



## **Social Security Advisory Committee consultation**

### **The Social Security (Claimants Dependent on Drugs)(Pilot Scheme) Regulations 2010**

#### **DrugScope/London Drug and Alcohol Network (LDAN) response**

DrugScope is the UK's leading independent centre for expertise on drugs and the national membership organisation for the drugs field. In 2009 DrugScope merged with the London Drug and Alcohol Network (LDAN).

DrugScope's objectives are:

- To provide a national voice for the drug sector
- To inform policy development drawing on the experience and expertise of our members
- To support drug services and promote good practice
- To improve public understanding of drugs and drug policy

DrugScope believes in drug policy that:

- Minimises drug-related harms
- Promotes health, well-being, inclusion and integration
- Recognises and protects individual rights
- Recognises and respects diversity

DrugScope is committed to:

- Promoting rational drug policy debate that is informed by evidence
- Involving our membership in all our policy work
- Ensuring our policy interventions are informed by front-line experience
- Speaking independently and free from any sectoral interests
- Highlighting the unique contribution of the voluntary and community sector.

## 1. Introduction

1.1 DrugScope welcomes the opportunity to respond to the Social Security Advisory Committee (SSAC) consultation on the Social Security (Claimants Dependent on Drugs)(Pilot Scheme) Regulations 2010. DrugScope's response reflects wide consultation with our membership on welfare reform. We have over 700 members (individuals and organisations) representing a wide range of people and organisations working in drug policy, drug treatment and related services (including criminal justice, homelessness agencies and mental health services). We are also working with Clinks, Homeless Link and Mind to develop the Making Every Adult Matter campaign, with funding from the Calouste Gulbenkian Foundation, which has a particular focus on treatment and social (re)integration for highly marginalised people who experience multiple needs and multiple exclusions.

1.2 We have appreciated the opportunities we have had to inform the development of policy since the publication of the Green Paper 'No-One Written Off' in 2008. These included a joint consultation event that DrugScope co-hosted with the Department for Work and Pensions (DWP) in Central London in October 2008; the development of our response to the Green Paper, based on extensive consultation with our membership; regular meetings with officials; and the opportunity to give written and oral evidence to the parliamentary scrutiny committee on the Welfare Reform Bill. We also worked closely with MPs and peers from all parties to ensure Clause 11 and Schedule 3 of the Bill were scrutinised in parliament. We are now participating in the steering group that has been set up by the Department of Work and Pensions for the evaluation of the welfare reform drug recovery pilots and Progress2Work-LinkUp.

1.3 DrugScope has been involved in a number of projects on pathways to employment for people with drug and alcohol problems. We were represented on the advisory group for the UK Drug Policy Commission's report 'Working Towards Recovery: Getting problem drug users into jobs'. DrugScope is responsible for the London Drug and Alcohol Network (LDAN), which is currently being funded by the City Parochial Trust to deliver a two-year project to identify and disseminate good practice in developing effective links between drug and alcohol treatment and education, employment and training provision in London, and to facilitate workshops on welfare and employment topics. We have worked closely with drugs-co-ordinators in London on this project and have involved senior officials at the DWP in recent meetings.

1.4 We note that the Explanatory Memorandum refers to the 'drugs lobby' in para 63 and 126. We are concerned that the use of this term could create a misleading impression in describing organisations which have responded to

previous consultations, while appreciating that this was not the intent. DrugScope, for example, does not lobby on behalf of a particular sectoral or interest group, nor have we been part of a wider lobby in this sense. Our arguments are based on consultations with DrugScope members and stakeholders from a wide range of backgrounds and with different views and interests. We believe our role has been to articulate the concerns of drug policy experts and specialists, including those involved in frontline services, both as providers and service users. One of our core commitments is to 'speaking independently and free from any sectoral interests'.

1.5 We appreciate the Government's flexibility in responding to some of the main concerns that DrugScope and others had raised about the Green Paper and the Bill. In particular, DrugScope was concerned that, as originally drafted, the legislation would have enabled the Secretary of State for Work and Pensions to require Jobcentre customers to submit to medical treatment. This would have represented a major expansion of the powers of the Secretary of State and introduced a novel form of conditionality into the social security system, with the potential to be extended to other medical or health conditions. We were pleased that the Government accepted changes to the Bill in the House of Lords, including the insertion of an explicit statement in the legislation that claimants cannot be required to comply with any form of medical or surgical treatment.

1.6 The Explanatory Memorandum (para 17) states that 'although some drug organisations and charities were concerned about coercing people into drug treatment, many welcomed the proposals for the introduction of compulsion to a series of assessments with treatment providers and believed that it will provide the impetus that many problem drug users need to get them into treatment. Many groups (including treatment providers and service users) were supportive of the aims and objectives, provided positive support processes, such as the proposed treatment allowance are introduced'.

1.7 DrugScope has consistently supported the policy focus on social inclusion for people with drug problems. We applauded the recognition in the 2008 Drug Strategy that drug problems 'may be both the cause and consequence of wider social and personal problems', and its recognition of the need for 'a radical new focus on services to help drug users to re-establish their lives'. Access to education, training and employment is critical for social (re)integration. People with a history of drug problems can find it extremely difficult to access work. The Drug Treatment Outcome Research Study (DTORS) has estimated that 80% of problem drug users are unemployed. We have supported Progress2Work. We are supportive of treatment allowance and the introduction of voluntary rehabilitation plans. We have welcomed and

supported the investment in the new drug co-ordinator roles within Jobcentres.

