

# An Independent Review into the impact on employment outcomes of drug or alcohol addiction, and obesity

Dame Carol Black

Presented to Parliament  
by the Secretary of State for Work and Pensions  
by Command of Her Majesty  
December 2016

Cm 9336



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# Foreword by Professor Dame Carol Black

At the heart of this Review is a concern to ameliorate the human, social and economic cost of drug or alcohol addiction or obesity, by addressing the challenges in finding work facing people who are affected. The aim is not to offer utopian solutions to deeply complex problems, but rather to offer, as far as possible, an evidence-based analysis of the factors that stand in the way of employment. We recommend practical interventions, including changes in services, practices, behaviour and attitudes. Whilst drug and alcohol addiction have common features, obesity is different and is treated separately.

The review recognises too that the factors at play in these specific groups of people are present in many others who are afflicted with recurring or persistent long term disorders. The principles of treatment and support in relation to working life, set out in this and my preceding reviews, are the same for all.

With drugs and alcohol, our research has highlighted three main areas where action is needed:

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

Our recommendations address these challenges and will, I believe, if properly implemented and evaluated, offer new productive pathways for these currently lost cohorts.

Our research into obesity has shown that its consequences for the labour market are more indirect, and evidence of its impact on employment and the benefits system is sparse. Most working-age people who are obese are in work, though severe obesity is associated with much lower employment rates. Obesity can lead to a host of other long-term health conditions, which bring their own risks for claim to disability benefits and early retirement, and obesity can deter employers at the recruitment stage.

Unfortunately, although we believe that obesity is widespread among benefits claimants, existing data has not allowed us to identify or enumerate them, nor can we establish the extent to which obesity caused their unemployment. To answer this question, as we indicate in the Review, will require further research and new information about how people with chronic conditions, such as type 2 diabetes, related to obesity, can best be supported to find and keep work.

I hope that this report provides further insights into the problems faced by the specific groups I was asked to consider and offers practical solutions for them, consistent with the Government's direction of travel.

I am grateful for over 120 responses to our Call for Evidence, and to health and local authority service providers, colleagues in devolved administrations, academic bodies and specialists in the field, benefit agencies, voluntary and charitable bodies, and employers, who gave so freely of their time. I am also deeply grateful to my team, led by Adam Bailey, for their unstinting support and good humour, and to the Scrutiny Group for their oversight, clarity and wisdom.

We sought to understand the perspective of people who have experienced these conditions and their journey through the health and benefits systems. Their stories, for which I am most grateful, are powerful, and a very clear message came through – within and after treatment for addiction there must be meaningful activity, preferably work, otherwise the void and boredom will soon be filled by a return to old habits.

We identified the currently limited discussion of the ways in which all the person's health conditions, including but not limited to the addiction itself, could be managed in work or addressed. We feel that requiring a structured conversation on this with a health professional early in a claim to benefit would be valuable to the individuals themselves and to government.

To quote Sigmund Freud, "No other technique for the conduct of life attaches the individual so firmly to reality as laying emphasis on work: for work at least gives one a secure place in a portion of reality, in the human community."

Finally, I do hope that this review will help to bring about the changes so clearly needed.



**Professor Dame Carol Black**

# Executive summary

1. This independent review has explored the challenges faced by individuals who are addicted to alcohol or drugs, or are obese, when they seek to enter, return to and/or remain in work. These three health conditions impose great costs, on individuals and on society, and they bring with them significant labour market disadvantages for those affected. The problems of drug and alcohol dependence have some common features. Obesity is different. It is far more common, the labour market consequences are more indirect, and we cannot easily infer a causal relationship between obesity and unemployment. We therefore consider in the first part of the report the question of supporting into employment those with addictions, and in the second part the labour market problems associated with obesity.
2. We have consulted widely and have taken evidence from health and local authority service providers, academic bodies and specialists in the field, benefits agencies, voluntary and charitable bodies, the devolved administrations and employers. We have also sought to understand the perspective of people who have experienced these conditions, and their journeys through the health and benefits systems. Our findings and recommendations are based on the best available evidence, both domestic and international. We are most grateful to all who have contributed.

## Alcohol and drugs

3. Alcohol dependence can harm individuals, their children and families, and society as a whole. Around a million adults in this country have some form of alcohol dependence<sup>1</sup>. Overall, alcohol harm costs society £21 billion a year, with the costs to the National Health Service (NHS) estimated at £3.5 billion<sup>2</sup>.

<sup>1</sup> NICE commissioning guides [CMG38]. (2011). Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adult.

<sup>2</sup> These costs are all given in the Department of Health's written evidence to the Health Select Committee (19 July 2012) [www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/132/132we02.htm](http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/132/132we02.htm)

4. Alcohol misuse may also be a cause or a consequence of unemployment. It is certainly a predictor both of unemployment and of future job loss, but evidence also suggests that increased alcohol consumption may follow job loss<sup>3</sup>. Unlike dependence on heroin and crack cocaine, alcohol dependence is not strongly associated with lower socioeconomic status although the resultant health harms are. Nevertheless, the employment rate for those who develop problematic dependence is less than half that of the rest of the population<sup>4</sup>.
5. Illegal drug use is common. About a third of the population admit to taking drugs at some stage in their lives, but few go on to develop significant problems. The cost of drug use and supply to society is estimated at around £10.7 billion per year, of which £6 billion is attributed to drug-related crime<sup>5</sup>.
6. A drug problem, however it begins – through a poor lifestyle choice or perhaps as a relief from adversity – once entrenched has profound social consequences. In medical terms, it is a specific long-term condition characterised by relapse and remission. The employability of those affected declines, their families suffer distress, and their children become open to risk of neglect.
7. Many people in alcohol and drug treatment are from, or are part of, families who both have problems and often cause problems. Like these families, many individuals with an alcohol and/or drugs problem face multiple and deep-rooted problems. While an integrated approach to supporting them makes sense, there are no easy solutions.

## Substance misuse treatment services

8. Our review started with an assessment of treatment services. In England, treatment is publicly funded and available through a network of about 1,200 NHS and voluntary sector community treatment services (spread across every local authority area) and around 100 residential rehabilitation services<sup>6</sup>.
9. Local authorities in England hold lead responsibility for commissioning alcohol and drug services, spending over £830 million in 2014/15<sup>7</sup>. Many local agencies, including the police, probation, education, Jobcentre Plus and health are responsible for providing services on the ground to support those in treatment.

<sup>3</sup> Janlert, U. (1997). "Unemployment as a disease and diseases of the unemployed." *Scandinavian journal of work, environment & health* 23: 79.

<sup>4</sup> According to analysis of those in treatment for alcohol and /or drug issues in England, opiate clients have the lowest proportion reporting any work in the 28-day period prior to starting treatment, at 15.2 per cent. Non-opiate, and alcohol clients, have similar levels reporting employment, at 26.5 per cent and 25.8 per cent, respectively. This compares with the overall employment rate for the UK of 73.9 per cent for August to October 2015. See Annex D, Figure 5.

<sup>5</sup> Mills, H., Skodbo, S. and Blyth, P. (2013). Understanding organised crime: estimating the scale and the social and economic costs. Home Office Research Report 73. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/246390/horr73.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/246390/horr73.pdf)

<sup>6</sup> Estimates from the National Drug Treatment Monitoring System, refers to treatment agencies (i) that take publically funded patients (ii) and that submit data to the National Drug Treatment Monitoring System.

<sup>7</sup> Department for Communities and Local Government (2015) Local authority revenue expenditure and financing England: 2014 to 2015 individual local authority data – outturn. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/478072/Revenue\\_Outturn\\_\\_RO3\\_\\_data\\_2014-15\\_by\\_LA\\_-\\_19-Nov-2015.xls](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478072/Revenue_Outturn__RO3__data_2014-15_by_LA_-_19-Nov-2015.xls)

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10. Fractured commissioning responsibilities and lines of accountability can make co-ordinated action challenging. Yet it is only by working together across these boundaries that improved recovery outcomes, including jobs, can be achieved for people with a drug and/or alcohol dependence.
11. In England, just over 150,000 adults<sup>8</sup> (out of the 250,000 to 300,000 with a severe dependence) were in specialist alcohol treatment in 2014/15. Of those leaving treatment last year, 57 per cent had completed the treatment successfully<sup>9</sup>. Waiting times for alcohol treatment in England and Scotland are short – three weeks or less for 95 per cent of individuals in England (an average of 4 days)<sup>10</sup>. But we heard from stakeholders that alcohol services are still inadequate to meet need in a number of areas.
12. In England just over 200,000 adults were in specialist drug treatment in 2014/15<sup>11</sup>. Success rates for those leaving drug treatment in 2014/15 differ markedly depending on the problem substance – 30 per cent of opiate users left treatment successfully last year, but the success rates for non-opiate users are more than double that<sup>12</sup>. These differences reflect the relative complexity and recovery capital of the different cohorts<sup>13</sup>. As with alcohol services, waiting times are short (an average of three days), but we heard concerns from stakeholders about the availability, and in some instances the quality, of drug treatment in some areas.
13. Government has recently assessed long-term success rates for people treated for drug dependence in England<sup>14</sup>. This concluded that although we compare well in international terms, not everyone who comes into treatment will overcome their dependence. We keenly support the view that treatment and support systems (understood as clinical treatment and the wider elements needed to secure recovery such as training or housing) should make every effort to provide the right package of support to maximise each individual's chances of recovery. Part of this support offer, and our particular focus, is whether addiction treatments help facilitate a return to work and also how work can improve addiction treatment.

## Recovery and employment

14. The Government's 2010 Drug Strategy listed a series of recovery-focused aims, among them sustained employment. We agree with this aim, as do all of the stakeholders we spoke to, but this has yet to be realised<sup>15</sup>.

<sup>8</sup> Of these, 89,107 were treated for problematic drinking alone, and 61,533 for alcohol alongside other substances. Source: Public Health England. (2015). Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS): 1 April 2014 to 31 March 2015.

<sup>9</sup> Public Health England define 'successful treatment completion' as being, "determined by clinical judgement that the individual no longer has a need for structured treatment, having achieved all the care plan goals and having overcome dependent use of the substances that brought them into treatment".

<sup>10</sup> From when they first presented for treatment to starting an intervention.

<sup>11</sup> There were 206,117 adults in contact with treatment services in England in 2014-15. Of these: 152,964 were being treated for a problem with opiate drugs (for example heroin), 25,025 for a non-opiate drug problem (for example, powder cocaine or cannabis) and 28,128 non-opiate drugs and alcohol. Source: Public Health England (2015) Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS): 1 April 2014 to 31 March 2015.

<sup>12</sup> See Public Health England definition in footnote 6. Source: Public Health England. (2015). Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS): 1 April 2014 to 31 March 2015.

<sup>13</sup> Recovery capital refers to the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from substance misuse (dependence).

<sup>14</sup> Advisory Council on the Misuse of Drugs (ACMD) Recovery Committee. (2013). What recovery outcomes does the evidence tell us we can expect?

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/262629/Second\\_report\\_of\\_the\\_Recovery\\_Committee.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262629/Second_report_of_the_Recovery_Committee.pdf)

<sup>15</sup> HM Government, Drugs Strategy 2010, London: Home Office, 2010. HM Government, Alcohol Strategy 2012, London: Home Office, 2010. These outcomes were (a) Freedom from dependence on drugs or alcohol; (b) Prevention of drug related deaths and blood borne viruses; (c) A reduction in crime and re-offending; (d) Sustained employment (e); The ability to access and sustain suitable accommodation; (f) Improvement in mental and physical health and wellbeing; (g) Improved relationships with family members, partners and friends; and (h) The capacity to be an effective and caring parent.

15. There is a mutually-reinforcing relationship between employment and recovery<sup>16</sup>. Being employed at the start of treatment improves the chances of completing treatment successfully, and completing treatment improves the chances of finding employment<sup>17</sup>. Evidence also suggests that employment can moderate relapse<sup>18</sup>.
16. However, only around one in five people starting treatment are employed. Those who are employed tend to stay in work throughout treatment. But few who enter treatment without work find it during or after treatment<sup>19</sup>.
17. It is clear that providing treatment alone, without additional support like employment, housing and skills, has limited and inconsistent effects on employment. Increasing the proportion of people with a drug and/or alcohol dependence entering treatment would not, of itself, deliver the Government's desired improvement in job outcomes<sup>20</sup>.

## Employment support in treatment services

18. We have become convinced, through our discussion with stakeholders, that work and other meaningful activity are essential elements in recovery. These components should feature much more prominently in the success measures used to assess the performance of treatment providers. We therefore **recommend the introduction of an expanded recovery measure that includes work and meaningful activity (including volunteering) alongside successful treatment completion. Measuring meaningful activity steps can represent important steps back towards a job, but should be subordinate to an overall job outcomes ambition. We recommend that this be reflected in revised UK guidelines on the clinical management of drug misuse and dependence<sup>21</sup>. We also recommend improving treatment and Jobcentre Plus data to help local Jobcentres and treatment services target, deliver and benchmark their efforts to find work for these groups.**
19. Improved performance metrics for providers that include work must be backed by a high-quality offer of employment support within treatment services. That is why **we recommend trialling several Individual Placement and Support (IPS) approaches and the co-location of Jobcentre staff in treatment centres**. This would provide unemployed people in treatment with individual advice and support to find a job, and ongoing support once in work. This approach has worked well for severe mental health patients, including some with addictions, who have complex support requirements and poor work histories<sup>22</sup>.

<sup>16</sup> There is strong evidence that securing employment (and engaging in vocational volunteering) is generally associated with improved treatment outcomes, and reduced frequency and severity of relapse. Source: Henkel, Unemployment and Substance Misuse: A Review of the Literature (1990-2010) (2011), Current Drug Abuse Reviews, 4, 4-27.

<sup>17</sup> See Annex D, Figures 11 and 12.

<sup>18</sup> See Henkel's 2011 Review of the Literature.

<sup>19</sup> See Annex D for discussion of this issue.

<sup>20</sup> Sumnall, H and Brotherhood, A. (2012). *EMCDDA Insights: Social reintegration and employment: evidence and interventions for drug users in treatment*. European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). [http://www.emcdda.europa.eu/system/files/publications/673/TDXD12013ENC\\_Web-1\\_394929.pdf](http://www.emcdda.europa.eu/system/files/publications/673/TDXD12013ENC_Web-1_394929.pdf)

<sup>21</sup> Department of Health (England) and the devolved administrations. (2007). *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.

<sup>22</sup> There is a large literature on IPS see particularly: (a) Crowther, R.E., Marshall, M., Bond, G.R. and Huxley, P., 2001. Helping people with severe mental illness to obtain work: systematic review. *Bmj*, 322(7280), pp.204-208. (b) Bond, G.R., Drake, R.E. and Becker, D.R., 2012. Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US. *World Psychiatry*, 11(1), pp.32-39.

## Alcohol and drug dependence and the benefits system

20. Most people with a drug and/or alcohol dependence who are out of work, are on benefits, and the benefits system, alongside the employment services that the Department for Work and Pensions (DWP) contracts from the private sector, is the main part of the Government responsible for helping them find work. Even when IPS services become available in treatment, the benefits system will be the main employment route for many, either because they do not volunteer for IPS or are not currently in treatment. It is therefore vital that these services are able to identify accurately claimants with addictions and offer specialised support.
21. However, we found many failings in the current benefits system. The first is a failure to identify addiction (and indeed other relevant health conditions). The benefits system only records a single health condition, usually originating in the General Practitioner's Fit Note, which is rarely reviewed or updated and seldom includes addiction. Individuals are very unlikely to disclose addictions to Jobcentre Plus due to mistrust and lack of a clear, high-quality offer of support if they did.
22. We consider it essential that the Government seeks to improve the health information in the benefits system. Doing so would be in the best interests of claimants and the Government. So we **recommend that the Government, working with the clinical community, reviews ways in which better health information could be provided to Jobcentre Plus in support of a claim.** There are a number of different ways this could be achieved (for example expanding the fit note to contain extra information) but to make a real difference this additional information must flow through to the staff in Jobcentre Plus supporting the claimant throughout their search for employment.
23. We have been struck by the limited discussion of a claimant's health conditions during a benefit claim, despite their health problems being the main reason for the individual making a claim to benefit. We therefore think that a conversation with a healthcare professional about the barriers to work arising from all their health conditions (including any addiction) would be valuable to drug and alcohol dependent claimants, those with health conditions related to obesity, and indeed claimants with other long-term health conditions, as well as being useful to the work coach. We therefore **recommend the Government trials a requirement for each claimant, early in their claim to benefit, to attend a structured discussion with a healthcare professional on the impact of their health condition on their ability to work**, to test the value of this approach and identify delivery issues.
24. Alongside improved health information, we have considered options to help encourage individuals to disclose their addiction in Jobcentres, as well as to accept appropriate support. Over the course of this review the positive role that peer mentoring plays (usually in treatment services) was repeatedly and strongly advocated as a means of demonstrating that recovery is possible. **We therefore recommend Jobcentre Plus trials the use of peer mentors to act as advocates and visible symbols of recovery, tasked with encouraging safe disclosure and engagement with appropriate support.**

25. Better identification of addiction, and improved engagement from claimants affected, must be accompanied by a better offer of support within Jobcentre Plus to encourage self-disclosure and positive engagement with employment opportunities and other steps toward the labour market. Where claimants have been identified as having addictions, they have far too often been left on benefits for very long periods – indeed, the average duration on Incapacity Benefit (IB) of this group is eight years. Our visits around the country showed that some current practice is effective but this is not the norm. We therefore recommend a new, universally-delivered **enhanced Jobcentre Plus drug and alcohol offer that has a greater number of work-based options for staff to refer claimants to. This offer must be underpinned by upskilling delivery staff, improving accountability, and maintaining links to drug and alcohol treatment services.**
26. The 2015 Spending Review announced a new Work and Health Programme to launch in 2017 following the end of referrals to the Work Programme and Work Choice. While the detail of this new programme is currently being developed, it is important that this gives better support to alcohol and drug dependent jobseekers, and indeed all jobseekers with a health condition. It should follow the principle of joined-up employment and health and social support, preferably co-located<sup>23</sup>.

## The role of employers

27. For many people, drug and alcohol problems start whilst they are still in work. It is therefore vital that employers encourage those who are still in work to reduce hazardous drinking and avoid drug use entirely. Some employers already offer best-practice support and we welcome the Government's efforts in trying to expand this. Specifically, we endorse the focus on preventative actions contained in the NHS Mandate<sup>24</sup>, the NHS's *Five Year Forward View*<sup>25</sup> and initiatives such as the Workplace Wellbeing Charter which asks employers to take steps to make workplaces healthier<sup>26</sup>.
28. Generally, although employers are willing to consider supporting existing staff who develop addictions, they are much less willing to recruit people with an existing history of dependence. Employers expressed a number of fears, including the reliability of potential candidates with addiction problems, the cost of offering support, the impact on other staff, and the reputation of the business. These views by employers on drug and alcohol dependent people mirror the wider stigma found in society. This is partly realistic and partly irrational. However, the damaging effect of these views is real and pervasive.

<sup>23</sup> HM Treasury. (November 2015). Spending review and autumn statement 2015. See section 11.7 on the DWP. <https://www.gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents/spending-review-and-autumn-statement-2015>

<sup>24</sup> Department of Health. (2016). *The Government's mandate to NHS England 2016-17*. A mandate from the Government to NHS England: April 2016 to March 2017. Presented to Parliament pursuant to Section 13A(1) of the National Health Service Act 2006. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/494485/NHSE\\_mandate\\_16-17\\_22\\_Jan.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/494485/NHSE_mandate_16-17_22_Jan.pdf)

<sup>25</sup> NHS England. (2014). *NHS five Year Forward View*. London: NHS England. <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

<sup>26</sup> See (i) Workplace Wellbeing Charter: <http://www.wellbeingcharter.org.uk/What-is-the-Charter.php> and (ii) Department of Health. (2015). Public Health England Strategic Remit and Priorities Letter. London: Department of Health. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/417629/Public\\_Health\\_England\\_\\_Remit\\_\\_Priorities\\_Letter\\_\\_2015-16\\_Final\\_\\_2\\_.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417629/Public_Health_England__Remit__Priorities_Letter__2015-16_Final__2_.pdf)

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29. Various recruitment processes are used to manage these perceived risks. These range from 'blanket' recruitment policies which rule out the employment of drug users, to the way in which criminal checks are used, even for low-risk roles, and the fact that curriculum vitae (CV) gaps are used as a filtering tool. We met several employers who had invested heavily in recruiting and supporting people with previous addiction problems and who had reaped benefits from doing so, but this was the exception not the norm.
30. To address some of the practical implications of recruiting this cohort, **we the recommend Government develops, with employers, guidance on best practice in recruiting alcohol and drug dependent people. We also recommend that See Potential and other campaigns are used to promote this guidance and to address the problem of stigma more generally.** The role of the Government also extends to its responsibilities as an employer where, in offering job opportunities for those in recovery, it should be an exemplar.
31. But additional government action is required as employers are clear that they need to 'de-risk' the decision to employ someone in recovery. Many suggested that they would value in-work, expert support if they were to employ people in recovery. The IPS model offers this type of in-work support to employers. Given that training costs might be an issue for some employers, we also **recommend that the employment advisors in the IPS trial have access to a small discretionary fund to cover legitimate additional costs that smaller employers incur when recruiting people with a history of alcohol or drug dependence. Finally, we recommend that the IPS trial incorporates Work Trials** so that employers are able to test out candidates for a period of time before committing to an employment offer.
32. Not everyone will be covered by an IPS trial, and it is important that the Government's own employment services support employers to recruit or retain drug or alcohol dependent people. **So we recommend extending the assessment and support services within Access to Work<sup>27</sup> to include drug and alcohol dependent people who are on a treatment programme but do not have an additional declared physical or mental health issue.**

## Obesity, employment outcomes and the benefits system

33. Obesity is a complex multi-factorial problem that is not yet completely understood. The UK has the highest obesity prevalence among European members of the Organisation for Economic Co-operation and Development (OECD). Only the US, Mexico, Chile and New Zealand have higher rates<sup>28</sup>.

<sup>27</sup> The Access to Work scheme pays grants for practical support for people with disability, health or mental health condition to them start and stay in working or to move into self-employment or start a business. See more at: <https://www.gov.uk/access-to-work>

<sup>28</sup> Sassi, F. (2010). *Obesity and the economics of prevention: fit not fat*. Organisation for economic cooperation and development.

34. In England, six out of ten men and five out of ten women are overweight or obese. Today one in four men and women are obese; obesity has been increasing over the last 30 years (in 1980, around only 7 per cent of adults were obese) – and is likely to continue to do so<sup>29, 30</sup>. Treating obesity and its consequences alone cost the NHS in England £5.1 billion in 2014/15 – costs that are expected to rise substantially<sup>31</sup>.
35. Our review has focused on the impact of obesity on employment, but we recognise that this is only a part of the wider societal endeavour required to tackle the obesity problem.
36. As almost one in four working-age adults are obese, many obese people will be in work. However, while 68 per cent of obese adults are in employment compared to 70 per cent of those of normal weight, the gap increases to over ten percentage points for the severely obese. Obese and severely obese people are over-represented amongst the sick and disabled<sup>32</sup>.
37. We cannot infer a direct causal relationship between obesity and unemployment. Obese and severely obese adults not in work are very likely to live in the most deprived areas and are likely to have poor qualifications. Obesity rates tend to be much higher amongst people with certain other long-term health conditions such as diabetes or heart trouble. There is also a big overlap with mental ill-health. Worse employment outcomes may be the result of multiple other labour-market disadvantages, some of them related to obesity (such as particular health problems) and others not<sup>33</sup>.
38. There is some evidence of discrimination against obese workers by employers. The labour market consequences appear worse for women (and women are more likely to be severely obese)<sup>34</sup>. In one UK survey, 57 per cent of respondents agreed with the statement that people were overweight because ‘they lack willpower’. Such views may promote wage or employment inequalities<sup>35</sup>.
39. Understanding the impact of obesity in the benefits system is difficult. Only 1,600 recipients of Employment and Support Allowance (ESA) have obesity recorded as their main disabling condition, but there are as many as approximately 800,000 recipients with a main disabling condition for which obesity could have been a contributory factor. As there are no figures on the risk of obesity for each disabling condition, it is impossible to estimate how many of these 800,000 are actually obese.
40. Obesity is associated with a wide range of risks of poor health, possibly cumulative, which can bring labour market disadvantages such as increased absenteeism<sup>36</sup> and presenteeism, discrimination and stigma<sup>37</sup>, and lower wages<sup>38</sup>. As a consequence it also holds the potential to add to the health-related benefits bill.

<sup>29</sup> Public Health England. (2015). *Patterns and trends in adult obesity*, <https://www.noo.org.uk/gsf.php5?f=14605&fv=21272> [accessed 26 October 2015] Overweight is defined as a BMI of 25-30 kg/m<sup>2</sup>; Obese is defined as a BMI that is equal or greater than 30 kg/m<sup>2</sup>; Severely obese is defined as equal or greater than 40 kg/m<sup>2</sup>.

<sup>30</sup> Department of Health. (2012). *Annual Report of the Chief Medical Officer Surveillance Volume, 2012: On the State of the Public's Health*. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/298297/cmo-report-2012.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/298297/cmo-report-2012.pdf)

<sup>31</sup> Estimates for England in 2014/15 are based on: Scarborough, P. (2011). The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs. *Journal of Public Health*. May 2011, 1-9. Uplifted to take into account inflation. No adjustment has been made for slight changes in overweight and obesity rates over this period. It's been assumed England costs account for around 85 per cent of UK costs.

<sup>32</sup> See Annex F, Figure 6.

<sup>33</sup> Public Health England. (2014). *From evidence into action: opportunities to protect and improve the nation's health*. [online] Public Health England (Publications gateway number 2014404). Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/366852/PHE\\_Priorities.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366852/PHE_Priorities.pdf)

<sup>34</sup> Sassi, F. (2010). *Obesity and the economics of prevention: fit not fat*. Organisation for economic cooperation and development.

<sup>35</sup> Beeken, R. J. and Wardle, J. (2013). Public beliefs about the causes of obesity and attitudes towards policy initiatives in Great Britain, in *Public Health Nutrition*, 16(12), 2132-2137.

<sup>36</sup> Niessen, M., Kraaijenhagen R., Dijkgraaf, M., Van Pelt, D., Van Kalken, C., Peek, N. (2012). *Impact of a web-based worksite health promotion programme on absenteeism*. *Journal of occupational and environmental medicine*, 54(4), 404-408.

<sup>37</sup> Puhl, R. M., Heuer, C. A. (2009). *The stigma of obesity: a review and update*. *Obesity* 17: 941-64.

<sup>38</sup> Sassi, F. (2010). *Obesity and the economics of prevention: fit not fat*. Organisation for economic cooperation and development.

## 14 Executive summary

41. What we know so far, coupled with alarming projections of obesity in future, convinces us that the Government needs to understand urgently the relationship between obesity and labour market outcomes. We therefore **recommend that the Government commissions research to investigate the impact of obesity on the working population and the extent to which obesity plays a role in health-related benefit claims, in particular long-term ones.** This will help understand the true labour market costs of the obesity epidemic and help build a case (if justified) for further societal, employer and government action.
42. Given the potential impact of obesity, we also **recommend that there is a minimum support offer that upskills Jobcentre Plus advisors on addressing obesity, and a referral pathway into local weight-management services when obesity is identified as a barrier to work.**

## Conclusions

43. This review has highlighted opportunities to promote employment of those with addictions and so help reduce the cumulative cost to the Government and society. Every year, around 300,000 working-age adults are in alcohol and drug treatment services in England but, despite the other benefits of treatment, the majority fail to find work (para 17). In the benefits system, there is no reliable way of identifying claimants with addictions (para 21), and there is a distinct lack of specialised support. We have also heard loud and clear from employers that hiring individuals from this group can present an unacceptable risk to their business (para 28)<sup>39</sup>.
44. These findings have important implications for one of the questions asked of this review: whether the Government should make benefit claimants with an addiction engage with treatment as a condition of their benefit entitlement.
45. We are clear that benefit claimants with addictions should, like all other claimants, do all they can to re-enter work. However, in view of the findings in paragraph 43 above, we doubt whether mandation of treatment – one of the possibilities mentioned in our terms of reference – should be the first response to the evident problems for the cohorts under discussion. Further, there is a strong consensus that mandating treatment would lead to more people hiding their addiction than reveal it. We also heard from health professionals serious concerns about the legal and ethical implications of mandating treatment and whether this would be a cost effective approach.
46. This review has therefore focussed its efforts on other measures, within the treatment, support and benefits systems, that could improve employment outcomes. As a result, we recommend, among other things, requiring benefit claimants to attend an early, structured discussion with an appropriate healthcare professional about the barriers to a return to work (para 23). If the measures we recommend are put in place and shown to be successful, the Government could then consider further ways to encourage engagement with the employment support package that would then be put in place.
47. We believe that the review's recommendations, if properly tested and implemented, will offer new, productive pathways for these lost cohorts. By bringing employment services into the treatment process, the Government can build on the positive aspects of the process of recovery and bring job search forward into a non-threatening environment. These reform principles also have wider applicability to other complex groups on health related benefits.

<sup>39</sup> Public Health England. (2015). *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS): 1 April 2014 to 31 March 2015*.  
<http://www.nta.nhs.uk/uploads/adult-statistics-from-the-national-drug-treatment-monitoring-system-2014-2015.pdf>

48. This challenge of integrating services is not new, and yet it offers a powerful way to improve employment outcomes; not just for the cohorts that have been the focus of this review, but for all those suffering with a long-term condition. Our analysis has reinforced our view that the **Government should promote more integrated collaboration across the benefits and health systems, to improve employment outcomes for this group and for others with long-term health conditions.** One promising approach is the ‘Universal Support’ initiative, which focuses on helping Universal Credit claimants make and maintain their claim and assists them with their financial and digital capability as they make the transition online. For workless alcohol and/or drug dependent people with high support needs, and other similar claimants with long-term health conditions, we want to see Government building on this approach, and join up the benefits system with other services, particularly health, but also the full range of Local Authority services (including treatment and housing). This type of approach, could, if expanded upon, address wider barriers to work and be an important catalyst in back to work journeys for these groups. The newly-formed Work and Health Unit offers a real opportunity to deliver steps towards realising this vision.
49. For people with a drug and/or alcohol dependence who interact with Jobcentre Plus, we have highlighted the need to improve the collection and flow of health information. Improving their engagement with employment support offered by work coaches will also be key. Alongside better support for employers, these changes should help ensure that few are unable to find a high-quality employment pathway, whichever government-funded system they enter.
50. We also hope that the Government will continue our investigation into the highly important question of obesity and employment. Most working-age people who are obese do in fact work. But obesity is linked to a host of long-term health conditions and is a significant risk factor for claiming disability benefits and retiring early. Severe obesity is associated with lower employment rates, especially for women, and obesity deters employers at the recruitment stage, on account of a host of perceived risks<sup>40</sup>.
51. This review has focused strongly on the benefits system – how to prevent people entering the benefits system or, worse, languishing in it. Unfortunately, although we believe obesity is a widespread issue for benefits claimants, existing data has not allowed us to identify most obese claimants nor understand the extent to which obesity may have caused their unemployment. This question will require in-depth research with collection of new information. We hope the Government’s new Work and Health Unit will take on this challenge as a high priority.
52. Government and employers also have a key role in supporting individuals to prevent these conditions arising in the first place. Health and care services can also play a critical leadership role by embedding work as a core consideration for the individuals they support and embedding the prevention within a ‘*Making every contact count*’ approach.
53. Finally, in conducting this review, we have been struck by how many people with long-term health conditions, including those with multiple other labour-market disadvantages, do nevertheless find work. In a diverse and flexible labour market, there are opportunities for most people to work and to enjoy the financial and social rewards that work brings. With the right support, we believe employment would be within the reach of tens of thousands more working-age people each year. This is a real prize for the Government and has been the motivation for this review, supported by the many stakeholders and people with experience of addiction, who have engaged with us.

<sup>40</sup> Robroek, S., Reeuwijk, K., Hillier, F., Bambra, C., Van Rijn, R., Burdorf, A., 2013. The contribution of overweight, obesity, and lack of physical activity to exit from paid employment: a meta-analysis. *Scandinavian Journal of Work, Environment and Health*, 39(3), 233-240.

## **Part 1 – Drugs and alcohol: employment outcomes, the benefits system and the role of employers**

# Improving the employment outcomes of drug and alcohol dependent people: the role of treatment

# 1

## Introduction

1. We started our review by examining the group of people in treatment for drug and alcohol dependence and the role of employment in recovery.
2. In this chapter, we give an overview of the known prevalence of alcohol and drug misuse, associated health and social harms, and the effect on employment. We then explore the role of employment in supporting recovery and the employment status of those in treatment. Next we consider the question of linking benefit entitlement to engagement with treatment. We end by setting out our employment ambition and how this can be delivered.

## Alcohol consumption

3. The UK was 13th highest of 40 Organisation for Economic Co-operation and Development (OECD) countries in overall alcohol consumption in 2012<sup>41</sup>. Most alcohol is consumed by the heaviest drinking 20 per cent of the population and it is estimated that 10.3 million adults now drink at levels that increase the risk of harm<sup>42</sup>. Around a million show signs of alcohol dependence<sup>43</sup>.

<sup>41</sup> Alcohol consumption (*Litres per capita (15+)*). OECD Health Data: Non-medical determinants of health: OECD Health Statistics. [http://www.oecd-ilibrary.org/social-issues-migration-health/alcohol-consumption-2013-2\\_alcoholcons-table-2013-2-en](http://www.oecd-ilibrary.org/social-issues-migration-health/alcohol-consumption-2013-2_alcoholcons-table-2013-2-en)

<sup>42</sup> DH analysis in support of the UK Chief Medical Officers' new guidelines to limit the health risks associated with the consumption of alcohol.

<sup>43</sup> National Institute for Health and Care Excellence. (2011). *Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults: commissioning guide: commissioning and benchmarking tool*. London: NICE. <http://www.nice.org.uk/guidance/qs11/resources/alcohol-services-commissioning-and-benchmarking-tool-304114141>

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4. As the Chief Medical Officer's proposed new guidelines make clear, the risks to health from alcohol consumption begin at any level of regular drinking<sup>44</sup>. Alcohol increases the risks of injury and accidents, heart disease, cancer and liver disease<sup>45</sup>. There are close links between alcohol abuse and crime, domestic violence, and traffic accidents<sup>46</sup>.
5. However, impacts on employment are not so clear. According to the OECD, whether alcohol use is a cause or a consequence of unemployment is not fully understood<sup>47, 48</sup>.
6. Some working conditions, such as long working hours and job insecurity<sup>49</sup>, have been linked to an increased likelihood of high-risk alcohol consumption, and alcohol misuse typically predicts unemployment and future job loss<sup>50</sup>.
7. Some evidence suggests that increased alcohol consumption can follow loss of employment<sup>51</sup>. This may, however, be partly mitigated by the reduced income typically faced by unemployed people<sup>52</sup>. Research suggests that there is only a limited relationship between 'binge' drinking and unemployment<sup>53</sup>.
8. In the UK, it is estimated that between 260,000 and 300,000 people are severely dependent on alcohol. Unfortunately the correlation with employment status is unknown<sup>54</sup>.

### Drug use

9. Illegal drug use is common in society. About a third of the population admit to taking drugs at some stage in their lives; but few people go on to develop problems.

<sup>44</sup> Department of Health. (2016). *UK Chief Medical Officers' Alcohol Guidelines Review. Summary of the proposed new guidelines*. London, The Department of Health.

<sup>45</sup> Jones, L., Bellis, M., Dedman, D., Sumnall, H. and Tocque, K. (2008). Alcohol-attributable fractions for England. *Alcohol-attributable mortality and hospital admissions*. Liverpool: Liverpool John Moores University and North-West Public Health Observatory.

<sup>46</sup> See (i) Murdoch, D. and Ross, D. (1990). Alcohol and crimes of violence: Present issues. *International Journal of the Addictions*, 25(9), pp.1065-1081. (ii) Budd, T., Tedstone, C. and Curry, D. (2003). *Alcohol-related assault: findings from the British Crime Survey*. London: Home Office. (iii) Rossow, I. (2000). Suicide, violence and child abuse: a review of the impact of alcohol consumption on social problems. *Contemporary Drug Problems*, 27(3), pp.397-433. (iv) (v). Department of Transport. (2015). *Estimates for reported road traffic accidents involving illegal alcohol levels: 2013 second provisional*.

<sup>47</sup> Devaux, M. and Sassi, F. (2015). *Alcohol consumption and harmful drinking*. Organisation for economic cooperation and development. [http://www.oecd-ilibrary.org/social-issues-migration-health/alcohol-consumption-and-harmful-drinking\\_5js1qwkz2p9s-en](http://www.oecd-ilibrary.org/social-issues-migration-health/alcohol-consumption-and-harmful-drinking_5js1qwkz2p9s-en)

<sup>48</sup> Sassi, F.(ed.). (2015). *Tackling Harmful Alcohol Use: Economics and Public Health Policy*, OECD Publishing, Paris. <http://www.oecd.org/health/tackling-harmful-alcohol-use-9789264181069-en.htm>

<sup>49</sup> Virtanen, M., Jokela, M., Nyberg, S. T., Madsen, I. E., Lallukka, T., Ahola, K., Alfredsson, L., Batty, G. D., Bjorner, J. B., Borritz, M. and Burr, H. (2015). Long working hours and alcohol use: systematic review and meta-analysis of published studies and unpublished individual participant data. *BMJ*, 350, p.g7772.

<sup>50</sup> Janlert, U. (1997). "Unemployment as a disease and diseases of the unemployed." *Scandinavian journal of work, environment & health* 23: 79.

<sup>51</sup> Janlert, U. (1997). "Unemployment as a disease and diseases of the unemployed." *Scandinavian journal of work, environment & health* 23: 79.

<sup>52</sup> Arcaya, M., et al. (2014). "Individual and spousal unemployment as predictors of smoking and drinking behaviour." *Social Science and Medicine* 110: 89-95.

<sup>53</sup> Backhans, C., et al. (2012). "Binge drinking--a predictor for or a consequence of unemployment?" *Alcoholism, clinical and experimental research* 36(11): 1983.

<sup>54</sup> Health and Social Care Information Centre. (2009). *Adult Psychiatric Morbidity in England – 2007, Results of a household survey*.

10. There are no statistics on the employment rates of drug users as a whole. In England, an estimated 300,000 people use opiates and/or crack<sup>55</sup>, but there are no reliable estimates of dependence levels of other illicit drugs<sup>56</sup>.
11. There is strong international evidence of adverse labour market effects of drug use<sup>57</sup>, although whether drug use is a cause or consequence of unemployment is contested<sup>58</sup>.
12. For affected individuals, drug misuse may be only one of a number of socially or economically excluding factors. Many, but not all, people with histories of substance misuse will have left school early. They may also have poor educational attainment and low functional or basic skills, such as literacy and numeracy<sup>59</sup>.
13. This labour market disadvantage is often compounded by high levels of mental ill health and psychiatric distress (particularly among drug users who are unemployed and/or not job seeking), poor physical health (whether or not related to the substance misuse), offending histories, chequered employment histories, and a tendency to live in deprived areas and to have limited social networks<sup>60</sup>.

## Substance misuse treatment services

14. Addiction is treatable but as a chronic, often relapsing, condition most people will need long-term or repeated care to stop using completely and recover fully. Achieving this will require support that covers a number of different domains.
15. Clinical treatment, including evidence-based talking therapies and prescribing interventions, play an important role. However, for people to sustain their recovery, they need to be linked in with a range of appropriate support, including family, social and peer support, and have access to stable housing and employment, training or education opportunities. Without these elements in place to build 'recovery capital' a dependent person is unlikely to sustain the gains made by clinical treatment. In this report we use the term 'treatment and support' to refer to all the clinical and wider support elements that need to be in place to help someone overcome their dependence. Two critical elements – Housing and the Criminal Justice system (CJS) – are considered at the end of the chapter.

<sup>55</sup> Hay, G., Rael dos Santos, A. and Worsley, J. (2012). *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2011/12: Sweep 8 report*. Liverpool John Moores University.

<sup>56</sup> Every year the Home Office examines the extent and trends in illicit drug use among a nationally representative sample of 16 to 59-year-olds resident in households in England and Wales, based on results from the Crime Survey for England and Wales (CSEW). This estimates the prevalence of drug use, but does not offer an estimate of drug dependence. See: Home Office (July 2015) *Drug Misuse: Findings from the 2014/15 Crime Survey for England and Wales: Statistical Bulletin 03/15*. London: The Home Office.  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/462885/drug-misuse-1415.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/462885/drug-misuse-1415.pdf)

<sup>57</sup> See (i) Henkel, *Unemployment and Substance Misuse: A Review of the Literature (1990-2010)*. (2011). *Current Drug Abuse Reviews*, 4, 4-27 and (ii) Bray, J. W., et al. (2000). "Symptoms of dependence, multiple substance use, and labor market outcomes." *The American journal of drug and alcohol abuse* 26(1): 77.

<sup>58</sup> Henkel, *Unemployment and Substance Misuse: A Review of the Literature (1990-2010)*. (2011). *Current Drug Abuse Reviews*, 4, 4-27.

<sup>59</sup> Tables 13a & 13b <http://www.dtors.org.uk/reports/BaselineAppendix.pdf>. Note that from 2015, the school leaving age will be increased to 18.

<sup>60</sup> Johnson, M. E., et al. (2001). "Employment status and psychological symptomatology among drug users not currently in treatment." *Evaluation and Program Planning* 24(2): 215-220.

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16. The evidence-base for treatment is robust and has been set out in recommendations from the National Institute for Health and Care Excellence (NICE) and UK guidelines on the clinical management of drug misuse and dependence. These set out the quality standards which are clear that treatment needs to be closely co-ordinated with non-clinical support such as housing and employment services. They conclude that treatment improves public health and supports other desired outcomes like recovery from dependence, improved social functioning and reduced crime – and provides value for money for the taxpayer<sup>61</sup>.
17. Most people self-refer to a treatment service, although a significant proportion are referred from the health or criminal justice systems. Treatment is provided by a network of National Health Service (NHS) and voluntary sector services, based in community and residential settings. Local authorities in England hold lead responsibility for commissioning alcohol and drug services, spending over £830 million in 2014/15<sup>62</sup>.
18. In England, just over 200,000 patients were in specialist drug treatment in 2014/15. Success rates for those leaving drug treatment in 2014/15 differ markedly depending on the problem substance – 30 per cent of opiate users left treatment successfully, but the success rates for non-opiate users are more than double that<sup>63</sup>.
19. Waiting time figures for drug treatment are also good. Nearly all individuals (98 per cent) waited three weeks or less to start treatment – an average of three days. This suggests that treatment services are accessible, although some concerns around availability of treatment were also raised by some stakeholders.
20. The figures for successful completion, waiting times, and the proportion of problematic drug users who are in treatment (over 60 per cent of opiate users) suggests that the drug treatment system in England functions well for those who need and access it.
21. As to alcohol, 150,000 patients received treatment in England for alcohol problems in 2014-15, and of those leaving treatment, 60 per cent left successfully. Waiting times in England and Scotland are short – three weeks or less for 95 per cent of individuals in England, an average of four days. These figures suggest that alcohol services function well for those who access them<sup>64</sup>.
22. Yet we heard from some stakeholders that there is insufficient capacity in alcohol treatment services in several areas to meet the needs of people dependent on alcohol.

<sup>61</sup> There are a range of alcohol and drug related NICE guidance, these include but are not limited to: (i) NICE. (2011). *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence*. NICE clinical guidelines 115. London: National Institute for Health and Clinical Excellence; (ii) NICE. (2011). *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence*. NICE quality standard QS 11. London: National Institute for Health and Clinical Excellence; (iii) NICE. (2011). *Drug misuse: Psychosocial interventions*. NICE clinical guideline 51. London: National Institute for Health and Clinical Excellence; (iv) NICE. (2007). *Methadone and buprenorphine for the management of opioid dependence*. NICE technology appraisal guidance TA114. London: National Institute for Health and Clinical Excellence; (v) NICE. (2007). *Drug misuse: opiate detoxification*. NICE clinical guideline 52. London: National Institute for Health and Clinical Excellence; (vi) NICE. (2009). *Needle and syringe programmes: providing people who inject drugs with injecting equipment*. NICE public health guidance 18. London: National Institute for Health and Clinical Excellence; (vii) NICE. (2012). *Drug use disorders in adults*. NICE quality standard QS 23. London: National Institute for Health and Clinical Excellence; (viii) Department of Health (England) and the devolved administrations. (2007). *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.

<sup>62</sup> Department for Communities and Local Government. (2015). Local authority revenue expenditure and financing England: 2014 to 2015 individual local authority data – outturn. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/478072/Revenue\\_Outturn\\_\\_RO3\\_\\_data\\_2014-15\\_by\\_LA\\_-\\_19-Nov-2015.xls](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478072/Revenue_Outturn__RO3__data_2014-15_by_LA_-_19-Nov-2015.xls)

<sup>63</sup> Public Health England define 'successful treatment completion' as being, "determined by clinical judgement that the individual no longer has a need for structured treatment, having achieved all the care plan goals and having overcome dependent use of the substances that brought them into treatment".

