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## **Drug and alcohol use as barriers to employment : final report**

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**DRUG AND ALCOHOL USE AS  
BARRIERS TO EMPLOYMENT**

**Final Report**

**CRSP 470S**

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**April 2004**

**DISCLAIMER**

The views in this report are the authors' own and do not necessarily reflect those of the Department for Work and Pensions

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## TERMINOLOGY

### Classification of Drugs

Drugs are classified under the Misuse of Drugs Act 1971 into three main categories, known as Class A, Class B and Class C.

#### Class A Drugs

Class A drugs include heroin, methadone, cocaine, Ecstasy, LSD, amphetamines (if prepared for injection) and magic mushrooms.

*Heroin* - opiate made from the chemical morphine, which is extracted from the dried latex of the opium poppy.

*Methadone* - synthetically produced, prescription-only drug used to treat people who have become dependent on opiates, such as heroin.

*Cocaine* - stimulant affecting the nervous system extracted from the leaves of the coca plant found in South America.

*Ecstasy* - a man-made psychoactive drug; can cause hallucination and hyperactivity in the user, masking normal sense of exhaustion and/or dehydration.

*LSD* (Lysergic Acid Diethylamide) - a hallucinogenic drug that is derived from a fungus found growing on rye and other wild grasses.

*Amphetamines* - man-made drugs that usually come as powder, and sometimes as tablet or in a liquid form, which is injected into the body. Most common form is amphetamine sulphate, or Speed.

*Magic mushrooms* (also known as psychedelic mushrooms) - a fungus, growing on cow dung and bruise with a bluish/purplish colour, altering sense perceptions and states of consciousness in the user.

#### Class B Drugs

Amphetamines (speed) and barbiturates are Class B drugs.

*Amphetamines* – see above.

*Barbiturates* – drugs depressing the central nervous system, causing mild forms of sedation and stronger forms of anesthesia, i.e. the loss of consciousness.

#### Class C Drugs

Cannabis, anabolic Steroids and benzodiazepines (tranquillisers) are Class C drugs, as well as some mild amphetamines.

*Cannabis* (also known, amongst others, as grass, hash, marijuana, weed) - a natural drug derived from the Cannabis Sativa plant.

*Anabolic steroids* - synthetic drugs affecting body growth and physical development.

*Tranquillisers* - drugs prescribed by doctors to relieve anxiety, depression and insomnia.

## **Other**

*Opiate* – drug that contain opium or an opium derivate.

*Opium* – narcotic extracted from the seed capsules of the opium poppy.

## EXECUTIVE SUMMARY

### Background

Part of the government's strategy for 'Tackling drug misuse' is to assist '*people who have graduated from drug treatment programmes into the labour market*' (UKDAC, n.d., p.26). In June 2002, the Department for Work and Pensions (DWP) commissioned the Centre for Research in Social Policy to undertake a study of the support needs of substance users, including drug, alcohol and drug and alcohol users, in Britain. The study also sought to estimate the number, and describe the demographic and socio-economic characteristics, of substance users who are claiming social security benefits and living in private households.

### Methodology

The research consisted to three distinct activities:

- i. a review of the international literature dealing with substance users' barriers to work, alongside a review of existing initiatives to assist substance users into work;
- ii. secondary analyses of the British Crime Survey (BCS) and the General Household Survey (GHS); and
- iii. interviews with
  - a. ten treatment organisations to explore their views on the employment support needs of substance users; and
  - b. 30 drug or alcohol users to obtain an in-depth account of the barriers they had faced in maintaining or obtaining work and of the type of support they would like to receive to help their entry or return to work.

### Literature and programme review<sup>1</sup>

Support programmes for substance users tended to combine employment with treatment services, either through external linkages or internal provision. Successful programmes had established a high level of inter-agency co-ordination, collaboration and communication. Employment service providers had thorough knowledge of drug- or alcohol-related issues (health, behaviour etc.) and close links with the local labour market. Support for substance users involved one-to-one case management, continuity of support after placement, relapse prevention and referrals to other support services (e.g. benefits/financial; childcare).

### Substance user estimates

It was estimated that, in 1998, approximately 120,000 claimants of Jobseeker's Allowance or Income Support and about 150,000 claimants of sickness or disability benefits living in private households engaged in heavy, or *problematic*, drinking. Problematic drinking was defined as consuming over 50 units of alcohol (men) or over 35 units of alcohol (women) per week. A unit of alcohol is equivalent to half a pint of beer or a small glass (125ml) of wine.

