drug court coordinator, a probation officer, a police officer, a nurse and an education coordinator. Upon admission, participants must abstain from their main drug. Although treatment itself is mandatory, offenders can choose from a range of treatment options. Participants are also required to take part in counselling and group work as well as educational and/or other community-based programmes (Department of Justice, Equality and Law Reform, 2010). Progress is measured by distinguishing three phases (stabilisation and orientation; continuation and progression; reintegration and self-management). The most recent review (Department of Justice, Equality and Law Reform, 2010) found that, between 2001 and 2009, 374 offenders were referred into the drug treatment court, out of whom 200 offenders (53.5 %) were deemed suitable for the programme ⁽²⁷⁾. Of these, only

⁽²⁵⁾ The National Association of Drug Court Professionals (NADCP) in the USA recently noted that 'In the 20 years since the first Drug Court was founded in Miami/Dade County, Florida, more research has been published on the effects of Drug Courts than on virtually all other criminal justice programs combined' (Marlowe, 2010, p. 8).

⁽²⁶⁾ The International Association of Drug Treatment Courts (IADTC) aims to provide an overview of available drug courts worldwide at <http://www.internationaldtc.org/countries>

⁽²⁷⁾ Identified reasons for low referral rates included eligibility restrictions (e.g. age restrictions, violent offences excluded) as well as lack of awareness among traditional judges of the possibility of referring offenders to the drug court. Addresses outside the defined catchment areas accounted for over 90 % of cases that were deemed unsuitable for the programme (Department of Justice, Equality and Law Reform, 2010). Eligibility criteria have since been revised.

29 participants (14.5 %) completed the programme ⁽²⁸⁾; this statistic did not allow a robust evaluation of the drug court's impact on offenders.

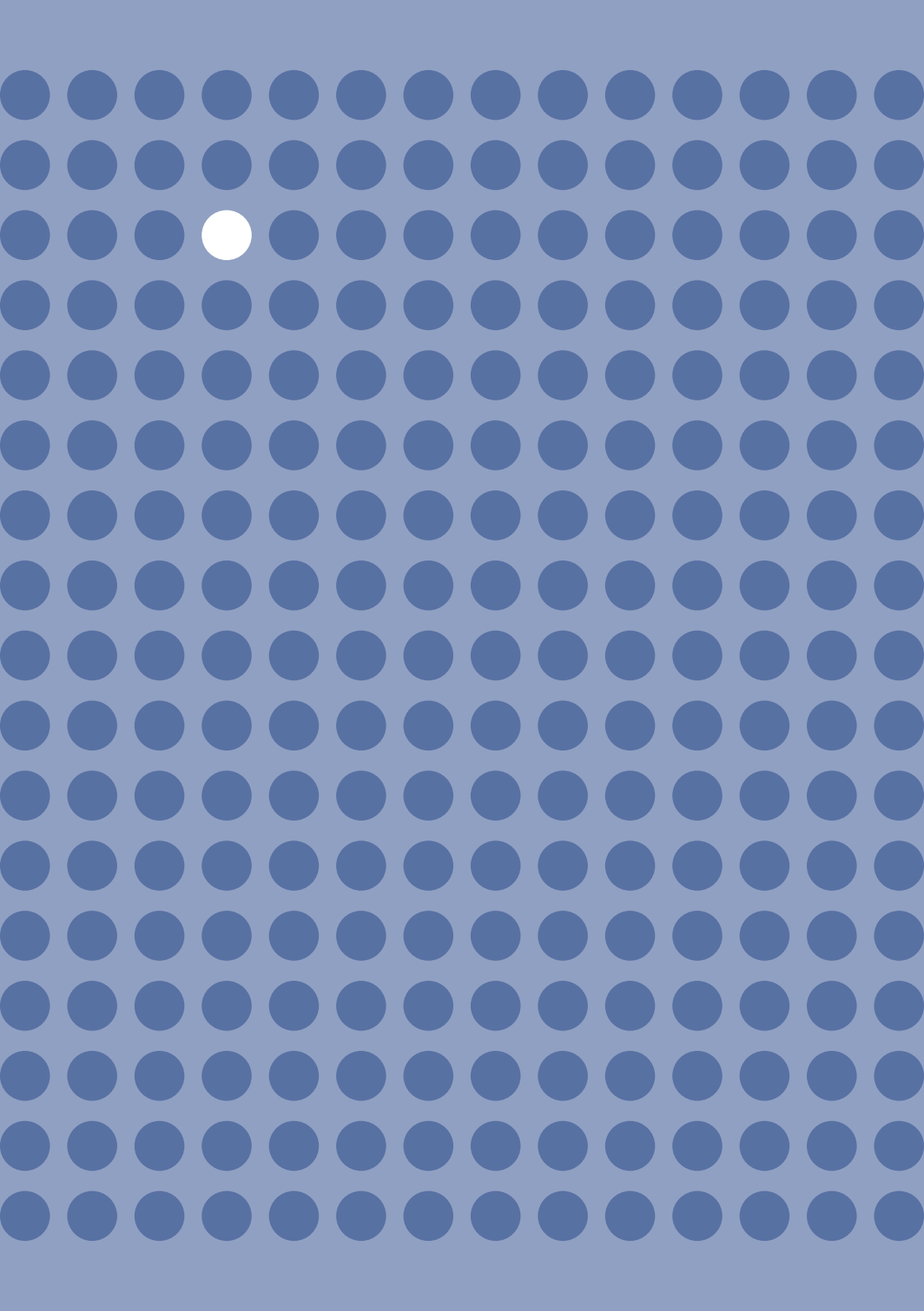
Unfortunately, even though training and employment activities may be included in the treatment plans set up by drug courts, evaluations of drug courts (as with drug interventions in the criminal justice system more generally) often focus on rates of reoffending and drug use as measures of effectiveness, whereas employment outcomes are not typically included (for a review of the effectiveness of drug courts, see Moyle, 2003). In a survey among drug courts in 12 countries, only the USA, Canada (Toronto) and Mexico stated explicitly that employment-related criteria are used to measure the effectiveness of drug courts (Cooper et al., 2010). For example, a multisite evaluation of a sample of 23 adult drug courts and six comparison sites from eight states located in the USA found that, at 18-month follow-up, participants were significantly less likely than comparison offenders to report a need for employment, educational services and financial assistance (Rossman et al., 2011a). The results also suggested that participants were slightly more likely to be employed or in school at 18 months (66 % vs. 60 %), and averaged a higher annual income; however, differences were modest in magnitude and not statistically significant. Positive effects were also seen in a small RCT conducted at county level in the USA (Webster et al., 2007). Attendance at court-mandated vocational training was associated with a reduction in substance use as clients entered full-time work. As earnings increased, self-reported substance use also decreased. Improved employment rates also appeared to prevent post-treatment criminal recidivism in another drug court evaluation (Sung, 2001).

However, it has been argued that US evidence should not be readily applied to the European context as effectiveness can be influenced by differences in the legal frameworks around drug-related offences or how drug courts are structured and implemented. The lack of employment outcomes in European drug court evaluations therefore limits the evidence that can be presented in this section. Finally, guiding principles and good practice recommendations for drug treatment courts have been developed by a series of organisations including UNODC (2005) and IADTC (n.d.).

⁽²⁸⁾ Similar completion rates have also been found in Canadian drug courts (Public Safety Canada, 2007, 2008).

7.6 Summary

Even though the majority of countries report the availability of specific social reintegration efforts in the prison setting and upon release, there is an overall lack of insight on the nature and coverage of these activities. Furthermore, there is little high-quality research evidence of what may work in prison and aftercare settings, although several countries have developed, or are in the process of developing, new strategies to improve prison-based care. Better evidence exists from drug courts and court-mandated treatment. A growing body of evidence suggests that diverting drug-using offenders into treatment services leads to an improvement in employment outcomes. However, most of this research has originated in the USA and Australia.





Chapter 8: Housing

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Chapter 8: Housing

There is a complex relationship between substance use, homelessness and other housing needs; they are seen as mutually reinforcing and often result from the same disadvantages and inequalities (see Pleace, 2008, for a comprehensive overview). Although fully independent living and sustained employment in paid work may not be a practical goal for some vulnerably housed and homeless people with a history of substance misuse (particularly those with multiple needs and co-morbidities such as severe mental illnesses), it is recognised that housing stability makes achieving employment more likely (Ferguson, 2004). Supporting problem drug users in finding stable accommodation requires a range of interventions, from assistance with rent arrears and finding a deposit to assistance in finding emergency or transitional accommodation and supported housing, as problem drug users can struggle to access and sustain accommodation on the open housing market. Accommodation needs may arise, for example from homelessness, being in unstable or temporary accommodation (e.g. staying with a relative or friend) or breakdown of relationships, after leaving residential treatment services or upon being released from an institution (e.g. prison, hospital). It is not within the scope of this report to review individual interventions that aim to reduce homelessness in problem drug users, but Somers and colleagues (2007) concluded that, although most studies have been conducted in community settings in the USA, there is sufficient evidence to suggest that housing provision for substance users had positive effects on a variety of social outcomes including employment. There is insufficient evidence to differentiate between different models of housing but an important feature of most successful models of provision was accessibility and flexibility to add in additional support in response to individual needs.

The findings from the EMCDDA Structured Questionnaire 28 indicated that national social protection and inclusion plans did not specifically address the accommodation needs of drug users in the majority of reporting countries, but these needs were addressed in other plans or as part of other targeted vulnerable groups. The majority of countries reported the availability of housing interventions that were accessible to drug-using populations, albeit usually only upon fulfilment of certain conditions. Further details on policies to address the housing needs of drug users and the availability of particular housing approaches can be found in Annex 2.

8.1 Temporary housing and emergency accommodation

In this report, 'temporary housing' and 'emergency accommodation' refer to services that target problem drug users who are homeless or at immediate risk of becoming homeless. The hostels satisfy clients' physical needs by offering a bed and food. They may also offer additional services such as counselling, access to health services or social activities. While the aim of such projects is to provide a temporary solution for those with the most pressing housing needs, staff may also support clients with finding and moving into more appropriate housing, such as supported housing, social housing or independent accommodation, as defined by their individual needs.

Although such services intend to provide short-term accommodation, owing to a shortage of other housing options (most European countries reported in EMCDDA Structured Questionnaire 28 that need was greater than demand), clients may remain in temporary housing for several years while waiting for a place to become available in supported housing or social housing (UKDPC, 2008a). Also, in order to protect homeless women with or without children from violent environments, including within male-dominated emergency accommodation services, a number of countries, including France, Germany, Austria and the United Kingdom, have set up women-only emergency accommodation facilities (see also the box on 'Good practice guidance on hostel accommodation'). However, the demand for safe emergency housing environments for homeless women and their children probably far exceeds the available offer.

Examples of this approach in reporting countries:

- In Denmark municipalities have entered into agreements with council housing organisations in order to let empty flats to individuals trying to reintegrate into society. These flats can be offered to problem drug users who have been living in supported accommodation (see below), inpatient treatment facilities or other kinds of residential setting. Drug users who do not fit into or who do not feel comfortable in traditional housing arrangements are offered places in settings referred to as 'alternative homes'.
- In Spain, the *Proyecto Hombre* Association provides emergency residential facilities for problem drug users who are undergoing treatment or who have recently completed treatment but are in need of accommodation prior to starting a completely self-dependent life.

- A project in Luxembourg called *Les Niches* provides accommodation for problem drug users. Approximately 35 flats and apartments are rented by a drug treatment centre and provided to problem drug users through individualised rental agreements. One of the aims of the project is to allow clients to take over the rental through their own finances in order to provide stable accommodation. The project is jointly financed by the Ministry of Health, the National Fund against Drug Trafficking and the City of Luxembourg.

Good practice guidance on hostel accommodation

Based on the views of homeless drug users, Stevenson and colleagues (2011) developed a list of good practice recommendations for hostels housing recovering and/or current drug users. The guidance highlights the need for good-quality housing (e.g. condition and cleanliness of facilities); provision of basic amenities (e.g. toiletries); flexibility of rules (e.g. regarding curfew, meal times, visitors); a recovery-oriented environment (e.g. separation of drug-using and non-using residents, prohibition of open dealing); tailored support for residents (e.g. medical services, treatment, harm reduction advice, further social reintegration activities); respect for residents' privacy (e.g. in relation to room searches); and the professional conduct of staff (e.g. friendly, non-stigmatising, abstinent). In addition, as noted above, a protective and safe physical and psychological environment for more vulnerable groups (e.g. women) has to be assured.

8.2 Supported housing: halfway houses and supported living

'Supported housing' refers to housing services targeted at clients who are not (yet) able to live in complete independence, including transitional housing as well as (permanent) supported living. There is great variation between services in terms of project aims, populations served (e.g. drug- and alcohol-dependent individuals, drug users with poor mental health, young people, women), admission criteria (e.g. whether or not abstinence is required), house rules (e.g. curfew, mandatory activities), their level of integration into the community, duration (e.g. as a short- or long-term solution), etc. Depending on the service, clients may be allocated a single room, a self-contained or shared flat, or a place in a shared house. Additional services, such as counselling, treatment or vocational training, may or may not be offered.

Transitional housing (also halfway houses, recovery homes) is targeted at drug users who have been discharged from an inpatient or residential treatment programme or,

in some cases, prison. The aim is to ensure continuity of care by providing a structured environment for clients until they are ready to live independently in the community. Therefore, residents are usually expected to attend daily treatment or work and pay rent. Halfway houses are typically abstinence-oriented, which means that being drug free is a criterion to gain access to and remain in such projects. This is generally the case in Europe, where, in 17 of the 21 countries that reported the availability of specific housing facilities meeting the transitional accommodation needs of drug treatment clients, there were criteria attached to accessing these services (see the Annexes for more detailed information). These included provision for only clients who had successfully completed (approved) drug treatment (e.g. Denmark, Germany, Ireland, Latvia, Poland, Portugal, Finland; current receipt of methadone maintenance prescription generally allowed) or who were referred by a drug treatment centre (Portugal). In Hungary, it was reported that access to transitional accommodation attached to rehabilitation programmes is conditional on both drug abstinence and current employment. It is reasoned that clients will find it easier to maintain abstinence in a drug-free environment (UNODC, 2008). However, this approach has been criticised because residents who relapse may be evicted and forced to return to living on the streets. The condition that clients should also have completed drug treatment was considered a reason for limited coverage in Hungary. It was reported that in Poland, Slovenia and Finland, the lack of these types of housing services for problem drug users reflected the lack of provision for the population in general.

Although rare in Europe, there also exist housing projects based on the 'housing first' philosophy, which advocates that housing should be offered independent of whether residents are abstinent or in treatment ⁽²⁹⁾. These projects also tend to impose fewer house rules upon residents (typically including the possibility of 'opting out' of receiving any support services). Consequently, transitional housing projects can be distinguished more generally according to whether housing is offered as a reward for abstinence ('treatment first' approach) or stable housing is seen as a condition for recovery ('housing first' approach) (Padgett et al., 2006).

An EU-wide project called Housing First Europe, funded by the Directorate-General (DG) for Employment, Social Affairs and Inclusion, is currently being carried out in

⁽²⁹⁾ The UKDPC (2008a) also reports on a project run by Thames Reach in London, where residents reduce their drug use in preparation for treatment; i.e. housing is offered not after but before treatment.

five European cities: Amsterdam, Budapest, Copenhagen, Glasgow and Lisbon. It will test and evaluate Housing First projects, leading to greater clarity on the potential and the limits of the approach, as well as the essential elements of Housing First projects in different European welfare contexts. It also aims at facilitating mutual learning with additional partners in five 'peer sites' cities where further Housing First projects are planned or being implemented, namely Dublin, Ghent, Gothenburg, Helsinki and Vienna.

Although 'housing first' projects have been criticised by some authors for promoting continued dependence rather than recovery (for a review of limits and risks of housing first from a European perspective, see Pleace, 2011), Padgett and colleagues (2006) highlight that a significant proportion of those residing in 'treatment first' housing projects do not actually comply with the requirement of abstinence. In their US-based randomised longitudinal comparison of clients in a 'housing first' project and clients in a 'treatment first' housing project, they found no significant differences between groups in relation to reported heavy drug use, even though clients in the 'treatment first' project were more likely to be in treatment. In his review, Pleace (2008) also found evidence from the USA that clients were more likely to drop out of abstinence-based services⁽³⁰⁾. The author concludes that a mixed service provision may be most appropriate, so that those who require an abstinence-based approach can be served as well as those whose main priority is housing.

'Supported living' refers to independent apartments with some form of psychosocial support by staff, i.e. the person is supported to live independently in his or her own home. Support is tailored to individual needs and its intensity may therefore range from a few hours a week to 24 hours a day. According to recent EMCDDA data (see Annex 2), supported living is rather uncommon in Europe, with only 13 countries reporting that specific housing facilities were available to meet the supported living needs of people in drug treatment.

Few studies have been conducted with regard to employment outcomes in recipients of supported housing, and findings mostly emanate from the USA. For example, Kerrigan and colleagues (2000) reported that clients (army veterans with substance use disorders) who received supportive housing (alongside vocational training and

⁽³⁰⁾ A longitudinal study of substitution patients in Germany also concluded that a high abstinence orientation in substitution settings may increase the risk of unfavourable client outcomes, including termination of treatment (Witthen et al., 2011b).

workplace therapy in the Veteran Industries Programme) were more likely to report legitimate employment than those who did not receive support. Although the study did not follow an experimental design and so the evidence is relatively weak, logistic regression analysis showed that receipt of the supported housing intervention significantly predicted employment status. In a follow-up study in a subset of 80 clients, it was found that 54 % obtained competitive employment, and that three months later 60 % had maintained this status (Kerrigan et al., 2004). Jobs were mostly entry-level service positions in the hospitality, transport and construction industries.

The housing approaches outlined so far are sometimes combined in ‘staircase’ or ‘continuum of care’ models. Under this scheme, homeless people gradually progress through different stages and (physically) distinct types of housing with the ultimate aim of abstinence and independent living (or, where this is not possible, permanent supported living). This model, however, has been criticised as clients are expected to move from one stage to another within a set time. In particular, it has been argued that the model is based upon simplistic assumptions about the nature of homelessness and drug use, and that it has negative implications for clients, such as losing vital relationships with staff at every transition (reviewed in Pleace, 2008).

Examples of these approaches in reporting countries:

- In Denmark, under Section 110 of the Consolidation Act on Social Services, homeless people are offered shelter in temporary nursing homes. Apart from being a housing service, these homes provide services that prepare and support the users in being able to function in their own homes after ‘discharge’ from the temporary nursing home.
- Merchants Quay Ireland (MQI) provides a transitional housing intervention for former drug users who have completed residential drug treatment. Accommodation is provided for a period of up to 24 weeks. There is an average of 12 residents in the house at any one time.
- In the United Kingdom, housing-related support for drug users is funded through the Supporting People programme, which provides housing-related services to vulnerable client groups at risk of social exclusion. The National Audit Office (NAO) has reported that there is no UK research assessing the efficacy of measures to put problem drug users in appropriate accommodation (NAO, 2010) and since 2010 Supporting People funding is no longer protected.

8.3 Support in finding long-term accommodation

These are services that support drug users with housing needs in finding appropriate long-term accommodation. This could be a place in a supported housing project (if the client is unable to live independently), accommodation in a social housing project (e.g. local council or housing association that offers housing at a low rent), access to property on the independent housing market, or rent/deposit subsidies received as part of treatment participation. Such services may be offered by a range of providers, for example as part of treatment/prison release programmes, temporary and supported housing projects, or employability programmes.

However, finding suitable accommodation may not always be sufficient to guarantee stable housing in the long term. Problem drug users may have spent a long time in institutional settings (e.g. residential treatment centre, prison, hospital). Some may subsequently have difficulties with the challenges of independent living (e.g. isolation ⁽³¹⁾, structuring the day, preparing meals, housekeeping duties, good neighbourly conduct). Consequently, there may be a need for continued support and oversight once independent accommodation has been secured.

8.4 Summary

Findings from EMCDDA data indicated the availability in most reporting countries of different types of housing interventions that were accessible to drug-using populations. There is evidence to suggest that interventions and strategies that improve housing provision for substance users have positive effects on a variety of social outcomes, including employment, but it is not possible to identify which types of approaches are the most effective. There is also a paucity of research regarding housing interventions for problem drug users within the European welfare contexts.

⁽³¹⁾ One of the problem drug users interviewed as part of the UKDPC-commissioned study explained: 'I've seen people be in there, from my own experiences, go onto second stage without support. And they just let them go, and within a week or two, ... they're on the streets, ... because ... first thing, isolation, on their own, when they've been used to people just being around, even though they've not probably connected with them, it's just that surrounding environment' (UKDPC, 2008, p. 27).



Chapter 9: Education and (vocational) training

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Chapter 9: Education and (vocational) training

In this report, 'education' is defined as a specific learning opportunity for former or current drug users. This implies that education is defined as the learning or upgrading of literacy or numeracy skills but does not include specific training for a given kind of job. Vocational training is designed to help participants acquire employment readiness and/or the practical skills and understanding necessary for employment in a particular occupation or trade or class of occupations or trades. Successful completion of such programmes often leads to a labour market-relevant vocational qualification recognised by the competent authorities in the country in which it is obtained (e.g. Ministry of Education, employers' associations).

