UKDPC

UK DRUG POLICY COMMISSION

Getting Problem Drug Users (Back) Into Employment

Part Two

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Evidence Review
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The **UK Drug Policy Commission** (UKDPC) is an independent body providing objective analysis of evidence related to UK drug policy. It aims to improve political, media and public understanding of drug policy issues and the options for achieving an effective, evidence-led response to the problems caused by illegal drugs.

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Executive summary

Aim

- The overarching aim of this research was to examine issues relating to the (re-)entry of problem drug users to the labour market, focusing both on barriers to employment and on effective support structures and mechanisms.

Methods

- We gathered data to explore the issues from three perspectives: employers, service providers, and problem drug users.
- Fieldwork took place in three local case-study sites across England and Scotland.
- Employer perspectives were examined through a UK-wide national web survey (135 respondents) and 52 telephone interviews.
- Service provider perspectives were gathered through 30 face-to-face and telephone interviews.
- Problem drug user perspectives were explored through 26 face-to-face interviews.

Findings

Getting 'job ready' – primary issues

- Individual problem drug users need to be motivated to begin the process of getting ready for addressing their primary needs before considering employment itself.
- Primary needs are often interwoven and need to be addressed together.
- Accommodation must be appropriate to the individual's stage of treatment. This is critical in providing a supportive and stable environment that is conducive to moving towards employment.
- Health issues, including but not restricted to those that are directly drug-related, need to be stabilised.
- Practical and emotional support from a variety of sources, both formal and informal, is felt by problem drug users to be essential at this preliminary stage.

Seeking employment

- There are differing views across all groups concerning whether abstinence or alternatively stabilisation through maintenance prescribing are necessary for moving into employment. These views in turn link to the options for employment that are made available.
- There is a process of matching the expectations of problem drug users and service providers regarding suitable employment. Health and drug status play fundamental parts in the types and number of job opportunities available.

- Developing a positive and realistic attitude to work, through building confidence and motivation (e.g. undergoing training, volunteering etc.), is an important task for service providers and will ease the transition to a 'mainstream' lifestyle.
- Service providers found it difficult but vital to locate willing local employers. The fragility of some of these links often made service providers cautious about recommending placements for some higher-risk individuals.

Employer perspectives

- Employers are generally reluctant to take on potentially 'risky' job applicants. Recruitment processes are used in different ways to manage these perceived risks. This can range from 'blanket' recruitment policies that rule out employing drug users through to a more discerning individual approach.
- A central concern is whether an individual is 'fit for the job' in terms of being reliable, capable and punctual. How 'fitness' is perceived varies for different employment sectors and company sizes. These perceptions are sometimes mediated by stereotypes and prejudices about drug users.
- Some employers identified support needs (e.g. updates on an employee's rehabilitative progress), while for others it was not relevant.
- Regional variations between the case-study sites were minimal among employers but local differences in drug treatment ideologies (e.g. abstinence orientation) could be significant from the perspective of employers.

Conclusions and implications for policy and practice

- Meaningful employment can be an important part of reintegration into society, bringing with it positive benefits to self-esteem, self-confidence and self-worth.
- Problem drug users can be employable across a range of sectors.
- Service providers should recognise that the search for employment is a significant step towards rehabilitation. Once employment is obtained, support must be provided to maintain motivation and to enhance the 'distance travelled'; this will increase the chances of avoiding relapse.
- Different types of accommodation provision need to be available for individuals at different stages of this process.
- A range of volunteering opportunities should be made available.
- A locally tailored employer engagement strategy should be developed.

1. Introduction

- Approximately 80% of the estimated 330,000 problem drug users in England are unemployed.
- Understanding the barriers to employment for problem drug users is vital to developing appropriate policy responses, yet little is known about the attitudes of employers towards problem drug users.

BACKGROUND

The most recent and accurate estimates suggest that there are approximately 330,000 'problem drug users' (PDUs) in England. PDUs are defined for the purposes of such estimates as users of heroin and/or crack cocaine (Hay et al., 2006). There are other definitions but in essence the group consists of those people whose drug use causes substantial difficulties not only for themselves but also for their friends, families and the wider community. Typically, these are heroin or crack users, often involved in drug dealing and acquisitive crime and suffering from drug-related health and other difficulties. They have become a major focus within British drug policy over the past ten years or so.

One feature of PDUs as a group which goes largely unremarked is that the overwhelming majority are unemployed, approximately 80% in the Drug Treatment Outcomes Research Study (DTORS) sample (Jones et al., 2007). Yet we know that paid work not only contributes to society but also provides an individual with a sense of responsibility, value and independence and of having a stake in society. Indeed, the Government's programme of 'welfare-to-work' initiatives is based on the importance of paid employment. This approach begs at least two important questions. Could work promote recovery for drug users? Should increasing rates of participation in the labour market be more of a priority for drug policy and practice?

Addressing these questions requires some understanding of why employment rates among this group are so low. Some of the reasons are obvious. It is well-established that many problem drug users live chaotic lives, suffer from health problems, live in unstable accommodation and have regular contact with the criminal justice system. None of these is conducive to getting, let alone keeping, a mainstream job. For many, their skills and levels of educational attainment may be limited too. The business of generating income and then accessing drugs can also be extremely time-consuming, as many ethnographic studies have found (e.g. Preble and Casey, 1969; Pearson, 1987). For many, there is simply not enough time for a legitimate job as day-to-day life is taken up by the cycle of 'hustling', 'scoring' and using.

Taken together, these factors provide a strong set of explanations for the difficulties this group can face in obtaining employment. There are a number of other equally, or perhaps even more, significant barriers to labour market entry, which can be defined

as 'external'. These external barriers include the structure of the benefits system and the operational practice of drug treatment and other support services; as well as criminal justice agencies such as probation services. It may be that these operational practices do not provide assistance into work for PDU clients. For example, are they flexible and accessible enough in terms of opening hours and other aspects of their operation? However, a more significant barrier to PDUs entering the labour market may be the attitudes of employers. Put simply, for many employers, heroin or crack users, even if in treatment or abstinent, are viewed as an extremely problematic group to be taken on as employees. We know relatively little though about the perspectives and attitudes of employers towards PDUs.

Understanding the barriers to employment for PDUs, particularly the employer perspectives, is clearly vital to developing appropriate policy responses to the issues concerning employment of PDUs. In recent years there has been a growing number of employment projects for PDUs in the UK and there is a need to review, synthesise and take stock of the evidence of their impact. There may also be much to learn from international comparisons of benefits systems as well as from efforts to support other 'vulnerable' or 'hard-to-place' groups into employment. This research study will make a significant contribution to our understanding of employment and PDUs and add to the current evidence base in this area.

However, two important issues in this area lie outside the scope of this study. We mention them here both to indicate that we are aware of them and to clarify the parameters of the research on which we report here. In the main, however, we bracket these issues out from our analysis in this report. First, although the unemployment rate among PDUs is very high, this does not mean that all those not in work are economically inactive. Research over a long period of time has shown that many drug users are involved in what have been termed variously the informal, shadow or underground economies; that is, those sectors of economic activity that lie outside the bounds of official recognition, measurement and regulation (Auld et al., 1986; Seddon, 2008). Our focus in the present study is on entry into employment within the *formal* economy. Second, not all commentators accept as an unqualified public good the thrust of 'welfare-to-work' and activation policies. For some, it is part of a policy direction that serves to prop up the precarious, casualised, insecure and low-paid end of the formal labour market (for a 'strong' version of this type of critique, see Wacquant, 1996). In other words, it perpetuates disadvantage rather than reducing it. While we do not necessarily fully share that view, we should be cautious about uncritically viewing (re-)entry in to the labour market as beneficial and positive in all circumstances.

Research aims and objectives

The overarching aim of this research is to examine issues relating to the (re-)entry of problem drug users to the labour market in order to make recommendations for future policy and practice. More specifically, it seeks to:

- review the particular challenges that PDUs face in re-entering the employment market (e.g. skills, medication, work experience, support mechanism, homelessness etc.);
- consider the impact of the current legislative frameworks and benefits structures on PDUs' participation in the labour market;
- understand the perceptions, attitudes, practice and experiences of employers with respect to employing PDUs;
- identify some examples of effective support systems for PDUs; and
- identify the subsequent implications for national policy and service delivery bodies.

The second of these aims, considering the impact of legislation and the benefits regime, is covered separately in our Part 1 Report.[1]

METHODOLOGY

In order to address the research aims described above, we adopted a mixed-methods approach, encompassing a national element and three local case studies. The case-study sites were selected to provide a degree of geographical and demographic diversity: site A was a city in Scotland; site B a city in northern England; and site C an inner-city London borough.

We sought the perspectives of three groups of respondents:

- employers;
- PDUs;
- drug treatment services and other relevant service providers.

Employer perspectives

Employer perspectives were gathered through two strands of fieldwork: first, a national web-based survey, and second, 52 telephone interviews with employers from the three case-study sites. We constructed a sampling frame, presented below, which we used for both strands. The frame was not an attempt to cover the entire labour market but instead included the principal sectors in which PDUs tend to find employment.

Table 1: Sampling frame

Employment sector	Small enterprise Fewer than 250 employees	Medium-sized enterprise Fewer than 500 employees	Large company More than 500 Employees
Construction	N = 42	N = 42	N = 42
Travel, leisure and retail (including food and beverage)	N = 42	N = 42	N = 42

[1] Harris N. (2008), *Social Security and Problem Drug Users: Law and policy,* UKDPC (available at www.ukdpc.org.uk/reports.shtml)

Catering and domestic/ commercial services	N = 42	N = 42	N = 42
Industrial and manufacturing	N = 42	N = 42	N = 42
Total	N = 168	N = 168	N = 168

National web-based survey

To publicise the survey, individual email invitations to participate were sent to over 2,000 enterprises, with a second reminder email following this. Trade associations were also contacted by email and telephone to request that they circulate the invitation to their members. Both the individual contacts and the trade associations were selected to provide coverage across the sampling frame. Our final achieved sample was 135, the distribution of which is presented below.

Details of respondents by company size, industry sector and source of lead are given in tables 2, 3 and 4 below. The 31 respondents who failed to return the questionnaire have been excluded; in addition, some respondents who selected 'Other' in response to the 'Sector' question have been reassigned on the basis of their self-described industry sector.

Table 2: Size of company

5 and under	7	7%
6–20	17	16%
21–50	18	17%
51–100	16	15%
101–250	13	13%
More than 250	31	30%
Don't know	0	0%
Prefer not to say	2	2%
Total	104	

Table 3: Sector

Construction	16	15%
Catering and domestic/ commercial services	10	10%
Industrial and manufacturing	37	36%
Travel, leisure and retail	8	8%
Financial and legal	7	7%
Health and social care	9	9%
Other public sector	9	9%
Voluntary/charitable	5	5%
Other	3	3%
Total	104	

Table 4: Level of respondent

Director/partner etc.	32	31%
Senior management	19	18%
Management	23	22%
Human resources	25	24%
Not specified	5	5%
Total	104	

To sum up, 40% of respondents work in relatively small organisations (50 or fewer employees), with the remainder evenly split between the '51–250 employees' (28%) and 'over 250' (30%) categories. 51% of respondents work in construction, industry or manufacturing, with industry and manufacturing accounting for the largest single group (36%). The remaining 49% are divided fairly evenly across the remaining retail, service and public sector categories. Sixty-nine respondents (66%) used generic survey URLs, meaning that they were not identified as being associated with any specific trade association. Food, drink and hospitality-related associations accounted for 23 of the remaining 35 complete responses (22% of the total). Most respondents are either in management or dedicated human resources positions, although over 30% are at the level of company director; the great majority of these (19 out of 32) are in organisations with 50 or fewer employees. We do not claim that the survey findings are nationally representative or can be generalised. Rather, they simply offer a snapshot of employer views across different sectors of the labour market.

Employer interviews

We conducted 52 telephone interviews with employers drawn from across the three case-study sites. Again, we sampled employers using the sampling frame in order to get some coverage across different employment sectors. The sample is described in the table below.

Table 5: Employer sample for telephone interviews

	Construction	Catering and domestic/ commercial services	Industrial and manufacturing	Travel, leisure and Retail (inc. food and beverage	Public sector	Voluntary sector
International and national	2	2	1	1	6	8
Medium-sized: 100–449 employees	2	3	3	3		
Small enterprise	5	7	4	5		
Totals	9	12	8	9	6	8

Interviews focused on the following issues: company policy towards the employment of PDUs; medical information requested at the time of application and how this is used in the appointment process; and concerns that the respondent had in relation to employing PDUs with reference to types of drugs used and length of time required for the candidate to be drug-free prior to appointment. Each respondent was asked series of questions concerning their experiences of employing PDUs and what their view was of the concept that companies have a social responsibility to employ PDUs. Respondents were also asked what types and level of support would increase their propensity to appoint PDUs.

PDU perspectives

We interviewed a total of 26 PDU from across the three case-study sites: six from site A, eight from site B and 12 from site C. Nineteen of the interviewees were male and seven were female. Twenty of the interviewees described themselves as white British, one as white European (Italian/Irish), three as black British and two as Asian or Asian/European.

Eight of the interviewees were currently in some form of employment, the rest were not. Of those who were working, one was in a 16-hour voluntary work placement within the drugs field, which was combined with studying at college on a health and social care course to complement his voluntary work placement. A further four were now in full-time positions within the drugs and housing support and resettlement fields; all four found employment after initially taking voluntary routes into these areas of work. The other three were employed in different sectors, with one working as a full-time carpet fitter/carpet warehouse operative (also after a six-month voluntary period with his employer) while the remaining two were on subsidised six-month full-time, paid work placements, working as a machinist and in furniture removal and delivery respectively.

Of the eight interviewees in employment, two were still on some form of medication while working. One of these was on 30 ml of methadone a day, but she hoped to reduce her dose and eventually to change her medication to Subutex, while the other was currently taking 14 ml of Subutex a day (increased from 8 ml after he began working). None was currently using heroin or crack cocaine. Interviews focused on: drug-using history; current situation; offending history; experiences of rehabilitation and treatment; education and training; and seeking, gaining and sustaining work experiences.

Table 6: Breakdown of PDU interviews by site

Site A (n = 6)	
Ethnicity	All six were white British
Gender	Three male, three female
Drug status	All six were abstinent from all drugs, including alcohol and any medication
Employment status	Two were currently in paid employment, both males – one as a drugs worker, one as a carpet fitter/warehouse worker; the remaining four were unemployed
Site B (n = 8)	
Ethnicity	Seven were white (six white British, one white European (Irish/Italian)) and one Asian
Gender	Six male, two female
Drug status	Five were currently on prescribed medication such as methadone or Subutex; three were no longer using any illegal drugs or on a prescription
Employment status	Three were working, one as a drugs worker volunteer, the other two in subsidised, six-month work placements as a machinist and a furniture removal/delivery worker; the other five were unemployed.
Site C (n = 12)	
Ethnicity	Eight white British, three black British, one Asian/European
Gender	10 male, two female
Drug status	Five people were still using heroin, crack or prescribed medication, three were using prescribed medication only, and the remaining four were no longer using either illegal or prescribed drugs
Employment status	Three were working, all of whom were male and employed within the drugs and supported housing fields as support and resettlement workers; the remaining nine were unemployed

Service provider perspectives

We interviewed a total of 30 service providers drawn from the three case-study sites. Interviews were conducted with staff from all of the service providers who facilitated access to the PDUs in each of the three chosen sites. In addition, interviews were conducted with other service providers mentioned in interviews with both service providers and PDUs and through consultation with local Community Drug Teams, Drug Action Teams and council officials with experience of the local drugs and employment provision. The sample included a range of agencies in both the voluntary and statutory sectors who worked with PDUs. While many of these service providers worked exclusively with PDUs, others engaged with PDUs alongside other client groups such as

the homeless, ex-offenders, long-term unemployed and people with a range of disabilities. Interviews with these service providers were used to compare PDUs with other service users to tease out any specific barriers that may exist for this group over others.