The BCS, which covers drug use in private households in England and Wales (the BCS does not cover Scotland), does not record whether individuals in the sample receive social security benefits. For this reason, the proportion of drug users in the sample was calculated for all individuals, whose economic status suggested that they might be claiming benefits ('individuals potentially claiming benefits'). In total, it was estimated that approximately 39,500 individuals potentially claiming benefits and living in private households had been using Class A drugs in the month before the interview and were, therefore, considered to be

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<sup>1</sup> The literature and programme review is published as a separate report (Sutton et al., 2004). Its findings, however, will be reported here as appropriate.

drug users. Amongst them, 27,500 individuals potentially claiming benefits had been using one or more Class A core drugs, which included heroin, cocaine, crack and methadone, but not LSD and ecstasy.

Approximately 51,000 potential benefit claimants in private households were estimated to have been heavy drinkers while at the same time consuming Class A or Class B drugs.

Neither the GHS nor the BCS are specifically designed to study benefit claimants and, for this reason, include only a comparatively small number of claimants and an even smaller number of drug or alcohol users who are, or might be, benefit claimants. As a result, the substance users estimates were, themselves, based on small numbers and, therefore, liable to be inaccurate and to lack robustness. The confidence interval indicated that the true value of an estimate had a 95 per cent chance of falling within the indicated ranges.

Two further estimates, based upon and extrapolating data about substance treatment registrants, suggest that the number of drug users in receipt of benefit in England and Wales was closer to 270,000, and that some 94,000 individuals in drug treatment in England were out of work and potentially receiving benefits. Unlike the present study, these estimates captured individuals living in communal establishments as well as in private households. Being based on treatment registrations, they also did not face the problem of non-reporting to the same extent that household surveys, such as the BCS, do. The additional estimates and the estimate derived for this study should, therefore, be seen as complimentary and partially overlapping.

### **Substance user characteristics**

Drug, alcohol and drug and alcohol users actually or potentially in receipt of benefits and living in private households tended to be largely male and young, typically aged between 18 and 24 years (18-34 years, in the case of drug and alcohol users). Other characteristics that significantly distinguished substance users from non-users, who were also claiming benefits, or were likely to be claiming benefits, included their place of residence: alcohol users in receipt of benefit and in private households were disproportionately likely to live in the North of England or in Scotland, while Class A core drug users were disproportionately likely to live in the North or the South of England. Most drug users potentially claiming benefits were also single and never married (Class A core drug users) or living in one-person households (drug and alcohol users). The latter group also often lived in neighbourhoods, which they described as places '*where people go their own way*' rather than areas where people '*do things together and try to help each other*'. Finally, alcohol users on sickness or disability benefits often lived in households with multiple, but unrelated members; they also tended to be cigarette smokers.

Although substance users also tended to be poorer or to have lower educational qualifications than was the case for the total working-age population, these characteristics did not significantly set them apart from other actual or potential benefit claimants and most differences were explained by their younger age.

Drug users and users of drugs and alcohol were, however, more likely than other potential benefit claimants to have been arrested, called before a criminal court or to have been in contact with the Probation Service.

### **Substance users' barriers to work**

Substance users were found to be prone to health problems, both mental and physical, some of which had resulted from their addiction, while others were described as the original triggers of substance use. Health problems also continued during recovery as users suffered from the side effects of their rehabilitation, in particular, the use of substitute drugs.

Psychological problems were particularly prevalent among alcohol users. Health problems presented the most immediate barrier to (former) substance users' ability to work and to sustain work.

Eroding social networks, homelessness, living in adverse social environments, low confidence or fluctuating motivation to resist addiction and to take steps to change one's lifestyle, were key obstacles to substance users' efforts to search for and obtain jobs.

Educational and occupational qualifications among substance users who claimed or potentially claimed benefits could be low and a number of substance users interviewed for this study admitted to having literacy and numeracy problems. At the same time, however, substance users expressed modest employment goals, including advocating education, training or re-training. They perceived interrupted work histories, gaps in their CVs, and the need to disclose health problems and criminal records to employers, as their greatest obstacles to obtaining work.

### **Assisting substance users' entry or return to work**

Substance users frequently expressed mistrust of government offices, including Jobcentres. Involving treatment service providers was seen as a means to build trust between substance users and employment service providers. Substance users and treatment service providers emphasised the need for employment service providers to understand the multiplicity and diversity of problems faced by (former) substance users, and the benefits of case management.

Substance users and treatment service providers argued for a step-wise (re)integration of substance users into the primary labour market, involving the private, public and voluntary sectors. This would allow substance users progressively to adapt to work, which would be increasingly more demanding in terms of hours worked, workplace performance and tasks undertaken.