This section focuses on specialist education and training interventions for unemployed problem drug users ⁽³²⁾; these have varied from brief interventions that emphasise rapid placement of individuals in low-skilled and low-wage jobs, to intensive, long-term interventions that provide education and training to teach participants both basic and job skills needed to acquire educational credentials prior to seeking employment.

The findings from the EMCDDA Structured Questionnaire 28 indicated that national social protection and inclusion plans did not specifically address the educational needs of drug users in the majority of reporting countries, but in some countries these needs were addressed in other plans or as part of other targeted vulnerable groups. The majority of countries reported the availability of programmes or services providing education or vocational training to drug users, although the coverage of these interventions according to the target population's needs appeared to be low. Further details on policies to address the educational needs of drug users and the availability of particular approaches to facilitate access to education and training can be found in Annex 2.

9.1 Vocational training

Vocational training incorporates a wide variety of programmes that aim to support employment-finding strategies, increase self-efficacy, improve commitment to work,

⁽³²⁾ Problem drug users may also access mainstream education, training and employment services; however, these are not discussed in this report.

enhance interview skills and develop transferable (e.g. time management, presentation, self-evaluation) and role-specific (e.g. computer literacy) skills. These are supplemented by schemes that aim to develop skills specific to particular fields or occupations. Training courses are often offered by both drug treatment services and specialist private or state providers (e.g. national employment services).

Regarding evidence of vocational training for recovering problem drug users, the large majority of studies emanate from non-European countries, and limitations regarding the transferability of interventions to European contexts may exist. However, nearly 20 evaluated projects that include vocational training for recovering problem drug users have been submitted by Member States to the European Exchange on Drug Demand Reduction Action (EDDRA) database coordinated by the EMCDDA⁽³³⁾. However, all the evaluations were process evaluations, which look at the progress of clients rather than at the impact or effectiveness of the intervention. Thus, the design of process evaluations does not allow for an assessment of the assumed relationship between the changes in the population and the intervention.

Regarding international evidence of effectiveness, in a comprehensive review of vocational training, Magura and colleagues (2004) concluded that, although there were examples of successful programmes, these were in the minority, and because of differences in approach, study population investigated and outcomes assessed, and a lack of replication, it was difficult to draw conclusions about overall effectiveness. Most interventions reviewed were shown to have no significant effects, limited effects or results that were confounded by poor study design (e.g. small number of participants, no control group). This conclusion was supported by Foley and colleagues (2010), who added that many studies were conducted several decades ago (thus reducing relevance to current policy and drug use behaviours) and, where effectiveness was demonstrated, it was often achieved by individual tailoring of programmes, which meant larger-scale implementation was not financially viable. French and colleagues (2002), however, indicated that where drug treatment centres were able to incorporate vocational training as part of a comprehensive suite of residential services (in this case for pregnant and new mothers) the service was cost-effective with respect to employment outcomes. Overall, for every USD 1 spent, a net saving of USD 3.10 was achieved. In one

⁽³³⁾ <http://www.emcdda.europa.eu/themes/best-practice/examples>

example of an individualised US-based approach, Magura and colleagues (2007) reported that theory-driven, individualised vocational training (where programme activities were not predetermined or manualised) could lead to improvements in paid employment. Regression analysis showed that employment was significantly predicted by prior employment, intervention participation and, importantly, receiving the intervention as intended.

Looking at programmed approaches in more detail, one intensive US programme, the Comprehensive Employment Support, which included individual counselling, job search, supported employment (see below), case management (see above) and other therapeutic interventions for methadone clients, led to a significant increase in paid and informal employment at six-month follow-up (Staines et al., 2004). Kemp and colleagues (2004) reported on the implementation of a number of strategies (job skills development and supported work; life skills development; job training; welfare to work) for parolees under the Helping Offenders to Work (HOW) programme. Although they did not compare employment outcomes between intervention types, overall, 54.6 % of programme participants had secured competitive employment at follow-up.

Other studies have yielded less promising results. Thus, Dennis and colleagues (1993) reported that their systemic development approach to implementing vocational training in drug services produced favourable outcomes with respect to client referrals to services and education, but this was largely site specific, and no effects were found on subsequent client employment rates. Kleinman and colleagues (1997) found that a comprehensive vocational training programme, an intervention based on the Adkins Life Skills employability programme and contingent upon client abstinence from illicit drugs (recipients were methadone maintained), yielded no significant increase in employment outcomes at 18-month follow-up. Other approaches have sought to help clients explore their attitudes and motivations to work, set vocational goals and develop employment strategies in response, but have produced similarly negative results, particularly when baseline differences in outcomes are controlled for (Platt et al., 1993; Karuntzos et al., 1994; Coviello et al., 2004; Lidz et al., 2004; Foley et al., 2010; Zanis et al., 2001).

Findings from a study by Foley and colleagues (2010) suggest that the success of vocational training programmes may largely be dependent upon individual employability factors and the environment in which clients seek work. In other words, programmes may successfully teach employability skills, but completers are still subject to the same economic conditions as other competitive employment applicants.

Examples of this approach in reporting countries:

- In Ireland, the Community Employment (CE) ⁽³⁴⁾ scheme, funded by FÁS, the national training and employment authority, provides 1 000 places ring-fenced for recovering drug users. The scheme operates through local projects in which community and voluntary groups are required to sign service agreements that outline the work programme and the target outcomes for the individuals placed on the CE schemes. The objective is to prepare participants for entry into the labour force, but the outcomes outlined by most projects tend to refer to personal development, improved literacy skills and education capital, and support progression to more specialised training and education rather than help the individual to find employment. (For more examples on Irish approaches, we recommend an overview by Keane, 2007.)
- In Greece, the OKANA Specialised Vocational and Social Reintegration Centre (EKKEE) implements workshops in the areas of photography, information technology, jewellery and decorative item making, landscape gardening, filmmaking, journalism, support in job seeking and remedial teaching of Greek and English.
- Co-financed by the Ministry of Labour and Employment and the European Social Fund, the Centre Emmanuel association in Luxembourg launched the project START in 2007, with the aim of reintegrating drug users into the employment market (Lambrette, 2009). A case management approach is adopted and counsellors provide job coaching and other activities aimed at helping clients to find work or professional training (e.g. establishing contact with companies, preparing job interviews, editing of résumés), and to assist them in their daily work routine (definition of tasks, conflict management, mediation between employee and employer, motivational follow-up, etc.).

9.2 Qualifications

These interventions refer to formalised education whereby the client undertakes examinations and other forms of assessment to gain nationally recognised qualifications.

These types of approaches also include formalised strategies that focus primarily upon educational re-engagement, and aim to allow younger problem drug users to

⁽³⁴⁾ <http://www.fas.ie/en/Communities/Community+Employment/default.htm>

return to educational institutions, where they are provided with both therapeutic and general academic support. Although popular in the USA (e.g. Recovery Schools in the USA; White and Finch, 2006) and extensively written about, few of these programmes have been implemented in the EU (although see 'Second Chance' schools in Germany and Greece) or been subject to rigorous evaluation (see White, 2001), and findings about their effects on subsequent educational and employment outcomes are inconclusive.

Examples of this approach in reporting countries:

- In Denmark, opportunities for catching up on lost schooling are offered through regional Adult Education Centres (VUC). These offer special programmes to those with poor literacy skills and it is also possible to complete primary education and the school-leaving certificate. There are also daytime secondary school programmes offering education to increase the individual's general and technical knowledge and skills, thereby increasing his or her ability and desire to take responsibility for his or her own life and to take part actively in society. For long-term unemployed drug users and other socially marginalised individuals, a national training course has been established ('Next stop job' under the Joint Responsibility II Project). This is targeted towards those who have previously completed education or who have some employment-related competencies. The aim is to rekindle professional competencies in order to improve employment opportunities.
- In Germany, former problem drug users, people at risk of becoming dependent or clients undergoing substitution therapy can earn a secondary school qualification in a 'second chance course' offered by the STEP-Therapy-School in Hanover. In 2008, 26 out of a total of 98 course participants were under 20 years of age, 44 between 21 and 25 years, 18 between 26 and 30 years and 10 over 30 years of age. Most of the associated costs were provided by the social security administration, with the remainder by youth services.

Retraining as drugs workers

This is not a formalised intervention per se, but many problem drug users who have recovered or are in recovery make valuable contributions to drug treatment services after retraining as drugs workers themselves. Clients enter the workplace in the drug treatment field either as volunteers or as specialist workers. A literature review carried out by Doukas and Cullen (2011) found that most research on this topic was conducted in the USA in the 1970s to 1990s, when former problem drug users were employed as 'paraprofessionals' owing to a shortage of professional counsellors. The reviewed literature suggested that employing former problem drug users can increase the credibility of the service for new clients as well as increase clients' motivation; former problem drug users were also found to develop better relationships with clients. However, such schemes do not assume that being a former problem drug user is a 'qualification' in itself, and candidates should be subject to the same scrutiny and requirements as others without a history of substance use (see also section 8.1). Also, the increasing justified call for quality assurance of services through professional accreditation in Europe (Uchtenhagen and Schaub, 2011) may also lead to the systematic exclusion of recovering users from this occupational field and consequently the loss of their personal expertise in the area ⁽¹⁾. In their review, Doukas and Cullen (2011) also note that there is a hesitancy in the field to acknowledge the experience of former drug users, for example because former drug users may be overcommitted to the treatment modality that facilitated their own recovery. Studies have also suggested the existence of an asymmetrical power relationship between those drugs workers with a history of substance use and those without ⁽²⁾. It must also be recognised that for some former drug service users, working regularly with current problem drug users may not be appropriate, as this may increase their risk of relapse or indeed be considered a continuation of dependence (Effective Interventions Unit, 2001). In the United Kingdom, the organisation Addaction offers a training scheme called the NEXT Project, which is specifically targeted at former clients who wish to become professional drug or alcohol workers. The course runs two days a week over a 12-week period and participants can obtain a Level 2 Award from the Open College Network under the Qualifications and Credit Framework (QCF). The training can then be followed up by work placements or enrolment in additional training.

⁽¹⁾ The exception is 12-step groups, where the experience of being a recovering drug user is more likely to be recognised and valued (Doukas and Cullen, 2011).

⁽²⁾ This effect has not only been observed in relation to former drug users. A study of 36 mental health professionals who used to be mental health service users found that they experienced similar forms of discrimination (e.g. not being taken seriously by colleagues and managers) (JRF, 1998).

9.3 Volunteering and temporary work experience placements

Volunteering and temporary work experience placements are often important components of vocational rehabilitation. The objective of volunteering (with respect to the long-term goal of gaining employment) is to allow the individual to gain workplace confidence and self-esteem, acquire new skills and demonstrate to potential employers that they are able to adapt to the workplace environment. Although volunteering is essentially altruistic in nature (and employers should not see this as a source of free labour), many employers or organisations require candidates to undergo some form of selection, and, as volunteering sometimes precedes temporary work experience, the volunteer may be subject to (informal) performance assessment. Volunteering is not cost-free for host organisations, as recruiting, deploying, supporting and training volunteers requires time, money and management supervision. Volunteers must also consider the opportunity costs of this type of activity. Temporary work experience aims to enhance existing skills and prepares the individual to conduct a specific role, particularly those of a more specialist nature. Selection processes often mirror those of paid employment, and work experience may attract a salary. Both placements are associated with costs to the host organisations. There is some evidence to suggest that work placements and work experience can have positive outcomes for unemployed individuals, including increased likelihood of job entry (reviewed in Hasluck and Green, 2007); however, there is a lack of research relating specifically to the impact of such interventions on problem drug users (see also the box on 'Retraining as drugs workers' on p. 97).

9.4 Summary

Vocational training is a common approach in European countries and it is also one of the most frequently investigated approaches to improve employment and employability in problem drug users. However, although there are examples of successful programmes, many have limited or no effects, and because of differences in intervention approach, study population investigated and outcomes assessed, and a lack of replication, it is difficult to draw conclusions about overall effectiveness.



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Chapter 10: Employment

Although problem drug users can in theory access the employment market through traditional means (e.g. individual job search, mainstream employment services), in practice there are significant barriers that prevent them from securing employment in this way (see Introduction). The following sections therefore focus on specialist interventions that provide a supportive work environment for drug users (see sections 10.1–10.5) as well as the role of drug screening

The findings from the EMCDDA Structured Questionnaire 28 indicated that national employment plans did not specifically address the employment needs of drug users in the majority of reporting countries, but in some countries these needs were addressed in other plans or as part of other targeted groups. The majority of countries reported the availability of general or specific programmes facilitating employment for drug users on the intermediate and the open labour market, although support was commonly offered only to long-term unemployed individuals (typically six, 12 or 24 months). Further details on policies to address the employment needs of drug users and the availability of particular approaches to promote employment can be found in Annex 2.

10.1 Intermediate labour market

The intermediate labour market (ILM) is a supportive system targeted at disadvantaged individuals to bridge the gap between (long-term) unemployment and the open labour market. It is characterised by offering paid work on a temporary contract, together with training, personal development and job search activities (Marshall and Macfarlane, 2000).

Although, depending on the definition of ‘intermediate labour market’, different interventions can be included, it is common to consider social enterprise projects under this heading. These enterprises produce socially useful goods or services and employ groups that face labour market disadvantages. A recent innovation in some European countries (Borzaga and Defourny, 2001), they incorporate paid and voluntary work to provide training, work experience or supported employment to clients. Some social enterprise projects are businesses although they may not necessarily be market or profit led. Social enterprise businesses primarily have philanthropic aims, but are delivered through standard business methods to provide

goods or services, with the attendant economic risk. Social enterprises pay their employees the market rate and adopt employment policies that grant the same rights and promotion opportunities as other sectors (O'Bryan et al., 2000). They differ from standard businesses in that they aim primarily to address social needs through either their products and services or the types of people they employ. Often social enterprises offer limited employment contracts in order to encourage work in the competitive employment marketplace and to ensure that new referrals can be accepted. Many social enterprises are registered as cooperatives, which are owned and controlled by their members. Italy may be considered as an example of good practice in terms of social enterprises for the reintegration into the labour market of disadvantaged people, including problem drug users. There are nearly 3 000 *cooperative sociali* (type B) ⁽³⁵⁾ across Italy, employing 35 000 disadvantaged people, of whom 16 % are recovering problem drug users, the largest group after disabled people (46 %). As in Belgium and Poland, social cooperatives are legally defined in terms of obligations and restrictions. Their objective is the general benefit of the community and the social integration of citizens. Thus, Italian law stipulates that disadvantaged people have to represent at least 30 % of the workforce and if possible become joint owners. Recovering drug users are included by law in the category of disadvantaged people. The latest data available (2005) indicate a yearly turnover of EUR 1.4 billion, reflecting an average turnover per cooperative of EUR 600 000 (ISTAT, 2008). Generated profits are generally distributed among members but distribution is limited by law to no more than 80 % of profits.

Further examples of this approach in reporting countries:

- The De Sleutel organisation in Belgium provides access to social enterprise businesses for current and former problem drug users. The aim of these activities is to provide clients with the opportunity to reintegrate slowly in the 'normal' structures of life. Clients are provided with additional support to address drug dependence, financial problems and interpersonal and other social and relational problems.
- In Spain there are approximately 137 social enterprises aimed at social reintegration, and all are available to problem drug users. The types of work

⁽³⁵⁾ *Cooperative sociali* in Italy are divided into types A and B. Type B cooperatives are dedicated to labour market integration of disadvantaged people. Therefore, only data regarding type B cooperatives are presented here.

offered include gardening, construction, waste recycling, graphic arts, cleaning, laundry, ecological farming, hotel, restaurant and bar work, wholesale products and textiles. Similarly, in Germany, specific ILM interventions are offered by drug-counselling, treatment and social reintegration providers. These organisations provide work opportunities in different fields such as house cleaning, laundry, gastronomy, joinery or home removal.

- The Mano Guru café was established in 2004 and is the only social enterprise workplace for problem drug users in Latvia. Upon completion of drug treatment, clients are able to work in the café for six months and to train to become a chef, waiter or bartender. Upon successful completion of the training, participants receive a certificate and the employer's recommendation and are assisted with their job search. Participants are also provided with training related to general life skills, as well as temporary residence and domestic care alongside. The project also aims to improve public awareness of drug dependence and provide positive representations of drug users and treatment by highlighting their skills and abilities. In 2011, Mano Guru was granted a Responsible and Inclusive Entrepreneur award in the EC European Enterprise scheme.
- A café run by the Mérföldkő Egyesület (Milestone Association) in Hungary (2006–9) was the country's only reported social enterprise business for former problem drug users. The café provided employment for abstinent clients who had completed treatment at the Association's residential centre.
- In Finland, the government provides financial incentives for entrepreneurs to start social enterprises employing vulnerable people, including problem drug users, who would face difficulties in the open labour market.

10.2 Simulated work and contingency management

This type of intervention is similar to contingency management under general drug treatment, but the reinforcer or the contingency behaviour is employment specific (e.g. the reinforcer is a salary, the contingent behaviour is work performance). Benefits are usually conditional on provision of negative urine toxicology ⁽³⁶⁾, but the client must also demonstrate satisfactory employment performance before the reward (employment, salary) is received. The 'workplace' is usually a simulated environment

⁽³⁶⁾ See the box on p. 111 for the ethical issues surrounding drug screening.

set in a treatment centre or university. Although this approach has been designed to promote abstinence (thus effectiveness is usually reported with respect to clinical outcomes, particularly initiation or maintenance of drug abstinence, rather than employment outcomes), it has been included here as it can also improve job skills and later employability. It should be noted that these interventions are more prevalent in the USA than in European countries and the evidence of effectiveness presented below emanates exclusively from outside Europe. This may hinder transferability of such interventions to the European context as factors such as differences in access to financial social support for problem drug users (discussed in Chapter 12) between the USA and European countries and within European countries may affect the strength and relevance of the financial reinforcers and thereby the outcomes of such interventions. For example, in the USA, reception of most social supports is often contingent upon being in drug treatment or being abstinent as revealed through drug testing. Such conditions are rarely applied in Europe, where, although different welfare models exist, a common feature of the European welfare states is that comprehensive social protection is a fundamental right (access to healthcare, housing, social support benefits, etc.).

However, a meta-analysis shows this approach to be effective in promoting abstinence (Dutra et al., 2008) and it is an approach that is also considered acceptable to both policymakers and the public because problem drug users are not considered to be 'rewarded' for abstinence, a behaviour that is ordinarily socially and legally accepted as the norm (Magura, 2011). Some studies have shown that this intervention model can increase employment (e.g. Donlin et al., 2008; DeFulio et al., 2009; DeFulio and Silverman, 2011) or improve precursors to stable employment such as résumé completion, completing job searches, attending job interviews or workplace/professional discipline (Wong et al., 2004a,b; Drebing et al., 2005, 2007). A range of different client groups also seem to benefit from this model, with Silverman and colleagues (2001, also included in the systematic review of Terplan and Lui, 2008) reporting that, in pregnant or post-partum women with a substance use diagnosis, workplace attendance was significantly associated with drug abstinence (there were no between-group differences, meaning that benefits were not unique to this type of client group), although attendance at the simulated workplace was low (mean of 45 % of the population attending per day). In a follow-up study (Silverman et al., 2002) it was reported that 60 % of the participants maintained periods of sustained employment, but it was not possible to compare this directly with a control group (only intervention subjects were provided with access to

the simulated workplace), and so it is difficult to generalise to the competitive workplace. Other studies have shown less favourable longer-term results, with one (Knealing et al., 2006) suggesting that, once study workplace opportunities are withdrawn, rates of competitive employment do not differ from control subjects. Many clients also find it difficult to maintain abstinence during the contingency phase, suggesting that either they are not ready to become drug free or additional support is required (Silverman et al., 2007).

As both clinical and employment 'relapse' can occur after cessation of the intervention it has been suggested that employment that is dependent upon abstinence should also be continued indefinitely by integrating it into competitive workplaces (DeFulio and Silverman, 2011). However, Magura (2011) has argued that this approach is unfeasible and many employers would be unlikely to employ individuals who would be active substance users were it not for the condition of urine testing. Instead, he has suggested that contingency management and other behavioural reinforcement approaches should be considered a treatment modality in itself. According to Magura, the intervention promotes drug reduction/cessation, provides clients with an earned income, develops employability skills and financially supports the treatment service that operates the workplace.

Consequently, an adaptation of contingency management approaches to the European context would require careful consideration of the intervention aims (i.e. abstinence or employment) and possible ethical implications (see also the box on the ethics of social reintegration on p. 105).

Examples of this approach in reporting countries:

- In Greece, social reintegration centres emphasise vocational rehabilitation for problem drug users; in most reintegration structures, finding a steady job within a certain period of time is a condition for remaining in the programme. According to data reported by specialised social reintegration centres, in 2009, 36.7 % of their total clients were already employed at the beginning of the reporting year and 41.2 % found a job during the year.