While an important focus of the service user interviews included drug treatment providers and projects such as those services that provided structured daycare activities and training opportunities, the service provider interviews also incorporated several housing associations, hostels and supported housing projects, and residential treatment providers. A further central component of the service provider interviews included both voluntary and statutory sector employment services. These ranged from the more mainstream support services, such as the Department for Work and Pensions funded Jobcentre Plus, Progress 2 Work and Working Links, to local voluntary, community and cooperative groups, which provided a range of training, voluntary and paid employment opportunities to drug users and other targeted groups, for instance ex-offenders.

While the interviews primarily focused on the nature, extent and availability of service provision available for those seeking employment as part of their rehabilitative process, it was common for many of the service providers interviewed to have worked in a variety of related roles and organisations. They were therefore often able to provide contacts and information that extended beyond a description of their current role and what they provided. In particular, they were able to provide a professional opinion of what they viewed as the main barriers to employment for PDUs based on many years of experience of working with this client group.

2. Lessons from the research literature

- Six key obstacles have been identified: low levels of education or skills; poor physical or mental health; evidence of multiple forms of deprivation; gaps in provision of support services; personal and presentation barriers; and interpersonal barriers (Sutton et al., 2004:5).
- Two main concerns are highlighted: 'job-readiness' – an individual's beliefs and feelings about their readiness for work; and 'employability' – employers' perceptions of the suitability for employment of individual jobseekers.
- Support services for problem drug users need to cover three stages: building job-readiness; practical support in the search for employment; aftercare support to help sustain employment.
- Good partnership working between drug services, employment services and local employers is needed for successful initiatives.
- External factors have a significant impact. Some external factors are beyond control; for example, during an economic downturn, jobs are scarce and employers have a greater pool of applicants to choose from. It is at times like the present when the least 'attractive' will tend to get left behind (South et al., 2001:26).
- Other external factors are within our control: employment and social security legislation and administrative practices may themselves create barriers to employment. Conversely, they can also be used to enhance pathways to work.

In this chapter, we provide an overview of relevant findings from previous research. We focus on research in three specific substantive areas: a) barriers to the employment of PDUs; b) successful approaches to helping PDUs into work; and c) lessons from initiatives designed to help other 'hard to place' groups (e.g. ex-offenders) into employment.

The preparation of this review took place between June and August 2008, alongside the other research covered in this report. Given the time and resource constraints for the project as a whole, it was not possible to conduct an exhaustive and systematic review of the literature. To maximise the usefulness of our brief review within these constraints, we focused on using other reviews in order to draw out the most significant themes relevant to our research aims. Readers looking for more detailed and extensive surveys of the literature are referred to the following: Richards and Morrison (2001); South et al. (2001); Sutton et al. (2004). A special mention should be made of the review by South and colleagues published in 2001, which manages to be admirably concise at the same time as being detailed and insightful. Apart from these reviews, the other major report worth reading in its entirety is the study by Klee et al. (2002).

BARRIERS TO THE EMPLOYMENT OF PDUS

It is well-established that PDUs face a range of difficulties both in getting into employment and then in sustaining it. What does the research literature tell us about these barriers to employment? In other words, why is it that this group experiences such a high rate of unemployment?

One important strand of research has sought to identify 'factors' that hamper PDUs in getting a job. For example, Sutton et al. (2004:5), reviewing the international literature, suggest that there are six key obstacles: low levels of education or skills; poor physical or mental health; evidence of multiple forms of deprivation; gaps in the provision of support services; personal and presentational barriers; and interpersonal barriers. This body of work is important in highlighting the central difficulties faced by this group in getting into and sustaining employment. A limitation of this work though is a tendency towards a 'laundry list' approach, which struggles to capture the interactive and dynamic nature of drug users' lives. One way of developing this work might be to separate those barriers that are linked primarily to the impact of socio-economic disadvantage from those that are more closely and directly connected with problem drug use. However, while this distinction is clearly important for analytical purposes, perhaps it is of less significance in terms of policy and practice, as those with multiple problems will ultimately require help and support that is equally multifaceted. We suggest that a more profitable way of viewing the literature on barriers to employment is through the lens of two (related) concepts: job-readiness and employability.

Job-readiness

The concept of 'job-readiness' can be defined as the state of being ready to seek, find and start a job. It encompasses several areas, which we will describe below, but in essence refers to an individual's beliefs and feelings about their own readiness for work. Klee et al. (2002) make the important point that for PDUs many of the issues here may be rooted in personal histories of adverse family and school experiences and, as a result, can be extremely difficult to address. For example, low self-esteem and lack of confidence have been found to lower motivation and capacity to seek employment (Atkinson et al., 2001; Sutton et al., 2004:6), but in many instances these may have much longer-term causes. It should be added too that an individual's low confidence in their ability to find a job may also be based on rational judgments about their likely success – many drug users are acutely aware that low skills, poor (or no) qualifications, gaps in their CV and a criminal record will make the job-searching enterprise very difficult (Klee et al., 2002:17–21). In some cases, this awareness may make it seem a hopeless exercise and scarcely worth embarking on.

Poor current health, including mental health problems, has been found to hinder job-readiness (Klee et al., 2002:18–19; Sutton et al., 2004:6–7). Common health issues among PDUs include anxiety, depression, miscellaneous pains and fatigue, and chronic illnesses (e.g. hepatitis or septicaemia). The side effects of methadone treatment that some experience – dizziness, poor concentration and drowsiness – have also been reported to impede job-readiness and job-searching activity (Neale, 1998). Put simply, poor health can mean that some PDUs are not ready for employment.

Being actively engaged in a drug-using lifestyle is another factor that can hamper job-readiness. At one level, involvement in the daily routines and activities of being a habitual drug user can be too time-consuming to allow for adequate attention to be paid for job-searching (Auld et al., 1986; Seddon, 2008). Perhaps even more significantly, the status and sense of identity that the drug lifestyle can bring for some users can be difficult to break away from (Pearson, 1987). Even when an individual attempts to do so, fears of relapse and the general fragile state of mind experienced by those trying to move away from drugs can adversely affect job-readiness (Klee et al., 2002:23-24). Fears about losing benefits can be a particular hurdle to overcome for many and a disincentive to beginning to search for legitimate employment (Richards and Morrison, 2001:23).

Employability

The idea of 'employability' is related to 'job-readiness' but refers to employers' perceptions of the suitability for employment of individual job-seekers. From the perspective of employers, PDUs may present with a range of characteristics that may make them appear less employable than other applicants in a competitive recruitment market. At the most basic level, these include some of the fundamentals of employability: lack of formal skills and qualifications (Richards and Morrison, 2001:19); limited or no work experience (Richards and Morrison, 2001:16, 19); substantial gaps in work history, evidencing long-term detachment from the labour market (Kemp and Neale, 2005); and perceived lack of generic attributes such as reliability, timekeeping, enthusiasm and honesty (Klee et al., 2002:34–35). Poor health can also limit drug users' employability, either through raising general fears about absenteeism (Klee et al., 2002:34) or where an individual's particular condition is directly related to their capacity for undertaking specific job tasks.

In some sectors, a criminal record is a major impediment from an employer's perspective (Sutton et al., 2004:8). Again, like health status, this may raise generic concerns, this time about honesty or safety, but it may also raise concerns more directly related to the job in question. The whole question of disclosures is a complex one.

External factors

As South et al. (2001:26) observe, it is important to recognise that there also several important barriers to employment for this group that lie beyond the individual. The general state of the labour market is obviously vitally important. During economic upturns, when jobs are more plentiful, helping the 'hard to place' into work is clearly much easier than when the labour market is shrinking and the economic outlook is gloomy. Further, when jobs are scarce and employers have a greater pool of applicants from which to choose, it is the least 'attractive' who will tend to be left behind. In other words, as the economic tide goes out, PDUs are more likely to be among those left stranded out of work (along with those with criminal records, the mentally ill and other such groups). Against the backdrop of the national economic climate, there may also be significant variations by employment sector and geographical area. A period of recession may affect some parts of the country more than others or be concentrated in particular sectors of the economy. The long-term decline in the British manufacturing

base, for instance, does not affect the employment prospects of all social groups in the same way or to the same extent.

One of the external factors over which policymakers can exert some control is that of legislation in the areas of employment and social security. The benefits regime is of particular significance and we cover this in detail in our Part 1 Report. However, the general point that emerges is that legislation and administrative practices may themselves create barriers to employment. Conversely, they can also be used positively to enhance pathways in to work.

Finally, employers' attitudes are a very important factor, not least as they will tend to mediate questions of employability. These attitudes are based sometimes on previous experiences and sometimes on general perceptions about drug users. These attitudes may often include views on important attributes such as honesty and reliability (Klee et al., 2002:34–35).

SUCCESSFUL APPROACHES TO HELPING PDUS INTO WORK

What do we know about 'what works' in initiatives to help PDUs (back) into work? Sutton et al. (2004) provide a helpful checklist from their review of the international literature, although they note the overall weakness of the evidence base. They suggest the following are features of the most successful employment projects for drug users:

- close partnerships between drug services and employment service providers;
- customised, flexible, intensive and diverse one-to-one support services;
- well-trained support staff;
- close links with local employers.

Less successful projects by contrast were characterised by:

- poor partnership working (including with local employers);
- lack of appropriately skilled and expert staff;
- short-term or non-intensive support.

South et al. (2001) are more cautious and suggest that it is premature to point to the most effective approaches, arguing that there is, as yet, no blueprint for best practice. They concur that staff training and close partnerships between drug services and the training and employment sector are vital components. Drug services also need to ensure that they are compatible with their clients' working. For example, alternative or flexible opening hours and different methods of 'supervised consumption' for those on methadone should be offered (Richards and Morrison, 2001:50).

Richards and Morrison (2001:39) observe that treatment itself has been shown to improve employment outcomes (primarily in US studies). In other words, providing effective help and support for drug problems can improve, in turn, the prospects of getting a job. Supplementing treatment provision with vocational services can further enhance employment outcomes. In terms of projects that specifically and directly focus on supporting drug users into training and employment, they again suggest that the

evidence points towards the importance of effective interagency partnerships, including with agencies that span across wider fields such as housing (Richards and Morrison, 2001:40–41). Individualised and tailored support, including work focused on basic personal development (e.g. self-esteem and confidence), is also important. They highlight as well the value of post-employment support, or 'aftercare', designed to ensure that a job is sustained (2001:45–46). Aftercare is a neglected area, particularly given what we know about the risks of relapse, and this suggests that support services for PDUs need to span from helping to build job-readiness through to getting a job and then to sustaining employment.

Kemp and Neale (2005) argue that this first stage in the process, helping to build job-readiness, is particularly crucial as many PDUs will be facing multiple difficulties in diverse areas of their life. They argue that addressing these complex and chronic problems alongside drug use is vital for getting this group 'job ready', and that it needs to be tackled before directly engaging in training and employment issues. In this sense, 'activation' or 'work-first' approaches may be less appropriate for PDUs than what they term 'human capital' strategies, which focus initially on building up skills, capacity and motivation before starting the transition to employment.

Conceptualising the process of getting drug users into employment in terms of these three phases – job-readiness, job search, and aftercare – may be useful for local planners and providers. A local strategic approach will need to make sure there is appropriate provision across all the phases and that the issue is on the agenda not only of drug services and specially targeted training/employment projects but also of mainstream employment services. Strategic and coordinated engagement with local employers is important too, not just to facilitate job placements, but also to ensure that planning and provision are informed by an up-to-date understanding of local labour market conditions.

LESSONS FROM EMPLOYMENT INITIATIVES FOR OTHER 'HARD TO PLACE' GROUPS

As noted in the first chapter of this report, PDUs are just one of a number of groups that are particularly 'hard to place' into employment – ex-offenders and people with mental health problems are perhaps the most prominent of the others. Are there any lessons to be learnt from employment initiatives for these other groups?

An important study by Fletcher et al. (1998) reviewed approaches to labour market reintegration for ex-offenders. They drew several conclusions about effectiveness. Their study implies three key strategic points, some of which have been confirmed through a wider body of research (although the evidence base remains relatively weak):

- Addressing the 'job-readiness' and 'employability' of ex-offenders – through focused work to build up basic skills, confidence, motivation and so on – needs to take place alongside the provision of more holistic long-term support for individuals.
- Support for employers (including information provision) relating to disclosures and employing people with criminal records remains critical, so that it becomes possible

for more open sharing of information to take place between job applicants and employers (e.g. Haslewood-Pocsik et al., 2008).
- Engaging with local labour markets, including the establishment of working partnerships with local employers, is also essential (e.g. Buck, 2000).

In the mental health field, British evidence about effective approaches is thin on the ground. A large body of North American research shows the value of initiatives involving integrated mental health and vocational services; what they term 'vocational rehabilitation' (Bond et al., 1997). This supports the findings from the drugs field about the importance of interagency partnership working. A more distinctive strand in the mental health literature, which draws on a social disability model, concerns the importance of employer adaptations to the needs of employees with mental health problems (Perkins and Repper, 1996; Evans and Repper, 2000) – the equivalent of providing a ramp for wheelchair users, but in this case a 'virtual ramp' for people suffering from mental ill health (Hooper, 1996). The extent to which this model ought to apply to those with drug problems is a matter of some controversy and debate.

CONCLUSIONS

The research literature gives us some clear indications as to why employment rates are so low among people with drug problems. A range of issues affect their readiness to even begin the search for work as well as their employability in a competitive labour market. External factors, such as the availability of jobs in the local economy, the benefits regime and employer attitudes, can and do create further barriers to employment.

Looking at the literature – not only at studies focused on drug users but also those on other 'hard to place' groups – we can draw out perhaps two headline lessons. The central components required for successful initiatives to help PDUs (back) into work are:

1. intensive tailored support from skilled and well-trained staff, provided on a long-term basis where necessary, addressing a broad range of areas beyond just the directly vocational;
2. good partnership working between drug services, employment services and local employers.

3. Getting 'job ready' and confronting the primary issues

- In both the survey responses and interviews, motivation was viewed as an essential first step to successful engagement.
- There was a lack of support for mandatory treatment across respondent groups.
- Service providers stressed the need for problem drug users to be 'job ready' and highlighted the dangers of rushing them back in to employment too soon.
- Becoming 'job ready' incorporates a range of factors, from primary issues of stabilising drug use and accommodation, and related health issues, to re-engaging with the labour market, including volunteering, to build up a CV and a skills base.
- An acute shortage of appropriate 'move on' accommodation was discussed and linked to increasing likelihood of relapse and to problems in maintaining employment.
- The vulnerability of problem drug users entering independent accommodation and employment was highlighted, and continued practical and emotional support suggested.

PRIMARY ISSUES

A chaotic lifestyle is a common feature of those PDUs seeking, or in the early stages of, treatment for problem drug use and therefore they may be far from ready for steady employment (Kemp and Neale, 2005). Many are unlikely to have experience of recent employment and so are detached from the labour market. They may also face a series of additional issues at the beginning of the process of rehabilitation, such as managing their addiction and the associated health problems, and a lack of stable accommodation, all of which may hinder the gaining of employment. One of the central aims of service provider agencies is to help PDUs resolve these problems by means of an array of interventions that assist the PDU to become 'job ready'. One consistent theme from the service provider interviews in relation to PDU treatment is that seeking employment should be part of the final stage of the rehabilitative process. Gaining and sustaining employment is unlikely to be successful unless the primary issues are addressed and there is evidence of stability. A PDU respondent provided an interesting insight in to the early stages of treatment:

> *"There's a lot of stuff that we're going through … and I'm not someone who can do 500 things at once, once I'm into the housing … take it from there kind of thing, you know? ... a lot of people don't go to their appointments because the appointment is at 10.30 in the morning and they've got to go and score first."* (LPDU4)

In particular, accommodation was frequently cited as an important primary need that has to be in place:

> *"There is a lot more that needs to be invested into the whole issue of helping people back into employment and obviously helping people towards housing ... Because if you don't have secure housing then it's very difficult, that's you know a primary need and it's very difficult to develop your life from there"* (DTA2)

Addressing the primary issues is a key factor in ensuring that a PDU can reach the point of being job ready.