1.8 However, we have also argued consistently for an approach based on voluntary participation with the emphasis on 'carrots' not 'sticks'. We continue to have concerns about the fairness and effectiveness of the new investigative procedures detailed in Schedule 3 of the Welfare Reform Act, as well as about mandatory rehabilitation plans and the related use of benefit sanctions. We are unclear, therefore, what consultation process the Memorandum is referring to where it states that 'many' drug organisations and charities 'welcomed the proposals for the introduction of compulsion to a series of assessments'. DrugScope was not formally consulted on compulsion to attend assessment and education programmes, and we have reservations about these plans.

1.9 To summarise our overall position, we support welfare reform to increase the numbers of people with drug problems in contact with treatment services and who access education, training and employment opportunities. Nor are we opposed to the idea that rights to benefits imply corresponding responsibilities on the part of claimants. However, we believe that the application of the 'responsibilities' agenda in its extended form to people with a history of serious drug problems has underestimated the formidable barriers that can deter them from accessing education and employment, and the long-term processes of change which motivate people to engage with drug treatment services and move on with their lives.

1.10 Potentially coercive measures directed against extremely marginalised and stigmatised people risk reinforcing negative attitudes to them, entrenching their disengagement from statutory services and mainstream society, causing hardship and damaging communities, if they resort to other, illegal, sources of income. We believe an appropriate 'sanction' for problem drug users in the social security system who do not disclose drug problems or engage with treatment is that they are not able to access the additional benefits associated with a 'treatment allowance' and the personalised support provided through a 'voluntary rehabilitation plan'. They should not be sanctioned further by loss of benefit.

1.11 If we are to succeed in achieving the shared objective of moving more problem drug users on benefits into treatment, education and employment, we believe that the benefit regime must recognise that:

- Many problem drug users will find it difficult to disclose that they have drug problems, and will need reassurance and support in an appropriate setting to talk about them;

- There is no evidence that benefit sanctions will be effective for this group and there are concerns about the impact, both on the individual and others;
- Expectations of treatment must be realistic. Research has established that recovery journeys out of long-term drug dependency can take many years;
- Multiple need is common among people with serious drug problems (for example, many problem drug users have physical and mental health problems, are homeless or in insecure housing and have criminal records);
- Problem drug users often face other significant barriers to employment (including skills deficits and employer attitudes);
- For many problem drug users entry into mainstream employment may be an appropriate long-term aspiration, but not a realistic short term goal (in the language of the Gregg Report they belong to the 'progression to work' group), and it is important that benefit levels be set at an adequate rate and other forms of meaningful activity are available for this group.

1.12 The Welfare Reform Act responds positively on some of these issues (for example, the treatment allowance recognises that problem drug users may need a significant period of time and support before they will be ready for mainstream employment), but raises concerns in other respects (for example, in its approach to disclosure and sanctions). We'd also like to see more investment in work with employers. The UK Drug Policy Commission's research found that two thirds of employers would not be willing to take on a recovered problem drug user even if satisfied that they had the skills for the job (although experience among employers who did recruit from this group were reported to be very positive). Such attitudes are a formidable barrier to recovery.

## **2. General Comments on the Explanatory Memorandum**

2.1 Para 9 promises an expansion of Progress2Work, combined with the LinkUp scheme. DrugScope would like to see a sufficiently thorough evaluation of the impact of Progress2Work-LinkUp outside the pilot areas, partly to allow some comparison of outcomes with those in the Welfare Reform Drug Recovery Pilots (WRDRPs). We note that the Audit Commission report 'Tackling Problem Drug Use' (2010) recommended that Progress2Work should be reviewed in order to evaluate outcomes, identify the aspects of Progress2Work that are most successful and assess value for money. The Audit Commission suggested that the Progress2Work programme was expensive for each drug user helped into a medium or long-term job and that the success rate is low and below target. The cost of the programme for each

drug user who kept a job for 13 weeks or more was £10,900 in 2006-07, fell to £8,000 in 2007-08 and increased to £11,600 in 2008-09. DrugScope would question whether this is 'expensive' in view of the potential economic and social benefits of getting problem drug users into sustainable employment. We would also like to see a wider range of outcomes taken into account in assessing the impact of the Progress2Work-LinkUp programme (i.e. the sorts of 'distance travelled' measures that will be considered in the WRDRP evaluation).

2.2 Para 13 states that the Government view is that 'sanctions have been shown to be an effective mechanism to encourage compliance with the requirements of the benefit system and should be used to encourage drug users to engage in treatment services'. We are unaware of research or other evidence for a positive impact of sanctions for this client group. Research conducted by the Department of Work and Pensions suggests that benefit sanctions have little positive impact on key client groups (offenders and lone parents), and that they can have a negative impact on claimants' children, and local communities if people turn to illegal sources of income.<sup>1</sup> In February 2009, prisons minister, David Hanson, announced the results of a pilot scheme to impose benefits sanctions on offenders who were not complying with their community orders. The minister admitted that improvement in compliance had been "modest" at only 1.8% and had cost the taxpayer £5.60 for every £1 it saved. The scheme has now been abandoned.

