DRUG & ALCOHOL FINDINGS Hot topic

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GO Promoting recovery through employment

Almost wherever you look among the UK's national drug policies in England, Scotland and Wales (and perhaps only peripherally in Northern Ireland), employment is seen as both an asset to rehabilitation and recovery from dependent drug use, and a social obligation for drug users who can work and contribute to society. In contrast, employment is more likely to feature in alcohol strategies as a benefit of leisure industries.

Setting the stage for a discussion of employment interventions, this hot topic first examines the prominence of unemployment in the population of problem substance users, and the many barriers to work. It also raises questions about: how realistic competitive employment is for people whose lifestyles have revolved around obtaining drugs (rather than honing their CVs) and perhaps gaining a criminal record in the process; at what point in a person's journey the goal of employment should be on the table; and if employment is predominantly a 'means to an end' of achieving recovery and reintegration, whether it would be more fruitful to look beyond the binary outcomes of 'being in work' or 'not being in work'?

Unemployment and other social factors compound social exclusion

Unemployment is remarkably high amongst people in treatment for substance use issues, yet arguably one of the under-reported socioeconomic characteristics of this group. In England between 2015 and 2016, only 24% of patients were in paid work at the start of treatment (much lower for opiate patients at 16%) according to the National Drug Treatment Monitoring System, and this was increased only very slightly at the six-month re-assessment to 25% (and 18%).

There is arguably a tendency for low levels of employment among this and other stigmatised groups to be framed in the pejorative, as 'worklessness' or being 'workshy'. But for many, unemployment is one of a multitude of factors that signify social exclusion, and have the cumulative effect of obstructing their ability to participate fully in society (including finding gainful employment). Across Europe, for example, many problem drug users have unmet housing, education, employment, and other social needs, often evident before their substance use. This includes income below the poverty line, insecure or no housing, fewer years of education, and fewer educational qualifications than the general population.

At an individual level, reasons for being unemployed could include being too unwell or having a lifestyle too unstable to work, and being unable to find or maintain work, as well as official figures not recording engagement in unpaid work or work not recognised by the state.

For those who are employed, it can be seen as a sign of recovery, and a way to increase financial independence, build new social networks, and improve self-esteem. Yet sometimes overshadowed by urgent health, social and housing needs, employment is not always the immediate priority.

In the Drug Treatment Outcomes Research Study, which predated the 2008 English national drug policy that adopted 'reintegration through employment', treatment-seekers themselves reported that they didn't prioritise this objective. At treatment entry most prioritised ending drug use; for half their goals included "Sort life out/get it together", but just 1 in 5 specified employment as a way of sorting their lives out, and for just 1 in a 100 was this a primary goal. This was despite the fact that over three quarters (77%) were unemployed. As background notes on the study explain, it could be that they saw it as too early in treatment to contemplate

such a goal, except that for 71% it was not actually early in their treatment careers because they had been in treatment before.

A realistic ambition?

In December 2016 Professor Dame Carol Black published the findings of her independent review into the impact of drug and alcohol addiction on employment outcomes, which she assessed alongside obesity. She identified three areas of action:

> *Addiction treatment does not, in itself, ensure employment, though it brings other social gains. Work has not hitherto been an integral part of treatment, and it needs to be if progress [with employment outcomes] is to be made.*
>
> *The benefits system, which has a central role in helping people enter or return to work, requires significant change. The system is hampered by a severe lack of information on health conditions, poor incentives for staff to tackle difficult or long-term cases, and a patchy offer of support for those who are reached.*
>
> *Employers are the gatekeepers to employment and, without their co-operation employment for our cohorts is impossible. Employers are understandably reluctant to hire people with addiction and/or criminal records. They have told us that they need Government, quite simply, to de-risk these recruitment decisions for them.*

Although the "mutually-reinforcing relationship between employment and recovery" was acknowledged, the focus of the review was on employment as the endpoint, rather than employment as a way of boosting recovery – made clear in the foreword where she prefaced the report by saying, "The aim is not to offer utopian solutions to deeply complex problems, but rather to offer, as far as possible, an evidence-based analysis of the factors that stand in the way of employment".

Employment along with housing and education are the pillars of 'social reintegration' – an approach to substance use (and an aim beyond substance use) that looks at building a person's involvement and stake in their community. In a 2012 report, the European Monitoring Centre for Drugs and Drug Addiction identified an urgent need to increase access to social reintegration interventions for problem drug users; and, although unable to pin down the best approaches, stressed that reintegration measures should be embedded into drug treatment at an early stage.

The focus on reintegration into mainstream society through employment is not new. In the 1960s it was fundamental to the original US methadone programme organised and evaluated by Vincent Dole and Marie Nyswander of New York's Rockefeller Institute for Medical Research. However, when their treatment had become a mass programme, the economic climate had changed and patients more often had multiple needs while their reintegration was impeded by diminished access to affordable housing and suitable jobs.