One strategy under serious consideration is that of mandatory treatment, whereby failure to take up treatment would be penalised by withdrawal or reduction of benefits. Mandatory treatment was not seen as a being a positive way forward, for example:

> *"I've been dealing with these people for about 20 years, I know them, [they are] quite a difficult group of people, and I don't think I'd like to force people into treatment, they've got to want, you've got to want treatment."* (DTA1)

This respondent from a drug treatment agency was also an employer and regarded the voluntary nature of treatment as the key to successful rehabilitation. Another respondent was similarly sceptical about the linking of treatment and employment:

> *"... we think to even put someone into a job a month or two months into all this life changing is not just potentially detrimental to the organisation but also to the development and the welfare of the individual themselves."* (DTA3)

This respondent was from a drug treatment service that also provides employment opportunities for PDUs. It was important for this respondent that the risks for both the organisation and the individual are considered; employment that is linked to mandatory treatment was seen as increasing the risk to both parties. The respondent viewed the issue of mandatory treatment as being very complex and requiring a specific set of guidelines, an Equal Opportunities Policy and a structured regime to ensure that organisations and individual are both protected. Finally, there was no overwhelming support for mandatory treatment from employers; one employer commented that they had no view about mandatory treatment:

> *"As long as they did it in their own time."* (E116)

It could be argued that if employment is made an integral part of mandatory treatment, an extra burden would be placed on employers. Many of the employers considered that this burden is not one that they should have to bear. There was little support for mandatory treatment among the respondent groups, most viewing it as being more problematic than rehabilitative.

The following sections of this chapter explore the primary issues in more detail, under the headings: 'Motivation' and the process of change; Accommodation; Health; and Support.

'MOTIVATION' AND THE PROCESS OF CHANGE

Being ready to move towards independence, or being 'motivated', as the service providers describe it, is the essential first step for a PDU in engaging successfully in the process of rehabilitation and ultimately getting back into employment. One of the most important elements of motivation is the engagement with treatment programmes and activities, many of which include the provision of strategies to re-enter the labour market. For many PDUs the single biggest motivating factor was hitting their own 'rock bottom', and most saw this as a turning point in their experiences.

On their experience of going through treatment, a PDU commented:

> *"It's the hardest thing I've done in my life, 15 years [taking drugs] you know what I mean? I sort of flirted with the idea five years ago … went into drug treatment for a little while, little bits and pieces … I was quite happy I could do it myself but I was taking 8 or 9 grams of coke and drinking every day … but I got nicked and that was my rock bottom … it's probably the best thing that happened to me to be honest, getting nicked it opened my eyes."* (LPDU3)

For some it was only at their lowest point that they sought treatment. Many had not sought support in the past and this was their first attempt at seeking help from service providers. Those who had previously accessed support described years of moving in and out of failed treatment in an unmotivated state before 'hitting rock bottom' and finally 'being ready' to respond to interventions:

> *"I'd never thought about detox centres or rehab, I never really wanted to come off drugs … never had any real employment, it all just became chaotic … prison then back on the street … the drugs had taken me to a point where I just couldn't cope any more, I thought it was the end of me … I was starting to lose contact with my kids and people were just seeing the same never ending pattern … I know nothing's going to stop me now."* (SPDU1)

Those that had previously accessed services without success were described by the service providers as 'just not ready' for this type of intervention:

> *"I think with the drugs aspect, really, it's whether or not that person's ready to move on into employment … because we see ourselves as the last line of support. I mean, having gone through detox and having the drugs counsellors and we are the last people that I feel that they should be referred to because they're ready. … And we have many referrals where you just know they're not ready."* (NSP2)

One service provider, however, commented on the pressures placed on them to get PDUs into employment:

> *"… one of the things that worries me is the fact, you know, they [probation officers] think: 'Right, people are clean now, they've detoxed and they're clean, get them back into employment.' But they're not ready for it because of … the*

mental health issues around them, and damage can be done by trying to rush somebody." (NSP3)

It was suggested that PDUs were often fast-tracked on to Education, Training and Employment-based projects in the voluntary sector in order to fulfil the mandatory hours of contact time prescribed by the various statutory supervision orders and licences that some PDUs are subject to because of their offending:

> *"We see a lot of probation referrals, [the] probation officer wants to set things up to keep them busy and looking good on the papers for court and stuff."* (NSP2)

Those former drug users who were now in employment explained that the critical factor was not the quality of the treatment or support, rather that this time they were motivated, having reached a point where they were ready for change:

> *"I haven't been forced into it … I made the decision; I said 'right, my children are far more important to me and if I stop now I've still got a chance of making something of my life'."* (NPDU4)

There were many examples of the point of change, and this was frequently presented in the interviews as a single event that prompted a realisation of the situation. These examples included: begging for the first time; being taken into hospital after an overdose or other health scare; losing custody of children; being arrested; or being sent to prison. The image of the 'point of change' enables the service user to describe and understand their experiences around one pivotal point; it is a common narrative tool used to explain, justify and account for what is often a series of events and perspective-shifts on their personal journey. While service users frequently identify a single point of change, their descriptions of their experiences are usually far more complex and detailed that this suggests. Many of the respondents discussed the process of change and their own epiphany or moment of realisation in detail.

ACCOMMODATION

Moving in, and the difficulties of moving on

Accommodation is a critical factor in the rehabilitation process as it provides stability and security. Lack of stable accommodation is one of the reasons for returning to using drugs. Many PDUs have experienced periods of imprisonment and subsequently lost their accommodation. Many of the PDUs at the time of our interviews were in accommodation that was linked to the provision of treatment or detoxification at the beginning of a treatment programme.

For many respondents there was a need to move into accommodation on release from prison. However, on occasions prison was used as a means of easing an accommodation and drug-using crisis:

> *"I got a prison sentence last September, shoplifting, but had to get caught nine times because of the homeless situation and there was nothing going for me …*

I needed to [do] time, it was coming winter so I needed some shelter, food, et cetera, and so on the ninth time of being caught shoplifting I got a 12-month sentence … I was taking amphetamines and alcohol up to last September, and I needed a clean break from it all." (NPDU5)

Respondents described how the need for proper accommodation on release from prison is critical:

"… when you leave prison if you haven't got something sorted around your housing, if you don't get that organised before you leave you're fucked, you're going straight back to using." (LPDU7)

The need for there to be a release plan in relation to housing and how the respondent was to manage their drug use was critical in maintaining abstinence immediately on release. This respondent vividly highlights the need for accommodation and support on release:

"because I'd stopped smoking in prison I'd managed to save up a hundred and odd quid, I got a discharge grant. So when I left prison, you know, I had a payment already in there from the September before, so left prison and I had £375. And to have nowhere to go, what I was going to do? I was going to go to the dealer, I was going to get a load of amphetamine and just go on a train and go somewhere and survive, carry on surviving. So I was preparing myself for that, but I wasn't sleeping well, you know, because it was a worry. So … she [my key worker] just took all the worry away. And it made me feel a whole lot better about things. And I thought, you know, thank [the project], you know … And then I left and come out of prison and the car was there. She brought me down to the city. I couldn't get into Sampson Court until the Monday, so she took me to … a bed and breakfast because I had that money, and then I come to [the city] on the Monday and really appreciate it, you know, still appreciate it." (NPDU5)

The most common experience of accommodation on release or on entering treatment was a hostel or shared accommodation. Some respondents moved initially into hostels that provided shelter and food before moving into self-catering accommodation, and then onto 'independent living space' provided by the treatment project:

"Well they look upon it as like phase one, phase two, phase three. They're looking to bring people who … can deal with their problems, looking to like filter them into … First I went to [the] restaurant where they cater for you, [then] into what's called self-catering, where you cook your own food. And then I got approached, 'Can you move into the studio flat?' I said, 'Yes, please. Please allow me to move in there.' And that's where I've been for the last seven months." (LPDU10)

The progression through the different types of accommodation appears to have been relatively straightforward for this respondent. However, this was not so in all cases:

> *"It's funded for two years and then you can get an extension to that, I could end up being there for four years, depending on the waiting lists and what's going on. But I've already been told by the staff that I'm ready to move on, and I've got my letter from the doctor to support a move. But like I say, it's just about waiting now, and for something to come through."* (NPDU5)

The progression from accommodation that is provided as part of a treatment programme is at times thwarted by the lack of appropriate accommodation to move on to, so respondents who had been deemed suitable to 'move on' were often faced with lengthy waiting lists. This is a common theme in the interview data: one respondent had been living in supported hostel-type accommodation for 15 months and had overstayed the 12-month period of residence:

> *"It's 12 months, supposed to be 12 months but that depends whether they've got somewhere to move you further on to, which they have but the guy that's occupying where I'm supposed to be moving, he's having problem moving himself, so I've got to wait 'till he moves and then I can."* (LPDU6)

There were a number of other reasons for the delay in moving out of supported hostel-type accommodation into independent living, but by far the most common was the shortage of appropriate accommodation:

> *"I mean I live in C, and in C there is a real shortage of houses and then I've worked in L and I've seen people come through in six months, get a flat basically … so different boroughs work in different ways … I just think some boroughs are better than others to get housed at because I think they might have more houses available, more options … I just feel like I'm just a nobody basically, do you know what I mean, you know with regards to my housing situation."* (LPDU5)

Therefore, for many respondents their housing situation had a bearing on their emotional state and self-esteem, as the above respondent describes. For others, the housing situation led to a sense of frustration at the shortage of accommodation and the impact of this on their own sense of progress:

> *"Sometimes I feel like throwing the towel in and just going off and renting somewhere but … I'm just going to be back to square one again, do you know what I mean?"* (LPDU5)

For some respondents, supported accommodation brought with it a number of problems, especially if residents were still using. This respondent had lived in a hostel with between 30 and 40 residents:

> *"You was getting urine tested in there randomly every week or every ten days or so, but what I seen in there, people were still using, like the majority of people were using, and the ones that wasn't using class As, they were starting to hit the drinking all the time, you know, so they were either using drugs now and again, and the ones that wasn't, the rest of them were drinking every night."* (NPDU1)

It is apparent that some treatment projects condone residents using as long as they do not use on the premises. Other projects have abstinence as a central element of the treatment programme:

> *"I'm not on anything at the moment I'm totally clean, it's total abstinence in here. You're only on a detox for the first four weeks and then it's abstinence; you get tested twice a week, like when you go out and come back in here, if you've been away for a period of time you've got to submit yourself for a breathalyser as well so it's total abstinence in here and I think that's the best way to have it, I think that's the only way to have it."* (SPDU1)

For this respondent, support from the treatment project was critical in maintaining accountability, even though she was living independently:

> *"Just with at the time getting the support you know with my tenancy it's given me another six months of being out there by myself still being accountable to [the project]."* (SPDU1)

The opportunities and dangers of stable accommodation

For many respondents, appropriate housing also provided the opportunity to re-establish or maintain contact with children. This respondent had the care of her children, aged 12 and 13, at weekends as part of her resettlement programme:

> *"Yes they stay with me at weekends, through the week I'm quite busy but they stay with me at weekends you know."* (SPDU1)

Another respondent commented that he was unable to have his children to stay until he was able to access accommodation that guaranteed them privacy.

For some respondents, the move to independent living was also fraught with danger:

> *"I've seen people be in there, from my own experiences, go onto second stage without support. And they just let them go, and within a week or two, you know, they're on the streets, you know, because they've gone second stage, first thing, isolation, on their own, when they've been used to people just being around, even though they've not probably connected with them, it's just that surrounding environment."* (NPDU2)

In addition to the sense of isolation and lack of support that can accompany independent living, there is also the extra financial burden of independent living and employment:

> *"The rent is so high here that if you started work you'd lose your income support, or whatever. And you would then also lose your housing benefit. Which would mean you'd pay, I think it's 180 quid a week here … You've got to be on, sort of taking home 400 or 500 quid a week. You know what I mean? Which is not really practical. And, cos it's not that easy to get jobs where you're earning that kind of money, you know."* (LPDU9)

There are a number of problems that PDUs experience in relation to accommodation and they can all have an effect on the motivation to gain employment, the sense of being 'ready' for work and the need for support during the treatment phase. The main concern of PDUs was the 'logjam' in gaining accommodation that would allow them to live more independently. There were many examples of PDUs remaining in hostel accommodation after the 'official' time limit had expired. In those hostels where there was a tolerance of using (drugs and alcohol) off the premises, some PDUs found this to be disruptive and not conducive to their 'moving on'. The need for accommodation that would allow PDUs to have access to their children was also important as this access was viewed by some as being an intrinsic part of their rehabilitation. Again, the need for a planned and supported move to accommodation from prison was important. The lack of accommodation on release was a real source of anxiety, jeopardising PDUs' efforts to remain drug-free. However, for some PDUs the move to independent living could be difficult as a sense of isolation was not uncommon. All of these issues were significant, and it was only once these were managed that employment could be seriously contemplated. However, employment also brought with it financial difficulties, in particular being able to earn enough to afford appropriate accommodation.

Many of the service providers recognised the need to provide accommodation that is fully supported and linked to treatment. It was important for this service provider that they targeted the right kind of person for their accommodation scheme:

> *"… so that they can move in there and get ready for more structured treatment, … we get them linked in with a drug and alcohol agency who'll provide the treatment side of things, but at the same time, we'll work with them to try and increase the chances of them getting linked in to training."* (LSP1)

This service provider had established a project that increased the level of support provided and moved people out of the large access hostels that some PDU respondents complained were hampering their efforts to rehabilitate. The project also develops the link between housing, treatment and employment training. Interestingly, PDU respondents did not mention employment training linked to accommodation as an element of their rehabilitation. The lack of linkage between employment training and accommodation may be due to the fact that for many PDUs the treatment process tends to focus on issues other than employment.

The service providers all recognised that housing was a critical issue in maintaining an individual's motivation and so many committed resources to ensuring that housing issues were addressed:

> *"If there's any housing issues, we have a housing worker from Lighthouse Housing who comes in once a week, she helps them around that. But we'll also get people like NACRO in as well, they're sort of supported housing workers who come in. And then what they'll do is, they'll have a regular sort of care plan review to see if anything's changed, how they're finding it, if they need any additional help."* (NSP3)

Service providers also acknowledged that moving into work while living in supported housing was problematic for many PDUs because they had to start taking individual financial responsibility that supported housing mediated. So, the move to independent accommodation and work was felt to be a big challenge for a PDU:

> *"It's a big step if you're thinking about leaving supported accommodation, where everything's there for you, to going living on your own, paying all your bills and starting a new job, it's a massive leap for a lot of people."* (NSP3)

The service providers identified similar issues to those identified by the PDU respondents, especially the need to provide practical and emotional support. There was also an identified need to integrate support in relation to housing with employment training. Many of the service providers recognised the vulnerability experienced by many PDUs that employment brought with it, the lack of confidence at being able to manage in an unsupported environment, and how many of them found the responsibilities of employment to be particularly arduous.

