



Equinox



Improving the Housing, Training and Employment Prospects for Problematic Drug and Alcohol Users

Briefing No 5

CCROSS ██████████
PPARTY ██████████
GROUP ██████████
ON **D**RUG ██████████
AND **A**LCOHOL ██████████
TREATMENT ██████████
AND **H**ARM ██████████
REDUCTION ██████████

The Problem

The organisations that make up the Conference Consortium are all engaged in dealing with drug and alcohol use per se, but have to contend with the problems of maintaining any treatment gains made by those they work with that are often the result of those individuals' inability to access the basic requirements of adequate and secure accommodation and constructive activities – employment, education and training, volunteering, etc).

The problem has also recently been highlighted in a speech by the Chief executive of the National Treatment Agency (NTA) Paul Hayes. Speaking at a conference on reducing crime through offender- based interventions he outlined the success of the national drug strategy in increasing the numbers in treatment and the health gains and reduction in crime as a result, but he acknowledged that, 'If we can't persuade the public that integrating drug-misusing offenders into society is in the long-term interest of society, then all our strategies and plans are unlikely to translate into real jobs and homes', and calling for a centrally led and locally owned political purpose he concluded that, '...re-integration can consolidate success – but we have not yet worked out how to make that happen in local partnerships in a way that is acceptable to the public'.

Ironically the views Paul Hayes expressed echoed almost exactly those of the Audit Commission, in its report 'Drug Misuse 2004', which stated, '... government guidance suggests that one in three drug users presenting for treatment is in housing need, and some local research has found even higher rates of need' and pointed to an over emphasis on treating drug addiction, coupled with a lack of

emphasis on providing the support needed to bring order to the often chaotic lives of drug users. It concluded that housing, social care and other services must provide users with support to maintain progress made during treatment and ultimately help them become employed, housed and more self sufficient. The inference that might be drawn is that little has changed in the intervening 5 years.

In terms of accessing employment – paid and voluntary - training and education the antecedents of many of those seeking help from drug and alcohol treatment providers, as well as those subject to the supervision of the probation service, often present insurmountable barriers, even after significant periods of demonstrable stability. The establishment of the Independent Safeguards Authority (ISA) with its remit to determine the bona fides of those seeking to work with potentially vulnerable communities and populations, under its *'vetting and barring scheme'*, could potentially further frustrate the efforts of our client group to secure paid or voluntary employment. An article by Mark Johnson, in the Society section of the Guardian newspaper, on Wednesday 16th June, pointed out the extent of the powers of this body to rely on often unsubstantiated information to protect the vulnerable, without those subject to checks having sufficient access to an appeal mechanism or system to review decisions made. This may well be an unintended consequence, but is indeed something members of the Consortium have concerns about – both in terms of their assisting clients, as well as in their liabilities as employers to satisfy themselves about the bona fides of their employees.

Many people with a poor employment history, for whatever reason, begin the process of establishing a credible CV by undertaking

voluntary work, which often involves engagement with ‘vulnerable’ groups. The ISA rightly seeks to safeguard the interests of vulnerable children and adults, but its remit – which from 12th October this year extends to the whole of the NHS and the prison service – is wide and its powers to determine who is vulnerable and the criteria for fit and proper persons, together with the penalties for those who knowingly employ – paid or voluntary – someone who is, or should be, barred is likely to lead to exclusion of large numbers of our clients from activities that for most of those engaged in them have proved to be successful and to have benefitted those receiving their help.

Scale of the Problem

There are many estimates of the number of problematic drug users and drinkers in the UK. The ‘National Focal Point Report for the European Monitoring Centre for Drugs and Drug Abuse (EMCDDA) gives a figure in excess of 403,000 problematic users in the UK, although the figure for overall drug use has been put much higher, from 2m to 3m, if regular recreational use is included. In its 2007/08 Annual Report the NTA recorded 202,000 people entering treatment, with over 190,000 of these maintained in treatment for or beyond the benchmark 12 week period.

‘Models of Care for Alcohol Misusers’ (2006) produce by the NTA gives figures of 7.1m people (23% of the population between 16-64) drinking ‘hazardously’, with 1.1m of these ‘dependent’ on alcohol.