2.3 Para 14 states that: 'Drug users already fall foul of the sanctions regime. Each year Jobcentre Plus makes over 240,000 decisions to impose sanctions in JSA alone. It is likely that drug users receive a disproportionate number of sanctions by failing to sign-on at the right time, or failing to show that they are actively seeking employment due to the chaotic nature of their lives'. While this statement does not differentiate between claimants who may be using drugs and 'problem drug users' (i.e., users of heroin and/or crack cocaine) - the group subject to new measures in the pilots - it is an important point, and provides a strong argument for the 'treatment allowance'. Where Jobcentre customers are compliant with voluntary rehabilitation plans this would be expected to result in a significant fall in benefit sanctions against this group as it suspends job-seeking or work-related activity requirements in order to provide problem drug users with time and space to focus on treatment. However, Jobcentre customers on mandatory rehabilitation plans will continue to be subject to job-seeking and work-related activity conditions, while being required to comply with a range of additional conditions too (such as attending assessments and educational programmes). Among this group, it would be a

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<sup>1</sup> Department of Work and Pensions (2004), 'Research Report 198, Evaluation of the community sentences and withdrawal of benefits pilots' and Department of Work and Pensions (2008), 'The Effect of benefit sanctions on lone parents' employment decisions and moves into employment'.

reasonable expectation that they will experience an increase in sanctions, both under the JSA or ESA conditionality and the mandatory rehabilitation plan.

2.4 It is not only the number of sanctions that is significant to evaluation of the policy, but the different forms of conditionality that are involved. It is entirely reasonable to expect claimants receiving JSA to be available for work and to make this a condition of entitlement to benefit. A different form of conditionality is being introduced into the social security system to require JSA claimants, for example, to submit to medical assessment or attend an educational programme as a specific step towards undergoing medical treatment as a condition of receiving benefit, even allowing that this is only permissible where it is believed that they have a drug or alcohol problem that is 'affecting their prospects of obtaining or remaining in work'. This is a new form of conditionality, which represents a significant extension of the powers of the Secretary of State for Work and Pensions, and could be extended to claimants with other health issues which may be considered to affect prospects of employment. Under the Welfare Reform Act it could be applied to a much wider group of people who are dependent on or who have a propensity to misuse other illegal drugs and alcohol. It is a principle that it is possible to envisage being extended in future to cover issues such as diet and exercise when related to a medical or health condition.

2.5 Para 23 explains that 'if the pilot proves successful consideration will be given to taking powers to widen this approach to people whose dependency on other harmful drugs or alcohol affects their employability'. DrugScope would question the extent to which pilots for problem drug users – defined as people dependent on heroin and/or crack cocaine – will provide meaningful guidance on the impact of widening the same approach to people with other drug or alcohol problems. We have expressed concern that this regime could be extended to claimants 'dependent on' or who 'have a propensity to misuse' any drug. In particular, the term 'propensity to misuse' is amenable to potentially broad interpretations, and most people who use controlled drugs at some point in their lives address their drug use with no formal intervention from the drug treatment system, which may not anyway be able to provide appropriate interventions for them. Any widening of the approach would further extend the powers of the Secretary of State for Work and Pensions to impose conditions on Jobcentre customers to address health problems that could be a barrier to employment. This could be particularly controversial if applied to misuse of alcohol.

2.6 Paras 36-41 deal with mandatory referral outside the pilot areas. Para 36 states that the policy intent is 'to require suspected PDUs to attend a discussion with a drug treatment provider to ensure they are aware of the

support and services that are available to them', and that a benefit sanction may apply for failure to attend without good cause. Para 38 explains that this approach 'will apply to customers claiming JSA or ESA who self admit problem drug use and are not in treatment where their drug use is a barrier to their employment'. Para 41 explains that 'whilst PDUs will be required to attend these discussions, and can be sanctioned for not doing so, there is no similar requirement on them to answer questions about their drug use'. We remain unclear as to how mandatory referral outside the pilot areas will work, and would welcome further clarification. For example, it is stated that the policy intent is to engage '*suspected*' PDUs, but later that it will only apply to people who '*self-admit*' to problem drug use. It is unclear which Jobcentre customers will be asked about their drug use and under what circumstances? Will this be based on 'personal adviser suspicion' and subject to the same criteria, processes and safeguards that will apply in the pilot sites (paras 59-63)? Or is the intention to ask all new JSA and ESA claimants about their drug use? Or will mandatory referral only apply to customers who admit to a drug problem unprompted, but are not prepared to voluntarily attend for an assessment?

2.7 Paras 49-50 deal with 'random assignment' to support evaluation of the impact of the pilots. DrugScope comments on these proposals in the section below that looks at evaluation.

2.8 Para 54 states that where a Jobcentre customer has failed to attend a 'required assessment' - as part of the Drug Intervention Programme (DIP) - under section 63B of the Police and Criminal Evidence Act 1984 (as amended by section 7 of the Drugs Act 2005), this information can be provided to the Jobcentre. At this point, 'the personal adviser will call the customer into the office and notify them that they are required to answer questions about this information. This may then lead to a requirement to attend a substance related assessment'. This raises issues about possible duplication or overlap of interventions where information is shared between the criminal justice and welfare systems. Under these circumstances, will the individual concerned still face criminal sanctions for failing to attend a 'required assessment' under PACE, and/or be expected to attend at a future date? Are there circumstances in which the individual could be expected to attend for both a DIP assessment and an SRA through the Jobcentre? Or would the SRA effectively take the place of the required assessment, with the Jobcentre reporting back to the relevant criminal justice agencies on the outcome? This is not clear.

