



No one written off - reforming welfare to reward responsibility

Response from DrugScope

October 2008

DrugScope is the UK's leading independent centre of expertise on drugs and the national membership organisation for the drugs field.

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.

All DrugScope's policy work is shaped by our core values and beliefs.

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.
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Overview of DrugScope's response

DrugScope welcomed the commitment in the new drug strategy to focus on the social (re)integration of people with drug problems. We agree that problem drug users have too often been 'written off' by the welfare system - we need to be more ambitious. We agree that employment, training and other forms of meaningful activity (such as voluntary work) can have an important role to play in supporting and sustaining recovery from substance misuse problems.

We believe that a benefit regime for problem drug users will only work in supporting people in drug treatment if it recognises that:

- * 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 may not a realistic short-term goal.

We **support** the proposals in the Green Paper:

- * to improve links between JobCentres and drug treatment providers;
- * to provide individualised support for problem drug users to help them into education, training and work;
- * to introduce a treatment allowance if this will better support people in drug treatment, for example providing problem drug users with an opportunity to address their problems before requiring them to actively seek or be available for work;
- * to subject new approaches to proper pilot and evaluation processes before rolling them out.

We do **not support** the proposals in the Green Paper:

- * to identify all problem drug users entering the benefit system;
- * to consider drug testing or fraud investigation as part of a welfare claim process;
- * to increase information sharing between the welfare system and the criminal justice system;
- * to use the threat of sanctions to underpin a regime for problem drug users, linked to a condition to attend drug treatment.

DrugScope's response is based on consultation with our membership and other stakeholders. We have consulted directly with over 200 people through a series of consultation events and a survey. (See appendices 1, 2 and 3.)

1. Introduction

1.1 DrugScope welcomes the opportunity to respond to the Department for Work and Pensions consultation on the Green Paper *No one written off: reforming welfare to reward responsibility*. We also appreciate the opportunities that we have had to ensure that the Department for Work and Pensions team working on the proposals for problem drug users are aware of the views of DrugScope members and other stakeholders, including through a public consultation event on the proposals for problem drug users that we hosted jointly with the Department for Work and Pensions in October 2008.

1.2 DrugScope has over 700 members (individuals and organisations) representing a wide range of people and professions involved in different ways in drug policy, drug treatment and related services. To inform our response we have consulted widely with DrugScope members and other key stakeholders.¹ In total, we consulted directly with more than 200 people, with around 150 people participating in consultation events, and over 100 completing a DrugScope survey.

1.3 On 26 September we hosted an 'expert seminar' to discuss the Green Paper proposals with a small group of drug treatment and welfare specialists (including two participants responsible for delivering Progress2Work schemes for problem drug users - one in England and one in Scotland). We also discussed the Green Paper proposals at DrugScope regional consultation seminars in Newcastle, Norwich, Bristol and Cardiff. Finally, our Green Paper response is informed by feedback from the DrugScope/Department for Work and Pensions consultation event in London on 13 October. Tony McNulty MP, the new Minister of State for Employment and Welfare Reform, spoke at the event. Over 60 people attended the event representing a range of professions and agencies working in the drug sector or in services working with problem drug and alcohol users.

1.4 Members and stakeholders at both our expert seminar and four regional seminars were invited to complete a short questionnaire on the Green Paper proposals. A longer version of the survey was made available on the DrugScope website for completion on-line. Participants at our consultation events worked in drug services, including drug treatment, or provided non-drug specific support services for people with substance misuse problems. The vast majority of respondents to our online survey worked in drug services.

1.5 The welfare reforms proposed in the Green Paper impact on problem drug users in two ways. First, the *general* reforms to welfare provision will impact on the estimated 240,000 benefit recipients who are problem drug users. Second, there are *specific* proposals to identify problem drug users and get them into drug treatment and employment ('A new regime for problem drug users - Breaking the cycle of dependency', paras 2.28 to 2.49). The primary

¹ We have also discussed the Green Paper proposals with membership organisations in related sectors - including Homeless Link, Mind and Clinks (with whom we are working on a campaign called Making Every Adult Matter, which focuses on people with multiple needs).

focus of DrugScope's response is the specific proposals on problem drug users.

2. Key messages

2.1 On the basis of our consultation work with the drugs field and with welfare rights specialists, and our understanding of the available evidence base, our response to the Green Paper consultation is framed by six key points.

2.2 First, we strongly support the focus on poverty and social exclusion in the 2008 UK Drug Strategy, and the recognition of the importance of social (re)integration for problem drug users. One of the key messages of DrugScope's response to the consultation for the new drug strategy was that: 'the current criminal justice and specialist treatment focus of the strategy needs to be balanced with a tangible and explicit commitment to tackling poverty and social exclusion through a package of interventions including healthcare, employment, housing and education'. We therefore welcomed the recognition in the new drug strategy - *Drugs: protecting families and communities - The 2008 drug strategy* - that drug problems 'may be both the cause and consequence of wider social and personal problems', and of the need for 'a radical new focus on services to help drug users to re-establish their lives'.²

'We want now and in the future to see deprivation given its full and proper place in all considerations of drug prevention policy, at both local and strategic levels, and not let slip from sight'.

Advisory Council on the Misuse of Drugs (1998): *Drug Misuse and the Environment*.

2.3 Second, we believe that the welfare system has a key role to play in supporting the social (re)integration of problem drug users. According to the Drug Treatment Outcome Research Study (DTORS) approximately 80 per cent of problem drug users are unemployed (that is, not employed within the formal economy).³ We welcome the recognition in the Green Paper that many problem drug users will need intensive and individualised support to help them to access education, training or employment. We welcome the Government's continued investment in Progress2Work, a voluntary scheme which is helping problem drug users to access training, education and employment, with intensive support from a specialist case worker, including help with issues such as housing and debt. We hope to see - as highlighted in the new drug strategy - the development of innovative funding, commissioning and case management approaches that can help to address the complex and interlocking needs of many problem drug users. We support the development of better links between JobCentre Plus and local substance misuse treatment services. It is important to recognise that many problem drug users in drug

² See key messages from DrugScope's response to the drug strategy consultation on our website at <http://www.drugscope.org.uk/NR/rdonlyres/50A8F3B8-C7B9-4DBA-8212-E5041DE9BC65/0/messages.pdf>

³ Jones A, Weston S, Moody A, Millar T, Dollin L, Anderson T and Donmall M (2007), *The Drug Treatment Outcomes Research Study (DTORS): Baseline Report*, Research Report 3, Home Office, London.

treatment are not ready for employment. We are therefore encouraged by proposals to introduce a 'treatment allowance' that, we assume, would recognise, for example, that it is neither sensible nor reasonable to expect all problem drug users at all stages in the treatment process to be active in employment markets.

2.4 Third, we believe that some parts of the Government's broader welfare reform and employment agenda will benefit problem drug users. Specifically, we welcome the recommendations of the Leitch Review of Skills in England.⁴ We support proposals for a legal right to free training in numeracy and literacy, 'skills accounts' for benefit claimants and a new adult career service. We also welcome the Government's recognition of the key role of employers. If Local Employment Partnerships - announced in the 2007 Budget - can recruit employers who will provide a 'fair shot at a job' for problem drug users then this will help to remove one of the main structural barriers to employment. We note that, unlike other groups who experience discrimination in labour markets and at work, problem drug users have no legal protection from anti-discrimination laws on the basis that they are or have been in treatment. Nor has there been any significant anti-stigma work on problem drug users targeting employers (or the wider public).⁵ (One of our concerns about aspects of the public debate on welfare reform, particularly in some sections of the media, is that a tendency to portray problem drug users on benefits as 'feckless', 'uncooperative' and as the authors of their own problems is entrenching stigmatising attitudes and therefore *reinforcing* the structural barriers to employment.)

'Drug users often lack basic inter-personal skills and so may need training in very basic things like how to interact in the workplace, etc. I suggest a stepping stone approach - e.g., volunteering.'