The ethics of social reintegration

Health and social interventions must not only be informed by scientific evidence of effectiveness, but also be subject to ethical scrutiny ⁽¹⁾. Even the very nature of health and social interventions, regardless of the specific activity, may raise ethical issues. This is because they are designed to change aspects of people's lives based on assumptions on what is 'good' and 'bad'. However, different stakeholders (e.g. clients, general public, government) often have different viewpoints on what is desirable behaviour and what is not. Whereas, in the past, drug treatment clients were often considered ethically non-competent (paternalistic approach), current practice places a greater emphasis on respecting clients' rights, including their right to have a say in what intervention to receive (non-paternalistic client-focused approach) (Anokhina et al., 2005; Svedberg, 2005). Moreover, interventions often focus on members of vulnerable groups who require particular support or protection (in the case of social reintegration, problem drug users who are socially excluded or at risk of being socially excluded). Therefore, the same ethical principles and professional standards that apply in the fields of drug prevention ⁽²⁾, treatment or harm reduction (see Padieu, 2005) should also be taken into account when designing and implementing social reintegration measures.

The most important question is whether social reintegration measures are implemented in the best interest of current/former problem drug users, or primarily because of their positive consequences for the rest of society. This highlights a potential conflict with the ethical principle of autonomy. In the context of health and social interventions, the principle of autonomy describes a respect for an individual's freedom of will and action, particularly the right to self-determination (Beauchamp and Childress, 2001; Naidoo and Wills, 2009) ⁽³⁾. Even the very aim of most health and social interventions in the drugs field — helping individuals stay or become drug free — raises many questions as it limits the autonomy of individuals (Ives, 2005). The principle of autonomy can therefore be in conflict with other ethical principles, most importantly the principle of beneficence or 'doing good'. Consequently, it is often necessary to weigh up the importance of different ethical principles in practice. When responding to drug use, it is common to argue that an intervention is justified if its positive consequences for the individual and for society are likely to significantly outweigh its negative consequences (including those arising from limiting the individual's autonomy). In relation to social reintegration, it is specifically the aim of improving the labour market participation of drug users that requires consideration. Although many drug users do want to work and see employment as an important aspect of a steady life (Neale and Kemp, 2010), it must be recognised that work is not equally important to all individuals and that some individuals may not easily be able to, or may simply not wish to, have a (paid) job. As noted by Sansoy

(2005, p.12) in relation to treatment, 'Recognition of drug addiction for what it really is, a state of dependence, means that the availability of care must be such as to give the drug-using population back its freedom to accept or refuse treatment'. A similar perspective can be taken in relation to employment, arguing that the limitation of drug users' right to self-determination is less justified if the advantages to society outweigh the advantages for the individual. In an extreme view, employability-related social reintegration measures could be understood as a form of discrimination against drug users, as drug users are expected to participate in the labour market whereas some other unemployed groups are not.

Although this report does not discuss the ethics of social reintegration in detail, it highlights those issues that appear to be most salient, such as respecting clients' right to autonomy, ensuring that clients consent to taking part in the intervention and do so voluntarily, and preventing discrimination (see also the boxes on pages 111 and 119). Offering interventions that are tailored to clients' needs (see box on p. 139) is important both from an ethical point of view and to increase the effectiveness of interventions.

(1) As it is not possible to explore the issue of ethics in great detail in this report, interested readers are referred to the Council of Europe's (2005) Ethical eye publication on drug addiction.

(2) Ethical principles for drug prevention activities, for example, have been formulated in the publication *European drug prevention quality standards* (EMCDDA, 2011c).

(3) It might be argued that a rights-based approach overestimates the ability of (some) problem drug users to take responsibility for their own life and to make rational choices. However, it would be a fallacy to dismiss rights-based approaches altogether and revert back to a paternalistic approach to clients. Instead, it highlights the need to tailor interventions to individual needs, resources and aspirations (see the box on p. 139 on adjusting interventions).

10.3 Supported employment

Supported employment is paid work that takes place in normal work settings (on the open competitive employment market) with provision for ongoing support services. Ancillary services may include job coaches, role 'shadowing' and mentoring schemes.

Supported employment approaches are distinguished by six key principles (Crowther et al., 2001; Becker et al., 2005):

1. The goal is competitive employment in work settings integrated into a community's economy;

2. Clients are expected to obtain jobs directly, rather than following lengthy pre-employment training (rapid job search);
3. Employment is an integral component of treatment rather than a separate service;
4. Services are individualised and are based on clients' preferences and choices;
5. Assessment is continuous and based on real work experiences; and
6. Follow-on support is continued after starting a job.

In Portugal, supported employment of recovering drug users is carried out through a state-supported nationwide programme, 'Life Employment' (Programa Vida Emprego, PVE). The PVE is targeted specifically at people with addiction problems, of working age, who are in or have completed a treatment process in a therapeutic community or outpatient care, including drug users undergoing treatment in prison. The PVE aims at promoting social and professional reintegration of people with drug problems as an integral and fundamental part of the treatment process. This is achieved first through coordination mechanisms at national and regional level between the National Institute on Drugs and Drug Addiction and the Institute for Labour and Professional Training, which coordinate the planning and implementation of the programme, particularly between treatment centres and employment offices. Second, mediators financed by the state and associated to the above institutions are in charge of providing continuous support to recovering drug users in accessing vocational training, apprenticeships or work and in providing support in the workplace. The mediators are also in charge of advocacy and engaging employers and businesses to take part in the programme. The programme is made operational through specific measures: the 'stage of socio-professional integration' aims at providing a nine-month training experience in real work conditions. Employers offering apprenticeships are supported through the reimbursement of expenses linked to the provision of guidance and tutoring. The trainees receive the national minimum wage and other social benefits.

An additional measure is the specific PVE 'employment support', which is intended to assist employers who employ recovering drug users, by contributing to 80 % of salary and social security expenses for periods not exceeding two years.

A fourth measure is the 'award of socio-professional integration'. With this measure, employers receive for each job created — under a commitment to maintain it for a

minimum of four years — a grant for the salary and social security expenses of the recovering drug user, who meets eligibility criteria in regards to treatment status, amounting to 12 times the national minimum wage. Support for self-employment or starting a business is also available. The feasibility of the business plan is verified by the coordination mechanisms and the support provided is twofold, technical and financial. The financial value goes up to 12 times the national minimum wage for the start of employment and up to six times the national minimum wage for initial operating expenses. Every year, more than 1 000 recovering drug users benefit from one of the above-mentioned measures, while micro-enterprises (businesses with fewer than 10 employees) and small enterprises (10–50 employees) represent more than 70 % of the companies participating in this programme.

Specific evidence gained through systematic reviews exists for some client and patient groups, although these have not reported on outcomes for problem drug users. While the needs of these may be different from those of problem drug users, some of the evidence-based principles may be useful in formulating responses for drug users. In individuals with severe illnesses, for example, supported employment (see below) was significantly more effective than extended training schemes in promoting employment outcomes (Crowther et al., 2001). People who had received supported employment interventions were more likely to be employed, earn more and be working more hours. In a systematic review of employment-enhancing interventions for patients with cancer (De Boer et al., 2011), it was concluded that there was ‘moderate quality evidence’⁽³⁷⁾ that multidisciplinary interventions involving physical (i.e. interventions that included any kind of physical training), psychological and vocational (person and work-directed) components led to higher return-to-work rates than care as usual.

Few studies of supported employment have been conducted with problem drug users and so these have not been subject to systematic review. All were conducted in the USA. On the basis of data obtained from those that have been conducted it can be concluded that while some variants are promising (e.g. individual placement and support, see below) there is currently not strong enough evidence to support its general effectiveness for problem drug users (Magura et al., 2004). In one early

⁽³⁷⁾ Cochrane Collaboration grading of evidence. ‘High quality evidence’ refers to evidence whereby 75 % of the RCTs reviewed have no limitations on study design and have consistent findings, direct and precise data, and no known or suspected publication biases. ‘Moderate quality evidence’ refers to evidence for which one of these criteria is not met.

study of supported employment for US clients who had apparently successfully completed treatment (the population was defined as 'ex-addicts'), participants were randomly assigned to either supported employment or a control condition (Dickenson and Maynard, 1981). Small groups were engaged in supervised supported employment, mostly on construction sites and in business services, with the objective of increasing preparation for competitive employment. Up to three years after the programme, intervention clients were significantly more likely to be in employment (49 % vs. 32 %), although there were no corresponding effects on drug use outcomes (other than cannabis and alcohol). Once employment is secured, clients may require continued support to help retain them in work (Kemp et al., 2004). One programme that did offer group sessions and one-to-one counselling reported that employment absences decreased from 58 % at admission to 27 % at follow-up; furthermore, the rates of lateness for work and workplace conflict also decreased (Jordan et al., 2008). Notably, 70 % of clients reported improved workplace performance after one month of participation.

Useful evidence has emerged from the individual placement and support (IPS) model of supported employment for problem drug users with co-diagnosis of severe mental illness (Mueser et al., 2011). In this model, clients are provided with intensive individualised support in order to place them in appropriate jobs in the competitive employment market as soon as possible rather than providing them with extended periods of vocational training and gradual introduction to employment. Across four RCTs conducted in different geographic regions of the USA, clients receiving IPS reported better employment outcomes than those who received vocational training and counselling as normal (Mueser et al., 2011). These included significantly higher rates of employment, more weeks and hours worked and more wages earned than those who received the comparison vocational programmes. The authors noted that these outcomes were similar to results obtained from studies of other populations with severe mental health diagnoses, but without problem substance use.

Examples of this approach in reporting countries:

- In Ireland, the Local Employment Service Network (LESN) is a community-based employment support service. The LESN provides tailor-made job placement or mediation and guidance progression support as well as employment support for disadvantaged unemployed people.

- In Greece, the public employment service (OAED) operates special Accompanying Support Service Units in its Employment Promotion Centres, its Employment Bureaus and other services run by it. These aim to improve cooperation with employers and the beneficiaries of the salary subsidy scheme in order to ensure optimum adaptation and job retention after the end of the scheme.

10.4 Pre-employment and workplace drug screening

These are policies whereby employment is conditional upon provision of negative toxicology, typically collected through urine, saliva or hair samples⁽³⁸⁾. Although not an intervention used to promote social reintegration, drug testing is included here in relation to reinforcement of abstinence and as an example of the barriers that problem drug users may face in returning to work⁽³⁹⁾. Employee drug testing is much more frequently used in the USA than in Europe and elsewhere (Hartwell et al., 1996; Verstraete and Pierce, 2001; George, 2005), and the International Labour Organization (ILO) has estimated that around 80 % of drug testing worldwide occurs as part of pre-employment screening (Shahandeh and Caborn, 2003). Safety and deterrence of drug use are the main aims of workplace drug screening, although screening may also occur to identify treatment needs among employees (see next section) or following an accident (ILO, 1996). According to Shahandeh and Caborn (2003), there can be different motivations underlying the implementation of drug tests, such as ensuring physical safety, ensuring productivity and protection of reputation ('business-related safety') or upholding 'moral' values among the workforce (note that this is primarily concerned not with the performance but with the morality of employees in not breaking laws). In the EU, health and safety aspects are emphasised as motivations for drug testing, rather than moral considerations (EMCDDA, 2006). Along with other forms of health screens, though, it is recommended by many European Member State governments that they should not be introduced as a requirement for roles where the physical or mental standards it assumes are not relevant (EMCDDA, 2006; Pachman, 2009), that is they should be used not as a

⁽³⁸⁾ Pre-employment drug screening is usually only carried out once (cf. random drug testing) and so is discussed separately in this report from contingency management interventions whereby repeated samples are taken and continued employment is usually contingent upon a negative toxicology.

⁽³⁹⁾ Drug testing is also used in other contexts such as housing (e.g. where admission to a hostel is conditional upon abstinence) or the criminal justice setting (e.g. drug courts, prisons). However, these types of drug testing are not explicitly discussed in this report as they are not specific to employment.

drug prevention intervention, but to promote workplace safety (see also box below). Italy, Finland and Norway are currently the only European countries that have specific laws on the regulation of drug testing in the workplace. These address primarily health and safety for particular positions.

Ethical issues in workplace drug screening

Drug testing can be ‘humiliating, uncomfortable or embarrassing’ if it is not conducted in a professional and sensitive manner (Mellish, 2005, p.110). If testing is mandatory, it raises a number of moral, ethical and legal concerns that must be considered (ILO, 1996; Shahandeh and Caborn, 2003; Mellish, 2005; ILO, 2006; UKDPC, 2008a). The most salient issues are summarised as follows:

- *Invasion of privacy*: Do employers have the right (or the obligation) to know or to determine what employees are doing in their private time, even if employees’ private activities do not influence their behaviour at work or their work performance? This is not a clear-cut issue, as such an approach could be considered in conflict with the right to privacy as defined in international human rights charters; however, these charters also provide broad exceptions (e.g. safety considerations may take priority over human rights). Moreover, drug tests are also sensitive to legitimate drug use (e.g. prescription or over-the-counter cold and cough medication may produce false-positive results for amphetamines or opiates; drug tests may also indicate use of medication to control mental health conditions or for opioid substitution treatment, e.g. methadone). Therefore, non-drug-using individuals may also fail the test and involuntarily disclose details about their private life that are of no relevance to the employer or are covered by anti-discrimination legislation (e.g. mental health disorders).
- *Informed consent*: Although a signed work contract including a clause agreeing to drug testing may be considered by employers as evidence of informed consent, it could be argued that such consent is invalid because the employee or job applicant is dependent upon the employer to obtain income.
- *Data protection and (medical) confidentiality*: As drug tests collect sensitive data, the procedure must comply with relevant data protection laws and regulations.
- *Discrimination*: Depending on the scheme, drug testing may promote discrimination if it is targeted at ‘suspicious’ individuals or groups without good reason; it may also lead to negative ‘labelling’ of individuals who refuse to take the test.
- *Validity of drug tests*: Urine drug tests can only indicate the presence of a substance in the sample; they do not necessarily prove that an individual is currently intoxicated (a

positive drug test can be the result of drug use that occurred days or weeks earlier). Moreover, they cannot indicate the behavioural outcomes of drug use (e.g. performance at work). Likewise, a negative test does not guarantee that drug use will not occur in the future. It can therefore be questioned whether drug tests actually measure what is relevant to employers (i.e. whether an individual is able to perform the work or not).

- *False positives:* As indicated above, food or legal medication can also produce a positive drug test result. According to the ILO ⁽⁴⁴⁾ code of practice (1996), a positive test result should therefore always be confirmed by an independent medical ⁽⁴⁵⁾ investigation and in consultation with the employee.
- *Consequences of a positive test:* Where results are an accurate reflection of problem drug use, referrals to counselling or other forms of treatment should take priority over disciplinary measures.

It is therefore important that employers are aware of the potentially harmful consequences for the employee and the workplace of introducing drug testing (e.g. negative 'climate' marked by fear and mistrust, breach of ethical and legal rules) (ILO, 1996). In the EU, drug testing is not generally prohibited or recommended; the EMCDDA (2006) provides an overview of the legal status of drug testing in the workplace in individual EU Member States.

10.5 Employee assistance programmes

Employee assistance programmes for problem drug users allow employers to address substance use among employees once they have secured employment. Substance use needs may be pre-existing or develop during the period of employment. Programmes are designed to identify and address a range of health and other problems that can impact upon wellbeing and productivity (Merrick et al., 2011). These strategies often comprise screening, assessment, counselling and referrals to more specialist care and aim to provide opportunities for managers to forestall discipline or dismissal of employees with personal problems contingent

⁽⁴⁰⁾ The International Labour Organization (ILO) is a specialised agency of the United Nations focusing on the promotion of social justice and internationally recognised human and labour rights.

⁽⁴¹⁾ A comprehensive workplace policy may cover employee assistance, employee education, supervisory training, information and health promotion initiatives, and drug screening (ILO, 1996).

upon their ability to constructively address personal issues that negatively affect job performance ⁽⁴²⁾. Employees may refer themselves, be referred by their peers or be referred by their employer or line manager. Substance use is usually detected on the basis of visible intoxication, impaired work performance or drug screening (e.g. pre-employment or ‘random’ drug testing). Published guidance (ILO, 1996; Mellish, 2005; CIPD, 2007; UKDPC, 2008a) suggests that workplace policies on drug use among employees should aim to ⁽⁴³⁾:

- recognise that drug use is a health problem;
- prevent drug use by developing awareness programmes;
- identify employees with a problem at an early stage; and
- provide assistance to employees with drug-related needs.

Much of the evidence and discussion of these types of approaches is derived from the USA and no comprehensive effectiveness reviews have been published. However, evaluation of individual programmes suggests benefits for employers and employees (e.g. O’Donnell Brummett, 1999) and, where offered, employee assistance programmes are accessed by individuals with substance use needs, often as an initial health service, and referrals to specialist drug treatment are common (Merrick et al., 2011). Interestingly, Italy is the only country known to, by law, oblige employers to keep positions of employees with a drug dependence open for up to three years (without pay) while the employee is in treatment.

10.6 Summary

According to the EMCDDA Structured Questionnaire 28, interventions to promote employment among drug users on the intermediate and the open labour market are offered in the majority of countries. There is currently not strong enough evidence to support the general effectiveness of supported employment approaches for problem

⁽⁴²⁾ Note that the ILO (1996) code of practice on alcohol- and drug-related issues in the workplace states: ‘It should be recognized that the employer has authority to discipline workers for employment-related misconduct associated with alcohol and drugs. However, counselling, treatment and rehabilitation should be preferred to disciplinary action. Should a worker fail to cooperate fully with the treatment programme, the employer may take disciplinary action as considered appropriate’ (ILO, 1996, p. vii).

⁽⁴³⁾ Further guidance on how to write and implement a policy on drug use among employees can be found, for example, in Mellish (2005) and CIPD (2007) (although it was written for the UK context, this guidance may also be relevant to other countries).

drug users. Good evidence exists, however, for the effectiveness of simulated employment and contingency management interventions. Nevertheless, the intervention models evaluated so far have been based in the USA and focused on promoting drug abstinence, rather than employment, and so may not be acceptable in EU settings. Providing employment that is contingent on adherence to agreed treatment plans rather than abstinence may improve the acceptability of this intervention approach. Employee drug-testing programmes have been shown to reduce workplace substance use but no body of research has investigated whether they improve safety or employee retention and performance. There is relatively more evidence in support of employee assistance programmes, and these are a cost-effective way of retaining individuals in work and ensuring their return once their substance use needs have been met.



Chapter 11: General policy

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Chapter 11: General policy

11.1 Welfare (benefits) and welfare-to-work

Welfare describes a system that provides financial and other support to ensure (at least at a basic level) the health and wellbeing of individuals, particularly of those in need (e.g. because of low income, unemployment, ill health or disabilities). In Europe, welfare support is generally provided by the government but can also be provided by private, commercial or religious institutions. This report focuses on welfare provided by governments. One aim of welfare benefits and services is to prevent or mitigate the social exclusion of vulnerable groups, and thus, even though not targeted specifically at problem drug users, general welfare can also be considered as a social reintegration measure ⁽⁴⁴⁾. General welfare provides a lifeline to many problem drug users, protecting them from further exclusion, and provides a supportive environment that allows them to increase their employability capital. Thus, financial support can take the form of grants, pensions and other benefits, whereas other types of support may include, for example, free or subsidised health and social care, schooling or housing. There are national and regional differences in relation to what welfare benefits and services are offered and how they are funded, as well as the specific eligibility criteria and conditions for receipt of benefits or services. However, it is beyond the scope of the present report to describe the different national social welfare systems or the different degrees of welfare protectiveness that problem drug users may be entitled to in the various Member States ⁽⁴⁵⁾. The debate on problem drug users and general welfare is important in regards to social exclusion and reintegration, but nonetheless complex.

For example, qualitative studies among problem drug users in receipt of welfare support in Ireland and Scotland have revealed that the fear of losing welfare or secondary benefits is a major barrier to entering education, training and employment. As cited by Keane (2007), interviews conducted among participants and providers of reintegration projects in the Dublin North East Drugs Task Force area revealed fears

⁽⁴⁴⁾ The significance of state benefits for this population group is underlined by an example statistic from England, UK, where it has been estimated that 80 % of heroin or crack cocaine users receive state benefits (Home Office, 2010).

⁽⁴⁵⁾ There are only a few publications on general welfare and problem drug use in Europe. The following can be consulted in order to have some insight on the differences between Member States on this topic: UKDPC (2008c); Lenski and Wichelmann-Werth (2009); Moskalewicz and Zygadło (2009); Spirig et al. (2009).

among participants about the possibility of losing their rent, fuel, dietary and back-to-school allowances while participating in training (Lawless, 2006). The concern was that money earned on the scheme was treated as income from work, and therefore other benefits were means tested against it, but participants did not qualify for Family Income Supplement because they were not seen as being in employment. Removal or reduction of secondary benefits can lead to a reduction in the levels of real income. Thus, tax and benefit legislations may have disincentive effects and consequently entrap vulnerable groups into long-term welfare dependence.