2.9 A person can be required to attend a DIP 'required assessment' if, after charge or arrest, they test positive for a Class A drug. A drug test does not differentiate between crack cocaine and powder cocaine and cannot of itself

determine whether someone is dependent on or is a regular user of drugs. As stated below (para 6.1), we are concerned that the regulation setting out the power to require someone to answer questions does not include a threshold, condition or standard of proof which the Secretary of State must first satisfy. The purpose of the requirement to answer questions is to enable the Secretary of State to determine whether someone is currently using heroin and/or crack cocaine and whether they are 'dependent on' or 'have a propensity to misuse' the drug(s). As a positive drug test can only establish that a drug was present in the body at the time the test was conducted, it is questionable whether evidence of a positive test provided by a third party is sufficient and reasonable grounds alone to require someone to answer questions.

2.10 Para 56 deals with sharing of prison data. It states that this could result in an individual leaving prison being "fast tracked" to the welfare reform drug recovery pilots 'if the customer has admitted problem drug use is a barrier to work'. It is not clear how this will make a difference in practice, given that a Jobcentre customer in the pilots will be placed on a voluntary rehabilitation plan if they admit that problem drug use is a barrier to work. Is it envisaged that people identified as problem drug users by prison data could be placed on mandatory rehabilitation plans, and, if so, what information will they be given when asked for consent to the data being shared? Will ex-prisoners identified in this way be subject to the 'random assignment' processes that are being used for purposes of evaluation?

2.11 Para 59 states that 'if there is no disclosure during interview, but the personal adviser has reasonable grounds to suspect that an individual is a problem drug user, they will review the case at a minimum with their manager and the Drugs Co-ordinator to agree there are reasonable grounds for suspecting problem drug use'. It is unclear what will constitute the basis and form of this review. It will occur at a very early stage in the process, and neither the manager nor the Drugs Co-ordinator will necessarily have spoken to or seen the client. We infer that the kind of oversight they will be able to provide at this stage will primarily be to ensure that the personal adviser is following the relevant guidance, as well as providing support for the personal adviser's actions at a more senior level.

2.12 Para 61 identifies a series of 'factors' that personal advisors will be asked to take into account in deciding if there is reasonable ground for suspicion that a customer is a problem drug user. This is a particularly controversial area. DrugScope has consistently expressed concern that Jobcentre Plus staff without specialist knowledge of substance misuse and assessment will have to make these judgements based on limited observation. We are unaware of any methods for reliably identifying people with drug problems on the basis of

observation, and are not clear of the evidence-base for this particular set of criteria.

2.13 We seek reassurances that personal advisers will not have powers or permission to submit claimants to any form of 'medical examination' (for example, by asking them to roll their sleeves up for signs of injecting or asking them questions with the specific intent of making an assessment of their mental functioning). We are concerned that these criteria will disproportionately target claimants who are already subject to a high level of sanctioning under normal JSA and ESA conditionality (for example, for missing appointments), and subject them to additional forms of conditionality, in the absence of robust evidence that this group are significantly more likely to be problem drug users. We would also seek reassurances that it would not be permissible to introduce systems that would automatically flag people for referral to answer questions about drug use where – for example – they have made a set number of crisis loan applications.

2.14 We have concerns that the application of these criteria will raise equality issues – not least, because they may result in disproportionately targeting Jobcentre customers with mental health problems and other disabilities (in particular, as drowsiness, disorientation and incoherent answers to questions can be side-effects of a number of prescription drugs). For similar reasons, the application of these criteria will tend to identify Jobcentre customers who may be drug and/or alcohol users, but are not problem drug users in the required sense (i.e. users of heroin and/or crack cocaine). For example, somebody may be missing appointments or may provide incoherent answers to a question because they have an alcohol problem. Jobcentre advisers will need guidance on how to deal with other substance misuse issues that emerge during this process in an appropriate way. Could a Jobcentre customer argue that he or she should not be referred for further questioning or a substance-related assessment because the behaviour that has led to a 'reasonable suspicion' is the result of other forms of drug and alcohol use? If so, what will be the appropriate response (and we note that this would not qualify the customer for a 'voluntary rehabilitation plan' or for a 'treatment allowance' even if the drug and/or alcohol problems were serious).

2.15 Paras 61 and 62 state that the guidance will set a 'minimum standard' for advisers to follow. It is a concern that the proposed guidance for the important matter of setting a minimum standard has not been included in the Explanatory Memorandum. While having serious reservations about the list of factors, if they are to be used DrugScope would prefer an approach where 'reasonable grounds for suspicion' depended on a minimum number of criteria (e.g., at least three) being met on at least two separate occasions. We would like to see 'unkempt appearance/hygiene issues' removed from the list of factors, as it

does not relate directly to problem drug use and will be especially difficult to apply in a consistent way. It could also raise equality issues, as there are different understandings of what constitutes an 'unkempt appearance'.

2.16 We note that the 'pilot volumes' data provided by the SSAC estimates that only 50 customers will be 'identified via adviser suspicion' in the pilot areas, and would question whether this level of throughput is a sufficient return given the problems and risks associated with these proposals.

**Comments from DrugScope and LDAN members on list of factors for identifying PDUs**

'We do not believe that a list approach to signs and symptoms of potential drug use is ever useful, particularly when used by people that are not training and qualified in substance misuse'.

'Could be a personal judgement by staff along the lines of either prejudice or "I don't like the look of you"'.

'There needs to be an understanding that it will probably be a combination of these factors and not just one in isolation. I doubt that there will be sufficient training or understanding by Jobcentre Plus Personal Advisors around problem drug use, and there is every likelihood that assessments will be made incorrectly. I know there is a caveat that this needs to be agreed with the line manager or the drug co-ordinator, but in effect the decision will be left to the front line staff'.