Problem use of drugs like heroin and crack tend to be concentrated in areas of high unemployment and deprivation, where finding a job is even harder than the national average. For example, in 2011 the most deprived areas of Scotland saw over seven times more GP consultations for drug problems per 1000 of the practice population than in the most affluent areas, a differential not seen for non-drug use consultations. And in 2015/16, half (51%) of patients with a hospital stay for an acute issue related to drug use lived in the 20% most deprived areas in Scotland. Unlike recreational drug use, addiction to illegal drugs thrives in areas distinguished by poverty, few job opportunities and a lack of community resources.

Though employment is at the heart of the government's 'recovery' agenda, finding a job has been omitted from national payment-by-results criteria which determine how treatment services in some areas will be funded, perhaps an acknowledgement that in the recessionary times when the criteria were drafted, jobs were an unrealistic target for this patient group. At local level too, only a minority of areas have exercised their discretion to include employment-related criteria.

Reticence to set payment-by-results schemes up to fail is understandable given the barriers to employment faced by problem drug users, enumerated in a report commissioned by the Department for Work and Pensions: lack of education and skills; physical and mental health problems; low self-confidence; social disadvantage; drug use itself; inadequate access to support services; problems engaging with employers and support professionals; dealing with stigma; criminal records and spells in prison; the need to attend for (especially methadone) treatment; fear that job-related stress might precipitate relapse; reluctance of employers.

Under-resourced effort

Rather than more resources to help overcome these barriers, the recent picture has been one of the withdrawal of resources or the abandonment of support plans. Lost on the way were the Progress to Work scheme for problem drug and alcohol users, and funding for dedicated JobCentre coordinators to organise support for drug-using claimants. Lost too were the planned Welfare Reform Drug Recovery Pilots, a voluntary set of extra supports for benefit claimants being treated for their drug problems, relieving them of the need to look for work while they focus on their recovery.

Under previous Universal Credit benefit arrangements, patients in addiction treatment could be relieved of the need to look for work for six months, though by the end of 2014 this benefit was available to few claimants and just 0.3% of the anticipated recipients were receiving it. In April 2017, guidance on Universal Credit support for people dependent on drugs or alcohol was withdrawn, and is no longer being updated. The latest guidance omits to mention whether this group specifically is entitled to any support.

The decision whether to offer time free of the requirement to seek work for patients in addiction treatment lies in the hands of local JobCentre officials, a sign of the localism which has taken over in the JobCentre front line, anything more than the minimum being subject to the priorities and flexibilities afforded to district managers.

GOVERNMENT PROGRAMMES

At a national level the main initiative is the Work Programme launched in June 2011 for people at risk of long-term unemployment. As with other claimants, problem substance users on job-seekers' benefits can be mandated to this programme after nine or 12 months depending on age or other circumstances.

> *People often face a steep climb before paid employment is an option*

Like some addiction treatment services, the Work Programme operates on a payment-by-results basis. The large companies responsible for delivering the programme are free to do more or less what they think best to achieve these results, including arranging addiction treatment for claimants. A prime disadvantage is the programme's binary 'working or not' criterion for rewarding these companies, one out of kilter with the gradualist approach more suitable for people facing a steep climb before paid competitive employment is an option, who generally want and need to traverse education, training, job-finding skills, volunteering, and supported employment, and may get stuck at any of these stages.

According to the (now defunct) national drugs charity DrugScope, the result is that the Work Programme "is delivering very little for people with histories of drug and alcohol use … because the funding model has failed to incentivise the provision of specialist services". Addicts and ex-addicts are among the jobseekers furthest from the job market who tend to be 'parked' by Work Programme companies, which gain more from lower hanging fruit. With little to prompt this, the partnership working between job centres, treatment services, and Work Programme providers expected to benefit problem substance users "is generally absent", said DrugScope. These shortcomings were also identified by the parliamentary Work and Pensions Committee as obstructing progress to work for the most disadvantaged jobseekers in general, and drug and alcohol users in particular.

Seemingly acknowledging that routine arrangements were not working well for problem substance users, in January 2013 the Department for Work and Pensions announced two pilot schemes involving extra payments to Work Programme providers which help these clients find jobs, or for closer working between the Work Programme and addiction treatment providers. It appears these fell under the scope of the Drugs and Alcohol Recovery Payment by Results Pilot Programme – the interim report of which was published in June 2014. The follow-up report was expected in October 2014, and final report in March 2015, but these, if they were published, are not readily available.

Whilst acknowledging shortcomings, guidance published in 2012 by the National Treatment Agency for Substance Misuse (now part of Public Health England) determinedly accentuated the positive, highlighting examples of good practice developed locally, which support the rather limited conclusion that since 2009 there has been significant progress "in some parts of the country" in addressing the employment-related needs of people in drug and alcohol treatment. For this guidance, "progress" was defined mainly in terms of improving the *process* (rather than outcomes for clients), for example: partnership working between job centres, treatment services, and Work Programme providers of the kind (see above) DrugScope and the Work and Pensions committee found generally missing; good communication facilitated by a single point of

contact in each treatment system, JobCentre Plus district office and Work Programme provider or local subcontractor; shared training; outreach in the form of JobCentre Plus and Work Programme staff in treatment and recovery services, and vice versa; three-way review meetings between client, treatment keyworker and either JobCentre Plus or Work Programme advisor; and continuity of care afforded by treatment, recovery and employment support providers working in a joined-up way.