HEALTH

For the majority of the PDU respondents, health was a key issue. Prolonged drug use often results in serious chronic health conditions. It was apparent that in order to begin thinking about the world of work, health concerns need to be addressed in the preparation for work phase. One of the positive outcomes of treatment and rehabilitation is that by not using drugs, the general health of the PDU improves. Some of the respondents had longstanding health issues as a consequence of their drug use. For example, one male respondent had hepatitis C+ damage to his leg as a result of injecting:

> "*I've got hepatitis C and this is down to the drugs, I've bad circulation in both legs, this leg is probably because of … the fact that I was kneecapped but I also nearly lost my leg, I nearly lost this one from injecting because … I hit the artery and the leg fucking just blew up.*" (LPDU7)

Such chronic health problems were not uncommon. Another respondent (female) related a number of physical and mental health issues:

> *"And they told me about my legs, that if I carry on, eventually I will lose my legs, you know? Because where I'd used so chaotically in the end … I was on the streets, I had a crack psychosis, I used to pick my legs … when my hands was always dirty from smoking …"* (LPDU12)

This respondent had a number of longstanding health issues to resolve before she could begin to consider employment a viable option for the future. It was also apparent that the link between health issues and drug use is known by many PDUs:

> *"And they [legs] got infected and, eventually, they went into ulcers and they got really, really bad, because, obviously, I was pushing myself out every night walking and they got really bad, badly infected, and everything. And that was*

through to my chaotic using. I mean, everyone's got … a thing from using, whether it be mentally, physically or whatever." (LPDU12)

So for many long-term drug users, health issues had to be addressed and negotiated in their day-to-day lives. It also had an effect on a number of associated areas, for example the respondent quoted above was restricted by her housing needs:

"… I'm on the working women's[2] floor still … I've been here for 18 months now, but I'm still in the first floor and I haven't been working for about a year. But, because there's a certain part that, where the women are, either on the first floor, or on the top floor, which because of my legs, I can't go all the way to the top." (LPDU12)

The physical restrictions caused by her health requirements resulted in her experiencing difficulties in terms of her rehabilitation process; she was not able to progress from the 'working women's floor' to accommodation that was more suitable for her rehabilitation. Another female respondent also commented on the long-term effects of injecting:

"*And then with my injecting I think it was 2001 I ended up with five clots in my leg, septicaemia, yea my leg was actually 11 centimetres bigger then I woke up in hospital and … I'd been in a coma for five days and I had a priest over me, my parents were all crying and I was getting my last rites."* (SPDU1)

Another respondent noted that his treatment for hepatitis C had interfered with attempts at rehabilitation programmes:

"It's really hard I must admit, it's not an easy job. A few people have done it here and they've done it successfully but I have … for medical reasons I had to drop out." (LPDU6)

The significant issue for this respondent was that the combination of his methadone prescription and associated prescribed amphetamines meant that he would not be in a proper mental state to engage actively in the rehabilitation programme once he was also taking prescribed medication to treat his hepatitis C. The management of some ongoing health issues is complex:

"I mean I only take one temazepam at night … temazepam is, you know, very short acting where diazepam are the total opposite, you know, they're longer acting and I think they've got a fear of them and methadone mixed together. When you're mixing them together it's depressing you down and they're worried if you … like my doctor keeps going on, you know, 'I'm always worried about you you're on a lot of methadone and Valium and, you know, I always wonder if you're going to come in the next fortnight' you know, I say, 'You shouldn't be thinking like that', you know, so that's how it is, it ain't like that." (LPDU6)

[2] 'Working women' refers here to women who are working in on-street prostitution.

For many respondents, chronic health conditions were ongoing and were a result of either drug use or a condition exacerbated by intravenous drug use. For many respondents, serious health issues caused by drug use were not triggers to entering treatment; for many there seemed to be an air of invincibility:

> *"… I was in hospital for all that time I think about 14 weeks and when I come out … I was thinking I'm indispensable man no-one can beat me cos I've got through that period I had my last rites six times I went into a coma three times I was on life-support machine, high dependency …"* (SPDU1)

Severe health issues often do not act as a trigger to stop using drugs:

> *"I overdosed … I went in, and there was an abscess there, but I didn't know it was there. And the poison was going into my blood system … me into septic shock. And like [they] thought it'd be a good idea to put me up to 100 mil of methadone to stop me using. And did it fuck!"* (LPDU7)

This respondent experienced ongoing health problems that appear to be a hindrance to future planning:

> *"I've got to do something but I don't know what I can do with my leg fucked, I don't want a free bus pass, I want my leg back."* (LPDU11)

For some respondents, health issues are identified as the beginning of the downward spiral to drug taking:

> *"I had a breakdown in 1997 when I was married. I was a trained nurse, everything going for me, but then forces beyond my control seemed to start spiralling out of control, my marriage broke down and I lost my son, my career and then ended up in a very self-destructive cycle. To get through the day, having that sense of loss, I turned to drugs and drink."* (NPDU5)

This respondent did not experience the chronic physical health problems of other respondents; however, he experienced mental ill health. In relating his use of heroin, which was for a relatively short period, he comments on the effects of his transition from a position of having achieved career goals to being a drug user:

> *"I got a habit in Blackpool, but I realised very quick, because I was coming from a place where I had achieved things in life, and then the stark reality, the contrast. So it wasn't long before I started to get the suicidal ideation."* (NPDU5)

This respondent did give up heroin, but he substituted it with amphetamines. However, giving up heroin had mental health consequences for him: "I can remember when I come off the heroin I was very, very down, everything was an effort". This illustrates that there are a number of mental health related issues associated with drug use:

> *"If I didn't have any amphetamines I would be lethargic and be depressed and, and somehow learned to live with it."* (NPDU5)

There appear to be three types of health issues. First, there are chronic conditions either brought on by drug use or exacerbated by drug use. These chronic conditions are highly debilitating and often interfere with the rehabilitation process by excluding the individual from certain benefits, for example access to improved or more private forms of accommodation within a rehabilitation project. Second, there are a range of physical health issues that require prescribed drug treatment. These treatments need to be managed alongside those prescribed drugs used to *maintain* the drug user. There is some evidence to suggest that certain treatments or medical procedures are not available until there is evidence of desistance from illicit drug use. Finally, there are mental health issues, which may have pre-dated the drug use or may be a result of the drug use.

The physical and mental health consequences of prolonged drug use are complex, and the management of these chronic conditions makes demands of both the individual drug user and the medical services. However, what is indicated in the PDU interviews is that health issues have to be addressed before an individual can begin to experience a sense of stability in their life. So, as this respondent comments:

> *"I think the last time it went to a stable dose was when I went into that AAU, and I had it really bad for a few days in there, for about a week, and then I got on to a stable dose."* (LPDU12)

The idea of tackling her need for maintenance doses of methadone before she has resolved the health issue relating to her legs, is not seen as a viable rehabilitation strategy. The findings from this research are in line with findings from other research that has investigated health and PDUs:

> "In reporting recent mental health symptoms the most common was depression. Over a quarter were currently prescribed anti-depressants. A similar proportion said they had experienced paranoid delusions … Half of the sample reported hepatitis B or C and 12 people reported thrombosis induced by drug injecting. A wide range of general health problems of a more minor and temporary nature were also mentioned."
>
> (Klee et al., 2002:18–19)

The service providers reiterate the importance of managing the complex health issues of PDUs during the rehabilitative process. Addressing the health issues of a PDU is viewed as a central part of the approach to ensuring that the opportunities for a successful period of rehabilitation are maximised. Furthermore, service providers recognised that health is a critical long-standing issue for many PDUs:

> *"And when you start talking to people, 'What do you think your barriers are to employment and training?' or I bring up any health issues, and so many times, you know, they'll mention … a history of depression, or they're already on antidepressants."* (NSP3)

These partially hidden mental ill health issues are similar to those described by Klee et al. (2002). The service providers are able to bring an understanding of the health issues that is similar to that of the PDUs:

> *"… generally by the time someone gets to 28, 30 their health starts to deteriorate, they've been alienated by their family and friends, their close peer groups are all doing long-term prison sentences or in the graveyard so they start to think hmm, now's the time, party's over, they're not getting what they used to get and that's why it's usually the time that this age group, more and more people are not accepting of that kind of life anymore if they've got themselves caught up in the addiction at 16 or 17 and I think the stigma of getting yourself sorted is not the same any more."* (SSP1)

However, what is apparent is that there are a number of factors that combine to provide a focus for PDUs and provide an impetus to enter treatment: the loss of the sense of invincibility that PDUs talked about when they were younger, the failure of the lifestyle to deliver and the loss of the stigma attached to treatment. This change in attitude to treatment is important as it allows service providers to access services for PDUs and begin to resolve their outstanding health issues:

> *"If there's a mental health problem I can talk to them and link them up with [the] Mental Health Team, with the training, and they have mental health nurses with back-up, which again is knowing who is there to help them."* (SSP1)

The link between health provision and maintaining people in treatment is also underscored by the service providers:

> *"… like the work that we're doing at BS and a few other schemes … we've got a much bigger role in maintaining people in treatment."* (LSP1)

Furthermore, many service providers recognise that resolving health issues is one way of achieving stability for PDUs:

> *"their mental health needs to be well and I think what we're thinking is now…, you need a bit of stability."* (LSP1)

And:

> *"But physical issues is usually stuff through the long-term drug and alcohol misuse, you know, it's usually stuff they could have problems with their liver or they could have troubles breathing or, you know, with their joints or you know, mobility issues and stuff like that."* (NSP5)

Service providers understood the link between physical health and mental ill health and recognised the need to deal with health issues during the rehabilitation period. However, many service providers identified that the post-detoxification period was also fraught with difficulties related to mental health:

"And the other thing is that, you know, you can work with somebody around detoxing and things like that, but quite often most of their problems start when they come out of detox and they're coming back into the project here as a kind of, you know, a community rehab, and then all the issues that the alcohol and the drugs have suppressed over the years, all come back, and they haven't got anything to, you know, to calm those feeling" (NSP3)

The post-detoxification mental health issues were viewed by some service providers as not having been given a proper level of interest and concern:

"… you do get a lot of paranoia when people come out of detox, you know, and people tend to get very low. After the initial excitement of 'Great, I'm free from drugs' reality hits and, you know, you do tend to see a change in people, and people get quite low. But, yeah, I'm surprised that, you know, it's not been mentioned more, because I think it's a massive problem." (NSP3)

This PDU corroborates the view of the service providers in relation to the after-effects of detoxification:

"I didn't find the detox part that hard cos I was only on 40 mils at the most but when I, sort of, came off it left sort of, like a big gap in my … you know, like a big deep hole and my chest felt empty, you know and then you ended up back in society and, you know, I sort of just ended up back around the old acquaintances that I left and I ended up using again, you know, it's just a matter of time, it was a matter of time before I used again." (LPDU6)

In relation to health, the overwhelming view of the service providers was that it is critical to ensure that the PDU has stability, that their health issues are addressed and that the post-detoxification period is recognised as one in which the PDU is vulnerable and where mental ill health is a common feature.

SUPPORT

Informal support

The support of the family, and in some cases close friends, has been seen as a crucial factor in the transition towards a pro-social lifestyle (Maruna and Immarigeon, 2004), including the changes involved in preparing for and sustaining employment. The informal network of support discussed in interviews with those seeking employment revolved largely around parents and their supportive role in managing housing and other primary problems.

Several PDU respondents discussed their parents' role in helping them to come off heroin and return to a healthier lifestyle:

"When I came back to my mum's I became aware of the family life again, and that made a lot of difference, the love and that, and things that one can't see, and just the idea that I'm being looked after, that made a hell of a difference,

much more than having medicine and methadone and things like that." (NPDU5)

And:

> *"I feel a hell of a lot better, I've put on about three stone since I've been living with my mum and dad and I just feel better."* (LPDU3)

Another respondent described his relationship with family members:

> *"The best thing you need to have in this life, the network support will help, it will give you hope, will make you feel that you're worth it … people need hope, people need some objective on their life … achieve something for you to get, feel proud of yourself because if not there is no objective … it's like plants you water every day … I've got the help; I've got the support of my family."* (LPDU2)

Another respondent who was living independently valued the support provided by her family:

> *"I've got my family behind me, my mum and that, my sister, I've got two sisters and a brother, you know, I'm always phoning them now … and I've sort of got my family back."* (NPDU1)

For some respondents it was when their drug and/or alcohol use was noticed by their children that they recognised the need to do something about their addiction:

> *"And that's when, you know, things was getting serious as a problem and I was hiding, you know, my son, he'd come and start smelling my breath, you know, and that's when I knew it was a real problem, you know, because it was affecting my kids more than I even noticed."* (NPDU2)

For this respondent, the treatment programme that she has engaged in is likened to a family:

> *"It's a nice little family, you know, it is a nice family, yeah, it really is."* (NPDU2)

The 'family' is a concept that is used to express acceptance, love and support. Throughout the interviews with PDUs and service providers, reconnecting with the family – particularly with children who had become estranged as a result of their parents' chaotic lifestyles and problematic drug use – was discussed as a key objective. In many cases, it was only once the immediate problems with housing, health and addiction issues had been stabilised did the focus turn to reconnecting PDUs with estranged family members, particularly children. This was seen as an important element of maintaining a pro-social lifestyle and reducing the risk of relapse. Alongside gaining employment, (re-)establishing contact with children was often seen as a final goal of the lengthier process of rehabilitation. Both of these goals were usually seen as longer-term risk-reduction strategies, and achievable only once the other primary factors have been stabilised or resolved.

However, not all respondents were able to gain support from relatives. Many struggled with the problems they faced without any input from family members:

> *"My mum's dead. I haven't spoken to my father for about 18 years, 19 years. So I don't even know where he lives anymore. So I don't actually see much, I haven't really effectively got any family*." (NPDU2)

Friends could prove to be a mixed blessing. For some PDUs, friends were a source of support, but for others the only friends they had were those who they had used drugs with:

> *"… as soon as I get back there to live … I seem to relapse and that's because all my old haunts old associates."* (SPDU5)

Some PDUs who could not rely on the support of family and friends had to utilise the support offered by the voluntary and statutory agencies.

Formal care

The need to be engaged in positive and supportive relationships with agency workers was viewed by many PDU respondents as being an important element of their rehabilitative journey:

> *"My probation officer … very, very helpful, she's very, very good, very good, my order finished last week and I really will miss her, she's seen me nine stone wet through crying my heart out, I couldn't mention my children's names without getting upset or my ex partner and she's gone from there to where I am now … she guided me subtly to where I am now. It's all slotted at the right time, I just happened to have a good probation officer, I got good advice and so on and so forth and it's all happened at the right time for me."* (NPDU4)

One service user articulates the need for formal care in the rehabilitation programme; it is the expression of care that is viewed by him as being central to the rehabilitative process as it deals with the fears and anxieties about control over the key aspects of his life:

> *"You know … what's important is the care, the care, the straightforward, simple care, making sure that things like that don't happen, that people's houses aren't taken, that their benefits aren't just stopped like that and, you know, to look out for that and then deal with it as it comes along. And eventually everything will develop and be okay, but it's just allaying fears isn't it, in the meantime, that people have."* (NPDU5)

Central to this relationship is the concept of trust. As one service user explained:

> *"I trust these people, I think they will … if it was up to my managers and things I'd have a job tomorrow, these people know what I'm like, they really like me."* (LPDU3)

The idea of care and trust appears to be fundamental to developing confidence and providing the foundations for PDUs to begin seeking work, even to the point of accompanying a person to get appropriate clothes for an interview. One service provider commented:

> *"We've been out with people to go and get them suits and stuff, so we've done all that."* (LSP2)

Another service user describes how, on leaving prison, his key worker, through a range of practical actions:

> *"… just took all the worry away. And it made me feel a whole lot better about things."* (NPDU5)

Relationships with drug agency workers were almost always described in positive terms; as providing practical advice and assistance, helping to increase confidence and offering emotional support. In some cases key workers were the only source of emotional support the service user was offered. It is this practical and emotional support that provides a framework for rehabilitation, and ultimately employment.

4. The second stage of rehabilitation: Work as a key objective of treatment

- Opinions differed in relation to whether problem drug users need to be abstinent or in maintained (e.g. on methadone). Highlighted here are the increased barriers faced for those on prescribed medication in terms of stigma, practicalities of collecting prescriptions, ability to operate machinery and whether they are 'job ready'.
- Service providers discussed the need to manage expectations of PDUs, noting the need to be realistic about the type of employment many can initially expect to find – often low paid, unskilled, unrewarding and with poor career prospects.
- The significant role that volunteering can play in developing a work ethic and skills base was noted. Volunteering was viewed as important in establishing a work ethic, focus, timekeeping ability and an attendance record.
- Problems in establishing links with employers were discussed. Related to this is the fear of damaging existing links through sending more 'high-risk' clients to employers.

INTRODUCTION: TREADING CAREFULLY ALONG A VERY NARROW PATH

A number of key issues related to work or employment have to be addressed once the primary issues have been managed; in particular, thinking realistically about the different types of employment and developing and maintaining a positive attitude to work. However, there is a longstanding debate between service providers concerning the appropriateness of maintaining a PDU on a methadone prescription or insisting on abstinence. The issues raised in this debate plus the types of work and the development of a positive attitude to employment are discussed in this chapter. The final section of this chapter explores how PDUs are managed into work.

MAINTENANCE OR ABSTINENCE?

The ability of a PDU to fulfil the requirements of a job at different stages of the rehabilitation process is a thorny issue; it raises a variety of diverse views between service providers and between employers. Previous research has found that current drug takers, and users of methadone, can be estranged from conventional activities, and as a result those that do work tend to be frequently absent, have poor timekeeping and lack concentration. Views from within each of the respondent groups ranged from the necessity for complete abstinence from drugs to an acceptance of 'stable' drug-taking with low doses of prescription drugs. These different approaches

from within each group reflect different ideologies with regard to treatment, and consequently a different approach to the suitability of service users for different roles.