<sup>64</sup> Of these, 89,107 were treated for problematic drinking alone, and 61,533 for alcohol alongside other substances. Source: Public Health England. (2015). Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS): 1 April 2014 to 31 March 2015.

23. Understanding the extent of the gap between the number who would benefit from alcohol treatment and the capacity currently available is complex. Estimates suggest that there may be up to a million people in England who have some level of alcohol dependence<sup>65</sup>. Not all of these will need structured treatment, but the number of severely dependent drinkers in England is estimated to be between 260,000 and 300,000. These most problematic drinkers will likely need structured treatment to help them overcome their dependence and sustain their recovery<sup>66</sup>.
24. These figures support the views we heard from stakeholders that many dependent drinkers who could benefit from treatment do not receive it. The reasons for this are not fully understood, but we heard suggestions from stakeholders that this might be because some people have not recognised their dependence, or that complex additional needs (particularly mental health problems) make it harder to access treatment. Others might feel that services are not attractive to them.
25. Stakeholders from across local authorities and the treatment sector raised concerns that funding pressures have affected the ability of commissioned services to deliver successfully. This could prevent them from embarking on partnerships with other organisations, such as employment support, that NICE says are essential to high-quality treatment. Whilst decisions on funding are a matter for the government, we note that some of the measures proposed in this report go beyond the current funded expectation of treatment, including the trialling of new labour-market interventions for addiction cohorts and supporting peer-mentoring arrangements in Jobcentre Plus offices.
26. We also heard concerns from some clinical leaders about the quality of current substance-misuse treatment. While there has been a focus on quality in recent years, there is clearly still more to be done. It is important that the Care Quality Commission's new approach to inspecting substance-misuse services seeks to form a robust view about clinical quality, alongside local commissioners' assessment of their services<sup>67</sup>.

<sup>65</sup> National Institute for Health and Care Excellence. (2011). *Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults: commissioning guide: commissioning and benchmarking tool*. London: NICE. <http://www.nice.org.uk/guidance/qs11/resources/alcohol-services-commissioning-and-benchmarking-tool-304114141>

<sup>66</sup> See (a) *ibid* (b) Public Health England. (2014). Alcohol treatment in England 2013-14: commentary. <http://www.nta.nhs.uk/uploads/adult-alcohol-statistics-2013-14-commentary.pdf>

<sup>67</sup> Care Quality Commission. (2015). New approach to inspections of substance misuse services to be rolled out following public consultation. See: <http://www.cqc.org.uk/content/new-approach-inspections-substance-misuse-services-be-rolled-out-following-public>. [Accessed 10 February 2016]

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the role of treatment

## The role of employment in recovery and current employment outcomes

27. In England, the cross-Government 2010 drug strategy emphasised the need to create local, ambitious, recovery systems (i.e. networks of services) that enabled more people in alcohol and drug treatment to overcome dependence. It listed the following aims of successful treatment of drugs and/or alcohol:
- freedom from dependence on drugs or alcohol;
  - prevention of drug-related deaths and blood-borne viruses;
  - a reduction in crime and re-offending;
  - sustained employment;
  - the ability to access and sustain suitable accommodation;
  - improvement in mental and physical health and wellbeing;
  - improved relationships with family members, partners and friends; and
  - the capacity to be an effective and caring parent<sup>68</sup>.
28. We agree with these aims and see our work as supporting them. Full recovery means escape from dependence accompanied by improvements across all the areas listed above. This is an individual journey, and for some it will take a long time, with false starts and relapses.
29. The recovery committee of the Advisory Council on the Misuse of Drugs (ACMD) found that most people overcome their addiction in their lifetime, but the probability of success varies with the substance misused. It is also influenced by individual factors and histories, the quality of support they receive, and their interplay<sup>69</sup>.
30. Those with heroin dependence typically have poorer outcomes, and optimism for recovery must be tempered with reality. Some recovery journeys are hesitant, and some fail. This was confirmed by people with experience of addictions and by frontline staff supporting them. Treatment and support goals must be appropriate to the range of individual complexities.
31. It is not yet possible to predict with confidence which individuals will eventually overcome their dependence. Encouraging clinicians to be more ambitious for employment as part of recovery is legitimate, deliverable and overdue. Realising this ambition will involve linking safe, evidence-based recovery-orientated practice with greater work-focused ambition and support, earlier in people's recovery journeys.

<sup>68</sup> *Drug Strategy 2010: Reducing Demand, Restricting Support, Building Recovery: Supporting People to Live a Drug Free Life*, p18, HM Government, 2010.

<sup>69</sup> ACMD Recovery Committee. (2014). *What recovery outcomes does the evidence tell us we can expect*. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/262629/Second\\_report\\_of\\_the\\_Recovery\\_Committee.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262629/Second_report_of_the_Recovery_Committee.pdf)

## The role of work in the recovery journey

32. Employment can play a key role in supporting recovery. We spoke to and heard from many unemployed people being treated for alcohol and/or drug problems who want to work. Getting (and keeping) a job is a top objective for people in treatment, second only to ‘getting clean’<sup>70</sup>.

*All I’m after is help to find a job. That’s it. I’m not going to go to Atos and start crying when I have my next medical, and go, “Oh, I don’t want to work coz I might relapse”. Well, I might relapse because it’s a Wednesday...Really all I’m after is somebody to know me and my skillset in the same way that I have a support worker where I live and, from that, go “Well, these careers are fitting, and these employers do those things.”, and then put me in contact perhaps with...this is going in a circle...with...I was gonna say with people who will hopefully see potential not past<sup>71</sup>.*

33. There are obvious reasons for this. Work can increase financial independence, engender responsibility, boost confidence and self-esteem and provide meaningful activity. It introduces people to new non-substance-misusing social networks, and adds distance from old substance-misusing networks – all factors boosting recovery that combat the ever present risk of relapse<sup>72</sup>.
34. There is also evidence that the unemployed relapse more severely and earlier than those who are still in paid employment or who found employment after treatment. One study found that during the first six months after treatment for alcohol misuse 45 per cent of those who were unemployed relapsed, compared to 23 per cent of the employed. The relapse also tended to be more severe for the unemployed group<sup>73</sup>.
35. In particular, those who were being treated for a dependence spoke of the fear that existed during their recovery when they were faced with nothing to do during the day. Employment offered a way of occupying time, being valued and preventing boredom, as well as earning a living.
36. It is also important to recognise that employment is only part of the story. As Jamie’s story below shows, the recovery journey can take many paths, have some false starts and include the benefit, criminal justice and treatment systems.

<sup>70</sup> See (i) Alam, F. (2012). Medically assisted treatment of opioid dependence in the era of recovery: a survey of UK patients, users and physicians. Poster presented at the Royal College of Psychiatrists International Congress by Dr Farrukh Alam Central & Northwest London NHS Mental Health Trust, UK, 10–13 July 2012, Liverpool UK. <http://www.hiwecanhelp.com/documentdownload.ashx?RelatedDocumentID=142> and (ii) London Drug and Alcohol Network and DrugScope. (2014). Pathways to Employment. <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/PathwaystoEmployment2014.pdf>

<sup>71</sup> Aznar, C., MacGregor, A. and Porter, L. NatCen Social Research (forthcoming). *Views of claimants: Qualitative findings of the Dame Carol Black Review*. London: Department for Work and Pensions.

<sup>72</sup> Neale, J. and Kemp, P. A. The role of employment in recovery from problem drug use in J Barlow (ed.) *Substance Misuse*, London: Jessica Kingsley Publishers, 2010.

<sup>73</sup> Henkel, D. (2011). Unemployment and substance use: a review of the literature (1990–2010). *Current drug abuse reviews*, 4(1), pp.4–27. This refers to a single study on the relationship between employment and relapse among alcohol patients.

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**Jamie's story**

They say life begins at 40 – which certainly rings true for Jamie. Before his 40s, Jamie's life had been characterised by some significant 'firsts'. First time taking drugs, first use of heroin, first borstal sentence – those all came before his 15th birthday.

The youngest of the siblings, he grew up in a deprived area of the North of England where he first took drugs aged 12 and was expelled from school at 13. He was 14 when he first tried heroin and was sent to a young offender's institute that same year. When he was 17 his sister – "I always thought of her as a mum" – died.

From there, with no positive role models, no work experience and limited literacy and numeracy skills Jamie did what he could to survive...he became one of the town's most prolific criminals. He racked up 16 years of incarceration, never spending more than six months out of prison in that time. Between sentences he would keep himself busy – "getting off my head" – funded by crime.

There was some meaningful work along the way, but, "my main occupation was burglary", he admits.

"How did you know which house to target?" a police officer once asked.

"I didn't target a house...I targeted a street," he explained.

Despite stints on drug treatment programmes and under a police programme to resettle and rehabilitate priority prolific offenders, without a holistic approach to break his cycle of drug use, offending and homelessness, he slipped back into his old lifestyle. This was made all the easier as the only accommodation available to him was inadequate and generally with no protection from local using and dealing networks.

Despite feeling he had 'had enough' in 2010 it took a five-year prison sentence for burglary for Jamie to detox from street drugs and engage in methadone treatment. He came to Jobs Friends & Houses' within 48 hours of release, thanks to a referral from a charity. While there have been some bumps in the road, "the constant support from Jobs, Friends & Houses" keeps him going.

Intensive support from the Jobs, Friends & Houses' team – professionals and peers – and the resulting sense of belonging to the community and family, has helped him to rebuild his shattered confidence, improve his decision-making and problem-solving abilities, and resist the temptations that still abound in the town.

"I'm determined not to give up," he said. "There have been times where I've thought I don't deserve to be here, but I've carried on."

Nowadays his firsts are overwhelmingly more positive; first clear drug test, first pay cheque, first dream home... first birthday party, even.

Today he is 'Jamie the tiler', putting the finishing touches to bathrooms and kitchens in Jobs, Friends & Houses' properties – including his own home – and undertaking an accredited apprenticeship in his trade. He moved into a duplex apartment in November 2015; his first safe, stable tenancy ever, in a property shared with four of his friends and workmates: "It's the nicest place I've ever lived, and I built it!"

## Current employment outcomes from treatment

37. Given the importance of employment to recovery, it is alarming to find employment rates are so low for those starting treatment. In 2014/15, just over a quarter of those starting treatment for an alcohol or non-opiate drug problem were working. This fell to 15 per cent for people with an opiate dependence – indicating the greater complexity of this group<sup>74</sup>.
38. Currently, progress in treatment does not lead to significantly more people finding work. Our analysis suggests that the employment rate for those successfully exiting treatment increased by five percentage points for adults in drug treatment and just two percentage points for alcohol clients<sup>75</sup>.
39. People being treated for opiate drugs, such as heroin, tend to be the most entrenched users. They face significant labour-market disadvantages. We looked at a cohort of opiate users in treatment for five years. The majority, 68 per cent, were unemployed when they came into treatment and remained so over a five-year period. During this period 8 per cent found some work, but a further 8 per cent became unemployed; the remaining 16 per cent were consistently employed<sup>76</sup>.
40. While employment can support successful completion of treatment, successfully completing treatment leads only infrequently to employment. It is clear that specialist employment support is required, alongside treatment, to achieve results.

## The employment ambition

41. We asked the question when in the recovery journey is it appropriate to start looking for work. Answers varied, but a common view – held by a number of treatment providers, plus Work Programme and Jobcentre Plus colleagues – was to take a ‘recover first/find work second’ approach.
42. We believe that this prevalent attitude may delay progress to employment for those who are ready to take steps towards a job. It means that all staff treat employment as a second-order challenge, to be tackled only after achieving stability and full recovery goals.
43. We believe enabling work and meaningful activity should be at the heart of all engagements that clients have with their treatment provider. Employment support should be available from the start of the recovery journey, in a firm and deliberate move away from the ‘recover first/find work second’ approach. Treatment providers are responsible for ensuring that they address employability early via the client’s recovery plan, and that employability-focused goals are agreed in partnership with Jobcentre Plus who will also be supporting the client to achieve them.

<sup>74</sup> See Annex D, Figure 5.

<sup>75</sup> See Annex D, Table 1.

<sup>76</sup> See Annex D, Figure 13.

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44. Of course this must be tempered by a realistic assessment of ability to enter employment. In some cases volunteering and other work-focused activity might be appropriate transitional steps, and local labour-market conditions will play an important role.
45. In practice, this ambition means four things:
  - all staff (benefits, employment support and treatment) understand that work may well aid recovery, and should be an integral component of treatment;
  - work-focused conversations for all those entering treatment;
  - support for immediate competitive job search for those able and willing to work; and
  - DWP, treatment and other support staff working together on job search and skills gaps, with meaningful activity aims, checked in regularly-reviewed and jointly-owned recovery plans.
46. During the course of our review we found much promising practice to build on. Many local authority commissioners and treatment providers recognise the role that education, training and employment can have in supporting and sustaining recovery. Such good practice is typically driven by local champions.

### **BAC O'Connor Centre / Langan's Tea Room's**

BAC O'Connor Centre provides rehabilitation and support to people with a drug and / or alcohol misuse problem in two centres across Staffordshire. It specialises in the rehabilitation of individuals experiencing dependence and operates as a residential therapeutic community, with participative, often group-based approach to treatment as well as practical activities, aiming to support a recovery process where the client and their family can work towards gaining a more satisfying and healthy lifestyle without the need for substances.

It offers a safe environment and aim to deal with the 'whole' person rather than simply their addiction. It can start with an in-house detoxification, the process of overcoming physical dependence on alcohol and/or drugs. It also offer full medical and health screening and onward referral to specialist secondary medical treatment (if required). Detoxification usually takes between one to three weeks depending on individual need. It does not address the often-complex reasons why people use substances, which the subsequent therapeutic rehabilitation programme seeks to address.

The structured 14-week therapy programme involves a client working in groups and alone with their therapist to explore patterns of behaviour. Many clients have strong emotional reactions of guilt, shame and anger to overcome on the road to recovery. Many also have to find new and better ways to deal with the issues that may have led them into active addiction. The programme uses evidence- based talking therapies to tackle these issues and to address motivation and relapse prevention. It also draws on 12-step model of substance abuse treatment , and clients are introduced to Alcoholics Anonymous and Narcotics Anonymous as an alternative peer support network. Their Family Programme offers family members and concerned others the opportunity to learn about addiction and its effects. Being armed with knowledge and understanding is in itself empowering, and can help reinforce their loved ones' process of recovery.

The service also offers complementary therapies such as massage, relaxation and acupuncture. There is also an emphasis on practical activities such as fitness, outdoor activities and practical help with finance and debt issues, and resettlement in the community after the programme.

One of the basic elements of the programme is independence and self-care. The four-week resettlement programme aims to equip clients with practical skills they need to re-engage with the community and to live an independent life. Clients are taught to budget, shop and cook – and each has weekly chores. There is practical support too – with maintaining a tenancy, literacy and numeracy, debt and budgeting, training, vocational skills, volunteering and work placements. Clients are encouraged to become mentors as part of the service user committee called R.I.O.T (Recovery is out there).

For many the move from rehabilitation straight back into the community is a fearful time, particularly if individuals have never lived independently before. The BAC O'Connor Centre has 36 semi-independent self-contained flats for those who have completed the Rehabilitation and Gateway to Independent Living Programme. Service graduates can live there for two to six months dependent on individual need. Only those that apply, commit to recovery-focussed aftercare, and are in further education, voluntary work, work placements or employment, are housed."

Their Langan's Tea Rooms, in Burton-on-Trent, were renovated by former BAC O'Connor clients. Service users who have completed the rehabilitation programme now run the Tea Rooms which, since opening in September 2011, has provided job placements, work experience, training and qualification to people in a paid or voluntary role.

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**Angela's story**

Angela was at a very low point in her life when she first accessed support around her crack cocaine use. As a mother with adult children and grandchildren, she felt a lot of shame and guilt. She had not worked for many years, she was falling into debt, her family relationships were suffering, and she was experiencing low mood and depression.

Driven by a desire to find some self-worth – she attended Lorraine Hewitt House in Brixton, the first stage of treatment. She was offered an assessment and health checks and was allocated a key-worker.

After a few weekly sessions with her keyworker, she was referred to the group programme at The Harbour Recovery Centre. Initially Angela found it very difficult to engage with groups. She was often seen sitting in the drop in, avoiding eye contact, and saying little. However, with encouragement from her keyworkers she gradually found the confidence to start attending groups, which she began to enjoy, particularly the Women's Group, Relapse Prevention and Recovery Groups.

Due to her debt problems, Angela had built up rent arrears and was at serious risk of losing her tenancy. Angela was supported by the benefits/housing advisor at the Harbour to manage this situation. The advisor attended court with her and was able to successfully retain her tenancy and agree a repayment plan.

Angela stopped using crack cocaine and was discharged from treatment. With the support of her community link worker she established clear recovery goals, which included gaining employment.

The first step towards this goal was training: Angela undertook several courses in Personal Development and IT. She was helped to buy a laptop with a charitable grant.

Angela's confidence soared, and after nine months of treatment and recovery support, Angela decided to start her own cleaning company, which she did on a part-time basis for a few months.

Angela was then successful in obtaining a full time position as a receptionist.

Angela is very happy. She still occasionally "checks in" to The Harbour on her days off.

Angela says: "In the last 12 months so much has happened for me, the staff have continued to encourage me to take my life seriously and to value myself. My recovery continues, and I am now working full time as a receptionist. It is my first proper job in 20 years, and I feel emotional because of the joy I feel inside"

47. At present the key measure of successful recovery is freedom from substance (alcohol and/or drugs) dependence<sup>77</sup>. Treatment works by getting people off their dependence, but if they are to sustain their recovery, they need to be linked in with a range of appropriate support services, including family and peer support, mental health, stable housing and especially access to employment, training or education opportunities.

<sup>77</sup> Public Health Outcomes Framework, Indicators 2.15i and 2.15ii which offers the opportunity for local authorities to measure their progress for successfully completing drug treatment (broken down by opiate and non-opiate drug users). This does not include people being treated for alcohol.

48. So to signal the importance of employment to the recovery journey **we recommend the Government expands the headline recovery measure to include work and meaningful activity outcomes (including volunteering) alongside successful treatment completion.** This raised employability ambition should also be **reflected in the next version of the UK guidelines on clinical management of drug misuse and dependence**<sup>78</sup>.
49. A fresh articulation from the Government to this effect will send an important signal for all parties to be more ambitious in their support for people's journeys back to work.
50. **We also recommend enhancing the Jobcentre Plus and treatment data sets, to support and illustrate joined up work between Jobcentres and treatment services, and record steps towards both the labour market and job outcomes.** These could include recording 'time since last worked' and standardising 'distance travelled' measures, to include (i) attainment of accredited qualification(s) (ii) volunteering and work placement starts (iii) employment: starts and sustainment.
51. These new nationally-consistent measures would help local commissioners of alcohol and drug services to understand better who would most benefit from employment interventions (and when), guide better targeting of resources, and help them benchmark and improve<sup>79</sup>.
52. Public Health England (PHE) and commissioned treatment providers will need to deliver this recommendation. Changes to the National Drug Treatment Monitoring System (NDTMS) are routine occurrences, subject to consultation, and are supported by PHE.

## Delivering the ambition

53. People with drug- and alcohol-related barriers to employment can generally access the same type of employment support as others who are unemployed and eligible – currently Jobcentre Plus, the Work Programme and, potentially, Work Choice<sup>80</sup>.
54. However, we found the engagement between the three systems – benefits, employment support, and treatment and support at a local level – to be inconsistent. We heard from stakeholders that it often took local champions to really bring services together, and this joint working could quickly end if the local champion left<sup>81</sup>.
55. This close working between local benefit and treatment providers can often lead to strong outcomes. Since 2009, the Department for Work and Pensions and Public Health England (and its predecessor) have tried to facilitate effective joint working between employment, benefits and treatment services, to improve job outcomes for people with alcohol and drug dependence. The principles underpinning this are set out in the 2012 document *Employment and Recovery: a good practice guide* which outlines six key good-practice principles: working in partnership, information exchange, mutual training, targeted outreach, three-way review meetings, and continuity of care<sup>82</sup>.

<sup>78</sup> The next iteration of; Department of Health (England) and the devolved administrations. (2007). *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive.

<sup>79</sup> This refers to the England's National Drug Treatment Monitoring System.

<sup>80</sup> Work Choice is DWP's specialist outsourced provision for people with disabilities. See <https://www.gov.uk/work-choice/overview>

<sup>81</sup> Adams, L., Tindle, A., Ponomarenko, A. and Coburn, S. IFF Research (forthcoming). *Drug and Alcohol proof of concept evaluation, and wider approaches to supporting clients with a dependency*, DWP Research Report.

<sup>82</sup> National Treatment Agency for Substance Misuse. (2012). *Employment and recovery a good practice guide*. <http://www.nta.nhs.uk/uploads/employmentandrecovery.final.pdf>

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56. So to deliver our ambition we believe that treatment and employment support need to be brought together in a stronger way. However, while we have seen encouraging examples of good practice, and a number of models show promise, the evidence based on effective interventions is under-developed.
57. This leads to our conclusion that a robust trial to explore promising practice is important. We believe that the Individual Placement and Support (IPS) approach is worthy of further study in the addictions area.

## The Individual and Placement Support approach

58. This well-evidenced approach supports people who have a severe mental illness and aims for sustained employment through mainstream, competitive jobs. It is based on a set of eight principles:
1. Eligibility is based on individual choice;
  2. Supported employment is integrated with treatment;
  3. Competitive employment is the goal, (not sheltered placements or volunteering);
  4. Rapid job search (within four weeks), minimal prevocational training;
  5. Job finding, and all assistance, is individualised;
  6. Employers are approached with the needs of individuals in mind;
  7. Follow-along supports are continuous; and
  8. Financial planning is provided<sup>83</sup>.
59. The distinguishing feature of IPS is that employment support is included alongside clinical treatment. It works by integrating an employment specialist within treatment as an equal member of the multi-disciplinary team. This makes employment a key aim of recovery and integral to the aims of treatment<sup>84</sup>.
60. There is also a strong focus on sourcing jobs through local employer networks. Employers benefit from on-going in-work support (alongside job seekers) from the employment specialist. Employer support through IPS is discussed further in Chapter 3.

<sup>83</sup> IPS is a standardised, replicable supported employment intervention with consistently strong employment and health outcomes across multiple countries in both academic studies and provider experience. A survey of 19 international Randomised Control Trials, which included trials conducted in the UK, showed a 34 point increase in job outcome rates versus control groups. Studies have also shown reduced hospitalisation rates, reduced inpatient days, and improved overall wellbeing. Source: Bond, G. R., Drake, R. E. and Becker, D. R. (2012). Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US. *World Psychiatry*, 11(1), pp.32-39.

<sup>84</sup> Shepherd, G., Lockett, H., Grove, B. and Bacon, J. (2012). Establishing IPS in clinical teams – Some key themes from a national implementation programme. *Journal of Vocational Rehabilitation*, 78(1): 37-41.

61. The employment outcomes of services offering IPS to substance users are encouraging, albeit limited in scale<sup>85</sup>. IPS is a component of DWP's "Disability and health employment strategy"<sup>86</sup> and DWP is testing the IPS model within mental health services. There is 20 years of international high-quality evidence demonstrating the efficacy of this approach in getting people with severe mental health issues into jobs<sup>87</sup>. This evidence has persuaded us of the case to test, at a larger scale, this approach for people with substance-misuse issues. Therefore **we recommend a robust randomised control trial of a high-fidelity Individual and Placement Support (IPS) approach**. This will help to build the evidence base to enable effective future commissioning. Anticipated outcomes could include improved job outcomes, shared accountability, closer collaboration, cultural alignment, information sharing and the opportunity to make better, more integrated, use of employment and treatment funding. Our indicative, high-level estimates for the costs and benefits of the high-fidelity IPS option suggest that those who find employment must sustain this for between 145 and 181 days, on average, in order for the Exchequer to break even. If we include wider benefits to society, this falls to between 93 and 116 additional days in employment to achieve the break-even point<sup>88</sup>.
62. However, high-fidelity IPS may be expensive. We therefore **recommend that an arm of the trial offers limited duration of support** (rather than having it open-ended). This 'IPS lite' approach has been demonstrated to deliver similar results in mental health settings and could increase potential service capacity<sup>89</sup>. Finally, **we recommend testing the co-location of Jobcentre Plus work coaches in treatment premises**, tasked with finding employment and providing in-work support.
63. The government should also explore appropriate funding models to support treatment/employment outcomes. One idea is to trial an IPS funded by social impact bonds. These are ways of commissioning public services on a payment-for-outcomes basis. They involve socially-motivated investors paying up-front for the delivery of a service by provider(s). The performance of the provider is assessed against specific outcomes sought. For every outcome successfully delivered, the commissioner then repays the investor at an agreed rate of return<sup>90</sup>.
64. We fully support the ongoing collaborations between DWP and local authorities. These have rightly focused on integration and how we can capitalise on the expertise of local authorities who know their local labour market and are able to bring together the services that claimants may need alongside employment support, for example housing or debt support. This continued joint work will be essential to underpin the success of IPS or any other type of labour-market intervention.

<sup>85</sup> The Central and North West London NHS Foundation Trust (CNWL) IPS service offers this job brokerage support as part of a mental health and addictions service. In 2013-2014, their IPS service saw 406 people, and by the end of that year 167 were in paid employment of whom just under half were still in work after six months. These are very strong results compared to comparative, more generic programmes for similarly disadvantaged clients.

<sup>86</sup> Department for Work and Pensions. (2013). *The disability and health employment strategy: the discussion so far*. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/266373/disability-and-health-employment-strategy.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266373/disability-and-health-employment-strategy.pdf)

<sup>87</sup> Bond, G. (2013). *Evidence for the Effectiveness of Individual Placement and Support Model of Supported Employment*, Bond, G. et al. (2012). *World Psychiatry* 11, 1, 32-29 (IPS studies outside the US), Burns, T., Whiste, S., Catty, J. (2008). Individual Placement and Support in Europe: the EQOLISE trial, Centre for Mental Health. (2011). Doing what works: Individual placement and support into employment, Hoffman et al., "Long-Term Effectiveness of Support Employment: Five-Year Follow-up of a Randomized Controlled Trial" (May 2014): Study of 100 participants in Switzerland over 5 years and DWP and RAND Europe (2014) Psychological Wellbeing and Work.

<sup>88</sup> For more detail see Annex G: High level costs and benefits for key recommendations.

<sup>89</sup> High-fidelity IPS is built on the premise of open ended support for small caseloads. A UK 'IPS LITE' trial tested a 'time limited' IPS (employability support for nine months and for those that find work – in work support for four months). In every other respect trial maintained IPS fidelity (i.e. adherence to the eight principles, similarly trained and supported staff, max caseloads of 25, co-location with clinical teams and so on). Source: Burns, T., Yeeles, K., Langford, O., Montes, M. V., Burgess, J. and Anderson, C. (2015). A randomised controlled trial of time-limited individual placement and support: IPS-LITE trial. *The British Journal of Psychiatry*, 207(4), pp.351-356.

<sup>90</sup> In 2015, Social Finance Ltd (working with the Cabinet Office, local authorities and the NHS) launched a social impact bond for people with mental illness (alongside one for vulnerable young people). The aim was to raise investment to fund the expansion of Individual Placement and Support (IPS), an evidence-based supported employment intervention.

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**Greater Manchester's (GM) Working Well programme**

Greater Manchester's (GM) Working Well Employment and Support Allowance (ESA) pilot programme has been developed to tackle the issue of entrenched worklessness in the area.

Working with 5,000 GM residents, it is built on the principle of better integration of public services, and aims to support more long-term unemployed people to make progress towards employment.

Funded by GM, DWP and HM Treasury, this collaborative initiative involves work between local government, Jobcentre Plus and the NHS.

All Working Well ESA pilot clients are out of work despite having spent two years on the Work Programme, on top of time spent on benefits before that.

Clients generally enter the programme needing help with one or more of the following issues: housing, health needs, financial difficulties, or substance abuse. Addressing these basic needs allows clients to focus on employment.

Each has a key worker who offers intensive support and connects them to relevant support services. The programme has set a target of 50 – 60 clients per key worker in order to ensure that this focused support is consistently delivered across GM. Key workers are sometimes co-located with existing teams that can provide advice and support, such as Troubled Families teams. A case conferencing approach helps to identify ways to join up support.

Key workers are supported by managers (local leads) who build relationships and regularly liaise with other managers across jobcentres, health and council services. Their role is to deal with any issues that arise from partnership working and ensure that there are as many referrals as possible. This vital integration work is overseen by local authority integration boards who can also advise on difficult cases.

While it is too early to draw firm conclusions about the approach being adopted, GM believes the initial signs are promising.

Working Well is helping to join up existing services and changing the way that services are functioning for Working Well clients. The active ingredients are strong senior support, a focus on service integration, and the role of key worker and local leads.

GM is committed to an expanded Working Well programme, ultimately supporting 50,000 people to remove barriers that are preventing them moving forward and supporting them into sustained employment.

### **Improving employment opportunities for individuals in recovery in Glasgow**

The Scottish Government's 'Road to Recovery' strategy recognises that the links from treatment to volunteering to education are important steps for improving employment opportunities for individuals in recovery.

A high percentage of addiction service users in Glasgow are unemployed. In 2014 NHS Greater Glasgow and Clyde together with Glasgow City Council commissioned an innovative recovery-orientated training and employment project with emphasis placed on the individual's previous life experiences as an asset rather than an insurmountable barrier.

The Scottish Association for Mental Health (SAMH) were commissioned to provide supported, 38 week, waged placements to individuals recovering from drug and alcohol problems.

Trainees had to be long-term unemployed and with multiple barriers to employment. Whilst on placement, they were given the opportunity to work towards the attainment of a Scottish Vocational Qualification (SVQ) in Health and Social Care provided by Glasgow Council for the Voluntary Sector (GCVS).

More recently, trainees have received Steps to Excellence training on the STEPS® concepts<sup>91</sup>. This model is designed to equip the long-term unemployed (and other groups with high level support needs and/or low resilience) to imagine a better future for themselves, and gives them tools to realise this ambition.

In 2014, the first year of the programme, ten trainees achieved a Health & Social Care qualification. Of these, eight are still in paid employment within the health and social care field working with adults and young people, and one is in full-time education. In the following year's intake, all 10 trainees attained certification for Steps to Excellence\* training and eight trainees completed their Health and Social Care qualification. The programme is now in its final year, and all trainees are expected to complete their training and secure employment by April 2016.

The programme has been extremely successful and in 2014 won The Glasgow City CHP Staff Awards and the NHSGG&C Chairman's Gold Award in the category 'Using Resources Better'

To continue the success of the project, NHS Greater Glasgow and Clyde Health Board and Glasgow City Council has launched a new Employability Public Social Partnership 'Elevate-Glasgow'. This forum is tasked with improving employment opportunities for individuals with multiple barriers, through partnership working and using resources more effectively to develop new programmes. It is focussing on four areas: personal development and mentoring work, training and education, placements and volunteering and social enterprise work. The partnership consists of 40 key organisations working in the employment, recovery, mentoring, training/education, volunteering and social enterprise sectors. Glasgow Council on Alcohol have been appointed as the lead agency.

65. Even if IPS proved successful and cost effective we do not envisage that this model can help all of those with addiction issues who need labour market support. Jobcentre Plus provides most labour-market support and is likely to do so for the foreseeable future. In the next chapter we review how the benefits system currently offers this support. We make practical suggestions on how we can build on this to help improve employment outcomes.

<sup>91</sup> The Pacific Institute. (2016). *Steps*. See more at: <http://www.pacificinstitute.co.uk/solutions/steps/>.

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## Housing and the criminal justice system: two other critical elements in recovery

### **Housing, homelessness and recovery**

It is difficult for someone to make progress in treatment of dependence, and sustain their recovery, if they do not have stable, suitable housing. Having a housing problem hampers engagement in addiction treatment and reduces the likelihood of successfully completing it, or of subsequently going on to find employment.

If they are homeless, or if their accommodation draws them into a social circle which misuses substances, the likelihood of relapse is high.

People in treatment for substance-misuse experience high levels of homelessness and housing need. In 2014-15 7 per cent of people presenting for alcohol and drug treatment were homeless/had no fixed abode, while a further 12 per cent had other housing problems, with the highest level of need seen among opiate users<sup>92</sup>.

It can be difficult for those who need specialist accommodation, such as supported housing, to access it at the right time, and difficult to move on from specialist into general needs accommodation. While some people will secure accommodation from a social landlord – a council or housing association – many live in or move into private rented sector housing. Supported housing providers in high housing demand areas explained to us that delays in securing general needs accommodation can have the effect of reducing the capacity of the supported housing sector.

Many social landlords are active partners in treatment and recovery systems, as are more specialist housing providers such as the homelessness and supported housing sectors. During the course of this review we heard from housing associations and local authorities about the role they play in supporting drug and alcohol dependent people into work. This included training, work placement opportunities and mentoring. Some do this as providers of the current DWP Work Programme or Work Choice, while others provide employment support because they recognise the opportunities they can provide for their tenants and the positive impact that can have.

Similarly, many treatment providers, where not accommodation providers in their own right, work closely with providers of housing and housing support to give their clients the best chance of making a lasting, positive change.

Whatever the reason for a particular individual's situation, supporting them to address their housing need as part of an integrated package of support is likely to create a virtuous circle, in which both gaining employment and making a lasting move away from substance misuse become more likely.

<sup>92</sup> Public Health England. (2015). *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS)*. 1 April 2014 to 31 March 2015. London: Public Health England.

### **Drugs and alcohol and the criminal justice system**

The dependent use of heroin and crack is frequently associated with acquisitive crimes such as shoplifting, theft and burglary. The cost of drug use and supply to society is estimated at around £10.7 billion per year, of which £6 billion is attributed to drug-related crime.

The problematic use of alcohol is also a driver of criminal activity. The social and economic cost of alcohol use has been estimated at £21 billion per year, of which around £11 billion is attributed to alcohol-related crime.

In 2014-15, 17 per cent of referrals to drug and alcohol treatment came from the criminal justice system, a proportion that rises to 28 per cent for opiate users. Being referred from the criminal justice system is associated with reduced likelihood of being in employment at treatment start, and limited prospects of moving into employment during engagement with treatment.

Evidence shows that getting offenders into effective treatment while they are serving community or prison sentences can reduce subsequent drug related offending. Linking up an offender's treatment upon admission to, and release from prison is important. We note the significant reforms to the prison, probation and broader criminal justice system since 2010 and that reform programmes like 'Transforming Rehabilitation' are still in the early stages of operational delivery.

Additionally, the continuing roll-out of Liaison and Diversion services, while primarily targeted at people experiencing mental ill health, also offers opportunities to intervene earlier with substance misusers in contact with the criminal justice system.

The Work Programme was tasked with finding prison-leavers work but performance has been below expectations. We know that an offending history on its own can seriously adversely affect the likelihood of a person finding paid employment – yet there is a clear association between employment and reduced recidivism.

Finding work for addicted offenders has the potential to reduce bills for both benefits and the criminal justice. This emphasises the need for good integration between criminal justice agencies and the other agencies which support people recovering from dependence. Pressure on public finances will be eased if offending can be tackled before reaching a stage where a prison sentence is warranted. It is much less expensive for the tax-payer to support someone in the community than in prison. When designing local systems to support people suffering multiple deprivation, good coordination is essential to ensure effective responses and to minimise cost-shunting between agencies.

# Improving employment outcomes for drug and alcohol dependent people: the role of the benefits system

# 2

## Introduction

66. Currently, Jobcentre Plus is the main part of the Government with formal responsibility for securing employment for working age adults with drug and alcohol addictions. Even when IPS services are trialled in treatment centres, many people will still rely on Jobcentre Plus for support, either because they are not suitable for the Individual Placement and Support (IPS) route or because they are not currently in treatment.
67. Given the central role of the benefits system in helping people with addictions to enter or return to work, we are clear it requires significant change. The system suffers from a lack of information on health conditions, an absence of staff incentives to tackle difficult or long-term cases, and an inconsistent offer of support for those who are reached. This chapter explores the current journey of claimants through the benefits system and proposes a number of changes which, when taken together, should result in better identification of addictions and improved support for those affected.

## Numbers and characteristics of alcohol and drug dependent claimants in the benefits system

68. The first problem is the inability of the benefits system to identify most of the claimants within it who are drug or alcohol dependent. DWP data can only identify a small proportion of claimants with drug and alcohol problems because its systems were designed to capture only the main health condition associated with being out of work, if health information is collected at all.

69. This has made it impossible to assess precisely how many people with addiction problems are on benefits. Given that employment rates for these groups are so low, it is fair to assume that most are on benefits. Indeed, one estimate suggests that around 60 per cent of individuals in treatment for drugs or alcohol in 2012 were also on benefits<sup>93</sup>.
70. Most of those known to be in alcohol or drug treatment are recorded as having a different health reason for being on benefits, most commonly mental ill-health. This means their addiction remains largely invisible to the Jobcentre Plus work coaches (the employment advisors who meet with claimants, charged with helping them back to work).
71. These claimants tend to be in receipt of benefits relating to their disability, or benefits providing other support, for long periods of time (for example, the average duration of this group on Incapacity Benefit (IB) was eight years). They tend to move between different benefits or come off and return to benefits very frequently.
72. Disclosure or knowledge of an alcohol and/or drug problem enables Jobcentre Plus to adapt job search requirements. However, only 86,700 claimants on Employment and Support Allowance (ESA), the main working age disability benefit, have been identified on the system as having an alcohol or drug problem as their 'main disabling condition'<sup>94</sup>.
73. Our analysis showed that most of these individuals identified with a drug and/or alcohol problem within the benefits system had some past contact with treatment services. Just over half of those with a drug addiction were currently in treatment and a further quarter had been in treatment at some point in the preceding seven years<sup>95</sup>.
74. The equivalent figures were lower for alcohol-dependent claimants. Of these, 16 per cent were currently in treatment, a further third had been treated in the past ten years, and half had never been in contact with treatment. We do not know the reasons behind this although it does mirror the current alcohol treatment penetration in the wider population. Possible factors are likely to be varied and might include having successfully completed treatment in the past (but their condition has not been updated on the benefits system), being unaware that they have a drink problem, or not being willing to seek help<sup>96</sup>.

## Identification and disclosure of dependence within the benefits system

75. Clearly, Jobcentre Plus work coaches cannot be as effective at supporting people if they are unaware of all their relevant health problems. Improving the identification of dependency, and encouraging more self-disclosure, are important to ensure the appropriate support can be provided and the right job-seeking conditionality applied.
76. For some benefits (such as Income Support (IS) and Jobseeker's Allowance (JSA)), having a health condition is not one of the factors that is used to decide whether someone receives the benefit. Therefore Jobcentre Plus does not routinely record or access robust health-related information about these claimants.

<sup>93</sup> See Annex D.

<sup>94</sup> See Annex E, Table 1.

<sup>95</sup> See Annex D, Figure 14.

<sup>96</sup> See Annex D, Figure 14.

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the role of the benefits system

77. For health-related benefits, such as ESA and Personal Independence Payment, the GP's Fit Note is an important source of health information. This is generally confined to a single condition and any other information is compressed as it goes through the benefits system. This leaves the work coach with very limited information on the claimant's health – typically of only a single, often broadly defined, condition, such as a mental health disorder.
78. During the course of our review, the quality of this information was also questioned: stated health conditions appear to be rarely updated and the condition identified may not be the condition that is the real barrier to work.
79. We consider it essential that the quality of the health information in the benefits system is improved – for the conditions within the scope of this review and for any long-term condition that affects a claimant's ability to work. The information must be more accurate and reflect the full range of health issues the person faces. It is also important that it is more regularly updated to reflect the changing nature of a long-term condition.
80. Improving this information will ensure the work coach is better able to marshal the right support for the claimant and adjust their benefit requirements appropriately. We recognise that this is a difficult topic given the sensitivity of the information and importance of patient consent, particularly around disclosure of a dependency. However, our strong belief is that improving the quality of the information will be to the benefit of the claimant.
81. We therefore **recommend that the Government, working with the clinical community, reviews ways in which better health information could be provided to Jobcentre Plus in support of a benefit claim.** There are a wide range of ways that could be considered to get clinicians to validate and enhance the information, including enhancing the Fit Note to capture better the full range of health conditions, using trusted intermediaries (such as Fit for Work) to provide a safe means of disclosure, or taking advantage of the better approach to gathering information under Universal Credit. We are encouraged that *Improving Lives – the Work, Health and Disability Green Paper* announced a review into the operation of the Fit Note and we hope that this review thinks ambitiously about how to improve the provision of appropriate health information to the benefit of these groups.
82. Of course, if the information is improved, DWP needs to ensure that the full range of health information provided by claimants and health professionals (primarily GPs) flows through the system better, wherever and whenever it is provided. For example, we encountered some scepticism that, even if a dependence was identified as part of a Work Capability Assessment, the information would be guaranteed to flow to the work coach meeting the claimant in the local Jobcentre Plus.
83. However, just as better information should be provided to Jobcentre Plus, we have also been struck by the limited discussion of a claimant's health condition during a benefit claim, despite the health problem being the main reason for the individual making a claim to benefit. For example, the Work Capability Assessment is used to determine entitlement to ESA. It assesses claimants against a set of descriptors to determine how their illness or disability affects their ability to work. It does not provide a fuller assessment of what actions a claimant can make to address their health-related barriers to work. Such conversations will be left to the work coach, who may not be an expert on the health condition faced by the individual.

84. We think that a conversation with a healthcare professional about the barriers to work arising from their health condition would be valuable to drug and alcohol dependent claimants, those with health conditions related to obesity, and indeed claimants with other long-term health conditions, as well as to the work coach.
85. It is important that the discussion considers all the health issues, not just any addiction, in a holistic way that is not mechanical. This discussion should cover all of the health barriers to work and how the conditions could be managed in work. It should include setting out clearly the benefits of treatment for any addiction and provide an opportunity for the claimant to sign up to treatment on a voluntary basis. Given that these claims to benefits are related to health conditions, we think that it would be reasonable for the Government to require such a conversation as part of making a claim.
86. We therefore **recommend the Government trials a requirement for each claimant, early in their claim to benefit, to attend a discussion with a healthcare professional on the impact of their health condition on their ability to work** to test the value of this approach and identify delivery issues. We are aware that similar approaches have been used previously with work-focused health-related assessments, and so it will be important to ensure the learning from those trials is used to inform the design of this conversation. We believe such a discussion with a healthcare professional could be an important input into the Health and Work conversation (with work coaches) that was announced in the Government's recent Health, Work and Disability Green Paper.
87. It will be important to trial the conversation with a broad range of health conditions to establish the claimant groups who would most benefit from such a discussion with a health professional, ensuring value for money. Given our wider focus in the terms of reference, we suggest the trial seeks to include a number where the main health condition has been identified as a drug or alcohol dependency, as well as health conditions connected with obesity (such as type II diabetes), mental health and musculoskeletal conditions. The 2011 (Black and Frost) review recommended an early-intervention service that could identify and deal with all the barriers to work for an individual client (health, social, organisational etc). This service, now in its infancy, could possibly provide the structured discussion suggested, in selected trial areas.<sup>97</sup>

## Self-disclosure

88. These improvements in health information need to be underpinned by a greater willingness by claimants themselves to disclose their condition to Jobcentre Plus work coaches. Claimants must also be willing to engage with an employment support offer and play their role in securing and sustaining employment.
89. We have heard many reasons why claimants might be unwilling to disclose all their health problems. For some, addiction is a source of shame; others might be in denial; others are aware of their problem and engaged in treatment, but are not confident in revealing this to their work coach, perhaps for fear that their benefits might be taken away or that they would not be treated fairly.

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90. The Jobcentre Plus environment itself – typically open plan and lacking in privacy – can reduce the likelihood of disclosure. Building trust with claimants was identified as the most likely route to encouraging self-disclosure, but infrequent Jobcentre Plus contact (for some benefits), and being seen by different work coaches, may reduce the probability of building the trust and rapport needed for a claimant to self-disclose.

*I think I stopped at that point because it is a sort of open office. It's...The Jobcentre is a sort of... Yeah. It's an open office environment and therefore, you know, there's certain things I feel that I can say in an open space, and other things that I will sort of stop myself from fully explaining, because I don't think it's everyone's right to know, and also there are other clients<sup>98</sup>.*

91. Claimants themselves told us the value of building a relationship with a single Jobcentre Plus work coach so they could build a trusting relationship and not have to provide the same information to many different staff members.
92. This is an important point. We are heartened by the current direction of travel within Jobcentre Plus. This is exemplified by the new Universal Credit work coach model where the claimant remains with the same work coach for the duration of their time on benefits whether in work or not.

*And obviously I've got my work coach, who's fully aware, at the Jobcentre about, you know, my history and where I'm coming from, and he's been pretty supportive... Coz I know a lot of people actually do Jobcentres down, but this guy particularly has been great<sup>99</sup>.*

93. Improving the employment support offer (discussed below) and communicating this clearly to claimants and treatment providers will be crucially important. However, we believe more should be done. We have heard repeatedly about the positive role that peer mentors (people who have been through a similar journey) play in supporting treatment, by role-modelling a successful recovery and explaining how frank disclosure can help.
94. **We therefore recommend Jobcentre Plus works with treatment providers to trial a network of peer mentors to engage with claimants with suspected addictions** to act as advocates and visible symbols of recovery, tasked with encouraging safe disclosure and engagement with appropriate support. We see this network as complementing treatment and Jobcentre Plus staff.