Respondent to DrugScope survey

'The biggest barrier to training is the lack of suitable training programmes that recognise the multiple issues faced by recovering drug users and that gives some flexible supportive training with realistic targets for achievement ... there is a need to link employment, training and education programmes in as part of structured day programmes'

'JobCentre Plus requirements limit the time people can spend on training without losing benefits to 16 hours a week'

Participants in DrugScope/Department of Work and Pensions event

2.5 Fourth, we oppose the proposals for benefit sanctions for problem drug users. We recognise that there is public support for a welfare system that balances rights and responsibilities, and we accept that it is not unreasonable

⁴ DIUS (2007), *World Class Skills: Implementing the Leitch Review of skills in England*.

⁵ There has been no Government investment in anything like the Department of Health's anti-stigma 'Shift' campaign on mental health for PDUs. There is nothing comparable to the £18 million Time for Change campaign, currently being funded by the Big Lottery Fund and Comic Relief to tackle stigma and discrimination against people with mental health problems.

to expect benefit claimants to take advantage of the help and support available to help them to address drug dependency issues. But that is not the same as endorsing sanctions.

Government ministers have given public assurances - at national conferences and consultation events - that the intention of these reforms is to improve support for problem drug users and that sanctions will be a very last resort.⁶ However, the overwhelming response from DrugScope members is one of concern that the threat of sanctions is linked to a requirement to undergo drug treatment or follow a 'rehabilitation plan'. We accept the intention is not to resort to sanctions except in exceptional circumstances, but we do not see a role for sanctions linked to drug treatment at all, and it is unclear to us how there could be an assurance that sanctions would rarely be used if the proposals set out in the Green Paper were implemented.

Seventy three per cent of respondents to the survey distributed at DrugScope consultation events *disagreed* with the proposition that 'so long as you are providing appropriate support, it is fair to require problem drug users on welfare benefits to engage with treatment and employment services and to sanction people who do not engage by cutting their benefits'.⁷ Sixty three per cent of respondents to our on-line survey also disagreed with this proposition. Many respondents supported an 'entitlement' vision of welfare. They considered a basic income to be a human right and pushing people below that basic minimum in order to engineer behavioural change to breach that right. There are also widespread concerns about the potential negative impact of sanctions, including deepening poverty and social exclusion (including child poverty), increased levels of crime and offending, the impact on therapeutic relationships if drug workers are involved in 'policing' the benefit regime and pressures on services as clients enter treatment under threat of sanction. DrugScope shares these - and related - concerns, which are set out and discussed in more detail later in this consultation response.

'If benefits are cut, then how is a person meant to live if they do not have any other means of financial support?' Respondent to DrugScope's online survey

'I have concerns that those to whom sanctions are applied and who lose their benefits (the most chaotic, homeless, those with mental health issues) will be moved further to the margins'.

Participant at DrugScope/Department of Work and Pensions Event

⁶ For example, at the National Treatment Agency's 2008 Annual Conference, Dawn Primarolla, Minister of State (Public Health) explained: 'Many media reports at the time [that the new drug strategy was launched] misrepresented the reality of what we are trying to achieve on this issue by suggesting that the government were focussing on cutting benefits from drug users. Let me be clear, this is *not* the case – it is *not* the case. In fact, our aim has been to secure *more* not less support for drug users in treatment and in particular help drug users' reintegration and recovery, through support into employment – a point that they make time and time again; and I strongly believe that most drug users want to overcome their addiction and that we need to support them in doing this and that therefore the government has a duty to champion the needs of the most vulnerable groups in our society and given the complex nature of drug addiction, this is such a group.'

⁷ This included 37.5 per cent who *strongly disagreed*.

2.6 Fifth, an effective benefit regime for problem drug users must be realistic and evidence based. Over half of respondents (53 per cent) to the DrugScope survey distributed at our consultation events disagreed with the proposition that 'the majority of PDUs could get into education, training or employment *within three to six months* with the right support from drug and employment services'. By comparison, 33 per cent agreed with this proposition - provided the right support was available.

DrugScope is concerned that some (implicit) assumptions in the Green Paper about what drug treatment services can deliver (and how fast) are unrealistic. While 12 weeks retention in drug treatment is used by the National Treatment Agency as a minimum benchmark for treatment 'effectiveness', research has established that recovery journeys out of long-term drug dependency can take many years. Coming off drugs can mean confronting problems that drugs have been masking and containing for years, such as experience of childhood abuse. One respondent to DrugScope's survey explained that 'for people who have a history of using for 10, 20 or 30 years, three to six months is no time at all'. Others highlighted the complex needs of many drug users, including 'very complicated family, social and housing issues'. Many problem drug users claiming welfare benefits have little or no experience of employment, skills deficits, low self-esteem, multiple problems (such as homelessness, mental health issues and contact with the criminal justice system) and experience of stigma and discrimination in employment markets.

2.7 Sixth, changes must be piloted and evaluated. There is a dearth of evidence on 'what works' in supporting problem drug users into education, training and employment. We believe it is vital that any new initiatives and approaches are piloted. Evaluation of pilot projects must be rigorous and independent, with a focus on 'distance travelled' by service users and on effectiveness in supporting people in drug treatment, and (where appropriate) into training and employment that is sustainable and genuinely helps to move people out of poverty, while supporting recovery.

2.8 A note on scope. Generally, DrugScope has supported the focus of drug policy since 1998 on problem drug users defined as people dependent on opiates and/or crack cocaine, which is reflected in the Green Paper proposals. However, we are increasingly concerned that this focus is marginalising other harmful patterns of substance misuse, including alcohol, cocaine, cannabis and poly-drug use (often involving alcohol and illicit drugs). We note that the Green Paper says the Government will subsequently consider the case for extending the approach proposed for problem drug users to others - for example, those 'dependent on cannabis, powder cocaine or dependent on alcohol'. Our response focuses on "problem drug users" as defined by the Green Paper (i.e., those misusing or dependent upon heroin and/or crack cocaine). While many of our key points would be equally applicable to other forms of substance misuse, we would note that extending these proposals to different groups of drug and alcohol users would raise different sets of issues (e.g. different characteristics of users, potential case load, applicability of the notion of dependency and the availability of treatment services). We would

hope there would be a full consultation on any future proposals to extend the approach proposed in the Green Paper.

3. Identification of problem drug users on benefits

Consultation Question 6: Do you agree with the proposed approach for identifying problem drug use? How should it be implemented? Do you think that everyone claiming a working age benefit should be required to make a declaration of whether or not they use certain specified drugs?

3.1 The Green Paper states that up to 100,000 problem drug users on benefits are not in treatment and says that 'we cannot help people through drug treatment programmes if we don't know who needs them'. We understand that the Green Paper approach to identifying problem drug users comprises the following proposals:

- systematically building identification of problem drug use into the new claim process for Employment and Support Allowance;
- strengthening guidance for Job Seekers Allowance advisors to help them to identify claimants who may be problem drug users;
- primary legislation to enable JobCentre Plus to receive relevant information from police authorities, probation service and prisons; and
- an invitation for 'views on the merits of changing benefit rules to require all applicants for benefit to declare whether they are addicted to heroin or crack cocaine'.

Those who are identified through these mechanisms 'will then be required to see a drug treatment provider'.

3.2 General observations. Before considering these proposals in detail we would make three general observations. First, if a regime for problem drug users is going to be fair and equitable, the identification process must be reliable. It will not be fair if liability to incur benefit sanctions falls only on a sub-group of problem drug users who are most easily identified, particularly if this is a minority and/or is disproportionately drawn from particular sections of the problem drug using population. Second, there are ways in which the welfare system could help to improve participation in drug treatment services without a formal process for 'knowing who needs them'. The need for a reliable identification process arises only once an approach based on incentivising voluntary participation (such as Progress2Work) is no longer considered adequate. Third, there are various ways in which problem drug users on benefits can be helped, supported and encouraged to engage with drug treatment services without this happening through the direct *agency* of JobCentre Plus (for example, benefit claimants on Drug Rehabilitation Requirements should be in treatment and are already liable to incur legal sanctions for failure to comply with the court's order).