'I do not believe that a person can judge through a one-off assessment ... there needs to be repetition of the various factors to enable a pattern to emerge'.

'How many [factors from the list] ... need to be in place for the process to be activated?'

'Many of the items on the list could be misinterpreted and indeed are not indicators of drug use. They are value judgements on drug users. Not all drug users are dirty and unkempt. It would also lead to discrimination against people with mental illness who also often display some of the traits on this list'.

2.17 Para 68 states that there is an expectation that the new additional support programme (ASP) 'will build to a full time schedule of up to 30 hours a week'. DrugScope would welcome additional information on what it is expected to be included in the ASP. There is a concern that this could result in people being required to attend programmes with limited or inappropriate content, and that this could significantly increase the numbers of benefit claimants who fail to comply with voluntary rehabilitation plans.

2.18 Para 72 states that ‘there will be no sanction should an individual withdraw from treatment. They will return to mainstream conditionality.’ DrugScope welcomes this approach, which we proposed in our original response to the Green Paper ‘No-one Written Off’, it means, in effect, that the ‘sanction’ is to be deprived of the ‘benefits’ associated with the treatment allowance, and represents a form of ‘contingency management’ for which there is a promising evidence base in the drug treatment field. We would, however, welcome clarification on two key issues. First, at what point will an individual be considered to have ‘withdrawn’ from treatment? It is normal for people with serious drug problems to miss some sessions and appointments and relapse is often a part of the journey to recovery. There may also be circumstances in which a customer on treatment allowance is not satisfied with the particular treatment provision that was agreed in their original rehabilitation plan, but is committed to seeking out some alternative form of Tier 3 or Tier 4 treatment. What would happen under such circumstances? Second, where people who continue to have serious drug problems have failed to comply with the conditions of a voluntary plan could this be a basis for picking them up through the mandatory route? If so, will they be informed that this is a possible consequence of non-compliance?

2.19 Para 75 deals with ‘substance related assessments’. It explains that ‘the treatment provider will assess whether the claimant is a PDU, and if so whether their condition requires and is susceptible for treatment’. Para 78 states that ‘no further action will be taken if the customer is found not to be a problem drug user’. DrugScope would like further clarification of what the response will be in three sets of circumstances. First, if a customer is identified as a problem drug user, but the treatment agency does not believe that their condition is susceptible to treatment (this might be the case, for example, if someone had a crack cocaine problem and a personality disorder, such that they were not judged to be susceptible to the available psycho-social interventions). Second, if the treatment agency determined that someone was only treatable in a particular setting or agency (for example, a residential drug treatment service). Third, that the customer is assessed as having a drug or alcohol problem that requires and is susceptible to treatment and is a barrier to work, but does not relate to heroin and/or crack cocaine use.

2.20 Para 80 deals with the treatment awareness programme, stating that one of its key objectives is to ‘develop a flexible structure in order to provide 1-to-1 sessions where referral volumes do not constitute a group, or where individuals request it on an exceptional basis’. DrugScope has raised a number of concerns about the content of the proposed treatment awareness programme, and we would be interested in further details of the evidence base on what is effective in engaging people who are attending a programme under threat of a benefit sanction, and are likely to be resistant to entering drug treatment

services. We have a particular concern about some confidentiality and equality issues. It appears unreasonable to require Jobcentre customers to participate in group work who are, at best, extremely reluctant to disclose a drug problem, and may deny that they are a problem drug user. It is also important that people are not compelled to attend or engage with aspects of treatment awareness programmes that are not appropriate given their age, gender, ethnicity, culture, religion, sexuality and/or disability status. We seek reassurances that these points will be taken into account in determining the 'exceptional basis' on which individuals can request 1:1 sessions.

2.21 Para 83 states that 'failure to attend any session without good cause will result in benefit sanctions'. DrugScope would be concerned if a sanction was incurred for missing a single session, and had understood from officials at the Department of Work and Pensions that this was not the policy intention.

2.22 Para 84 is concerned with voluntary drug tests. It states that 'we intend to apply this provision only to customers who have been referred to a SRA on the basis of personal adviser suspicion alone. If such a customer has been required to attend a SRA, but fails to do so the adviser may offer the individual the opportunity to take a voluntary drugs test to confirm this prior to any sanction being applied'. It is unclear why the option of taking a voluntary drug test should only be available once somebody has failed to attend an SRA, and not as an alternative to being referred for an SRA in the first place. If the Government's view is that, where there is a 'reasonable suspicion' that a Jobcentre customer is a problem drug user, this can be challenged by voluntarily submitting to a drug test, then it would seem logical that the claimant should have recourse to this option at any point in the investigative process. It is relatively quick and, given the estimated number of claimants in the pilot areas to which it could apply, inexpensive.

2.23 Para 88-92 deals with mandatory drugs tests. DrugScope does not believe that benefit claimants should be subjected to mandatory drug tests in any circumstances, and we have set out our concerns in previous responses to Government consultations. We note that para 89 states that for mandatory drug testing to be permitted 'the Secretary of State must be satisfied that one or more tests will determine whether the claimant is a problem drug user'. While drug testing can determine whether someone has recently used heroin or cocaine, it cannot distinguish between crack and powder cocaine, and it cannot distinguish between one-off users and people with drug dependency problems. DrugScope would therefore question whether, given the current drug testing technology, the Secretary of State can ever be satisfied that one or more tests, in the absence of an assessment, can determine if the claimant has a drug dependency problem that requires and is susceptible to treatment.