<sup>98</sup> Aznar, C., MacGregor, A. and Porter, L. NatCen Social Research (forthcoming). *Views of claimants: Qualitative findings of the Dame Carol Black Review*. London: Department for Work and Pensions.

<sup>99</sup> *Ibid.*

**A peer mentoring project in Wales to enter employment or further learning<sup>100</sup>**

Between October 2009 and September 2013, 9,627 clients were registered as participants in the project. Only 30 per cent had GCSE level qualifications or above and at least a third had none at all. Well over a third had been dependent on substances (most commonly alcohol, followed by heroin) for most of their adult lives, and most of these had been unemployed for a similar period. On average, clients remained with the project for about seven months.

Participants were allocated a peer mentor to assess the case and make an action plan; and offered courses to enhance their social skills or confidence levels, or relevant to their planned area of employment. Others would begin volunteering or start work experience, and still others would start applying for jobs. A minority, too, would begin to train as a peer mentor. Results showed that ten per cent of participants started work; nine per cent entered further learning; 14 per cent gained a qualification; and 65 per cent had achieved at least one 'other positive outcome' – most often, completing a course or volunteering (the above figures are not mutually exclusive).

95. We believe that this approach could offer a number of benefits. A peer mentor can be a trusted messenger, and becoming a peer mentor for others can be an important part of a person's recovery journey and a visible symbol of their own progress – which should ultimately lead to full employment elsewhere.
96. Stakeholders also suggested that a peer-mentoring scheme could benefit Jobcentre Plus itself, by providing greater insight of the conditions to help marshal more effective support.

*If a support worker's sitting in front of me, and they're going, "Stop lying to me. I know you were smoking crack", you'll say, "Oh, how do you know?", and then they say...if they open up and tell me something about them and say, "because I used to be a crack-head too for how many years, but look at me now", that alone gives you that sense of, "\*\*\*\*\*! Really?", and you start...sit up in your chair and pay attention<sup>101</sup>.*

<sup>100</sup> Maguire, M, Holloway, K and Bennett, T. (2014). *Evaluation of ESF Peer Mentoring Wales*. Welsh Government Social Research number: 14/2014. <http://gov.wales/docs/caecd/research/2014/140207-evaluation-european-social-fund-peer-mentoring-report-en.pdf>

<sup>101</sup> Aznar, C., MacGregor, A. and Porter, L. NatCen Social Research (forthcoming). *Views of claimants: Qualitative findings of the Dame Carol Black Review*. London: Department for Work and Pensions.

## Enhancing the support offer for drug and alcohol dependent people

97. The current Jobcentre Plus offer to those known to be dependent on alcohol or drugs was launched in 2011, against a backdrop of increased autonomy afforded to local Jobcentre Plus managers. The offer was based on the Government's stated principle of shaping practice to bring treatment and employment closer together<sup>102</sup>. This minimum service standard should be reached in every Jobcentre Plus district. Although the offer can be tailored to individual circumstances, it generally involves one of three scenarios:
- a. For claimants in treatment, job search conditions can be relaxed<sup>103</sup>. However, there should be regular joint case conferencing with treatment providers, and measures such as volunteering should be encouraged to help move the claimant closer to the labour market;
  - b. For claimants not in treatment, the work coach can refer them to a voluntary discussion of options with a treatment provider;
  - c. Work coaches can also refer claimants to DWP employment programmes such as the Work Programme earlier than other claimants<sup>104</sup>.
98. This offer is available for all Income Support, Employment and Support Allowance and Jobseeker's Allowance claimants and a similar offer is available under Universal Credit. Work coaches can also allow claimants the opportunity to engage with structured recovery-orientated treatment and reduce the requirements they place on them, so as to enable claimants to focus on their recovery.
99. The offer has a number of positive features. However, stakeholders have told us that application of it is inconsistent across the country. For example, treatment providers and commissioners reported a wide disparity in the quality of partnership working with Jobcentre Plus. One commissioner highlighted different approaches in two Jobcentre Plus offices in his area, one actively engaged, the other not.
- I found Jobcentre Plus frustrating to be a client of... all they have done is look up and read verbatim the web site to me, and not be able to expand upon it<sup>105</sup>.*
100. We have, however, also found innovative approaches to supporting local claimants dependent on alcohol or drugs. For example the Durham/Tees Valley Pathway Advisory Service has co-located Jobcentre Plus advisers in 35 GP surgeries and treatment providers, including five specialist drugs/alcohol venues. In Hanley, a peer mentor attends the Jobcentre once a week and discusses with claimants the benefits of disclosure and treatment.

<sup>102</sup> National Treatment Agency for Substance Misuse. (2012.) *Employment and recovery a good practice guide*. London: NTA. <http://www.nta.nhs.uk/uploads/employmentandrecovery.final.pdf>

<sup>103</sup> For example, ESA claimants in residential treatment are automatically treated as having limited capability for work, and are exempt from mandatory referral to the Work Programme and Claimant Commitment can be tailored for JSA claimants.

<sup>104</sup> Claimants who are identified as stable in recovery who have a history of substance dependence which presents a significant barrier to employment and are no longer in treatment are offered the option to volunteer for the Work Programme at the 13 week point.

<sup>105</sup> Aznar, C., MacGregor, A. and Porter, L. NatCen Social Research (forthcoming). *Views of claimants: Qualitative findings of the Dame Carol Black Review*. London: Department for Work and Pensions.

101. The good examples we saw were typically driven by dedicated Jobcentre Plus alcohol and drugs staff (and external partners and associates) who go above and beyond their job requirements to support claimants. They are able to build rapport and trust with claimants, engaging in employment-focused discussions from the outset. In the process they acquire specialist knowledge, work well with treatment and support providers, and are supported by their managers.

**Woolwich Jobcentre Plus work coach**

I have been working with the treatment providers since October 2009. I started at one site and now work across four. In each case, I start by explaining exactly what my role is, and the type of support I could offer to service users, regardless of the Jobcentre Plus office they attend, and to treatment staff.

At first, I concentrated on training advice, creating and updating CV's, job searching and budgeting and benefits advice. With the introduction of our digital services I now advise people on using the self-service channels for claiming benefits online, benefits calculators and universal job match. I also have three-or four-way interviews with service users and their treatment workers. We use these to look at the level of jobcentre support required after benefits reviews, calculate any deductions they have and agree any flexibilities needed so they can make the most of treatment.

We have peer mentors within our Jobcentre Plus services. They must complete initial peer mentoring training and benefits courses. Once they have done this, they help us provide advice and guidance on benefits and how to apply for them to service users, help them create email accounts, register for universal job match, update their CV's and upload them to various job sites.

I provide support and guidance to our peer mentors and update most of them on a weekly basis on what's new and on changes as they happen. They can then provide the support to the service users during the time I am not with them. If they have a complicated case which they are unable to help with they book them an appointment to be seen by me at my weekly sessions or if it's urgent they will either call or email me to ask for advice and support.

102. We want the employment offer from Jobcentre Plus for claimants with addictions to be substantial, visible, collaborative and consistently applied. Some current practice is effective but it is inconsistently applied. It could be strengthened by upskilling delivery staff, improving accountability, improving the links with treatment, and providing a greater number of work-based options for advisers to refer claimants to. **We therefore recommend the core Jobcentre Plus drugs and alcohol offer is enhanced.** Annex C contains the full list of proposed enhancements which, in summary, seek to:
- Ensure better data is available to local Jobcentre Plus areas to enable a better understanding of drug and alcohol prevalence in an area;
  - Embed a focus on increasing on three-way case conferences and joint claimant commitment and recovery plans and job outcomes for these cohorts more fully in the Jobcentre Plus performance management regime
  - Enhance the consistency of the current offer by providing dedicated resource focused on drug and alcohol issues to build partnerships with all relevant Local Authority services (including treatment providers) and their commissioners with a view to integrating support around the individual (this could be done via local Health and Wellbeing Boards, or an approach like Universal Support);

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- Enable work coaches to have a more structured engagement with claimants and treatment providers to enable a joined-up recovery plan and claimant commitment, and further support for those in work;
- Provide volunteering opportunities and other incremental steps towards the labour market;
- As part of a wider IPS trial, testing the co-location of Jobcentre Plus work coaches in treatment premises. Supporting a smaller than normal caseload, they would be tasked with finding claimants employment and providing in-work support to employers.

*I think the fact that you can volunteer while on ESA,... really helps. The last two jobs have come through volunteering<sup>106</sup>.*

### The Work Programme and other support

103. In addition to the support by jobcentres, described above, some claimants will be referred to the Work Programme.
104. Over the course of the review we heard from stakeholders that the Work Programme had not delivered good outcomes for alcohol and/or drug dependent clients. They described the limited provision of specialist support, and incentives that caused at least some Work Programme providers to prioritise those closest to the job market<sup>107</sup>.
105. The Work and Health Programme will start in 2017 following the end of referrals to the Work Programme and Work Choice. Work on developing this new programme is ongoing including consideration of what support claimants might need to move into work, and how that support might best be delivered within the new programme. It is expected that it will provide support for claimants who are disabled people, the long term unemployed and disadvantaged groups and who require additional support than that available through Jobcentre Plus to enter employment.
106. Given the characteristics of our drug and alcohol dependent group, we believe that many may be within the scope of the programme, since it is aimed at claimants who require additional support.
107. As the Government considers the shape of the programme we think some of the lessons we have identified may help inform its development. Integration – ensuring a joined-up discussion between the programme and the other support services engaged with the claimant – will be important, as will ensuring that this support engages with treatment providers to have a consistent plan that is regularly, and jointly, reviewed. Finally, all available data can be used to create a joined-up picture of employment outcomes for these cohorts in the local area.

<sup>106</sup> Aznar, C., MacGregor, A. and Porter, L. NatCen Social Research (forthcoming). *Views of claimants: Qualitative findings of the Dame Carol Black Review*. London: Department for Work and Pensions.

<sup>107</sup> See (i) National Audit Office. (2014). Department for Work & Pensions. The Work Programme. HC 266 Session 2014-15. <https://www.nao.org.uk/wp-content/uploads/2014/07/The-work-programme-executive-summary.pdf> and (ii) Newton, B., Meager, N., Bertram, C., Corden, A., George, A., Lalani, M., Metcalf, H., Rolfe, H., Sainsbury, R. and Weston, K. (2012). Work Programme evaluation: Findings from the first phase of qualitative research on programme delivery. DWP: asp. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/193323/rrep821.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193323/rrep821.pdf)

## Universal Support

108. Within Universal Credit, in addition to the support available to help claimants find work, there is also support available to help claimants make and maintain their claim and assist people with their financial and digital capability throughout the life of their claim.
109. Those out of work with alcohol and/or drug dependence issues can come from a wide cross-section of society. Some will find work relatively quickly. Others, often people with multiple or more complex needs, will require more joined-up support to help them make or maintain a Universal Credit claim.
110. The 'Universal Support' initiative focuses on providing Universal Credit claimants with the digital and budgeting support they need to take account of the new way Universal Credit is delivered. A number of local trials have explored how, using a case-worker approach, Jobcentre Plus, local authority and third party support services could be brought together to offer this support through local partnerships. The trials completed on 30 November 2015, and on 6 July 2016 we published the evaluation<sup>108</sup>.
111. This example of integration between DWP and Local Authorities, could if expanded upon, offer to link up some of the wider factors (such as housing, skills etc) that play such an important part in supporting alcohol and/or drug dependent people to find work.

## Conclusion

112. Most working-age adults with addictions interact with the benefits system at some point in their lives. This is the key point where the Government could change employment outcomes. Too often this has been a missed opportunity, with claimants being parked on disability benefits for long periods, most with their underlying addiction unrecognised.
113. We believe that our recommendations offer an opportunity to improve radically the journey of claimants with addictions through the benefits system. Our recommendations range from enhancing information provided by the Fit Note, through improving the relationship with claimants by the help of peer mentors, to enhancing the practice of work coaches. This must be underpinned by a much stronger and more attractive offer to such claimants, with incentives for it to be applied consistently across the country.
114. Our vision is for a strong employment pathway in both Jobcentre Plus and treatment and support services, in which there is consistent engagement between these services to assist the dependent person. This additional support by the Government needs to be underpinned by strong employer engagement, which we consider in the next chapter.

<sup>108</sup> [www.gov.uk/government/publications/evaluation-of-the-universal-support-delivered-locally-trials](http://www.gov.uk/government/publications/evaluation-of-the-universal-support-delivered-locally-trials)

# The role of employers: in recruitment, support and prevention

# 3

## Introduction

115. None of the additional employment support measures, outlined in the previous two chapters, will succeed without employers who are willing to provide opportunities for this cohort. We have considered the role of employers both in retaining existing staff with addiction problems and recruiting new staff in recovery. We found that employers are generally supportive of existing staff who develop drug or alcohol problems but are much more reluctant to hire new recruits with addiction histories.
116. Employers have told us that they need the Government, quite simply, to ‘de-risk’ the recruitment decision for them. This chapter outlines what we learned about employer practice currently and the policies we recommend to support employers in recruiting people in recovery.

## Prevention

117. There is limited information on the numbers with a dependence who are in work. As outlined in Chapter 1, we know that only around 15 per cent of opiate users and 30 per cent of those with other drug or alcohol dependence are in work at the start of treatment.
118. The number of people in work with drug and alcohol problems (including much less severe dependencies) is unknown, although the Crime Survey of England and Wales<sup>109</sup> reports that 69 per cent of adults who reported any drug use were in employment, compared to 77 per cent in the general population<sup>110</sup>.

<sup>109</sup> Source: Crime Survey for England and Wales (CSEW). This household survey asks adults aged 16–59 whether they had taken a variety of illicit drugs in the 12 months prior to interview. Data from the latest three survey years (2012/13, 2013/14 and 2014/15) have been combined to robustly describe the demographic make-up of those who said they had used drugs in the last year. These data are routinely made available via the UK Data Service: <https://discover.ukdataservice.ac.uk/series/?sn=200009>.

<sup>110</sup> Also 73 per cent of those reporting Class A drug use, Household surveys such as the CSEW are unlikely to capture drug users who are homeless or lead chaotic lives. It also does not identify whether people have a dependency.

119. The workplace itself can be a factor in encouraging increased levels of alcohol consumption. Stakeholder responses to the review gave evidence of particular risk factors, among them long working hours, jobs with high physical demand and risk of injury, monotonous work, poor supervision and job insecurity<sup>111, 112</sup>. Different professions and groups have been shown to use substances as a coping strategy<sup>113</sup>.

*(M)y director had... picked up that I was using alcohol, and I was going to the toilet somewhat more frequently, and noticed alcohol on my breath, and maybe my mannerisms as well, and...and it didn't make me the most reliable person really, and I was drinking...drinking obviously when I was...when I was there and stuff, so...so it was difficult. It was difficult (...) their attitude was really that (...) then there's no point in coming back really<sup>114</sup>.*

120. Employers are clear that alcohol and drugs problems cost them money. In one survey, four out of ten employers saw alcohol as a significant driver of lost productivity through absenteeism, and a third of respondents reported similar concerns for drugs<sup>115</sup>. This is supported by evidence provided by Drinkaware of the increased absence and reduced reliability of high-risk drinkers<sup>116</sup>.

## The importance of preventative action

121. Preventative action in the workplace can guard against future dependence and improve productivity and workplace culture more generally. Yet helping employees to manage problems with drug or alcohol use can be challenging for employers. A survey from the Chartered Institute of Personnel Development found only 33 per cent of employers have formally trained their managers on alcohol and drug policy and management issues, and 43 per cent of workplaces did not have a specific alcohol policy, while just 27 per cent had capability procedures for managing staff with alcohol problems<sup>117</sup>.

<sup>111</sup> Stockwell, Tim, Gruenewald Paul. J., Tombourou, John W., and Loxley, Wendy (eds.), *Preventing harmful substance use: the evidence base for policy and practice*, Australia, John Wiley and Sons, pp. 191–205.

<sup>112</sup> See (i) Barnes, A. J., and Zimmerman, F. J. (2013). Associations of occupational attributes and excessive drinking. *Social Science and Medicine*, 92, 35–42 (ii) Bergin, A and Jimmieson, N. L. (2014). Australian Lawyer Well-being: Workplace Demands, Resources and the Impact of Time-billing Targets. *Psychiatry, Psychology and Law* 21(3), 427–441. (iii) Buchanan, M., and Keats, P. (2011). Coping with traumatic stress in journalism: a critical ethnographic study. *International Journal of Psychology* 46 (2) 127–35 and (iv) Martin, J. K., Blum, T. C., and Roman, P. M. (1992) Drinking to cope and self-medication: Characteristics of jobs in relation to workers' drinking. *Journal of Organizational Behavior* 13 (1) 55–71.

<sup>113</sup> See (i) Buchanan, M. and Keats, P. (2011). Coping with traumatic stress in journalism: A critical ethnographic study. *International journal of psychology*, 46(2), pp.127–135. (ii) Beck, C. J., Sales, B. D. and Benjamin, G. A. H. (1995). Lawyer distress: Alcohol-related problems and other psychological concerns among a sample of practicing lawyers. *Jl & health*, 10, p.1. (iii) Benjamin, G. A. H., Darling, E. J. and Sales, B. (1990). The prevalence of depression, alcohol abuse, and cocaine abuse among United States lawyers. *International Journal of Law and Psychiatry*, 13(3), pp.233–246. (iv) Richman J. A., Flaherty, J. A., and Pospenda, K. M. (1996). Perceived workplace harassment experiences and problem drinking among physicians: broadening the stress/alienation paradigm. *Addiction* 91 (3) 391–403 (v) Brewster, J. M. (1986). Prevalence of alcohol and other drug problems among physicians. *Jama*, 255(14), pp.1913–1920.

<sup>114</sup> Aznar, C., MacGregor, A. and Porter, L. NatCen Social Research (forthcoming). *Views of claimants: Qualitative findings of the Dame Carol Black Review*. London: Department for Work and Pensions.

<sup>115</sup> Chartered Institute of Personnel and Development. (2007). *Managing drug and alcohol misuse in the workplace: A guide for people management professionals*.

<sup>116</sup> Drinkaware's annual 'Monitor' survey examined the drinking attitudes and behaviour of UK adults. A nationally representative sample of 2,294 UK adults aged 18–75 were surveyed online between 17 November and 10 December 2014. They found that high-risk drinkers were more than three times as likely as low-risk/non-drinkers to say that they had ever missed a day of work due to drinking alcohol in the last year, and were twice as likely as increasing risk drinkers to say that this had happened at least monthly. See more at: [https://www.drinkaware.co.uk/media/362885/drinkaware\\_monitor\\_2014\\_adults.pdf](https://www.drinkaware.co.uk/media/362885/drinkaware_monitor_2014_adults.pdf). [Accessed on Monday 8 February 2016]

<sup>117</sup> Chartered Institute of Personnel and Development. (2007). *Managing drug and alcohol misuse at work*, London, CIPD.

122. Employers could do more to help prevention but the Government is already active in promoting this. We endorse the focus on preventative actions contained in the NHS Mandate<sup>118</sup>, the NHS Five Year Forward View<sup>119</sup> and other national and local initiatives such as the Workplace Wellbeing Charter<sup>120</sup>, NHS Health Checks and health promotion campaigns such as Dry January<sup>121</sup>. The crucial role of employers in promoting health was highlighted in both earlier reviews of 2008 and 2011.<sup>122</sup>
123. Workplace Wellbeing Charter schemes are in place through many local authorities. These provide an evidence-based approach for accredited employers to implement strategies to improve outcomes for all three of the conditions at the centre of this review. Under the scheme, the most severely affected employees can be signposted to their GP or specialist treatment.

#### **Northern Devon Healthcare NHS Trust and Alcohol Awareness Week**

The Trust took advantage of Alcohol Awareness Week during November 2015 to promote alcohol awareness among employees.

In the run up to Christmas and the office party season, the Trust promoted the Drink Checker website – including a unit calculator to help employees keep track of their drinking and a completely anonymous drink test to find out how much they drank and what this meant for their health.

The website also had tips on keeping safe while out drinking and articles on how to avoid drinking too much at the work party and in the run up to Christmas. Employees could also sign up to the drink diary to set goals to have regular drink-free days and see how much they could save by drinking less.

The Trust promoted the website via their intranet and e-communications. For employees that found themselves to be drinking at increasing or higher risk levels, links were made available to contact local alcohol services as well as a confidential phone-back option from Alcohol Health Network.

## **Recruitment of drug and alcohol claimants**

124. Encouragingly, most employers told us that they would support employees who became dependent on drugs and alcohol and, when safety concerns permit, enable them to remain in or return to work. There is practical advice to medical professionals to help them understand and support working patients and employers to address the use of alcohol and illicit drugs in people who work.<sup>123</sup>

*'I know my employers who I'm working for now they were really concerned when I said I had a criminal record and a long history of drug addiction. They were very concerned, very supportive, they wanted to know what I needed to keep me well they've given me everything I've asked for'*<sup>124</sup>

<sup>118</sup> HM Government. (2016). *The Government's mandate to NHS England 2016-2017*, available at [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/494485/NHSE\\_mandate\\_16-17\\_22\\_Jan.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/494485/NHSE_mandate_16-17_22_Jan.pdf) [accessed 25th January 2016].

<sup>119</sup> NHS England. (2014). *Five Year Forward View*, available at <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> [accessed 25th January 2016].

<sup>120</sup> See (i) Workplace Wellbeing Charter: <http://www.wellbeingcharter.org.uk/What-is-the-Charter.php> and (ii) Department of Health. (2015). *Public Health England Strategic Remit and Priorities Letter*. London: Department of Health. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/417629/Public\\_Health\\_England\\_\\_Remit\\_\\_Priorities\\_Letter\\_\\_2015-16\\_Final\\_\\_2\\_.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417629/Public_Health_England__Remit__Priorities_Letter__2015-16_Final__2_.pdf)

<sup>121</sup> Alcohol Concern's Dry January campaign is an annual campaign challenging people to give up alcohol for the 31 days of January. See more at <http://www.dryjanuary.org.uk/>

<sup>122</sup> Black, C (2008) *Working for a Healthier Tomorrow* London: Department for Work and Pensions and Black, C and Frost, D (2011) *Health at Work – an independent review of sickness absence* London: Department for Work and Pensions

<sup>123</sup> BMA (2014, updated 2016) *Alcohol, drugs and the workplace*. The role of medical professionals. [http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21\\_1/apache\\_media/U1IC6LL8K44P92F5HRQR5614CGFC51.pdf](http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/U1IC6LL8K44P92F5HRQR5614CGFC51.pdf)

<sup>124</sup> Aznar, C., MacGregor, A. and Porter, L. NatCen Social Research (forthcoming). *Views of claimants: Qualitative findings of the Dame Carol Black Review*. London: Department for Work and Pensions.

**Marks & Spencer – ‘Marks & Start’ and ‘Make your Mark’ programmes**

Through its ‘Marks & Start’ and ‘Make your Mark’ programmes, the retailer Marks & Spencer looks to give young people the skills and experience to find work in the retail sector. It does this through offering skills training and on-the-job experience to around 1,500 young people a year, some of whom go on to become permanent members of staff. Marks & Spencer recognise that some young people may be ex-offenders with unspent convictions and have histories of substance misuse: in the last year 70% of those accepted onto the programme had unspent convictions, 40% of whom referenced some form of substance abuse.

125. However, evidence, from stakeholders and elsewhere, shows that there is great reluctance among employers to recruit alcohol and drug dependent people.  
*“From an employer’s point of view, it feels like quite a big risk to take somebody on who’s a self-declared drug user or self-declared alcohol user. (...) So I think certainly service users tend to think it’s far better not to say anything, and then they feel that they’re not being honest to themselves in trying to do what they needed to do to recover, so quite often I think people don’t declare that they have had a drug and alcohol problem, although they think they’d like to.”<sup>125</sup>.*
126. When asked about their willingness to recruit people recovering from alcohol and/or drug problems half of employers said that they were not. DWP-commissioned research showed that offenders and people in recovery from alcohol and drugs are the two groups that employers are least likely to employ<sup>126</sup>.
127. Overall, employers’ views on drug and alcohol dependent people mirror the wider stigma found in society, but employers’ attitudes are not uniform. We heard divergent views depending on the sector and size of company. Larger companies were more likely to help people from disadvantaged groups find job opportunities, seeing it as part of their corporate and social responsibility<sup>127</sup>.
128. During the review we heard dependent people, both in treatment and in prison, speak powerfully of the need for meaningful activity and work both during the recovery process and afterwards. The opportunity to start a job can be life changing, and research confirms that people in recovery are often highly motivated, because employment offers an opportunity to achieve desired financial, social and personal stability<sup>128</sup>. Some examples of outstanding practice by employers in recruiting and supporting people in recovery and the benefits to their business, are provided at the end of the chapter.

<sup>125</sup> Aznar, C., MacGregor, A. and Porter, L. NatCen Social Research (forthcoming). *Views of claimants: Qualitative findings of the Dame Carol Black Review*. London: Department for Work and Pensions.

<sup>126</sup> ‘See Potential’ is a Department for Work and Pensions campaign encouraging employers to think differently about how they recruit people: in long-term unemployment, recovering from an addiction, with a criminal record who’ve spent time in care and are homeless or at risk of homelessness. Source: a You Gov survey of employers in support of ‘See Potential’: [https://d25d2506sfb94s.cloudfront.net/cumulus\\_uploads/document/42yrwvixdo/YG-Archive-160126-DWPwaves.pdf](https://d25d2506sfb94s.cloudfront.net/cumulus_uploads/document/42yrwvixdo/YG-Archive-160126-DWPwaves.pdf)

<sup>127</sup> UK Drug Policy Commission. (2008). *Working Towards Recovery: Getting problem drug users into jobs*. London: UKDPC.

<sup>128</sup> *Ibid*.

## The challenge for employers

129. We asked employers about the issues they take into account when considering whether to offer jobs and opportunities to people in recovery. These included the impact of drugs or alcohol on safety-critical roles, which is understandable, but sometimes extended to zero tolerance across the whole organisation, concerns over the reliability of such employees and whether they would 'fit in', and the impact on the reputation of the business.
130. Together these help illustrate the scale of the challenge in supporting employers to give people in recovery a chance. We are encouraged to hear that the Government is planning a strategy to consider the contribution employers can make to labour-market outcomes and hope that these cohorts are part of it.

## Recruitment practices

131. These factors (outlined in paragraph 13) act as a real barrier to employment for people in recovery. We have heard how they drive recruitment practices that filter out such job seekers before an assessment is made of their suitability for roles.
132. Criminal record checks play an important part in the recruitment process. The information that employers can take into account, once an offer of employment is made, is defined by the Rehabilitation of Offenders Act 1974<sup>129</sup>. The Act sets out the period of time<sup>130</sup> within which all cautions and convictions must, if they are asked, be disclosed by candidates for an excepted occupation<sup>131</sup>.
133. Under the Act, and for 'regulated' roles (involving handling sensitive information or taking responsibility for children or vulnerable adults), a person's full criminal record history of both spent and unspent convictions, and whether they are barred from any particular types of work, is disclosed via a full criminal records check. The checks are undertaken by the Disclosure and Barring Service (DBS). All other roles are 'unregulated', and for these it is illegal for employers to ask about spent convictions. However, a 'basic check' for unspent convictions and cautions is available for any job role.

<sup>129</sup> The Rehabilitation of Offenders Act 1974 allows people with convictions to be reintegrated back into society by having the right to legally ignore their conviction(s) after a period of time. The provisions of the Rehabilitation of Offenders Act 1974 were amended by Section 139 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO). The changes were implemented on 10 March 2014. The reforms aimed to establish the right balance between enabling people with convictions to successfully resettlement back into society while at the same time maintaining public safety. For more detail see: <http://www.legislation.gov.uk/ukpga/1974/53/contents>

<sup>130</sup> The Rehabilitation period depends on the sentence imposed, not the nature of the offence.

<sup>131</sup> The ROA identifies a number of excepted occupations, offices or professions where employers may be permitted, or even required, to check a person's official criminal record rather than relying on voluntary disclosure.

*I think if...if there was a more even playing field in the workforce, I think people would...would feel more comfortable revealing them. I think in this country, particularly so, we've...we've got a hard job of actually (...) being accepted with...with any potential previous convictions. And (...) it's not really helped as well by the increasing use of enhanced disclosures when they may not be needed. Enhanced disclosures which would...which would highlight these...these things are increasingly being used willy nilly...er...when...when they maybe not be appropriate<sup>132</sup>.*

134. We recognise the importance of these checks, but they can discourage people who are recovering from dependence from applying for a job and reinforce the tendency for them to be filtered out at an early stage.

*When it comes to disclosures in the past...when I have been trying to look for work...I lie and say, "You know what? I haven't got a criminal record". What they don't know don't hurt them. If they find out, they find out, but I'd rather lie and take the chance at getting a job than being honest and then you're not getting nothing...it's not fair. I think.... that's a form of discrimination. We can't get a job because we've got a past<sup>133</sup>.*

135. Business in the Community's 'Ban the Box' campaign calls on employers to create fairer job opportunities for ex-offenders by removing these tick boxes and only asking about criminal convictions later in the recruitment process. This can help ensure that more people in recovery, and with offending histories, have an opportunity to explain their recovery journey and why they are the best person for the role. This is a positive way to balance business needs with providing people in recovery a chance, and so we welcome the Prime Minister's recent announcement about adopting this approach for the UK Civil Service<sup>134</sup>.
136. Gaps in the employment record, because of spells in prison or for some other reason, can also be used by employers to sift out applications early on in the recruitment process. Some employers also make use of Health and Safety legislation to test potential employees for drug-use, both at the recruitment stage and while in work. Some stakeholders reported that testing at the pre-recruitment stage had increased in recent years.
137. Some of current employer practice is a rational response to the extra risk employees in recovery pose. But employers also report fear of tackling these issues and a lack of understanding about what they can do if the recruitment goes wrong.

<sup>132</sup> Aznar, C., MacGregor, A. and Porter, L. NatCen Social Research (forthcoming). *Views of claimants: Qualitative findings of the Dame Carol Black Review*. London: Department for Work and Pensions.

<sup>133</sup> Aznar, C., MacGregor, A. and Porter, L. NatCen Social Research (forthcoming). *Views of claimants: Qualitative findings of the Dame Carol Black Review*. London: Department for Work and Pensions.

<sup>134</sup> See more about Business in the Community's (BITC) 'Ban the Box' scheme here: <http://www.bitc.org.uk/programmes/ban-box>

138. We believe more should be done to provide employers with information to support them in employing drug and alcohol dependent people. **We therefore recommend the Government develops, with employers, guidance on best practice in recruiting drug and alcohol dependent people. We also recommend that See Potential and other campaigns are used to promote the guidance and to address the problem of stigma more generally**<sup>135</sup>.
139. The public sector should take the lead with the recruitment and employment of people in alcohol and drug recovery, where safe to do so, and progress should be monitored. Without this public service example, encouragement of the private sector to recruit people in recovery will ring hollow. In addition, government procurement can be used to encourage change.
140. Both these aims were articulated in the 2010 Drug Strategy but to our knowledge have not been widely adopted. We believe government (national and local) can also set expectations on providers on recruiting effectively from local talent pools, including job seekers from the groups under study here.

## De-risking recruitment decisions

141. We asked employers what practical measures of support the Government could offer to help encourage them to consider people in recovery as candidates for employment. Offering staff to provide, ongoing in-work, support for both employers and new employees would be the most welcome form of support, to be offered early, but also available later as needed.
142. The provision of such support is integral to the proposed trial of the Individual Placement (IPS) and Support model. One purpose of the trial we recommend in Chapter 1, therefore, would be to test whether expectation of this expert support would persuade employers to recruit more people in recovery. Evaluation will also be important to understand the extent to which the support is used by employers, whether this addresses employer concerns, how much it influences outcomes, and how long the person concerned remains in employment. Any evaluation should explore the impact of such in-work support to employers to see whether this makes a tangible difference.
143. Some employers also identified extra costs at the point of permanently recruiting staff in recovery. This could include additional training or management time, a particular issue for micro, small and medium-sized enterprises. So we **recommend that the employment advisors in the IPS trial have access to a small discretionary fund to cover legitimate additional costs that smaller employers incur when recruiting or employing people with a history of alcohol or drug dependency.**
144. Since many potential recruits will come to employers through Jobcentre Plus, rather than the new IPS route, **we recommend, as part of the enhanced drug and alcohol offer by Jobcentre Plus, developing additional interventions to keep work coaches in touch with alcohol and drug dependent claimants who secure employment.** In practice, this could offer in-work support and identify and assist those who relapse.

<sup>135</sup> See Potential is about encouraging employers to think differently about how they recruit and recognise the potential within people regardless of their background. This includes people recovering from an addiction, in long-term unemployment, those with a criminal record, who have spent time in care and who are homeless or at risk of homelessness. See more at: <https://www.gov.uk/seepotential>

145. In Chapter 2<sup>136</sup>, we recommend testing the co-location of Jobcentre Plus work coaches in treatment premises. A key element of this will be to see how well they are able to provide support for employers, as well as offering help finding work, and administering benefits.
146. We were persuaded by employers and third sector organisations that offering ‘try before you buy’ work placements also makes sense. These would allow employers and prospective employees a period in which to evaluate the suitability of an individual while they are still on benefits and part of the Jobcentre Plus system.
147. Jobcentre Plus already has a programme that enables such a process, called a Work Trial, and relates to a specific vacancy that an employer is actively trying to fill<sup>137</sup>. It is offered to a claimant on a strictly non-competitive basis. This means that for the duration of the trial, the person taking part is the only person under consideration for the vacancy in question and remains on benefits – the job becomes permanently theirs if both they and the employer are satisfied. Usually the trial lasts about five days, but it can be up to six weeks at the discretion of the Jobcentre Plus work coach.
148. Anecdotally we understand that many claimants stay in the job after such a Work Trial period. We therefore **recommend that the IPS trial also incorporates the ability to offer such Work Trials to employers** to evaluate whether this ‘try before you buy’ option encourages employers to recruit dependent persons in recovery<sup>138</sup>.

*There are no perfect people....Everyone’s got a past. So I think my message to employers is ‘be a little bit more open-minded and have your door a little bit more open, because there are people out there with pasts that will execute jobs spot-on’<sup>139</sup>.*

149. Access to Work is an excellent example of the Government providing a much valued service to employers. It is currently only available to drug or alcohol dependent people who have a physical or mental health co-morbidity. Many, but not all dependent people have such a co-morbidity so we **recommend extending the assessment and support services within Access to Work to include all drug and alcohol dependent people who are on a treatment programme even if they do not have an additional declared physical or mental health issue**<sup>140</sup>.

<sup>136</sup> See paragraph 102 in Chapter 2.

<sup>137</sup> The Department for Work and Pensions Work Trials scheme are designed to find out an individual’s suitability for a particular job vacancy by giving them an opportunity to try out the job for a short period. They reduce risk for both employer and employee and also equip job seekers with a valuable period of experience in a work-based environment. See more at: <https://www.gov.uk/jobcentre-plus-help-for-recruiters/work-trials>

<sup>138</sup> Whilst data on Work Trials is not kept, anecdotally we know that many claimants are successful in finding work this way and that some employers take on someone they would not otherwise have done so without this scheme.

<sup>139</sup> Aznar, C., MacGregor, A. and Porter, L. NatCen Social Research (forthcoming). *Views of claimants: Qualitative findings of the Dame Carol Black Review*. London: Department for Work and Pensions.

<sup>140</sup> The Access to Work scheme pays grants for practical support for people with a disability, health or mental health condition to help them start and stay in work or to move into self-employment or start a business. See more at: <https://www.gov.uk/access-to-work>

## Conclusion

150. For those in work, the workplace provides an opportunity for support and encouragement of healthy behaviour, particularly reducing alcohol consumption, to the benefit of business. So we support national and local government's existing efforts to spread evidence-based best practice in this area.
151. We have identified the recruitment of new employees with a history of addiction as the most important barrier to overcome, without which the new employment support services we have recommended in the previous two chapters will fail. Therefore, the recommendations outlined in this chapter offer a package of support to employers recruiting individuals from either the new IPS service or Jobcentre Plus.
152. We believe that a trial period with potential recruits coupled with an offer of real in-work support (both advice and financial support, as appropriate) after recruitment will encourage more employers to come forward. This in turn could offer a real chance to many more people to find and sustain work, thus reinforcing recovery, as well as offering financial and social benefits.

### **Jobs Friends & Houses**

Social enterprise Jobs, Friends & Houses (JFH) was founded by serving police officer Steve Hodgkins in 2014. The organisation was founded on the principle that employment, stable accommodation and positive relationships can support and sustain recovery and reduce crime.

JFH 'does what it says on the tin'; offering access to training and meaningful employment, a positive peer group, and stable accommodation to past prolific offenders and those in recovery from addiction. The organisation renovates and maintains properties while training team members in trades; improving some of the inadequate accommodation in the resort well known for its social problems: alcohol harm, drug addiction, health inequalities, poor mental health, broken homes, transiency, low educational attainment and domestic violence.

Two-thirds of the 51-strong team are 'in recovery', whether from addiction, offending or family breakdown. Of these, 75% have been addicted to drugs and 62% have been alcohol dependent. So this organisation provides opportunity to substance using and offending populations who are the hardest to engage and reach.

### **Recycling Lives**

Recycling Lives is a socially minded business that combines the success, financial viability and material benefits of a busy provider of recycling and waste management services with the positive social impact of a separately registered charity.

By building strong ties with customers and corporate partners, Recycling Lives provides accommodation, training, work experience and, ultimately, employment to homeless and unemployed people, including those with a criminal record or complex issues.

Every project the Recycling Lives business undertakes is designed to integrate seamlessly with their long-term commitment to corporate social responsibility, and every project undertaken by the charity is designed to build revenues and increase UK recycling rates.

They are now implementing the proven methods of work into UK prisons to help offenders develop employability skills that may dissuade them from re-offending. The Recycling Lives Prison Academy offers offenders the chance to learn new skills whilst incarcerated and, upon completing the final stages on release, these new ex-offenders are awarded a full-time employment contract. The work commitment is structured so that offenders work five days a week, three of which are on a voluntary basis, creating revenue for charity, and two of which are paid at the national living wage, from which appropriate contributions to victim-support funds are drawn.

This charity's primary objective is to provide accommodation and employment to people on probation, as they will be during the latter stages of the programme. This self-sustaining solution will create real opportunity for rehabilitation, both for current and future offenders, while ensuring full buy-in from prison staff.

**Freshfields' approach to Ban the Box**

Freshfields has been involved in Business In The Community's (BITC) Ready for Work programme since 2001. This offers placements, training and coaching opportunities to people who have experienced or face the risk of homelessness. Over the years, the firm grew to realise that homelessness was often a symptom of many underlying issues and barriers to work, and focused their support towards those with criminal records who they recognised faced significant exclusion.

The unspent convictions of candidates coming through the Ready for Work programme were assessed on a case-by-case basis, with a policy and process put in place to understand the risk and relevance of their convictions to the firm. A robust and clear policy was implemented to ensure that the firm was comfortable with their duty of care, both to the individual and their wider workforce.

It was a natural step for this work to influence the practices and policies of the business as a whole. So shortly after the launch of BITC's Ban the Box campaign, Freshfields removed the tick box from their online and paper application forms that asked applicants whether they had any unspent criminal convictions. Now, for all roles in their UK office, they only ask for criminal record information after a job offer has been made.

Philip Richards, Partner at Freshfields says:

"The Ban the Box campaign is an excellent initiative that highlights the major role businesses can play in helping ex-offenders back into work, away from homelessness and from adding to re-offending rates.

In opening up our recruitment opportunities to these individuals we now have access to a wider talented, motivated and loyal workforce that might otherwise have been disregarded because of an unrelated conviction."

## **Part 2 – Obesity, employment outcomes and the benefits system**

# Obesity, employment outcomes and the benefits system

# 4

## Introduction

153. During the course of the review it became clear that obesity is qualitatively a very different condition from dependence on drugs or alcohol. It is far more common than addiction, its labour market consequences are more indirect, and the evidence on its impact on employment and the benefits system is sparse.
154. This chapter starts by considering the prevalence of obesity, its role as a risk factor for other health conditions, and future trends. We then consider the impact of obesity on employment or leaving work because of associated long-term sickness or disability, and the consequences for the benefits system. We then turn to the impact of obesity on people in work, and the role employers could play in helping to address this.

## Obesity prevalence

155. Six out of 10 men and five out of 10 women are overweight or obese in England with one in four men and women obese. Obesity has been increasing over the last 30 years and there has also been a sharp increase in the proportion who are severely obese<sup>141, 142</sup>.

<sup>141</sup> Overweight is defined as a BMI of 25-30 kg/m<sup>2</sup>; Obese is defined as a BMI that is equal or greater than 30 kg/m<sup>2</sup>; Severely obese is defined as BMI equal or greater than 40 kg/m<sup>2</sup>.

<sup>142</sup> Public Health England. (2015). *Patterns and trends in adult obesity*, <https://www.noo.org.uk/gsf.php5?f=14605&fv=21272> [accessed 26 October 2015].

156. Within the OECD as a whole, fewer than one in five adults are obese and around one in two are over-weight. The UK therefore ranks amongst the highest in terms of obesity prevalence (after countries such as the United States, Mexico, Chile and New Zealand) and is the highest of the European countries<sup>143</sup>.
157. The main factor driving obesity is an overconsumption of calories, underpinned by a broad spectrum of societal and individual influences which have been widely documented. These include biological predisposition, individual choices about food consumption and exercise, and the external environment such as the ready availability of calorific food and drink<sup>144</sup>.
158. Suggesting that the widespread (and increasing) obesity prevalence is simply down to poor individual choices is too simplistic a reading of a complex phenomenon that incorporates powerful social influences and multiple risk factors.
159. Obesity affects all sections of society, but is somewhat more prevalent among lower socio-economic groups and in certain black and minority ethnic groups<sup>145</sup>. We also see variation among local authority areas, with the highest level of overweight or obese adults close to 75 per cent. Thus obesity is a significant problem across all socio-economic groups and areas in the UK, associated with deprivation but certainly not confined to it<sup>146</sup>.
160. The problem is not exclusive to adults. One in ten children in Reception class (usually aged between four and five) are obese, a figure which increases to one in five for children in Year 6 (usually aged between nine and ten)<sup>147</sup>. Obese children are more likely to be obese later on when adult<sup>148, 149</sup> and childhood obesity is associated with lower educational attainment<sup>150</sup>.
161. Obese parents are much more likely to have obese children: in the OECD the chance of a boy being obese is three times higher if a parent is obese (for girls three and a half times higher). Given the impact of obesity on health, addressing obesity among children – the workers of tomorrow – forms an essential part of minimising the impact of obesity on the working population<sup>151</sup>. We therefore believe it is important that the Government takes action in this area.

<sup>143</sup> Sassi, F. (2010). *Obesity and the Economics of Prevention*. The Organisation for Economic Co-operation and Development. <http://www.oecd.org/els/health-systems/46044572.pdf>. Data from some European countries can be based on self-reports which can be underestimates compared to physical measures.

<sup>144</sup> Government Office for Science. (2007). *Tackling obesities: future choices – project report (2nd edition)*. [online] at: <https://www.gov.uk/government/publications/reducing-obesity-future-choices>

<sup>145</sup> Public Health England. (2015). *Patterns and trends in adult obesity*, <https://www.noo.org.uk/gsf.php5?f=14605&fv=21272> [accessed 26 October 2015].

<sup>146</sup> Source: Active People Survey 2012, quoted in, House of Commons Library. (2015). *Obesity Statistics briefing paper*. <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN03336> [accessed 29 October 2015].

<sup>147</sup> Public Health England. (2015). *Patterns and trends in child obesity*, <https://www.noo.org.uk/gsf.php5?f=14604&fv=21271> [accessed 26 October 2015].

<sup>148</sup> Kral, T. V. and Faith, M. S. (2009). *Influences on child eating and weight development from a behavioral genetics perspective*. *J Pediatr Psychol*, 34, 596-605.

<sup>149</sup> Simmonds, M., Burch, J., Llwellyn, A., Griffiths, C., Yang, H., Owen, C., Duffy, S. and Woolacott, N. (2015). *The use of measures of obesity in childhood for predicting obesity and the development of obesity-related diseases in adulthood: a systematic review and meta-analysis*. *Health Technol Assess*, 19, 1-336.

<sup>150</sup> Devaux, M. and Sassi, F. (2013). Social inequalities in obesity and overweight in 11 OECD countries. *The European Journal of Public Health*, 23(3), pp.464-469.