3.3 Do you think that everyone claiming a working age benefit should be required to make a declaration of whether or not they use certain specified drugs? No. In our view this proposal is impractical, and possibly unlawful too.

Investigation as to whether the requirement has been met could also have significant administrative costs. No fewer than 88 per cent of respondents to the DrugScope survey distributed at our consultation events *disagreed* with this proposal, including almost 60 per cent who *strongly disagreed*. Only 6 per cent *agreed* - none *strongly agreed*. The results from our on-line survey were similar: only 2.1 per cent 'strongly agreed', with a further 12.5 per cent 'agreeing'; by comparison almost 73 per cent 'disagreed', including 35.4 per cent who 'strongly disagreed'.

3.4 Addiction. We note that the Green Paper talks about requiring people to make a declaration as to whether or not they are 'addicted' to heroin or crack cocaine. This would raise additional problems, as 'addiction' is a complex and contested concept. Some people who are regular users of these drugs would not consider themselves addicted, some people who have achieved voluntary and sustained control over their substance misuse may still identify as 'addicts'. Some people who may not be classified as 'addicts', may nonetheless be using heroin and/or crack cocaine as part of deeply damaging forms of poly-drug use. We would also note that it is not possible to establish 'addiction' through one-off drug tests. (In addition, drug testing is not able to distinguish between crack cocaine and powdered cocaine.)

3.5 Lawfulness. It is unclear to us what the administrative purpose or legal basis would be for asking people to declare whether they are problem drug users as part of the process of *applying for benefit*. 'Problem drug user' is not a relevant status for the purposes of qualifying for benefit and the Green Paper does not explicitly propose making it one.⁸ As one participant in DrugScope's expert seminar put the point: 'You don't get benefits because you are a problem drug user; you get benefits because you are out of work and/or have a health problem. Being a problem drug user is not a grounds for receiving or not receiving benefit. So how can it be fraudulent not to declare it?'

'This is not an appropriate environment to disclose such personal information (and about unlawful activity). Such disclosures among more excluded groups require the development of a trusting association with an agency/worker and it is unlikely that DWP staff will be able to give the time or have the experience to develop this'.

Respondent to DrugScope survey

'[There is a need for] training of benefit staff - not currently an atmosphere conducive to disclosing and being supportive of treatment. Prejudice on part of staff can drive people away. You cannot force people to disclose in this environment.'

Participant at DrugScope/Department of Work and Pensions Event

⁸ Currently it is only a basis for qualification for benefits if it causes physical or mental health problems that result in incapacity for employment or disabling conditions affecting capacity for employment.

3.6 Dealing with claimants who decline to answer. The Green Paper includes proposals for dealing with people who answer this question dishonestly, but not for people who decline to answer it at all. We believe that some claimants may decline to answer yes or no (including people without drug problems).⁹

3.7 'Fraud' and detection of 'fraud'. The Green Paper proposes bringing in sanctions for benefit claimants who answer this question incorrectly. The Green Paper says that fraud detection mechanisms could include 'information sharing with the police and, in a small number of cases, contracted out drug testing'.

3.8 Concerns about these proposals. We are strongly opposed to drug testing in these circumstances. This is an invasive process that it would be very difficult to apply in a non-discriminatory way and that should have no place within a welfare claim process. There are significant practical and procedural issues. First, the police could only provide information on those claimants known to the criminal justice system. Second, it is unclear how JobCentre Plus staff would identify people to be drug tested in a reliable, non-invasive and non-discriminatory way. Third, it is unclear what the basis is for assuming drug testing would be required only in a 'small number of cases'. With an estimated 240,000 problem drug users claiming benefits, what assurance is there that drug testing will not become widespread? Fourth, in order to determine whether someone is using drugs problematically it may be necessary to test them regularly and over a sustained period of time. Is this envisaged? Fifth, if someone tests positive for drugs several weeks or months after the initial claim, this would not establish that they answered dishonestly at the time that they made their claim.¹⁰ Finally, what redress, if any, will there be for people who are drug tested inappropriately and/or with no evidence subsequently emerging that they are problem drug users?

3.9 Guidance for advisors. We note that the Green Paper proposes to strengthen guidance for Job Seekers Allowance advisors to help them identify claimants who may be problem drug users. It is important to ensure that any guidance avoids stereotyping and stigmatising generalisations.¹¹ Participants in DrugScope's expert seminar indicated that there would be workforce development challenges in preparing JobCentre Plus staff to deal fairly and sensitively with this group (for example, in their reaction to a declaration that someone is a problem drug user).¹² One point made at our consultation event

⁹ A number of respondents to DrugScope's survey felt that this proposal raised rights issues (for example, 'there are questions raised by this around people's right to privacy' and 'this is a civil liberties issue'). Some people who take this view may refuse to respond on grounds of principle.

¹⁰ Raising the issue of whether JobCentre Plus would invite declarations of problem drug use only at the initial claim stage, or periodically over the life of a claim.

¹¹ At worse, similar issues could arise as in other areas of policy where suspicion is identified on the basis of appearance and external behaviour, such as stop-and-search laws.

¹² Two participants involved in delivering Progress2Work reported that in their experience JobCentre Plus staff often lacked time and motivation to develop skills for dealing with PDUs. One commented, 'none of the local JobCentre staff have correct training to work with problem drug users ... or to assist clients in doing things like writing disclosure forms ... they just don't know how to work with these clients'.

is that claimants disclosing a serious drug problem - perhaps for the first time in their lives - will need sympathetic treatment, in a supportive environment and immediate access to relevant support services.

3.10 Training for JobCentre staff. Contributors to our expert seminar with frontline experience of working with JobCentre Plus told us that none of the JobCentre staff they worked with had the correct training to work with problem drug users or offenders ('they just don't know how to work with these clients'). Another noted that meeting these training needs had been a requirement of the original Progress2Work pilot projects, but added that, in their experience, when training was provided JobCentre staff never had time to attend ('JobCentre staff would be absolutely furious if they were suddenly to be told they had to work with clients around their drug use').

DrugScope/Department of Work and Pensions Consultation 13 October 2008

Comments on barriers to employment included:

'...a lack of training for JobCentre Plus and housing staff for raising awareness about problem drug users'

'...better training for staff working with this client group'

'Department for Work and Pensions workers to have effective training to work with and understand the issues faced by people with complex needs'.

Respondent to DrugScope online survey:

'The most important thing is for benefit office staff to be educated to understand the difficulties of addiction in the same way that they are trained to understand issues like diversity.'

3.11 Mitigating factors - reasons for not declaring problem drug use. There are a number of reasons why problem drug users may be reluctant to declare drug use particularly to a statutory agency. First, this would *require* people to disclose a criminal activity - i.e. potentially to incriminate themselves.¹³ Second, the default position for problem drug users is to *conceal* drug use from statutory agencies or when seeking employment, as this is often a barrier to accessing services as well as to training and work (see below). Third, a point that was repeatedly made at our consultation events is that many parents (particularly women) with drug problems will not declare drug use because of fears that social services may be informed and the possibility their children may be taken into care. One contributor to our expert seminar commented: 'my organisation has conducted focus groups and clients who participated said they just would not declare drug use. They will deal with sanctions as and when it happens. They are also concerned with information sharing. They are concerned about how staff in JobCentre Plus will treat them and that the level of stigma they experience will increase'.

¹³ At the least, there needs to be robust protections in place to ensure that information disclosed in this way is not admissible as evidence in drug-related criminal proceedings.

'Parents with children may be particularly concerned about information sharing about child protection concerns on the basis of drug use. Withdrawal of benefit could be a significant risk for the family'.