This is one among other reasons why several Member States have reformed their welfare system and implemented welfare-to-work programmes (e.g. Germany, United Kingdom), i.e. programmes that aim to encourage long-term recipients of unemployment benefits to progress into the job market. They may be targeted at recipients of welfare benefits in general or at drug-using subpopulations in particular. Services provided under such schemes aim to increase the employability of clients and to facilitate their entry in the job market, although specific services and models of service provision differ between countries. In the first instance, clients typically present to job centres where they can register for unemployment benefits and receive support in searching and applying for vacancies. Job centre staff can also make assessments and referrals to more specialist welfare-to-work services such as education, vocational training, drug treatment, job placements and/or long-term employment in the open or social employment market. Other welfare-to-work schemes have used financial incentives to encourage (long-term) unemployed individuals to take up work (e.g. becoming eligible for receipt of in-work benefits; lump sum payment upon entering a job).

Welfare-to-work programmes may also offer a specific service to drug users whereby staff members identify individual barriers to work and make appropriate referrals depending on client needs, for example into vocational training or treatment. An example of such a scheme was the Progress2work (p2w) programme in the United Kingdom ⁽⁴⁶⁾. In this programme, unemployed drug users on welfare benefits were assigned a case manager who would support them on a one-to-one basis to overcome individual barriers to employment.

⁽⁴⁶⁾ This programme is currently being phased out as the UK government is implementing a new welfare-to-work scheme that targets unemployed benefit recipients in general. At the time of writing, the government is considering whether (given the complex needs of this client group) a specialist programme for drug users should be provided as part of the new scheme or their needs can be met sufficiently by more general programmes.

However, welfare-to-work policies may also target employers rather than clients, for example by providing financial incentives (e.g. tax shelter schemes, wage subsidies) to companies that take on unemployed individuals in a competitive job. Again, such programmes may be targeted at benefit recipients in general or at drug users in particular. As most welfare-to-work type interventions are described elsewhere in this report (see in particular Chapter 9 on education and (vocational) training), the evidence of effectiveness for these interventions is also reported in the respective sections. The literature search did not find any up-to-date evidence in relation to the specific approaches discussed in this section (e.g. employer incentives) ⁽⁴⁷⁾.

Finally, when asked whether there were legislations attached to the welfare system that facilitate the movement of people in drug treatment to the labour market, fewer than half of all reporting national focal points indicated the availability of such measures within the welfare (EMCDDA 2009 Survey – further details are provided in Annex 2).

Examples of this approach in reporting countries:

- In Denmark, the Ministry of Social Affairs coordinates interventions in accordance with the The Joint Responsibility II Project. The Ministry of Employment focuses on socially marginalised individuals, including drug users, receiving cash benefits as part of the government's New Ways to Work programme. The overall aim of this programme is to support socially marginalised groups to take the necessary steps towards employment and to enhance the individual's quality of life. The aim is to create better opportunities for self-sufficiency, better opportunities of being assimilated into social networks and a better structure to everyday life. The activities are tailored specifically to the individual drug user, the private labour market and the local case handlers. To facilitate the transition to employment, mentor schemes have been established at drop-in centres in partnership with drug treatment services or other local programmes. Mentors support clients with advice and guidance about how to function in the workplace and act as advocates between the client and potential employers.
- In 2010 Cyprus implemented the Employment and Social Integration of Vulnerable Population Groups programme, which offered employers 65 % of the salary costs for the first year of employment of members of vulnerable groups

⁽⁴⁷⁾ Only one comparative study (Gardiner, 1997) on the (cost-)effectiveness of welfare-to-work programmes was identified in the literature search. The findings of that study are not reported here as they are specific to the UK context at that time.

(including problem drug users). A similar scheme was introduced in Latvia in 2006 through the Law on the Support to Employment. Employers (including drug treatment services) were provided with a salary subsidy from the Employment Fund to recruit former problem drug users; however, it is reported by the Latvian focal point that take-up has thus far been quite low. Similar schemes of financial incentives to employers through wage subsidies and tax reductions are also available in Greece, Hungary and Austria. Experiences with this approach in Malta highlight some of its limitations: if employment is at the discretion of the employer, then employers may take advantage of the first few months of subsidy and terminate employment once the subsidy is removed.

- In 2011, the United Kingdom introduced its new Work Programme, which provides tailored welfare-to-work activities (e.g. work experience, training) for those claiming unemployment-related benefits. Benefit claimants can volunteer to take part in the programme, although participation in the programme can become mandatory after a certain period of time. For clients facing significant disadvantages, participation can be mandatory or voluntary depending on individual circumstances.

Welfare benefit conditionality and ‘forced’ treatment

In some welfare-to-work (workfare) models (e.g. in Germany), the receipt of unemployment and similar benefits is conditional upon, for example, looking for a job, being available for work, participating in welfare-to-work programmes or entering treatment (‘benefit conditionality’). Regulations vary but may include, for example, a minimum number of hours spent per week on such activities or a maximum number of unconditional months after which clients must start engaging in welfare-to-work activities in order to continue receiving benefits. Consequently, if clients do not pursue activities as specified in the conditions, then they may be sanctioned (e.g. benefits reduced or stopped).

Benefit conditionality is used to ensure that benefits do not function as a disincentive to taking up work, and to prevent individuals from over-relying on benefits as a long-term source of income when they are intended to provide only temporary aid. Private employment insurance companies might pressure unemployed individuals to take up work for commercial reasons. However, where benefits are funded through tax income, they can also be based upon a sense of resentment among the tax-paying population. For example, in relation to unemployed drug users, providing welfare benefits can be framed or perceived as a way of sustaining drug habits with taxpayers’ money. The resulting discourse argues that drug users

must contribute to society by obtaining paid work and paying taxes, thereby putting pressure on governments to introduce benefit conditionality and to ensure that drug users actively participate in the job market. Hence, although this report argues that employment of current or former drug users should be promoted on account of its potential to support and facilitate the individual recovery process, in practice employability-related social reintegration measures can be motivated by policymakers' desire to decrease the costs 'caused' by unemployed drug users (through claimed welfare benefits and/or, as opportunity costs, through missed tax income) (Neale and Kemp, 2010). This highlights that (unemployed) drug users are often stigmatised, particularly by those who believe drug dependence to be a consequence of a lifestyle choice rather than a consequence of disease, health and social circumstances (Lloyd, 2010; American Society of Addiction Medicine, 2011).

Furthermore, sanction-based welfare relies on the assumption that all services and processes involved are available, clear protocols are in place and programmes are efficient. However, a recent German study (Henke et al., 2010) on the implementation of a sanction-based welfare within the new labour reform Hartz IV showed that among a representative sample of employment offices and treatment centres there was a great deal of heterogeneity in the level of implementation as regards the organisational setting (number of unemployed people per placement officer, level of addiction-specific qualifications among placement officers, specific concepts for working with unemployed problem drug users) and the practices in handling this specific target group. This involved problems in recognising problem drug use, failures in communication and cooperation with treatment centres, the application of sanctions and specific job placement programmes. The authors concluded that job integration of long-term social security recipients with drug dependence within the current scheme was for the most part not successful, mainly because of bad practices taking place within service providers. The authors also made recommendations to improve the current situation. Thus, the authors argued that progress could be made by an intensified cooperation with treatment centres, a better relationship between placement officers and unemployed people, addiction-specific qualifications for placement officers, consideration of specific needs of problem drug users in job placement programmes and better information for providers on data protection and professional secrecy.

In summary, it could be argued that neither treatment nor employment should be seen or used as a 'punishment' for drug users. Consequently, a client-centred perspective would mean that drug users should be 'encouraged' or 'forced' to enter treatment or to take up employment only if this is guaranteed to significantly improve their level of rehabilitation and/or social reintegration (Anokhina et al., 2005). Temporary loss of autonomy might then be justified as it will increase clients' autonomy in the long term (Svedberg, 2005) (see also the box on the ethics of social reintegration on p. 111).

11.2 Disability Discrimination Acts

The ILO code of practice on alcohol- and drug-related issues in the workplace from 1996 states that '[w]orkers who seek treatment and rehabilitation for alcohol- or drug-related problems should not be discriminated against by the employer and should enjoy normal job security and the same opportunities for transfer and advancement as their colleagues. ... The employer should adopt the principle of non-discrimination in employment based on previous or current use of alcohol or drugs, in accordance with national law and regulations' (ILO, 1996, p. vii).

One way of addressing potential discrimination against drug users in the workplace and increasing their employability is to recognise drug dependence as a protected characteristic (e.g. a disability) in anti-discrimination and equal opportunity policy and legislation ⁽⁴⁸⁾.

International anti-discrimination and equal opportunity policy and legislation does not specify types of disabilities, which means that drug use or drug dependence is neither specifically excluded nor included as a disability. For example, the United Nations Convention on the Rights of Persons with Disabilities (2008) specifies that persons with disabilities include 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'. In the European Union, the Employment Framework Directive (2000/78/EC) of 27 November 2000 is in place to prevent discrimination at work on the grounds of religion or belief, disability, age or sexual orientation ⁽⁴⁹⁾ but it provides no definition of disability. The European Agency for Safety and Health at Work provides the following definition: 'Disability covers both physical and mental impairments and covers all employees who might be hampered in work performance. This includes people with long term or progressive conditions as well as people with more stable disorders' (OSHA, n.d.).

⁽⁴⁸⁾ It is recognised that this might be controversial. Although addiction is classified as a chronic brain disease by organisations such as the American Society of Addiction Medicine and as a mental health disorder in ICD-10 (World Health Organization *International statistical classification of diseases and related health problems*, 10th revision)/DSM-IV (*Diagnostic and statistical manual of mental disorders*, 4th edition published by the American Psychiatric Association) and so could be considered a disability, other professionals do not accept this view.

⁽⁴⁹⁾ A proposal for a new directive [COM(2008) 426] against discrimination based on age, disability, sexual orientation and religion or belief beyond the workplace is currently being negotiated.

It is believed that international policy and legislation cannot provide a more specific definition of disability (e.g. examples of what would or would not be considered a disability) because of national differences in how disability is viewed and approached (OSHA, n.d.). Consequently, although anti-discrimination policies exist in all EU Member States, the specific definitions and criteria for determining disability vary between countries. At the national level, in Europe it is currently uncommon to consider drug dependence as a condition that qualifies for antidiscrimination protection.

For example, in the United Kingdom, disability is one of the protected characteristics under the UK Equality Act 2010. In the Act, a person is considered to have a disability if he or she has a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. People who have had a disability in the past are also protected by the Act. The Act names specific medical conditions that are considered as a disability from the point of diagnosis, namely HIV/AIDS, cancer or multiple sclerosis. Moreover, the accompanying guidance (ODI, 2011) lists a range of impairments that can lead to disability, including organ-specific and cardiovascular diseases, learning difficulties, mental health conditions (e.g. eating disorders, personality disorders and some self-harming behaviours) and mental illnesses (e.g. schizophrenia, depression). The inclusion of mental health disorders, but the exclusion of drug dependence, in the list of qualifying impairments in most national disability acts in Europe (e.g. Austria, France, Germany, Poland, the United Kingdom) is particularly noteworthy as substance dependence is recognised under ICD-10/DSM-IV as a mental health disorder. However, generally a drug user could be considered disabled by a *different* qualifying impairment (e.g. depression, physical impairment), regardless of whether or not this has been caused by drug use and dependence. Nevertheless, former/current drug users are not protected from discrimination because of drug dependence per se, which may cause barriers to problem drug users given the negative stereotypical views that some employers hold of them and the impact these are likely to have on employee selection and treatment (UKDPC, 2008a) (see also Chapter 12 and the box on 'Employer beliefs about problem drug users', p. 128).

In the USA, the Americans with Disabilities Act of 1990 provides some level of protection for *former* drug users. It covers those who have been diagnosed with dependence (and are therefore likely to be in treatment or are seeking treatment) as

well as those who have undergone rehabilitation or are currently participating in a rehabilitation programme. These individuals may be discriminated against on the basis of their diagnosis of drug dependence or engagement in rehabilitation activities only if these circumstances are in direct conflict with the requirements of the job (e.g. safety concerns) and if there are no means of eliminating or reducing this conflict by reasonable accommodation. However, the Act specifically excludes current drug use as a qualifying condition under anti-discrimination legislation (regardless of whether or not the user is dependent). Although not directly pertinent to the EU, this model offers an interesting example of how anti-discrimination policy can be formulated to protect the rights of drug-dependent individuals while also satisfying moral concerns of policymakers and the general public.

To date there have been no prospective evaluations of the effects of disability anti-discrimination policy upon the employment of substance users. Brucker (2007) reported through a cross-sectional design that substance users who received publicly funded disability allowances (because of their drug dependence) were more likely than non-recipients to access treatment, but not to report employment in the previous week. It has been argued that in the USA, despite anti-discrimination laws, people with substance abuse disorders are viewed negatively and as less deserving of public assistance. This was confirmed by another US study, which showed that, despite the existence of anti-discriminatory legislation, employer discrimination was adversely affecting the career prospects of former substance users (Baldwin et al., 2010). These findings further highlight the need to better inform prospective employers about the benefits of employing recovering problem drug users and judge their employment potential based on their actual capacity to perform the required tasks rather than on their former condition.

11.3 Summary

As with many other areas of drug policy, to date there have been no prospective evaluations of the effects of European employment-promoting/protecting policies. One relevant example from the USA, the Americans with Disabilities Act (1990), was designed to protect the employment rights of individuals who had completed drug treatment. However, studies have indicated that, despite the existence of this Act, employer discrimination was adversely affecting the career prospects of former substance users, highlighting the detrimental stigma that recovering and former problem drug users experience.

To our knowledge, there is no anti-discrimination legislation in European countries for recovering problem drug users comparable to those in the USA. However, employment-supporting measures within the welfare benefit system that are targeted (also) at problem drug users are available in about half of the reporting Member States (see Annex 2 for further information).



Chapter 12: Advocacy and reducing stigma

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Chapter 12: Advocacy and reducing stigma

Stigmatisation has a societal function in that a society attaches 'stigma' to characteristics or behaviours that are thought to be undesirable. The stigma associated with drugs can relate to use as such, intoxication, dependence and/or the adverse consequences of use (Room, 2005). Techniques such as stereotyping (i.e. drawing general conclusions about the person based solely on the presence of the stigmatised characteristic or behaviour) and discrimination (i.e. treating the stigmatised person less favourably) are then used to marginalise those with a stigma, which in turn is intended to discourage others from acquiring the stigma or engaging with the stigmatised; thus, stigma is an instrument of social control (Room, 2005; Lloyd, 2010). This has led to some authors praising the stigmatisation of drug use as a measure of prevention and a motivating factor for users to seek treatment (Satel, 2007). However, available evidence suggests that stigmatisation produces, sometimes unintended, serious disadvantages for the stigmatised (reviewed by Lloyd, 2010; see also UNODC, 2008; UKDPC, 2008a; Doukas and Cullen, 2011; Livingston et al., 2012). For example, (fear of) stigmatising views and behaviours by professional staff (e.g. doctors, job centre staff) can motivate recovering or current drug users to keep their drug use a secret; however, clients can receive appropriate support only if they (feel safe to) declare their drug use. Similarly, stigma can also be a barrier to seeking treatment because drug users seek to maintain a 'normal' self-image and also fear the negative reactions of friends and family (e.g. disappointment, rejection, blame). Stigma is attached not only to current but also to former drug use, which means that even recovered drug users may be stigmatised and hindered in their rehabilitation and social reintegration. Importantly, stigmatisation by others can be internalised and lead to a negative attitude towards the self ('self-stigma'), which in turn reduces the chances of recovery.

Drug dependence is associated with greater stigma than many other health and social conditions (e.g. Room et al., 2001), partly because drug dependence is often believed to be the consequence of a lifestyle-related choice over which users have control (Lloyd, 2010; Livingston et al., 2012). It has consequently been argued that the negative consequences of stigmatisation for drug users disproportionately outweigh any potential merits for wider society because the stigma attached to drug use is so strong (Lloyd, 2010). Stigmatisation of drug users is reinforced further

where drug use is viewed as a criminal justice matter rather than a health and social issue (Ahern et al., 2007; Lloyd, 2010). Reducing the stigmatisation, stereotyping and discrimination of (former) drug users and increasing awareness of the needs of this population can be addressed through advocacy. Advocacy targets decision-makers at community and government levels to gain support for a particular goal or programme. Strategies may include the use of mass media (e.g. information campaigns), political lobbying and community mobilisation. Advocacy activities may be carried out by the individuals or groups affected by the issue and/or on their behalf by individuals who are in a position of greater power (e.g. political figures, celebrities in popular culture).

Livingston et al., (2012) presented a review of interventions designed to reduce stigma related to substance use disorders. These focused on (i) self-stigma (i.e. from the substance users themselves), (ii) social stigma (e.g. from the general public) and (iii) structural stigma (e.g. from professional groups who treat or come into contact with problem drug users). Most interventions were designed on the basis that, although negative population attributes (stereotypes) might be accurate for a small number of drug users, they are not generally applicable to all; however, more general interventions such as employment skills training were also found to decrease drug users' feelings of alienation⁽⁵⁰⁾. Although evidence was limited, over half of review studies produced positive results on a range of indicators of stigma. The findings of the review are reported in the respective sections below. Unfortunately, no outcomes examining how reduced stigma might lead to improvements in employment and employability were reported. It should also be noted that it is beyond the scope of the present publication to present the process that may have led to the reduction of stigma or the people and organisations engaged in advocacy in Europe.

⁽⁵⁰⁾ The review also found that self-stigma was significantly reduced by psychosocial interventions such as group-based acceptance and commitment therapy (Livingston, 2011).

Employer beliefs about problem drug users

Employer prejudice towards current and recovering problem drug users is thought to be widespread and difficult to overcome (Klee et al., 2002; UKDPC, 2008a). A survey among employers in Slovenia about the employability of recovering drug users showed that, if job seekers had been treated for drug dependence in the past, their likelihood of getting a job would have been lower in 53 of 57 (93.0 %) cases; if they were taking part in opioid substitution treatment at the time of job searching their chances would have been lower in 54 of 57 (94.7 %) cases (Bilban et al., 2008). Employers may be concerned either about drug use at the workplace or that the employee may come to work intoxicated⁽⁵¹⁾. Specifically, employers associate three types of risks with recruiting a current or former drug user: risk related to managing drug use; risk to business reputation; and risk to co-workers or customers (Bilban et al., 2008; UKDPC, 2008a). According to Klee and colleagues (2002) most employers think that current drug users do not make good employees. Many problem drug users are thought to have a criminal record, and are considered 'problem people' rather than 'people with problems' (O'Connell, 2007). Preconceptions and prejudices may prevent (former) problem drug users from declaring drug use to current or potential employers and co-workers and thereby possibly delay seeking help. Although in light of such attitudes this decision may be understandable, if employers subsequently become aware of a condition it may be considered deliberate withholding of important information, which could lead to disciplinary action.

12.1 Guidance to prevent discrimination and stigmatisation of (former) drug users

Prevention of discrimination and stigmatisation can take the form of formal policy and legislation (e.g. in the form of equal opportunities legislation, see section 11.2) as well as guidance published by governmental or other professional bodies, which are typically targeted at particular groups such as employers or media professionals.

In Denmark, companies are able to participate in the 'From Exposed to Employed' course under the national Joint Responsibility II policy. The course aims to prepare

⁽⁵¹⁾ However, interviews carried out in a UKDPC study on supporting employment of problem drug users suggested that hiring recovering drug users can be a positive experience for employers. For example, one interviewee responded: 'Recovering PDUs [problem drug users] are seen as good employees [...] extremely loyal and dependable employees, because they are very grateful to have been given the chance to turn their lives around' (UKDPC, 2008a, p. 17).

employers to employ socially marginalised problem drug users, through information provision and a number of supportive tools. Another example comes from Germany, where practice-oriented guidelines for professionals working in drug rehabilitation and labour market integration have been developed. The 'Models of adequate technical cooperation between agencies of labour market integration and addiction help facilities' have been developed on the basis of the current (2009) '4-Phase-Model of Integration Work' by the ARGE (working group formed between the municipalities and the employment agencies). The tool provides well-founded and practice-oriented answers to questions on addiction. Also, partly in response to popular misconceptions about the length of time that drug service clients should be drug free for before taking on employment, the National Treatment Agency (2010) in the United Kingdom issued guidance to employers who are considering recruiting a current or former problem drug user.

Additionally, media reporting of drug users, dependence and treatment can be highly stigmatising, using sensationalist language and pejorative terms (e.g. criminal, 'druggie', 'junkie'), which does not show respect or understanding for those who are affected by these issues (Lloyd, 2010). Consequently, in 2009 the International Harm Reduction Association (IHRA) published a guide to responsible reporting on opioid dependence and its treatment. The guidance contains facts and figures about opioid use and substitution treatment, and provides real examples of stigmatising news coverage to raise awareness among journalists for the potential negative impact of their reporting style ⁽⁵²⁾. The guidance includes 'dos and don'ts' when reporting on drug-related news coverage.