<sup>151</sup> Sassi, F. (2010). *Obesity and the Economics of Prevention*. The Organisation for Economic Co-operation and Development. <http://www.oecd.org/els/health-systems/46044572.pdf>

## Obesity as a risk factor for physical and mental health conditions

162. Obesity has negative impacts on health and can even be life-threatening for individuals, reducing life expectancy by an average of three years (severe obesity can reduce it by eight to 10 years)<sup>152</sup>. The British Medical Association has estimated that poor diet contributes to 70,000 premature deaths a year<sup>153</sup>.
163. Being obese increases the risk of type II diabetes, hypertension, heart attack and colorectal cancer. The increased risk is significant: an obese woman is almost 13 times more likely than a woman of normal weight to develop type II diabetes; a man is five times more likely. Obesity is also associated with musculoskeletal conditions such as osteoarthritis of the knee or back pain<sup>154</sup>.
164. It has been estimated that the NHS in England spent £5.1 billion on overweight and obesity-related ill-health in 2014/15<sup>155</sup>. Diabetes, much of it related to obesity, now accounts for around 9 per cent of the NHS budget. More widely, obesity has been estimated to cost the economy between £27 billion and £46 billion per year<sup>156, 157</sup>.
165. Among adults there is a complex relationship between obesity and mental health conditions. Obesity has been associated with mental health problems due to poorer perceived health, low self-esteem and concern about body image. It is also seen as a consequence of mental health conditions, with people eating as a coping strategy<sup>158</sup>.
166. Responses to our Call for Evidence reiterated the importance of taking psychological as well as physiological aspects into account when considering obesity and employment. It is commonly held that being obese is the person's own fault: in one survey 57 per cent of respondents agreed or strongly agreed with the statement that people were overweight because 'they lack willpower' and that being overweight 'was mainly the person's own fault'<sup>159</sup>.

<sup>152</sup> Prospective Studies Collaboration (2009). *Body-mass index and cause-specific mortality in 900,000 adults: collaborative analyses of 57 prospective studies*. The Lancet, 373(9669), pp.1083-1096.

<sup>153</sup> British Medical Association. (2015). *Food for thought: promoting healthy diets among children and young people*. London: British Medical Association. <http://www.bma.org.uk/news-views-analysis/news/2015/july/food-for-thought-getting-the-recipe-right>

<sup>154</sup> Eastwood, P. (2013). *Statistics on Obesity, Physical Activity and Diet: England, 2013*. Leeds: The NHS Information Centre. <https://catalogue.ic.nhs.uk/publications/public-health/obesity/obes-phys-acti-diet-eng-2013/obes-phys-acti-diet-eng-2013-rep.pdf> [accessed date: 28 January 2016].

<sup>155</sup> Estimates for England in 2014/15 are based on: Scarborough, P. (2011). The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs. *Journal of Public Health*. May 2011, 1-9. Uplifted to take into account inflation. No adjustment has been made for slight changes in overweight and obesity rates over this period. It's been assumed England costs account for around 85 per cent of UK costs.

<sup>156</sup> Jebb, S., Kopelman, P., McPherson, K., Thomas, S., Mardell, J. and Parry, V. (2007). *Tackling Obesities: Future Choices: Project Report*. Department of Innovation Universities and Skills.

<sup>157</sup> Dobbs, R., Sawers, C. and Thompson, F. (2014). *Overcoming obesity: An initial economic analysis*. 2014. The McKinsey Global Institute.

<sup>158</sup> National Obesity Observatory. (2011). *Obesity and mental health*. Available at: [http://www.noo.org.uk/uploads/doc/vid\\_10266\\_Obesity%20and%20mental%20health\\_FINAL\\_070311\\_MG.pdf](http://www.noo.org.uk/uploads/doc/vid_10266_Obesity%20and%20mental%20health_FINAL_070311_MG.pdf) [accessed 28 October 2015].

<sup>159</sup> Beeken, R. J. and Wardle, J. (2013). Public beliefs about the causes of obesity and attitudes towards policy initiatives in Great Britain, in *Public Health Nutrition*, 16(12), 2132-2137.

## Future increasing prevalence

167. Although the rate of increase in adult obesity has decreased in recent years, obesity is already a significant issue and continues to increase, as does severe obesity<sup>160</sup>. The impact of obesity on health is, therefore, likely to become even more significant in future. The UK Health Forum has modelled the future impact of obesity for Cancer Research UK, and estimated that three out of four adults will be overweight or obese by 2035<sup>161</sup>.
168. This increasing obesity prevalence will have a real impact on resulting disease prevalence. Between 2015 and 2035 it could lead to an additional 670,000 incidences of cancer, 1.6 million additional cases of coronary heart disease and 4.6 million additional cases of type II diabetes. This is estimated to cost the NHS an extra £2.5 billion annually by 2035<sup>162</sup>.
169. Tackling the problem of obesity will require a wide portfolio of action<sup>163</sup>, as the recently published *Childhood Obesity: A Plan for Action* states, “Long-term, sustainable change will only be achieved through the active engagement of schools, communities, families and individuals.”<sup>164</sup> However, this review has sought to explore a specific part of this wider topic: the impact of obesity on employment.

## The impact of obesity on unemployment and the benefits system

170. We first considered evidence that being obese could itself cause unemployment. Our analysis identified a (quite small) two percentage point gap between the employment rate of normal and overweight adults, and the rate for obese adults. For the severely obese there was a wider gap of 10 percentage points<sup>165</sup>. These differences could be explained by other factors, and many obese people are successful in work. So we cannot infer a direct causal relationship between obesity and unemployment.
171. However, obesity is very likely to contribute to worklessness for some people indirectly, through other health conditions associated with obesity – but the data does not allow us to quantify this effect. Obese and severely obese adults are somewhat more likely to report being out of work due to long-term sickness or disability<sup>166</sup>.
172. Obesity is also associated with early retirement, as obese and severely obese adults are over-represented amongst the over-55 age group who have retired from paid work. Whilst the reasons for this are wide-ranging some might have been due to obesity-related ill health<sup>167</sup>.

<sup>160</sup> Public Health England. (2015). *Patterns and trends in adult obesity*, <https://www.noo.org.uk/gsf.php5?f=14605&fv=21272> [accessed 9 February 2015].

<sup>161</sup> Cancer Research UK and UK Health Forum. (2016). *Tipping the scales: why preventing obesity makes economic sense*. <http://nhfshare.heartforum.org.uk/RMAssets/Modelling/Tipping%20The%20Scales%20-%20CRUK%20Full%20Report.pdf>

<sup>162</sup> *Ibid.*

<sup>163</sup> For example, *Overcoming obesity, an initial economic analysis*, McKinsey. (2014). [http://www.mckinsey.com/insights/economic\\_studies/how\\_the\\_world\\_could\\_better\\_fight\\_obesity](http://www.mckinsey.com/insights/economic_studies/how_the_world_could_better_fight_obesity) [Accessed 24 January 2016]

<sup>164</sup> HM Government. (2016). *Childhood Obesity: A Plan for Action*. London.

<sup>165</sup> This percentage difference aggregates respective ‘employed’ and ‘self-employed’ rates. See Annex F, Figure 6 for more detail.

<sup>166</sup> See Annex F, Figure 6.

<sup>167</sup> See Annex F, Figure 6.

## Obesity in the benefits system

173. If obesity causes job loss because it gives rise to health conditions, it is likely that obese people will be over-represented in the benefits system. However, as discussed in the previous chapter, several of the main working-age benefits do not routinely record a claimant's health condition, and those that do only record one 'main disabling condition'.
174. Our analysis of the main benefits where a health condition is recorded suggests that there are only around 1,600 claimants with a main disabling condition of obesity who claim Employment and Support Allowance (ESA)<sup>168</sup>. Many individuals in this cohort moved between different benefits, but around a third spent three to five years on DWP's main benefits<sup>169</sup>.
175. Given that obesity is a risk factor for other health conditions that can lead to long-term sickness or disability, this number 1,600 seems very low. We think it likely that obese people are claiming benefits for a different health condition. We looked at the health conditions given for ESA and selected a wider set of conditions where obesity could be a risk factor. From this analysis, we estimate that up to 807,000 cases (35 per cent of the ESA caseload) have conditions that may arise due to obesity<sup>170</sup>.
176. However, the strength of association with obesity varies. For example, around 27,600 cases were due to 'unspecified Diabetes Mellitus'<sup>171</sup> which would be likely to have a stronger link with obesity than 'depressive episodes'. Further, some of these cases will be due to obesity and others will not. Given the current data and evidence, therefore, it is not possible to come to a definite conclusion on the numbers of obese people within the benefits system<sup>172</sup>.
177. As obesity is clearly a risk factor for a host of health conditions that can lead to worklessness, and as the problem is growing, we believe that the Government should prioritise a thorough investigation of this issue. This will take some time, and require new information to be collected, but we believe it is an important factor for the sustainability of the benefits system. We therefore **recommend that the Government commission research to investigate the extent to which obesity plays a role in health-related benefit claims, in particular long-term ones.**

## Obesity treatment

178. Obesity and lifestyle weight-management services are provided locally, based on local population need, commissioned by local authorities and clinical commissioning groups with several referral routes. A recent mapping exercise by Public Health England (PHE) reported that 61 per cent of local authorities who responded provided or commissioned an adult lifestyle weight-management service. The provision of clinical obesity services was more variable<sup>173</sup>.

<sup>168</sup> See Annex E, Table 1.

<sup>169</sup> See Annex E, Table 4.

<sup>170</sup> Based on an ESA caseload of 2.3 million claimants in February 2015. Source: DWP benefits caseload statistics (WPLS data), February 2015 <http://tabulation-tool.dwp.gov.uk/100pc/tabtool.html>

<sup>171</sup> This figure relates to ESA only, see Figure 13 in Annex F for more detail.

<sup>172</sup> See Annex F, Figure 13.

<sup>173</sup> Public Health England. (2015). *National mapping of weight management services: Provision of tier 2 and tier 3 services in England*. London: Public Health England. Source: <https://www.gov.uk/government/publications/weight-management-services-national-mapping>. [Accessed 28 January 2016].

179. Almost without exception stakeholders stressed the limited availability of weight-management services in England, which was not commensurate with the challenge of tackling obesity in their area. This was particularly the case at tier three (clinical teams) and tier four (bariatric surgery) levels. However, there is limited information held centrally to form a clear picture on the availability of obesity treatment across England.
180. The impact that obesity might have on the benefits system is likely to be indirect. However, the factors we outline in this chapter suggest that obesity could be identified by a claimant as a barrier to work.
181. We therefore think that Jobcentre Plus work coaches should have guidance available to support them in helping claimants who identify their obesity as a barrier to work. So we **recommend that there is a minimum support offer that upskills Jobcentre Plus advisors on addressing obesity, and has a referral pathway into local weight-management services where obesity is identified as a barrier to work.**

## The impact of obesity in work

182. We have also reviewed how obesity affects individuals in work and their employers. The evidence indicated higher rates of sickness absence amongst obese people, a suggestion of impact on productivity, and – as a consequence of these effects, or of wider societal stigma – some suggestion that obese employees earn lower wages than those of healthy weight.

## Sickness absence and productivity

183. Obesity is a risk factor for musculoskeletal conditions and poor mental health – the two most commonly cited reasons for sickness absence. International evidence suggests that employees with different levels of BMI have different levels of sickness absence<sup>174</sup>.
184. A systematic review of 36 studies of the relationship between obesity and sick leave concluded “obesity was found to be associated with increased risk of sick leave in the great majority of studies.” In the USA obese workers had one to three extra days of absence per year; in Europe the figure was as much as 10 days<sup>175</sup>.

<sup>174</sup> Office for National Statistics publication. (2014). *Sickness Absence in the Labour Market 2014 release*, <http://www.ons.gov.uk/ons/rel/lmac/sickness-absence-in-the-labour-market/2014/rpt---sickness-absence-in-the-labour-market.html#tab-Sickness-Absence-in-the-Labour-Market> [accessed 26 October 2015].

<sup>175</sup> Neovius, K., Johansson, K., Kark, M., and Neovius, M. (2009). *Obesity status and sick leave: a systematic review*. *Obesity reviews*, 10(1), 17-27.

185. This evidence review included only two UK-related studies, so we should be cautious in applying the conclusion to this country. However, it does suggest that the impact of obesity can be felt by employers, and the cost is not limited to the health system. As an illustration, if obese workers take one day a year more than the average absence by all other workers, this would account for around £500m of the total estimated £9bn of sick pay annually paid by employers<sup>176</sup>.
186. Evidence also suggests a potential impact on productivity, with obese workers finding it harder to complete job tasks in the workplace. A small number of studies suggested that obesity was linked to reduced productivity in manufacturing, a consequence of experiencing greater difficulties with job-related physical tasks and completing work on time<sup>177</sup>.

## Stigma and wage penalty

187. Perhaps on account of these issues, we also saw evidence that recruitment decisions can reflect the stigma that exists in society generally. For example, in a recent survey of 1,000 employers 45 per cent of them were less inclined to recruit those seen at interview to be obese<sup>178</sup>.

<sup>176</sup> The £500 million estimate is the cost of one extra day per obese worker. The total cost of sickness absence of all obese workers would be close to £3 billion.

<sup>177</sup> Sassi, F. (2010). Obesity and the Economics of Prevention. *The Organisation for Economic Co-operation and Development*. <http://www.oecd.org/els/health-systems/46044572.pdf>.

<sup>178</sup> Crossland Solicitors. (2015). *Employers' Attitude to Obese Candidates*. See: [http://www.crosslandsolicitors.com/site/crossland\\_news/Employer\\_survey\\_obese\\_candidates\\_2015\\_html](http://www.crosslandsolicitors.com/site/crossland_news/Employer_survey_obese_candidates_2015_html) [Accessed 26 October 2015].

188. Employers' comments in this survey reflected a wider perception of obese people as 'lazy', or that people's size reflected poorly on them or suggested an inability to perform required job tasks. This discrimination against obese workers has been suggested to extend to fewer promotion opportunities and a greater likelihood of being made redundant. However, the OECD were unable to validate the role employer discrimination made in its review of studies of the issue<sup>179</sup>.
189. We also found that obesity is associated with lower wages, at least in some international studies. An OECD review suggests that obese people earn less than non-obese people performing the same tasks and in equivalent positions. Most studies put the wage gap at around 10 per cent, but it was as high as 18 per cent in one study. The picture may not be uniform: US evidence suggested that obese white women experienced substantial disadvantage in wages, while obese African-American and Hispanic women were virtually unaffected<sup>180</sup>.
190. However, it has not been possible to infer a causal relationship between obesity and employment wages. As outlined above, obesity is associated with a wide range of other factors that confer labour-market disadvantage and it is difficult for studies to control for all of these.
191. Therefore our conclusion about the impact of obesity on people's productivity in work largely mirrors that on the impact of obesity on employment prospects. Obesity gives rise to health conditions which can limit people's performance in the workplace, but the extent is unclear.
192. We also found limited evidence, particularly in UK studies, that quantified the impact of obesity on employers. In their submission to us, an insurance company highlighted the limited data available to help understand the impact of long-term conditions such as obesity.
193. Given the current prevalence of obesity and future trends, and the potential scale of its cost for both businesses and individuals, we believe the Government should consider the in-work aspects of obesity more fully. So we recommend the Government undertakes further research to investigate the impact of obesity on the working population. Stronger evidence on the financial cost of obesity for employers could help build the business case for employer action.

<sup>179</sup> Personnel Today. (2005). *Obesity research: Fattism is the last bastion of employee discrimination*. See: <http://www.personneltoday.com/hr/obesity-research-fattism-is-the-last-bastion-of-employee-discrimination/> [Accessed 26 October 2015].

<sup>180</sup> Sassi, F. (2010). *Obesity and the Economics of Prevention*. The Organisation for Economic Co-operation and Development. <http://www.oecd.org/els/health-systems/46044572.pdf>, pp99-100

## The role of healthy workplaces

194. Chapter 3 highlighted the importance of the workplace in influencing peoples' lifestyle. Reviews by OECD and the World Health Organisation concluded that workplace interventions do help tackle obesity<sup>181</sup>.
195. Companies can take steps to ensure that workplaces do not unduly contribute to staff obesity, through measures such as providing healthier food and drink in work canteens and the promotion of physical activity. In doing so employers can support their employees to make changes to their lifestyles.

### Simple steps to change dietary habits at BP

In 2011, BP signed up to seven public health responsibility deal workplace pledges. One aspect they considered was how to work with their UK catering contractors to make healthy eating the easier option when employees are at work.

They made this nutrition pledge central to their catering strategy to make sure that healthier choices were increasingly available and visible to staff. Their suppliers removed trans fats from their procured product lists and worked with their supply chain to replace products that did not meet the Food Standard Agency salt targets. Their suppliers now prepare vegetables without adding salt; reduce the salt volumes in sachets; and position "lo-salt" sachets away from tables. Butter has been replaced with a lower calorie spread, 1% milk helps reduce the calories in meals, and undressed salads and low calorie dressings are supplied as standard.

"Healthy labelling," posters and leaflets have helped staff to make informed food choices about what they eat. Careful considerations about restaurant layouts and product placement have increasingly made healthy options the first rather than the last thing that is seen when going for lunch. Finally, their cashless card pay system has enabled BP to add a few healthy incentives where, for example, a fifth salad or tenth bottle of water purchased are automatically free of charge.

There has been a measurable increase in the uptake of healthy foods, and a decrease in the consumption of less healthy snacks, since introducing this approach. Catering managers and chefs have welcomed the opportunity to work together and take a more active part in supporting a healthy approach to menu selection, and food preparation. There have been food theatre events and inspirational speakers to allow chefs to demonstrate easy ways to cook healthily and well.

196. The National Institute for Clinical Excellence (NICE) have published guidance for all employers on how to encourage employees to be physically active, aiming to help prevent the diseases associated with obesity<sup>182</sup>. Also, the Workplace Wellbeing Charter offers evidence-based strategies to help employers provide healthy choices for their staff<sup>183</sup>.

<sup>181</sup> See (i) Sassi, F. (2010). *Obesity and the Economics of Prevention*. The Organisation for Economic Co-operation and Development. <http://www.oecd.org/els/health-systems/46044572.pdf> and (ii) World Health Organization Fact sheet: obesity and overweight. Available online: <http://www.who.int/mediacentre/factsheets/fs311/en/> [Accessed 26 October 2015].

<sup>182</sup> National Institute for Health and Clinical Excellence. (2008). *Physical activity in the workplace*. NICE public health guidelines PH13. See: <http://www.nice.org.uk/guidance/ph53>

<sup>183</sup> The Charter is a health, safety and wellbeing award scheme endorsed by Public Health England, which provides organisations of all sizes with best practice advice, guidance and support to improve health and wellbeing in the workplace. For more information see: <http://www.healthatworkcentre.org.uk/the-charter/>

#### **A holistic approach to health promotion: BT's Work Fit**

Work Fit is BT's vehicle for health promotion. Conceived in 2004, Work Fit set out to adopt an innovative approach to health promotion in the workplace. Each campaign focuses on a specific health issue and adopts a modular approach so that messages are "drip fed" to the workforce. The consistent theme is that small changes, if sustained, can have a big impact but that individuals have got to want to make those changes and the company cannot do it for them – the philosophy is encapsulated in the strap line "helping you to help yourself".

The first campaign launched in September 2005 was concerned with nutrition and exercise as a means of reducing obesity and associated diseases. Some 16,500 BT people actively engaged with the programme and over the course of 16 weeks the average weight loss was 2 kg. A follow-up survey showed that six months later 75 per cent of those that took part had maintained lifestyle improvements and that as many people again as those who had formally registered with the programme had also been influenced to improve their diet or take more exercise. Campaigns have also been run on smoking cessation, mental wellbeing, cancer, diabetes and physical activity.

Surveys have revealed that 66 per cent say they make positive lifestyle changes and 82 per cent that they benefit from the campaigns.

## **Conclusion**

197. From the limited evidence we cannot draw definite conclusions about the labour market effects of obesity. Any impact that obesity has on employment appears indirect, and is likely to be a consequence of other health conditions for which obesity is a risk factor. We are unable to quantify the impact of obesity on the benefits system in any robust way.
198. We believe there is a long-term risk that obesity becomes an ill-defined, but widely accepted, reason for absence from work or receipt of benefits (rather like 'back pain' nowadays). We therefore believe that the employment dimension should form an important part of the wider government response to obesity, which should start with further research to understand the problem more fully.
199. There is, perhaps, stronger evidence of the disadvantages for obese people who are in work, such as increased absence and lower wages. Better understanding of these would help the Government and employers build the case for further action, if justified.

## 5

## Review conclusions

200. This review has highlighted opportunities to promote employment of those with addictions and so help reduce the cumulative cost to the Government and society. Every year, around 300,000 working-age adults are in alcohol and drug treatment services in England but, despite the other benefits of treatment, the majority fail to find work (chapter 1, para 40). In the benefits system, there is no reliable way of identifying claimants with addictions (chapter 2, para 68), surprisingly poor health-related information (chapter 2, para 78), and a distinct lack of specialised support. We have also heard loud and clear from employers that hiring individuals from this group can present an unacceptable risk to their business (chapter 3, para 141)<sup>184</sup>.

### Linking benefit entitlement to treatment

201. These findings have important implications for one of the questions asked of this review: whether the Government should make benefit claimants with an addiction engage with treatment as a condition of their benefit entitlement.
202. We are clear that benefit claimants with addictions should, like all other claimants, do all they can to re-enter work. However, in view of the findings in paragraph 200 above, we doubt whether mandation of addiction treatment – one of the possibilities mentioned in our terms of reference – should be the first response to the evidence problems for the cohorts under discussion.

<sup>184</sup> Public Health England. (2015). *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS): 1 April 2014 to 31 March 2015*. <http://www.nta.nhs.uk/uploads/adult-statistics-from-the-national-drug-treatment-monitoring-system-2014-2015.pdf>

203. Further, there is a strong consensus that mandating to addiction treatment would lead to more people hiding their addiction than revealing it. We also heard from health professionals serious concerns about the legal and ethical implications of mandating treatment and whether this would be a cost effective approach.
204. We have also not found consistent evidence that obesity itself is a causal factor for unemployment. Nor did we find evidence that the weight-loss achieved through non-surgical treatment approaches (experts suggested around 5kgs) would lead to employment. Of course there is evidence of the health benefits that lifestyle weight-management services can bring, supporting their commissioning by local authorities and clinical commissioning groups.<sup>185, 186, 187</sup>
205. Further, a health-related benefit claim is more likely to be made after a health condition other than obesity has developed. At that stage, obesity treatment may not, in itself, completely resolve the condition that prevents a claimant from returning to work. In any case, the claimant would have been awarded health benefits for a different condition, making the link to obesity treatment very hard to implement.
206. For all these reasons we conclude that mandation of clinical treatment should not be the first response to the evident problems of cohorts under this study in getting back to work. However we do recommend trialling in selected areas a requirement that claimants for health-related benefits have a structured discussion, with an appropriate healthcare professional, about the barriers to work facing that individual, and possible means of overcoming them. If the measures we recommend are put in place and shown to be successful, the Government could then consider further ways to encourage engagement with the employment support package that would then be put in place.

## Other recommendations

207. We believe that the review's recommendations, if properly tested and implemented, will offer new, productive pathways for these lost cohorts. By bringing employment services into the treatment process, the Government can build on the positive aspects of the process of recovery and bring job search forward into a non-threatening environment.
208. This challenge of integrating services is not new, and yet it offers a powerful way to improve employment outcomes; not just for the cohorts that have been the focus of this review, but for all those suffering with a long-term condition. Our analysis has reinforced our view that the **Government should promote more integrated collaboration across the benefits and health systems, to improve employment outcomes for this group and for others with long-term health conditions.** The newly-formed Work and Health Unit offers a real opportunity to deliver steps towards realising this vision.

<sup>185</sup> National Institute for Health and Clinical Excellence (2014) *Managing overweight and obesity in adults – lifestyle weight management services*. <http://www.nice.org.uk/guidance/ph53>

<sup>186</sup> National Institute for Health and Care Excellence (2014) *Preventing obesity and helping people to manage their weight*. <http://www.nice.org.uk/advice/lgb9/chapter/what-can-local-authorities-achieve-by-taking-action-to-prevent-obesity-and-help-people-who-are-overweight>

<sup>187</sup> National Institute for Health and Care Excellence (2014) *Obesity: identification, assessment and management*. <https://www.nice.org.uk/guidance/cg189/chapter/1-Recommendations>

209. For people with a drug and/or alcohol dependence who interact with Jobcentre Plus, we have highlighted the need to improve the collection and flow of health information and improve engagement with work coaches, underpinned by employment support. Alongside better support for employers, these changes should help ensure that few are unable to find a high-quality employment pathway, whichever Government-funded system they enter.
210. We also hope that the Government will continue our investigation into the highly important question of obesity and employment. Most working-age people who are obese do in fact work. But obesity is linked to a host of long-term health conditions and is a significant risk factor for claiming disability benefits and retiring early. Severe obesity is associated with lower employment rates, especially for women, and obesity deters employers at the recruitment stage, on account of a host of perceived risks<sup>188</sup>.
211. This review has focused strongly on the benefits system – how to prevent people entering the benefits system or, worse, languishing in it. Unfortunately, although we believe obesity is a widespread issue for benefits claimants, existing data has not allowed us to identify most obese claimants nor understand the extent to which obesity may have caused their unemployment. This question will require in-depth research with collection of new information. We hope the Government's new Work and Health Unit will take on this challenge as a high priority.
212. Government and employers also have a key role in supporting individuals to prevent these conditions arising in the first place. Health and care services can also play a critical leadership role by embedding prevention within a '*Making every contact count*' approach and by making retention in, or return to, work an important clinical outcome to be aimed for.
213. Finally, in conducting this review, we have been struck by how many people with long-term health conditions, including those with multiple other labour-market disadvantages, do nevertheless find work. In a diverse and flexible labour market, there are opportunities for most people to work and to enjoy the financial and social rewards that brings. With the right support, we believe employment would be within the reach of tens of thousands more working-age people each year. This is a real prize for the Government and has been the motivation for this review, supported by the many stakeholders and people with experience of addiction who have engaged with us.

<sup>188</sup> Robroek, S., Reeuwijk, K., Hillier, F., Bamba C., Van Rijn, R., and Burdorf, A. (2013). The contribution of overweight, obesity, and lack of physical activity to exit from paid employment: a meta-analysis. *Scandinavian Journal of Work, Environment and Health*, 39(3), 233-240.

## Annex A

# Glossary of key terms

**Access to Work** grants can pay for practical support for people who have a disability, health or mental health condition to help them: at interview, start in a job, stay in work and/or move into self-employment or start a business. The grant is not for business start-up costs.

**Advisory Council on the Misuse of Drugs (ACMD)** is the independent expert body, sponsored by the Home Office, that advises government on drug-related issues in the UK. The ACMD considers substances which are being misused and carries out in-depth inquiries into aspects of drug use that are causing particular concern in the UK. They aim to produce considered reports that will be helpful to policy makers and practitioners.

**Alcohol dependence** is a psychiatric diagnosis in which a person is categorised as **physically** or **psychologically dependent on drinking alcohol**. Clinicians use tools such as the Severity of Alcohol Dependence Questionnaire (SADQ) or the Leeds Dependence Questionnaire (LDQ) to assess drinking levels and the severity of dependence before offering one of three diagnoses:

- Mild alcohol dependence: a score of 15 or under.
- Moderate alcohol dependence: a score of 15–30. These people typically have an increased tolerance of alcohol, suffer withdrawal symptoms, and have lost some degree of control over their drinking. They may recognise they have a problem.
- Severe alcohol dependence: a score of 31 or more. These people feel unable to function without alcohol and require intensive specialist treatment.

**Alcohol Use Disorders Identification Test (AUDIT)** is an assessment tool developed by the World Health Organisation and used to assess the nature and severity of alcohol misuse. It can help in screening for and identifying excessive drinking and it provides an intervention framework to help hazardous and harmful drinkers reduce or stop drinking.

**Benefits** are payments administered by the Department for Work and Pensions to reflect the particular circumstances of a claimant. Common working-age benefits include Jobseeker's Allowance (JSA), Employment and Support Allowance (ESA), Income Support (IS) and Universal Credit.

**Benefit entitlement:** The eligibility conditions that need to be met in order to receive a benefit.

**Claimant** is a person claiming a benefit.

**Claimant Commitment** is the record of the responsibilities that the claimant has accepted in return for receiving some working-age benefits. It is based on the claimant's personal circumstances and is reviewed and updated on an ongoing basis. It also sets out the consequences of not meeting those responsibilities.

**Crack cocaine** is a 'rock' like form of cocaine which can be smoked. All types of cocaine are addictive, but by reaching the brain very quickly crack cocaine tends to have a much stronger effect and be more addictive than snorted powder cocaine. Crack is also often injected on its own or alongside heroin, which has serious additional risks, including damaging veins and spreading blood borne viruses, such as HIV and hepatitis C.

**Disability benefits** such as Personal Independence Payment can be received whether or not someone is in work. Incapacity Benefits, such as ESA, are related to an inability, or reduced ability, to work.

**Distance travelled:** The shorter term milestones such as volunteering, work experience or skills training that contribute to the long term goal of securing employment.

**Employment advisor** is a generic term for a person who provides employment, education and training support, developing individually tailored action plans and pathways into employment. In Jobcentre Plus they are known as 'work coaches'.

**Employment and Support Allowance** is a sickness and incapacity benefit which offers financial support for people who are unable to work due to a health condition or disability.

**Fit for Work** is a government service to provide work-related health advice for people who have been off work on a period of sickness absence for four weeks or more. It also provides more generic advice via a website and telephone line.

**Fit Notes** replaced the sick note. They are issued by doctors (usually GPs) to people to provide evidence of the advice they have given about their fitness for work. Fit Notes record details of the functional effects of the patient's condition so the patient and their employer can consider ways to help them return to work.

**Health and Wellbeing Boards** were established by the Health and Social Care Act 2012 as local bodies where leaders from across the health and care system work together to improve the health and wellbeing of their local populations

**Individual Placement and Support (IPS)** is an evidence-based approach that supports people into sustained employment in the mainstream competitive labour market. It was originally developed for severe and enduring mental illness and is based on eight principles:

1. Eligibility is based on individual choice;
2. Supported employment is integrated with treatment;
3. Competitive employment is the goal, (not sheltered placements or volunteering);
4. Rapid job search (within 4 weeks), minimal prevocational training;
5. Job finding, and all assistance, is individualised;
6. Employers are approached with the needs of individuals in mind;
7. Follow-along supports are continuous; and
8. Financial planning is provided.

**Incapacity Benefit (IB)** is an older benefit that provides support for people unable to work due to a health condition or disability. It is being replaced by ESA.

**Income support** is a government benefit for people on low income who fall into one of the qualifying categories, e.g. lone parents of very young children, carers and students.

**Jobcentre Plus** is the government organisation that helps people move from benefits and into work. It also administers benefits for people who are unemployed or unable to work due to a health condition or disability.

**Job search conditions** are the specific requirements set by a work coach and recorded on the claimant commitment that a claimant must meet in order to continue to receive benefit. For JSA and some Universal Credit claimants this is checked weekly or fortnightly.

**Main disabling condition** is the main condition recorded for an ESA claimant that means they are unable to work.

**Meaningful activity** in the context of employing people with alcohol and drug problems, this means intermediate steps towards full labour market entry. Activities include but are not limited to education, skills training and volunteering opportunities.

**National Drug Treatment Monitoring System (NDTMS)** is managed by Public Health England. NDTMS collects information from drug and alcohol treatment services in England. It contains detailed information about people in drug and alcohol treatment and is used by local areas to support their local needs assessment and commissioning, and to monitor the performance of their local treatment system.

**National Institute for Health and Care Excellence (NICE, [www.nice.org.uk](http://www.nice.org.uk))** provides national evidence-based guidance and advice to improve health, public health and social care. It also develops quality standards and provides a range of informational services for commissioners, practitioners and managers across health and social care.

**Obesity** is a condition of being noticeably over weight, categorised by Body Mass Index (BMI) a measure of body fat based on height and weight which applies to adult men and women.

BMI categories are:

- Underweight = under 18.5;
- Normal weight = 18.5 to 24.9;
- Overweight = 25 to 29.9;
- Obese = 30 to 39.9; and
- Severely obese = 40 or over

**Opiates** are drugs or medicines with effects similar to opium. They act by stimulating opioid receptors in the brain and nervous system. There are a large number of opiates including codeine, morphine, dihydrocodeine, methadone, buprenorphine and diamorphine (also known as pharmaceutical heroin). The majority of people in drug treatment are there for opiate addiction.

**Non-opiates** is a term used by drug treatment professionals to describe the drugs used by people in drug treatment services who are not using opiate drugs. The most widely used non-opiate among people in treatment is cannabis; other widely used non-opiates include cocaine, benzodiazepines and amphetamines.

**Peer mentor** is a person with similar lived experience now in recovery or in treatment, who can provide support, encouragement and information and also serve as a role model. **Peer support** is the support provided both by an individual or a group with similar lived experience.

**Personal Independence Payment** is a benefit to provide help with some of the extra costs caused by long-term ill-health or disability for people aged between 16 and 64. It is replacing the Disability Living Allowance (DLA).

**Recovery and recovery journey:** This is an individual, person-centred journey that leads to a dependence-free life. To ensure this happens for as many people as possible, it is important that services are commissioned with the following best practice outcomes in mind:

- freedom from dependence on drugs or alcohol;
- prevention of drug-related deaths and blood-borne viruses;
- a reduction in crime and re-offending;
- sustained employment;
- the ability to access and sustain suitable accommodation;
- improvement in mental and physical health and wellbeing;
- improved relationships with family members, partners and friends; and
- the capacity to be an effective and caring parent.

**Recovery capital** refers to the internal and external resources that help people make and sustain behavioural changes and achieve and maintain recovery from substance misuse. It includes:

- Social capital – the resource a person has from their relationships (e.g. family, partners, children, friends and peers). This includes both support received, and commitment and obligations resulting from relationships;
- Physical capital – such as money and a safe place to live;
- Human capital – skills, mental and physical health, and a job; and
- Cultural capital values, beliefs and attitudes held by the individual.

**Recovery systems:** Alcohol and drug treatment works in getting people off their problem substance, but if they are to sustain their recovery, they need to be linked in with a range of appropriate support services, including family and peer support. They also need adequate resources, stable housing and access to employment, training or education opportunities. Recovery system is a term used to describe these interconnected services working together to support people to realise their recovery ambitions.

**Referral pathway** is the source or method by which a person has been referred to their latest treatment episode.

**Residential rehabilitation** is alcohol and drug treatment where people receive psychosocial interventions and other interventions in a drug and alcohol-free residential environment. The aim of residential rehabilitation is to help move people towards recovery from dependence, over the course of a programme lasting several weeks or months.

**See Potential** is a communications campaign run by the Department for Work and Pensions that encourages employers to recruit people from disadvantaged groups. These groups include people who have been long-term unemployed, ex-offenders, people in drug and/or alcohol recovery, lone parents, care leavers and the homeless, or those at risk of homelessness.

**Social Impact Bond** is an outcomes-based contract that enables government or donors to pay directly for successful social outcomes and unlocks investment for organisations that have the expertise needed to tackle complex social problems. A third party – the investor – supplies capital upfront to cover the costs of the intervention, with returns being contingent on the successful delivery of the agreed social outcomes.

**Specialist alcohol treatment:** There are a number of treatment options for people with alcohol misuse disorders, including behavioural, psychological and pharmacological therapies. The type of treatment recommended to an individual will depend on a number of factors, including levels of alcohol consumption and familial situation.

**Sustained employment** is described by the National Audit Office as remaining in work either in one job or by moving to other jobs, but it can also mean work that provides opportunities to advance and earn more.

**Treatment services** are organisations (NHS, voluntary sector or private) which deliver a range of different interventions (e.g. pharmacological, psychosocial, harm reduction) to reduce the harm to users, help them overcome their addiction and sustain their recovery.

**Treatment and support systems** includes treatment (as above) but also the wider package of support for those people that need it, such as family and peer support, stable housing, employment support and/or training opportunities designed to help a dependent person achieve recovery.

**Universal Credit** replaces some in-work and out-of-work benefits and is being introduced in stages. It supports people who are on a low income or out of work, and helps ensure that claimants are better off in work. Universal Credit gives the support needed to prepare for work, to move into work, or earn more in work. In return for this support, it is the claimant's responsibility to do everything they can to find a job or increase their earnings.

**Universal support** is offered to help Universal Credit claimants make and maintain their claim by providing local digital support and personal budgeting support.

**Unspent criminal convictions:** Under the Rehabilitation of Offenders Act, a conviction becomes spent after a period of time. The rehabilitation period varies according to the sentence given, not to the offence committed. Unspent criminal convictions are disclosed on all types of criminal record disclosure (basic, standard and enhanced). Convictions resulting in a prison sentence of over four years are never spent.

**Weight management services** are locally-based services that individuals and families can access if they are above a healthy weight. Different tiers of weight management services cover different activities. Definitions vary locally but usually tier 1 covers universal services (such as health promotion or primary care); tier 2 covers lifestyle interventions; tier 3 covers specialist weight management services; and tier 4 covers bariatric surgery.

**Working-age benefits** are the benefits available to **working-age** claimants who are aged between 16 and State Pension age.

**Work and Health Programme** is the programme that was announced in the 2015 Spending Review and will launch in 2017 following the end of referrals to the Work Programme and Work Choice. It will provide specialist support for the long-term unemployed and claimants with a disability.

**Work and Health Unit** is a new organisation established by the Department for Work and Pensions and the Department of Health to consider policies and issues relating to health and employment.

**Work Capability Assessment (WCA)** is the assessment used to determine an individual's entitlement for ESA and, where appropriate, the type of work-related activities they need to perform. The WCA assesses individuals against a set of descriptors to determine how their illness or disability affects their ability to work, and takes into account the functional effects of fluctuating or progressive conditions. It has a similar function in Universal Credit determining entitlement to LCW (Low Capability to Work) or LCWRA (Low Capability to Work-Related Activity) additional components.

**Work Choice** is a voluntary specialist disability employment programme that provides tailored support for disabled people who face the most complex employment barriers to find and stay in work. To be eligible for Work Choice, a customer/claimant must be of working age, resident in the UK and disabled as defined by the Equality Act 2010.

**Work coach** is the Jobcentre Plus advisor who helps the claimant secure employment and/or move closer to the labour market.

**Work Programme** was introduced in June 2011 and is designed to support people who are long-term unemployed or at significant risk of becoming long-term unemployed. The majority of people referred to the Work Programme have been unemployed and in receipt of benefit for 9 or 12 months before joining and are then supported over a minimum of two years.

**Work trial:** The purpose of a work trial is to overcome any remaining suitability doubts an employer and/or jobseeker may have following a formal interview for a vacant post. In simple terms, for both customers/claimants and employers, it is an opportunity to 'try before you buy'.

## Annex B

# Review terms of reference

The purpose of the review is to consider how best to support those suffering from long-term yet treatable conditions back into work or to remain in work.

The review will primarily consider individuals with the following long-term yet treatable conditions: obesity, alcohol addiction and drug addiction. It will consider the holistic needs of these individuals including the effects of multiple health conditions and other barriers to work.

The review aims to:

- Establish the role which such treatable conditions play in causing worklessness and estimate the associated cost to the Exchequer and the economy;
- Understand the characteristics (including overlapping conditions and other disadvantages) of individuals and the pathways they take through the healthcare and welfare systems and the roles played by providers and employers in these pathways;
- Consider also the group(s) most at risk of becoming workless through treatable conditions in future and the support available to them, including incentives on employers;
- Assess the availability and cost effectiveness of treatments and interventions to facilitate a return to work for different sub-groups within the affected population;
- Explore the support provided by the existing benefit system and the incentives/barriers created, taking full account of the opportunities presented by full delivery of Universal Credit. This includes considering the case for linking benefit entitlements to take up of appropriate treatment or support; and
- Understand the whole system in the context of relevant international comparators and learn from policy successes abroad; make fully costed, robust and deliverable recommendations for government with consideration of the role and incentives on providers and employers. These recommendations must generate net savings to the Exchequer over time and enhance the health, well-being and future life chances of individuals and families affected.

## Scrutiny Group

The review team is grateful to our panel of experts who have provided welcome challenge and helped us to refine our thinking during the course of the review:

Nic Adamson

Dr Zofia Bajorek

Prof. Clare Bamba

Prof. Stephen Bevan

Andrew Brown

Robin Burgess

Prof. Sir Cary Cooper

Prof. Mark Gabbay

Gouy Hamilton-Fisher

Prof. Theresa Marteau

Phil Nichols

Dr Paul Nicholson

Mark Pearson

Hugh Robertson

Chris Shaw

Shruti Singh

Prof. Sir John Strang

Dr. Christian van Stolk

Dr Justin Varney

Tony Wilson

## Annex C

# Summary of recommendations

### Note on geographical scope:

These recommendations touch on employment and welfare issues that extend across Great Britain, but substance misuse and wider health issues that apply to England only. Some recommendations (such as Jobcentre Plus working more closely with treatment providers) will require close working between the UK Government and devolved administrations to ensure an effective outcome across the UK.

1. Government should agree an expanded recovery measure that includes work and meaningful activity outcomes (including volunteering) using available data sets across the whole system. It should also introduce a raised employability ambition in the next version of the UK guidelines on clinical management of drug misuse and dependency.
2. Government should enhance Jobcentre and treatment data sets, to support and illustrate joined-up work between Jobcentres and treatment services, and record steps towards both the labour market and job outcomes. This is intended to ensure Jobcentre Plus, local authority commissioners and others understand the level of need and progress made in their areas.
3. Government should conduct a trial of the Individual and Placement Support (IPS) approach. This will include testing how IPS performs compared to a time-limited version ('IPS-lite') and Jobcentre Plus work coaches co-located in treatment services providing employer support.
4. Government, working with the clinical community, should review ways in which better health information could be provided to Jobcentre Plus in support of a benefit claim.
5. Jobcentre Plus should work with treatment providers to trial a network of peer mentors to act as advocates and visible symbols of recovery, tasked with encouraging safe disclosure and engagement with appropriate support.
6. Government should enhance the core Jobcentre Plus drugs and alcohol offer (see below for detail).

7. Government should conduct a trial of a requirement for each claimant, early in their claim to benefit, to attend a structured discussion with a healthcare professional on the impact of their health condition on their ability to work, to test the value of this approach and identify delivery issues.
8. Government, working with employers, should develop guidance on best practice in recruiting drug and alcohol dependent people. We also recommend that See Potential and other campaigns are used to promote this guidance and to address the problem of stigma more generally.
9. Government should ensure that the employment advisors as part of the IPS trial have access to a small discretionary fund to cover legitimate additional costs that smaller employers incur when recruiting people with a history of alcohol or drug dependency. They should also be able to offer Work Trials to employers.
10. Government should extend the assessment and support services within Access to Work to include all drug and alcohol dependent people who are on a treatment programme, but do not have an additional declared physical or mental health issue.
11. Government should commission research to investigate the impact of obesity on the working population and the extent to which obesity plays a role in health-related benefit claims, in particular long-term ones.
12. Government should ensure that there is a minimum support offer that upskills Jobcentre Plus advisors on addressing obesity, and has a referral pathway into local weight management services where obesity is identified as a barrier to work.
13. Government should promote more integrated working across the benefit and health systems to improve employment outcomes for this group and for others with long-term health conditions.

The enhanced elements of the Jobcentre Plus offer include:

- (i) Jobcentre Plus District Managers to be provided with drug and alcohol prevalence data by Department for Work and Pensions and Public Health England (PHE) to ensure they understand the scale of the issue in the Jobcentre Plus offices within their district.
- (ii) Jobcentre Plus District Managers to be more accountable for their area's performance in identifying and assisting this group of claimants find employment by embedding 1) a focus on increasing on three-way case conferences and joint claimant commitment and recovery plans and 2) job outcomes for this cohort overtly in the performance management regime. Delivery expectations should be set at a local level, taking into account local labour market conditions and complexity of the local treatment population.
- (iii) Explore ways to improve disclosure of a drug or alcohol dependency, and job outcomes for these claimants – particularly through support of peer mentors.
- (iv) A named person in each Jobcentre Plus district to have a strategic focus on drug and alcohol employment issues in the district. Their role would include:
  - ensuring the current offer is implemented coherently and consistently;
  - formally evaluating and sharing best practice;
  - building partnerships with all relevant Local Authority services (including treatment) and their commissioners with a view to integrating support around the individual (via local Health and Wellbeing Boards, or through an approach like Universal Support if expanded in Universal Credit);
  - supporting and upskilling work coaches with delivery of the drugs and alcohol offer;
  - overseeing peer mentoring;
  - coordinating employer engagement for this cohort.

- (v) At the point of identifying an alcohol or drug dependence, joint working with treatment providers to be established with three-way case conferences to be held to create a joint recovery plan and claimant commitment. Further progress reviews to follow every six months. Benefits conditionality should be tailored appropriately to reflect the shared treatment and employment ambition – but also mindful that recovery is rarely a linear process.
- (vi) Work placements for drug and alcohol dependent claimants who are receiving treatment, engaging the local public and private sector employers as much as possible.
- (vii) To ensure that those at risk of falling out of employment are supported through light touch in-work support for Universal Credit claimants. Addiction is a relapsing and remitting condition, that is why additional ‘keep in touch’ support should be offered by Jobcentre Plus work coaches to those in recovery as they get a job to ensure any relapse risk is dealt with quickly and effectively.
- (viii) Equipping Jobcentre Plus work coaches with recognised training and tools (such as AUDIT) to improve the identification of people who may have a dependency.
- (ix) Emphasising the importance of volunteering and ‘distance travelled’ measures to Jobcentre Plus work coaches. While it is right that part of a renewed ambition for many should be for job starts and sustainment, these interim steps are important for people with addictions issues as they embark on their back to work journeys. However, we heard that there was some inconsistency about the way in which volunteering for this cohort was considered within Jobcentre Plus.