Participant at DrugScope/Department of Work and Pensions event

3.12 Penalties for failure to declare. The Green Paper states that sanctions for failing to declare problem drug use 'could include ... recovering overpayments and investigations for fraud against those who mislead'. On the matter of fraud we refer back to our questions about the legal status of requiring claimants to declare problem drug use (para 3.4). We assume that it would become a condition of receiving out-of-work benefits to answer this question accurately. By implication, *any* benefit received on the basis of false information would technically constitute 'overpayment'. To require someone to repay all of this, perhaps after a period of weeks or months on benefit would be both unrealistic and unreasonable. We assume that in practice people would be asked to pay a fixed or capped amount, and this would operate in a similar way to a fine. We would have many of the same concerns about this proposal to those to the use of benefit sanctions. Should the requirement be introduced there should be a discretion not to seek overpayment recovery where, for example, this may cause hardship.

3.13 Primary legislation to enable JobCentre Plus to receive relevant information from police authorities, probation services and prisons. Generally, there is a presumption against sharing information about people's criminal records or histories unless there are strong and identifiable benefits. We would question what the benefits are in this case. As one contributor to DrugScope's expert seminar argued, there appears to be a kind of 'double counting', for if 'somebody has been on a Drug Rehabilitation Requirement or has been identified through the Drug Intervention Programme, they should have already been referred for treatment - so, this looks like another unnecessary layer of intervention'. For example, as the law stands, people who test positive for heroin and/or crack cocaine at the police station under Drug Intervention Programme arrangements can be referred for *assessment*, but not required to *engage* with treatment. Under these proposals the police would notify JobCentre Plus of a positive test, and engagement in treatment could *then be required* as a condition of receiving full benefit. This appears to add an unnecessary bureaucratic loop into the process, while significantly extending the degree of coercion in drug treatment, over and above that deemed necessary and desirable within the Drug Intervention Programme.

'What will the information provided by prisons, probation and police be used to achieve? Is this merely to cross reference? Is this a good enough reason for joining together two quite different systems?'

'The conditionality is already there. If you breach the terms of the Drug Rehabilitation Requirement, then you will go straight back to prison anyway.'

Participants in DrugScope expert seminar

3.14 Administrative costs. Asking all benefit claimants if they are addicted to heroin and/or crack cocaine and processing that information will have additional administrative costs. In addition, there will be costs in dealing with claimants who refuse to answer or are suspected of answering falsely. Similarly, information sharing between JobCentre Plus and criminal justice agencies will pose legislative, administrative and operational challenges. We do not believe that the case has been made for adding to the existing ways of getting offenders and ex-offenders into drug treatment (notably through the Drug Intervention Programme).

3.15 Systematically building identification of problem drug use into the new claim process for Employment and Support Allowance. DrugScope has not had an opportunity to look in detail at the Employment and Support Allowance process. One issue that did emerge in our consultation events was the problems that problem drug users can have in reaching the relevant thresholds for Incapacity Benefit through the old Personal Capability Assessment process. One participant in our expert seminar involved in delivering Progress2Work commented that 'my clients record their drug use on their medicals, but rarely get any points when they are assessed for Incapacity Benefit, although some have received one point for their addiction to heroin. There is a reluctance to acknowledge the other problems that are attached to this or the support needs of people with drug problems'. (We understand, however, that the descriptors on which the new ESA 'work capability assessment' is based - specifically the mental health descriptors - could make it easier for problem drug users to qualify for this new benefit than the old Personal Capability Assessment for receipt of Incapacity Benefit.)

'My organisation has conducted focus groups and clients who participated said that they won't declare their drug use. They will deal with sanctions as and when it happens. They are also concerned about information sharing. How will the staff in JobCentres treat them if they know about contact with criminal justice? They have concerns that the level of stigma will increase'.
Participant in DrugScope expert seminar

4. Requirement to see a drug treatment provider and specialist employment advisor

Consultation Question 7: What elements should an integrated system of drug treatment and employment support include? Do you agree that a rehabilitation plan would help recovering drug users to manage their condition and move towards employment?

4.1 Specialist employment support. We support the Government's commitment to provide claimants with drug problems with access to drug treatment and employment support. We welcome the aspiration to build further on Progress2Work, which has provided specialist support for thousands of recovering drug users. As the Green Paper recognises, problem drug users can face formidable barriers to education, training and employment, and they often have multiple needs. These include physical and mental health problems, being vulnerably housed, lacking basic skills, social

exclusion and debt. If problem drug users are going to make the first steps into work, many need intensive and specialised support over a period of time. The employment support proposals are discussed in more detail in the next section.

4.2 Treatment provision. We welcome the expansion in drug treatment capacity, which means that more problem drug users can get access to treatment more quickly than before. The new drug strategy explains that the numbers of people in treatment services has increased from 85,000 in 1998 to 195,000 in 2006-07. Three-quarters of new entrants are retained in treatment for 12 weeks or more, which is recognised as a key indicator for effective treatment. The average waiting time for drug treatment has been reduced from nine weeks to less than two and a half weeks in England.¹⁴

4.3 Treatment capacity and the Green Paper proposals. However, a number of concerns about the system's capacity were raised at DrugScope's consultation events. First, in some parts of the UK people can still wait a long time for treatment, this is true in Wales.¹⁵ Second, will there be available treatment services appropriate to the claimant's age, gender, ethnicity, culture, religion, sexuality and/or disability status? Third, how will decisions be made as to what treatment is appropriate for a particular claimant at a particular time? We presume that this will be entirely a matter for the drug treatment service the claimant is referred to, although this is not stated explicitly in the Green Paper. We presume, for example, that the DWP will not require claimants to participate in a particular form of treatment - e.g., a methadone script or to participate in a 12 step programme. Nor should the DWP require someone to attend a particular treatment service (although in some areas there may be limited local availability of services). There is also a general legal presumption against requiring someone to undergo a particular form of treatment. Some contributors to DrugScope's expert seminar raised human rights concerns about requiring someone to take methadone, which may seem like requiring a claimant with depression to take seroxat. Where local treatment opportunities are limited a requirement to access treatment may effectively leave someone with little choice than to have a particular kind of treatment.

'...available treatment must be appropriate to need - that means no brief interventions for chronic misusers who require tier 3 and 4 interventions'.

Participant in DrugScope/Department of Work and Pensions event

4.4 Expectations of drug treatment. The new drug strategy states that 'in return for benefit payments, claimants will have a responsibility to move successfully through treatment and into employment'. Such formulations can encourage unrealistic expectations of what outcomes the drug treatment

¹⁴ Figures from *Drugs: Protecting Families and Communities* (HO, 2008).

¹⁵ It is identified as a problem in the Welsh drug strategy, *Working together to reduce harm*, published on 1 October.

system can deliver and how soon. It is unclear, for example, how the proposed regime for problem drug users will deal with relapse. We presume that JobCentre Plus will be provided with information about progress in treatment, but this is not stated explicitly. If so what information, in what circumstances, for what purposes, subject to what safeguards and through what processes and agencies?

'...it is naive to assume that referral to treatment will lead to a drug free outcome within a few months.'

'...they need to recognise drug misuse as a chronic and relapsing condition'

'...[there needs to be] acknowledgement from the Department for Work and Pensions that this journey of recovery involves small forward steps and at times backward steps'.

Comments from DrugScope/Department of Work and Pensions event

'Substance users and treatment service providers both emphasised the need for employment service providers to understand the multiplicity and diversity of problems faced by (former) substance users, and the benefits of case management. They also argued for the stepped (re)integration of substance users into the primary labour market, involving the private, public and voluntary sector, thus allowing them to progressively adapt to work. Substance users and treatment organisations also agreed that, before entering employment, substance users needed to have stopped using drugs or alcohol completely, but there was disagreement among substance users as to whether they could also, first, stop using substitute drugs'.