It was frequently mentioned in both PDU and service provider interviews that the boundaries between different levels of drug taking and abstinence are less than clear-cut. What is clear from these discussions is that recovery is a non-linear process, in which periods of abstinence can precede further chaotic drug use; or one step forward can be followed by several steps back. The 'static' labels that are used to describe service users are therefore, in reality, fairly fluid.

Service users provided a variety of diverse views; ranging from the necessity to abstain from all drugs while working, to the acceptability of using a low dose of between 20 and 40 ml of methadone. The debate over stability and abstinence focused on the use of a maintenance prescription of methadone[3] and whether it is appropriate for PDUs to use alcohol during the recovery and treatment period. Simply put, the debate is between those who consider some form of maintenance as acceptable or necessary and those who insist upon abstinence to demonstrate commitment and motivation.

For those PDUs using higher doses of methadone, and large amounts of alcohol, there was an awareness that they needed to reduce their consumption before they could be in a position to change:

> *"I mean there's a lot I could be doing I'm not in a position to do at the moment coz people are saying, you know, your methadone's too high."* (LPDU6)

Service providers had varying views on the drug status of service users, with some requiring complete abstinence from any alcohol or illegal or prescription drugs:

> *"They can detox in here for 21 days if they're on any medication they can detox during that period because we're a total abstinence unit, it's not a methadone unit and no alcohol also …"* (SSP1)

Other service providers argued that service users can be using lower doses of methadone and still undertake and meet the demands of work. Service users and service providers were in agreement that a daily methadone prescription of above 40 ml would significantly impair a person's ability to work.

However, being on a daily prescription is in itself a problem in terms of having to collect it; for example, collection from a GP at an allotted time (usually during normal working hours). There were a few examples of how this was resolved by arranging for a prescription to be collected in the evening or, in some cases, weekly. Additionally, those on a methadone prescription are limited in the work they can do as they are unable to drive or use any form of machinery while taking methadone. Given that much of the work that service providers found to be available for their client group was within the construction and warehousing/packing fields and so involved forklift truck or other driving work, a methadone prescription severely limited their options.

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[3] Some of the respondents had or were using prescribed Subutex.

High levels of alcohol consumption were highlighted by many of the service providers as a common problem among PDUs in recovery and a significant hindrance to obtaining or keeping a job:

> *"The drinking has turned into a massive problem and it's become a dependency … you do see it in here a lot when people swap one for the other … I think alcohol, from what I've seen here, is an absolutely massive problem."* (NSP3)

And:

> *"Some of the people that have gone through … have still been drinking, we've had some problems in how they manage that … I'm thinking of one case in particular where they weren't going to have their probationary period renewed because of problems of days off work, sick days which were suspected, you know, linked to being out drinking the night before and off with a hangover and it was all managed in the normal way that sickness would be managed in the organisation … how much is someone drinking and how much does that impact on their work?"* (LSP1)

THINKING ABOUT EMPLOYMENT

Service providers were able to identify appropriate employment possibilities and the barriers that may need to be overcome before the application and recruitment phase. Again this is the concern of both the statutory and voluntary sector service providers, as one service provider explained:

> *"I think that it's crucial for pathways to employment to be established with drug users otherwise it makes a detox and rehab and treatment avenue almost a farce really. Unless you have something at the end of it what is the point of going through all of that?"* (DTA2)

So, identifying the types of work PDUs want to undertake is a critical element of the process. The interviews with PDUs and service providers explored both the type of work/sectors that PDUs want to enter and the types of work that are typically available. Many of the PDUs were interested in working within fields that they felt would value their experiences as ex-drug users, such as the voluntary and statutory drug support agencies. Commonly, they felt that drug treatment and intervention would provide an avenue for them to exploit their own experiences and skills, and an opportunity to help those in similar situations. When asked what work they would like to do, this respondent replied:

> *"… possibly outreach work, working with homeless, street, substance users. Well, you've got to have the experience, even working in a hostel, something like that. I think you've got to have the experience in it to be able to do it, I'll probably be quite good at it."* (NPDU3)

Service providers, although open to the idea of clients seeking work within the voluntary sector, indicated that there were more possibilities available within other

sectors that had less stringent rules about the length of time applicants must be drug-free:

> *"For one customer I phoned round all the local drug agencies and basically, the hard and fast rule is, you have to be drug-free for 12 months and crime-free for 12 months as well."* (NPDU2)

The policy of a number of other voluntary agencies is only to employ an ex-drug user after two years of being drug-free and crime-free. Most of the service providers found some success placing clients within the construction and catering/domestic sectors, where the rules are more flexible:

> *"It's generally relatively unskilled work and the people with criminal records would perhaps find work on building sites, in labouring jobs, warehouse work, forklift truck, sometimes call centres, cleaning jobs."* (NSP2)

All of the three local case-study sites had recently experienced a construction boom which had resulted in a demand for labourers. It was noted that it is relatively easy to send somebody for a construction health and safety card or on short course to get a proficiency certificate in the use of a hoist or mini-digger and so forth. Likewise, a further common certificate that service providers cited as being useful in gaining employment is the forklift truck (FLT) licence, which enables work in warehouses:

> *"They get their industrial cleaning certificate, their NVQs inside, warehousing too … we put a lot a lot of people through their FLT training, although there are jobs out there but it's a bit of a sting really, they'll get their licence but a lot of employers want experience so they want both, that again is a tricky one and the FLT waiting list is about three months."* (NSP2)

And:

> *"I'd like to see more on-the-job training opportunities, especially in construction and specific trades like plumbing and electrician and plastering, where they can do something practical as well as work towards a qualification."* (NSP3)

It was noted that much of the work available for PDUs is at the minimum wage and is insecure agency work. This causes problems in terms of sustainability and enabling people to get off benefits. For many PDUs, the cost of supported accommodation was very high, as was reasonable accommodation in the private sector, and this acted on occasions as a disincentive to moving into employment. Furthermore, several of the male respondents discussed the possibility of working within the construction sector but said that this was often not possible because of health problems, in particular those that prevented PDUs from being able to engage in work of a physical nature.

Service providers and PDUs discussed a variety of health problems that influenced the nature of work that could be considered and which prevented the PDU from seeking work in certain fields. One respondent, who had trained as a builder, listed a range of health issues that had plagued him for over 15 years. Most of these were directly attributable to problem drug use. He discussed "bad circulation" in his legs, hepatitis C,

a clot on his lung, and an embolism caused by injecting heroin. He came close to having a leg amputated "after hitting an artery injecting", he takes blood-thinning medication, and is prescribed medication for epilepsy, which he developed after hitting his head. The extent of his health problems has severely limited his opportunities to return to work as a builder; he has begun to look for work in the voluntary sector with young people at risk.

Despite the questions around suitability of ex-heroin users for manual labour, most of the service providers suggest jobs in construction and warehouse work as employment possibilities for their clients. It is these typically male areas of work that seem to be seen as priorities. Female clients were more likely to engage in jobs related to healthcare and social care, or to take up call centre or cleaning work.

The types of employment that are recommended to most service users are low-skilled jobs with little job security, little potential for career progression and a low expectation of job satisfaction. For some service users there is a corresponding level of incentive in terms of obtaining and sustaining this type of employment. The health and drug status of service users plays a fundamental part in the types and extents of jobs that are suitable and available.

DEVELOPING A POSITIVE ATTITUDE TO WORK

A consistent theme in the data from the qualitative interviews with the service providers is the need to develop and sustain a positive attitude to work. Many service providers structured their interventions to address issues of managing the self in the working environment and the development of a positive approach to employment. For some service providers, the fact that a PDU wanted work was due to a number of factors, including the need to replace the rhythm of the drug-using day with an alternative structure. There were dangers in a PDU not having a structured day, and work is seen as one way of providing a structure:

> *"They [PDUs] want an instant job because they need something instantly to fill the days while they're on abstinence because if they've got nothing to fill that day, the chances are they will relapse, especially if they've come from heavy drug use, because their empty days, if they're completely empty, will end up [with] them going back the way they started."* (NSP4)

So, for this service provider it was necessary to address the problem of what you put in place to replace drug use. This PDU respondent also discusses the problems of being in treatment:

> *"It's boredom. It's just, I don't know. Sorry. It's just hard to get out of here. It's true. I mean I can't say much more. I mean I'm running out of steam."* (LPDU10)

Using drugs for some provides excitement; there is a 'buzz' from the daily efforts of 'taking care of business'. The removal of this focus of everyday life is what, for the above service provider respondent, creates 'empty days'. For some, it was important to

remain positive about the potential for rehabilitation and treatment, even if the person had relapsed a number of times:

> *"… if you do relapse, you can always come back, or if you want to leave and you find it too much for you with all your appointments for probation and what have you, you can self-refer again, and leave that door open, it's like with any service, can just leave the door open."* (NSP4)

However, for this respondent the real problem was about being ready for work:

> *"… but I think the only barrier is themselves. They think they're ready when in actual fact they're not."* (NSP4)

The need for a PDU to be ready for work was a consistent theme in the service provider interviews. Eagerness on the part of the PDU to take up employment may be for reasons other than a desire to work; it could be as a means of finding an activity to focus on during the day to substitute for their previous drug-using behaviour.

One of the strategies to developing a positive attitude to work is through treatment where work is an integrated element of the intervention:

> *"… let's work together because quite often having something meaningful to do … gives people confidence and makes people feel good about themselves … like when they've just finished decorating someone's room."* (LSP2)

For some PDUs, the use of 'training' programmes is a positive reinforcement. This PDU, who had been taking the European Computer Driving Licence, commented positively:

> *"… we've just actually produced a magazine. We've got a magazine launch tomorrow … and we use Publisher to do that with. So, yeah, I mean it, there's quite a lot here if you're prepared to sort of engage."* (LPDU9)

The treatment programmes provide support and guidance in helping PDUs to perceive themselves as employable and 'job ready'. There are important issues in how to make a person 'presentable':

> *"… the employment project is … a really good example where … people who have kind of gone in, got their teeth sorted out and stuff and they've felt so much more confident then to kind of go for a job … they are key issues ... we shouldn't underestimate the impact that [it] has on somebody so it's almost like it's part of the whole job readiness thing."* (LSP2)

A female PDU respondent reflects on how the focus for her was different when she was using drugs and was involved in on-street prostitution as means of funding her habit:

> *"Because my lifestyle was more involved in working[4] and staying out, instead of having something structured and a proper time for breakfast. I wasn't used to all that … so I didn't want to know."* (LPDU12)

This shift in focus is a common theme in the service provider and PDU interviews. Developing a positive approach to work requires a positive intervention from the treatment programme and needs to be linked to the PDU's motivation for change. This respondent in many ways summarises the struggle of attempting to positively engage in a work-based treatment programme and the acute feelings of depression experienced:

> *"Yeah, I try to like engage myself with the facilities here. Often, like at the end of the day, I find it quite difficult, because I'm stuck in a certain environment. And I get depressed … And because you are depressed, and you're deprived of your own feelings, you know, emotions, and the society you want to be a part of again, because you can't look sort of forwards. Like it's very hard to get back to work cos of the financial status. So, yes, it's very hard. You're deprived of life. But you also know that the privilege is you live in a community which accepts you. So that might be a privilege of being actually in a hostel."* (LPDU10)

Work is viewed as an important element of a future life, but for some it is recognised as a being difficult goal to achieve. This respondent had recently begun volunteering in a local museum and described the benefits and fears of undertaking such a role:

> *"So now I go, I can go down any time I want, I'll do Wednesday mornings and Friday mornings, I walk in, it takes some doing, I only did it for the first time on my own last week, and I was absolutely terrified just walking in on my own, getting the key, setting up the handling station with the fossils and then displaying, you know, to the public and the kids that come along the different fossils and things like that. Very nerve-wracking, but very rewarding."* (NPDU5)

This description of the volunteering experience highlights the anxiety that many PDUs feel when they apply for a job. A service provider respondent also commented on the benefits of volunteering:

> *"… we offer … volunteering opportunities and we CRB [Criminal Records Bureau] check people, so their whole history comes through and then we do a kind of risk assessment but … it's not stopped anybody and what we hope to do is to be able to then to give someone [a] proper experience, like a proper work placement, so that they have a reference so it's almost like … they've done this, this and this and they've proved that they can be reliable."* (LSP2)

In this way, volunteering is used to build confidence, to enhance the PDU's CV and to provide some of the discipline of work but without the obligations. Volunteering is also

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[4] 'Working' refers to prostitution.

viewed by PDUs and service providers as a positive contribution to the community. Volunteering also appears to build confidence through encouraging routine and reliability, even when a person is still managing their drug use through a methadone prescription:

> *"And it's fine and we have people who … volunteer or work with us … who are still scripted and you can work around that, there's a level of honesty, but at the end of the day that you kind of know that they're going to be reliable."* (LSP2)

However, it is also apparent that seeking work and preparing for work can be a difficult time for PDUs as any setbacks can be perceived as a reflection on their social acceptability:

> *"… sometimes people can kind of get to that first hill, go to an interview and then completely fall apart, and we've found that at the traineeship level when people have gone for traineeships jobs they've kind of gone 'oh my God it was horrendous'."* (LSP2)

For another service provider the lack of support or a social network resulted in the PDU failing to turn up for an interview:

> *"I've seen them come in; they get CSCS [Construction Skills Certification Scheme] certificates, even to the point of an interview on a job and not turn up for the interview."* (NSP4)

For some service providers it was important to stimulate the motivation for work for those who were on their programmes but at the same time to ensure that the reality of the working world was apparent. One service provider related how there was a very popular plastering course and that the waiting list was a year. Such a long waiting list collided with the need that many PDUs expressed for 'instant employment'. The service provider also knew that the waiting list could be shortened considerably because those on the waiting list were required to phone every 12 weeks to demonstrate their interest in the course:

> *"He had the motivation then, and I think this guy will keep ringing because that's what he wants. He's done bits and bobs for his mate and his dad and whathaveyou [sic], but not skilled and he wants his skill."* (NSP4)

This course was used by the service provider to maintain the PDU's level of motivation, and also to give the PDU some responsibility for ensuring they got a place on the course. This service provider respondent indicated that many PDUs do understand the waiting time before entering employment:

> *"… they will wait and they do understand … it probably took them three months to get the detox, it will take them three months to get into a training course or something that they want."* (NSP4)

However, in recounting an interview with a job-seeking PDU, the respondent was also perceptive in assessing when motivation was lacking:

> *"Why can't you spend another three hours a night and get the qualification? You want to do catering, if that's what you want. I work full time, I've just done a full year's college course after doing my counselling course, I've got a five-year-old son and I still manage to volunteer twice a week. I says I fit that in so why can't you fit three hours in and he went 'why should I?' And I thought you've got your barrier straight away."* (NSP4)

For many of the service providers, maintaining motivation and providing support for those PDUs who were anxious to gain employment was crucial. It is apparent from the service provider interviews that there are many barriers to gaining employment, and while some of these are structural, for example previous convictions, there are also a number of barriers that are a consequence of drug use. These barriers include a lack of confidence and the need to maintain the PDU's confidence in their abilities. There is an identified need to sustain motivation for work and at the same time to be realistic about the world of work – that some jobs are not available, some jobs require skills that need to be acquired, and some jobs although available will not be suitable because of the toll of persistent drug use on the individual's health or overall fitness.

There are a range of strategies used to maintain motivation and to build confidence, one of the most successful appears to be volunteering. It provides the individual with a sense of purpose and feeling that they are making a positive contribution but does not carry the obligations of employment. It also allows PDUs to re-enter the workplace in a less threatening manner than by going immediately into work. It also allows for some PDUs on a methadone prescription to enter a working environment in a controlled manner. However, what underpins the attempts to create hospitable working environments is the support that PDUs receive from the treatment programmes. For some it was more than support, it was a demonstration of care and concern. It may be that such expression of care and concern by service providers reinforces a positive sense of self-worth.

What is apparent from the interviews with service providers and PDUs is that the move to employment is a difficult one; it is not simply about the acquisition of skills for the workplace, it is also about the sense of self-worth that the PDU possesses. The task of many service providers is to develop the sense of self-worth, while at the same time ensuring that unrealistic expectations of employment are dispelled and that goals for the future are realistic. Employment appears to be a key element of a PDU's return to mainstream society, and as such it provides a sense of a future life.