Although the effectiveness of such approaches has not been evaluated, they provide points of reference for those professionals seeking guidance on the topic (e.g. if employers are unsure about the rules for recruiting drug users) as well as for those advocating against stigmatisation and discrimination (e.g. enabling them to 'prove' that a press article does not adhere to good practice guidance).

12.2 Education targeted at the general public

Information and advocacy campaigns targeted at the general public typically include success stories about former drug users who have successfully recovered, to tackle

⁽⁵²⁾ Other drugs charities have also produced guidance for journalists, including on how to interview drug users, e.g. DrugScope (2011).

the belief that drug dependence is personal fate, and/or factual information about drugs, dependence and the multiple causes of dependence. The media used in such campaigns can include articles, brochures, posters, film and the Internet. The aim of such campaigns is to dispel common myths and to improve the social image of drug users. Communicating positive stories about drug users as well as motivational interviewing with particular target groups (e.g. landlords, employers) have been found to be effective strategies to reduce social stigma (Livingston et al., 2012).

12.3 Training treatment, employment and other support centre staff

These interventions consist of educational training for those who come into contact with drug users in a professional (and supporting) capacity, such as treatment professionals, employment centre staff, other support workers (e.g. social service workers), health professionals (e.g. doctors, nurses, pharmacists) and/or law enforcement professionals (e.g. police officers). Similarly to education initiatives targeted at the general public, training (particularly for non-specialists) can provide facts around drug use and dependence and the realities of being a drug user in order to reduce negative attitudes and increase understanding for drug users' needs. Training can also address how to communicate with and treat drug users in everyday practice and what actions to take upon disclosure of drug use by a client (e.g. making an appropriate referral). Interventions can include leaflets, training courses or direct contact with drug users. Contact-based training and education programmes targeting health, social and criminal justice professionals have been found to be most effective at reducing structural stigma (Livingston et al., 2012). Positive effects included reduced levels of discomfort having clients who are drug users; increased sense of responsibility towards drug users; reduced desire to maintain social distance from drug users; and reduced negative thoughts about drug users. Finally, those working in employment and other support centres often require additional training to help improve understanding of the impact of drug use and dependence on the abilities of clients to sustain employment (Baum et al., 2003) (see also box on p. 131 on barriers to employment).

Barriers to helping problem drug users as perceived by employment service professionals

Employment service professionals face (perceived) barriers in helping to place problem drug users into work (e.g. Klee et al., 2002; UKDPC, 2008a; Dorsett et al., 2007; EMCDDA, 2010a; Neale and Kemp, 2010), including:

- Staff are often working with a client group who have experienced multiple disadvantages, who may have a lack of commitment to employment and/or who lead chaotic lifestyles.
- Although this is possibly true for only a minority of job seekers who are problem drug users, some clients may attend employment services only in order to present evidence of a commitment to change to criminal justice or social welfare tribunals (e.g. where proceedings have been initiated to take children into state care) rather than a real desire to get a job.
- Many staff feel uncomfortable probing the personal circumstances of clients (particularly with respect to the extent of substance use and criminal convictions) lest this disrupt the developing professional relationship.

12.4 Managing physical signs of problem drug use

Managing the physical signs of problem drug use can include having surgery to remove visible needle marks from injecting drug use or replacing missing teeth. Although not advocacy, this example is included here because such interventions make it more difficult for others to identify the individual as a current or former drug user, and can therefore reduce the likelihood of stigmatisation by others as well as self-stigma. The Livingston et al. review (2012) found only one (possibly outdated) example of research on such interventions suggesting that needle track removal surgery may be beneficial for recovering drug users (Shuster and Lewin, 1968).

12.5 Summary

There is some review-level evidence to suggest that interventions designed to reduce stigma in (former) substance users are effective. Social stigma can be reduced through communicating positive and accurate stories about substance use and substance users, and motivational interviewing with key target groups (e.g. landlords) has also been shown to be effective. Structural stigma can be effectively

reduced through contact-based training and education programmes targeting health, social and criminal justice professionals.

Table 2: Overview of evidence of interventions that target directly or indirectly the employability and employment of problem drug users

	Indication of positive effect
General vocational rehabilitation	+
Drug treatment	+/?
Criminal justice	
Prison treatment	?
Prison vocational education, training	+
Parole management	?
Referrals into community-based treatment	+
Drug (treatment) courts	+
Housing	
Temporary housing and emergency accommodation	?
Supported housing	+
Support in finding long-term accommodation	?
Education and vocational training	
Vocational training	+
Qualifications	?
Volunteering and temporary work experience	?
Employment	
Intermediate labour market	?
Simulated work and contingency management	+
Supported employment	+
Pre-employment and workplace drug screening	?
Employee assistance programmes	+
General policy	?
Advocacy interventions	?

Key:

+ intervention has positive effect.

? either lack of effect or a lack of research/studies on the impact of the specific intervention in improving the employability or employment of problem drug users.



Part III: Conclusions

Conclusions

Introduction

The expansion of treatment provision over the last decades in most European countries has resulted in a significant increase in the number of problem drug users receiving drug treatment. Currently more than a million drug users are in contact with drug treatment providers in Europe. Research has repeatedly shown the positive impact that drug treatment has on clients' physical and psychological health, while recent European and national drug policies have called for further improvements in the provision of evidence-based drug treatment. However, drug use affects many spheres of life, including family and relationships, housing, education and employment, and is associated with social and economic exclusion. These have been shown to undermine the gains people have made while in treatment. Therefore, social reintegration is central to long-term positive treatment outcomes and sustained recovery. In order to better inform policymakers, practitioners and the public, this report aimed at reviewing recent discussions and developments concerning the social reintegration of problem drug users and examined the evidence for the effectiveness of interventions that aim to increase their employability and improve their labour market participation.

What is the evidence of effectiveness for social reintegration approaches?

This review identified a range of research and discussion papers that presented either evidence of effectiveness or good practice in social reintegration. This review primarily focused on the employability of problem drug users but, as has been noted throughout the report, social reintegration also includes other life domains (e.g. family relations, individual identity, community ties). The focus on employment in this report should not inadvertently contribute to a misleading impression that achieving employment is the main or only aim of social reintegration.

Strategies included in the review were specific to problem drug users and so must be considered alongside other general population and targeted programmes to promote stability, employability and economic prosperity. Unfortunately, few general policy approaches to improve employability have been subject to evaluation, and fewer still have examined the effects in subgroups such as problem drug users.

Evidence almost exclusively focused on structured interventions and services in opioid users, and so consideration of 'self-help' and other informal approaches to social reintegration, as well as interventions for non-opioid-using groups, are also lacking. Furthermore, this review is based on English-language publications available in the public domain or through databases of scientific publications. Additional evidence may have been available in other languages or information sources, which were not considered.

Thus, recommendations for policy and practice in the EU would have to take all available evidence into account; therefore, it would be unwise to consider this report an exhaustive overview. This report does, however, provide a good basis for the development of evidence-based policy, and strategies that promote a new way of looking at the long-term aims of drug treatment.

Overall, there was little evidence — especially from European Member States — to clearly suggest 'what works' with regard to social reintegration interventions, although it was clear that contextual factors (social attitudes to drug users, local and national economic prosperity, professional training, stability in problem drug users' lives, etc.) were extremely important moderators of effect and determine the conditions in which interventions are delivered.

In general, review findings suggested that providing drug treatment alone had limited and inconsistent effects on employment outcomes, although the lack of research in this area must be noted. Furthermore, most research examined intervention effects in opioid and, to a lesser extent, crack cocaine users in treatment. Problem users of other drugs, cannabis and amphetamines, for example, may also experience harm and social exclusion as a result of use, but no evidence specifically addressed the needs of these groups.

At best, it could be concluded that vocational training, which aims to improve job-seeking skills and motivation for work, shows promise, but because of non-randomised research designs (or the use of high-quality non-randomised designs such as interrupted time series), lack of replication, inconsistent research designs and populations, and lack of long-term follow-ups, no particular intervention models were identified as producing consistently positive outcomes.

Contingency management approaches, whereby rewards (e.g. monetary vouchers) are contingent on successfully performing a particular activity (e.g. getting a job), showed promise, but these types of interventions would raise particular ethical

concerns in the EU, and have largely been developed to motivate drug abstinence rather than social reintegration. It has been proposed that if introduced they should be seen as a treatment modality in itself, with interlinked employment- and drug-related objectives.

Court-mandated treatment is a popular approach in some EU Member States, and research showed that such quasi-compulsory treatment produced similar outcomes to 'voluntary' drug treatment. Drug courts specialising in drug-related offences and drug-dependent offenders have also received increased attention, but have been evaluated with high-quality research designs only in the USA and Australia. Evidence from the former country showed that drug courts might be an effective way of improving employment outcomes as intervention recommendations are individualised and a relationship is built up with criminal justice-based services that is not entirely punitive in nature.

There was not enough evidence of effectiveness available to be able to make recommendations about whether the intervention models reviewed should be promoted in the EU, although in the 2009 EMCDDA survey Member States reported delivery of most of these already. However, there was little coherence between the approaches described in the literature and the way in which these activities were delivered. Most examples of EU implementation have not been evaluated and overall coverage appeared to be less than complete.

It was also difficult to identify the best ways in which these types of approaches should be delivered alongside traditional drug treatment or as part of individualised care planning. In the EU, social reintegration measures are often delivered as multi-component packages across different sectors and combine several approaches according to client need (e.g. offering advice and guidance, facilitating job search, enabling access to state benefits). European research should therefore prioritise the development of science-based interventions with particular attention paid to implementation and coverage. As most research has been conducted outside Europe (primarily in the USA), policymakers should consider adapting interventions developed elsewhere to the European context. During adaptation, particular attention should be paid to the theories of behaviour change on which interventions are based, rather than actual activities and delivery structures, which will differ greatly between countries. The views, experiences and preferences of relevant stakeholders such as practitioners, clients and the general public must also be considered in order to improve the likelihood of success.

Only a few studies considered the cost-effectiveness of interventions. Where cost-effectiveness data were available (e.g. vocational training for pregnant problem drug users (French et al., 2002); employee assistance programmes (Jordan et al., 2008); drug courts (Rossman et al., 2011a)) it could be concluded that specialist programmes for social reintegration were cost-effective, partly because of reduced welfare and public services burden and increased tax revenues. However, the small number of studies and their non-EU social and legal context limits the relevance to European discussions and highlights the need for EU studies on this topic.

The review of the literature, information from the national reports of the Reitox national focal points and analysis of the specific EMCDDA data collection on social reintegration measures in the Member States identified a number of intervention approaches. Examples included helping former treatment clients establish their own businesses through small loan schemes (available in some EU countries); legislation ensuring that an individual can return to his or her job after completing treatment (available in Italy); centralised treatment access⁽⁵³⁾; and pre-employment risk assessment (e.g. Appendix 4 in CIPD, 2007). However, no published evaluations of effectiveness (specific to problem drug users) of these approaches were available. The review also identified suggestions for approaches raised by expert groups and other authors that have not yet been implemented and are therefore not evaluated; for example, a call for regulating criminal records checks to ensure that they do not represent an unreasonable barrier for problem drug users' access to employment (UKDPC, 2008a). Given the lack of evidence it was not possible to judge the effectiveness of such approaches.

Do certain types of clients benefit most from intervention?

Identifying which clients may benefit most from a particular intervention is important both for screening (so that particular client groups are not offered activities from which they are unlikely to benefit) and for individually targeting the activities received by indicated groups. This report can only make general statements about which clients

⁽⁵³⁾ A system whereby staff at a central unit make an assessment of client needs and subsequently refer them to specific services and programmes. This is in contrast to those types of treatment access where a client may self-present or be referred by a non-specialist (e.g. medical practitioner), and needs are subsequently assessed within the service. This system is most commonly used in the USA, although it is also applied in some European countries, for example the Netherlands.

might benefit most from social reintegration interventions, as few studies investigated client-level factors in detail. The review suggested that groups of (former) problem drug users with the greatest level of employment-related skills, longer employment histories and most stabilised substance use seemed to benefit most from interventions.

Hasluck and Green (2007) conducted a review of UK government-commissioned research to identify which types of interventions provided by the UK government worked best for which groups. Populations investigated included young people, long-term unemployed adults, older benefit claimants, lone parents, partners of benefit claimants, disabled people and people with health conditions, ethnic minorities, and the most disadvantaged. One of the study's key findings was that individual motivation appeared to be one of the stronger predictors of success in entering employment, rather than being a member of any particular group. The authors concluded that establishing 'what works for whom' was difficult for a number of reasons, including the heterogeneity of clients within groups. This is supported by other evidence from the general employment field suggesting that, rather than focusing on population descriptors, tailoring intervention activities according to job readiness is more worthwhile (Meadows, 2008). For example, those clients who are considered ready for work will mostly require job-seeking support and advice on interview skills. Advice is also often required to help them negotiate the sometimes complex transition from welfare support to paid employment so that they do not suffer financially in the first few months of work (e.g. tax relief, income support). For those clients who are assessed as not ready for the competitive job market, particularly those who have only recently entered treatment and whose lack of employment-related skills means that they would struggle to find and maintain a job, an initial period of vocational training is likely to be appropriate. There will of course be some clients who for a number of reasons will not benefit from social reintegration interventions (see the box on adjusting interventions on p. 139). For many of these clients, stabilising drug use and reducing risk behaviours, addressing health concerns and providing safe and secure accommodation are priorities. Only when these are met should further social reintegration measures be considered.

A multisite evaluation of drug courts in the USA (Rossman et al., 2011b) found that nearly all categories of offenders benefited from participation in drug courts. Only a few subgroups were affected differently by the intervention: those who reported more frequent drug use at baseline (greater reduction in drug use); those with a history of violence (greater reduction in crime); and those showing symptoms of

Staying realistic – adjusting interventions and outcomes to individual needs

The earlier discussion on recovery in this report (see section 2.2 in Part I) highlighted the difficulties of defining ‘recovery’ in a way that could adequately account for the different experiences of clients. Clients’ experiences of recovery depend not only on their patterns of drug use, but also on the causes of drug use, the coexistence of other problems (e.g. mental health), the availability of resources (e.g. skills, work experience, social supports), their personal goals and the wider societal circumstances. The UK Drug Policy Commission Recovery Consensus Group (2008) consequently argues that recovery should be seen as an individual journey, in which the client determines the end point of the journey (i.e. what ‘recovery’ means), how he or she will get there (i.e. type of treatment if any) and how long it will take. This individualised approach is also promoted by a recent report to the National Treatment Agency in the United Kingdom recommending that ‘[t]he construction of a recovery care plan should be built around the individual patient’ (Strang, 2011, p. 3). As noted in the main text, however, individual tailoring can sometimes be prohibitively expensive, and, although its importance has been highlighted in the literature (Hasluck and Green, 2007), there is not a great deal of scientific evidence available to demonstrate its (cost-)effectiveness. Individualising client outcomes also means that determining indicators of success in research studies is also made more difficult.

Social reintegration measures must equally consider individual differences between problem drug users, and in particular the implications for clients’ employability. Some clients may be able to find employment relatively quickly thanks to, for example, previous work experience, whereas others, particularly those with multiple or severe needs and few resources, may not be able to progress as quickly or as far (e.g. employment may be a longer-term aim). Clients with severe physical and mental health problems may never be able to sustain a job that can support them and their families and to conform to the ideals of mainstream society (Baum et al., 2003). Particularly with this client group, it is important to note that some individuals have never been well integrated into society (i.e. they were already socially excluded before they started using drugs). In such cases, it is a matter not of social reintegration but indeed of first-time integration so that the individual does not simply return to a previously stable life but enters an entirely unfamiliar world (UK Drug Policy Commission Recovery Consensus Group, 2008; UNODC, 2008). It is therefore important to be flexible and to recognise that there may be limits to what can be achieved. This could mean paying greater attention to small gains as well as personal achievements that are not necessarily employment-related (Baum et al., 2003; Hasluck

and Green, 2007; UKDPC, 2008a; UK Drug Policy Commission Recovery Consensus Group, 2008; Neale and Kemp, 2010). This point is of particular relevance at times of recession, when both the resources available to the general population and general living standards are decreased.

Consequently, aspirations to achieve open labour market participation for problem drug users must be considered in relation to the individual and his or her circumstances. In order to avoid systematic failure (which would be unethical), measures must be tailored and realistic in relation to (1) what individual clients wish to achieve and what they can actually achieve (e.g. individual interests, nature and severity of needs) (1) and (2) what support services and other opportunities are actually available (e.g. availability and waiting times of training courses, job vacancies, aftercare support once employment has been obtained (2)) (UKDPC, 2008a; Neale and Kemp, 2010; Monaghan, 2010). This is particularly important as problem drug users are more likely to obtain a job that is less secure and less well paid, which in turn can diminish the personal gains of employment (Effective Interventions Unit, 2003). As the main objective of employment services is getting clients directly into work (and many services are performance assessed on such targets), some organisations do not have sufficient resources, or flexible working policies, to provide the extended training and preparation required by many job seekers who are problem drug users. Research on workless people in general has indicated that job retention and progression depend on the individual being in the right job, having the skills required for the job, and working suitable hours and in a location that can be easily accessed (e.g. does not require unreasonable commuting) (Meadows, 2008).

Findings from the 2009 EMCDDA Survey indicated that employability is a regular treatment objective in half of all reporting countries. However, many countries acknowledged that employment may not always be an attainable (short-term) goal (see Annex 2 for further details).

(1) For example, in light of evidence to suggest that the problem drug-using population is ageing (EMCDDA, 2010c) and that older drug users experience new health challenges, most notably longer-term health conditions (Beynon et al., 2010), their fitness to work must also be taken into account. Tackling long-term ill health by offering problem drug users health interventions tailored to their additional needs may play an important role in supporting other social reintegration activities.

(2) The Effective Interventions Unit (2001) identified aftercare as an essential element of sustainable employment. The report highlighted that interventions focused too often on securing employment rather than providing the ongoing support necessary to sustain employment.

narcissism or depression (smaller reduction in drug use and crime). With respect to gender, Roman and colleagues (2003) reported that female drug court graduates had lower rates of re-arrest than males. Rossman and colleagues (2011b) concluded from their evidence that drug court policies should not restrict eligibility, but target a broad spectrum of offenders. Cost-effectiveness calculations conducted as part of this study indicated that savings were driven by a reduction in the most serious offences by a small group of individuals (i.e. drug courts are particularly cost-effective if they manage to prevent future offending by the most serious offenders). However, more serious offenders are often excluded from taking part in non-custodial activities and are more likely to receive punitive sentences. The authors therefore argued that, in order to achieve greater return on investment, eligibility criteria should allow the inclusion of more serious offenders. Related to this finding, McIvor (2010) presented evidence that drug courts appear to have better outcomes with drug-dependent offenders with longer criminal histories (regardless of severity of offence), whereas younger offenders appeared not to benefit from drug court involvement.

Recommendations for policy and practice

In the absence of specific recommendations on intervention models (e.g. vocational training), the recommendations below present general considerations on activities promoting social reintegration. These are based upon the authors' synthesis of the implications of primary studies, reports from expert groups (including existing good practice guidelines) and wider discussions of social exclusion and associated factors. The lack of a consistent set of research findings and the paucity of EU research into this topic means that these recommendations should be considered only the first steps in promoting social reintegration activities and it is essential that this work be expanded in the coming years.

- There is a need for social reintegration interventions. This should also be acknowledged in funding provision and national drug policies. Drug treatment alone cannot address the complex needs of problem drug users. Treatment alone is also not sufficient to prevent social exclusion of marginalised individuals, particularly as many problem drug users were already marginalised before they started using drugs. Without social reintegration interventions, there is a serious danger that the gains made during treatment will be undermined.
- There is an urgent need to increase the availability of and access to social reintegration interventions for problem drug users in the EU. The availability and

coverage of social reintegration measures currently delivered in EU Member States are overall limited and interventions are often subject to particular conditions that may exclude those most in need of support (e.g. drug-free status, stable housing). Additionally, policymakers should encourage the expansion of intermediate labour market interventions and the role of social enterprises within their economies, as these have been shown to be profitable for the wider society and to provide a bridge back to the world of work for disadvantaged, long-term unemployment individuals.

- It is important that definitions of social reintegration use a broad understanding of social reintegration that, besides economic integration, should also prioritise components related to human, social, economic and institutional capital. This also allows a better understanding of what level of social reintegration individuals can achieve. The logic model presented in this report promotes a comprehensive approach to social reintegration which systematically addresses the multiple barriers faced by problem drug users. It is also important to recognise that many individuals were already socially excluded prior to their drug use, and thus the term social (re)integration may be more appropriate in some cases.
- Social reintegration measures can, and should, be embedded into drug treatment at an early stage. Depending on individual client needs, the provision of supportive structures, such as stable housing in the short term and vocational training in the medium term, may lead to improved treatment outcomes. Drug use abstinence should not necessarily be a condition of social reintegration support.
- Treatment providers should consider social reintegration outcomes as part of individual care planning and make use of multisectoral working to address these. Although stabilising and reducing drug use and associated harms is a primary outcome of drug treatment, outcomes related to social reintegration should also be considered important. Therefore, it is recommended that the monitoring of effectiveness of drug treatment has to include data on social reintegration.
- Research funders should provide sufficient resources to allow high-quality outcome evaluations and cost-effectiveness studies of existing interventions in the EU or consider commissioning work that aims to adapt promising models of social reintegration developed elsewhere for delivery in the EU. Once sufficient evidence is available on 'what works', evidence-based guidelines should be developed.
- Problem drug users are not a homogeneous population and consist of many different subgroups with different needs. Social reintegration services need to be

oriented accordingly. For example, most EU services target opioid users, which means that users of other drugs such as psychostimulants or cannabis may have even less access to social reintegration provision.