Summary of research findings of Cebulla at al in Scottish Drug Forum's *Drugs and Poverty - A literature review*

4.5 Abstinence, methadone and employment. Seventy per cent of employers told a 2003 Scottish study that they were 'absolutely certain they would not employ someone on a methadone programme'.¹⁶ If 'moving successfully through treatment' means emerging 'drug free' - where this is taken to include 'freedom' from substitute drugs like methadone - then it is doubtful that the drug treatment system is configured to deliver a 'drug free' outcome for most of the problem drug users who would enter through the Green Paper route. A National Treatment Agency audit of prescribing in England published in June 2006 found that 74.5 per cent of clients in specialist drug services were prescribed opioids as part of their treatment.¹⁷ According to National Treatment Agency figures for 2006-07, just 3 per cent of people had completed treatment and left 'drug-free' (where this includes 'freedom' from substitute drugs).¹⁸

¹⁶ Scott and Sillars (2003), *Employers attitudes to hard-to-employ groups*, Report prepared for Westworking partnership, Glasgow Caledonian University and Scottish Poverty Information Unit.

¹⁷ Best D and Campbell A (June 2006), *Summary of the NTA's national prescribing audit*, NTA/DH.

¹⁸ National Treatment Agency (October 2007), *Statistics for drug treatment activity in England 2006/07 National Drug Treatment Monitoring System*.

4.6 Complex need. Nor is recovery simply about addressing problem drug use. Complex need - i.e., a combination of drug and/or alcohol issues with other problems such as mental illness, homelessness and contact with the criminal justice system - is the norm. Research cited in *Drug Misuse and Dependence - UK Guidelines on Clinical Management* found that 75 per cent of past year users of drug treatment services - and 85 per cent for alcohol services - had a past year psychiatric disorder.¹⁹ Many are homeless and have a history of offending. The Green Paper proposals have a focus on access to drug treatment. It is unclear how it is proposed that they will link up to wider care planning processes or ensure that claimants with complex needs are provided with the right packages of support and realistic treatment goals and time frames.

'Problematic drug use will often be accompanied by a range of other social support and care needs ... It may be the case that a number of other stabilising issues (e.g., access to housing, physical and mental health services, benefits and debt advice, basic nutrition, social and relationship issues) may all appear more pressing at any given time'.

Respondent to DrugScope Survey

4.7 Conditionality - the evidence base. We are concerned that the most vulnerable, excluded and marginalised are the most likely to fail to comply with a new regime for problem drug users, and the most likely to incur sanctions. Research shows that problem drug users claiming incapacity benefit are among those claimant groups who are most likely to fail to attend for work focussed interviews and least likely to undertake training or avail themselves of other available support.²⁰ This suggests that the use of benefit sanctions could be widespread, despite assurances to the contrary. We also note that research suggests that sanctions have little impact on other key groups such as offenders and lone parents, but can impact on claimants' children and have a negative impact on local communities if people turn to illegitimate sources of income.²¹

4.8 Conditionality - other problems. A number of the people we consulted questioned the efficacy of benefit sanctions as a means of engineering behaviour. Some problem drug users can spend many hundreds of pounds each week on drugs. They raise the money in a range of ways, including working in the informal economy, drug dealing, acquisitive crime and sex work. It was widely felt that benefit sanctions could result in more drug-related crime. There was also a lot of concern about the impact on families and children. The Advisory Council on the Misuse of Drugs 2003 report *Hidden*

¹⁹ Department of Health and devolved health authorities (2007), *Drug Misuse and Dependence - UK Guidelines on Clinical Management*, p. 83.

²⁰ Discussed in Sophie Johnson (August 2008), *Substance use and Welfare to Work*, Lifeline. See also Shaw A, Egan J and Gillespie M (March 2007), *Drugs and poverty - A literature Review*, Scottish Drugs Forum.

²¹ DWP (February 2004) *Research Report 198, Evaluation of the community sentences and withdrawal of benefits pilots*. DWP (July 2008), *The effect of benefit sanctions on lone parents' employment decisions and moves into employment*.

Harm estimated that there were between 250,000 and 350,000 children of problem drug users in the UK.²² Benefit sanctions could contribute to child poverty.

'... normally benefits are a fairly minor source of income for the people we work with - under this regime, it will not be worth the hassle of going to the JobCentre for £46 or whatever a week. It is just more likely that they will simply not bother to sign on'.

Participant in DrugScope expert seminar

4.9 Conditionality: 'carrots' not 'sticks'. A recurring theme at DrugScope's consultation events was the potential to incentivise claimants with drug problems to engage with drug treatment and employment services by positive inducements (carrots) rather than sanctions (sticks). JobCentre Plus is likely to have more impact on people who have often been routinely subject to sanction by statutory agencies throughout their lives if it acts as an enabler, not an enforcer.

'...there is a lot of fear around service users engaging with agencies such as JobCentre Plus. An approach which emphasises "incentives" rather than sanctions might work. But as soon as the emphasis is on "sanctions" service users will not disclose drug use'.

'The drug users who have chaotic lifestyles and multiple needs (mental health, offending, homelessness, physical health) have often been sanctioned through eviction, benefits, criminal justice, loss of children.'

Participants at the DrugScope/Department of Work and Pensions consultation

'There is a growing evidence base in this country that enforcement/sanction approaches for some of the most vulnerable do not achieve the desired effect and serve only to displace individuals away from engagement or exclude them from services many problematic drug users have a diverse range of multiple and complex needs and are less likely to have even the basic stability of secure housing. Many supported accommodation projects exclude homeless drug users ... However, a number of projects have developed that do not require treatment engagement or progress for homeless drug users to access services. Such projects have successfully housed and supported large numbers of "unhousable" individuals with substantial success. Such approaches will be substantially challenged if the proposals come into force'.

Respondent to DrugScope Survey

4.10 Contingency management. 'Contingency management' provides positive reinforcement when clients achieve specified goals and there is a growing body of evidence that this can have positive impacts on treatment retention and completion. National Institute of Clinical Excellence (NICE) Guidelines on opioid detoxication (CG52) and psychosocial interventions (CG51) recommend the use of contingency management to incentivise compliance

²² Advisory Council on the Misuse of Drugs (2003), *Hidden Harm*, Home Office.

with treatment and to improve physical health care. Incentives could include vouchers and 'privileges' such as take-home methadone doses. The UK Clinical Guidelines on Drug Misuse and Dependence also say that 'there is a strong evidence base for contingency management'. The use of 'incentives' as a means of influencing behaviour could be replicated by the Department of Work and Pensions and could be more effective than sanctions. They might include permitting claimants to 'sign on' at the drug treatment service rather than attend the JobCentre (which could be linked to the period of the 'treatment allowance'), vouchers to attend training programmes, financial support to take up volunteering opportunities or vouchers, say, to purchase clothes for job interviews.

'Use of positive reinforcers, leniency and understanding that users in treatment sometimes relapse and can require a lot of support to recover from their addiction'

Respondent to DrugScope survey question on how the benefit system could be better meet the needs of problem drug users

4.11 Treatment allowance. DrugScope's on-line survey asked whether 'the benefit system should take into account the fact that someone is taking part in a drug treatment programme, for example by not requiring someone to meet usual conditions for actively seeking and being available for employment'. Almost 80 per cent of respondents agreed with this proposition, including a third of respondents who 'strongly agreed'. We are encouraged by proposals to introduce a treatment allowance, which we assume would, for example, relax the job seeking requirement on claimants with drug problems to enable them to focus on treatment. The treatment allowance could provide a positive inducement to claimants with drug problems to come forward for treatment. There will need to be flexibility in how long the treatment allowance continues, as it will otherwise be problematic to shift people from treatment allowance and back onto benefits at pre-determined times particularly if decided extraneously to the individual claimant's progress through treatment. (It was pointed out by welfare specialists at our expert seminar that introducing a treatment allowance *specifically* for problem drug users is difficult to reconcile with the aim of simplifying the benefit system.²³)

²³ It is unclear whether drug users who are already on benefits and in treatment will be transferred onto treatment allowance, and, if so, in what circumstances and on the basis of what form of assessment? It is also unclear how it will be determined whether people with drug dependency and other related problems (such as mental health problems) are routed into treatment allowance or transferred into Employment and Support Allowance.