## **Annex D**

# **Analysis of employment status and outcomes of individuals in contact with the substance-misuse treatment system**

## **Statistics from the National Drug Treatment Monitoring System and Labour Market System**

### **Overview**

1. The following annex provides information from analysis carried out using 2014/15 data from the National Drug Treatment Monitoring System (NDTMS) held by Public Health England (PHE); it is used alongside analysis utilising an anonymous data match between the NDTMS and the Labour Market System held by the Department for Work and Pensions (DWP) containing data from 2011/12.

### **The National Drug Treatment Monitoring System**

2. The information held in NDTMS is collected from approximately 1,300 drug and alcohol treatment services on a monthly basis. This data is regularly fed back to local service commissioners and service providers in the form of benchmarked reports, toolkits and bespoke data packs to inform local Joint Strategic Needs Assessments.
3. These resources are integral in assisting local areas to respond to need and improve outcomes. They can also help local authorities ensure that the services they commission are both effective and good value for money within the context of competing local priorities. Further information on the NDTMS, including details of the data collected can be found here – <http://www.nta.nhs.uk/ndtms.aspx>

### **DWP Administrative Data**

4. DWP collects various data during its claims processes, such as National Insurance number, name, gender, geographical information, whether currently in receipt of benefits, amongst other information, on a monthly basis. However, this data has not been collected specifically for statistical analysis. A subset of this information was used for this data match.

## **Executive Summary**

5. Employment rates at the start of treatment are generally low, with nearly twice the proportion of non-opiate and alcohol clients employed compared to opiate clients. Employment rates are even lower for offenders and this is consistent across all substances.
6. The main factors associated with employment at treatment start are being male, having better physical and mental health, using drugs for less time, and living in more affluent areas.
7. Net employment in the main remains static or improves very slightly during treatment, with the greatest gains in employment occurring when individuals successfully complete treatment.
8. Being in paid work is consistently associated with successfully completing treatment.
9. The factors that increase the likelihood of achieving employment by the time of leaving treatment include: being younger, male, stably housed, having self-referred to treatment, using substances for a shorter time, and living in more affluent areas.
10. Most opiate clients (68 per cent) do not report any paid work whilst in treatment, reflecting the difficulty these individuals have in obtaining paid work and the challenge that Jobcentre Plus, the Work Programme and treatment providers face in working together to help them to do so.
11. The longer an individual in treatment is in receipt of benefits, the less likely they are to gain employment, with many drug and alcohol clients remaining on benefits for a significant amount of time.
12. The majority (81 per cent) of individuals with a main disabling condition of drugs misuse were either currently in treatment or had been in contact previously; this compared to 51 per cent of individuals with alcohol misuse as a main disabling condition.

## **Data Matching Methodology**

13. The NDTMS holds some limited personal information, such as date of birth, which has enabled a data match to DWP administrative data on working-age benefits. However, at no time were individuals identifiable during this analysis.
14. Records were matched with DWP datasets using the following variables:
  - Date of birth.
  - Gender.
  - First name initial.
  - Last name initial.
  - Local Authority area.
15. Only those records that matched on all five fields were included in the final matched dataset. As well as capturing information about the latest local authority where a claimant lives, DWP records included details of previous local authority areas. When matching records, if the most recent local authority did not result in a match with NDTMS records, then earlier local authorities were considered (in reverse date order) to see whether they produced a match against NDTMS clients.

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16. When more than one DWP record matched a single NDTMS client, or where more than one NDTMS client was matched to the same DWP record, none were retained in the final matched dataset as the correct match could not be verified.
17. More information on this data match is available in the following ad hoc statistical publication:  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/449581/individuals-in-drug-or-alcohol-treatment-in-receipt-of-working-age-benefits.doc](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449581/individuals-in-drug-or-alcohol-treatment-in-receipt-of-working-age-benefits.doc)
18. As with any data match there is some uncertainty in the matching process. If the details of an individual in one dataset have not matched any records in the other dataset, it is not certain whether the individual is absent from the other dataset or if there were other factors that prevented a match. These factors could include mistakes being made when the data was initially inputted or changes in the characteristics that are used in the match, such as a change of second name. The result of this uncertainty is that the results may be an undercount of the number of people on benefits who are in, or have been, in treatment.

## **Analysis of data from the National Drug Treatment Monitoring System**

### **Background**

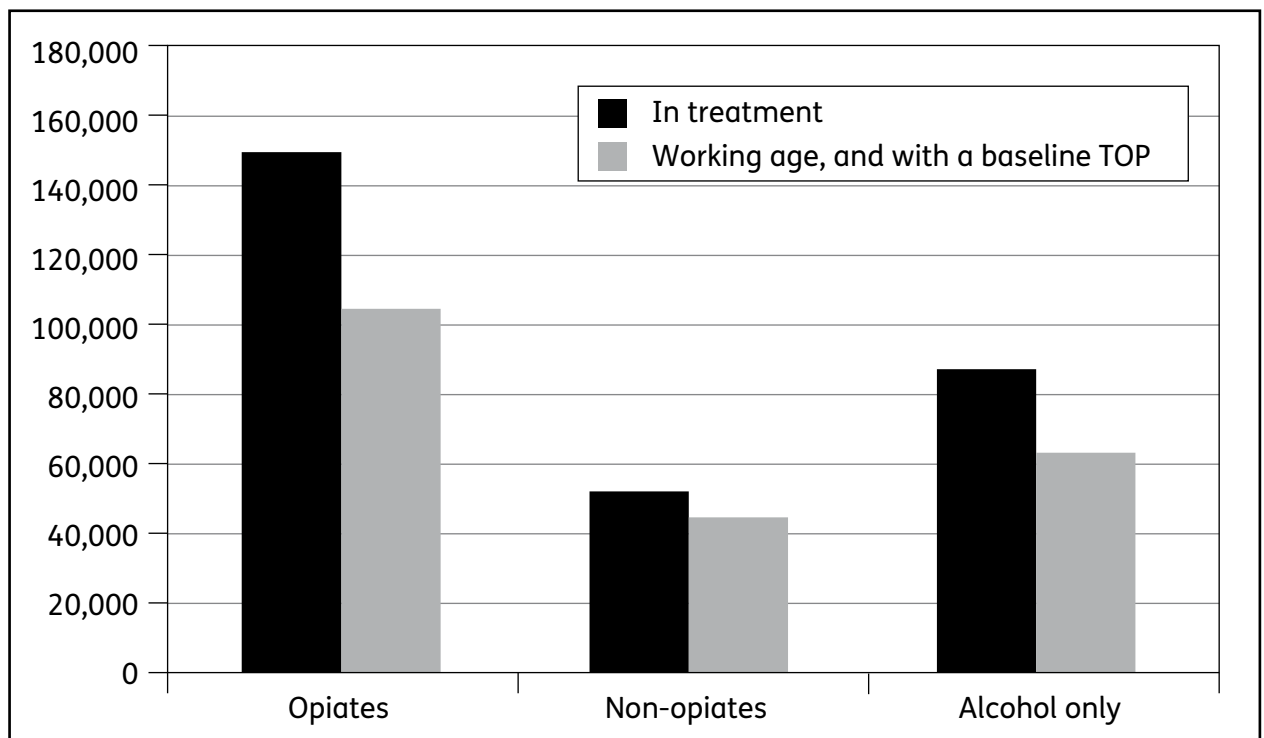
19. There were 295,224 individuals in contact with the English drug and alcohol treatment system during 2014/15. The majority of individuals (152,964) were accessing treatment for problems with opiates (mainly heroin). This was followed by 150,640 individuals in contact with treatment services for problem drinking (89,107 alcohol only and 61,533 presenting alcohol alongside other drugs). There were 53,153 clients in treatment for other substances, which were primarily cannabis and cocaine.
20. Further information can be found here: <http://www.nta.nhs.uk/uploads/adult-statistics-from-the-national-drug-treatment-monitoring-system-2014-2015.pdf>
21. Information on employment in NDTMS is collected primarily via the Treatment Outcomes Profile (TOP); a validated, self-reported, 20-item questionnaire that is used to measure outcomes during and at the end of treatment.
22. The TOP is completed at the start of treatment (the baseline TOP), every six months while in treatment, and again at discharge from treatment. In October 2007, the TOP was implemented across the English drug treatment system; in November 2013 it was further rolled out to those receiving treatment for alcohol.
23. The TOP primarily asks about individual behaviour (such as drug use) in the previous 28 days. With respect to employment, an individual is asked about the number of days they carried out paid work. Further information on the Treatment Outcome Profile can be found here: <http://www.nta.nhs.uk/healthcare-top.aspx>
24. Responsibility for delivering job outcomes lies with Jobcentre Plus, the Work Programme and, going forward, the Work and Health Programme (from 2017). Treatment has a key role to play in supporting people to become job ready, but their primary role is treating the person's drug or alcohol addiction problems. As part of the client's recovery plan, treatment staff set goals around a range of recovery-focused issues, including education, training and employment

needs. A key expectation of treatment provider staff is that they work in partnership with the employment support advisor who is equipped to meet the needs they identify as part of the recovery plan.

### Characteristics of individuals included in the analysis

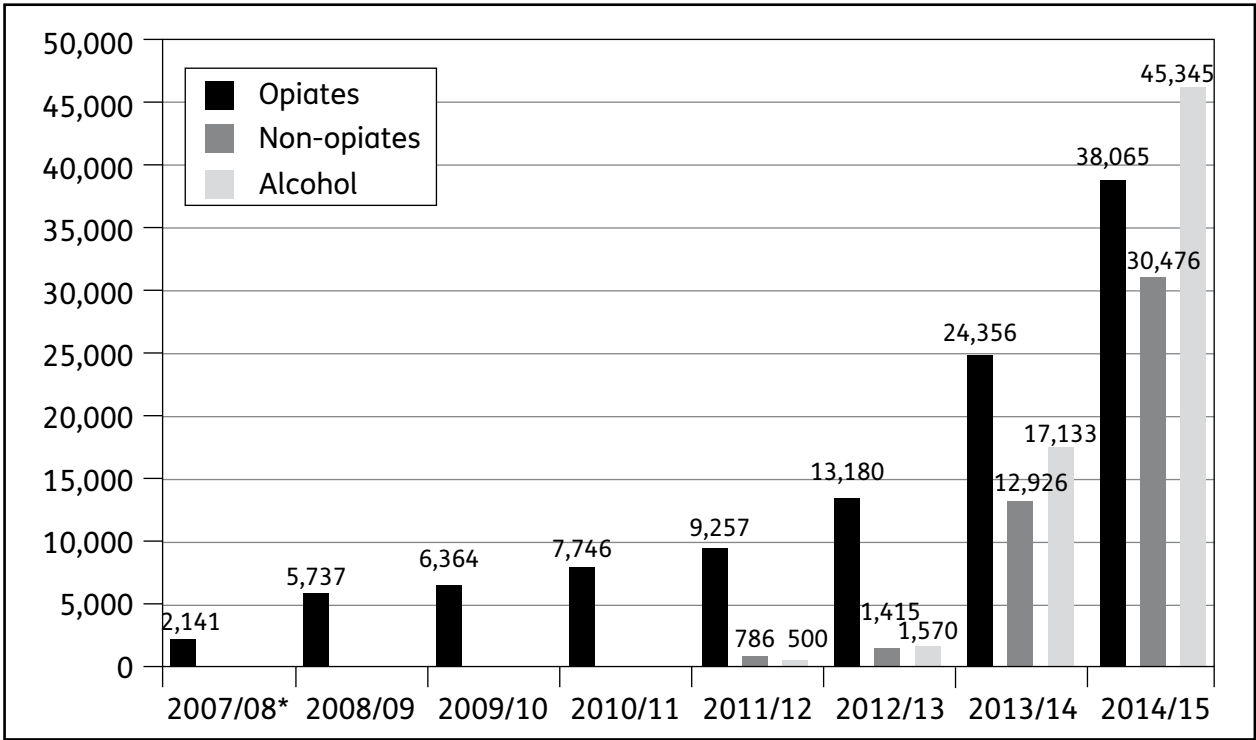
25. Only adults of working age (18-65 years) who were in contact with the drug and alcohol treatment services during 2014/15, and who also have a baseline TOP completed at the start of their treatment, are included in this analysis.
26. As such, there were 106,846 opiate clients included, representing 70 per cent of the total number of opiate clients in treatment during 2014/15, 45,603 non-opiate clients (86 per cent of non-opiate clients in treatment), and 64,548 of alcohol clients (72 per cent of alcohol only clients in treatment in 2014/15).

**Figure 1** Clients in contact with the treatment system in 2014/15, and those included in analyses



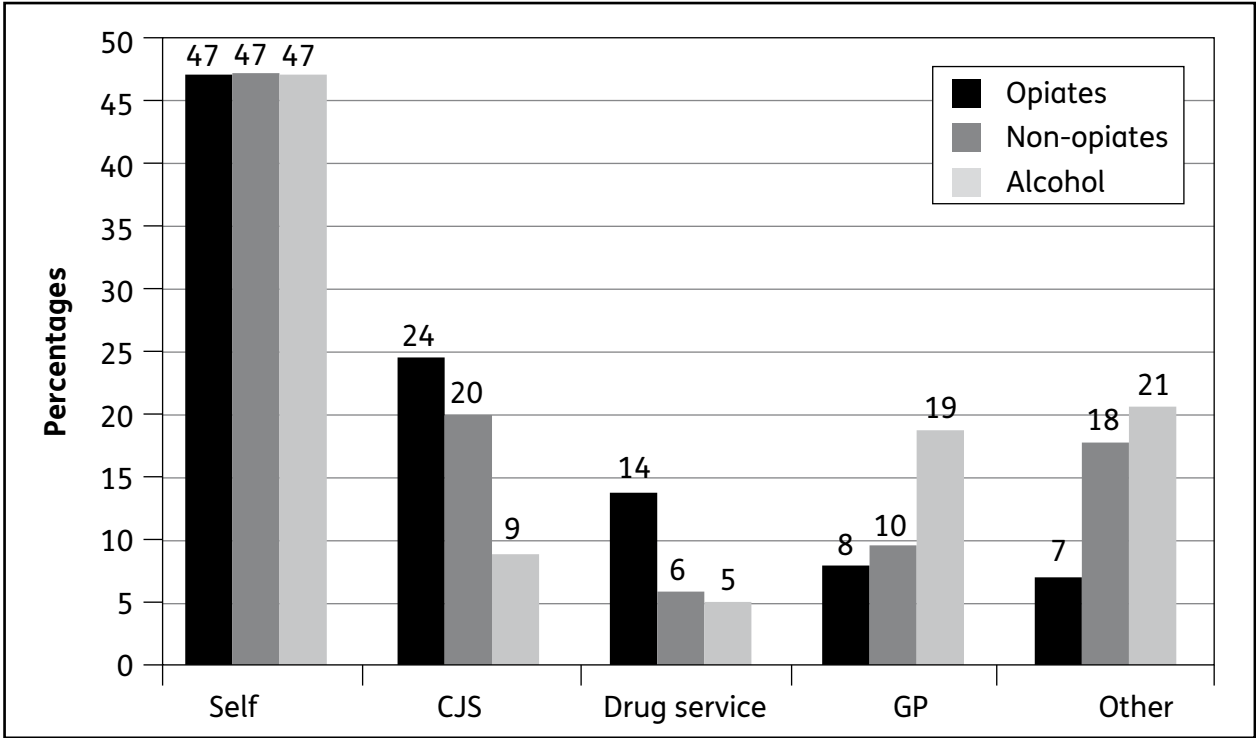
27. For the majority of demographics there is little difference between the proportions or values for those that have a baseline TOP form completed and those that do not. Therefore, it is likely that the rest of the treatment population faces similar challenges in securing employment and share many of the other personal and social characteristics identified within this annex.
28. Opiate clients tend to have more entrenched drug use and other associated problems than non-opiate users and those using alcohol only, requiring a longer period in treatment. In contrast, non-opiate and alcohol clients tend to have more recovery capital i.e. better physical and mental health, housing, peer and family support, and therefore spend less time in treatment.
29. Consequently a larger proportion of opiate clients started their treatment before 2014/15 (64 per cent) compared to non-opiate (33 per cent) and alcohol clients (30 per cent).

Figure 2 Year of treatment commencement, for those in contact during 2014/15



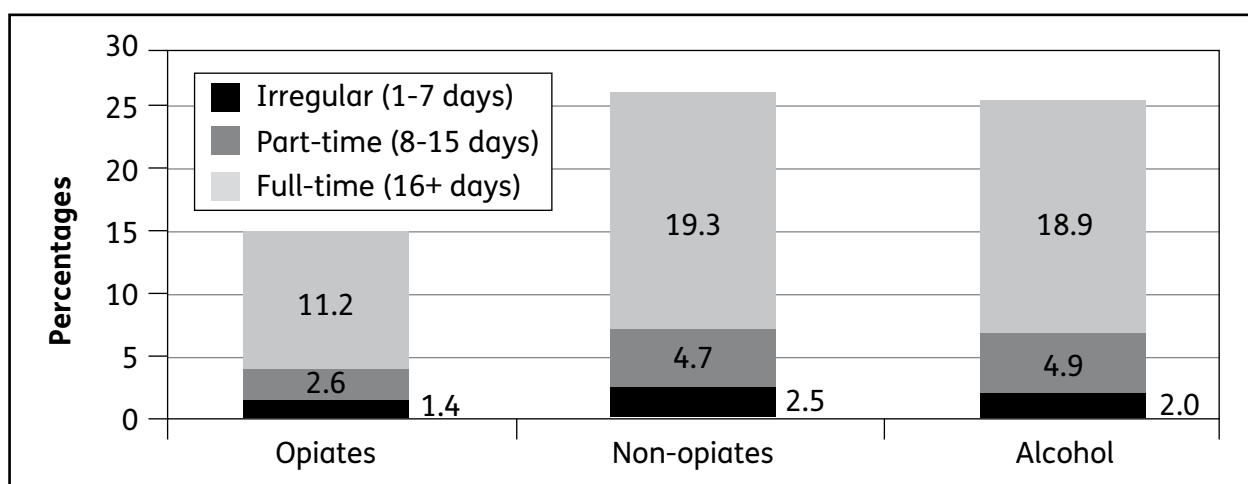
30. The most common referral route into treatment is self-referral, with 47 per cent of all referrals across the three substance groups occurring this way. The next most common route into treatment for opiate clients (24 per cent) and non-opiate clients (20 per cent) is from the Criminal Justice System (CJS), while for alcohol clients it is from GPs (19 per cent) and other sources (21 per cent).

Figure 3 Referral sources into treatment



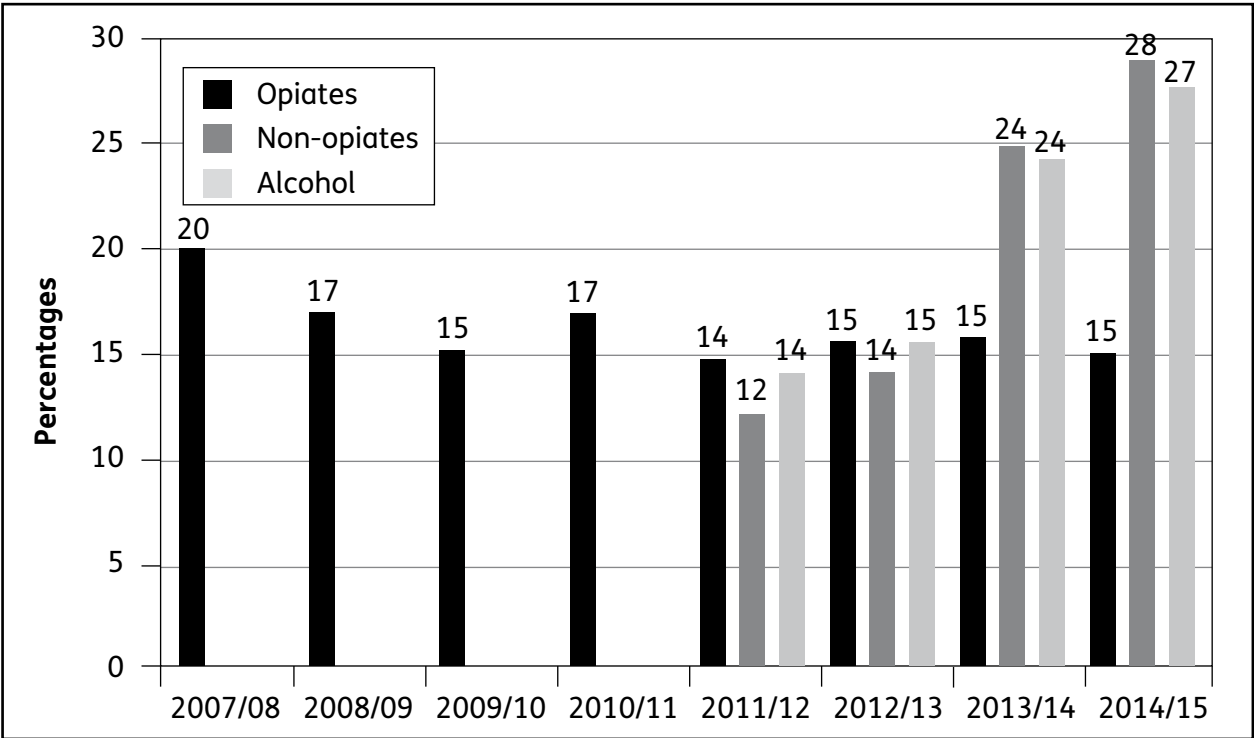
31. The TOP records the number of days paid work in the previous 28 days that an individual has reported. The number of days worked have then been segmented into three categories to give an indication of whether the employment could be categorised as irregular, part time or full time.
32. Figure 4 presents the proportion of clients that have reported paid work in the 28 days before commencing treatment, broken down by the three substance groups and the three work categories.
33. Opiate clients have the lowest proportion reporting any work in the 28-day period prior to starting treatment, at 15.2 per cent. Non-opiate and alcohol clients have similar levels reporting employment, at 26.5 per cent and 25.8 per cent, respectively. Across all drug groups, the majority of employment reported pertains to full-time employment, defined here as working for 16 or more days of the previous 28 days.

**Figure 4 Proportion of individuals reporting paid work at the start of treatment**



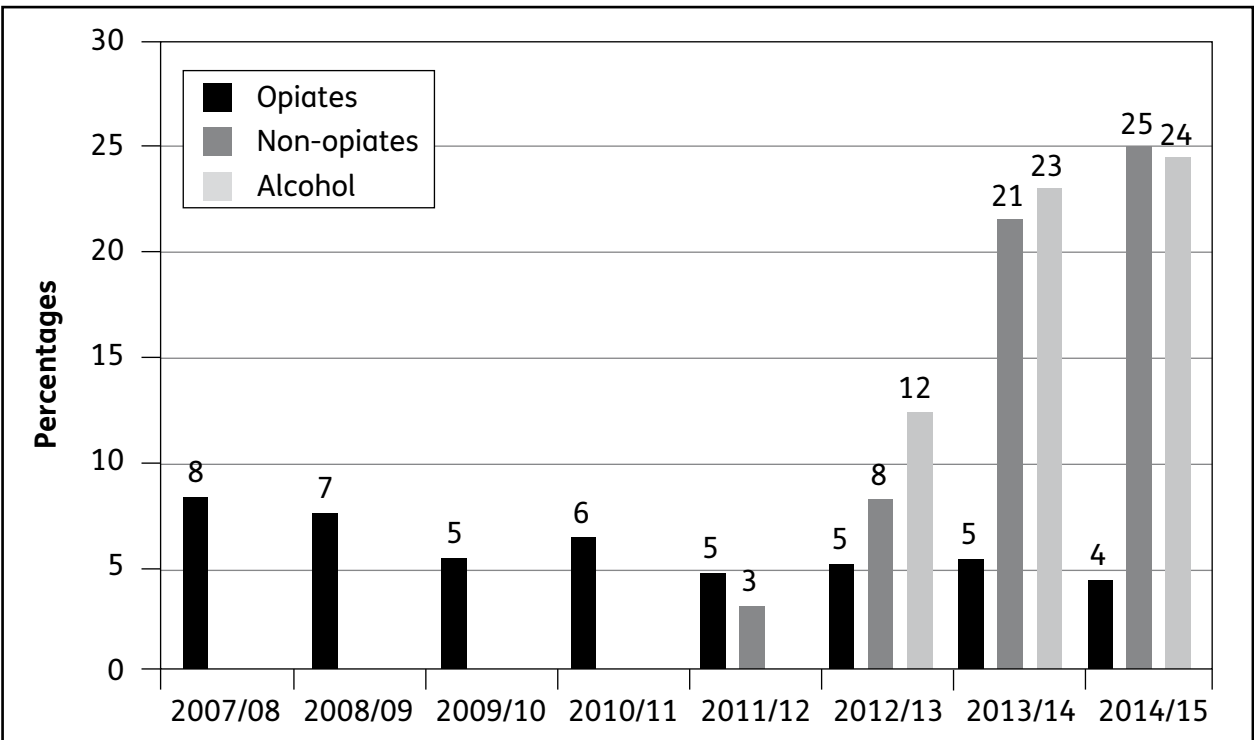
34. Figure 5 below presents how rates of paid work differ depending on the year in which treatment commenced. For opiate clients, the rate has been relatively constant at around 15 per cent for those starting treatment in the last four years, with the rates being slightly higher previous to this.
35. For individuals starting treatment in 2014/15, nearly twice the proportion of non-opiate and alcohol clients were in employment, 28 per cent and 27 per cent respectively, compared to opiates clients (15 per cent). The rate in the general population for working-age people is 74 per cent (<http://www.ons.gov.uk/ons/rel/lms/labour-market-statistics/january-2016/index.html>)
36. For non-opiate and alcohol clients who started treatment prior to 2013/14 the reported employment rate is just below that of opiate clients. As the numbers involved are very low this would likely be a result of these individuals having much more entrenched alcohol and non-opiate problems as well as less personal and social capital, therefore requiring a longer time in treatment.

**Figure 5** Proportion of clients in any employment by financial year of treatment start



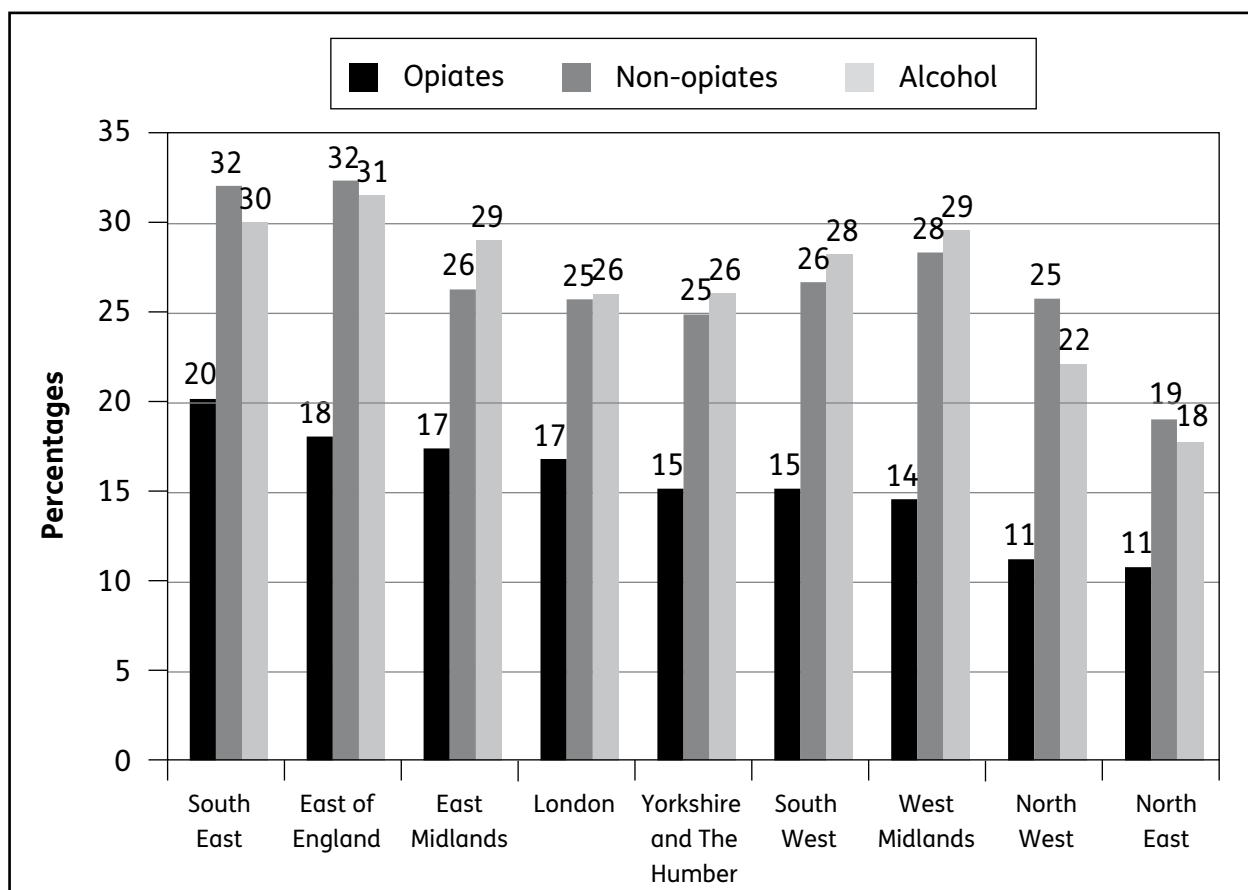
37. For individuals referred through the criminal justice system, employment rates are below those of the general treatment population, with only 4 per cent of opiate CJS clients reporting any paid work at the start of treatment in 2014/15.

**Figure 6** Proportion of CJS clients in any employment by financial year of treatment start



38. Figure 7 below presents the variation in employment rates at the start of treatment between English regions. Employment rates for individuals commencing treatment in the South East (20 per cent) are nearly twice that reported in the North East (11 per cent). However, in all areas the rate of employment of non-opiate and alcohol clients is far greater than that of opiate clients, with the difference in the North West and West Midlands being the most pronounced.

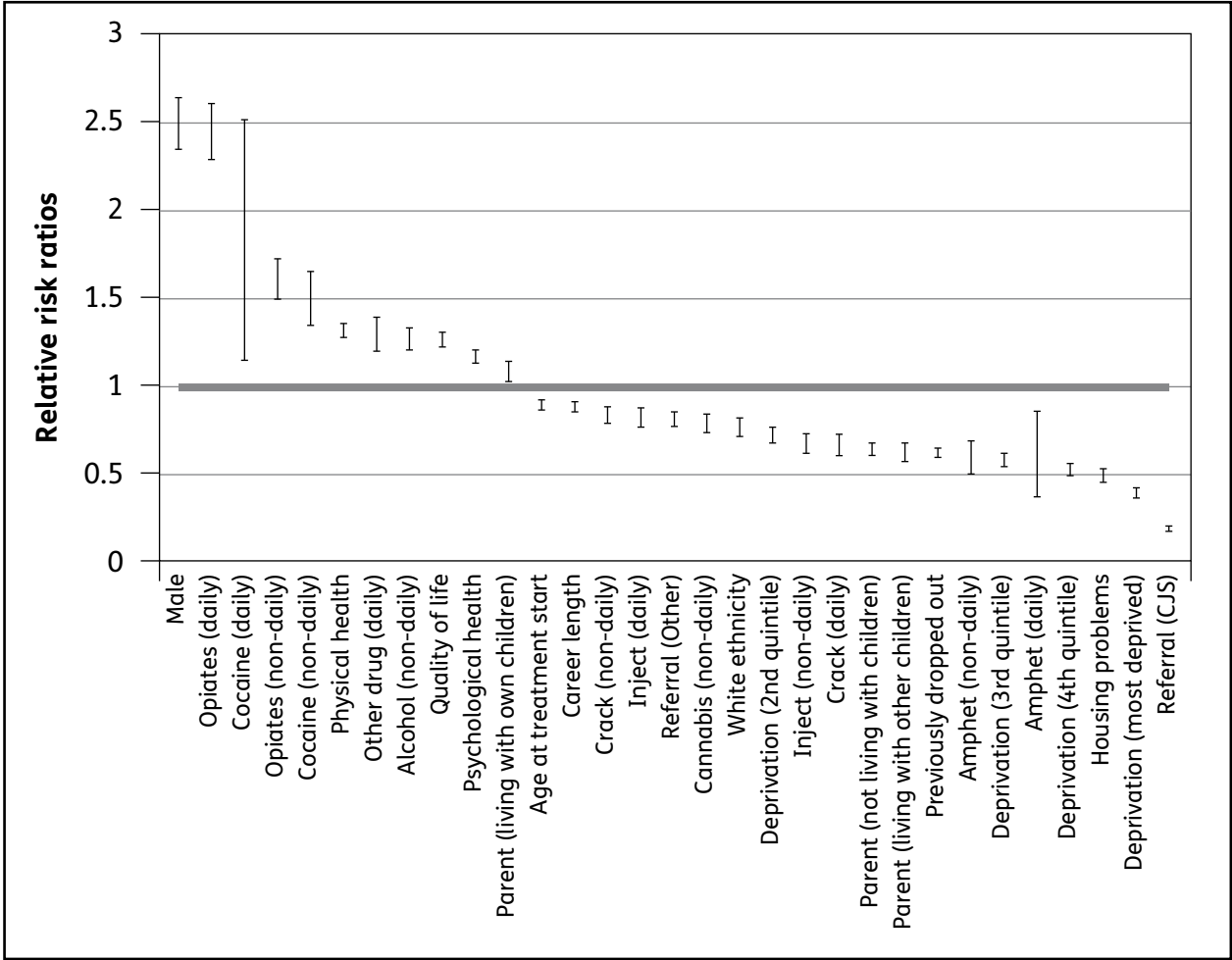
**Figure 7 Regional variations in employment at the start of treatment**



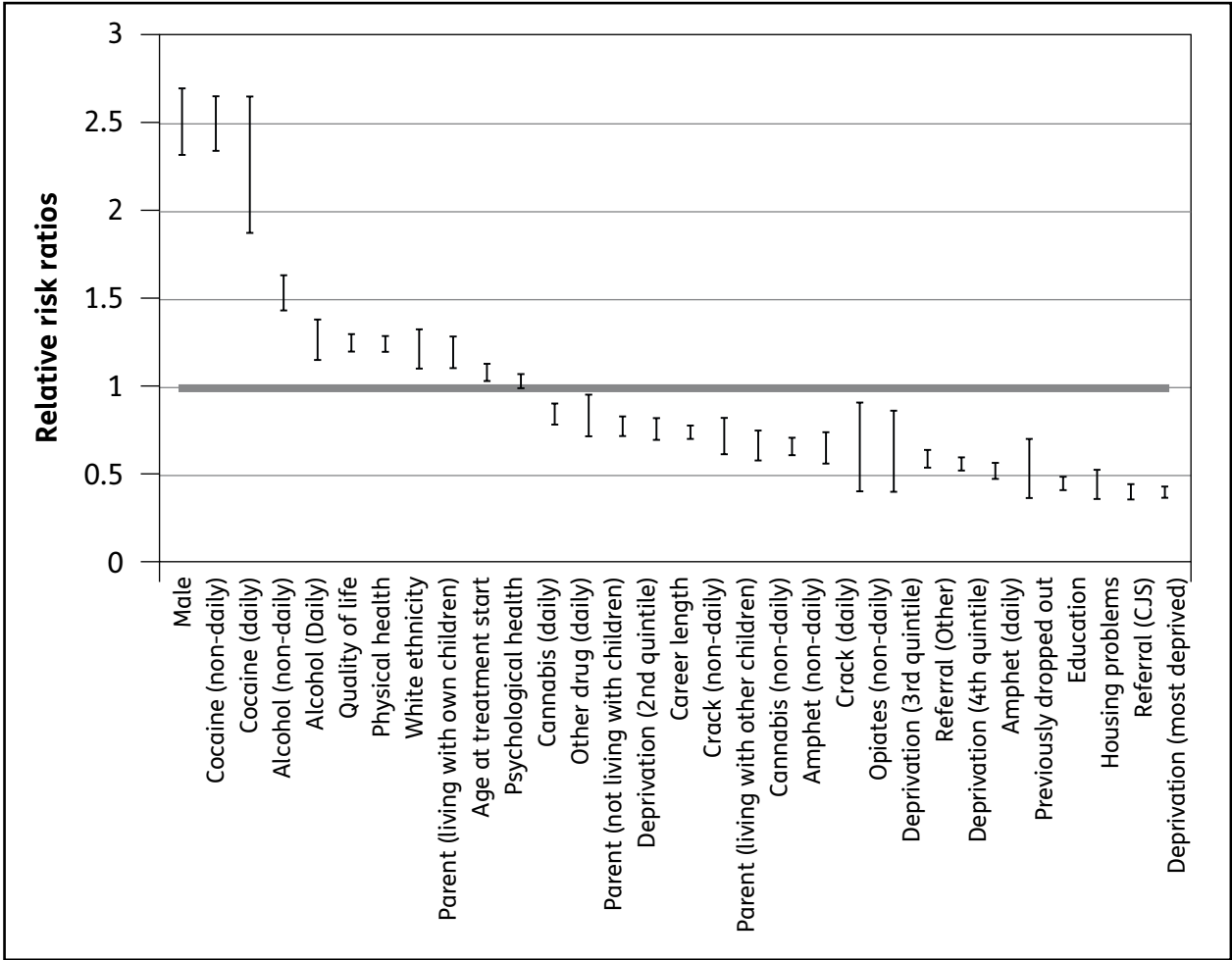
39. Using a series of multinomial logistic regressions it is possible to identify which client characteristics and other factors collected through the NDTMS are most likely to predict an individual being in paid work at the start of treatment. The strength of this association with the identified characteristics can also be demonstrated.
40. In Figures 8-10, characteristics with confidence intervals above the line are statistically associated with more full-time employment, while those below the line are associated statistically with less full-time employment. The further from the line, the greater the association between the characteristic and being in full-time employment at the start of treatment (or not).
41. Characteristics that are consistently positively associated with being in employment are: being male, having higher physical health, psychological health and quality of life ratings, together with being older at the start of treatment and being a parent who is living with their own children.

42. Conversely, being referred to treatment from the Criminal Justice System, living in deprived areas, having housing problems, previously dropping out of treatment, not living with one's own children, being a non-daily cannabis user and being of white ethnicity were statistically associated with not being in full-time employment at the start of treatment.

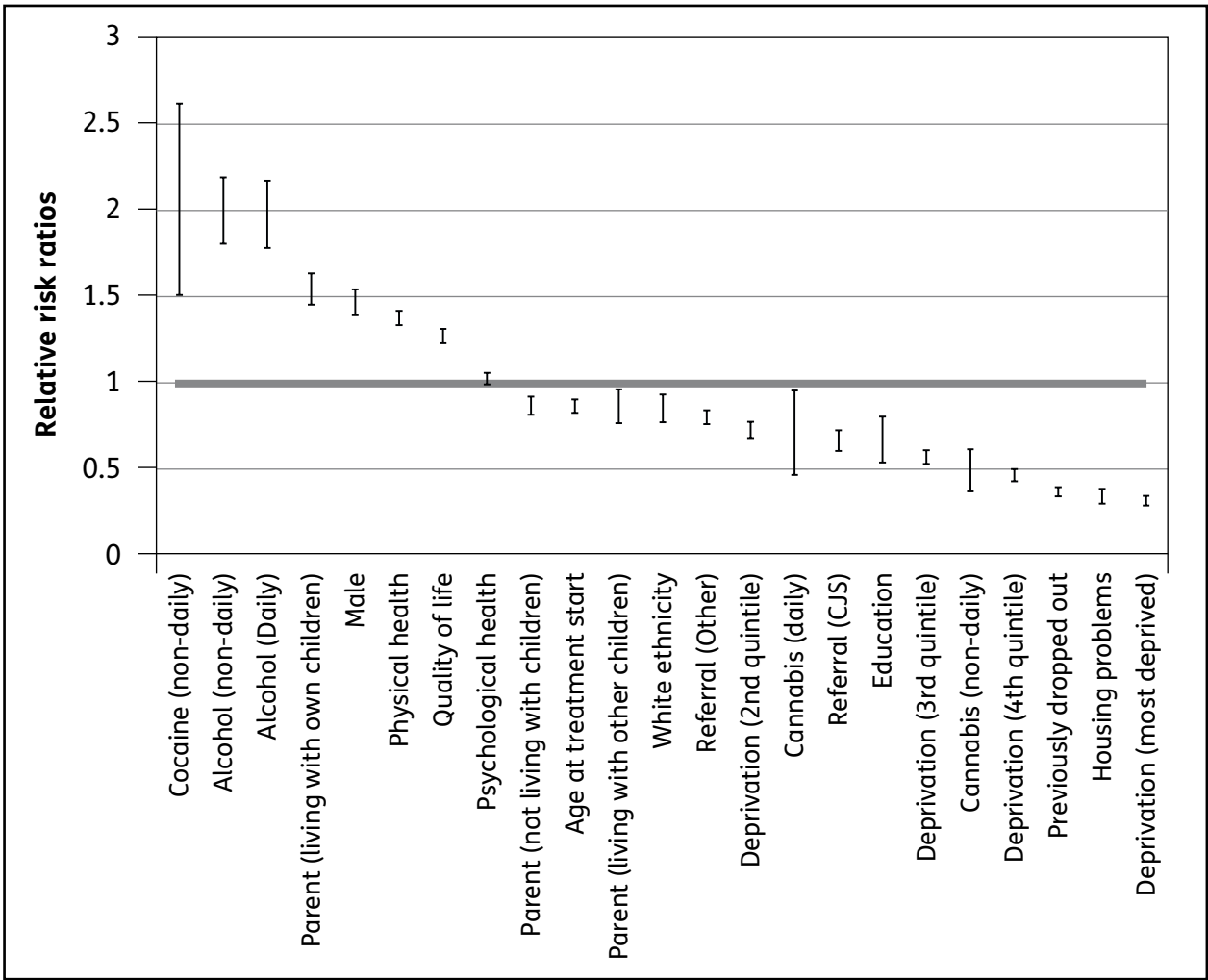
**Figure 8      Associations between covariates measured at the start of treatment and full-time employment in opiate clients**



**Figure 9      Associations between covariates measured at the start of treatment and full-time employment in non-opiate clients**



**Figure 10    Associations between covariates measured at the start of treatment and full-time employment in alcohol clients**



**Employment outcomes**

43. Using information from the TOP it is possible to compare the employment status of individuals from when they started treatment to different time periods during treatment as well as at the end of their treatment.
44. Table 1 below presents, by the three substance groups, the proportion of individuals that self-reported any paid employment at the start of treatment and the proportion of the same cohort that were in paid employment at:
- Six months after treatment start.
  - 12 months after treatment start.
  - When they left treatment in an unplanned way.
  - When they successfully completed treatment.
45. For all three substance groups there is little change in net employment during the first year of treatment, i.e. at six and 12 months, with small gains in net employment for opiate clients and slight reductions in employment for individuals in treatment for alcohol only.

46. Opiate clients who exited treatment in an unplanned way showed a small increase in net employment, while those in treatment for other substances showed a small decrease. The largest gains in levels of net employment were seen in clients that exited treatment successfully, with increases seen across all three substance groups.