What ‘good practice’ guidance is available in the EU?

In an earlier study conducted by the University of Hamburg on behalf of the EMCDDA (ZIS, 2008), findings from the EMCDDA Structured Questionnaire 27 on quality assurance as well as an additional survey of the national focal points showed that 6 out of 28 reporting countries (21 %) reported the availability of national guidelines on social reintegration. Of these, two were developed based on expert consensus, four took into account both expert consensus and the evidence base and none was exclusively based on a review of the evidence. For comparison, 18 countries reported the availability of substitution maintenance guidelines, of which three are based exclusively on the evidence base. This difference probably reflects differences in the existing scientific evidence base on the topic as well as the wider context in which medical and social interventions are situated. Clinical interventions are usually subject to stricter governance and quality assurance; however, there is an increasing awareness that social interventions (including social reintegration measures) must adhere to the same principles as clinical interventions (e.g. evidence based, ethical). The most recent analysis by the EMCDDA on the availability of guidelines identified 24 guidelines across eight countries which addressed social reintegration interventions (EMCDDA, 2011b).

Where scientific research evidence of effectiveness of particular approaches is limited or inconclusive, general quality standards and good practice guidance based on professional opinions can help ensure adherence to a minimum level of quality. The following is noteworthy in this regard; specific quality standards for social reintegration are currently not very common⁽⁵⁴⁾ as treatment/rehabilitation and social reintegration are often not distinguished (EMCDDA, 2003a). However, quality

⁽⁵⁴⁾ Based upon the findings of the EQUUS research project funded by the European Commission (Justice, Freedom and Security DG). This project collected and reviewed existing quality standards in the areas of prevention, treatment and rehabilitation, and harm reduction, to develop an EU framework for minimum quality standards and benchmarks in drug demand reduction. The standards represent a concise list of minimum quality standards for services and interventions. Data were kindly provided by the project coordinators, Ambros Uchtenhagen and Michael Schaub, for the purposes of this report.

standards for treatment/rehabilitation are available in many Member States. Although these standards are not specific to social reintegration, they can serve as a valuable tool in working towards good practice and assessing the quality of services and interventions. An overview of available national guidance (in particular guidelines) in treatment is available on the EMCDDA Best practice portal ⁽⁵⁵⁾.

The European minimum quality standards project in drug demand reduction (EQUUS, Uchtenhagen and Schaub, 2011) identified several national documents that are specific to social reintegration. For example, Slovakia *has developed a document entitled 'Quality at Social Reintegration Centres for Drug Addicts and other Dependencies in Slovak Republic – Standards and Good Practices', which specifies that the individual care plan of the client must address social welfare (such as employment, education, housing, and legal issues) (56)*. In Switzerland ⁽⁵⁷⁾, the QuaTheDa accreditation system ⁽⁵⁸⁾ includes specific sections for employment support and housing services. The UNODC (2008) has published good practice guidance on 'Sustained Recovery Management', which addresses eight different domains of recovery capital, including housing, education and employment. This document highlights how existing treatment services can be improved to facilitate the social reintegration of individuals.

However, even adherence to quality standards and good practice guidance cannot guarantee the effectiveness of approaches. Consequently, there is a need in Europe for pilot interventions and outcome evaluations using high-quality methodologies to determine whether the available measures are indeed effective and cost-effective.

A broad understanding of social reintegration

At the time of writing, the EMCDDA defined social reintegration as 'any social intervention with the aim of integrating former or current problem drug users into the community'. The three 'pillars' of social reintegration are (1) housing, (2) education and (3) employment (including vocational training). Other measures, such as counselling and leisure activities, may also be used.

⁽⁵⁵⁾ <http://www.emcdda.europa.eu/best-practice/standards/treatment>

⁽⁵⁶⁾ See <http://www.infodrogy.sk/index.cfm?module=Library&page=Document&DocumentID=646&mo=6&yr=2010>

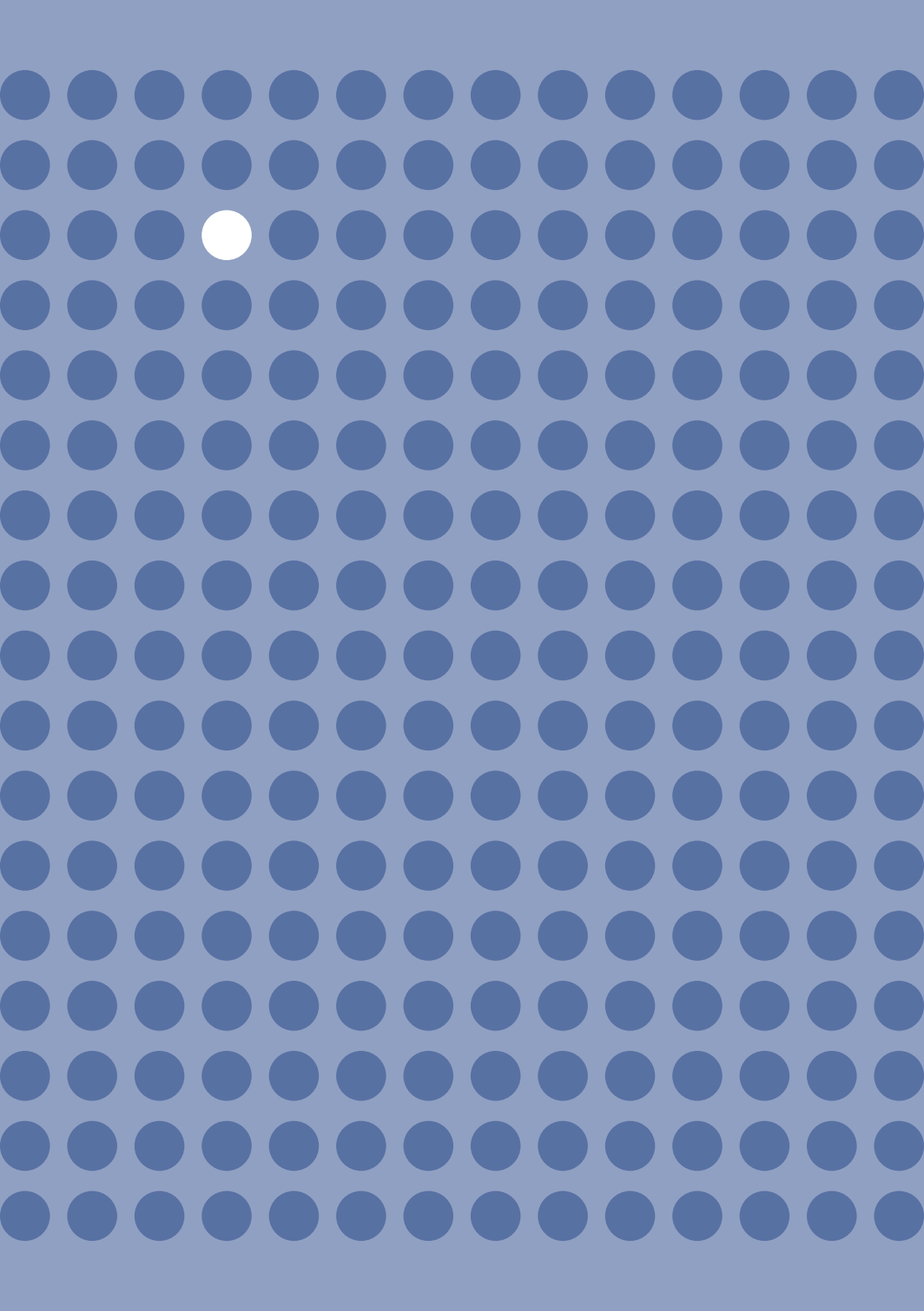
⁽⁵⁷⁾ Switzerland is not usually included in EMCDDA surveys; however, it was included in the EQUUS research project.

⁽⁵⁸⁾ See <http://www.quathedada.ch/d/referentiel.htm>

In light of the findings from the preceding review and discussion, the final section of this report proposes the following broader definition:

Any activity with the aim of preventing or reversing the social exclusion of former and current problem drug users. Social reintegration activities address needs that are not drug related, such as access to housing, education and vocational training, employment, rebuilding personal networks and relationships, and reducing discrimination. Activities can be carried out with different stakeholders (e.g. drug users, health professionals, the general public), in different settings (e.g. treatment centre, criminal justice, workplace), using different methods and contents (e.g. skills training, counselling, case management, government policy) and by different providers (e.g. specialist treatment providers, non-specialist employment advisors). Social reintegration is an integral part of the treatment process, although it can be implemented independently of treatment. In practice, differences between individuals as well as societies, together with changes over time, determine what type and level of social reintegration is desirable.

In summary, the revised definition is underpinned by the positive notion expressed in this report that social reintegration is about increasing the human, social, economic and institutional capital of vulnerable individuals with the ultimate aim of ensuring that all members of society have the same opportunity to participate fully in societal life.



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Annex 1: Glossary of technical terms

The glossary provides brief explanations of key terms used in this report. Definitions are based on a variety of published sources ⁽⁵⁹⁾, which also include definitions of drug-related terms not covered here. For definitions of social reintegration approaches and intervention types please refer directly to the respective sections in the report.

Advocacy: A political process by an individual or a large group which normally aims to influence public policy and resource allocation decisions within political, economic and social systems and institutions.

Contingency management: The use of incentives, privileges and responsibilities as rewards to enhance motivation and maintain patients' compliance in the recovery process. This method, used extensively in hospital and residential treatment programmes, is based on the principle that if behaviour is reinforced or rewarded it is more likely to occur in the future.

Cost-effectiveness: A measure of the relationship between an intervention's costs and positive outcomes. If several effective interventions are available, a cost-effectiveness analysis helps identify which intervention achieves, in relative terms, the best outcomes with fewest resources. An expensive intervention may be more cost-effective than a cheaper alternative if it produces significantly better outcomes.

Drug treatment: According to the EMCDDA Treatment demand protocol 3.0, 'Drug treatment is defined as an activity (activities) that directly targets people who have problems with their drug use and aims at achieving defined aims with regard to the alleviation and/or elimination of these problems, provided by experienced or accredited professionals, in the framework of recognised medical, psychological or social assistance practice. This activity often takes place at specialised facilities for drug users, but may also take place in general services offering medical/psychological help to people with drug problems'. However, other definitions are also available. For example, the UNODC *Demand reduction glossary* makes

⁽⁵⁹⁾ Including the following sources: WHO (1994, 1998); UNODCCP (2000); Flay et al. (2005); OCEBM (2009); Cochrane Collaboration (2010); EMCDDA website/online glossary; EMCDDA Structured Questionnaire 28; EMCDDA (2011c).

reference to reducing the negative health and social consequence of use and achieving social reintegration as part of treatment (see also Part I of this report).

Drug (treatment) courts: Courts that specialise in dealing with drug-related offences and drug-dependent offenders.

Education: In this report, 'education' is defined as a specific learning opportunity for former or current problem drug users. This implies that education is defined as the learning or upgrading of literacy or numeracy skills but does not include specific training for a given kind of job.

Effectiveness: The extent to which an intervention produces, in the real world, the desired outcomes without causing harm. Effectiveness trials test whether interventions are effective under real-world conditions or in natural settings, e.g. when delivered by a typical classroom teacher rather than a specially trained professional.

Efficacy: The extent to which an intervention produces, under ideal conditions, the desired outcomes without causing harm. Efficacy trials test whether interventions are effective under ideal conditions, e.g. when delivered by the programme developer or specially trained professionals.

Efficiency: A measure indicating whether an intervention makes optimal use of resources. An intervention is inefficient if the same outcomes could be achieved with fewer resources (e.g. fewer staff members) or if the same resources could produce better outcomes (e.g. reach a greater number of clients).

Employability: According to EMCDDA Structured Questionnaire 28, 'a person's capability of gaining initial employment, maintaining employment, and obtaining new employment if required (Hillage and Pollard, 1998). For individuals, employability depends on the knowledge, skills and attitudes they possess, the way they use those assets and present them to employers, and the context (e.g. personal circumstances and labour market environment) within which they seek work. Crucially, the ability to realise or actualise "employability" assets depends on the individual's personal and external circumstances and the inter-relationship between the two. Personal circumstances include caring responsibilities, disabilities, and household status which can all affect their ability to seek different opportunities and will vary during an individual's life cycle'.

Evaluation: The systematic collection, processing and analysis of data to assess whether an intervention's goals and objectives have been achieved, and how. Methods can utilise qualitative and/or quantitative approaches.

Evidence of effectiveness: Information on the effectiveness of interventions, typically derived from outcome evaluations and scientific research trials and reported in the professional literature, e.g. scientific journals. Different levels of evidence can be distinguished according to how the evidence was produced. In critical evidence appraisals, randomised controlled trials are usually considered to produce the highest level of evidence, whereas professional opinions are considered to represent the lowest level of evidence.

Intermediate labour market: A supportive system targeted at disadvantaged individuals to bridge the gap between (long-term) unemployment and the open labour market. It is characterised by offering paid work on a temporary contract, together with training, personal development and job search activities.

Opioid substitution treatment: A long-term intervention with the use of an agonist substance with the goal of reducing or eliminating the use of an illicit opioid drug, or to reduce harm from a particular method of administration and the attendant dangers for health.

Parole management: Specialist activities, often delivered as part of prison release programmes, whereby problem drug users with criminal convictions are paroled into drug treatment services. Assessments and referrals are made by specially trained parole officers, who act as case managers, but usually with a reduced caseload and working in partnership with a range of professionals representing treatment and vocational services.

Problem drug user: These include problem users of a broad range of illicit substances. In some Member States the definition may also include aspects of *outcomes* of drug use (i.e. social, psychological, physical or legal problems associated with use, including dependence). Differences in national definitions may be due to differences in substances that are considered problems in a country. These differences in definition of which drugs are considered problems reflect not only geographical variation in the availability and prevalence of drugs, but also the priorities of national drug policy and the relative acceptability of use of different drugs. In acknowledgement of these differences, this report uses the term ‘problem drug users’ as a proxy for all individuals who experience significant negative health and social consequences from their drug use, regardless of the type of drug used and the way it is administered.

Randomised controlled trial (RCT): In outcome evaluation research, a study type involving random allocation of individuals or natural groups (e.g. treatment centres)

to intervention groups and control groups. The assignment is random if each unit (i.e. individual or group) has the same chance of being selected for the intervention or the control group. The control group serves as a reference point to interpret changes in the intervention group (i.e. the individuals in the control group are essentially similar to the intervention participants but do not receive the intervention). Outcomes are measured in both groups before and after the intervention. Randomised controlled trials are considered to produce the most robust evidence of effectiveness.

Recovery: According to the US government Substance Abuse & Mental Health Services Administration (SAMHSA), 'a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential'. However, other definitions are also available and some have argued that (the aims of) recovery should be defined only by the individual concerned (see also Part I of this report).

Social exclusion: A process by which society (advertently or inadvertently) prevents an individual or group from participating fully in mainstream society. Social exclusion can express itself economically (e.g. poverty), politically (e.g. not having a political voice), socially (e.g. discrimination) and/or culturally. An important aspect is that socially excluded individuals or groups are unable to access services and support structures that are available to the general public (e.g. healthcare) (see also Part I of this report).

Social reintegration: According to the EMCDDA online glossary, 'any social intervention with the aim of integrating former or current problem drug users into the community'. The three 'pillars' of social reintegration are (1) housing, (2) education and (3) employment (including vocational training). Other measures, such as counselling and leisure activities, may also be used (see also Part I of this report). Note that this report proposes a revised definition (Part III).

(Social) stigmatisation: Severe disapproval of, or discontent with, a person on the grounds of characteristics that distinguish him or her from other members of a society.

Supported employment: Paid work that takes place in normal work settings (on the open competitive employment market) with provision for ongoing support services.

Supported housing: Housing services targeted at clients who are not (yet) able to live in complete independence, including transitional housing as well as (permanent) supported living.

Systematic review: According to the Cochrane Collaboration, ‘a systematic review attempts to identify, appraise and synthesize all the empirical evidence that meets pre-specified eligibility criteria to answer a given research question. Researchers conducting systematic reviews use explicit methods aimed at minimizing bias, in order to produce more reliable findings that can be used to inform decision making’.

Vocational rehabilitation: All those processes, ideas or interventions that enable people with functional, psychological, developmental, cognitive and/or emotional impairments or health conditions to overcome barriers to accessing, maintaining or returning to employment or other useful occupation.

Vocational training: Vocational training is designed to help participants acquire employment readiness and/or the practical skills and understanding necessary for employment in a particular occupation or trade or class of occupations or trades. Successful completion of such programmes often leads to a labour-market relevant vocational qualification recognised by the competent authorities in the country in which it is obtained (Ministry of Education, employers’ associations etc.).

Annex 2: 2009 EMCDDA Survey on the availability of social reintegration measures in the European Union, Croatia, Turkey and Norway (Structured Questionnaire 28)

This Annex presents further detail with regard to the findings from EMCDDA Structured Questionnaire 28 on 'Social reintegration and reduction of social exclusion of drug users'. This questionnaire was launched in 2009 in order to assess the current situation in relation to the availability, accessibility and diversity of social reintegration measures⁽⁶⁰⁾. The questionnaire requested information on the policies and interventions that EU Member States have put in place to protect drug users from further exclusion and to improve their social inclusion. Data collection took part from 2009 to 2011. The questionnaire was sent by the EMCDDA to the national focal points of Reitox, the European Information Network on Drugs and Drug Addiction, in the 27 EU Member States, Norway and the candidate countries Croatia and Turkey (30 countries in total). All countries returned the questionnaire; however, two countries (Belgium and Turkey) were not able to provide information on any of the policies or interventions. These two countries were consequently excluded from the data analysis and appear in the maps under the answer category 'No information'.

For each analysis, percentages are calculated on the basis of the number of countries reporting information for that question, taking into account that some countries were not able to provide information on specific interventions or policies, and that questions about some policies or interventions were not applicable to all countries for legal or practical reasons (e.g. a question about the content of the national drug strategy is applicable only where a national drug strategy exists). Thus, the total number of reporting countries varies between policies and interventions. It is indicated in the text on what number of countries the percentages are based (reported as 'n') and details are provided on why some countries have not been included in the calculations (e.g. whether information was not available or the question was not applicable). It should be noted that many of the figures cited

⁽⁶⁰⁾ Further information on the Questionnaire can be found on the EMCDDA website at <http://www.emcdda.europa.eu/html.cfm/index1573EN.html>

from this questionnaire relate to drug users in outpatient and residential treatment, although this report usually refers to problem drug users in general (including but not limited to those currently receiving treatment). Textual responses providing examples and qualifications are summarised and the most pertinent or common are also included. Selection of example projects is on the basis of geographic representation rather than endorsement of the approach and it must be noted that few have been evaluated for effectiveness.

The presentation of results follows the order of topics in the report, and references to sections in the report are made in italic font.

Interagency collaboration

See also the box on p. 54 on interagency collaboration

In Structured Questionnaire 28, 25 reporting countries (83 %; $n = 30$) provided information on the existence of inter-agency partnerships. Of these, 18 countries described mechanisms to coordinate the work of different ministerial departments (e.g. with responsibilities for employment, social inclusion, drugs issues). Five countries (28 %; $n = 18$) highlighted documents such as action plans, working agreements and protocols as the main means of coordination. Interestingly, 13 countries (72 %; $n = 18$) reported the existence of dedicated coordinating bodies in the form of centralised drugs agencies or committees with representation from all relevant ministries and, in some cases, additional stakeholders. For example, in the Czech Republic the Council of the Government for the Drug Policy Coordination (CGDPC) is the main coordination and advisory body to the government on drug-related issues. Members represent ministries, regions, medical associations and non-governmental organisations (NGOs) dealing with drug prevention, treatment, harm reduction and social reintegration. Where implementation of drugs strategies resides with local authorities or regions, countries also reported on efforts to coordinate the work at national and local/regional levels. In Poland, the National Bureau for Drug Prevention under the Ministry of Health oversees implementation of the drug strategy at the local level. In Austria, the Ministry of Health chairs the national drug forum, which meets twice a year to discuss relevant topics; members represent all federal ministries as well as all regional drug coordinators.