Respondents to DrugScope survey

'If the individual is providing evidence that they are attending their programme and making positive steps towards rehabilitation, then give them some realistic time for recovery'.

'People need to focus fully on their recovery. There should be a two year period after a recovery programme for flexibility and support whilst people become part of society once more'.

'This [i.e. the treatment allowance proposal] is positive, but I have concerns about what will happen when someone drops out of treatment. Interlinking an individual's treatment journey with benefits also runs the risk of undermining any genuine therapeutic work being done - would it mean someone being rushed through residential, for example? More likely is poor community treatment being counted as an engagement with services and a claimant then being deemed to have completed treatment and to be ready for work, irrespective of what had been achieved.'

'There needs to be a period of condensed time to work on self, underlying issues, reasons why people used in the first place. Twelve months is more realistic for long-term success'.

4.12 Does conditionality require new rules, and if so why? It is unclear to us why a requirement for problem drug users to meet with a drug treatment service and/or participate in a drug treatment programme needs a new and discrete legal framework. Benefit claimants on Jobseekers Allowance can already be subject to a 'Jobseekers Direction' that requires them to take a specific action to find a job or increase their chances of being employed. Most people coming through the Employment and Support Allowance route will be required to attend a work-focussed interview and to draw up and implement an 'action plan'. If existing rules on Jobseeker's Direction and definitions of work-related activity for the purposes of Employment and Support Allowance do not permit people to be required to attend for an assessment for treatment, then we presume there are good reasons for this exclusion and there needs to be a clear explanation of why it is proposed (uniquely) to over-ride it for problem drug users. If existing rules do not preclude this, then why introduce a new allowance instead of making better use of existing provisions?

5. Routes into employment

Consultation Question 7: What elements should an integrated system of drug treatment and employment support include? Do you agree that a rehabilitation plan would help recovering drug users to manage their condition and move towards employment?

'Drug dependency can easily place people within the "recalcitrant minority" that are the increasing focus of welfare policy, yet they are amongst the groups of people who face the most significant social barriers to employment'.
Klingemann H et al (2001), Promoting self change from problem substance misuse

5.1 Barriers to employment. Alongside the range of health, social and criminal justice problems identified above, research shows that the primary employability barriers for drug users include fear of drug relapse (which may require re-applying for benefits) and restrictive pharmacy dispensing of substitute drugs like methadone. The key structural barriers are a lack of joined up working by drug and employment services and employer attitudes to people with a history of substance misuse (and often, also, mental health problems and/or offending).²⁴ A research study by Cebulla et al (2004) concluded that educational and occupational qualifications among substance misusers claiming benefits were low, with literacy and numeracy problems prevalent. Service users said that the greatest barriers for them were interrupted work histories and CV gaps and the need to disclose health problems and criminal records to employers.²⁵

5.2 Joseph Rowntree Foundation study of services for people with drug problems seeking work.²⁶ This 2002 study concludes that 'many of the clients were living in deprived areas where access to drugs put them at risk of relapse. Although most wanted a job they had reservations: they felt that they were not ready and needed to get off drugs and be sure they could stay off; those receiving sickness or invalidity benefits feared a drop in income if they got a poorly paid job.' The clients of education, training and employment services 'had reached a point where they wanted to change their lifestyle', but 'most felt they were not ready for work ... they had a strong fear of relapsing once they were in work. This would be a serious setback if their social security benefits had been stopped and they faced delays in payments being resumed'. Education, training and employment workers 'described several barriers that drug users faced getting into work'. These included a lack of commitment, a chaotic lifestyle, lack of confidence, lack of qualifications, criminal records, waiting lists for both drug treatment and education or training courses, services that were not perceived as user friendly, poorly paid work and a lack of collaboration between key agencies. Employers main concerns

²⁴ Shaw A, Egan J and Gillespie M (March 2007), *Drugs and Poverty - A Literature Review*, Glasgow Caledonian University.

²⁵ Cebulla et al (2004), *Drug and alcohol use as barriers to employment*, Loughborough University, Centre for Research in Social Policy.

²⁶ Klee, H at al (2002), *Employing drug users: Individual and systemic barriers to rehabilitation*, Joseph Rowntree Foundation.

were about trustworthiness, reliability and absenteeism - they needed reassurances that people with a history of problem drug use would not be a risk to their companies.

5.3 DrugScope surveys. Participants in DrugScope's regional consultation events and expert seminar were asked to respond to the proposition 'The majority of problem drug users could get into education, training and employment *within three to six months* with the right support from drug and employment services'. Ten per cent 'strongly agreed', 23 per cent 'agreed', 14 per cent 'neither agreed nor disagreed', 43 per cent 'disagreed' and 10 per cent 'strongly disagreed'. Concerns included risk of relapse if people return to work too early, lack of education and employment opportunities and the need for prolonged and intensive interventions to address complex problems. Other respondents stressed that this is not a homogeneous population - what it is realistic to expect and require will depend on the individual's needs and circumstances. This point was also made by Paul Hayes, Chief Executive of the National Treatment Agency, at the DrugScope/ Department for Work and Pensions consultation event (see below). Not all problem drug users in the benefit system will have complex needs or lack skills. By implication, an effective approach will need an assessment process for individuals that identifies their particular support needs and sets realistic goals on this basis.

5.4 DrugScope/Department of Work and Pensions consultation event. Participants were asked to identify the principal barriers to training and employment for problem drug users. A familiar list emerged from this exercise: stigma and prejudice; more support for employers; training for staff working with this client group; inflexibility in benefit rules (e.g. to support volunteering or work trials); complexity of need; availability of accommodation; skills gaps; lack of confidence and self-esteem; treatment capacity; appropriate support to deal with relapse (and fear of relapse); availability of varied opportunities (part-time employment, volunteering, basic social skills training, etc); attitudes of Job Centre Plus staff; training in 'soft skills' (e.g. how to open a bank account); and the impact of economic downturn.

5.5 Good practice in getting problem drug users into employment. The evidence base on good practice is thin. One of the few published studies is the Joseph Rowntree Foundation report *Employing drug users: Individual and systemic barriers to rehabilitation*. Its key messages are a need for:

- assessment procedures that 'provide full information about the nature and extent of any disadvantage that may affect the job prospects of clients';
- training for education, training and employment providers on drug dependence (including issues such as risk of relapse);
- 'a debate on the meaning of "readiness to work"', which 'would clarify the criteria to be used in identifying the current needs of clients';
- 'throughcare' as an integrated system of life skills, non-vocational skills and training 'delivered either as a "package" or through a system of referrals';
- aftercare to prevent relapse and identify risk factors;

- modification to the rules governing benefits to ensure clients do benefit financially from moving into jobs;
- investigation of current funding arrangements for education, training and employment provision;
- better support for education, training and employment staff;
- tackling stigma and prejudice and improving support for employers.

The report concludes that 'although the prejudice attributed to employers was not extreme, special measures aimed at reassuring them may need to be developed that allow for supervision and monitoring progress'.

5.6 New research. To a significant extent, policy to get problem drug users into education, training and employment is being developed in an evidential vacuum. DrugScope notes that the UK Drug Policy Commission has commissioned work from the University of Manchester on barriers to employment for problem drug users, and asked researchers to consider what approaches might get people with a history of drug misuse into training, education and employment. The findings should guide the development of Government policy. Evaluation of Progress2Work should also guide policy as far as DrugScope is aware, little or no real evaluation has been published.²⁷

'[We need] research - is there a full understanding of what kind of employment is typically suitable for PDUs? And what the usual barriers are to their success - is it social skills? Is it the junkie stigma? Is it substitute medication?'
'Homeless people require homes - among drug users are long or short term homeless'.