2.24 We note that the SSAC estimated that only five customers will take each of the voluntary and mandatory drug tests. It is unclear how these estimates have been arrived at.

### **3. Comments on assessment of impact**

3.1 Para 120 states that 'evidence will need to be collected to show the reasonable grounds that were used to refer a customer to a SRA or a series of mandatory drug tests'. DrugScope is concerned that these processes should be transparent and open to challenge. What access will Jobcentre customers have to this evidence, and what opportunities, if any, will there be for independent challenge of a decision to refer somebody for an SRA or mandatory drug testing?

3.2 Para 123 explains that 'there is a significant training requirement for personal advisers', particularly if they are going to 'use the reasonable grounds for suspicion powers', and further notes that 'Health and Safety considerations will also need to be considered for personal advisers'. DrugScope welcomes the commitment to training personal advisers, and believes that it's content should be focussed not just on the 'use of the reasonable grounds of suspicion powers' as such (which will be based on applying a list of factors, and where there is not an established knowledge base), and more on challenging negative attitudes to PDUs and their prospects of recovery; identifying and discussing reasons why Jobcentre customers could be reluctant to disclose a drug problem to an adviser; and on dealing with people who may be disclosing substance misuse issues for the first time in a sensitive and supportive way.

3.3 Para 131 states that 'we will engage with drug treatment service user groups in each of the pilot areas to ensure that they have a full understanding of pilot activity, and to enable them to feed into the planning and implementation process'. DrugScope strongly supports this commitment to service user involvement. We would like to see an explicit commitment to involving service users in the training programme for Jobcentre personal advisors and in peer reviewing the suitability and fitness-for-purpose of leaflets and other communication literature produced for Jobcentre Plus customers in the pilot areas. We would also expect to see service user representation on the joint Jobcentre Plus/NTA implementation groups in each pilot area if the decision is made to create these groups to manage the deployment of the pilots (para 135)

#### **4. Comments on design of the pilot evaluation**

- 4.1 The plans to carry out the pilots on a 'random assignment basis' with customers being allocated to either a control or intervention group is first outlined in paras 49 and 50. Para 50 explains 'that customers already in treatment will be informed about the pilot and if they express an interest in participating on a voluntary basis will also be randomly assigned. Customers not in treatment will be randomly assigned at the point at which they are identified as problem drug users by advisers. Given the mandatory nature of the interventions their consent as to their participation in the pilot will not be sought'.
- 4.2 DrugScope has a number of concerns about this approach, which have both practical and ethical dimensions. For example, whether a new or existing customer who has a serious drug problem and is complying with a treatment programme will be placed on a treatment allowance and offered support will be determined on an arbitrary basis, without reference – for example – to level of need or likely responsiveness to treatment. Those who are not selected for the programme may continue to incur a high rate of sanction under the JSA or ESA regimes, while others with an identical profile are no longer subject to this conditionality. Could someone who is identified as a problem drug user by Jobcentre advisers applying the 'reasonable suspicion' criteria, but who subsequently consents to drug treatment, be denied access to a voluntary rehabilitation plan and treatment allowance at this point? It seems unfair to subject someone to a mandatory process of investigation and then to deny them access to help if they elect to take this option as a response to this investigative procedure. Will those who are not selected for the intervention group be referred to, or provided with, other kinds of help?
- 4.3 We note that para 159 states that 'random assignment has been used with mandatory activity in the past for the Intensive Activity Period for over 50s and the JSA signing pilots'. We would welcome further consideration of whether these research studies are analogous and the identification of any specific issues and concerns that might be raised by random assignment to mandatory assessment and education programmes within the welfare reform pilots.
- 4.4 Para 168 and 169 state that 'the advice we have received from our contractor is that the volumes in the "not in treatment intervention group" are too small to allow us to robustly estimate the net impact of mandatory interventions' and that 'the contractor has similarly advised us that, in order for us to robustly assess the net impact of the mandatory interventions, we will need to identify around double the number of the current estimates of drug users not in treatment'. Depending on the outcome of on-going investigations it may be

decided 'to apply the mandatory pilot regime to all such customers' (rather than dividing them into a control and intervention group) with the consequence that 'the evaluation of this aspect of the pilot will be mainly qualitative in nature'. Our understanding is that this means it may not be possible to robustly evaluate the elements of the welfare reform pilots that have been the most controversial, and where there is currently a lack of any reliable evidence on effectiveness (for example, outcomes for people who are referred to treatment awareness programmes following identification via adviser suspicion).

4.5 DrugScope welcomes the plans to use distance-travelled tools and to assess non-employment outcomes. We do note, however, that the primary justification for introducing this welfare regime was to ensure that people with drug problems were not 'written off' by the welfare system, but that they were helped to progress towards employment. It is, therefore, notable that there will be limited information available on employment outcomes at the point that the Secretary of State reports to Parliament on the pilots and may seek parliamentary approval to roll out this approach. Para 174 states that the 'longer term tracking exercise' to measure the impact on employment outcomes is not expected to be in a position to report on its findings before mid-2014.

## **5. Comments on the Equality Impact Assessment**

5.1 As outlined above DrugScope is concerned that the list of factors that it is proposed for personal advisors to establish a 'reasonable suspicion' may result in some groups being disproportionately subject to questions on problem drug use. In particular, some of these behaviours could be a result of mental health problems or learning difficulties or the side effects of prescription medications. It is also possible that people might be considered to have given 'incoherent answers to questions' where this reflects language or cultural barriers, and there are cultural aspects to determining what constitutes an 'unkempt appearance'. DrugScope welcomes the recognition of these issues and the commitment to continue to work with stakeholder groups in an attempt to address them as stated in para 13 of the Equality Impact Assessment.