Given that the figures above are global and that the number of individuals in acute need of help and support with accommodation, employment, training and education comprise only a fraction of the total, the context and potential scale of the problem indicates that

some remedial action is necessary. This also against a lack of political will, especially given the lack of popularity of the client group, particularly at a time when resources funded through the public purse are increasingly scarce.

Members of the Consortium provided information in relation to their own services as to how many people were inadequately housed and not engaged in employment, education or training, on admission to their service and how this might have changed at the point of discharge/disengagement from the service. The results varied from 7% improving their housing situation in one place, to 69% in another, with the remainder somewhere in between, which probably reflects the different levels of provision in each area and showing a lack of consistency - a ‘post code lottery’ one might say.

When looking at employment, training and education, again there were differences, although data collected was not uniform. The largest improvement in this area for those exiting treatment was 22%, with other services estimating less than this.

Whilst the latter information is less than scientifically robust, the snapshot, given the wider context in the earlier part of this section points to a significant challenge to deliver effective change in these areas.

Possible Ways Forward

There are no simple solutions to the issues raised above. Needs always outstrip resources, protecting the vulnerable can often create problems for those who are themselves vulnerable. The balancing act to ensure that reintegration of those on the margins has benefits for

both the individual and the community as a whole is one that requires a skilled and multi-agency/multi-disciplinary approach.

In researching for this paper there were numerous sources that could be referenced and a plethora of good practice that might be described. What follows is a distillation of the many, with only a limited number of specific references for the sake of brevity.

In beginning to develop any policy related to drug and alcohol use it is essential to accept that continued use and relapse are inevitable for many, if not most, who seek help and treatment. With this in mind the admission criteria and contracts for occupancy, or for that matter employment, have to take this into account. Decisions should be based on being inclusive, whilst not being seen as giving a licence to those whose behaviour or conduct becomes unmanageable through their using behaviour.

When we apply this to employment the issues are possibly clearer cut, where a person's ability to perform tasks effectively and safely are paramount. The obvious example here is the impossibility of a public transport driver for example being unable to drive a bus or train whilst intoxicated, or suffering from the results of intoxication. However, where this might be an issue there should be employee assistance programme available to help and support them and enable them to return to work when appropriate. This approach also helps employers to maintain trained staff and saves the other costs resulting from dismissal. There is no current requirement on employers to provide access to such programmes and maybe this is something that should be considered in future legislation in this area.

In terms of housing, Shelter advocates the provision of a range of housing and support for drug users, from abstinence based projects to those that operate a harm reduction approach, all with some security of tenure for residents. The idea being that all requirements in the occupancy agreements (whether assured, or assured short-hold tenancies) are necessary and confer on tenants some security. Such a sense of security is an essential part of all of our lives and contributes to our well-being, why should it be any different for those with histories of problematic drug and alcohol use?

In its 2006 report '*Safe as Houses: an inclusive approach for housing drug users*', Shelter identifies as an essential requirement, 'a clarity of the aims, objectives, policy and practice of the provision....an inclusive drugs policy and its acknowledgement by staff, service users, and key stakeholders, including the police and local authorities'.

To support this a holistic, multi-agency/multi-disciplinary is required, employing a 'shared care' approach, with the resident at the centre and included in all decision making related to their care. This is consistent with NHS guidelines and evidence from the mental health field provides a large number of examples where this works extremely well.

When a harm reduction approach is adopted it has benefits for everyone involved. When problematic drug or alcohol use (or both) are identified and acknowledged strategies to manage this can be devised and implemented. A first step is to ensure that residents are linked into local primary healthcare and other services. If problems arise they can then be dealt with more easily and effectively. For example an intravenous drug user might be referred to a needle exchange, where their use can be discussed, monitored and

stabilised, reducing the risks to them and to the community, in terms of paraphernalia being disposed of safely. This might be a first step, but it is essential that any care plan needs to be reviewed and amended regularly to take account of changes. Obviously there are less extreme scenarios, but the process is the same.

The aim of all approaches is to make the resident/client a stakeholder with rights and also responsibilities and to ensure that they are fully engaged in the process of achieving and maintaining stability, improving the quality of their life and opening up new opportunities for their personal growth and development.