Participant at DrugScope/Department of Work and Pensions event

5.7 What elements should an integrated system of drug treatment and employment support include? On the basis of DrugScope's consultation work and the available evidence-base, we would identify the following key features:

- individualised recovery plans²⁸;
- integration of planning processes (e.g. care plans, rehabilitation plans, treatment plans and sentence plans);
- contingency plans to deal with relapse (for example, through crisis plans modelled on mental health and the use of in-work mentors and support);
- realistic goals and timescales;

²⁷ For example, we understand that the Progress2Work pathfinder sites provided for JobCentre Plus Drug Co-ordinators tasked with developing local employment plans between JobCentre Plus and other key agencies - including treatment providers, Drug Action Teams and the probation service. This seems similar to the role envisaged for the 'drug-co-ordinators' in the Green Paper. An assessment of the success of the Progress2Work pathfinders would be helpful.

²⁸ That is, care plans that are developed with full service user involvement and regularly reviewed, and are otherwise consistent with the National Treatment Agency's Care Planning Practice Guide (August 2006).

- simplified processes so service users are not subject to multiple assessment;
- where appropriate, exemption from normal jobseeking requirements to focus on treatment and recovery (this could be accommodated by the proposed 'treatment allowance');
- time restrictions on any 'treatment allowance' that reflect the client's progress towards recovery, rather than being determined extraneously;
- help with issues like mental health problems, housing and debt, which if not addressed could contribute to relapse;
- a strong focus on basic skills training (including social skills);
- integration with local funding, commissioning and service planning;
- involvement of JobCentre Plus in multi-disciplinary teams (e.g. Drug Action Teams);
- training for JobCentre Plus staff;
- training for education, training and employment support staff;
- a supportive and positive relationship between problem drug users and JobCentre Plus;
- targets and rewards for JobCentre Plus and education, training and employment providers that reward long-term and sustainable outcomes for clients and do not incentivise them to push people into inappropriate jobs which they are not ready for;
- a flexible system that supports volunteering, work trials and so on;
- 'aftercare' - including mentoring and support in training or employment;
- changes to benefit rules so people who relapse in work do not have to renegotiate benefits;
- improved links between education, training and employment and drug services (for example, through staff exchanges, joint training and placements);
- drug specialists within JobCentres (see below);
- an education, training and employment presence within drug treatment services;
- engagement of employers and support for employers;
- incentives for employers to take on problem drug users;
- incentivising engagement through positive reinforcers not sanctions (e.g. contingency management);
- available employment, that is suitable and offers a genuine route out of poverty and social exclusion (including possible changes to tax and benefit rules to improve the financial rewards when people move into jobs).

This may seem like a daunting list. However, it is important not to minimise the challenges, particularly when the use of sanctions is part of the approach, and there is real scope to improve positive outcomes by focussing on support, encouragement and incentives and by taking incremental steps forward. Many of these elements of a more integrated system of drug treatment and employment support are already in place or in development, as part of the work to implement the social (re)integration aspects of the new drug strategy.

5.8 Who does what. Many problem drug users are wary of statutory services, which they may associate with sanctions and constraints, more than with support and opportunity. As one contributor to our expert seminar explained: 'there is an issue of branding here. That is clients come in to do our vocational training specifically because we are a drug service and not an education provider. The clients feel safer with us, because they know we offer a supportive environment and that we will address their other needs'. There is a particular role for voluntary and community sector providers, as they can be more flexible and approachable.

'[Government could] assist small community charities to set up social enterprises to allow them to employ drug users, as we understand the needs and can be flexible in our approach to enabling service users back into work or even to begin working for the first time in their lives, as we are funding this work for our service users and ex-service users'.

Participant at DrugScope/Department of Work and Pensions Event

5.9 Do you agree that a rehabilitation plan would help recovering drug users to manage their condition and move towards employment? DrugScope is a strong advocate of care planning that addresses poverty, social exclusion and marginalisation. This should include help to move towards training, education, employment and other meaningful activity. The question is how the proposed rehabilitation plan will link up with other care and treatment planning processes? We would be concerned if rehabilitation plans were exclusively focussed on education, training and employment and did not include related needs (for example, housing, debt, physical health or mental health). Conversely, as more issues are included in the 'rehabilitation plan' it is more difficult to distinguish it from a decent care plan. Another point made at our consultation events is that the end point of a rehabilitation plan should not be entry into any kind of employment. It should reflect the service user's own long-term and wider aspirations. This will provide an additional incentive for him or her to work with it.

5.10 Role of the drug co-ordinator. DrugScope welcomes the proposals to improve links between JobCentres and drug treatment systems. We believe that locating drug co-ordinators within JobCentres could have the potential to improve support for claimants with drug problems and increase the numbers who engage with treatment services, and those in treatment services who engage with training and employment support opportunities. Some of the people we have consulted with have raised questions about whether introducing a new co-ordinator role within JobCentre Plus will 'add more complexity and fragmentation to an already complex system'. Others feel a sympathetic JobCentre Plus presence within treatment agencies is equally, or even more, important. Questions were raised about the role envisaged for drug co-ordinators. Our understanding is that the co-ordinators will have a training, support and facilitative role - both within JobCentre Plus and building partnerships and networks externally - rather than being directly involved in one-to-one case work. We welcome this approach. DrugScope would be concerned if the co-ordinators took on a performance monitoring role (there

should be agreed standards and methods for monitoring work with problem drug users).

Comments from DrugScope/Department of Work and Pensions event

'I am worried that new JobCentre Plus Drug Co-ordinators might add more fragmentation to an already complex system'.

'Second DWP workers into drug treatment services, rather than having an additional person that a service user has to see in the JobCentre (we already do this to a limited extent in structured day programmes).'

'There should be JobCentre Plus advice in hostels to help those drug users with potential to access work quickly but also with acceptance that for some a five year progression will be effective and positive'.

'Role of drug co-ordinator? Building relationships tailored to individual users, not just referring. Caseloads? Need guidance on "boundaries" between the drug co-ordinator and treatment provider. Understanding/awareness of treatment outcomes and milestones. Treatment providers could have a greater role to play in preparing clients for work/reintegration'.

5.11 Stigma and discrimination. There is abundant evidence that employer's have negative perceptions of people with a history of problem drug use. More than 60 per cent of employers who were questioned for a study by the Chartered Institute for Personnel Development said that they disregarded job applications from people with drug and alcohol problems, a criminal record, a history of mental health problems or incapacity. More than half of respondents said that nothing would persuade them to recruit from these 'core jobless' groups.²⁹ Twenty eight out of 33 employers who took part in a survey covering two Social Inclusion Partnerships in West Glasgow reported employing one or more people from a 'hard to employ' group. Yet only one had a member of staff known to have a history of substance misuse and no employers had any one working for them who was known to be on a methadone programme.³⁰ Another Scottish study found that one third of employers said that they would employ someone recovering from a substance misuse problem. Yet over 70 per cent were 'absolutely certain they would not employ someone on a methadone programme' - over half saw no benefits in employing from hard-to-employ groups.³¹

5.12 Methadone. The reluctance of employers to take on people on methadone scripts is particularly concerning, especially as the new drug strategy sees substitute drugs as having a key role in stabilising people's lives

²⁹ Study cited in Mind's written evidence to the Work and Pensions Select Committee inquiry on reform of incapacity benefit and welfare to work (September 2005) www.mind.org.uk/NR/rdonlyres/B6AAEB20-3CC5-4DA6-84F9-B09F073DF8FF/3547/Evidtoworkandpensionssconib.pdf

³⁰ Discussed in Scott and Sillars (2003), *Employers attitudes to hard to employ groups*, a report prepared for Westworking Partnership, Glasgow Caledonian University and Scottish Poverty Information Unit.

³¹ *Ibid.*

so they can sort out issues like housing and employment, before, where appropriate, attempting 'abstinence'. As one commentator has explained, 'there is no reason someone who is on a script can't work. One of the positives of substitute prescribing programmes is that they do enable people to regain stability - get into work, sort their finances and lives out'.³² The potential benefits of substitute prescribing for recovery will not be realised if employers are not prepared to take on employees who are on methadone and other substitute drugs. (One problem is that service users will often need to attend clinics for supervised methadone consumption during working hours. Harm reduction services need to be available before and after work times.)