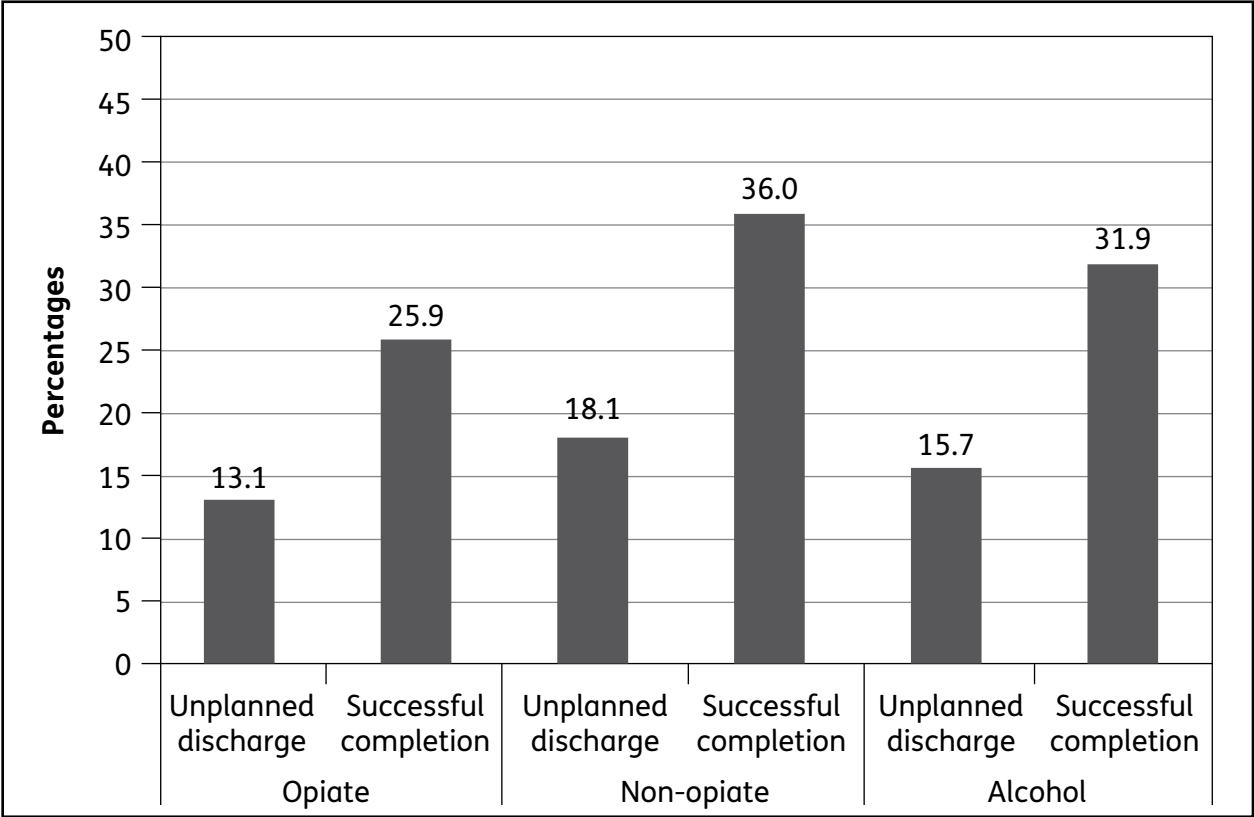
**Table 1      Employment outcomes at six and twelve months, and discharge**

|                                                                          |             | <b>Number of<br/>individuals</b> | <b>Number (%)<br/>working at<br/>treatment start</b> | <b>Number (%)<br/>working post-<br/>treatment start</b> |
|--------------------------------------------------------------------------|-------------|----------------------------------|------------------------------------------------------|---------------------------------------------------------|
| <b>Treatment start to<br/>six months</b>                                 | Opiates     | 78,181                           | 12,122 (15.5%)                                       | 14,798 (18.9%)                                          |
|                                                                          | Non-Opiates | 20,327                           | 4,704 (23.1%)                                        | 4,870 (24%)                                             |
|                                                                          | Alcohol     | 26,626                           | 6,456 (24.2%)                                        | 6,069 (22.8%)                                           |
| <b>Treatment start to<br/>twelve months</b>                              | Opiates     | 61,892                           | 9,622 (15.5%)                                        | 12,500 (20.2%)                                          |
|                                                                          | Non-Opiates | 7,631                            | 1,354 (17.7%)                                        | 1,434 (18.8%)                                           |
|                                                                          | Alcohol     | 9,592                            | 1,893 (19.7%)                                        | 1,750 (18.2%)                                           |
| <b>Treatment start<br/>to unplanned<br/>discharge</b>                    | Opiates     | 3,430                            | 384 (11.2%)                                          | 453 (13.2%)                                             |
|                                                                          | Non-Opiates | 1,756                            | 341 (19.4%)                                          | 319 (18.2%)                                             |
|                                                                          | Alcohol     | 2,429                            | 461 (19%)                                            | 380 (15.6%)                                             |
| <b>Treatment start<br/>to successful<br/>completion of<br/>treatment</b> | Opiates     | 8,260                            | 1,704 (20.6%)                                        | 2,142 (25.9%)                                           |
|                                                                          | Non-Opiates | 17,133                           | 5,381 (31.4%)                                        | 6,184 (36.1%)                                           |
|                                                                          | Alcohol     | 22,503                           | 6,705 (29.8%)                                        | 7,214 (32.1%)                                           |

Reported net change in employment will include some people that start work and some that stop.

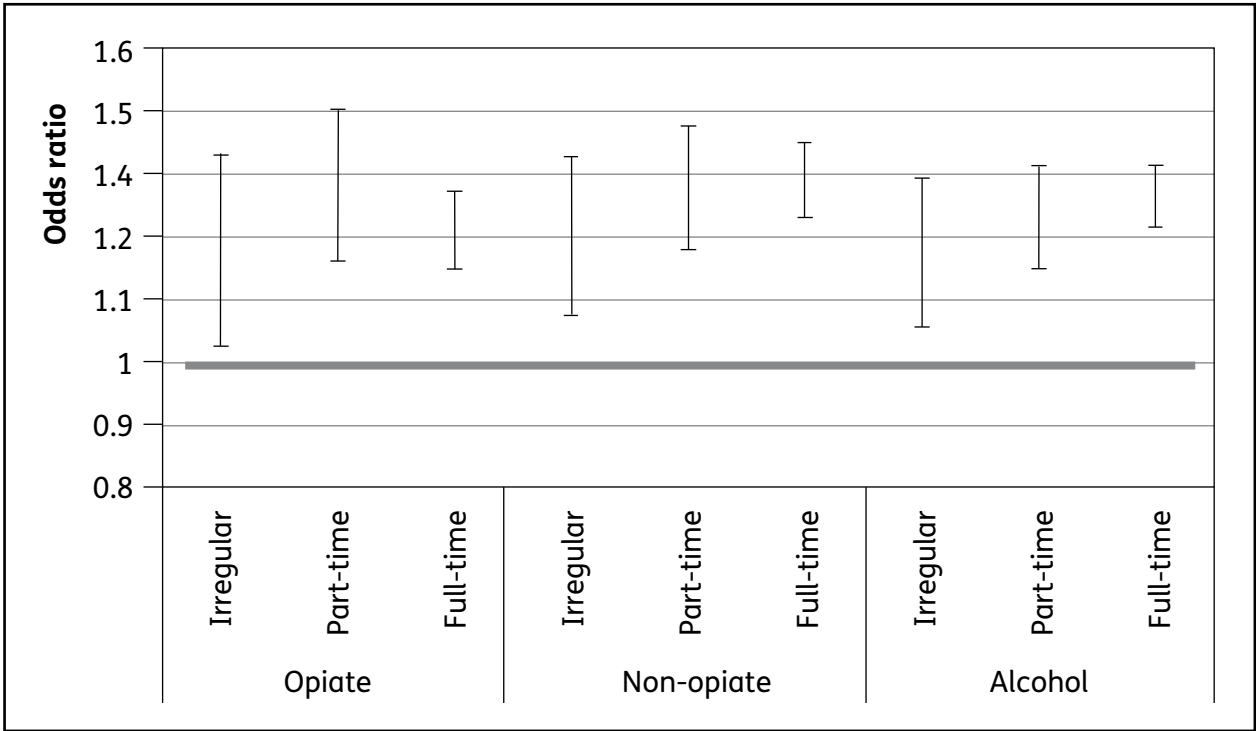
47. Figure 11 presents the proportion of individuals reporting any paid work who exited the treatment system in an unplanned way compared to those that exited successfully free of dependency. For all three substance groups the rate of employment for those leaving successfully were over twice those leaving in a unplanned way, with the largest proportional difference for individuals that were in treatment for problematic drinking only.

**Figure 11** Proportion of individuals employed by discharge status



- 48. The chart and table below present the increased likelihood of completing treatment for individuals reporting irregular, part-time and full-time work compared to those reporting no work at treatment start, controlling for all other baseline covariates.
- 49. Being in any paid work at treatment start increases the likelihood of an individual then going on to successfully complete treatment. Very similar odds ratios are seen for all three substance groups.

**Figure 12      Associations between employment at treatment start and successfully completing treatment**



**Table 2      Associations between employment at treatment start and successfully completing treatment**

|              |           | Number in model | Number with covariate | Adjusted odds ratio | Lower CI (95%) | Upper CI (95%) |
|--------------|-----------|-----------------|-----------------------|---------------------|----------------|----------------|
| Opiate       | Irregular | 98,828          | 1,396                 | 1.21                | 1.03           | 1.42           |
|              | Part-time |                 | 2,525                 | 1.35                | 1.20           | 1.51           |
|              | Full-time |                 | 10,979                | 1.26                | 1.19           | 1.35           |
| Non-opiate   | Irregular | 40,790          | 1,010                 | 1.24                | 1.09           | 1.41           |
|              | Part-time |                 | 1,892                 | 1.38                | 1.26           | 1.52           |
|              | Full-time |                 | 7,765                 | 1.36                | 1.29           | 1.44           |
| Alcohol only | Irregular | 54,558          | 1,075                 | 1.21                | 1.07           | 1.37           |
|              | Part-time |                 | 2,657                 | 1.29                | 1.19           | 1.40           |
|              | Full-time |                 | 10,164                | 1.33                | 1.27           | 1.40           |

### Employment over time and factors associated with individuals maintaining or gaining employment

50. Again using a logistical regression analysis, it is possible to identify the characteristics associated with individuals at the start of treatment, which predict whether a person will be in employment when they exit the treatment system and the weight of this association.
51. Table 3 presents the factors at the start of treatment that are significant in suggesting an individual will be in employment at the end of treatment. By far the biggest predictor is being in any paid work at the start of treatment. This is consistent across all three substance groups, as is being male and in good physical or psychological health.
52. Conversely, deprivation is a consistent factor negatively linked with an individual achieving employment at the end of treatment for all three substance groups, as is an individual having had multiple previous attempts at treatment. Housing issues were particularly significant in predicting that opiate clients would not be in employment.

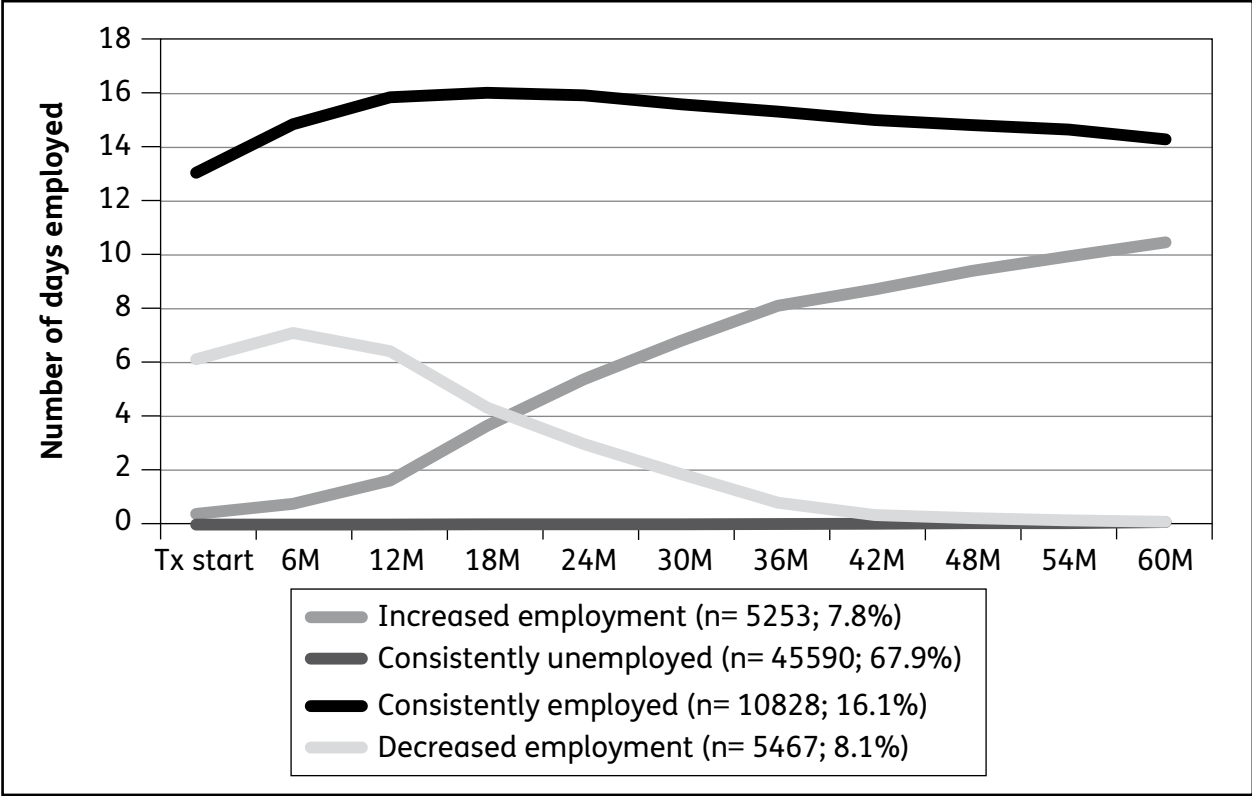
**Table 3 Associations between baseline covariates and full-time employment at treatment discharge**

| Opiates (n=10,883)             |                              | Non-opiates (n=17,193)              |                              | Alcohol only (n=21,847)           |                              |
|--------------------------------|------------------------------|-------------------------------------|------------------------------|-----------------------------------|------------------------------|
| Variable                       | Adjusted odds ratio (95% CI) | Variable                            | Adjusted odds ratio (95% CI) | Variable                          | Adjusted odds ratio (95% CI) |
| Deprivation (most deprived)    | 0.52 (0.43,0.63)             | Opiates (daily)                     | 0.21 (0.05,0.83)             | Deprivation (most deprived)       | 0.55 (0.48,0.64)             |
| Deprivation (4th quintile)     | 0.62 (0.52,0.74)             | Deprivation (most deprived)         | 0.64 (0.56,0.73)             | Cannabis (non-daily)              | 0.67 (0.44,0.99)             |
| Housing problems               | 0.66 (0.55,0.80)             | Deprivation (4th quintile)          | 0.70 (0.61,0.80)             | Deprivation (4th quintile)        | 0.69 (0.61,0.78)             |
| Crack (daily)                  | 0.74 (0.56,0.96)             | Deprivation (3rd quintile)          | 0.75 (0.66,0.86)             | Previously dropped out            | 0.70 (0.62,0.78)             |
| Inject (non-daily)             | 0.74 (0.58,0.93)             | Amphetamine (non-daily)             | 0.78 (0.63,0.95)             | Deprivation (3rd quintile)        | 0.82 (0.73,0.92)             |
| Deprivation (3rd quintile)     | 0.76 (0.64,0.91)             | Parent (living with other children) | 0.79 (0.65,0.95)             | Age at treatment start            | 0.83 (0.77,0.89)             |
| Previously dropped out         | 0.78 (0.68,0.88)             | Previously dropped out              | 0.79 (0.69,0.89)             | Deprivation (2nd quintile)        | 0.86 (0.78,0.96)             |
| Deprivation (2nd quintile)     | 0.79 (0.66,0.94)             | Referral (other)                    | 0.80 (0.72,0.89)             | Referral (other)                  | 0.88 (0.81,0.96)             |
| Inject (daily)                 | 0.80 (0.64,0.99)             | Referral (CJS)                      | 0.85 (0.76,0.95)             | Parent (not living with children) | 1.11 (1.01,1.23)             |
| Black and Minority Ethnicities | 0.81 (0.68,0.96)             | Cannabis (non-daily)                | 0.85 (0.76,0.96)             | Physical health                   | 1.16 (1.10,1.21)             |
| Referral (other)               | 0.82 (0.71,0.94)             | Alcohol (daily)                     | 0.86 (0.75,1.00)             | Parent (living with own children) | 1.24 (1.13,1.37)             |

| <b>Opiates (n=10,883)</b>         |                                     | <b>Non-opiates (n=17,193)</b> |                                     | <b>Alcohol only (n=21,847)</b> |                                     |
|-----------------------------------|-------------------------------------|-------------------------------|-------------------------------------|--------------------------------|-------------------------------------|
| <b>Variable</b>                   | <b>Adjusted odds ratio (95% CI)</b> | <b>Variable</b>               | <b>Adjusted odds ratio (95% CI)</b> | <b>Variable</b>                | <b>Adjusted odds ratio (95% CI)</b> |
| Age at treatment start            | 0.83 (0.76,0.91)                    | Age of first use              | 0.87 (0.80,0.94)                    | Male                           | 1.50 (1.38,1.64)                    |
| Age of first use                  | 0.89 (0.81,0.98)                    | Deprivation (2nd quintile)    | 0.88 (0.78,1.00)                    | Work (irregular)               | 5.36 (4.39,6.55)                    |
| Parent (living with own children) | 1.18 (1.01,1.38)                    | Psychological health          | 1.06 (1.00,1.13)                    | Work (part-time)               | 5.82 (5.09,6.65)                    |
| Psychological health              | 1.18 (1.09,1.29)                    | Physical health               | 1.13 (1.07,1.20)                    | Work (full-time)               | 20.37 (18.65,22.24)                 |
| Opiates (daily)                   | 1.19 (1.02,1.40)                    | Cocaine (non-daily)           | 1.47 (1.34,1.63)                    |                                |                                     |
| Cocaine (non-daily)               | 1.30 (1.01,1.69)                    | Cocaine (daily)               | 1.58 (1.20,2.07)                    |                                |                                     |
| Male                              | 2.05 (1.76,2.40)                    | Male                          | 2.11 (1.88,2.37)                    |                                |                                     |
| Work (part-time)                  | 3.25 (2.53,4.17)                    | Work (irregular)              | 3.19 (2.58,3.93)                    |                                |                                     |
| Cocaine (daily)                   | 3.27 (1.29,8.30)                    | Work (part-time)              | 4.15 (3.57,4.84)                    |                                |                                     |
| Work (irregular)                  | 3.99 (2.86,5.56)                    | Work (full-time)              | 15.77 (14.31,17.38)                 |                                |                                     |
| Work (full-time)                  | 10.38 (9.04,11.92)                  |                               |                                     |                                |                                     |

53. An assessment of the employment patterns over time for opiate clients in treatment was conducted using latent class growth analysis (LCGA). LCGA is a person-centred approach, which seeks to group individuals in terms of the similarity of their responses over time. An introduction to this approach can be found here: <https://www.statmodel.com/download/JungWickramaLCGALGMM.pdf>). The iterative process attempts to fit the best model to the available data and to identify populations with distinct characteristics. In the case of opiate clients who were continuously engaged in treatment over a five-year period, four cohorts of individuals and their employment trajectories were identified.
54. These four cohorts can be seen in Figure 12. By far the largest group (68 per cent) are individuals that had reported no paid work during the five-year analysis, with a much smaller proportion (16 per cent) consistently employed during this time, and smaller proportions still increasing and decreasing their levels of employment (both 8 per cent).

**Figure 13** Five-year latent class growth analysis of employment in opiate users that had been in treatment for five years plus or who were in treatment on the 31st March 2015



55. Tables 4-6 report the factors that are associated with an increased likelihood of individuals gaining employment (as reported on the TOP) during treatment compared to those with a reduced likelihood.
56. The approach identifies individuals who are not working and who go on to get a job at the point of discharge, it then fits a probability of gaining employment to each individual. The characteristics of those who had less than a 20 per cent chance of gaining employment are contrasted with those with greater than a 20 per cent chance of gaining employment<sup>189</sup>.
57. Across all three substance groups being male, younger, in better physical or psychological health, having used alcohol or drugs for shorter periods of time and living in less deprived areas are positively associated with an individual gaining employment.

<sup>189</sup> For example, based on Table 4, of opiate clients with <20 per cent chance of employment, 67 per cent are male. Similarly, of those with >=20 per cent chance of employment, 96 per cent are male.

**Table 4 Associations between an increased likelihood of opiate clients gaining employment during treatment**

| Opiate clients                    | <20% chance of employment | >=20% chance of employment |
|-----------------------------------|---------------------------|----------------------------|
| Male                              | 67%                       | 96%                        |
| Age at treatment start            | 38.4                      | 32.9                       |
| White ethnicity                   | 90%                       | 79%                        |
| Previously dropped out            | 47%                       | 30%                        |
| Referral (self)                   | 43%                       | 58%                        |
| Referral (CJS)                    | 25%                       | 24%                        |
| Referral (other)                  | 32%                       | 19%                        |
| Housing problems                  | 24%                       | 6%                         |
| Parent (living with own children) | 14%                       | 34%                        |
| Deprivation (least deprived)      | 14%                       | 34%                        |
| Deprivation (2nd quintile)        | 18%                       | 25%                        |
| Deprivation (3rd quintile)        | 20%                       | 22%                        |
| Deprivation (4th quintile)        | 22%                       | 12%                        |
| Deprivation (most deprived)       | 26%                       | 7%                         |
| Career length (start)             | 15.5                      | 10.4                       |
| Career length (discharge)         | 17.1                      | 12                         |
| Opiates (daily)                   | 37%                       | 52%                        |
| Cocaine (non-daily)               | 4%                        | 8%                         |
| Cocaine (daily)                   | 0%                        | 1%                         |
| Amphetamine (non-daily)           | 4%                        | 0%                         |
| Psychological health              | 9.5                       | 12.8                       |
| Physical health                   | 10.5                      | 13.8                       |

**Table 5 Associations between an increased likelihood of non-opiate clients gaining employment during treatment**

| <b>Non-opiate clients</b>           | <b>&lt;20% chance of employment</b> | <b>&gt;=20% chance of employment</b> |
|-------------------------------------|-------------------------------------|--------------------------------------|
| Male                                | 61%                                 | 95%                                  |
| Age at treatment start              | 36.3                                | 27.8                                 |
| Previously dropped out              | 25%                                 | 10%                                  |
| Referral (self)                     | 42%                                 | 48%                                  |
| Referral (CJS)                      | 17%                                 | 33%                                  |
| Referral (other)                    | 41%                                 | 19%                                  |
| Parent (living with other children) | 9%                                  | 4%                                   |
| Deprivation (least deprived)        | 13%                                 | 28%                                  |
| Deprivation (2nd quintile)          | 17%                                 | 24%                                  |
| Deprivation (3rd quintile)          | 21%                                 | 19%                                  |
| Deprivation (4th quintile)          | 23%                                 | 15%                                  |
| Deprivation (most deprived)         | 25%                                 | 13%                                  |
| Career length (start)               | 18.2                                | 9.9                                  |
| Career length (discharge)           | 18.8                                | 10.4                                 |
| Cocaine (non-daily)                 | 10%                                 | 44%                                  |
| Cocaine (daily)                     | 1%                                  | 3%                                   |
| Alcohol (non-daily)                 | 35%                                 | 60%                                  |
| Physical health                     | 10.5                                | 13.6                                 |

**Table 6 Associations between an increased likelihood of alcohol only clients gaining employment during treatment**

| <b>Alcohol clients</b>            | <b>&lt;20% chance of employment</b> | <b>&gt;=20% chance of employment</b> |
|-----------------------------------|-------------------------------------|--------------------------------------|
| Male                              | 55%                                 | 89%                                  |
| Age at treatment start            | 45.9                                | 34.9                                 |
| Previously dropped out            | 28%                                 | 19%                                  |
| Referral (self)                   | 42%                                 | 59%                                  |
| Referral (CJS)                    | 9%                                  | 20%                                  |
| Referral (other)                  | 48%                                 | 21%                                  |
| Parent (living with own children) | 20%                                 | 17%                                  |
| Deprivation (least deprived)      | 15%                                 | 45%                                  |
| Deprivation (2nd quintile)        | 22%                                 | 24%                                  |
| Deprivation (3rd quintile)        | 22%                                 | 18%                                  |
| Deprivation (4th quintile)        | 22%                                 | 8%                                   |
| Deprivation (most deprived)       | 19%                                 | 5%                                   |
| Career length (start)             | 28.6                                | 15.1                                 |
| Career length (discharge)         | 29.2                                | 16                                   |
| Cannabis (non-daily)              | 2%                                  | 4%                                   |
| Physical health                   | 10.3                                | 11.8                                 |

58. Table 7 presents the associations for those leaving treatment in 2014/15 between the length of time on benefits and the likelihood of an individual gaining employment by the time of leaving treatment
59. It uses the anonymous data match between the NDTMS and the Labour Market System to consider how their length of time on benefits (up until March 2012) impacts on their chances of having gained employment by the point they exit the treatment system. Each substance group has been equally divided into quintiles, with the length of time on benefits and the proportion starting work reported for each.
60. As length of time on benefits increases, the proportion starting work tends to decrease. This is consistent across all three substance groups. For opiate clients for each year on benefits the likelihood of gaining employment falls by 10 per cent, for alcohol clients it is 23 per cent.

**Table 7 Associations between time on benefits and likelihood of gaining employment**

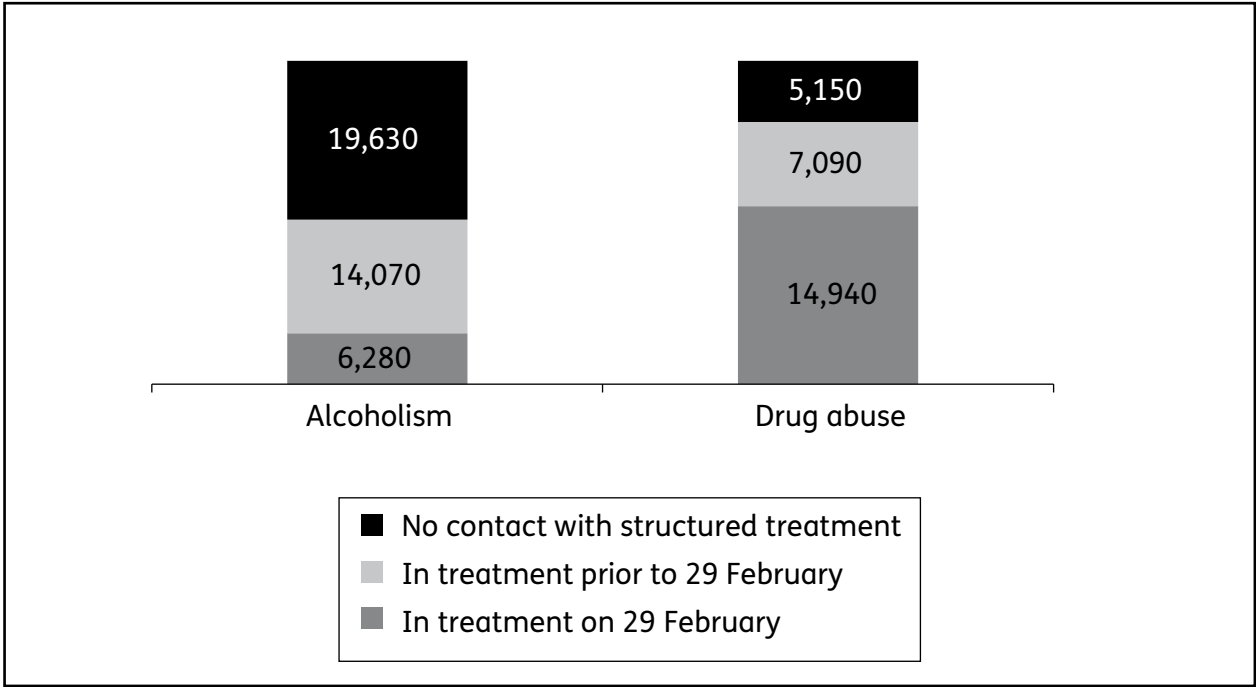
|                   | <b>Benefit quintile</b> | <b>Benefit length (years)</b> | <b>Proportion starting work</b> |
|-------------------|-------------------------|-------------------------------|---------------------------------|
| <b>Opiates</b>    | 1 (n=342)               | 0.3                           | 11%                             |
|                   | 2 (n=342)               | 1.1                           | 11%                             |
|                   | 3 (n=341)               | 2.9                           | 10%                             |
|                   | 4 (n=342)               | 6.0                           | 7%                              |
|                   | 5 (n=341)               | 13.3                          | 3%                              |
| <b>Non-opiate</b> | 1 (n=86)                | 0.2                           | 12%                             |
|                   | 2 (n=86)                | 1.0                           | 10%                             |
|                   | 3 (n=86)                | 2.6                           | 8%                              |
|                   | 4 (n=86)                | 6.3                           | 8%                              |
|                   | 5 (n=85)                | 14.2                          | 8%                              |
| <b>Alcohol</b>    | 1 (n=154)               | 0.2                           | 10%                             |
|                   | 2 (n=153)               | 1.0                           | 6%                              |
|                   | 3 (n=150)               | 2.7                           | 3%                              |
|                   | 4 (n=152)               | 7.0                           | 3%                              |
|                   | 5 (n=152)               | 15.0                          | 0%                              |

### **Analysis using claimant's Main Disabling Condition**

61. Claims for Employment and Support Allowance (ESA) or Incapacity Benefit (IB) have a main disabling condition (MDC) recorded which may be drug or alcohol misuse. This medical condition is recorded on the claim form and does not itself confer entitlement to ESA/IB/ Severe Disablement Allowance (SDA). So, for example, a decision on entitlement for a customer claiming on the basis of drug misuse would be based on their ability to carry out the range of activities related to physical and mental function, assessed by the Personal/Work Capability Assessment. The main disabling condition is based on evidence provided at the start of the claim and may not represent a claimant's most recent medical condition.

62.    Therefore people may be recorded as having a main disabling condition of drug abuse or alcohol addiction, but other health issues may be as or more important. Similarly there will be some people with main disabling conditions other than drug abuse or alcohol addiction who also have addiction issues
63.    Using the DWP/Public Health England data share it was possible to limit to the cases where the main disabling condition is alcohol or drug misuse. The analysis looked at those in receipt of ESA/IB/SDA on the 29th February 2012 for comparability with DWP National Statistics. Those in treatment on this date were categorised as ‘in treatment’, whilst those not in treatment on that date but were prior to this date were categorised as ‘previously in treatment’.
64.    Robust data is available from NDTMS dating back to 1 April 2005 and therefore this cut-off point was used in this analysis. Figure 14 shows the treatment status of the number of individuals with an MDC of alcoholism and drug abuse. As stated earlier this may be an underestimation of the number of individuals in treatment or previously in treatment as this relies on the successful matching of individuals in the DWP dataset with those on the NDTMS.

**Figure 14    Number of individuals in England claiming ESA/IB/SDA with a main disabling condition of drug abuse and alcoholism and their treatment status, 29 February 2012**



65.    Table 8 shows the other groups of main disabling conditions that are reported by those in treatment and previously in treatment and how these compare with the overall ESA/IB/SDA population that have a main disabling condition recorded. Clients in contact with the treatment system either on or before the 29 February 2012, which is the latest data available at the time of analysis, share broadly the same distribution of main disabling conditions as those in treatment previously. In comparison with all claimants of ESA/IB/SDA, however, clients in the drug or alcohol treatment system have a much greater propensity towards mental and behavioural health disorders (72-76 per cent versus 43 per cent) and are less likely to claim for diseases of the musculoskeletal system and connective tissue (4-5 per cent versus 16 per cent).

**Table 8 Main disabling condition of individuals in drug or alcohol treatment and the overall ESA/IB/SDA population in England, February 2012**

|                                                                     | In treatment on 29 February | In treatment prior to the 29 February | All ESA/IB/SDA claimants <sup>190</sup> |
|---------------------------------------------------------------------|-----------------------------|---------------------------------------|-----------------------------------------|
| Mental and behavioural disorders                                    | 48,670 (76%)                | 72,990 (72%)                          | 920,160 (43%)                           |
| Diseases of the nervous system                                      | 1,120 (2%)                  | 2,280 (2%)                            | 137,370 (6%)                            |
| Diseases of the circulatory or respiratory system                   | 1,920 (3%)                  | 2,870 (3%)                            | 131,530 (6%)                            |
| Diseases of the musculoskeletal system and connective tissue        | 2,730 (4%)                  | 5,520 (5%)                            | 337,650 (16%)                           |
| Injury, poisoning and certain other consequences of external causes | 2,240 (3%)                  | 4,620 (5%)                            | 120,020 (6%)                            |
| Other                                                               | 7,540 (12%)                 | 12,470 (12%)                          | 477,540 (22%)                           |
| Total <sup>191</sup>                                                | 64,210                      | 100,750                               | 2,124,280                               |

66. Table 9 provides a further breakdown of mental and behavioural disorders. This shows that as with the overall ESA/IB/SDA claimant population the most common mental and behavioural disorder is 'a depressive episode', as would be expected, those in treatment are much more likely to also report 'drug abuse' and 'alcoholism' than the overall group – 23 per cent of ESA claimants in treatment on 29 February 2012 had a main disabling condition of drug abuse (14,940 out of 64,210) and 10 per cent (6,280 out of 64,210) had a main disabling condition of alcoholism.

**Table 9 A breakdown of the 'Mental and behavioural disorders' for individuals claiming ESA/SDA/IB in drug or alcohol treatment in England, February 2012**

|                                         | In treatment on 29 February | In treatment prior to the 29 February | Overall ESA/IB/SDA population |
|-----------------------------------------|-----------------------------|---------------------------------------|-------------------------------|
| Depressive Episode                      | 17,040 (35%)                | 30,560 (42%)                          | 421,690 (46%)                 |
| Drug abuse                              | 14,940 (31%)                | 7,090 (10%)                           | 32,640 (4%)                   |
| Alcoholism                              | 6,280 (13%)                 | 14,070 (19%)                          | 43,860 (5%)                   |
| Other anxiety disorders                 | 4,010 (8%)                  | 7,400 (10%)                           | 106,630 (12%)                 |
| Mental disorder not otherwise specified | 1,540 (3%)                  | 3,400 (5%)                            | 51,680 (6%)                   |
| Other neurotic disorders                | 1,300 (3%)                  | 1,970 (3%)                            | 30,950 (3%)                   |
| Schizophrenia                           | 1,000 (2%)                  | 2,360 (3%)                            | 46,210 (5%)                   |
| Reaction to severe stress               | 990 (2%)                    | 2,170 (3%)                            | 39,210 (4%)                   |
| Other mental and behavioural disorder*  | 1,580 (3%)                  | 3,960 (5%)                            | 147,290 (16%)                 |
| Total <sup>192</sup>                    | 48,670 (100%)               | 72,990 (100%)                         | 920,160 (100%)                |

<sup>190</sup> These figures may differ slightly from those on TabTool due to rounding.

<sup>191</sup> Note that totals may not sum due to rounding.

<sup>192</sup> Note that totals may not sum due to rounding.

**104** Annex D: Analysis of employment status and outcomes of individuals in contact with the substance-misuse treatment system

Notes

\*These include: unspecified nonorganic psychosis, specific personality disorders, phobic anxiety disorders, specific development disorders of scholastic skills, persistent delusional disorder, unspecified mood disorder, eating disorder, recurrent depressive disorder, unspecified mental retardation, pervasive development disorders, persistent mood disorder, mental and behavioural disorders associated with the puerperium, not elsewhere classified, manic Episode, dissociative disorders, unspecified dementia, somatoform disorders, psychological and behavioural factors associated with disorders or diseases elsewhere classified

# Annex E

## Analysis of benefit data

### Introduction

1. This technical annex examines the benefits interactions of the population of individuals who were claiming Employment and Support Allowance (ESA), Incapacity Benefit (IB) or Severe Disablement Allowance (SDA) in February 2015 and had a main disabling condition (MDC) of drug abuse, alcoholism, or obesity. Specifically we have looked at their number of claims and length of time on benefit over the five-year period between March 2010 and February 2015.

### Methodology

2. The Work and Pensions Longitudinal Study (WPLS) data was used to identify the number of claimants who had an MDC of alcoholism, drug abuse, or obesity in February 2015.

**Table 1 Published population statistics of ESA and IB/SDA claimants: February 2015<sup>193</sup>**

| Benefit                    | Caseload  | Main disabling condition <sup>194</sup> |            |         |                                             |
|----------------------------|-----------|-----------------------------------------|------------|---------|---------------------------------------------|
|                            |           | Alcoholism                              | Drug abuse | Obesity | Total (alcoholism, drug abuse, and obesity) |
| <b>ESA</b>                 | 2,323,000 | 55,800                                  | 30,900     | 1,600   | 88,300                                      |
| <b>IB/SDA</b>              | 239,400   | 2,400                                   | 2,000      | 100     | 4,500                                       |
| <b>Total<sup>195</sup></b> | 2,562,400 | 58,200                                  | 32,900     | 1,800   | 92,900                                      |

<sup>193</sup> The DWP data can only identify a small proportion of claimants with drug abuse and alcoholism or obesity because its systems are set up to capture the main health condition associated with being out of work, as a result it is not possible to assess precisely how many people with addictions or obesity are on benefits.

<sup>194</sup> Please note that totals may not sum due to rounding.

<sup>195</sup> Please note that totals may not sum due to rounding.

3. The WPLS data on these claimants was matched with unpublished National Benefits Database (NBD)<sup>196</sup>; more specifically matched with live claims in February 2015 using encrypted National Insurance numbers. Given changes to the benefits system we looked at a five-year period between March 2010 and February 2015 and focused on the following working-age DWP benefits: ESA/IB/SDA<sup>197</sup>, JSA and IS.
4. We have examined only the subset of this population that is of working age – i.e. only those who were aged between 18 and 59 throughout the entire five-year period. Table 2 below presents the total number of claimants included in the analysis by MDC.

**Table 2      Subset of population in Table 1: number of ESA, IB/SDA claimants with live claims aged 23-59 in February 2015**

| Alcoholism | Drug abuse | Obesity | Total <sup>198</sup> |
|------------|------------|---------|----------------------|
| 53,200     | 31,700     | 1,400   | 86,400               |

5. The analysis examines the claimants' benefit histories using the following definitions:
  1. **Duration of individual claims** – the number of **separate** claims made to ESA/IB/SDA, IS and JSA over the five-year period and the duration of each claim.
  2. **Claimant cumulative duration on each benefit** – this combines separate claims made by the same individual to ESA/IB/SDA, IS and JSA, to give the cumulative length of time spent by each individual on each of these benefits over the five-year period.
  3. **Cumulative time away from benefits** – cumulative duration away from benefits to supplement the initial findings around time on benefits.
6. The analysis for drug and alcohol dependent claimants is conducted separately to those with an MDC of obesity, in keeping with the separate consideration of these conditions in the main report. It is also because the number of claimants with an MDC of obesity is very small and all results should be considered with this in mind. All data quoted in this annex is rounded to the nearest hundred.

## Summary of results

7. The interactions with the benefits system of this group are complex and varied, they are characterised by multiple claims, long claim durations and short periods of time off benefit.
8. For those in our cohort with an MDC of alcoholism or drug abuse the analysis shows a total of 301,700 individual claims to ESA/IB/SDA, JSA and IS over the five-year period. When we look at the cumulative time spent on benefits we find over 90 per cent of those that spent 4 to 5 years on benefit, spent it on ESA/IB/SDA. The analysis also finds evidence of cycling on and off benefits with over 15 per cent of those claiming JSA making five or more separate JSA claims over the five-year period.
9. Of the group with an MDC of obesity, the analysis shows their benefit journey is similarly characterised by multiple claims and short periods off benefit.

<sup>196</sup> NBD data is unpublished and has not been quality assured to National Statistics or Official Statistics publication standard; therefore this should therefore be treated with caution.

<sup>197</sup> Also includes claims to Passported Incapacity Benefits (PIB).

<sup>198</sup> Please note that totals may not sum due to rounding.

## Results

### Drug abuse and alcoholism

10. This analysis finds that claimants in our cohort with an MDC of alcoholism or drug abuse made multiple separate claims to DWP's main working-age benefits across the five-year period. Table 3 shows the total number of claims made amounted to 301,700, with 144,900 claims for one year and 15,500 claims lasting between 4 to 5 years.

**Table 3 Duration of individual claims to DWP main working-age benefits between 2010 and 2015, by those with an MDC of alcoholism and drug abuse.**

|            |              | Up to 1 year   | 1-2 years     | 2-3 years     | 3-4 years     | 4-5 years     | Total          |
|------------|--------------|----------------|---------------|---------------|---------------|---------------|----------------|
| Alcoholism | JSA          | 58,600         | 5,700         | 1,700         | 900           | 200           | 67,100         |
|            | ESA/IB/SDA   | 36,100         | 23,700        | 23,300        | 12,000        | 7,000         | 102,200        |
|            | IS           | 3,500          | 4,800         | 7,300         | 3,900         | 1,700         | 21,100         |
| Drug abuse | JSA          | 27,100         | 2,200         | 600           | 300           | 0             | 30,300         |
|            | ESA/IB/SDA   | 17,600         | 15,200        | 17,300        | 8,400         | 4,800         | 63,400         |
|            | IS           | 2,100          | 3,800         | 6,600         | 3,400         | 1,700         | 17,600         |
|            | <b>Total</b> | <b>144,900</b> | <b>55,500</b> | <b>56,900</b> | <b>28,900</b> | <b>15,500</b> | <b>301,700</b> |
|            | <b>%</b>     | <b>48%</b>     | <b>18%</b>    | <b>19%</b>    | <b>10%</b>    | <b>5%</b>     | <b>100%</b>    |

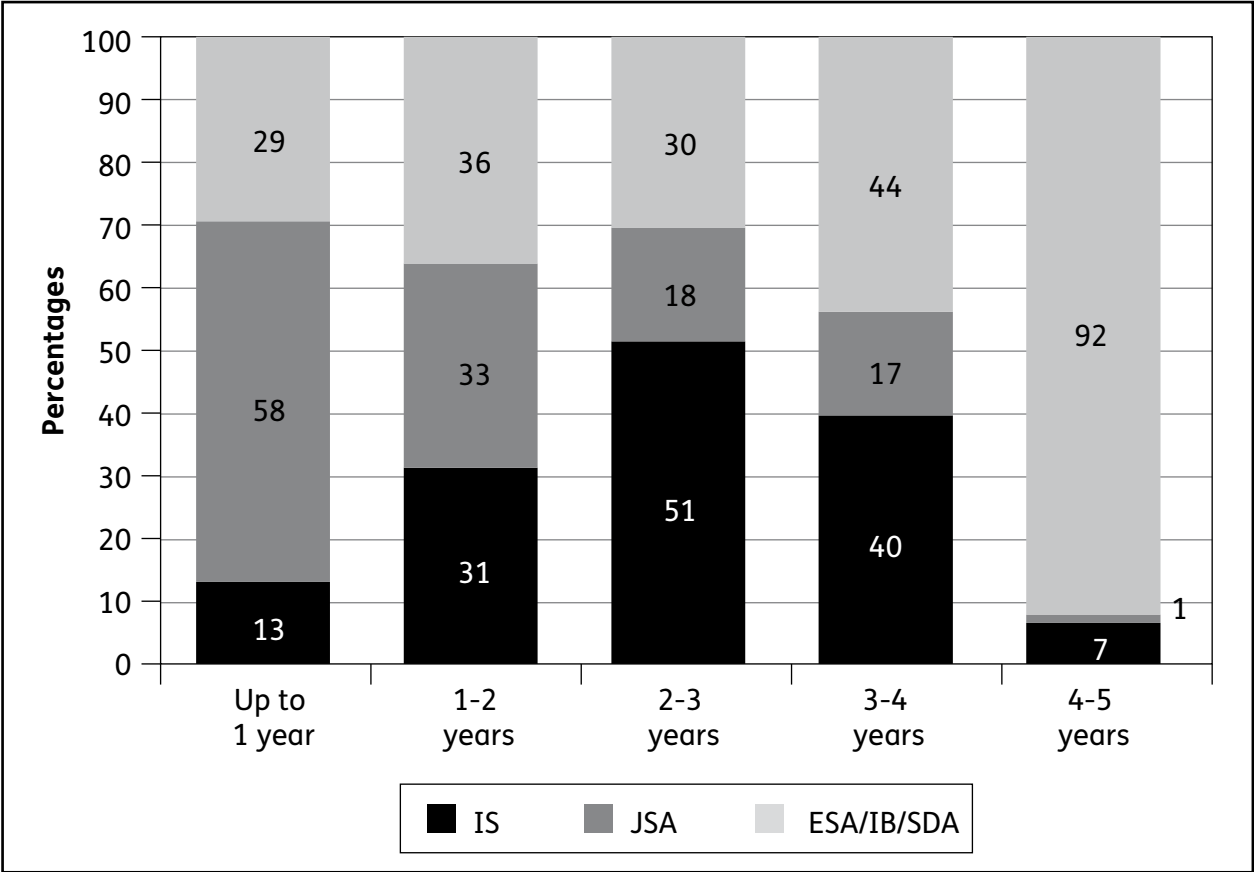
11. Combining these claims to examine **each claimant's cumulative duration on each benefit**, we see a different picture of much greater stability on certain benefits. Relatively few individuals spend a year or less on one type of benefit and most spend four to five years. In particular, combining claimants' separate claims to ESA/IB/SDA during the five years, the number who spent between four and five years claiming ESA/IB/SDA increases from 7,000 (Table 3) to 28,200 (Table 4) and from 4,800 to 21,800 for those with alcoholism or drug abuse, respectively. This suggests that even when their period on benefits is spread over multiple claims individuals with these conditions spend long periods of time claiming the same group of health-related benefits.