5.2 Para 20 of the Equality Impact Assessment states that 'for some minority ethnic groups, there is a greater stigma attached to the use of illegal drugs than for the white population which may well make them less likely to present to treatment'. However, the implications of this finding for the welfare reform pilots is not recognised or discussed. It means, for example, that members of some ethnic groups may be particularly reluctant to disclose drug use to personal advisers, and careful consideration needs to be given to equality

issues in creating an environment conducive to disclosure (for example, raising issues about the culture, ethnicity and gender of personal advisors). As discussed above, similar considerations apply when considering whether it is reasonable to expect somebody to participate in group work (particularly if it has any confessional dimension) as part of a treatment awareness programme.

## **6. Comments on Regulations**

6.1 Part 2 Reg 3 – Requirement to answer questions. As currently drafted, this section makes no reference to any prior threshold, condition or standard of proof that must be satisfied before the Secretary of State is able to require a person to attend a meeting to answer questions about their drug use. The absence of a threshold or condition is concerning as the requirement will inevitably require the claimant to answer questions which are personal, invasive, sensitive and potentially distressing. The requirement also carries the threat of a benefit sanction for non-compliance, and initiates a process which could require the claimant to undertake further actions such as participating in a substance-related assessment and potentially a requirement to undergo drug testing. Our understanding is that the Secretary of State can only exercise this power if the individual has (i) self-admitted to a substance misuse problem but is not prepared to enter treatment voluntarily, (ii) been identified via data sharing arrangements or (iii) has been identified via personal adviser suspicion. This should be made explicit in the regulations.

6.2 Nor does this regulation place or imply any restrictions on the time and place of a meeting to discuss drug use to ensure that an appropriate environment is provided for the disclosure of a drug or alcohol problem, including ensuring that the person conducting the interview is selected in a way that is responsive to the full range of equality issues, including the client's gender, religion, ethnicity, culture and sexuality. The notification to attend the interview should clearly state that information disclosed about drug use will be treated confidentially, and particularly that it will not be made available to the police or other criminal justice agencies, and cannot be used as a basis for a criminal prosecution.

6.3 It is unclear whether the requirement to answer questions will include whether the claimant, if they admit to using heroin and/or crack cocaine, is currently undergoing treatment. On the one hand, if the claimant says that they are undergoing treatment will this be sufficient for the Secretary of State to conclude that this is the case? On the other, information about medical treatment should be a matter that is confidential to the claimant (e.g., as stated in the NHS Constitution).

- 6.4 Part 2 Reg 4 Substance-related assessments. The points made above about ensuring a suitable environment, responsiveness to equality issues and assurances about confidentiality and non-incrimination apply equally to the regulation on substance-related assessment. Reg 4 (8)(a) places a requirement on the person to ‘fully answer all reasonable questions’. This is potentially amenable to a variety of interpretations and it would be helpful to have further guidance about what constitutes both a ‘reasonable question’ and a ‘full answer’.
- 6.5 Part 3 Reg 5 Drug testing. As discussed in our comments on the Explanatory Memorandum it is debatable whether Reg 5 (2)(d) will ever be satisfied given the available drug testing technologies. A drug test can determine whether someone has taken a drug within a particular time frame (which varies for different substances) but cannot establish whether they are ‘dependent on’ or have ‘a propensity to misuse’ a proscribed drug (unless ‘propensity to misuse’ is very loosely interpreted). As the welfare reform pilots will target only problem drug users we would suggest that a fifth condition is added to (2): i.e., ‘that the Secretary of State has reasonable grounds to believe that P’s drug misuse is of a nature and severity that requires and may be susceptible to treatment’. Reg 5 (5) should state that the notification in writing will explain the nature of the tests; cover privacy, information-sharing and confidentiality issues and make it clear that the results of the tests cannot be used as a basis for criminal prosecution.
- 6.6 Part 4 Reg 6 Voluntary Rehabilitation Plans. Reg 6 (3)(b) states that the requirements of a voluntary rehabilitation plan could include ‘taking part in specified interviews and specified assessments at specified places and times’. DrugScope is concerned that this is potentially very wide ranging, and would like to see an explicit statement in the regulations of the particular purposes for which any interviews and assessments could be conducted under a voluntary rehabilitation plan.
- 6.7 Part 4 Reg 8 Review, variation and revocation of Voluntary Rehabilitation Plans. Reg 8(2)(i) states that the Secretary of State may revoke a plan where he or she is satisfied that ‘P has failed to comply with, or provide evidence of compliance with, a plan’. We would appreciate further clarification of the level of non-compliance that would be required before the Secretary of State would revoke a voluntary rehabilitation plan (one option would be to reword this to read that ‘P has persistently failed to comply’ or ‘P has repeatedly failed to comply’). Reg 8 (2)(ii) states that the Secretary of State may revoke a voluntary rehabilitation plan where ‘P is not, or is no longer dependent on, or does not have, or no longer has, a propensity to misuse, a proscribed drug’. There is a concern that people should not be returned immediately to JSA or

ESA on achieving stability or recovery in drug treatment, given what we know about the risks of relapse.