MANAGING DRUG USERS INTO EMPLOYMENT – MAKING LINKS

A frequently cited problem throughout the interviews with service providers in the three case-study areas involved establishing links with employers. Service providers found it difficult to locate employers who were willing to engage with their client group, describing it as "potentially selling a difficult product" (LSP2). Much of the

anxiety expressed here centred on the disclosure of drug misuse issues, and the disclosure of criminal convictions:

> *"…we don't publicise the fact they have drug misuse issues, we think that would be a breach of confidentiality. We try to present people in a positive way … it's unlikely that employers would ask about drug or alcohol issues. It shouldn't be an issue because it shouldn't be a question that is asked, as long as the person presents properly on the day, they're interviewed, if they clearly present in a chaotic way then a college or employer would immediately think they have a problem so it's up to the individual to present on the day positively and stable."* (NSP1)

This service provider respondent details the difficulties in finding work placements and employment for ex-offenders:

> "… *once you start mentioning ex-offenders they don't want to know, and that's part of the problem, just approaching anybody and saying well you know we're trying to find placements, once you mention that they're ex-offenders, returning prisoners, it's very difficult to get people interested."* (NSP6)

And:

> *"A major concern is what people's offences are, that's the first one of the first things they'll ask is 'well what have they been in prison for? What are their offences?' It's an automatic bar with some offences, so if it's murder, firearms, sexual offences, it's almost impossible to get people in, you know?"* (NSP6)

Where links were established between service providers and employers, it was usually with cooperatives, not-for-profit social enterprises or agencies in the voluntary sector. Established links with private sector employers appear to be few and far between, but service providers were committed to encouraging those relationships:

> *"We do need more employers to get on board and think that not every ex-offender is going to be bad for their business because it's not the case, imagine how many people we've got jobs for that employers don't know … and they could have been one of their best workers, it's just a real stigma isn't it?"* (NSP2)

The scarcity of these links with employers results in an understandable reluctance on the part of service providers to send service users to employers unless they are deemed ready and likely to succeed. As many service providers discussed, there is a tendency to 'cherry pick' the clients who are most likely to be successful at application and in interview. A consequence of this careful selection of suitable individuals is that those who are not deemed suitable may be excluded from the recruitment process due to the risk they pose in damaging relationships with colleges and employers:

> *"… we had to be careful about who we sent … because obviously they could turnaround and say, you know, 'those two you sent, caught them shoplifting'.*

> *Do you know what I mean? So we don't want them in here, you know what I mean? And that could break down the entire sort of thing."* (NSP5)

This respondent underlines the need for the PDU to be job ready, and how if the PDU is not job ready it can jeopardise the provider–employer relationship:

> *"[If] they're not job ready … they get burnt and they can go oh well no … It's our responsibility to make sure that ... when we do send people they are as job ready a possible."* (LSP2)

This requirement on service providers to ensure that applicants are job ready has a number of underlying tensions. First, the credibility of the service provider agency to both assess a person as job ready and to have moved the person to the point of being job ready. Second, the anxiousness of some PDUs to get into work, to fill that empty gap; and associated with this are the demands of statutory criminal justice agencies to get PDUs into work once they have gone through the process of detoxification. Third, the possibility of getting it wrong can be damaging to the self-esteem and confidence of the PDU. Finally, not allowing a PDU to apply for work can be demoralising and might undermine the development of a positive attitude to work. Consequently, service providers have to tread very carefully along a very narrow path.

5. Employer perspectives on employing problem drug users

- Employers were concerned that problem drug users should be 'fit for the job', which incorporates concerns around both physical and mental health problems.
- Employers viewed as important the 'length of time clean' and 'extent of rehabilitation and treatment' when considering employing (former) problem drug users. Appropriate time periods suggested ranged from one to five years.
- Employing problem drug users was seen as 'risky', especially to the reputation of the business.
- Other key risk factors identified by employers focused on: risks to other staff; safety of customers; and safety of drug users.
- Staff reliability and attendance were particular concerns of small businesses.
- Approximately 75% of employers stressed the following three main areas of support required: guidance on risk assessments and safeguards; personal support for problem drug users; and information about indemnity insurance.
- There was a lack of employer knowledge about drug users in general, and specifically about prescribed medication such as methadone and Subutex.
- Criminal convictions were noted as a barrier to some sectors of employment.

INTRODUCTION

Employers' perspectives on employing PDUs were gathered from two sources. The overall, substantive questions were answered in the web-based survey and explanations and implications of these were developed in the interviews with employers. This chapter first considers the quantitative data, then explores these questions further using the interview data.

AN OVERALL VIEW FROM EMPLOYERS: QUANTITATIVE DATA

Experience of employing PDUs

Very few respondents gave positive answers to questions relating to employing current or former PDUs. Eight out of 135 (6%) answered 'Yes' to the question: 'To your knowledge, has your organisation ever employed an individual who they knew at the time of appointment to be a problem drug user?', although 12 respondents answered the follow-up question: 'How often in the past five years have you employed a problem drug user?' ('Once': 9; 'More than 5 occasions': 3). Twenty-three respondents answered the later question 'How would you describe your experience of employing problem drug users?' ('Mostly positive': 7; 'Mostly negative': 6; 'Mixed': 10). These numbers are clearly too low for any reliable inferences to be drawn. This also suggests that the bulk of the views canvassed by the survey are held by people with no direct experience of working with PDUs.

Attitudes to current and past drug use

Sharp differences are apparent between attitudes to current drug use and past drug use, as the following tables demonstrate:

Table 7: "If a job applicant who is otherwise suitable for the position admits to a history of drug use, would you offer them employment?"

Yes: offer employment regardless of applicant's drug using history	35 (26%)
No: decline to offer employment to applicant with history of drug use	35 (26%)
It depends: offer of employment would depend on type/level of drug usage	65 (48%)

Table 8: "If a job applicant who is otherwise suitable for the position admits to current drug use, would you offer them employment?"

Yes: offer employment regardless of applicant's drug use	4 (3%)
Yes, with treatment: offer employment only with evidence of support by drug treatment services	16 (12%)
No: decline to offer employment to applicant currently using drugs	74 (55%)
It depends: offer of employment would depend on type/level of drug usage	41 (30%)

The difference between 26% of employers prepared to employ a former drug user and 15% prepared to employ a current PDU, even with support by treatment services, is striking. There were no significant variations according to industry sector or company size in responses to these questions.

In each case, respondents selecting the last option ('It depends') were asked whether they would refuse employment to former and current users of specific drugs. While there were 65 and 41 respondents selecting 'It depends' for the first and second question respectively, the follow-up questions were answered by 63 and 56 respondents. Results for the two questions have been amalgamated below:

Table 9 "I would not offer employment to a former/current user of the following drug:"

	Former	Current
Heroin	58 (92%)	52 (93%)
Crack	55 (87%)	54 (96%)
Cocaine	38 (60%)	36 (64%)
Recreational/dance drugs	14 (22%)	23 (41%)
Cannabis	9 (14%)	17 (30%)
Total responses	63	56

A very similar ranking of drugs emerges from both questions, with almost universal refusal to employ current or former users of heroin or crack cocaine, and a less severe attitude towards users of other drugs. In all cases, relatively greater weight is given to current usage; this is particularly pronounced in relation to cannabis and 'dance drugs',

suggesting that concerns regarding these drugs attach mainly to the effect of drug-induced states on work performance. By contrast, a lifetime stigma appears to attach to the usage, or past usage, of heroin and crack cocaine. It is also worth noting that these responses are from respondents in the 'It depends' category; the high level of negative responses given here qualifies the relatively liberal picture given by the earlier questions. Where heroin is concerned, the 'No' category effectively amounts to 93 respondents instead of 35 for former users (69% of the sample as against 26%), and 126 respondents instead of 74 for current users (93% of the sample instead of 55%). Results for crack cocaine are similar.

The open-response opportunity at the end of the questionnaire provided further evidence of employers views. Some argued that PDUs could not or should not be employed:

> *"I would never knowingly employ a drug user ... They are lazy waste of spaces."*

> *"Employers have enough to deal with without having to manage problems created by an employee using drugs."*

Issues and concerns for employers

Respondents were asked two multiple-option questions: 'How important do you consider the following issues in deciding whether or not to employ an applicant with a history of problem drug usage?', relating to issues which the employer would take into account at application stage, and 'How important would the following be in dissuading your organisation from recruiting an individual with a history of problem drug use?', relating to concerns about the specific risks associated with employing a PDU. Respondents were given a list of issues or concerns and asked to rate each one on an 'importance' scale ('Very important', 'Important', 'Not too important', 'Not at all important').

The percentages selecting 'Important' or 'Very important' ranged from 76% to 94% ('issues') and from 71% to 94% ('risk factors'). Under the heading of 'issues', there was particularly strong endorsement for 'Length of time "clean" since last taking drugs', 'Extent of rehabilitation and treatment undertaken' and 'Availability of ongoing support for the employee', all of which were rated either 'Important' or 'Very important' by over 90% of respondents. Respondents were also invited to list any other relevant factors. Several comments related to the specific requirements of the job in question, e.g.:

> *"Considerations should be taken as to what job the applicant is applying for and whether their drug usage would impact on this."*

Other answers related to the applicant's general attitude (e.g. "Person's demeanour and appearance/behaviour important") and commitment to rehabilitation (e.g. "Attitude towards rehabilitation and willingness to engage with treatment programmes"). The key value appears to be, in the formulation of one respondent,

"evidence that their drug use is in the past", whether the evidence is provided by the time elapsed since last drug use or by the ex-user's commitment to rehabilitation.

When asked to nominate specific risk factors, respondents converged on direct and tangible risks. 'Potential risk to other staff', 'Potential risk to safety of customers' and 'Potential risk to safety of problem drug user' were all rated either 'Important' or 'Very important' by over 90% of respondents; less tangible risk factors such as bad publicity rated considerably lower. This suggests that potential employers' core negative perception of PDUs is not as idle, unreliable or untrustworthy, but as posing a risk to the safety of customers, staff and themselves. While this is a highly negative labelling, it is suggestive of fear of the unknown as much as prejudice: in effect, PDUs are seen as an incalculable threat rather than a potentially manageable deviation from the norm. Many respondents leaving additional comments in response to this question focused on the possibility of a former drug user 'relapsing', rather than any specific risk which might be posed as a result:

> *"The only factor that would dissuade me is if I thought they were going to reuse the drugs, in which case all the above would be important."*

The range of comments can be summed up by another respondent's terse formulation:

> *"Ex drug users yes, current drug users no."*

This again suggests that, for many employers with little direct experience of working with PDUs, the presence of a PDU is perceived as a threat in itself. These issues are considered in more detail in the next section of the report ("Exploring the qualitative data").

A number of other questions focused on the respondents' attitudes to the employment of PDUs as a component of rehabilitation. Attitudes were generally more positive than negative. Asked whether employers had a role in the rehabilitation of drug users, 42 respondents (37%) selected 'Agree' or 'Strongly agree', as against 30 (27%) selecting 'Disagree' or 'Strongly disagree'. Asked what effect the knowledge that an organisation had employed former PDUs would have on its credibility, 20 (18%) said that it would enhance the organisation's credibility, as against 14 (12%) saying that the organisation's credibility would be reduced. Finally, asked whether their organisation would be willing to adjust the duties or responsibilities of the post in order to make it suitable for a PDU, 48 (42%) said that they would 'always' or 'sometimes' be willing to do so, as against 33 (29%) selecting 'never'. Again, no significant correlations were found between these responses and industry sector or company size.

Specifically, several respondents argued, in the open-response question, that for someone employed as a former PDU, resumption of drug use should be a sacking offence:

> *"Being under the influence of non-prescribed drugs, alcohol or stimulants is considered Gross Misconduct and if they should lapse then they could be dismissed under the terms of their contract."*

Another respondent stressed that this 'zero tolerance' approach should apply to PDUs known to be undergoing rehabilitation:

> *"I would also want the opportunity to put a clause in the employment contract that allowed us to terminate the contract if the individual breached the rehabilitation programme."*

Support for employers and PDUs

Respondents were asked about forms of support for PDUs and the organisations employing them; 13 possible forms of support, guidance or information were listed, with respondents asked to rate them from 1 ('sounds useful') to 5 ('not interested'). 'Guidance on risk assessments and safeguards' and 'Personal support for the problem drug user' were both very popular, with over 75% of respondents giving them a '1' or '2' rating; 'Information about indemnity insurance' was rated '1' or '2' by 73%. These rankings suggest that employers see the employment of PDUs as a twofold process, offering rehabilitation for the individual involved while bringing risk to the employer. While many respondents clearly take a positive view of the rehabilitation of PDUs through employment, risk minimisation for the company is seen as a concern which must be addressed separately. Forms of support which do not fit into this two-part framework – support for the PDU, risk reduction for the employer – rated much lower: fewer than half of respondents gave a '1' or '2' rating to 'Awards recognising good practice in employing problem drug users' or 'Opportunities to meet problem drug users face-to-face'. Finally, two respondents argued, in the open-response section of the questionnaire, for an exploratory, partnership-based approach to employing PDUs:

> *"Any offer of employment would need to be a partnership between the organisation and employee designed to meet the needs of the organisation and support the employee's specific requirements."*

> *"I believe some problem drug users are not yet ready to return to work and that their return to work should be consensual, gradual, relevant and appropriate."*

However, these views were in the minority. A number of others argued that when former PDUs are employed, they should not be offered special support or treatment:

> *"Drug users have a responsibility to work within the rules of the firm and behave appropriately to colleagues and clients, like every other employee; the fact that they have a history of drug use does not come into it."*

EXPLORING THE QUALITATIVE DATA

Employing PDUs: More trouble than they're worth?

This section of the report is concerned with exploring further the attitudes and perspectives of employers in relation to employing PDUs. The central question is: why would an employer consider employing a PDU? There are plenty of reasons not to employ a PDU: harm that could be caused to the company's reputation, risk to other

employees, the potential for the PDU employee to have days off sick for health reasons, increased resources to manage PDUs in the workplace and a general perception that they 'might be more trouble than they're worth'. There are few reasons to employ a PDU, despite the fact that they may be committed and hard working if they are undertaking treatment and rehabilitation. So, for a majority of employers the issue of employing a PDU is a risky thing to do as PDUs are constructed as a potential risk to their business.

Employers are risk averse because they need to protect their business from those factors they can identify; there are enough unknowns in business to make risk reduction a key part of a day-to-day management strategy. Many employers want to be able to calculate the risk so they are in some control of possible events. To achieve this, a strategic approach is taken to minimise those factors that are identified as posing a risk. If an employer does decide to employ a PDU then strategies are implemented in an attempt to manage the risks. For many employers, PDUs are considered to be unpredictable in their work habits due to their chaotic lifestyles. This perception of unpredictability results in the calculation that PDUs are a risk to the company. For example, if it is 'general knowledge' that the company employs PDUs, there is an assessment that this will have a negative effect on how the company is perceived in the marketplace.

So one cluster of reasons why companies may be reluctant to employ PDUs relates to the perceived risk to the company's reputation. Another associated area of risk is that of potential risk to other employees. Organisations recognise that they have a duty of care to those they employ and that a PDU might pose a health risk or a workplace risk in terms of health and safety if they are under the influence of drugs or alcohol at work. Another significant perceived risk factor is that of having to alter systems and procedures for a small group of employees who may or may not prove to be reliable. This could be seen as providing PDUs with exceptional treatment in the workplace and could lead to conflict and tension with other employees.

It is important to note that the interview data indicate that there are different motivations to employing PDUs between the private, public and voluntary sectors. The private sector constructs risk as the risks to the business and the company – in a nutshell, putting profit at risk. Public sector employers demonstrate an approach that wants to be inclusive of PDUs in the workplace, but risks to the aims of their operation are identified in a similar manner. For voluntary agencies, most of which were drug treatment agencies, risks are again identified in employing PDUs, and strategies similar to those of the public and private sectors are used to reduce the risk. The question for employers is: why introduce an element of risk into the commercial operation when there are already enough risks to manage? What are the benefits in taking the (perceived) risk of hiring PDUs? These identified risks suggest that overall the motivation to employ PDUs is relatively low. The approach to risk and how employers attempt to manage it are discussed in more detail below.