Thirteen countries (73 %; $n = 19$) reported the availability of established protocols underpinning interagency coordination partnerships between different authorities and agencies involved in addressing the health and social needs of people in drug

treatment. In Ireland, the National Drugs Rehabilitation Implementation Committee (NDRIC) is responsible for developing national protocols and service-level agreements to facilitate the implementation of case management and interagency working. The committee has developed the National Drugs Rehabilitation Framework, which assists service providers to design and implement an 'integrated care pathway' for current and former drug users, identifying needs and making referrals to appropriate services. In Romania, the National Antidrug Agency has established protocols with the Ministry of Health, the Ministry of Education, the Ministry of Labour and local NGOs, coordinating the work at central level as well as at a local level through its national network of 47 centres. According to a survey carried out in Slovakia in 2010, 18 out of 19 treatment centres (facilities providing residential treatment for 8 months or more) stated that there was cooperation with other agencies such as local psychiatrist and health services and schools. However, 14 out of 18 centres highlighted that cooperation was typically informal and relied on good personal relations. It is also worth noting that following a government restructuring in 2007 the positions of regional drug coordinators were discontinued in Slovakia. Eleven countries were not able to provide information on this question.

Seventeen countries (81 %; $n = 21$) reported the availability of partnership agreements between treatment providers and other social services. However, partnerships are not necessarily based on formal agreements but can take different forms (e.g. informal collaboration based on individual professional relationships) (see also below about informal networks). Countries reported on collaborations between treatment providers and other agencies such as health services, mental health services, transitional housing, employment services (job centres), welfare and family support services, police and probation services. Some partnerships are established naturally through the work of existing coordinating bodies on drug issues. Interagency collaboration can also be promoted through individual treatment care plans, which highlight the different services required to address client needs. Some countries also noted that formal agreements and partnerships are of less relevance where the same organisation is responsible for a range of services or where services are integrated (e.g. mental health and drugs services). Nine countries were unable to provide information about this issue.

Of the 17 countries that reported having partnership agreements in place, nine countries (69 %; $n = 13$) rated the extent of partnership agreements between outpatient treatment facilities and relevant social services as full or extensive (i.e. at

least a majority of outpatient treatment facilities have a partnership agreement with at least one social service), whereas four countries (31 %; $n = 13$) rated the extent of such partnerships as limited or rare. Several countries noted that, in order to increase the extent and strength of partnerships, greater involvement of local authorities, potential employers etc. would be required. Four countries could not provide an answer to this question. Of the 13 countries that reported on the extent of partnership agreements between outpatient treatment facilities and relevant social services, five (45 %; $n = 11$) reported that interagency coordination within outpatient treatment facilities is most commonly conducted through structured protocols, whereas six countries (55 %; $n = 11$) reported that interagency coordination is most commonly established through informal networks. Two countries were not able to provide information on this topic. It is noteworthy that across Europe informal networks play a pronounced role in ensuring interagency collaboration. Out of all reporting countries, 14 (70 %; $n = 20$) reported that informal networks represent the most common established mechanism of coordination. Ten countries were not able to comment on this question.

Of the 17 countries that reported having partnership agreements in place, nine countries (64 %; $n = 14$) rated the extent of partnership agreements between residential treatment facilities and relevant social services as full or extensive (i.e. at least a majority of residential treatment facilities have a partnership agreement with at least one social service), whereas five countries (36 %; $n = 14$) rated the extent of such partnerships as limited or rare. As noted previously, these agreements are often of a rather informal nature. Three countries reported having partnership agreements in place but could not rate the extent of their availability.

Prison setting

See also section on Criminal justice in Part II of the report

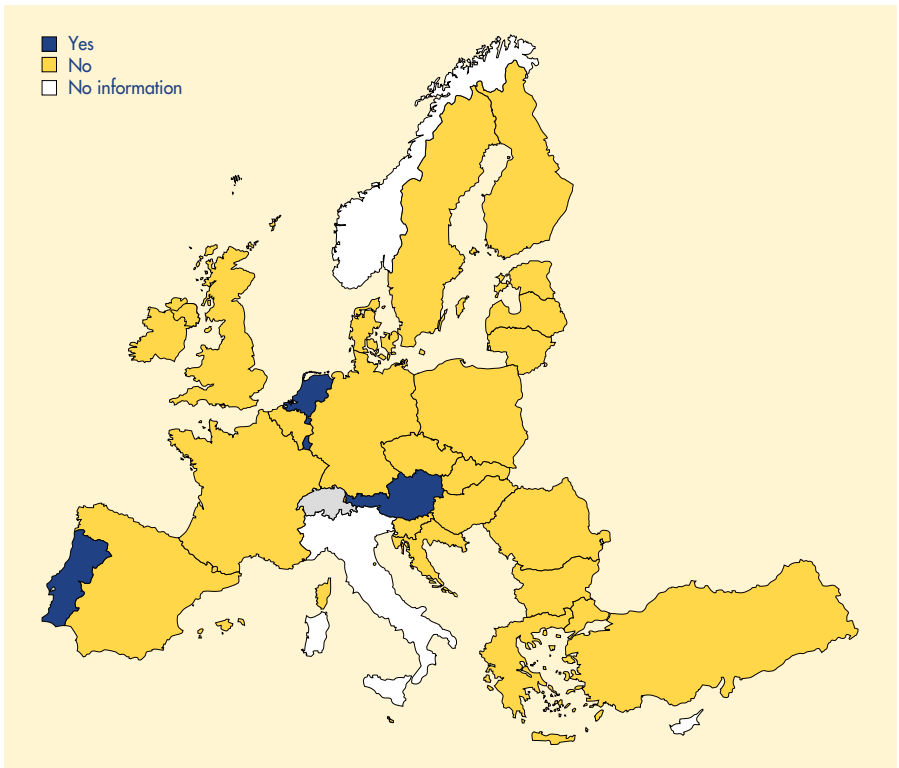
Nineteen countries (83 %; $n = 23$) reported that there are specific social reintegration interventions provided for drug users in prisons. These include general vocational training in prisons, which is available also for drug users, as well as assistance with health issues and education, training and employment (reintegration) on release. The Structured Questionnaire did not include any additional questions on social reintegration policies/interventions in the criminal justice system.

Housing

See also section on Housing in Part II of the report

Policies to address the housing needs of drug users

Figure A.1: Structured Questionnaire 28 analysis — European countries reporting that the housing needs of drug users are addressed by national social protection and social inclusion plans ⁽⁶¹⁾ (data collected 2009–11)



Four countries (16 %; $n = 25$) reported that the accommodation needs of problem drug users were specifically addressed by actions set out in national social protection and inclusion plans. In Austria the National Action Plan on Social

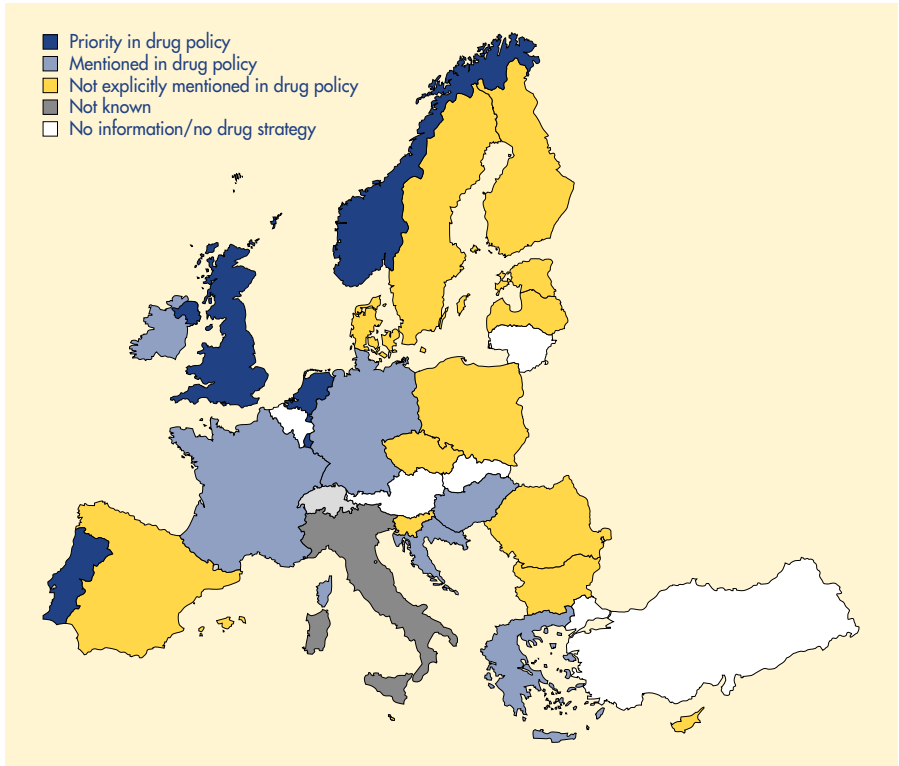
⁽⁶¹⁾ National plans responding to the wider European Social Inclusion Strategy, see section 4.1.

Inclusion (Nationaler Aktionsplan Soziale Eingliederung) states that socially assisted housing should be increasingly provided to drug-dependent people in the future. In the Netherlands, the national government and the municipalities of the four largest cities signed and funded the Strategy Plan for Social Relief (Plan van Aanpak Maatschappelijke Opvang) for those groups with the most complex and persistent needs. In a second phase of the plan, starting in 2010, the remaining 39 municipalities began implementation. In Portugal, the accommodation needs of drug users are addressed through explicit mention of the population in the National Strategy for the Integration of Homeless People.

Of the 21 (84 %, $n = 25$) countries reporting that accommodation needs are not specifically addressed, 10 (48 %) stated that drug-using groups are included in plans as part of other targeted populations, most often socially excluded or vulnerable populations. For instance, Denmark, Ireland, Poland, Romania and Sweden address these needs through homelessness strategies. In Germany the Social Service Code guarantees basic social care for all people needing social support including accommodation.

Six countries (25 %; $n = 24$) reported that accommodation needs of drug users are explicitly addressed in separate plans that support national employment strategies. These include policies on offender rehabilitation, mental health needs or other disadvantages.

Figure A.2: Structured Questionnaire 28 analysis — the priority placed on housing needs of drug users in reporting countries' drug policies (data collected 2009–11)



Eleven countries (39 %; $n = 28$) reported that the accommodation needs of drug users are a priority or at least mentioned in their drug policies. Almost half of the countries (46 %; $n = 13$) reported that accommodation needs are not mentioned in drug policy, and notably none of these reported that this group's housing status was explicitly addressed by their social inclusion plans. Where mentioned, examples of specific actions included (but were not limited to) the promotion of homelessness prevention measures and interdisciplinary cooperation in Germany, the United Kingdom and Norway; allocation of transitional and halfway housing to recovering drug users in Greece, Hungary, Ireland, Luxembourg, Portugal and Croatia; and the special provision of housing to drug users leaving prison in France.

Temporary housing and emergency accommodation

Nineteen (68 %; $n = 28$) countries reported that emergency housing was available to meet the needs of problem drug users in treatment. These tended to be night shelters, crisis centres, hostels or bed and breakfast hotels. Important features of such accommodation reportedly included the provision of sex-specific accommodation (Germany), open-ended tenancy (i.e. with no set eviction date; Greece), drug-free conditions (Latvia) and aftercare accommodation facilities co-financed by the local government (Poland). Of these 19 countries, 13 (68 %) reported that conditions were attached to the accommodation, by either local authorities or the housing provider. These were predominantly substance-free venue policies (confirmed by individual drug testing in Cyprus), preferential placement of 'stabilised' users (France, Poland), and confirmation of identity (Latvia). Greece reported that it was a requirement that tenants should not ordinarily be local residents and/or should lack family support.

Four countries (15 %; $n = 26$) reported that there was full coverage of drug treatment populations with emergency accommodation; six (23 %) that it was extensive; nine that it was limited; three rare; two not available (8 %); and two countries (8 %) provided no information. In countries where coverage was judged to be extensive (Denmark, Finland, Germany, the Netherlands, Slovakia, Norway) it was suggested that, although almost full coverage was available in the biggest cities, provision was often much less in smaller towns and cities.

Transitional/halfway housing and supported living

Twenty-one countries (75 %; $n = 28$) reported that specific housing facilities were available to meet the transitional accommodation needs of drug treatment clients. Different countries reported similar systems whereby accommodation was provided through either municipalities or private providers, with many services being offered by the voluntary sector. Overall, these services aim to support residents to become personally and socially independent and aid in helping the client to adapt to working life and social reintegration. Seventeen countries (65 %; $n = 26$) reported that there were criteria attached to accessing transitional accommodation. These included provision only for clients who had successfully completed (approved) drug treatment (e.g. Denmark, Finland, Germany, Ireland, Latvia, Poland, Portugal; current receipt of methadone maintenance prescription generally allowed), or those referred from a drug treatment centre (Portugal). In Hungary, it was reported that

access to transitional accommodation attached to rehabilitation programmes is conditional on both drug abstinence and current employment.

Regarding coverage of transitional/halfway housing, three countries reported full coverage (11 %; $n = 28$), six extensive (21 %), six limited (21 %), six rare (21 %), and five reported no availability (18 %). It is likely that in most countries, despite good or improving provision, need and demand far exceeds provision of this type of service, although this was reported explicitly only by Ireland. Latvia was one country that reported that these services were not provided to drug treatment clients for lack of resources, although they were available for people with mental health disorders. The condition that clients should also have completed drug treatment was considered a reason for limited coverage in Hungary. In Finland, Poland and Slovenia, the lack of these types of housing services for problem drug users reflected the lack of provision for the population in general.

Thirteen countries (46 %; $n = 28$) reported that specific housing facilities were available to meet the supported living needs of people in drug treatment. Several delivery models were reported by France. These included therapeutic communities, aftercare residential housing, and a family reception network which provides accommodation to drug treatment clients within groups of families trained and organised by professionals. The host families offer the client a personalised relationship in a family environment, and are paid depending on the actual time spent with them. Ten countries (77 %) reported that there were conditions attached to supported living. Most accommodation providers have their own specific entry criteria, but 'drug free' policies were common to all.

Coverage of drug treatment population's needs with respect to supported living provision was rated as full in two countries (7 %; $n = 28$); extensive in four (14 %); limited in three (11 %); and rare in four (14 %). Eight countries reported no availability (29 %). The reasons behind these ratings mostly related to lack of priority in national policy, although Finland reported that as well as overall provision being limited, where it was available, supported housing services were mostly targeted at problem drinkers as the illicit nature of drug users' dependency restricted access for service users who were still undergoing treatment.

Independent living support

Sixteen countries (57 %; $n = 28$) reported that problem drug users are offered programmes or services to facilitate access to independent living in the general

housing market. These types of programmes are considered a standard part of aftercare in the Czech Republic, whereas in Greece clients at some treatment services receive a rent subsidy while they are receiving care. Other countries (e.g. Denmark, Finland, Portugal, the United Kingdom) reported that, although no specific housing entry programmes exist, problem drug users are not excluded from general support activities (e.g. housing support payments, practical housing support such as debt counselling and life skills training). A model of 'sliding tenancies' (*baux glissants*) has been established in France, whereby the treatment centre takes on rental of private housing and sublets to a client. It signs the inventory of fixtures and lease and pays the rent to the owner. The housing allocation (housing support payment) is paid directly to the centre and the remaining rent (rent minus housing allocation) is paid for by the subtenant. After a probationary period, which may range from 6 months to a year, the tenancy 'slides' and the subtenant (client) then becomes the official tenant of the premises.

Access to social housing

Twenty-two countries (79 %; $n = 28$) reported that social housing facilities were accessible to problem drug users in treatment. In most of these countries, problem drug users were eligible under the same conditions as other population groups, whether deemed excluded/vulnerable or not. In Austria, however, it was reported that in some regions there is an explicit strategy to ensure that problem drug users are able to access social housing. In Poland, social housing is provided by the local council based on the recommendation of the local housing commission, taking into consideration the advice of the relevant social welfare centre and healthcare centre/doctor. It was not reported whether problem drug users receive preferential treatment under this system.

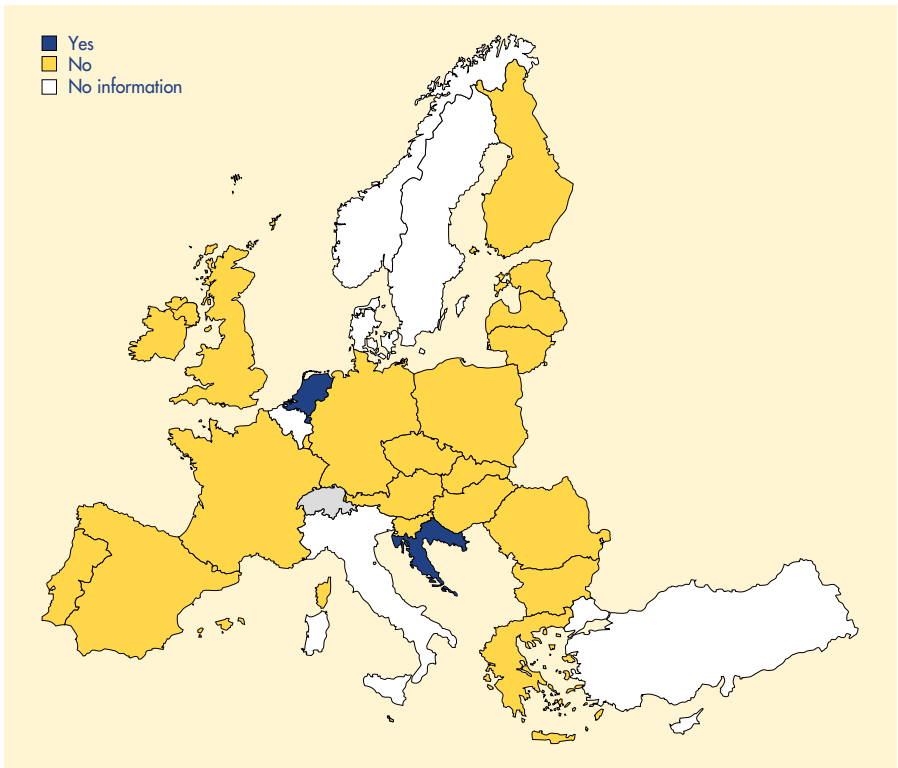
Of these 22 countries, eight (36 %) reported that criteria/conditions were attached to accessing social housing facilities for drug treatment clients. Few relevant examples of conditions were given, but it was reported that, in the Netherlands, social housing was generally allocated to only those clients who were assessed as being able to live independently, which would exclude some of those clients with the most severe drug-related needs or those with co-morbidities/additional needs.

Education and (vocational) training

See also section on Education and (vocational) training in Part II of the report

Policies to address the educational needs of drug users

Figure A.3: Structured Questionnaire 28 analysis — European countries reporting that the educational needs of drug users are addressed by national social protection and social inclusion plans (data collected 2009–11)

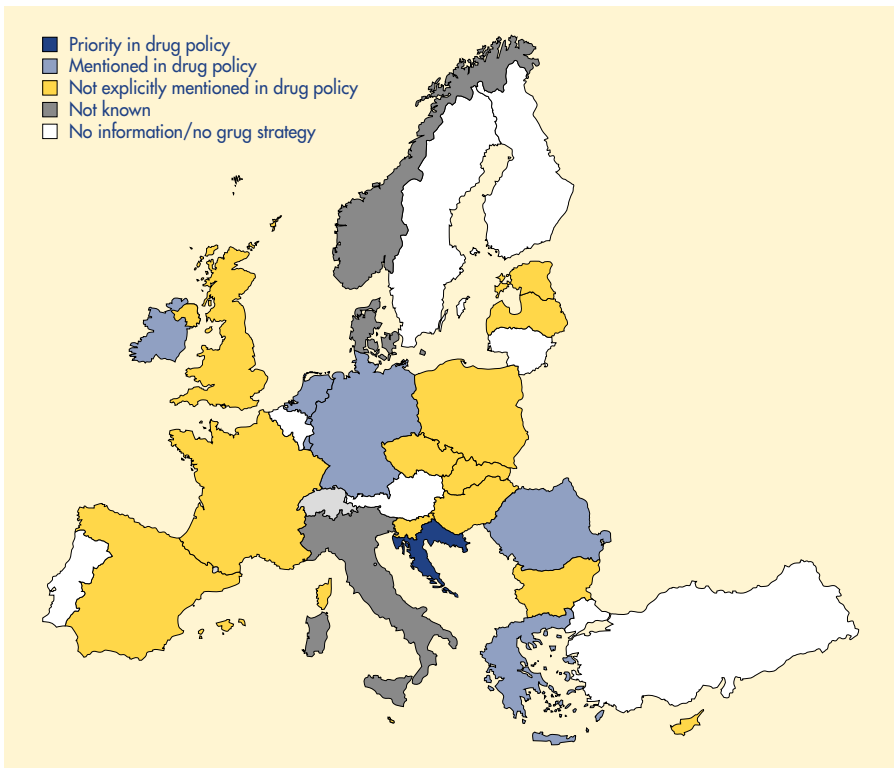


Two countries (9 %; $n = 23$) reported that the educational needs of drug users were explicitly addressed in their national social protection and social inclusion plans. In the Netherlands, addiction, social reintegration and educational needs are all mentioned; in Croatia, drug-dependent persons have a right (i) to access vocational and educational training while residing in therapeutic communities, specialist

housing facilities or prison, (ii) to finish high school education that was previously started upon leaving therapeutic community or prison and (iii) to attend education in accordance with labour market demands. Seven countries (30 %) were unable to provide any information on this issue.