6.8 Part 4 Reg 9 Mandatory Rehabilitation Plans. Reg 9 (3)(a) states that a mandatory plan may contain a requirement for P to ‘attend, and to the extent considered necessary by the Secretary of State, take part in an educational programme at specified dates, times and places’. It would be helpful to provide a clear statement of what forms of activity cannot be included in an educational programme on the grounds that they would constitute a form of medical treatment (for example, a range of psycho-therapeutic and psycho-social interventions). We would like to see an explicit statement in the regulations that the requirement ‘to take part’ in the programme will not include a requirement to take part in confessional activities, any form of group work or activity that is culturally inappropriate or in conflict with religious beliefs (or non-beliefs).

6.9 Part 6 Reg 12 Sanctions. DrugScope would question the reasonableness of requiring a person to show good cause within a five day time frame – for example, when failure to comply was due to a health problem or arranging a parent’s funeral – and would expect this regulation to be applied with flexibility. Some stakeholders have expressed concern to DrugScope about the five day time frame.

**Comment from member of DrugScope/LDAN Expert Group on Employment**

‘There are two main issues here: first, is the client capable of both understanding and/or complying with an instruction, and second, what is the definition of “physical or mental health” [in the list of grounds for ‘good cause’] – we would argue that this probably applies to most people who are problem drug users, and would be a satisfactory and reasonable excuse for not complying. With this in mind, I don’t think that five days is reasonable, and the ability to act that quickly and show “good cause” for problem drug use could be an issue. I think that ten working days would be more appropriate’

‘[The five day framework] should be looked at on an individual basis, what about childcare responsibilities and transport links to services? Will the client be provided with suitable alternatives such as all the services available to them, not just adult substance misuse services? Maybe a directory of services could be available to advisors’.

6.10 We would like to see the list of ‘good cause’ criteria provided in Reg 12 (5) extended to cover participation in voluntary work and caring responsibilities towards a vulnerable adult (extending beyond the circumstances identified in

Reg 12 (5)(e)(vi)). Other 'good causes' could be attending a college place, a training scheme or voluntary activity. We would also like to see the affects of prescription drugs included (for example, where somebody on a psychiatric drug is unable to make appointments in the early morning due to its side effects). We would also support a 'good cause' for people who had been arrested or in custody over night.

6.11 We would like to see the inclusion of 'good cause' criteria that could help to reinforce the Secretary of State's responsibilities to ensure the conditions imposed on people are reasonable. For example, that a 'good cause' for failing to attend an assessment or a treatment education programme could be that 'P was not provided with sufficient information by the Secretary of State' or that 'P was not provided with sufficient assurance that the requirement would enable P to participate in the activity without violating P's privacy, dignity or beliefs'. We would also like to see a 'good cause' condition which recognises the potential risks to some individuals if suspected drug use is disclosed to their partners or family – for example, 'P has reasonable grounds to fear that compliance could have resulted in significant harm to themselves or a dependent' (for example, where they or their children are at risk of domestic violence).

6.12 Reg 12(6) states that 'the fact that P is or was suffering from the effects of the use of a proscribed drug or the consumption of alcohol is not by itself to be regarded as good cause for a failure by P to comply with a requirement'. DrugScope accepts that intoxication as a result of drug or alcohol use would not justify non-compliance, but we would like to see this exclusion reworded to distinguish between intoxication and other 'effects' of the use of drugs and alcohol. For example, where someone with a long-term alcohol or drug dependency refrains from substance use to ensure they are drug and alcohol free for the appointment, and this results in a state of agitation and/or physical symptoms that prevent them from attending. More generally, the effects of drug withdrawal will, in some circumstances, be sufficiently severe to provide 'good cause' for non-compliance.

**Comments from DrugScope/LDAN members**

'It would be incredibly difficult for a person to attend an appointment when withdrawing'

'Dual diagnosis clients need to be taken into account. The client may be dependent on the prescribed medication, also if a client attends an appointment under the influence of alcohol they are unlikely to be seen anyway'.

‘One of the underlying but most evident characteristics of someone in a chaotic drug use cycle is the inability to comply with most things asked of them’.

6.13 A DrugScope member also raised the issue of circumstances in which a claimant might be excluded from the educational programme (or turned away from an appointment with an advisor or assessor), and how this would be dealt with. The question raised was ‘If P was due to attend an “educational” session and was “under the influence” due to consumption of drugs or alcohol it would be good practice to exclude, for various reasons including their capacity to engage in the assessment or activity, the affect it may have on other attendees if in a group setting, health and safety considerations; so there may be value in considering exclusion criteria’.

6.14 We are extremely concerned about the impact of sanctioning people by removing all their benefits for a period of weeks. We welcome the commitment to provide hardship payments to particularly vulnerable claimants, including those with responsibility for children. We do not believe that sanctions should ever be applied to Jobcentre customers with personal responsibility for children. But we believe the removal of all benefit from any claimant raises serious human rights issues. At a minimum we would like to see provision made to ensure they have access to essential goods – such as basic food and toiletries – during the period when the sanctions are in force.

### **Contact**

Dr Marcus Roberts  
Director of Policy and Membership  
DrugScope  
Prince Consort House  
Suite 204, 2nd Floor  
109- 111 Farringdon Road EC1R 3BW

Tel: 020 7520 7556  
Mob: 07793 090 826

**DrugScope’s work on welfare reform – including our response to the No-one Written Off Green Paper is available on our website at**  
<http://www.drugscope.org.uk/ourwork/Policy-and-public-affairs/topics-and-campaigns/key-topics/welfare-reform-bill>