The Shelter report contains much more policy advice together with a number of examples of good practice and can be downloaded from:

[http://england.shelter.org.uk/data/assets/pdf_file/0020/48062/Safe as Houses.pdf](http://england.shelter.org.uk/data/assets/pdf_file/0020/48062/Safe_as_Houses.pdf)

Regarding employment opportunities for our client group there are number of initiatives. However research conducted by Tim McSweeney and others and reported in a 2004 publication, *'From Dependency to Work (D2W): addressing the multiple needs of offenders with drug problems'*, which evaluated a scheme operated across 12 London boroughs, from 2000 to 2004, funded via the Single Regeneration Budget (SRB) provides some useful pointers, which might be applicable more widely.

The scheme aimed to increase the employability prospects of its clients was designed and managed by a multi-agency management board, including statutory authorities and services and the NGOs charged with the bulk of the delivery of services to clients. The

targets were ambitious and were not wholly met, however there was some valuable learning identified in the report.

The numbers passing from the referral stage to assessment and engagement (2187 individuals) was significantly less than targeted, but probably reflective of the chaotic client group targeted by the scheme. Those who did engage tended to be those who had 'done better' in their prior treatment, which again presents little surprise.

One impediment to the successful functioning of the scheme identified in the report was the lack of joint working and willingness of agencies to 'share clients', which could, in part at least, be attributed to the way funding was allocated to individual agencies, all with their own targets, which in some instances disincentivised joint working.

Good points from the scheme included the establishment of 'one stop shops' increasing the inclusivity of the scheme, including engaging successfully with users from BME communities. Also the use of mentors, drawn from the community and not necessarily specialists in the drug and alcohol fields, to help those seeking work was generally successful: having 'ordinary' people help them 'normalised' the process for a lot of those taking part in the scheme.

The average cost of providing the DTW service was in the region of £11,000 per participant (at 2004 prices) and it is arguable that such sums might be invested more effectively.

Other Considerations

One important factor in improving the prospects for problematic drug and alcohol users is changing society's view and attitudes towards them. This must start with 'culture carriers', including the users themselves, but also those in a position to influence others. One obvious way to drive this process is for government and local authorities to provide employment and training opportunities that are available to those who might not ordinarily qualify – either through lack of skills, or criminal convictions, etc. This might mean opening access to supported/sheltered and training schemes, currently available to other disadvantaged groups. It might also include skill and confidence building initiatives, utilising mentors, with an emphasis on 'active citizenship' and improving self-image and self-worth – often significant barriers to progress.

Such an approach, coupled with a positive campaign of promotion, can be effective: drug and alcohol users being seen as contributors, rather than threats to their communities. An example from Antwerp, in Belgium, illustrates how this might work, the 'Needle Patrol', which was organised and managed by local drug users, was established with financial and other support by the city council to provide a cleaning service in public parks, removing any discarded needles and other paraphernalia, making the spaces safe for everyone. Once the initial furore the scheme attracted died down, it became seen as a valuable service and an example of how drug users are responsible and have a stake in their community.

Where housing is concerned there is also a 'selling' job to be done. Looking at examples of how prejudice and discrimination have been addressed in relation to other groups may provide some help in

dealing with similar issues in relation to drug and alcohol users. As in the case of employment, training and education support from culture carriers is again important, but in this case this will need to be backed up by significant resources – bricks and mortar cost money.

A building programme, however ambitious and however funded would take a significant period of time to realise. One immediate way to begin to address homelessness would be to establish properly funded and supported rent deposit schemes, opening up private rented property to our clients. Again the selling of these schemes to potential landlords is critical, as is ensuring that properties let are of an appropriate standard. This requires skilled staff, with manageable caseloads for any scheme to be successful. Such schemes would meet the requirement expressed by Paul Hayes, being '*centrally led and locally owned*'.

Conclusions

This paper has attempted to present some of the main issues that the Consortium members have identified as requiring resolution. There are obviously others that are not covered within it. The paper also provides a glimpse at some possible ways to address these issues, although again there are many more not covered.

We hope that the contents at least provoke some thoughts and ideas for how issues can best be raised within parliament and government to progress a campaign for investment and development of services effective for both problematic drug and alcohol users and the communities in which they live.