Managing the risks

One of the key risks identified by private sector employers was that of the PDU using drugs or alcohol, or being under the influence of drugs or alcohol, in the workplace. For example, this respondent, a small property maintenance company, commented:

> *"Just using while working, putting themselves and others at risk, health and safety of clients and other people."* (EM68)

As noted above, the perceived risk was to other employees and to the company's reputation. Employers were clear about the consequences of using in the workplace:

> *"I'd just have to sack them to be honest, you understand if they've got a problem with or a history of drug use, but everybody else has got problems as well, some gamble some smoke some drink, we've all got our vices and if we had a problem with another member of staff they would go so you can't be giving them [PDUs] special treatment. I know if they lose their job it's going to be hard and they might get back into that, but you can't make that the only reason while you keep them in a job, they're as accountable really."* (EM94)

This respondent, from a small catering company, highlights the fact that PDUs are viewed as being as accountable for their behaviour as any other employee and that there can be no special favours to PDUs even though the consequences might be a return to drug use. For this respondent, a small community-based retailer, the issue of reputation is important:

> *"... we are very front of shop so the customers see what's going on and if they know the person serving them is a user they might not come and eat here any more, we're a local community shop."* (EM94)

For those employers in the service sector, the risk of employing PDUs was perceived as being very high. This respondent, from a small company in the construction industry, had a slightly different approach:

> *"Make sure they don't do it on the premises, just like with beer you can't have a driver going out drunk from the night before."* (EM72)

As this employer was hiring drivers he was obviously concerned about how much drug use might impair the driver and so was not going to allow people to use on the premises. For the following employer, who ran a cleaning contracting company, the issue was one of reliability:

> *"I'm just a sole trader so it reflects on the company if someone is unreliable."* (EM25)

This employer, from a small construction company, was specific about the consequences of drug use while employed:

> *"... having taken it once employed ... they are told if they are found with drug content in their system they would be dismissed."* (EM99)

The reason for this was that this employer had government contracts that specifically prohibited the employment of those with criminal convictions. For this employer the barrier was the criminal conviction rather than drug use, but many PDUs have criminal convictions and so could not be employed by this respondent. For many employers the response to drug use while employed was dismissal. However, employers take precautionary action during the hiring stage and implement a number of strategies to minimise the element of risk. For some employers, one way of managing the potential for drug use while in work is to insist on a period of time without drugs. The length of time a potential employee was expected to have desisted from drugs varied:

> *"As long as they were clean now or at least for a year or two."* (EM94)

This respondent, who ran a small catering company, would not employ anyone with a recent history of drug use and had a lengthy expectation of the time not using drugs:

> *"… no because they might do it again, length of time clean – five years."*
>
> (EM72)

Another respondent commented that they wanted the PDU to be "clean for a certain period of time" but were not able to say how long that period should be, presumably relying on their experience as an interviewer to decide on whether to employ the PDU or not. All of the interviews with employers in the private sector demonstrated a range of approaches to the issue of employing a PDU. Generally, to minimise the risk to other employees and to maintain the reputation of the company, they expected the PDU to be 'drug-free' for a period of time. This length of time varied from 2 to 5 years, although some employers stated that the period should be decided upon by the person doing the hiring. However, a drug user not using was a reassurance to the employer that the person was not a risk to the company; it also provided a way of reducing the risk that the person might be unpredictable.

Another means of managing the potential risk was by making a decision relating to the type of drug used. The majority of employers seemed to be tolerant of cannabis use, as long as it was not used in work time and did not impair the employee's ability to do the job. This respondent, from a small construction company, differentiated between the drugs used:

> "*… there's lads that use draw [cannabis] it would make a difference to crack though."* (EM65)

For the following employer there was a very real issue in terms of their government contracts and who they employed, and consequently they tolerated absolutely no drug use:

> *"… from our point of view it would be anything because some of the sites are tested. Random drug testing … and prior to the site visit they have to know who's attending, the vehicle and the registration and any previous history of convictions, and when they arrive on site they are urine tested.*" (EM99)

For some respondents the type of drug use was not important and would not prevent them employing the PDU; however, these tended to be employers in industries that experienced difficulties in recruitment and retention. One employer even demonstrated an approach that monitored the PDU's behaviour by ensuring that they:

> *"... did not nip out at dinnertime."* (EM72)

The issue concerning illegal drug use was difficult for employers to identify at the recruitment stage. Larger companies may have an Occupational Health Department that request medical information from applicants. The applicants are risk assessed in terms of health and the risk assessment is made available to the interview panel, so the panel knows the level of risk (if not the specific risk factors) for a particular applicant. Smaller companies tend not to have such elaborate systems. Some request medical information, especially where the person is going to be required to operate machinery. It is here that a drug user on a methadone prescription would have to declare their status. For some employers, employing a PDU on a prescription would be problematic. For example, a respondent from a small construction company did not think that his company would employ a PDU on a methadone prescription and a human resources manager from a large construction company was sure that being on a methadone prescription would "have a bearing" on whether they were appointed. A respondent from a small manufacturing company who was prepared to employ ex-PDUs was definite that he would not employ a PDU who was on a methadone prescription. In contrast, for another employer in the construction industry, there was no problem in employing a person if they were on methadone. This was mainly due to the physically hard and dirty nature of the work, and to the problems he experienced in recruiting people to do the work. Another employer took an approach that reflected a concern with social responsibility:

> *"... if they were on a methadone programme they're on the right track and they've got to start somewhere."* (EM32)

Some employers wanted evidence of commitment to treatment before they would consider employing a PDU who was maintaining:

> *"I think we'd be more likely to do it if they were doing it over a long time, at least over nine months before we would consider."* (EM94)

So while there are a range of views and approaches within the interview data from employers, it is apparent that they do approach the issue from a risk management perspective. For many employers, the person they are employing is being employed to do a job and consequently they are not overly concerned with being incorporated as part of the treatment process. Many service providers viewed work as being an important element of re-establishing routines and self-confidence. For them, work is an element of the rehabilitative strategy. Employers tend to construct the issue in terms of the risk that the PDU poses to the company or organisation. One service provider carried out a risk assessment in relation to the barriers to the PDU being appointed:

"… the workshop [is] to make sure that people who come through here are aware that … it's there to help them, it's a risk assessment basically on the job that they are applying for … if there's a definite no way they will get in I will tell them from day one and I'll explain why from day one." (SSP1)

This respondent demonstrates a detailed understanding of how employers risk assess candidates and consequently he is able to identify those risks and ensure that the PDU does not experience damage to their self-confidence by not getting an interview. For some of the voluntary sector organisations, some of which were drug treatment agencies, there was not an issue with employing an ex-PDU:

"The issue for me really is whether somebody has engaged in any professional training and has any work experience since their problematic drug history, and in addition to that I would assume that if they have had professional training and work experience then they will not be in a position where they will be using directly their own personal history, in their contact with clients." (DTA1)

This respondent is demanding high standards of professional practice and would also anticipate that the person appointed will not have been using for at least two years. For another voluntary drug treatment agency there was a similar demand that the applicant be drug-free for a period of two years, the reason for this is that:

"… relapse is obviously a big thing with drugs and alcohol and if someone has managed it for two years, they've got a better chance of keeping it up." (DTA3)

This approach mirrors the concerns of private sector employers, but possibly for different reasons. For private sector employers, it is a focus on minimising the risk, while for the voluntary sector employers it is that the two-year period of abstinence indicates the motivation to remain drug-free. For this voluntary sector respondent the possibility of employing a PDU on a methadone prescription was not an option:

"… we wouldn't consider them. We take people on a voluntary capacity, you know for maybe after x amount of months, people may want to come in and volunteer ..." (DTA3)

The value of volunteering is recognised by this respondent and again reflects the comments of PDUs who had undertaken periods of volunteer work. Similarly, this treatment agency also recognised that volunteer work was an entry to employment and, further, had the expectation that the applicant would be drug-free for a minimum of two years:

"… we've had previous clients and service users who have opted into volunteer positions and then subsequently have gone into employment with us but we tend to have sort of a knowledge of them … we don't have a current policy but the best practice is that that they've been clear for two years …" (DTA4)

Again, the approach of taking 'best practice' results in those PDUs on methadone prescriptions being seen as not able to be recruited.

Employers take an approach to recruiting PDUs that limits or reduces the risk. They identify potential damage to the company's reputation and possible harm that could be caused to other staff. Interestingly, these perceived risks appear to be greater in companies, or among those responsible for recruitment, where they have little or no experience of employing PDUs. This respondent from a community-based small retail establishment had employed PDUs in the past and reported positively on the experience:

> *"I found that with these two that they are keen to come in and work, it's just keeping them away from the scene that they were in before."* (EM94)

However, this respondent also commented on the negative aspects of employing them:

> *"We were always on our toes if they were going to mess up and if anything ever happened it was always pointed to them first."* (EM94)

This reflects the approach taken by service providers in having individuals ready for work, and it also highlights the need to manage the perceived risk that employers consider PDUs to pose. For the respondent quoted above, the potential for the PDU to 'mess it up' is very close to the surface, even when they have a positive experience of employing PDUs.

Such concerns are not mirrored in the voluntary agency interview data. These agencies understand the process and the need to ensure that there is a readiness to work, which for many is evidenced by the length of time a PDU has not used drugs. The reasons for employing PDUs in the private sector were varied. For some it was an expression of their social responsibility, for others it was because the work they were offering was 'dirty work' and they therefore had little choice in the labour market. For others, they were not concerned about an individual's drug use, only about their ability to turn up on time and do the job as required. For these employers, drug use was a personal matter and not one that concerned them, but if it interfered with an individual's capacity for work then they would be dismissed.

By understanding employer responses to recruiting PDUs as risk management, this provides a means of shedding some light on the barriers to employment. Private sector employers need to be convinced that the employment of an ex-PDU is not going to jeopardise their business reputation or place other employees at risk. Consequently, the approach and decisions they make are to minimise the risk. Many of the service providers understand this and structure their approach to employment accordingly; for example, through provision of volunteering and workshops to ensure that PDUs make realistic applications for work. However, what is consistent among both the private sector and voluntary agency employers is the need for the PDU to demonstrate that they are not using drugs and have not been doing so for a period of time. For private sector employers this significantly reduces the risk, and for voluntary sector agencies it demonstrates commitment to abstinence.

Fit for the job

A second key concern for employers is that an (ex)-PDU is not, for a variety of reasons, capable of doing the job they have on offer. This was, for the most part, a concern of those enterprises within the private sector. Respondents from voluntary and public sector agencies were less likely to raise this as a concern and were more likely to have strategies, procedures and policies in place to reduce this as a potential risk. The response of most of the enterprises was embedded within issues of practicality rather than any moral judgement about ex-drug users, posing the potential gains to the organisation in making the appointment against the potential risks.

First is the question of health. Is the applicant mentally and physically capable of undertaking the specific duties required? Will their health allow them to be reliable and punctual? Do they offer long-term opportunities for the company in terms of sustainability within the job and career progression?

Companies in the private sector varied in their approach to these questions. The most prevalent view, expressed across type and size of enterprise, was that provided health issues did not interfere with the quality of work, punctuality or reliability, previous problematic drug use would not prove to be a barrier to recruitment:

> *"I would have some concerns [about employing someone with a history of problematic drug use] if they showed signs of not being able to cope with the job, their tasks, you know? But I think as long as there's no physical problems, or depression or anything, you know, then it wouldn't really make a difference to us."* (EM101)

Indeed, some respondents pointed out that unless this was raised during the recruitment process they would be unlikely to know of past drug use.

A minority of companies maintained that current controlled drug and alcohol use was also not problematic provided it did not adversely affect work performance.

> "*People round here use recreational drugs, as long as they're working straight I don't think it would be an issue, and they can meet deadlines and do their duties, I don't think it is an issue."* (EM102)

However, others felt that because of the nature of their work (with machinery, handling alcoholic beverages, working with 'vulnerable young adults' or dealing with members of the public) or the size of their company, they could not risk taking on an ex-drug user, regardless of how mentally and physically capable they were to do the job:

> "*There's only five of us here, we're only a small business, we can't afford for one person to go down, there's just not the staff to cover it."* (EM103)

Respondents representing a variety of voluntary and public sector agencies had a similar approach to the majority of private sector employers in stressing that a person's ability to undertake a role is paramount:

> *"The key as already stated [is] is the person fit mentally and physically to undertake the role they are employed to do and are not a risk to the client group. Where the person has a specific role in the provision of services to vulnerable adults and children, clearly this risk will be factored into any decision. In addition, if the role contains high-risk activities such as driving and using machinery this will be considered as well."* (EM104)

And:

> *"As a mental health charity one of the issues that we consider are people who have got a long-term mental health condition, who we would still consider employing depending on how well they were managing, and whether they felt able to deal with the, with the work and I think the same thing would apply if we were aware that somebody had a previous history of drug use."* (EM105)

The use of medication such as methadone and Subutex was not something that many employers, particularly those in the private sector, had come across in the workplace, and many admitted to a lack of knowledge about these types of medication.

For those employers who had considered the possibility of employing someone undergoing treatment with methadone, it again raised questions around suitability for the post, and additionally the inconvenience for the company: will the medication impair the candidate's ability to do the job?

> *"Could they function? We work on machinery and it's dangerous if someone's not got their wits about them."* (EM106)

And will collecting prescriptions interfere with the daily work routine?

> *"I think if they're employed and you want to keep them you have to be flexible and give them permission [to collect a methadone prescription]."* (EM106)

The survey of service providers and service users, discussed in chapters 3 and 4 of this report, revealed a range of views about the use of methadone while working; the employers' responses showed a similar variation in views.

Most private sector employers did not have a specific policy in relation to prescription drug use as part of a treatment programme, and were uncertain about their company's approach. Many of the respondents from small and medium-sized companies said they had not given the issue any thought before and were tentative about giving a response. This lack of information seemed to lead to a fear, expressed by some employers, of addressing the topic at all:

> *"I'm not really sure about what that is [methadone], but I don't think we would be able to offer someone a job … it's still drugs at the end of the day."* (EM101)

A few respondents, again across the range of businesses within the private sector, believed that an overall policy was not helpful, and an individual assessment was required:

"I don't know the ins and outs of the treatment but I can tell from experience doing this work you can only judge for yourself if their drug use is going to be a health and safety issue. I'd have to see them and be with them for the day because alcohol is the same and it's just as bad, anything that impairs your judgement." (EM107)

The voluntary and public sector agencies usually required candidates to be drug-free for a period of time prior to an application before they could be considered, but the policies on the length of time that was necessary varied:

"[Applicants] need to be drug free and lived like that for some period – and our experience of ex service users is that the need for there to be a period clean is helpful to their recovery. We don't, however, specify a time for being clean – it's done on an individual basis." (EM105)

The trustworthiness and honesty of ex-PDUs was raised in interviews with employers. Many employers assumed that PDUs would have a range of criminal convictions for drug-related offences and acquisitive crimes. For some organisations, as discussed earlier, a criminal record would disqualify a candidate at the application stage:

"… if there was a criminal record … they wouldn't be employed. Because we work for the Ministry of Defence and the Queen's Estate we're not allowed to employ anybody with a criminal conviction at all." (EM99)

A minority of respondents, across the range of private sector employers interviewed, said a criminal conviction was something that would prevent them from employing an individual. Some PDUs recognised that criminal convictions for offences of dishonesty were problematic in terms of getting work:

"… [convictions] can hold you back from getting a job, because they want to trust you with their stuff." (NPDU8)

This female respondent sums up how criminal convictions are a hindrance to getting work, and that the criminal record is perceived as a significant obstacle to getting employment; it indicates not only their untrustworthiness, but also that they are a danger to vulnerable people:

"… I've got a criminal record, you know, I feel I get judged, it kind of sticks with you, you know? As soon as you mention, you know, a criminal record. I mean I worked as a carer, I've never done nothing to children or nothing like that, you know, but it sticks." (NPDU2)

Some employers, particularly those in the voluntary sector, did not see criminal convictions as a problem, as long as the requirements of the job could be met.