5.13 Discrimination law. Under disability discrimination laws (currently being reformed as part of the move towards a single equalities framework), employers are required to make 'reasonable adjustments' to enable people with physical and mental health problems to work. This could include flexibility on working hours to allow them to attend clinics or to deal with side-effects from medication. Other provisions include a duty on many employers pro-actively to promote disability equality at work. Drug dependency is explicitly excluded from the scope of these laws, and seems, at best, to be at the margins of the work of the Equality and Human Rights Commission. People in the drug treatment system - or who have been through it in the past - have no legal protection where the discrimination is related to their problem drug use or treatment status. DrugScope would like to see this issue revisited in the development of a single equalities law. We would like to see the Equality and Human Rights Commission take a lead in highlighting and tackling the discrimination experienced by people who are in drug treatment or who have been through the drug treatment system.

5.14 DrugScope's online survey. DrugScope's on-line survey asked people whether they agreed that 'it should be unlawful for employers and training service providers to discriminate against people simply because they are engaged in drug treatment (e.g. on a methadone programme).' The overwhelming majority of respondents believed that this should be unlawful. Nearly forty eight per cent 'strongly agreed' with this proposition, 37.5 per cent 'agreed', 6.3 per cent 'neither agreed nor disagreed', 6.3 per cent disagreed and 2.1 per cent 'strongly disagreed'.

DrugScope survey - some comments from respondents

'For some work environments, employers should be free to discriminate. Furthermore, if someone is on a methadone programme they are not abstinent. If they are on an abstinent drug programme and have been in recovery for 12 months then maybe it should be unlawful'.

'Difficult legislation to create, difficult to police, easy to sidestep and would aggravate employers and distort the market'.

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<http://homepage.mac.com/smcg1967/Sara%20McGrail/page14/files/Welfare%20Green%20Paper.html>

'There should never be a reason for an employer to discriminate against an employee. The only criteria should be whether or not that employee is fulfilling the duties for which they were employed and adhering to the organisation's policies and conditions'.

'This would depend on the individual business. Small employers are unable to support employees whose lives may be chaotic - poor attendance and/or performance may mean the difference between a company continuing to trade or going into liquidation'.

5.15 Anti-stigma work. There has been no significant public investment in anti-stigma initiatives for problem drug users, including work with employers. There has been nothing like the Shift initiative to tackle stigma and discrimination on mental health grounds, which is funded by the Department of Health, and has recently had a particular focus on employers.³³ While Addaction has launched a campaign to improve attitudes to people in drug and alcohol treatment, there has been no initiative for problem drug users comparable to the three year 'Time to Change' programme (formerly Moving People) to tackle stigma and mental illness.³⁴ Attitudes to people in drug treatment services are often extremely negative. There has been little or no public investment in addressing this.

5.16 Addressing employers concerns. Employers have legitimate and non-discriminatory concerns about employing people with drug problems. In safety-critical industries, drug use (including use of prescribed substitutes) may impair performance, should be disclosed and will impose necessary limits on opportunities. Nor will employers be enthusiastic about taking people on who are not prepared for employment, lack basic social skills, are constantly late or absent, have chronically low self-esteem and so on. This simply underlines the importance of not pushing people into unsuitable work prematurely. People with entrenched problems, little or no experience of employment and a lack of basic skills need time and support to reach a point where employment is a viable option. Pushing them into work too soon not only increases risks for the individuals involved (for example, of relapse), but will also tend to create and reinforce negative perceptions of this client group among employers, as people are set up to fail.³⁵

³³ www.shift.org.uk

³⁴ www.time-to-change.org.uk. This is a three year joint initiative by Mind, Rethink, Mental Health Media and the Institute of Psychiatry with £18 million from the National Lottery and Comic Relief.

³⁵ The basic terms of a Local Employment Partnership are that the Government will get disadvantaged people ready for work, though JobCentre Plus and partners (including drug treatment services) and, in return, employers undertake to give them a 'fair shot at the job'. Employers can only deliver their side of this bargain once the Government has delivered on its side. The people turning up for interviews must be genuinely at a point in their recovery when they are ready for work and not rushed into the labour market prematurely.

6. Conclusion

6.1 Access to existing provision. A consistent message from our consultation events is that better access to existing support could go a long way to helping more problem drug users into training, education and employment. We were told that JobCentre Plus staff often do not help problem drug users to access the support that is available.

'Progress2Work clients on incapacity benefit cannot access the services that are available Frontline Job Centre staff will not or can't deal with addiction or offending problems. Clients can't access Local Employment Partnerships as, in some cases, staff do not tell them this is an option. There is a form of gate keeping that means that some clients just don't get put forward for training that would assist them in getting employed. Problem drug users are being consciously excluded from the additional support that is available via JobCentres - at least, that is how it feels in my work.'

Contributor to DrugScope expert seminar

6.2 A range of employment and training opportunities. The Government envisages that Local Employment Partnerships will provide opportunities for work placements, work trials and mentoring. This is welcome, but it is unlikely that the mainstream economy will be able to provide opportunities for all - or even most - problem drug users, particularly at a time of economic downturn.³⁶

6.3 Other approaches. We believe a more radical approach may be necessary. We should be looking at incentives for employers (including financial subsidies). There should be more support for volunteering (including financial support to help people to take on volunteering opportunities, perhaps integrated into contingency management schemes). We would welcome a debate about alternative forms of employment provision for people with the most entrenched and complex problems. Opportunities to do public service work on a voluntary basis, with appropriate financial reward, could build self-esteem, provide work experience, aid recovery and (re)integrate problem drug users into their local communities. More support should be provided for drug treatment and voluntary organisations to develop social enterprises.³⁷

³⁶ As Sophie Johnson - who co-ordinates Progress2Work provision in Bradford and Calderdale - explains in a recent Lifeline Briefing on Substance use and Welfare to Work, 'if unemployment rises the least employable will find it increasingly difficult to find work in full-time, long term jobs that pay sufficient wages to avoid in-work poverty. The majority of drug service users accessing employability support are seeking to work in construction or jobs which are either in service industries or reliant on them (warehousing, retail, driving). These sectors will be hardest hit in any economic downturn'. Johnson (August 2008), *Substance use and Welfare to Work*, Lifeline

³⁷ Suggestions from our expert seminar included opportunities for drug treatment clients to work for several weeks in community projects for the national minimum wage ('this experience would also enable them to gain a reference and work experience that can help them to get a full time job').

6.4 Links to other initiatives. There is potential to develop new approaches in tandem with other innovative developments in the drug treatment sector, which are also aiming to improve social outcomes for problem drug users. For example, the National Treatment Agency will soon be piloting Drug System Change Pilots, giving local areas an opportunity to bring together drug treatment, employment support and other funding, and to commission services that support recovery in its broad sense. The skills agenda set out in the Leitch Review has enormous potential to help to remove some of the barriers to employment for problem drug users. (One key message from our consultation work is that drug treatment clients often need help with basic skills that are below the threshold to qualify as 'training' as ordinarily understood by JobCentre Plus and other key agencies - for example, conversation techniques, making eye contact or opening a bank account. We need to develop the "skills" agenda in its broadest sense, to include life skills.)

6.5 In conclusion. It is positive that the Government is recognising and trying to address the formidable barriers that prevent people with a history of problem drug use getting access to education, training and employment. We have too often aimed too low for the most marginalised. DrugScope believes that there are alternatives to a sanction based approach that will be both fairer and more effective. No doubt there are people in the system who are doing little to find work or move off benefits. But most don't need another 'stick', they need a fair chance, help to develop skills, realistic expectations and individualised help and support. A benefit regime for problem drug users will fail unless it recognises that many of these people have complex needs, and that for some treatment journeys can be long and arduous and that set back and relapse is common. We believe there is plenty of potential to improve outcomes for this group, and we look forward to working with the Department of Work and Pensions, and other key stakeholders, to develop innovative and evidence-based approaches.

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