Seemingly not so positive for those using the services, people with drug and alcohol problems participating in a 2017 Public Health England review experienced Jobcentre Plus and Work Programme staff as having few signs of knowledge or awareness of drug use and recovery, and as sometimes being unfriendly and unwelcoming. This changed, however, when Jobcentre Plus work coaches were co-located within the user group or treatment service, when users saw this as a much more positive and valuable feature.

From 2017, the Work Programme is expected to be replaced by a new Work and Health Programme, aimed at people who "require additional support than that available through Jobcentre Plus to enter employment". Though the full remit is still to be determined, it is expected that this would include people with drug and alcohol issues.

TREATMENT PROGRAMMES

Outside and predating the Work Programme framework, addiction treatment services have tried to promote employment to progress and embed their clients' recoveries. Assessing links between drug treatment outcomes and employment over a 20-year period (1995–2015), the Learning and Work Institute found:

- A strong relationship between being in work and positive drug treatment outcomes.
- Improved likelihood of entering into employment after successful drug treatment.
- Employment plays a role in improving engagement with, and adherence to, drug treatment.

From Scotland, came evidence that treatment services may indeed be able to help, as patients who received employment-related support as part of their addiction treatment package were three times more likely later to find work. However, the study observed normal treatment processes rather than deliberately allocating patients to receive or not receive employment-related help, maing it impossible to be sure that the help actually caused the elevated employment rates it was associated with. Further analyses established that patients who had started the study in residential rehabilitation were over twice as likely to have received employment-related help, yet were not significantly more likely to have found work – 29% had done so, but so had 20% in methadone services or other non-residential treatments. Another approach trialled in England was to place treatment staff in job centres to facilitate referral to treatment, intended to help ready claimants for employment. In three high drug use urban areas, it did raise the treatment entry rate, but not enough to recommend a national roll-out.

Background notes in the Effectiveness Bank examining the Drug Treatment Outcomes Research Study (DTORS) in detail suggest that an important component of treatment-generated employment outcomes is services presenting themselves as facilitators of employment – meaning that patients see employment-related goals as being achieved by going to those services. Only a minority of patients in DTORS recalled receiving employment-related help from any source, and presumably fewer still would have received this help from the treatment service. With few patients aiming for employment progress, few being offered help to progress, plus for many an unappetising CV, it was no surprise that little progress was made: 9% employed at baseline barely rose to 11% at three to five months and 16% at about a year, but the high proportion not followed up casts doubt on whether any progress was made at all, or whether it was just that employed people were easier to find and re-interview. Little progress was made too in laying the foundations for stable employment in terms of improved mental health and housing. The former would have been impeded by poor partnership working with mental health services, the latter was for some a major barrier to life changes, reportedly made intractable by the unavailability (physically or because of housing priorities) of suitable housing. In general, in-depth interviews with clients and staff suggested that individualisation of treatment in response to broader client needs and aspirations was limited.

Generally across the world the evidence for employment-promoting initiatives within addiction treatment is at best patchy. Among the studies is one from New York which found that even though it helped welfare applicants overcome substance use problems, intensive case management did not help men find a job, but women did benefit to a small extent. The traditional 'gradualist' approach taken in this study has been contrasted with appropriate support targeted at rapid competitive employment, among which the most prominent is the Individual Placement and Support model.

A “well-evidenced approach” for people with severe mental illness (with research spanning 20 years), Individual Placement and Support provides employment support alongside clinical treatment – uniquely casting employment specialists as equal members of multi-disciplinary teams. The evidence base for substance use clients is comparatively small, but promising, for example showing that it could help substance users find employment in the open labour market, rather than sheltered placements. Professor Dame Carol Black’s independent review recommends a robust trial of high-fidelity Individual Placement and Support, as well as an arm of the trial that tests the approach with a limited duration of support. An expensive approach, cost–benefit estimates suggest that those who find employment would need to sustain this for 145–181 days with the high-fidelity approach in order for the Exchequer to break even, or 93–116 days if the wider benefits to society were taken into account.

If the evidence that treatment promotes employment is patchy, so too is the evidence that employment programmes promote recovery from addiction. This disappointing record could partly come down to how success is being defined, and informing this, the extent to which the dual motivations of ‘employment for the individual’s sake’ and ‘employment for society’s sake’ are informing policy and practice. Edging away from the tendency to see employment as the only desirable outcome, the UK Drug Policy Commission’s 2008 report on getting problem drug users into jobs suggests an ‘employment continuum’ – where, sandwiched between long-term unemployment and long-term employment, are: treating mental and physical health problems; building motivation and aspirations; stabilising drug use; providing appropriate stable accommodation; developing ‘soft skills’ (eg, through volunteering); training; building financial skills; work trials and job placements; and in-work support.

Run this search to pick out the bright spots in the topic of employment and recovery, and, perhaps as importantly, get a feel for what does not work and what it is reasonable to expect.

Thanks to Paul Anders of Public Health England for bringing the Universal Credit arrangements to our attention.

Last revised 12 July 2017. First uploaded 01 January 2010