Of the 21 countries (91 %; $n = 23$) stating that these needs are not addressed, seven reported that drug-using groups are included in national plans as part of other targeted populations, such as young people with criminal offences, early school leavers or young people living in poverty. Eight countries (38 %) reported that drug users are not addressed as part of any other target groups, and six (29 %) countries did not provide information on this question.

Figure A.4: Structured Questionnaire analysis — the priority placed on educational needs of drug users in reporting countries' drug policies (data collected 2009–11)



Five countries (26 %; $n = 19$) reported that the educational needs of drug users are specifically addressed in separate social inclusion or education strategies or action plans, for example on a regional level. Eleven countries (58 %) were unable to provide information on this question.

Seven countries (35 %; $n = 20$) reported that problem drug users' educational needs were either an explicit priority or at least mentioned in written drug policy. Related actions and objectives include the provision of training and education as well as individual support and case management, interagency collaboration, earmarked funding and the identification and removal of possible barriers to access. For example, provision of education and vocational training is offered as part of drug treatment in Germany, Ireland and Croatia. In Luxembourg, a socioprofessional reintegration centre with accommodation facilities is included in the National Drugs Action Plan and is scheduled to open in 2012. In Romania, drug treatment clients are assigned a series of case workers as part of a multidisciplinary team, which typically includes an educational officer who is tasked to assess and respond to the client's educational needs. The Plan for Financial Assistance for the Rehabilitation of Former Substance-Dependent Persons of the Ministry of Labour in Cyprus covers the fees for taking part in vocational training or educational programmes as well as for attending higher education institutions. Six countries (30 %) did not answer this question, and this question was not applicable in four countries (20 %; including Austria and Lithuania, where there is no national drug plan available).

Education programmes

Twelve countries (55 %; $n = 22$) reported that there are interventions to facilitate the access of people in drug treatment to educational systems. For instance, Greece offers transitional schools that target treatment programme clients who dropped out of education at any level or are high school graduates who wish to prepare themselves for higher education admission examinations without being obliged to attend classes. Slovenia provides some special education programmes that are shorter than regular programmes but still lead to qualifications.

Sixteen countries (76 %; $n = 21$) reported the availability of educational programmes or services, accessible to drug users, that target socially vulnerable groups. These include vocational training, training through the National Adult Literacy Association (NALA) (Ireland), training schemes, employment training, and 'second chance schools' (Greece).

Six countries (37 %; $n = 16$) reported that there are conditions attached to accessing educational interventions for people in drug treatment. Across most countries these included demonstrable motivation and willingness on the part of the client and management of their substance use. In Greece, those attending 'second chance schools' must be over 18 and have at least graduated from primary education, and all prospective students are required to attend an interview conducted by a committee.

Vocational training approaches

Twenty-one countries (75 %; $n = 28$) reported that general vocational training interventions for socially vulnerable groups were accessible to people in drug treatment. Eleven countries reported that criteria were attached to participation. In Malta individuals need to be registered as actively seeking employment with the employment service. However, special arrangements are made between drug treatment agencies and the employment services so that residential drug treatment clients (who may not be actively seeking work) are able to benefit from training. In Austria and Finland it was reported that, although criteria differ between programmes, clients are often required to be 'job ready', which means that they need to be drug free or at least have stabilised their use.

Seventeen countries (61 %; $n = 28$) reported that specific vocational training interventions were provided to drug treatment clients. No examples of specific programmed approaches or intervention models were provided, but training was often provided within treatment services.

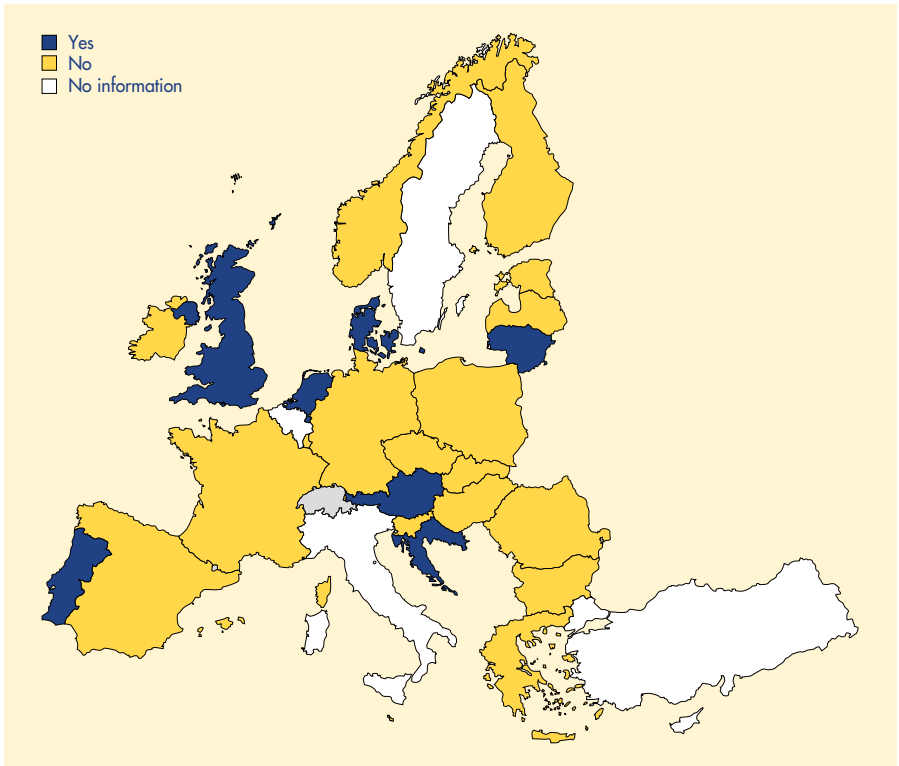
Coverage of population needs through vocational training was rated by one country (4 %; $n = 27$) as full; eight extensive (29 %); eight limited (29 %); three rare (11 %); and none as unavailable. In Malta attendance on vocational training courses is mandatory for people registering for employment and so provision was also rated as extensive. Lithuania reported that coverage was limited partly because clients had little motivation to pursue vocational training. Portugal rated its coverage as rare, reporting that in 2009 only 23 % of the 2 150 clients with identified professional training needs had received training.

Employment

See also section on Employment in Part II of the report

Policies to address the employment needs of drug users

Figure A.5: Structured Questionnaire analysis — European countries reporting that the employment needs of drug users are addressed by National Employment Plans ⁽⁶²⁾ (data collected 2009–11)



Seven countries (25 %, $n = 28$) reported that employment needs of drug users were explicitly mentioned in their national employment plans ⁽⁶³⁾. Activities in Croatia are

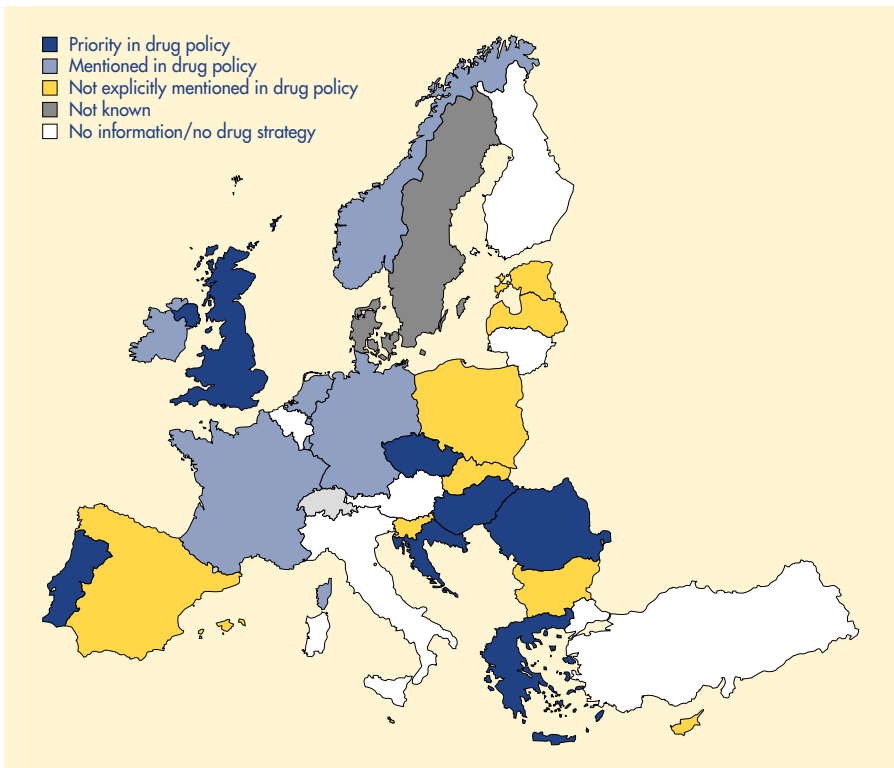
⁽⁶²⁾ National plans responding to the wider European social inclusion strategy, see section 4.1.

⁽⁶³⁾ Plans constructed in response to the wider European employment strategy.

specifically aligned with the European employment strategy (EU Guideline 7), Promoting the integration of, and fighting discrimination against, persons in an unfavourable labour market position. These measures are aimed towards prevention of discrimination against treatment clients and recidivism after completed treatment. The other countries reported policies relating to subsidised and supported employment and general vocational rehabilitation aimed at current and former treatment clients.

In those countries where employment needs of drug users were not included in national employment plans, six (29 %, $n = 21$) reported that they were included in other target groups, for example as part of long-term unemployed groups (Czech Republic) or socially excluded groups (Poland, Slovakia).

Figure A.6: Structured Questionnaire analysis — the priority placed on employment needs of drug users in reporting countries' drug policies (data collected 2009–11)



Four countries (14.3 %; $n = 28$) reported that employment needs of drug users were included in other plans that correspond to the national employment plans. These included regional addiction institute programme reports (Netherlands) and national drug policy that mapped onto employment plan reporting requirements (Croatia).

Seven countries (26 %; $n = 27$) include the employment needs of problem drug users as a priority in their written national drug policies. These range from more general measures to ensure that drug users are included in employment policies in the Czech Republic to specific objectives and actions in Greece (e.g. linking treatment with participation in the labour market, intersectoral and -departmental cooperation and ensuring the provision of vocational training programmes) and Portugal (providing easier access to academic training, professional skills development and employment). In Hungary, national policy outlines the requirement for appropriate funding in order to maintain protected work places and strengthen intensive multisectoral professional cooperation. United Kingdom drug policy includes multiple strategies to improve employment in problem drug users, for example joint working between treatment providers, housing and national employment agencies, and the development of national referral pathways to ensure that drug users who receive welfare are able to access treatment. In Croatia, vocational counselling is based, in part, upon treatment service clients' existing professional qualifications and skills and how these serve the demands of the competitive labour market.

Intermediate labour market interventions

Twenty-one countries (95 %; $n = 22$) reported the availability of general intermediate labour market interventions for socially vulnerable groups which were also accessible to people in drug treatment. Typically, individuals become eligible for taking part in such interventions by virtue of their long-term unemployment. Countries reported the availability of social firms and enterprises as described in Part II of this report, but also included job search support services, vocational training opportunities, job placement and financial incentives for employers in this category. Eight countries (36 %) did not provide any information on this question.

Intermediate labour market interventions specifically targeted at people in drug treatment (or those who have successfully completed treatment) were reported by 12 countries (52 %; $n = 23$). Examples given by countries included temporary employment within drug services, support in finding work (case management approach) and training opportunities. Seven countries (30 %) did not report on this question.

Of the 23 countries reporting the existence of general and/or specific intermediate labour market interventions, 13 countries (72 %; $n = 18$) stated that participation in these interventions is conditional upon fulfilling certain criteria. Requirements vary between countries and programmes, but included being abstinent from drugs or stable on substitution treatment, a minimum length of unemployment (typically 6, 12 or 24 months), demonstrating motivation and commitment, physical ability to work and age restrictions. Five countries (22 %) that had such interventions in place did not comment on this question.

Of the 23 countries reporting the existence of general and/or specific intermediate labour market interventions, eight (47 %; $n = 17$) stated that at least a majority of people in drug treatment in need of such interventions could participate upon request (full or extensive coverage), whereas nine countries (53 %; $n = 17$) reported limited or rare coverage of the treatment population. Germany reported the level of coverage as extensive but noted that the occupational field and geography may not always correspond to participants' needs. Of the countries rating the level of coverage as rare, Ireland reported that there were approximately 200 places available in the intermediate labour market that could be accessed by recovering drug users. France reported that an estimated 253 000 people (61 000 full-time equivalents) were employed in the intermediate job market in 2006; however, demand exceeded availability of places and because of this competition the most disadvantaged problem drug users are least likely to obtain a place. It is also important to note that coverage can be decreased because not all drug users who are interested in taking part are eligible to do so. For example, in Portugal (also rating its level of coverage as rare) the *Vida-Emprego* programme uses strict selection criteria to ensure that individuals are able to take responsibility for a work relationship. Six countries (26 %) with such interventions in place had no information on the level of coverage.

Employment support interventions

Eighteen countries (86 %; $n = 21$) reported the availability of general employment support interventions to assist socially vulnerable groups in securing and maintaining paid employment which were also accessible to people in drug treatment. Countries reported the availability of supported employment approaches as described in Part II of this report, but also included social firms and enterprises, job search support services, job placement, vocational training opportunities and financial incentives for employers in this category. Hence, programmes do not always distinguish clearly between the

intermediate labour market and supported employment in the open labour market. It was also noted that problem drug users may receive less formal forms of support from the occupational physician or through existing links with treatment services. Nine countries (43 %) did not provide any information on this question.

Employment support interventions specifically targeted at people in drug treatment (or those who have successfully completed treatment) to assist with securing and maintaining paid employment were reported by 11 countries (44 %; $n = 25$). Examples given by countries included not only supported employment but also education and vocational training and financial incentives. The Netherlands reported on a specific intervention which ensures that recovered problem drug users cannot lose their job if they relapse into dependence. Five countries did not provide information on this question.

Of the 22 countries reporting the existence of general and/or specific employment support interventions, 11 (69 %; $n = 16$) stated that participation in these interventions was conditional upon fulfilling certain criteria. Requirements included having difficulties in obtaining employment without support, being registered with the public employment service, receiving state benefits, a minimum length of unemployment (typically 6, 12 or 24 months), being abstinent or stable on substitution treatment, demonstrating motivation, physical ability to work and age restrictions. Six countries that had such interventions in place could not comment on this question.

Of the 22 countries reporting the existence of general and/or specific employment support interventions, five (36 %; $n = 14$) stated that at least a majority of people in drug treatment in need of such interventions could participate upon request (full or extensive coverage), whereas nine countries (64 %; $n = 14$) reported limited or rare coverage of the treatment population. Portugal rated its level of coverage as limited and reported that 1 115 clients took part in the Vida-Emprego programme in 2009; however, this figure is contrasted with over 4 600 users with identified employment-related needs. Eight countries with such interventions in place had no information on the level of coverage.

Welfare benefit system

See also section on General policy in Part II of the report

Thirteen countries (50 %; $n = 26$) reported the availability of measures within the welfare system to facilitate the movement of people in drug treatment (or those who

have completed treatment successfully) into the labour market, most commonly the provision of training courses, supported employment opportunities, as well as tax reduction and salary subsidies for employers. In some cases, it was reported that it was not drug dependence or being in treatment per se that qualified individuals to benefit from these measures but another condition (e.g. ill health, disability, long-term unemployment). Four countries were unable to answer this question.

The role of employability in drug treatment

See also the box 'Staying realistic — adjusting interventions and outcomes to individual needs', p. 139.

Employability of people in drug treatment is a regular standard objective (e.g. included in individual treatment care plans) in 15 reporting countries (71 %; $n = 21$). Employment is often seen as one of the key indicators for successful reintegration and it is consequently regarded as one of the main objectives of treatment and social reintegration. For example, Greece reported that finding a steady job within a certain period of time is a common condition for remaining in reintegration programmes. However, several countries recognise that employment may not always be feasible given the individual circumstances of the client (e.g. health status) or external conditions (e.g. availability of suitable jobs).

Consequently, employment is seen as a long-term (rather than a short-term) objective in some countries. The Netherlands reported that the goal of employment is included in treatment plans only for those people in drug treatment for whom it is thought to be feasible. In Portugal, there is the recognition that in some cases the achievement of intermediate objectives (rather than employment itself) may be the best possible result. Nine countries were not able to provide information on this issue.

Annex 3: Key employment indicators in social reintegration (employability) research

This Annex outlines indicators that might be useful in evaluating employment *outcomes* in European social reintegration research. This is not intended to be a review of research methodology (for that see, for example, EMCDDA, 1999, 2007, 2010d) but provides a range of indicators that might be used to assess service outcomes. These are derived from the current literature review. Please note that these examples are not intended as recommended sets of outcome measures, which would require extensive discussion and piloting, but instead provide measures to aid decision-making with respect to both intervention planning and research.

Tiffany and colleagues (2012) made five broad recommendations, listed below, to help select outcomes, and it is useful for the reader to refer to their full guidelines:

1. The outcome must be a consequence or a strong, concurrent correlate of excessive drug use.
2. The outcome has broad clinical or societal salience and relevance.
3. The outcome is common across abused substances and widespread among people dependent on those substances.
4. Practical measures with documented, strong psychometric properties are available to assess the outcome.
5. There is replicable evidence that the outcome can be altered following treatment for addictive behaviours.

It should be noted that ‘Days worked/employed or in school’ as an outcome was considered by Tiffany et al.’s expert working group (convened by NIDA, USA) but they concluded that it did not adhere to these guidelines. Reasons for exclusion of this outcome were not specified but, as suggested by our review, it probably reflects a lack of ‘evidence that the outcome can be altered following treatment for addictive behaviours.’ (Tiffany et al., 2012, p. 712).

Outcome domains

1. **General employment activities** — derived from outcomes reported in the studies included in the review
 - Full-time employment

- Part-time employment
- Education and training
- Volunteering
- Unemployed and seeking work
- Unemployed and not seeking work (carer responsibilities, health reasons)
(these two categories may also be assessed on the basis of welfare receipt)
- Ineligible for work (e.g. outside of the statutory working ages)

2. Employment classification

The ISCO-08 (International Labour Organisation, 2008) classification is recognised by the UN and divides jobs into 10 major groups:

- 1 – Managers
- 2 – Professionals
- 3 – Technicians and associate professionals
- 4 – Clerical support workers
- 5 – Service and sales workers
- 6 – Skilled agricultural, forestry and fishery workers
- 7 – Craft and related trades workers
- 8 – Plant and machine operators, and assemblers
- 9 – Elementary occupations
- 0 – Armed forces occupations

The statistical classification of economic activities in the European Community (NACE ⁽⁶⁴⁾) may also be used but its 21 categories may be too detailed for most outcomes-based research.

3. Employment outcomes

- Mean hours worked per week/month/other time period
- Length of employment
- Hourly wage
- Quality of employment, including job satisfaction

⁽⁶⁴⁾ http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Glossary:Statistical_classification_of_economic_activities_in_the_European_Community_%28NACE%29

4. Moderator variables

- Local employment rates
- Financial management (e.g. from the British Household Panel Survey, *How well would you say you yourself are managing financially these days? Would you say you are* [Living comfortably]; [Doing alright]; [Just about getting by]; [Finding it quite difficult]; [Finding it very difficult]; [Don't know])
- Employment readiness.

In **EMCDDA Structured Questionnaire 28** on social reintegration and reduction of social exclusion of drug users, 11 countries (40.0 %; $n = 27$) reported that they had developed outcome indicators regarding housing for people in drug treatment. Not all countries reported what these were. Examples of reported outcomes were number of housing units provided to treatment clients (Luxembourg); 'stable' housing (the Netherlands); accommodation status (the United Kingdom) and type of housing (e.g. social housing, emergency accommodation) of clients who have left treatment (Poland).

Eight countries (30 %; $n = 27$) reported the availability of outcome indicators regarding educational interventions or programmes. The Social Reintegration Questionnaire of the Greek Reitox national focal point includes questions about the number of people in treatment who attended educational interventions or courses and the number of students who successfully passed exams. Austria reported that individual monitoring and evaluation of programmes takes place, but that a national indicator is not available. In keeping with housing indicators, Poland collects information on educational participation in clients who have left drug treatment. In Croatia the total number of drug treatment clients and prisoners with drug problems receiving educational programmes is reported at a national level.

Nine countries (33 %; $n = 27$) reported the availability of vocational training indicators. Reitox national focal points in Greece, Poland, Portugal and Croatia collect data on the number of people in treatment or who have completed treatment who participate in vocational training courses, whereas in other countries this tends to be collected on a programme level and not reported nationally.

Eight countries (30 %; $n = 27$) reported that outcome indicators regarding labour market participation of people in drug treatment were available. The Social Reintegration Questionnaire of the Greek Reitox national focal point includes questions about the number of people who are employed and the number of people who have found a job. In the United Kingdom the Treatment Outcomes Profile, which monitors client drug treatment outcomes, includes data on employment-focused outcomes (days of paid work in the previous 28).

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