**Table 4 Cumulative duration on DWP main working-age benefits between 2010 and 2015, by those with an MDC of alcoholism or drug abuse**

|            |              | Up to 1 year  | 1-2 years     | 2-3 years     | 3-4 years     | 4-5 years     | Total          |
|------------|--------------|---------------|---------------|---------------|---------------|---------------|----------------|
| Alcoholism | JSA          | 12,400        | 5,900         | 3,500         | 2,300         | 600           | 24,700         |
|            | ESA/IB/SDA   | 6,700         | 6,800         | 5,900         | 5,600         | 28,200        | 53,200         |
|            | IS           | 2,600         | 4,500         | 7,300         | 4,000         | 1,700         | 20,200         |
| Drug abuse | JSA          | 5,300         | 2,700         | 1,400         | 800           | 200           | 10,300         |
|            | ESA/IB/SDA   | 2,300         | 2,700         | 2,400         | 2,500         | 21,800        | 31,700         |
|            | IS           | 1,400         | 3,700         | 6,600         | 3,400         | 1,800         | 17,000         |
|            | <b>Total</b> | <b>30,600</b> | <b>26,400</b> | <b>27,200</b> | <b>18,600</b> | <b>54,200</b> | <b>157,100</b> |
|            | <b>%</b>     | <b>19%</b>    | <b>17%</b>    | <b>17%</b>    | <b>12%</b>    | <b>35%</b>    | <b>100%</b>    |

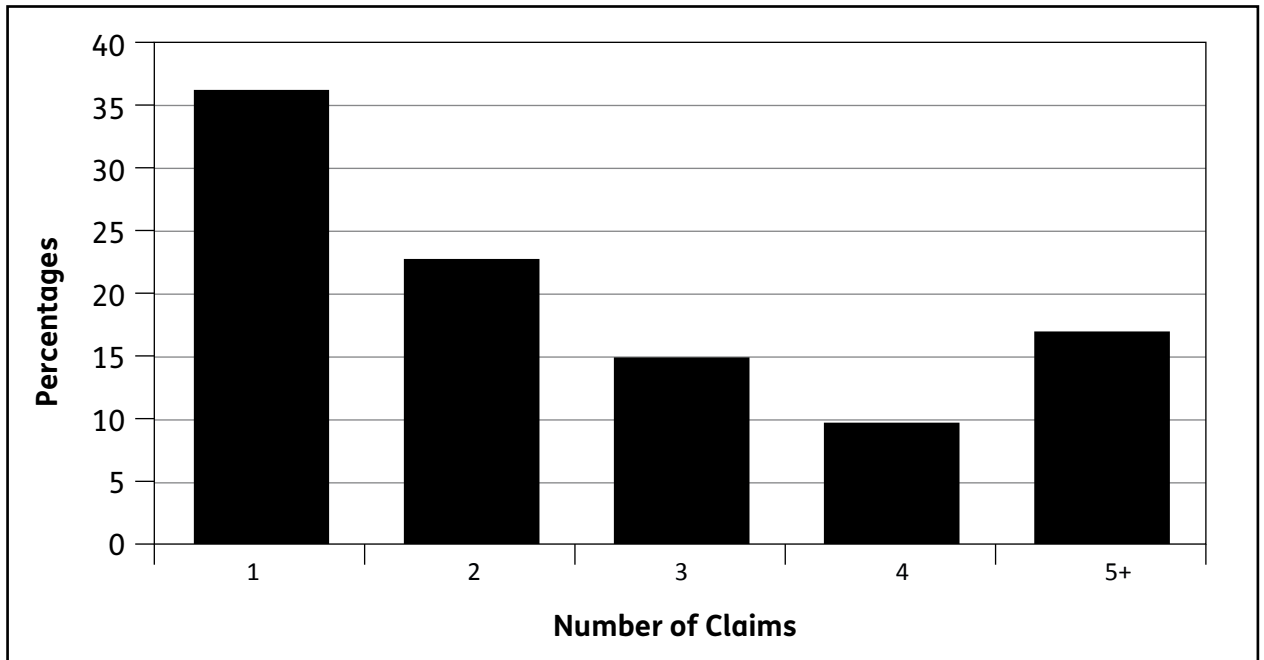
12.    As shown by Figure 1 58 per cent of claimants who spent a cumulative period of up to one year on benefits over the five-year period were claiming JSA. Over 90 per cent of those claimants who made a cumulative claim of between four and five years were claiming ESA/IB/SDA.

**Figure 1      Duration profiles in Table 4 by working-age benefit for those with an MDC of alcoholism or drug abuse**



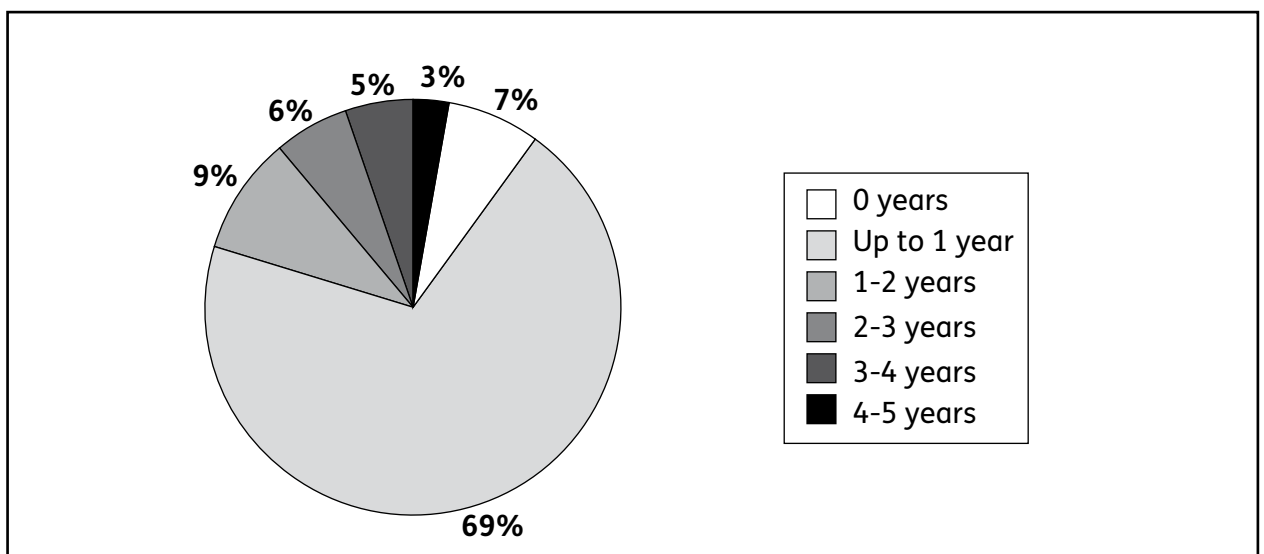
13.    Looking at the JSA claims made by our cohort, Figure 2 below shows that nearly 60 per cent made up to two JSA claims and over 15 per cent made five or more claims over five years.

**Figure 2** Number of JSA claims made by the cohort (Table 2) over the five year period



14. As this analysis is based on a cohort of ESA/IB/SDA claimants in February 2015, this suggests evidence of multiple claims and cycling on and off benefits over the five-year period *prior* to claiming ESA/IB/SDA with an MDC of alcoholism or drug abuse.
15. Our analysis shows that these claimants spend a long period of time in the benefits system overall, regardless of the benefit they claim. Figure 3 shows that across the five-year period, 76 per cent of claimants spent less than a year without a live claim to a main working-age benefit.

**Figure 3** Cumulative period not claiming any one of DWP's working-age benefits, for those with an MDC of alcoholism or drug abuse



**Obesity**

16. As shown in Table 2 only 1,400 had an MDC of obesity and so we present high level findings only for this group. This group of claimants made 3,700 separate claims, and combining multiple claims to the same benefit together suggests 2,400 claims were made to ESA/IB/SDA, JSA and IS between March 2010 and February 2015.

**Table 5      Duration of claims to ESA/IB/SDA, JSA and IS between 2010 and 2015, by those with an MDC of obesity**

|                                                                             | <b>Up to 1<br/>year</b> | <b>1-2<br/>years</b> | <b>2-3<br/>years</b> | <b>3-4<br/>years</b> | <b>4-5<br/>years</b> | <b>Total</b> |
|-----------------------------------------------------------------------------|-------------------------|----------------------|----------------------|----------------------|----------------------|--------------|
| 1 Duration of individual claims (including one or more of the same benefit) | 800                     | 800                  | 1,100                | 700                  | 400                  | 3,700        |
| 2 Claimant cumulative duration on each benefit                              | 300                     | 300                  | 300                  | 300                  | 1,200                | 2,400        |

17. Long claim durations amongst this group is evident from looking at their time away from benefit; this showed over 90 per cent spent less than one year off benefits.

## Annex F

# Analysis of obesity data

### Obesity prevalence

1. In the UK, around a quarter of all adults are obese and two-thirds are over-weight. Across the OECD<sup>199</sup> one in five adults are obese and around a half are over-weight.
2. The latest data from the Health Survey for England<sup>200</sup> (2011-2013) records the prevalence of obesity (BMI $\geq$ 30kg/m<sup>2</sup>) and severe obesity (BMI $\geq$ 40kg/m<sup>2</sup>) among working age adults (aged 16-64).
3. Obesity levels are the same for both sexes, but women are twice as likely to be severely obese. Obesity rates increase with age but levels out at age 75+. Severe obesity rates level out between ages 35-45. Obesity prevalence is fairly even across most regions, except London, where it is slightly lower. Obesity is more common among those who live in deprived areas<sup>201</sup>, have lower incomes and lower educational attainment. These are all factors that confer labour market disadvantage.

<sup>199</sup> *Obesity and the Economics of Prevention*, OECD. (2010).

<sup>200</sup> NatCen Social Research, University College London. Department of Epidemiology and Public Health. (2013). *Health Survey for England, 2011*. [data collection]. UK Data Service. SN: 7260, <http://dx.doi.org/10.5255/UKDA-SN-7260-1>

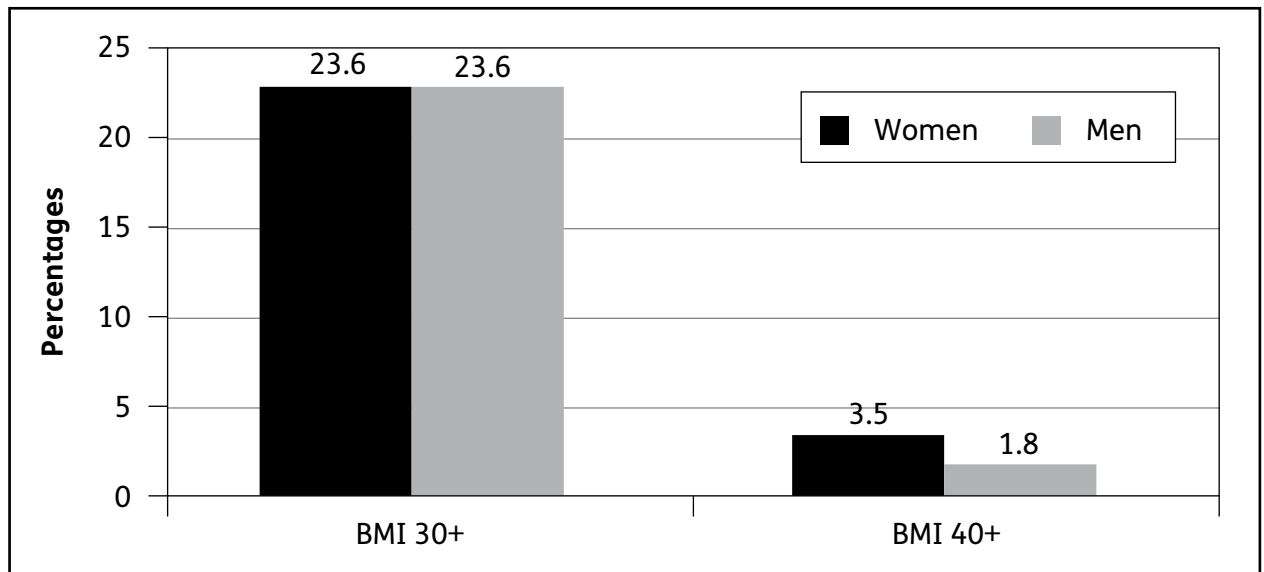
NatCen Social Research, University College London. Department of Epidemiology and Public Health. (2014). *Health Survey for England, 2012*. [data collection]. UK Data Service. SN: 7480, <http://dx.doi.org/10.5255/UKDA-SN-7480-1>

NatCen Social Research, University College London. Department of Epidemiology and Public Health. (2015). *Health Survey for England, 2013*. [data collection]. UK Data Service. SN: 7649, <http://dx.doi.org/10.5255/UKDA-SN-7649-1>

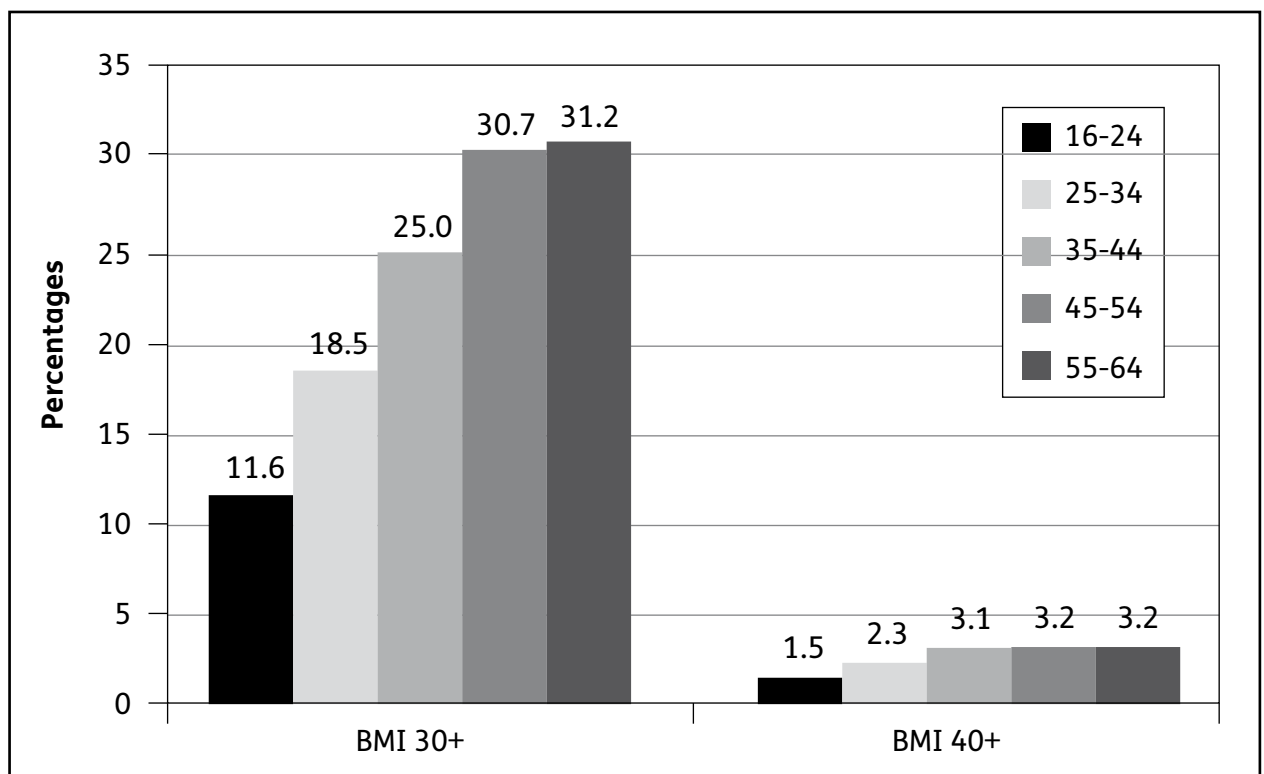
<sup>201</sup> Deprivation as defined using the index of multiple deprivation.

**Figure 1 Obesity and overweight in OECD and non-OECD countries**

**Figure 2 Obesity prevalence by gender<sup>202</sup>**

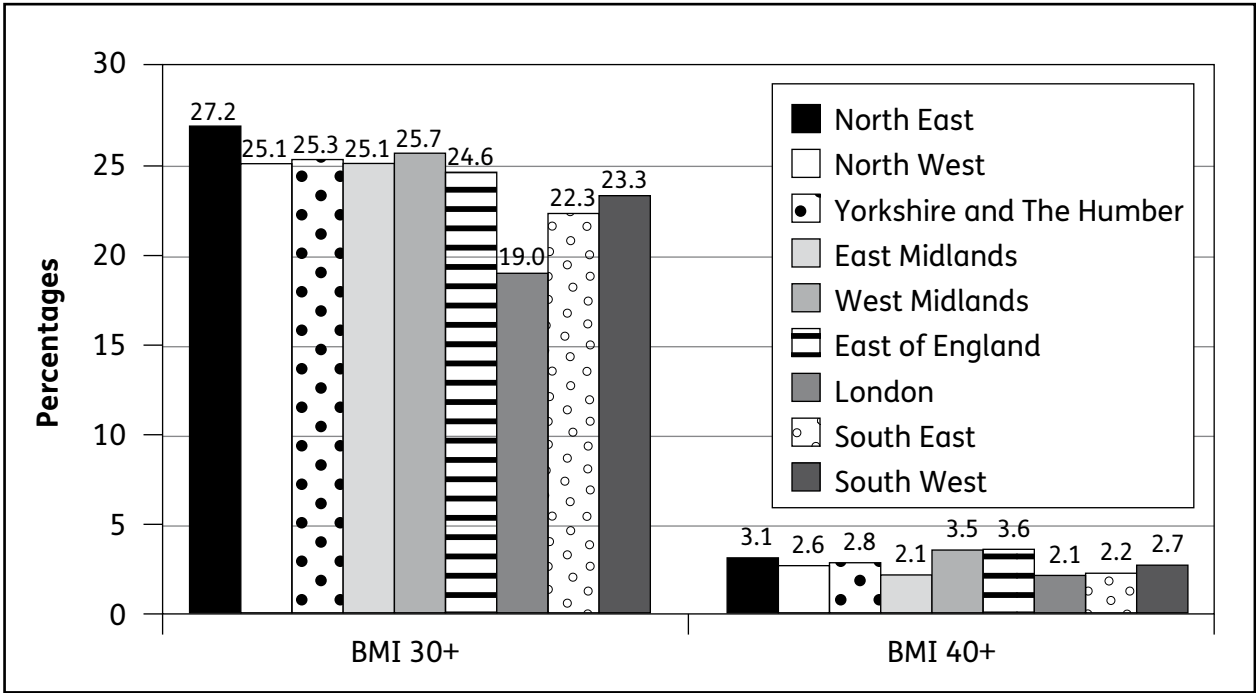


**Figure 3 Obesity prevalence by age**

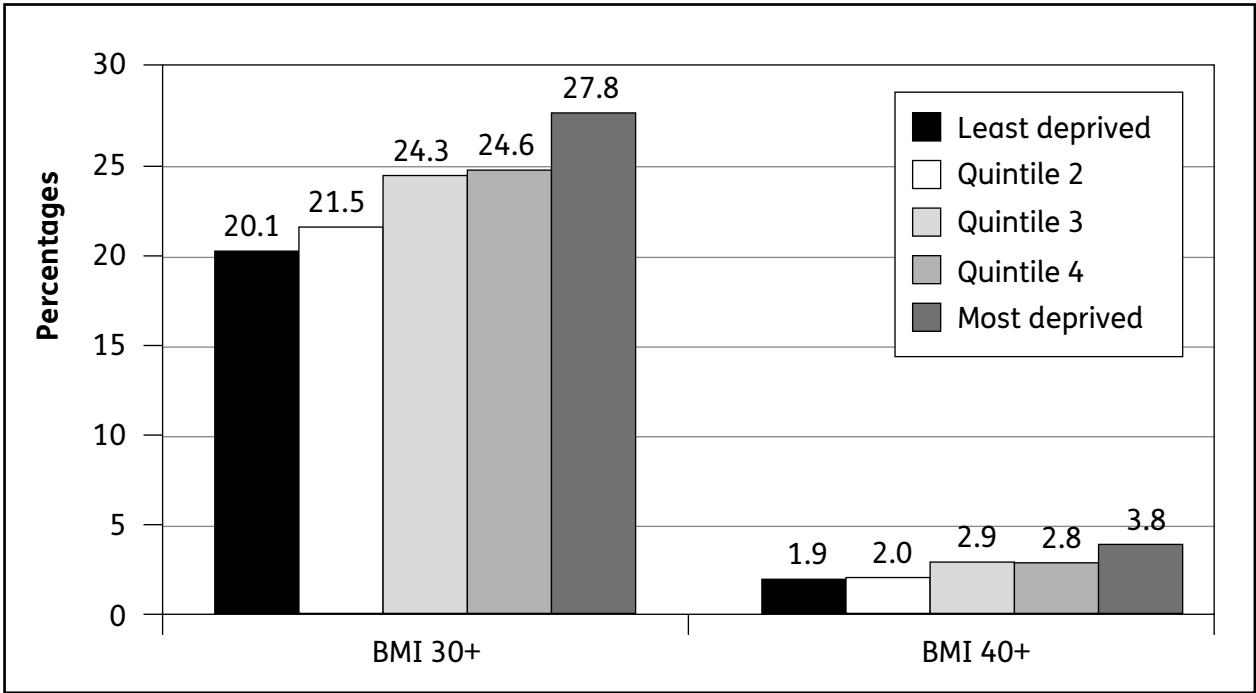


<sup>202</sup> The BMI 40+, severely obese group is a subset of the BMI 30+ obese group and respondents are included in both groups.

**Figure 4      Obesity prevalence by region**



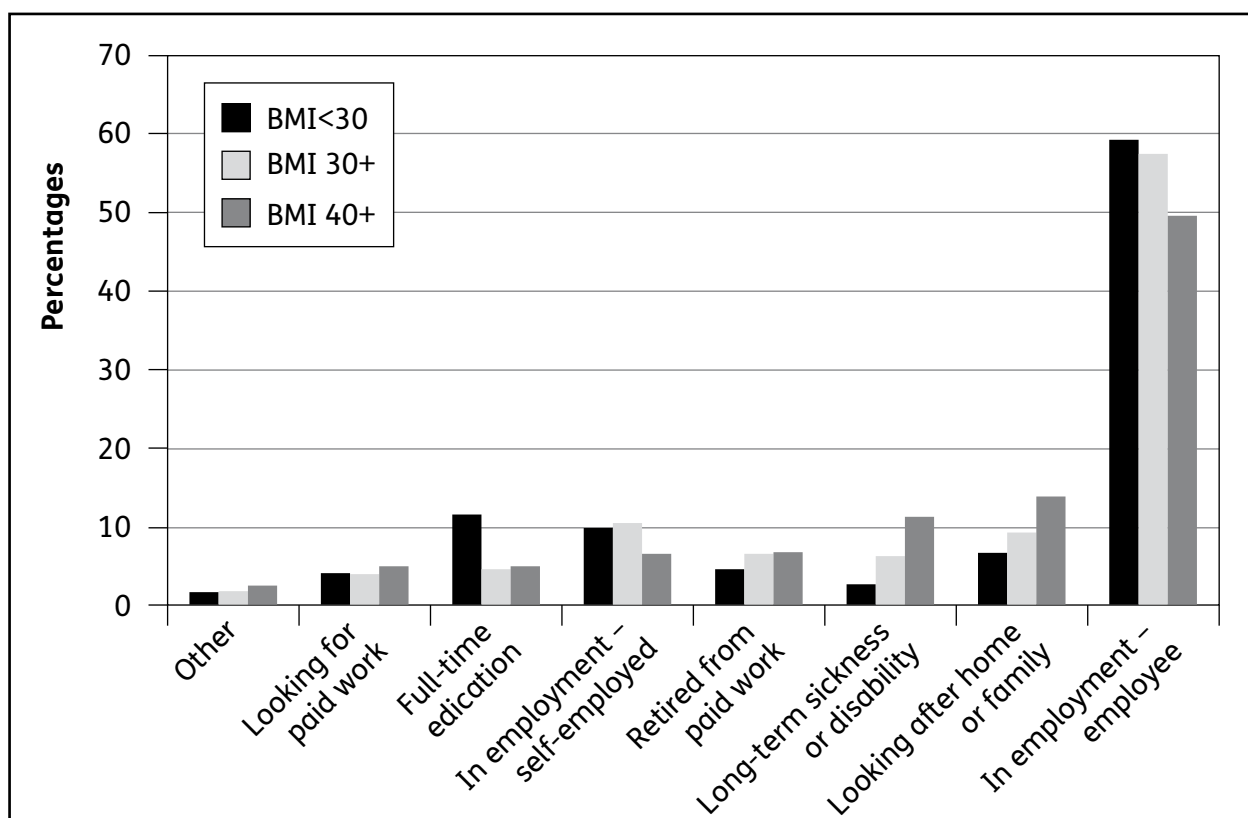
**Figure 5      Obesity prevalence by deprivation quintile**



4. Figure 6 illustrates economic activity status by BMI group. It suggests that obese and severely obese working age adults in England are relatively less likely to be in work than adults with BMI<30. These groups are relatively more likely to be long-term sick, disabled or looking after home or family. More than half of the obese and severely obese population are in work, but the likelihood of being employed is two percentage points lower for obese adults and the gap increases to 10 percentage points for the severely obese<sup>203</sup>.

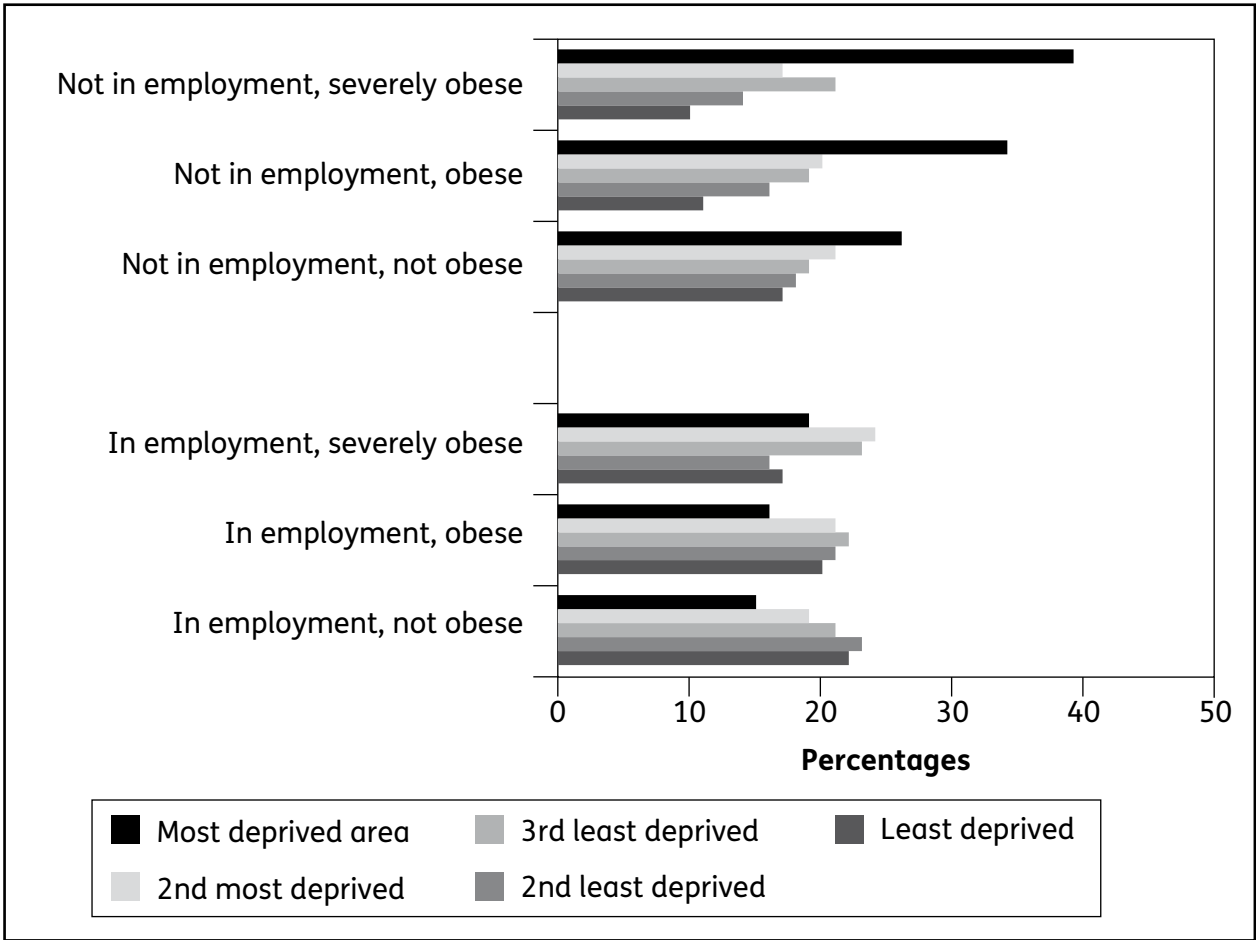
<sup>203</sup> Worklessness is affected by a range of wider factors, such as socioeconomic status and education, which can also be associated with obesity. The nature of relationship between obesity and worklessness is complex and not fully understood. It is therefore difficult to ascertain whether obesity is the primary reason for worklessness where other factors exist.

**Figure 6 Economic activity status by BMI group**



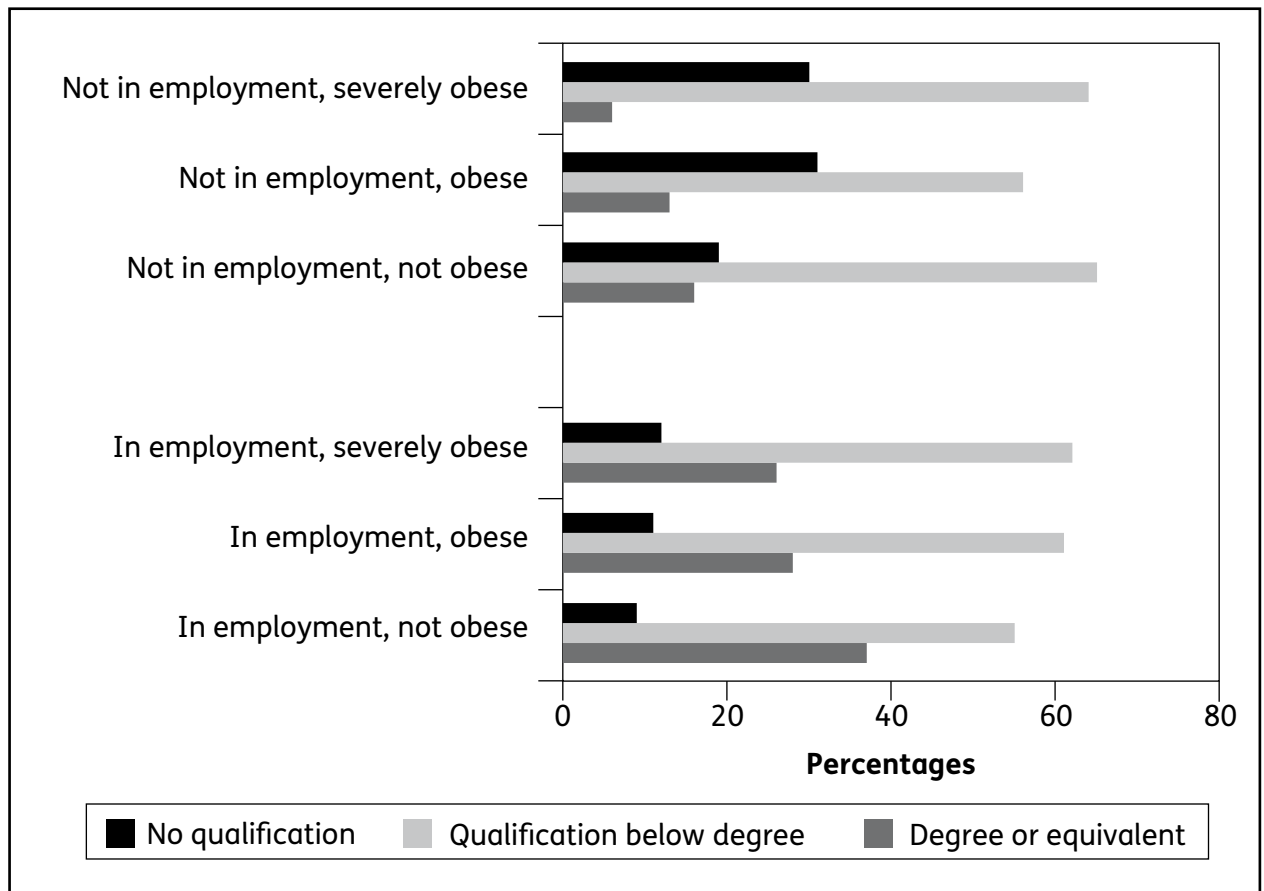
5. Using Health Survey for England data on BMI and economic activity status, a combined variable has been constructed as defined below to analyse the characteristics of the obese population in work. Sample sizes for each group are shown in brackets. The severely obese sample size is relatively small which limits the scope for detailed analysis of this group. The combined variable includes:
  - a. In employment, not obese i.e. BMI<30 (sample size 9,205)
  - b. In employment, obese i.e. BMI 30-40 (sample size 2,537)
  - c. In employment, severely obese i.e. BMI 40+ (sample size 261)
  - d. Not in employment, not obese (sample size 4,070)
  - e. Not in employment, obese (sample size 1,108)
  - f. Not in employment, severely obese (sample size 200)
6. There is a clear deprivation gradient within both obesity and economic activity data. Over a third of those not in employment, and who are either obese or severely obese, are from the most deprived areas.

**Figure 7      Breakdown by deprivation quintile**



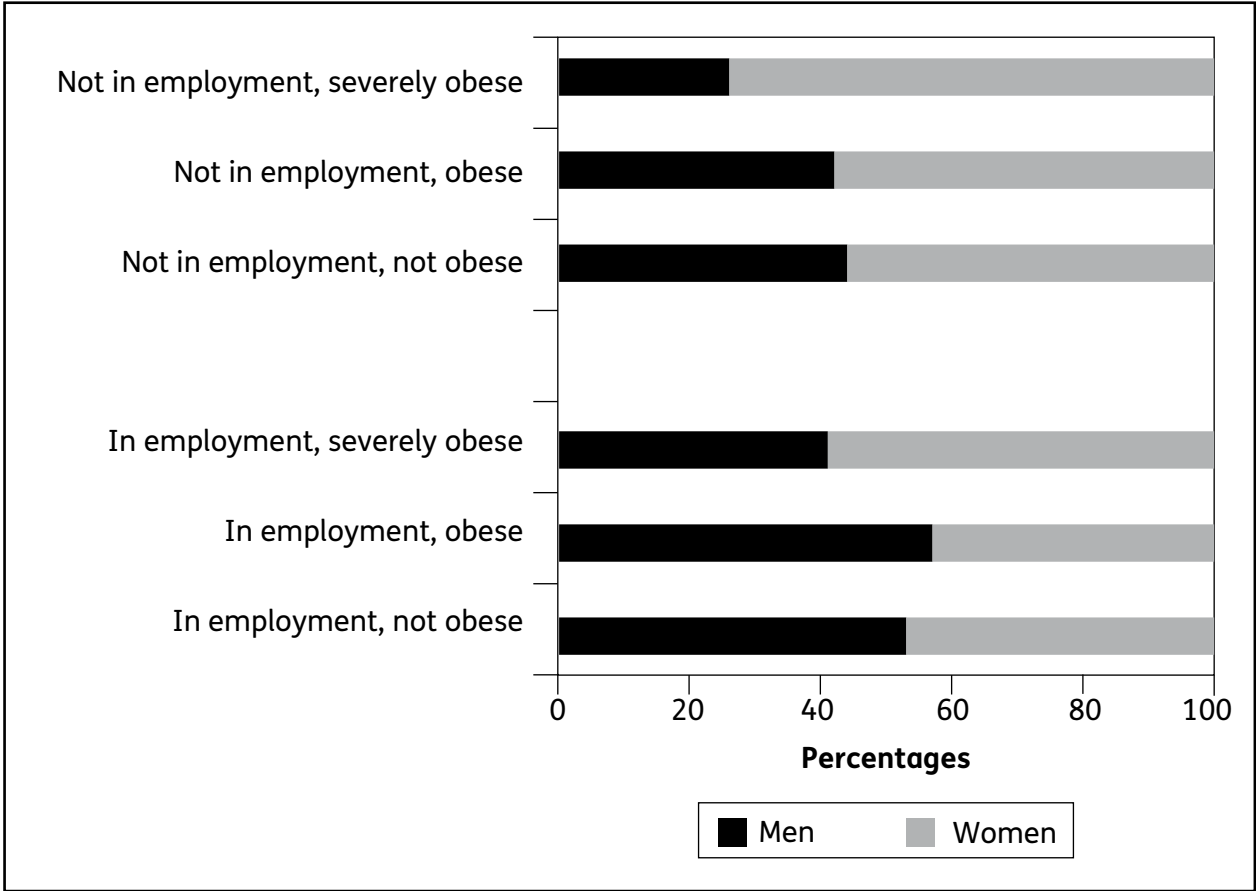
7. Approximately 30 per cent of those who are not in employment, and who are obese or severely obese, have no qualifications, and are on average, less well qualified than non-obese adults who not in work.

**Figure 8 Breakdown by highest qualification**



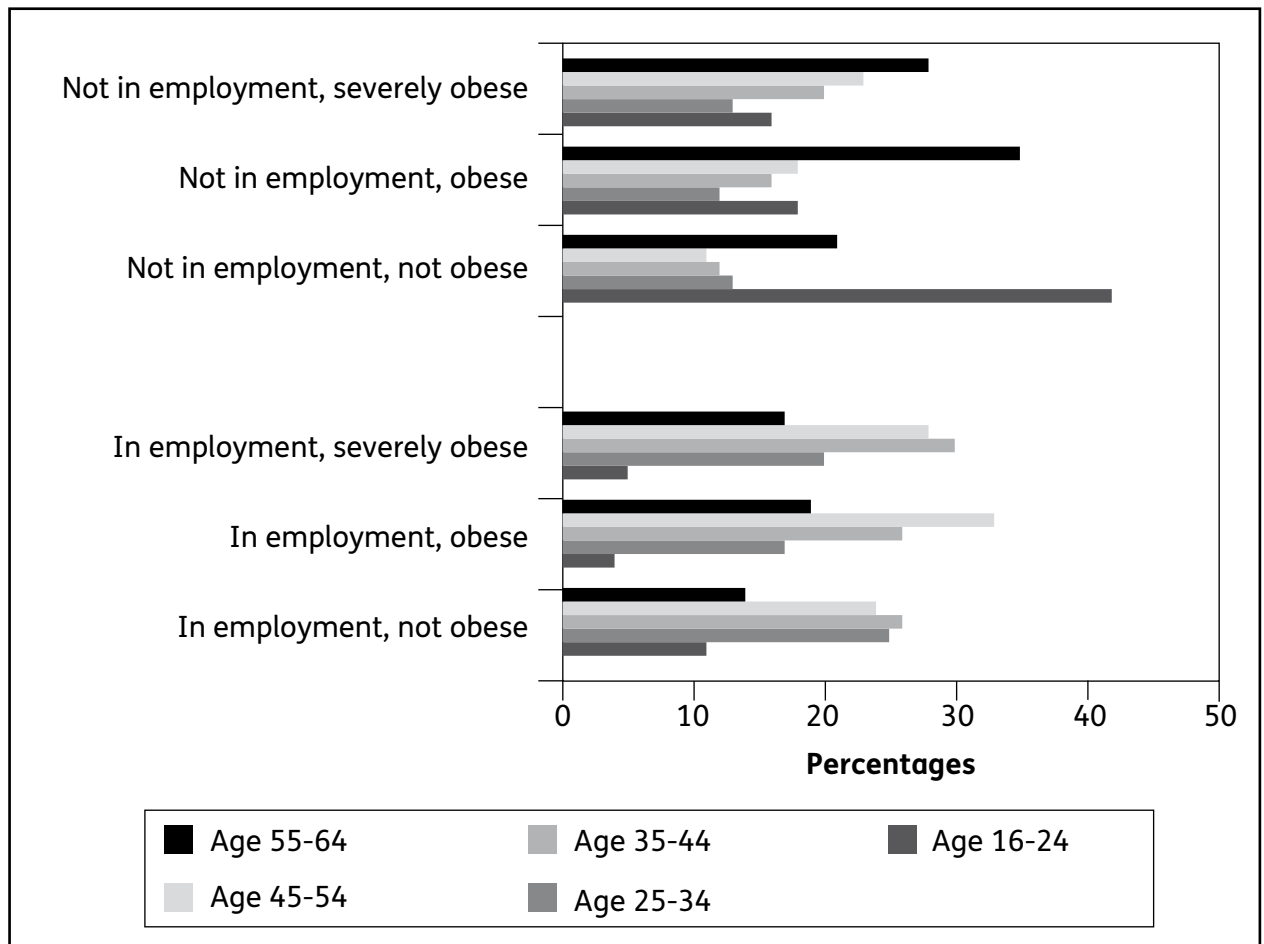
8. Obese women are less likely to be in employment than obese men. The employment gap for obese adults is greater than for normal-weight adults. Although there is roughly an even number of obese men and women in England, the gender split is 60:40 between obese men and women who are in work.

**Figure 9      Gender split within each of the six named groups**



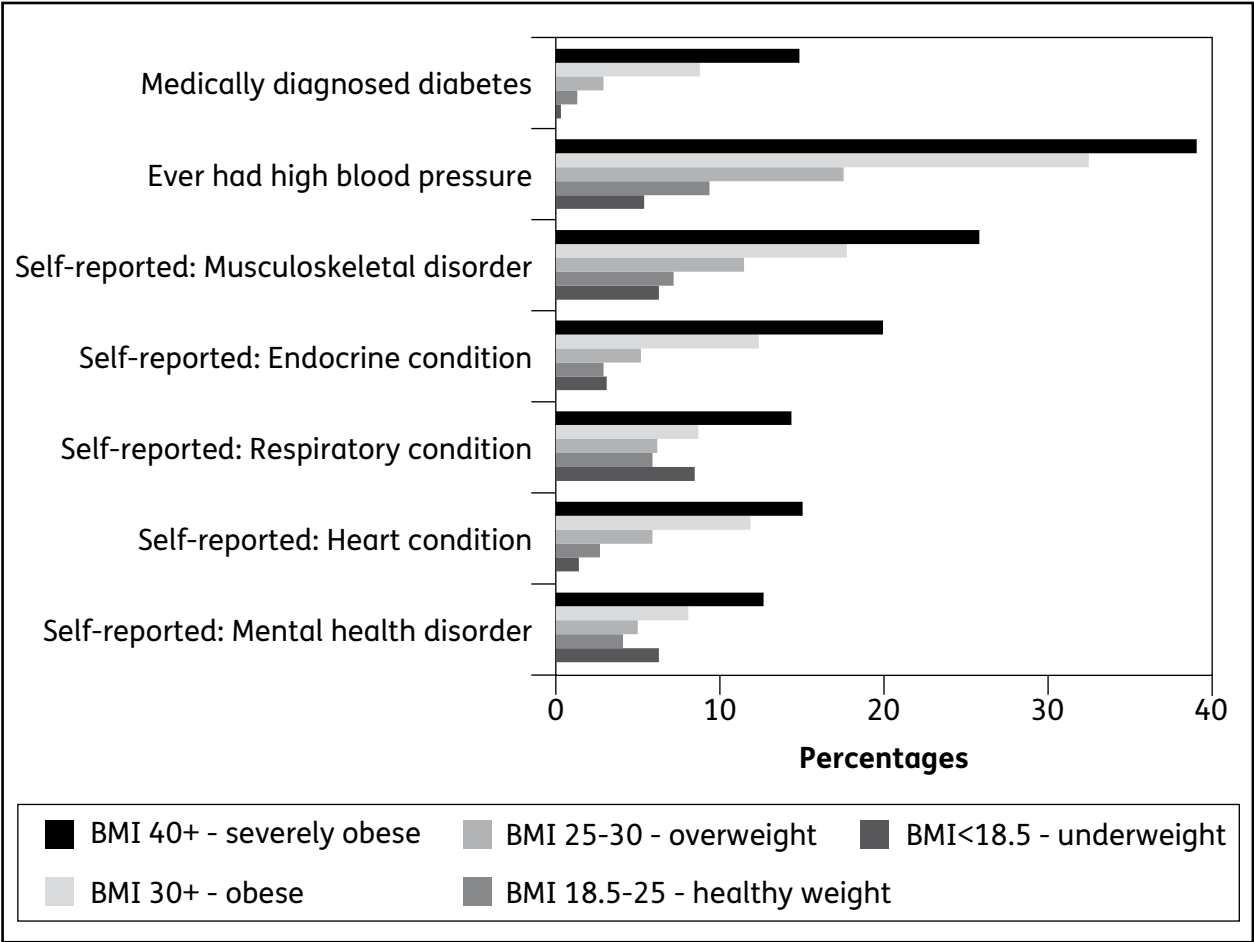
9. Those who are in employment and obese or severely obese are most likely to be aged between 35 and 55; whereas those who are obese and not in employment are most likely to be over 55 or under 25.