"… whether they have a lengthy criminal record or whether they have a lengthy drug using history is not in itself my concern, my concern is what they've done since then and whether that qualifies them for the position that they are coming here for." (DTA2)

One public sector organisation described the individual approach they adopted:

> *"Some jobs require a CRB and this may well throw up past offences in regards to convictions related to drugs etc., each case would need to be considered on the individual circumstances, the recruitment panel would receive specific support and advice from the service undertaking the CRB, HR [human resources] and OH [occupational health]."* (EMP1)

Clearly, employers are keen to select the most productive, reliable and loyal workforce. For many, particularly the smaller companies, the potential risks posed by an ex-PDU appear to be too great to contemplate. For the small and smaller-medium-sized companies, the disruption to working practices is significantly greater if one employee is unable to perform at a satisfactory level or has difficulties with reliability or punctuality. While issues around staff reliability can be absorbed by larger companies, smaller enterprises are less likely to have the resources to meet the additional demands.

> *"It's never going to be easy [to employ a PDU]; it's like with anyone who has time off on sick pay. I mean we're just a small outfit, we can't go round taking the world's problems on our shoulders, that's something more that big-business should be doing isn't it?"* (EM106)

However, other small companies felt that not all ex-PDUs presented a significant risk, and that the level of that risk could be calculated using evidence of previous performance:

> *"I look for a track record for performance, attendance and reliability, I wouldn't treat a drug user differently from anyone else … as long as they're clean for a period of time I wouldn't discriminate at all."* (CEM108)

Supporting employers

One possible strategy to minimise the perceived risk that PDUs might be thought to present is that of providing support for the employer. This can be seen to provide a means of securing employment and managing the risk elements for the employer. The response from employers to the question of the provision of support for them was mixed. Some considered it vital that they received support and updates on the PDU's progress:

> *"If I had a drug user on board I would expect some kind of help, regular updates on how they're doing, if there was anything else we could do as a company to help and just keeping us informed."* (EM68)

And:

> *"As an employer I think it would be to have full reports of their progression and what they do and where they're up to, a report from the support worker to know where they're up to."* (EM01)

So, for some employers it was important to have some idea of how the PDU was progressing, allowing them to monitor risk on an ongoing basis. For other employers, the concept of support for employers who employed PDUs was one they had not previously thought about. Generally, employers could see the benefit of support, but it was also seen as a means of doing work for the Government:

> *"No I wouldn't want to get paid by the government for doing it, that's not fair, if they can do their job that's all you need."* (EM32)

For some employers, the idea that PDUs would be getting support was more important:

> *"… the amount of help they're receiving just shows they're willing to come off drugs, the more help they're receiving shows the more they want to come off drugs."* (EM96)

For one of the drug treatment agencies that employed ex-PDUs the idea of support for the employer was not relevant:

> *"… I am employing the person to do the job and their history is not what particularly interests me, it is about how they are at the point of application for the job."* (DAT2)

However, for a small catering company the idea of there being links between businesses and service providers was important in supporting PDUs into employment:

> *"If they're better prepared to come out looking for work, maybe those rehab places if they link up with businesses and say we're going to send so many to you over a year and give them skills that would raise awareness there's places round here that do that."* (EM94)

The support is seen to be valuable in the process of gaining employment and equipping the PDU with skills for work. Once again, this can be understood as also being a strategy that is seen as being valuable in addressing the issues of risk to the employer.

Service providers recognised the need to monitor a PDU's progress in the workplace and to provide some form of support and ongoing contact:

> *"… you'd basically give them a ring once every couple of weeks, just check how they are, check that they haven't dropped out … we did monitor up to 26 weeks."* (NSP4)

For one service provider who employed ex-PDUs on traineeships, the notion of providing support was crucial:

> *"… we definitely had one employee who really wobbled, and had a lapse, but we were able to support her in that, and work with her, and get her back on*

the programme on a, sort of, a part-time basis, and extend her traineeship, and she's still employed now in the organisation." (LSP2)

However, it is apparent that employers in the private sector are not prepared to invest this level of resources to support a PDU in employment; essentially, employers want an employee who is not problematic.

COMPARISONS OF RESEARCH AREAS AND EMPLOYERS

Introduction

This study was structured to provide qualitative data from three case-study sites, one in Scotland, one in London and one in the North of England. One of the reasons for this was to ascertain if there were any significant differences between these regions. The second area of comparison was between employers. The sample of employers was selected to ensure that there were employers from the private sector, the public sector and the voluntary sector. One of the reasons was to see if there were differences in attitudes and approach to employing PDUs. Within the private sector employers, the sample was structured to consider small and medium-sized enterprises and large national and international companies

Comparison of research sites

There were no consistent differences between employers in the three research sites. Employers in each of the research sites expressed a range of views, so it is not possible to say that there are marked differences in approach to employing a PDU that is regionally specific.

It is worth commenting on the differences between employers. The approach taken by the majority of private sector employers was one of managing the risk that a PDU could present to the business. Large companies had developed human resources and health policies that could indicate that a person was a risky employee from a health perspective. Small and medium-sized enterprise did not have such well-developed systems and so they were reluctant to consider employing a PDU in most business categories. The exception to this was in particular subsectors of construction. Some of the work available was menial, very physically demanding and poorly paid, described by one respondent as 'dirty work'. In this subsector for this type of employment there was a labour shortage and so the employer was prepared to employ whoever was available. However, any misdemeanour once in employment would typically be dealt with by dismissal.

Within the public sector there was a greater propensity to consider employing PDUs, but again there were requirements concerning both period of abstinence and previous convictions (following legislative and policy guidance). Again, this approach can be interpreted as public sector employers managing risk; however, they appeared slightly less anxious about the employment process and this may be due to their experience of implementing equal opportunities policies. Within the voluntary sector the approach was similar to the public sector. Many of the voluntary sector agencies were drug

treatment orientated agencies. To demonstrate commitment they required a period of abstinence.

There were common themes across all employers, but no significant regional differences. Within the private sector there was slightly more variation due to size, but not in relation to subsector. It was also apparent that where there are labour shortages in a particular sector or locality, there is a probability that the employer will take a risk of employing a PDU. It should be remembered that these subsectors are often employing labour mainly for manual work that is hard and physically demanding and so is unpopular. PDUs can be seen then as having a position within the labour market similar to other disadvantaged groups, such as some people with convictions, migrant labourers and those lacking educational and workplace skills. Interestingly, none of the employers from any of the sectors made any distinction between men and women. The interview data suggest, however, that female PDUs may have a more difficult time in obtaining employment.

The comparison in terms of service providers is less clear. In Scotland there was a strong ethos of abstinence by one of the larger service providers, and this tended to be a dominant view of the approach taken to treatment and intervention with PDUs. In London and the North of England, there was not such a strong emphasis on abstinence with there being a range of provision, including maintenance prescribing. However, the difference in approach may not be related to regional issues but rather to different treatment ideologies within the different service providers. What is apparent is that the abstinence approach to treatment was one that was mirrored in the expectations of employers in all of the research sites who were looking for a period of abstinence prior to employment. So the different approaches to treatment may have a knock-on effect on the probability of a PDU gaining employment.

CONCLUSION

For employers, there are a range of potential risks associated with employing PDUs. For some, these risks are simply too great to take on. Essentially, what employers want are people who are honest, reliable and keen to get on with the job. A drug-using history is not in itself significant, provided that applicants fulfil the basic criteria for being a good employee. On the other hand, once in post, drug use that interferes with an employee's ability to undertake the tasks of their employment is not tolerated by employers. There are few positive benefits for an employer in employing a PDU and there are many reasons why they might choose not to. Knowing a job applicant has a history of drug problems may sometimes be enough to tip the balance against them, as it may be viewed as a proxy indicator that there is a risk they will not be 'fit for the job'. PDUs generally occupy a marginal position in the labour market and typically have to take jobs that are poorly paid and lack security, as well as often work that is dirty, physically demanding and unattractive. The longer term sustainability of such employment, and of any positive impact on confidence and self-worth, remains an open question.

6. Getting problem drug users back into work: Myths, problems and opportunities

- Employment is as an integral part of a problem drug user's recovery.
- Volunteering is an important element in preparing problem drug users for work.
- The common view that employing a problem drug user is problematic was in contrast to the actual experiences of employers who had done so.
- Problem drug users generally demonstrate a high level of commitment to their work.
- Problem drug users are employable across a range of sectors.
- Accommodation that is appropriate to a problem drug user's stage of treatment is critical.
- Employers have a lack of knowledge about problem drug users and perceive employing them as a high-risk strategy.
- There should be easily accessible information and support available for employers.
- There is a need for incentives to encourage employers to employ problem drug users.

Introduction

Meaningful employment can be an important part of a PDU's reintegration into society; it can have positive benefits to self-esteem and self-confidence and may provide a sense of purpose and self-worth. For the majority of PDUs interviewed, employment was an integral part of their recovery programme, a goal to be strived for and an important part of what can be described as being part of mainstream society and of losing the label of 'problem drug user'. Employment also provided opportunities to demonstrate their commitment to being drug-free and so was an outward sign of intentions. It was evidence of their recovery and was an element that facilitated the reconnection with children, family and significant others. All of this was important in establishing, and being seen to lead, a drug-free lifestyle. However, there were a number of myths that both the PDUs and employers subscribed to that hindered employment opportunities. There were also very real problems experienced by employers and PDUs in engaging in work. Finally, there are a number of opportunities that are in particular recognised by the service providers that could provide employment opportunities for PDUs.

The myths, problems and reality of PDU employment

Every good myth has a seed of reality within it, and PDU employment is no exception to that rule. For many employers, the risks of PDU employment are too great to

contemplate and so it is an area where their knowledge of the issues and opportunities is sparse. For many employers a PDU employee is 'problematic'. The interview data from employers who had hired PDUs tend, in most cases, to contradict this perception. Those employers who had knowingly employed PDUs tended to report positively on their experiences. There were very few reports of employees arriving at work under the influence of drugs or using drugs in the workplace. There were no examples of a PDU endangering other employees by their reckless behaviour, and there were no instances of dishonesty reported. One employer did discuss having given a PDU a chance who then "blew it", but they dismissed the employee, a strategy that any employer would use with an employee who does not meet the requirements of their employment. Nevertheless, the myth of the unpredictable PDU employee who is high risk does have a seed of reality. As many service providers noted, the route back into employment is a long and circuitous one; it demands that the PDU has demonstrated a period of being abstinent and of demonstrating their ability to work within the rules and requirements of an employer. To reach this position from a drug-using lifestyle requires the PDU to be motivated and committed to being drug-free, to have undergone different forms of training and to have developed a positive attitude to work. So, the first general finding of this study is that *paid employment should be established as an end goal of treatment and rehabilitation and not as a primary goal of intervention programmes*.

The second general finding from this study is that in developing a positive attitude to work *it is important that the primary issues – motivation and the process of change, accommodation, health, formal and informal support and reconnecting with the family – are given the appropriate time within the treatment programme to be managed effectively*. Consequently, it is important that criminal justice supervision does not place conflicting requirements on recovering PDUs; for example, the need to fulfil supervision requirements by obtaining employment in order to meet criminal justice targets when it is obvious to service providers that the primary issues have not been addressed and so entering employment has a high probability of failure.

The third general finding, contrary to some views, is that *PDUs are employable across a range of sectors and generally demonstrate a high level of commitment to their work*. There was evidence in the interview data with employers, PDUs and service providers that once employment had been obtained at the appropriate point in the treatment and recovery plan, PDUs were able to maintain themselves in work and make a positive contribution to their employer. For the employer it was apparent that skills acquisition was not the paramount concern, but rather that the PDU would prove to be a loyal, trustworthy and keen worker.

A fourth general finding from the study is that *volunteering is an important element of preparing a PDU for work.* Volunteering was positively reported on by service providers and PDUs and provided the opportunity to re-enter a working environment without all the disciplines and stresses of paid work. It also provided the PDU with a sense of 'giving something back' or of making a positive contribution to the community, thus bolstering self-esteem and enhancing self-confidence.

There are, however, a number of problems that need to be addressed. In relation to housing there are two main issues that can jeopardise getting work for a PDU. Some PDUs found it frustrating that they were not able to move into accommodation that was more suitable for them in relation to their treatment. A number of PDUs commented that living in direct-access or first-entry hostels meant that they were in close proximity to people who were still using or who had replaced drug use with alcohol. This resulted in a living environment that was frequently disrupted, making it difficult to establish a lifestyle and routine that was conducive to employment. The second issue in relation to accommodation is that although employment brings with it responsibilities, the paying of high rents was difficult to achieve through the type of work on offer. This problem appears to be one of lack resources. Service providers and PDUs reported that it was difficult to move people into appropriate accommodation because the demand was so high. This is an important finding because it is clear that accommodation is central to developing a treatment strategy that is properly managed and where a person can be supported in their drug-free lifestyle and as they enter the labour market. The fifth general finding from this study is that *accommodation that is appropriate to the PDU's stage of treatment is critical in providing a supportive and stable environment that is conducive to employment.*

Many of the employer respondents demonstrated little or no knowledge about drug treatment. Consequently, their lack of knowledge meant that they were generally more hesitant in considering employing PDUs as they assessed the risk as being too severe. Some of the employers commented that it would be helpful to have an easily accessible information package. A minority of employers also considered that it would be of benefit to have the provision of support from service providers if they employed a PDU. The sixth general finding is that *there should be easily accessible information available to employers, possibly through a website, that provides information and identifies possible sources of support for employers*.

The interview data from employers indicates that there are three interrelated factors that make the employment of PDUs a low priority. First, employers perceive that employing a PDU who is not drug-free as a considerable risk, even if the PDU is maintaining via a methadone prescription. The majority of employers required that a PDU has been drug-free for a significant period of time, often around two years. This was a common finding across all employment sectors and categories. There is clearly potentially a meeting here between different types of treatment provision and employer requirements. The second related issue for employers was that of criminal convictions. For many employers, a criminal conviction increases the perception of risk and so is a factor that mitigates against employing a PDU. Third, problem drug use is a hidden activity and so increases the sense of anxiety for employers. Some employers demonstrated a tolerance towards cannabis use, as long as it did not affect the person's ability to do the job, but nearly all were very anxious about employing those who were users of opiates. The bringing together of these interrelated issues suggests that the reality is that employing PDUs is perceived as being too risky; the question many employers appear to ask is: why subject my organisation to a set of risks that can be avoided? The seventh general finding of this study is that *employers have little knowledge about drug use and perceive the employment of PDUs as being a high-risk strategy*. The eighth general finding is that *employers have little or no incentive to*

employ PDUs, so to encourage employers to engage with employment of PDUs requires a series of incentives that address their concerns and make it 'worth their while' to take what they perceive as a risk.

IMPLICATIONS FOR POLICY AND PRACTICE

1. Employment should not be used by criminal justice agencies as a measure of the 'success' of supervision. Employment should be recognised as a point at the end of the treatment process and at the beginning of the PDU's experience of being reintegrated into society.
2. Appropriate staged accommodation that supports PDUs through treatment and into employment should be more readily available.
3. Voluntary work should be available for PDUs across a number of sectors to assist in the development of a positive attitude to work. Volunteering can be an important part of rehabilitation back into employment.
4. An employer engagement strategy should be planned, which could include some of the following elements:
   - An information website for employers. This could be linked to a helpline managed by one of the service providers to provide more detailed information and ongoing support for employers. This idea could be piloted.
   - A traineeships scheme for PDUs. Drawing on the experience of existing successful schemes, a traineeships scheme could be established to allow employers to offer work-based placements for PDUs for specified periods. A traineeship would allow the trainee to be supported by their service provider while the employer provides training; the PDU would then get real-time experience of the workplace. Traineeships should only be offered where there will be actual jobs available at the end of the training period. During the training period, the trainee should receive enhanced benefit, thus the incentive to the employer will be that they are able to make a real-time assessment of the risks posed by the PDU and will gain the support of the service provider during the training period at little cost to their enterprise.
   - Employer forums. Service providers should draw on their combined knowledge and experience to demonstrate that PDUs can be keen, reliable and honest workers. This could be achieved by establishing employer forums in target areas, which would focus on the employment of PDUs linked to traineeships.

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