**Figure 10 Breakdown by age group**



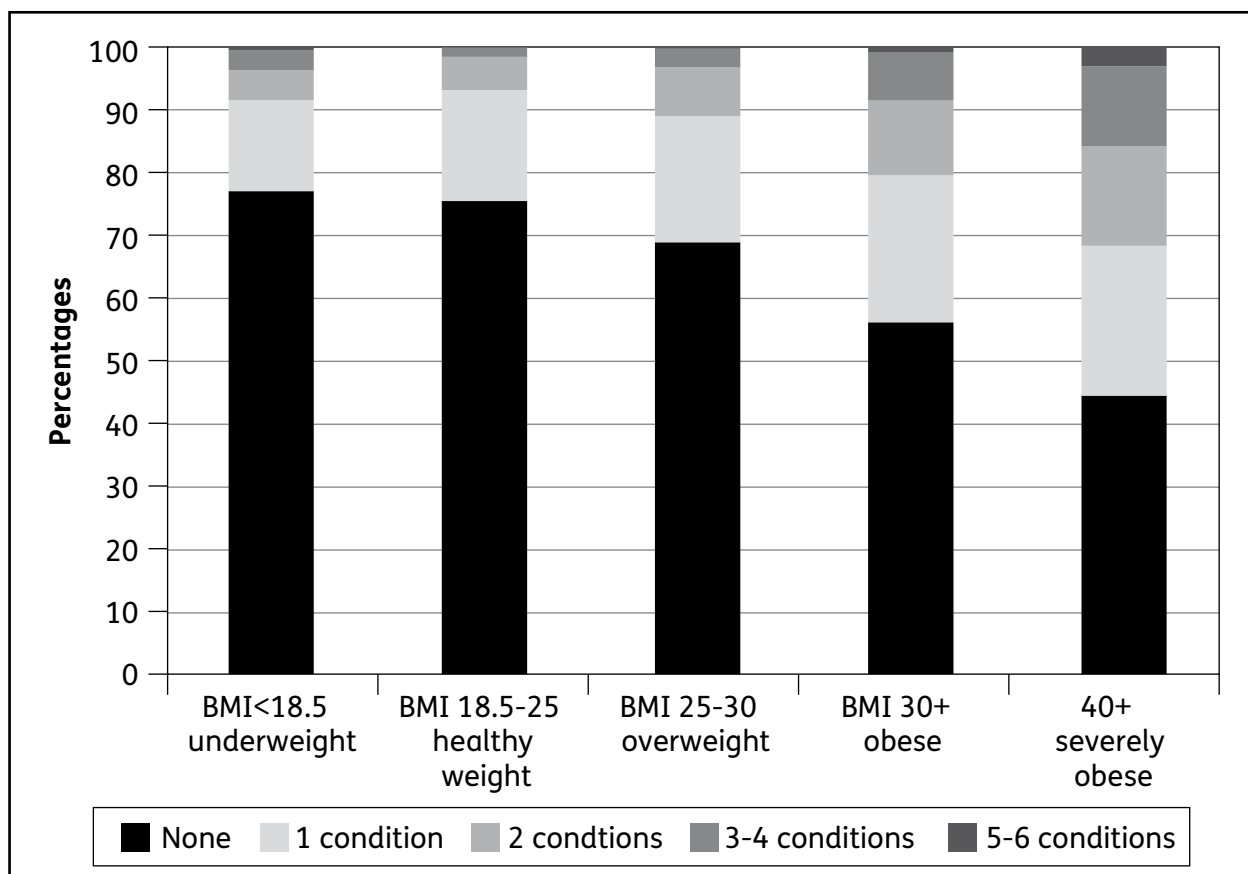
10. The Health Surveys for England collects data on long-standing health conditions. Up to six conditions can be listed. With the exception of medically diagnosed diabetes, all of this data is self-reported and not medically diagnosed, so there is likely to be an element of both over and under-reporting.

**Figure 11    Proportion reporting top most common long-standing health conditions by BMI group**



- 11. All conditions show an increased prevalence in the obese groups with the clearest relationships evident for endocrine conditions and medically diagnosed diabetes.
- 12. Those in the obese category have more complex health conditions; they are more likely to report having a long-term health condition but also more likely to report multiple conditions with 20 per cent of the obese and more than 30 per cent of the very obese reporting two or more long-standing health conditions.

**Figure 12** Number of health condition reported by BMI groups



## Obesity prevalence in the benefits system

13. The distribution of prevalence for obesity suggests that, all else being equal, benefit recipients are relatively more likely than the general population to be obese. However, very few people on the benefits system are identified as having obesity as their main disabling condition. These people may be on benefits for various other health reasons, whether related to obesity or not but causation can not be inferred.
14. Only 1,600 of the 2.3 million ESA claimants in February 2015 are identified as having obesity as their main disabling condition. However, around 800,000 ESA claimants have other health conditions that are identified as prevalent among the obese group as shown in Figure 13; the majority are found to have a mental health-related main disabling condition<sup>204</sup>.

<sup>204</sup> DWP WPLS data February 2015.

**Figure 13 Breakdown of other prevalent health conditions among the obese group subject to QA, February 2015.**

| Main Disabling Condition                        | ESA caseload | IB/SDA caseload <sup>205</sup> | Total   |
|-------------------------------------------------|--------------|--------------------------------|---------|
| Non Insulin dependent diabetes mellitus         | 100          | –                              | 100     |
| Insulin dependent diabetes mellitus             | 300          | 100                            | 400     |
| Pneumonia, organism unspecified                 | 1,300        | –                              | 1,300   |
| Sleep disorders                                 | 1,500        | 100                            | 1,600   |
| Ulcer of lower limb, not elsewhere classified   | 1,500        | 100                            | 1,600   |
| Other peripheral vascular diseases              | 2,400        | 200                            | 2,700   |
| Unspecified mood disorder                       | 5,500        | 400                            | 5,900   |
| Other joint disorders, not elsewhere classified | 5,600        | 400                            | 6,000   |
| Essential hypertension                          | 11,900       | 1,100                          | 13,100  |
| Unspecified diabetes mellitus                   | 27,600       | 1,900                          | 29,500  |
| Other neurotic disorders                        | 30,800       | 5,500                          | 36,300  |
| Reaction to severe stress                       | 45,900       | 2,000                          | 47,800  |
| Mental disorder not otherwise specified         | 75,600       | 8,600                          | 84,100  |
| Unknown and unspecified causes of morbidity     | 102,400      | 29,500                         | 131,900 |
| Depressive episode                              | 494,500      | 26,700                         | 521,200 |
| Total <sup>206</sup>                            | 807,000      | 76,700                         | 883,600 |

## Obesity projections

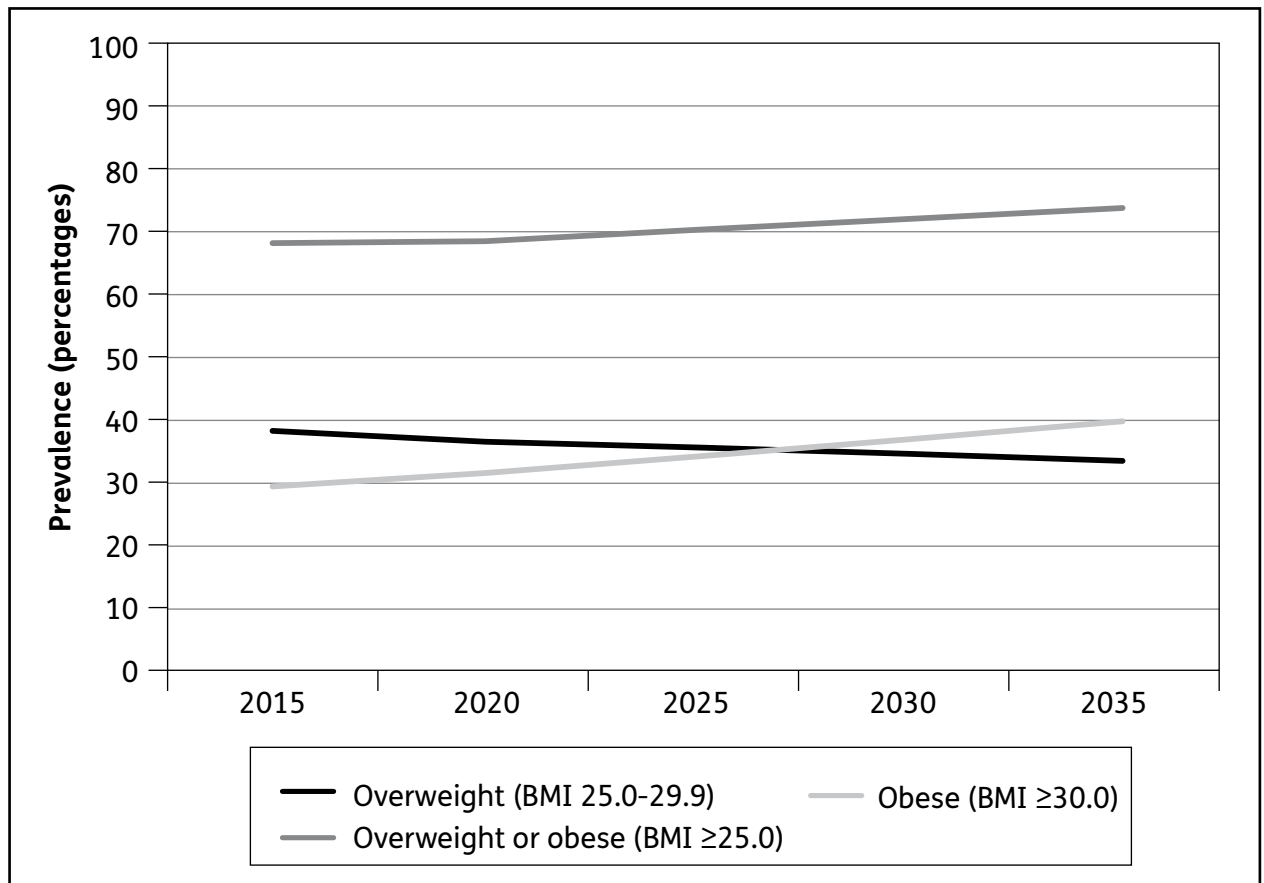
15. Research conducted by Cancer Research UK and UK Health Forum in ‘Tipping the scales: why preventing obesity makes economic sense’<sup>207</sup> suggests that if current trends were to continue almost three in four adults of the adult UK population could become overweight or obese by 2035.
16. Between 2015 and 2035 the prevalence of obesity among the UK adult population is predicted to increase from 29 to 39 per cent. The prevalence of those overweight is predicted to fall, as more people will go from being overweight to being obese. Overall, the total proportion of those who are in an unhealthy weight category (overweight or obese) is predicted to increase during this period.

<sup>205</sup> Incapacity Benefit (IB)/Severe Disablement Allowance (SDA).

<sup>206</sup> Total may not sum due to rounding.

<sup>207</sup> Cancer research UK and UK Health Forum. (2016). *Tipping the scales: Why preventing obesity makes economic sense*. UK Health Forum, London. <http://www.ukhealthforum.org.uk/prevention/pie/?entryid43=54575>

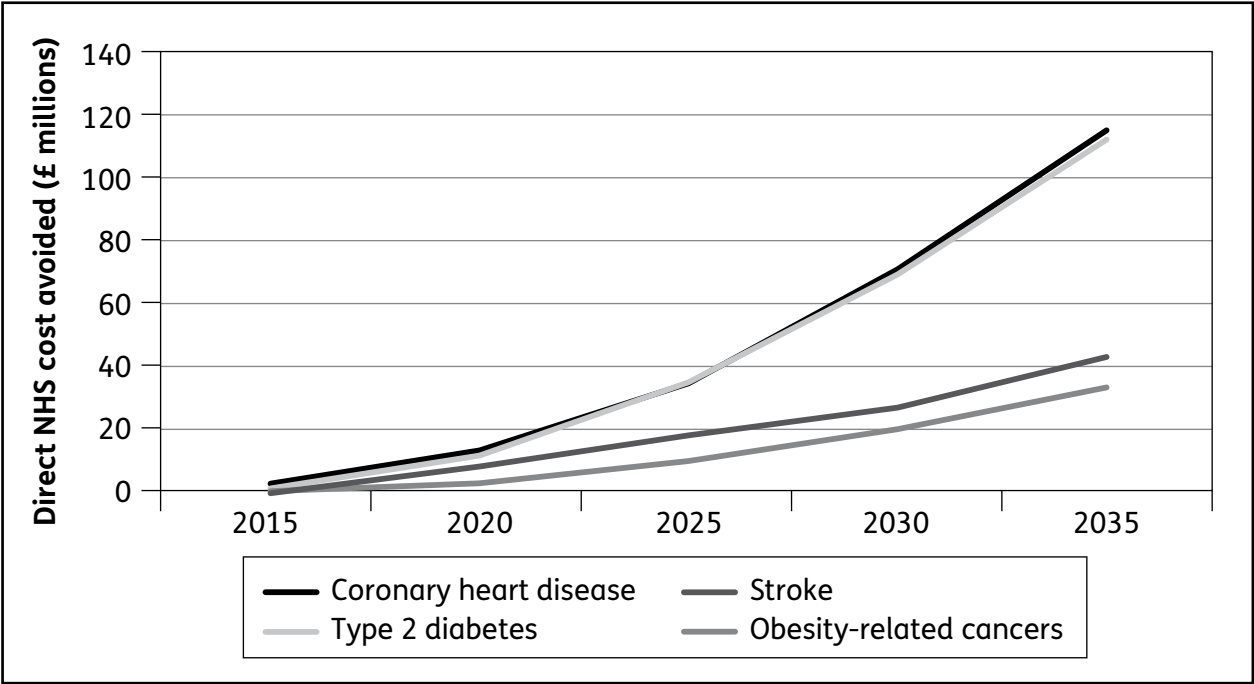
**Figure 14 Predicted trend: prevalence of overweight and obese adults in the UK**



17. The report also looks at the impact of an increase in overweight and obesity prevalence on costs to the Government and the number of new diseases arising over the period 2015 to 2035<sup>208</sup>.
18. The graph below shows the direct NHS costs that can be avoided if the prevalence of overweight and obesity were to be reduced by 1 per cent each year below the predicted trend.

<sup>208</sup> Annual incidence for the year 2035 and cumulative incidence between 2015 and 2035 of new diseases attributed to being overweight and obese can be found on page 21 of the 'Tipping the scales' report.

**Figure 15    Direct NHS costs avoided if prevalence of overweight and obesity was reduced by 1 per cent below predicted trend**



## Annex G

# High level costs and benefits for key recommendations

### Introduction

1. This annex presents the costs and benefits of the following recommendations outlined in the Review: an Individual Placement and Support (IPS) trial and a trial delivered through Jobcentre Plus work coaches co-located in treatment. Costs are also presented for the enhanced support offer in Jobcentre Plus, including peer mentoring support for claimants with addictions. We do not present cost-benefit estimates for the IPS-lite trial option, as the costs are anticipated to be broadly similar to the IPS option in the first year.
2. The cost benefit analysis of these proposals is based on the *DWP Social cost-benefit framework* (Fujiwara, 2010)<sup>209</sup>. The costs associated with the programmes are based on available evidence, where evidence is not available the analysis is underpinned by a set of assumptions<sup>210</sup>.
3. The analysis of benefits is outlined in the first section as the methods do not vary by programme. The next section presents the cost-benefit estimates of key policy changes recommended in the report. For each, we explain: the methodology and assumptions used to estimate participation volumes and employment impacts; the costs taken into consideration; and for the IPS proposals, the results of the estimated number of additional days of work required of participants in order for the proposal to break even in terms of the costs and benefits.

<sup>209</sup> Fujiwara, D. (2010). *The Department for Work and Pensions social cost-benefit analysis framework* (No. 86). Department for Work and Pensions Working Paper.

<sup>210</sup> Caution should be taken when interpreting these figures and a further sensitivity analysis should be carried out to test the robustness of the assumptions made within this cost benefit framework.

4. To estimate employment impacts we make assumptions of job retention and additionality. Retention rates are defined as the proportion of participants who complete the programme, which is a subset of the number who volunteer to be entered into the trial. Additionality is the employment impact of the proposal beyond what we would expect from the existing Jobcentre Plus offer. This means we include only those claimants who are assumed to become employed because of the programme in our benefits calculation.
5. The estimates in this annex refer to costs and benefits in the first year of the trials outlined. These are expected to improve as services provided as part of the trials mature over time.

## Estimating benefits

6. To estimate the benefits associated with the proposals we have assumed that all beneficiaries of the new programmes will be claimants in receipt of Employment Support Allowance (ESA). While in reality there may be JSA or other claimants, who enter the programmes, we have little evidence to indicate prevalence of our conditions for other benefits. The ESA claimants in this analysis are assumed to be either in the Work Related Activity Group (WRAG) or Support Group (SG) in the same proportion as all ESA claimants in the most recent published data at national level; 70 per cent SG and 30 per cent WRAG<sup>211</sup>.
7. The analysis considers separately the benefits to the Exchequer and the benefits to wider society. Benefits to the Exchequer are the estimated increases in tax receipts net of tax credits and a reduction in benefit spending, operational and healthcare costs of claimants moving into work. To calculate these benefits, we have made assumptions about the working pattern and earnings of ESA claimants who gain employment. Based on the DWP Destinations Survey 2011<sup>212</sup> and uprated in line with earnings growth to 2015/16, the annual earnings of claimants moving into work is assumed to be £13,572<sup>213</sup>. Benefits to society come from increased output, reduced health care costs, and changes to the distribution of household income.
8. The benefits are presented as £s per worker per additional day worked because of the proposed intervention – i.e. the benefit that results when one of our participants moves from unemployment to employment. This allows us to estimate how many additional working days are required from each participant who finds work, on average, in order for the policy to break even, considering benefits to the Exchequer and the wider benefits to society separately.
9. The two tables below outline the net daily benefits of ESA claimants moving into work from the Support and WRAG groups respectively. A weighted average of the benefits across both SG and WRAG groups from moving an SG and WRAG claimant into work gives a daily benefit to the Exchequer of £34. If we take wider social benefits into account, the daily saving rises to £54.

<sup>211</sup> We have excluded Assessment Phase as we assume everyone is assessed to be on ESA.

<sup>212</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/214578/rrep791.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214578/rrep791.pdf)

<sup>213</sup> For the purpose of this analysis, the salary estimates for SG are assumed the same as destination estimates for WRAG.

**Table 1 Support Group claimants: benefit and costs (net of programme costs) of moving an ESA Support Group claimant into employment**

| <b>The exchequer (£)</b>                  |           | <b>Society (£)</b>                |           |
|-------------------------------------------|-----------|-----------------------------------|-----------|
| Increase in income tax                    | 3         | Increase in output                | 40        |
| Increase in employees' NIC                | 2         | Reduction in healthcare costs     | 3         |
| Increase in employers' NIC                | 2         | Reduction in operational costs    | 1         |
| Increase in indirect tax                  | 1         |                                   |           |
| Reduction in healthcare costs             | 3         | <b>Total benefits</b>             | <b>44</b> |
| Reduction in Universal Credit             | 0         | Increase in travel costs          | 2         |
| Reduction in legacy benefit               | 19        | Increase in childcare costs       | 0         |
| Reduction in Housing Benefit payments     | 4         | <b>Total costs</b>                | <b>2</b>  |
| Reduction in Council Tax Benefit payments | 1         |                                   |           |
| Reduction in Free School Meals payments   | 0         |                                   |           |
| Reduction in operational costs            | 1         |                                   |           |
| <b>Total benefits</b>                     | <b>38</b> |                                   |           |
| Increase in Tax Credits                   | 3         | <b>Net benefit</b>                | <b>42</b> |
| <b>Total costs</b>                        | <b>3</b>  | Net distributional effects        | 11        |
|                                           |           |                                   |           |
| <b>Net benefit</b>                        | <b>35</b> | <b>Net distributional benefit</b> | <b>53</b> |

**Table 2 WRAG claimants: benefit and costs (net of programme costs) of moving an ESA WRAG claimant into employment**

| <b>The exchequer (£)</b>                  |           | <b>Society (£)</b>                |           |
|-------------------------------------------|-----------|-----------------------------------|-----------|
| Increase in income tax                    | 3         | Increase in output                | 40        |
| Increase in employees' NIC                | 2         | Reduction in healthcare costs     | 3         |
| Increase in employers' NIC                | 2         | Reduction in operational costs    | 1         |
| Increase in indirect tax                  | 2         |                                   |           |
| Reduction in healthcare costs             | 3         | <b>Total benefits</b>             | <b>44</b> |
| Reduction in Universal Credit             | 0         |                                   |           |
| Reduction in legacy benefit               | 16        | Increase in travel costs          | 2         |
| Reduction in Housing Benefit payments     | 5         | Increase in childcare costs       | 0         |
| Reduction in Council Tax Benefit payments | 1         | <b>Total costs</b>                | <b>2</b>  |
| Reduction in Free School Meals payments   | 0         |                                   |           |
| Reduction in operational costs            | 1         |                                   |           |
| <b>Total benefits</b>                     | <b>36</b> |                                   |           |
| Increase in Tax Credits                   | 3         | <b>Net benefit</b>                | <b>42</b> |
| <b>Total costs</b>                        | <b>3</b>  | Net distributional effects        | 14        |
|                                           |           |                                   |           |
| <b>Net benefit</b>                        | <b>33</b> | <b>Net distributional benefit</b> | <b>56</b> |

## Proposal A: Individual Placement and Support Trial

### i. Volumes

10. We assume that 10 local authorities will take part in the trial. Based on the National Drug Treatment Monitoring System (NDTMS) data, we can assume on average 2,000 people are in treatment in any one local authority. Therefore, in total around 20,000 people could potentially be involved in the trial. The trial itself will test these assumptions.
11. Previous experience with employment programmes suggests that the proportion that take up the offer of additional support into work tends to be relatively low, so we assume that around 15 per cent will take up the IPS offer. This suggests 3,000 participants could potentially take part in the trial.
12. We have estimated a retention rate of 67 per cent, which means we assume that two-thirds of all those who volunteer for the IPS programme stay on it for at least six months. This is a relatively high retention assumption, based on the fact the IPS trial is voluntary and only a small proportion of those in treatment will come forwards. This 'opt-in' component suggests a stronger commitment and readiness from the participants compared with compulsory programmes.

13. The trial will be offered to clients in treatment that either fall into the complex or non-complex category in terms of their motivation and ability to engage with recovery, and find and sustain work. Complex clients tend to be opiate clients who are furthest away from both recovery and labour market compared to alcohol and non-opiate drug users. There is little evidence to inform this, but we assume 10 per cent of our caseload will be made up of complex clients and 90 per cent non-complex.

**Table 3      Number of participants for the IPS proposal**

|                                           | Total  | 10% Complex | 90% Non-complex |
|-------------------------------------------|--------|-------------|-----------------|
| Total numbers in treatment in trial areas | 20,000 |             |                 |
| 15% take up assumed                       | 3,000  | 300         | 2,700           |
| 67% retention rate                        | 2,010  | 201         | 1,809           |

14. A survey of international evidence compared job outcomes among people with mental health issues in IPS<sup>214</sup> and normal employment support programmes. It suggested that IPS helps an additional 35 per cent of the target group who otherwise would remain unemployed. This significant beneficial impact of IPS is robust, and has been replicated internationally – but there have not been high quality studies looking at this approach for people with addictions issues.
15. Given this lack of evidence of effectiveness for our target population we have, in comparison to the survey evidence on mental health IPS, adopted a cautious estimate about anticipated impact. As discussed in Annex E, for individuals starting treatment in 2014/15, 15 per cent of the opiate group and 27–28 per cent of the non-opiate and alcohol group were already in employment. We have assumed twice as many people in IPS programmes are likely to find work as those who are in treatment generally (i.e. an additionality rate for the complex caseload of 15 per cent, and 25 per cent for the non-complex caseload). These assumptions result in an assumed 482 ESA claimants moving in to employment as a result of the trials each year.

## ii. Costs

16. The cost of the trial depends primarily on the cost of IPS Employment Support (ES) workers. Findings from research carried out by The Centre for Mental Health indicated a total cost of the service of around £45,000 to £50,000 per IPS ES worker per year<sup>215</sup>. However, staff and non-staff costs for disability employment advisors<sup>216</sup> is approximately £32,000 per year, so for the purposes of this analysis we assume a cost of £40,000 per IPS ES worker per year, which is the mid-point between these two estimated costs.
17. Evidence from IPS trials for mental health suggests that one IPS worker can manage a caseload of 20-25 cases at any one time, and participants require support for approximately six months. Therefore each IPS worker is assumed to support 40 to 50 participants over the year in our central and optimistic scenarios respectively.

<sup>214</sup> Bond, G.R., Drake, R.E. and Becker, D.R. (2012). *Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US*. *World Psychiatry*, 11(1), pp.32-39.

<sup>215</sup> Sainsbury Centre. (2009b). Briefing 41: Commissioning what works, the economic and financial case for supported employment, London: Sainsbury Centre for Mental Health. [http://socialwelfare.bl.uk/subject-areas/services-client-groups/adults-mental-health/centreformentalhealth/128975briefing41\\_Commissioning\\_what\\_works.pdf](http://socialwelfare.bl.uk/subject-areas/services-client-groups/adults-mental-health/centreformentalhealth/128975briefing41_Commissioning_what_works.pdf)

<sup>216</sup> Figures on the Overheads for Disability Employment Adviser were provided by DWP Finance Group.

18. Based on the total number of participants entering into the trial, the above scenarios give two estimates of the total number of IPS workers required to handle our assumed caseload. Under the central scenario 75 IPS workers are required which results in a total cost of £3 million. Under the optimistic scenario 60 IPS workers are required which results in a total cost of £2.4 million per annum.

### **iii. Results**

19. The results depend on whether the optimistic assumption of £2.4 million cost is used or the central estimate of £3 million; they have therefore been represented as a range. Based on the figures outlined in the benefits section, the trial would require those who successfully complete the programme and who find employment to sustain work for between 145 and 181 days, on average, in order for the Exchequer to break even. If we include wider benefits to society this number falls to between 93 and 116 additional days in employment to achieve the breakeven point.

### **IPS-lite trial**

20. The IPS-lite trial recommended in the report will test a 'time limited' version of IPS. This means that employability support will be offered for up to nine months and for those that find work, in work support will be offered for up to four months. In every other respect this approach mirrors the high fidelity IPS approach. It shares the same principles, involves similarly trained and supported staff, small caseloads and co-location with clinical teams.
21. This time-limited support is designed to increase an ES workers' capacity over time. The benefit of this additional capacity is unlikely to be seen at the start of the trial, but would yield benefits over time which is intended to help reduce costs in later years compared to the full IPS option shown above<sup>217</sup>.
22. The cost-benefit of the IPS-lite in the first year of the trial is likely to be broadly similar to the full IPS in the first year, therefore a cost-benefit analysis is not presented.

## **Proposal B: Co-location of Jobcentre Plus work coaches in treatment premises**

### **i. Volumes**

23. This trial will be delivered through work coaches co-located in treatment centres, who try to find employment within available local resources. They are expected to have slightly smaller caseloads than an average work coach in Jobcentre Plus. As with the other trials, we assume that a further 10 local authorities will take part in this trial, with the same take up, retention assumptions for complex and non-complex group as applied to potential participants as described in Table 3.

<sup>217</sup> A UK-based Randomised Control Trial of this approach for mental health patients suggested a 17 per cent increase in ES workers' capacity at the 18 months stage (the trial period). Source: Burns, T., Yeeles, K., Langford, O., Montes, M.V., Burgess, J. and Anderson, C. (2015). A randomised controlled trial of time-limited individual placement and support: IPS-LITE trial. *The British Journal of Psychiatry*, 207(4), pp.351-356.

24. Given this trial will be delivered through co-located work coaches, we have assumed a low additionality assumption of 5 per cent for the complex group and 7.5 per cent for the non-complex group. This low additionality assumption results in only 145 ESA claimants moving in to employment as a result of this trial.

## ii. Costs

25. As before the cost depends on the cost of the work coaches and the number of cases each work coach can manage per year. The salary and grade of a work coach are assumed to be the same as an ES worker, so a cost of £40,000 per work coach per year is assumed.
26. Given that the support offered to participants is not as intense as the first IPS trial, but more enhanced than that offered as business as usual by a work coach (expected to manage approximately 130 individuals a year); we assume each work coach can manage 80 to 100 participants across the year in our central and optimistic scenarios respectively.
27. Based on the number of participants entering the trial, the central scenario results in 38 work coaches required for the trial at a total cost of £1.52m. Under the optimistic scenario 30 work coaches are required resulting in a total cost of £1.20m per annum.

## iii. Results

28. Again the results are presented as a range depending on whether the optimistic cost estimate of £1.20m or a central cost estimate of £1.52m is used. Based on the figures outlined in the benefits section, the trial would require those who successfully complete the programme and find work to sustain work between 241 and 305 days, on average, in order for the Exchequer to break even. If we include wider benefits to society this number falls to between 154 and 195 additional days in employment to achieve the breakeven point.

## Public Health England estimate of wider benefits from completing treatment<sup>218</sup>

29. Using the same parameters and assumptions of IPS described above, PHE have conducted a cost benefit analysis using existing data from the NDTMS, and other sources<sup>219</sup>.
30. Access to drug and alcohol treatment through the IPS trials brings immediate social and economic cost savings and improvements in health-related quality of life for the individual. The benefits associated with successfully leaving treatment<sup>220</sup> and not relapsing are significant and can last a lifetime.
31. The benefits from the DWP social cost benefit framework used above to calculate break even for the above trials only takes account of the health benefit for an average ESA benefit claimant moving from unemployment to employment. However, alcohol and drug users are likely to present additional benefits to Criminal Justice Services (CJS) and a greater than average health benefit than stated in Tables 1 and 2.

<sup>218</sup> The estimation and methodology of the wider benefits of completing treatment refers to PHE led analysis.

<sup>219</sup> Health benefits were taken from: (Davies, Jones, Vamvakas, Dubourg, and Donmall (2009); crime benefits methodology taken from (NTA, 2012).

<sup>220</sup> 'Successfully' here refers to the National Drug Treatment Monitoring System (NDTMS) definition of drug/alcohol users that left treatment free of substance of dependence.

32. This analysis conducted by PHE compared the relationship between employment and sustained recovery among the treatment population and the additional gain IPS brings.
33. People with a psychoactive substance dependency in employment are more likely to leave treatment successfully. By increasing the proportion of individuals in employment it is assumed that this will in turn increase the successful completion rates.
34. PHE defined their complex and non-complex population as follows: all opiate users (OUs) were classified as complex, the rest of the cohort were defined as 'non-complex; made up of non-opiate users (non-OUs) and those presenting with alcohol only.
35. This resulted in the 482 ESA claimants in each trial moving into employment, which were disaggregated as follows: 30 OUs, 181 non-OUs and 271 alcohol only clients. NDTMS data shows that employment increases the likelihood of successfully completing treatment by an average of 1.32 (1.26 for the OUs, 1.33 for non-OUs and 1.36 for alcohol only clients.)
36. Average completion rates are 8 per cent for 'complex' and 39 per cent for 'non-complex' clients. By applying the increased employment likelihood to these rates, 243 people would additionally successfully complete treatment that otherwise would not have done so: 3 OUs ('complex') and 95 and 145 non-OUs and alcohol only clients respectively ('non-complex')
37. The relatively small number of additional 'complex clients' are a result of the low number overall that have been included in the analysis and the lower current completion rates, due to opiate clients being much harder to treat than users of other drugs.
38. Analysis shows that one year after leaving treatment successfully, 89 per cent do not re-present to treatment or criminal justice services with a substance-misuse-related problem or offence. This equates to just two people in the complex group, i.e. opiate users, and 214 from the non-complex group.
39. We assume that those not re-presenting sustain the health gains<sup>221</sup> they received in treatment, commit no substance-related crimes<sup>222</sup> and do not receive any future treatment.
40. The additional gross benefit of IPS participants who leave treatment successfully and sustain recovery amount to £3.13 million in the first year for the IPS trial. The same methodology was applied to estimate the gross benefits of the co-located work coach proposal. The results of both analyses can be seen in Table 4 below.

<sup>221</sup> Health gains are taken from the Drug Treatment Outcomes Research Study available here: [http://www.dtors.org.uk/Content/PDF/DTORS\\_CostEffect\\_Main.pdf](http://www.dtors.org.uk/Content/PDF/DTORS_CostEffect_Main.pdf)

<sup>222</sup> Crime gains for drug clients derive from: <http://www.nta.nhs.uk/uploads/vfm2012.pdf>, while the analysis for alcohol only clients was informed by: <http://www.sciencedirect.com/science/article/pii/S037687161600048X>

**Table 4 Estimated benefits in the first year of each trial**

| Type of benefit                                   | IPS trial     | Co-location of Jobcentre Plus work coach trial |
|---------------------------------------------------|---------------|------------------------------------------------|
| Health benefits <sup>223</sup>                    | £1.28m        | £0.38m                                         |
| Criminal Justice Services benefits <sup>224</sup> | £1.61m        | £0.20m                                         |
| No treatment required savings                     | £0.25m        | £0.07m                                         |
| <b>Total<sup>225</sup></b>                        | <b>£3.13m</b> | <b>£0.66m</b>                                  |

41. This PHE estimate excludes benefits for people who were in treatment, but did not leave successfully or who did so but went on to relapse, as we cannot gauge how much of their outcomes were treatment-related, nor how long any benefits lasted. As a result, the benefits of recovery as a consequence of IPS may have been underestimated.

## Proposal C: Jobcentre Plus enhanced support offer

42. The summary of recommendations in Annex C provides a detailed description of all elements of the recommended enhanced Jobcentre Plus support offer including the peer mentoring trial. This cost estimate presented here focuses on the following components of the offer:
- a. A named person in each Jobcentre Plus district to have a strategic focus on drug and alcohol employment issues in the district;
  - b. Case conferences with treatment providers to create and review a joint recovery plan and claimant commitment;
  - c. 'Keep in touch' support to claimants in work to ensure any relapse risk is dealt with effectively;
  - d. A peer mentoring trial at Jobcentre Plus.

### i. Volumes

43. We do not have a defined and fully-identified population of people on benefits with addictions. Therefore the volumes for this proposal are uncertain and will depend on operational decisions, such as whether to target help at those flowing onto benefits/onto different types of benefits etc. The assumptions on volumes eligible, take-up and success rates should all be tested by DWP in trialling and implementing the offer. Given the uncertainty of the volumes, only the cost of this proposal is presented. This is based on case conferencing for 200,000 individuals who are in treatment and on benefits. We assume 20,000 individuals find work<sup>226</sup> of whom 50 per cent would take up the in-work keep in touch support, and 5,000 would participate in the peer mentoring trial.

<sup>223</sup> Health benefit includes quality adjusted life years benefit.

<sup>224</sup> Benefits to Criminal Justice Services include crime victim reductions from victims' quality adjusted life years.

<sup>225</sup> Totals may not sum due to rounding.

<sup>226</sup> The assumption of 20,000 individuals finding work refers to anyone who finds work across all Jobcentre Plus offices, and is different to estimates of individuals moving into work for the trials outlined in proposal A and B.

## ii. Costs

44. We have assumed that a named person will be a Higher Executive Officer (HEO) in each of the 34 Jobcentre Plus districts and will be supported by one full time Executive Officer. This results in an annual cost of £2.44 million, which includes staff costs plus an additional 3 per cent for non-staff cost<sup>227</sup>.

**Table 5 Cost estimates for a named responsible office per district**

|                                          | No. of Districts | Total FTEs <sup>228</sup> | Av. Salary (£) <sup>229</sup> | Annual Cost (£m) |
|------------------------------------------|------------------|---------------------------|-------------------------------|------------------|
| Full-time Higher Executive Officer (HEO) | 34               | 34                        | 38,280                        | 1.30             |
| Full-time Executive Officer (EO)         | 34               | 34                        | 31,382                        | 1.07             |
| Total staff cost                         |                  |                           |                               | 2.37             |
| <b>Total staff and non-staff cost</b>    |                  |                           |                               | <b>2.44</b>      |

45. For the case conference element of the offer we assume two 30 minute sessions with an HEO are offered to 200,000 claimants. Based on productive minutes per person<sup>230</sup>, 171 HEO Full Time Equivalents are required at a cost of £6.55 million, plus an additional 3 per cent non-staff cost. Therefore total cost for the case conferencing element of the offer is estimated to be £6.74 million.
46. For the keep-in-touch support for in-work claimants' element we have assumed three 20 minute sessions with an HEO will be offered. Therefore, a total of 60 minutes are offered to each claimant over the year. Take up is assumed to be 50 per cent of the 20,000 individuals eligible for this support. Therefore, overall projected costs are estimated to be £0.35 million.
47. The costing for peer mentoring is based on all 5,000 claimants taking up the offer of the first 1.5 hour mentoring session but with only 50 per cent returning for the second 1.5 hour mentoring session. We have further estimated that the cost per hour of mentoring will be £10, this includes both staff costs (based on the minimum wage) and non-staff costs. Based on 11,250 hours of mentoring per year (7,500 for the first 1.5 hours plus 3,750 for the second 1.5 hours) the total cost for this proposal is £0.11 million.
48. Based on these four elements of this proposal, the total annual cost is estimated to be £9.65m.

**Table 6 Total cost of the Jobcentre Plus support offer proposal**

|                                                            | Total projected annual costs |
|------------------------------------------------------------|------------------------------|
| Named drug and alcohol officer per Jobcentre Plus district | £2.44m                       |
| Case conferencing                                          | £6.74m                       |
| 'Keep in touch' support                                    | £0.35m                       |
| Peer mentoring                                             | £0.11m                       |
| <b>Total<sup>231</sup></b>                                 | <b>£9.65m</b>                |

<sup>227</sup> Non-staff costs estimated to be 3 per cent of staff costs to reflect general office overheads.

<sup>228</sup> Full-time equivalents (FTEs).

<sup>229</sup> National average salaries based on December 2015 data for work services.

<sup>230</sup> Productive minutes a year 70298.21 – this reflects the amount of direct activity time available having taken into account weekends, bank holidays, annual/special leave, sickness, training, and indirect work allowance. It calculated by taking total days available multiplied by daily hours (7.4) less indirect allowances, and multiplying by 60 to convert to minutes.

<sup>231</sup> Totals may not sum due to rounding.

# Annex H

## Summary of the submitted evidence

### Introduction

1. The call for evidence was launched on the Gov.uk website on 29th July 2015 and ran for approximately six weeks ending on 11 September 2015. A total of 120 responses were received. We are grateful to everyone who replied.
2. Of the responses received, 10 per cent were personal testimonies from people with lived experience of one or more of these conditions. The remaining 90 per cent came from a variety of organisations and individuals who work with, or have conducted research on these groups.
3. These included service and treatment providers, local authorities, academics and clinicians and clinical bodies, charities, Jobcentre Plus and other government departments, a pharmaceutical company, an insurance company, a legal firm, a campaign organisation concerned with confidentiality and consent in health and social care and the Trades Union Congress. 14 per cent of the responses dealt specifically with obesity. 22 per cent covered all three conditions in their response. The majority, 64 per cent, of responses covered dependence on drugs and/or alcohol.

### Drug and alcohol dependency

#### The individual experience

4. Questions 1, 3, 6, and 8 of the Call for Evidence cover the claimant experience and engagement with key support services including Jobcentre Plus, health care and treatment and support services.

5. Many of those responding identified people with problematic drug and/or alcohol use as often having very chaotic and irregular lifestyles who were more likely to come from low income groups. They would likely have a poor or non-existent work history and few, if any, qualifications. Multiple health problems (both mental and/physical) were also frequently highlighted, together with lack of confidence and self-esteem. Family breakdown, potential impact on children and criminal behaviour were all associated impacts of dependency. Taken together respondents therefore identified this cohort as particularly vulnerable.
6. A reticence to disclose a drug or alcohol dependence to those working in the benefits system featured very strongly. There was a belief that self-disclosure could affect their benefit entitlement which meant respondents were afraid to reveal their condition to the Jobcentre Plus. Jobcentre Plus staff were perceived as having a lack of understanding of the causality and complexity of a dependency, being time bound and target driven. None of this promoted the building of a trusting relationship and claimants were often reluctant to disclose that their dependence was a barrier to employment.
7. Stigma and shame was also identified as commonly experienced by alcohol and drug misusers and by those who are overweight or obese. In the first two groups it can lead to secrecy and avoidance of help. Among the overweight it also causes shame, low self-esteem and distress, which can worsen the problem. Many submissions made clear that these disorders are not simply the consequences of lifestyle choices but follow powerful antecedent social influences and often are accompanied by physical and mental co-morbidities and adverse current social factors. It was reported several times that addictions – but not obesity – are excluded from the disability provision of the single Equality Act.
8. A number of respondents stated that many people with a problematic dependence did not access healthcare and, of those that did, some reported their experience of healthcare professionals was mixed. A respondent with lived experience of alcohol dependence admitted his treatment by staff while in hospital varied from 'brilliant' to 'disdain' with an inference by staff that his condition was 'self-inflicted'.
9. The Work Capability Assessment for those claiming Employment and Support Allowance received criticism in that it often did not identify an alcohol and/or drug dependence.
10. Many respondents identified pockets of effective practice but more often than not agencies worked in isolation or disconnectedly. Examples given included the fact that mental health services could not be accessed until alcohol and/or drug abstinence was achieved and clashes between treatment and Jobcentre Plus appointments. Among other things this results in a client having to repeat their life history and builds belief that no one has a complete or balanced view of the problems they face.
11. Many respondents emphasised the importance of close communication, and coherent arrangements for integration of services. This helps provide a unified service which gives the sense of a joined up and personalised approach to their support and care.
12. Housing issues were identified as a common factor preventing sustained recovery and employment. Respondents noted that many drug or alcohol dependent people have a criminal record which would make a significant impact on the employment opportunities a claimant may secure in the future.

### **Specialist employment services**

13. Questions 2, 4 and 5 of the Call for Evidence explore what support and services are currently available and how accessible and effective they are.
14. The importance of education, training and employment (ETE) was highlighted and the need to provide realistic and achievable employment and training opportunities.
15. There was much criticism of the Work Programme chiefly because providers were unable to work with others in addressing the wider challenges faced particularly by substance users.
16. Many service providers responded with details of the services they are currently commissioned to deliver. Bar a few notable exceptions, few provided data or evaluation to support claims of effectiveness.
17. Several responses emphasised the lack of evidence of effectiveness of services targeted at people with drug or alcohol addiction or obesity issues in getting people back into employment. Others suggested that any return to work interventions for these groups should be piloted and evaluated for effectiveness and cost effectiveness before wider implementation.
18. A need for a joined-up approach which offered integrated support for the dependent person to secure work was a near-unanimous feature of responses, and there were a number of examples of good practice.
19. Many respondents recommended that treatment and support should be tailored to the individual and their needs as a 'one size fits all' approach rarely succeeded.
20. Employment was recognised as an aid to recovery yet employment support is often delayed until the treatment programme is completed. The Individual Placement Support model was highlighted in several responses. Respondents also gave examples of volunteering and work placement opportunities that helped dependent people take steps into the labour market.
21. Respondents highlighted a wide variation in the availability of treatment services across the country – particularly for alcohol and obesity.

### **Employer and employee view**

22. Questions 9, 10 and 11 of the Call for Evidence focused on the position and views of the employer.
23. Several submissions made the point that employers are reluctant to employ current or ex-users. Drug Scope (2010) reported that two-thirds of employers would refuse to employ a former heroin or crack user even if they were suitable for the job.
24. There was also a perception that employers have low expectations of the reliability and stability of an employee with a history of drug and/or alcohol dependence thereby reinforcing the stigma and discrimination experienced by people in recovery.
25. There were examples of employers who actively recruited this cohort and were able to run a successful business whilst also providing opportunity to this cohort. These employers emphasised the significant additional costs of providing supportive work environments, without which failure is likely.

26. The Council for Work and Health response concentrated on the workplace. They cited evidence that identified the workplace environment as a key factor to future addictions, with stress, bullying and harassment in the workplace often acting as triggers. They supported the position in the *NHS Five Year Forward View* (NHS 2015) and recently published NICE (2015) guidelines which argued that health and well-being should be a strategic (i.e. Board level) obligation in all NHS organisations rather than as a devolved and sole responsibility of an occupational health service.

### **Implications of mandating appropriate treatment or support to benefit entitlement**

27. There was a strong rejection on ethical, legal and practical grounds of linking benefit entitlement to take up of appropriate treatment or support.
28. Representatives of health professionals stated that they would be in breach of their professional code of conduct and challenged the ethics and legality of removing voluntary informed consent. Many felt that introducing this mandation option would undermine the trust between the patient and doctor. Clinical respondents noted that there was much stronger evidence base around using small financial incentives to change behaviour (so called contingency management approaches).
29. Further concerns were raised regarding the identification of the target population. This included the difficulties of Jobcentre Plus work coaches identifying members of the cohort who require treatment.
30. Concern was also raised that mandating treatment may lead to already vulnerable claimants dis-engaging from treatment and support. Possible impacts included increased acquisitive crime with increased costs for criminal justice services.
31. Lack of available high quality treatment to accommodate an influx of claimants mandated to treatment was another issue raised by respondents.

### **Obesity**

32. Responses to the call for evidence that covered obesity were far fewer than those for drug and alcohol dependency, perhaps reflecting the relatively undeveloped understanding of links between obesity and employment outcomes.
33. Several submissions suggested that obesity is a population health problem and requires society and government to create the right environmental conditions to promote healthy weight. They also made the point that NHS care pathways for treatment of overweight and obesity are not as well developed as those for alcohol or drug misuse.
34. It was noted by a number of organisations and clinicians that obesity can lower life expectancy and is directly associated with numerous conditions, both mental and physical which can either be the reason behind or result in obesity.
35. The intergenerational aspect of obesity was highlighted by many contributors insomuch as obese parents are more likely to have obese children and obese children are more likely to become obese adults. Furthermore, no country has successfully decreased obesity rates.
36. When considering a mandation to treatment, the general concerns listed above were also raised for claimants who are obese. Respondents did question whether, assuming obesity was a barrier to work, there was sufficient availability of effective treatments that a claimant might be mandated to.

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