### **Timing intervention**

Substance users and treatment organisations agreed that, before entering employment, substance users needed to have stopped using drugs or alcohol completely. However, substance users disagreed as to whether they should, also, first stop using substitute drugs.





## **DRUG AND ALCOHOL USE AS BARRIERS TO EMPLOYMENT**

### **SUMMARY**

- ❖ In June 2002, the Department for Work and Pensions commissioned the Centre for Research in Social Policy to study the employment barriers of drug and alcohol users and to estimate the number of problematic substance users in receipt of state benefits who live in private households in Britain.
- ❖ The study involved a literature review, interviews with 30 substance users and representatives of ten substance user support organisations, and secondary analyses of the British Crime Survey and the General Household Survey. The secondary analyses used data from 1998 and 2000.

## **1 INTRODUCTION**

In June 2002, the Department for Work and Pensions (DWP) commissioned the Centre for Research in Social Policy (CRSP) to conduct a study of the barriers that drug and alcohol users experience in obtaining paid employment. The study involved a literature review that included programmes aimed at assisting drug and alcohol users into paid work; a secondary analysis of quantitative data to estimate the number of drug and alcohol users amongst the unemployed or benefit receiving population living in private households; and in-depth interviews with organisations providing support for drug and alcohol users as well as interviews with their clients.

### **1.1 Policy background**

In 1998, the United Kingdom government launched a new ten-year strategy for ‘Tackling drug misuse’ (Cabinet Office, 1998), which set out the agenda for reducing the illegal selling and use of drugs and for improving the help available to drug users in and after rehabilitation. Since 1995, Drug Action Teams (DAT) and Drug and Alcohol Action Teams (DAAT) had co-ordinated anti-drug initiatives at the local level, bringing together local authority and regional service providers, such as Social Services, the NHS, and regional police forces. ‘Tackling drug misuse’ suggested greater partnership development between the DATs and DAATs, and, among others, welfare-to-work initiatives.

One of the strategy's principal objectives has been to 'increase [the] take-up rate of further education and employment by former addicted criminals through welfare-to-work, New Deal and other means' (ibid, p. 19). By April 2000, six pilot projects had been put into place, which were designed to assist '*people who have graduated from drug treatment programmes into the labour market*' and to '*provide a bridge between treatment and the labour market*' (UKDAC, n.d., p.26). These *Progress* pilots operated in Liverpool, Glasgow, Plymouth, Kingston upon Thames and Hertfordshire under the auspices of the DWP until March 2002. Managed by local voluntary services and Training & Employment organisations, and in partnerships with private business and community drugs service (e.g. DATs), they provided (access to) drug counselling and treatment support, and job preparation services. Two of the six projects also offered direct employment placement services including, in one case, aftercare support for former programme participants, who had moved into employment. In their first year of operation, the projects had worked with 138 individuals, of whom 27 had found paid work (UKADC Annual report 2000/1).

In March 2001, the *Progress* initiative was extended under the new title of *progress2work*. By early 2002, Jobcentre-based *progress2work* co-ordinators and external specialist providers of employability or drug treatment services had been appointed in 31 pathfinder areas. Since then a further 27 *progress2work* pathfinders have been implemented across Britain in the second phase of rollout. By mid-2004, it is expected that *progress2work* will be available nationally in every Jobcentre Plus district.

## **1.2 Research aims**

Little is known about the number of drug or alcohol users among benefit recipients and there is currently no information available from DWP or other sources about the number of drug or alcohol users among benefit recipients who live in private households. This study was commissioned to provide this estimate of the population of substance users in England and Wales, who are in receipt of social security benefits and live in private households. These estimates would compliment additional estimates produced on behalf of the Home Office of drug users mainly living in communal establishments or, for other reasons, unlikely to be captured by household surveys. Similar estimates for alcohol users are currently in preparation.

The aim of this study was to help to gauge the likely scale of *progress2work* and other initiatives, which include recovering drug users among their clients. Research was also conducted to provide an account of the barriers to employment, which drug and alcohol users might encounter.

The initial research questions, outlined in the Invitation to Tender, were:

- How does substance misuse act as a barrier to job-search/employment?
- What is the evidence base, national and international, on problems of drug and alcohol misuse in the context of employment, benefit receipt and interventions designed to re-engage clients with the labour market?
- What can we say about the proportions of active and inactive clients that have drug or alcohol addictions? What are the known characteristics of benefit claimants (active and inactive) who have drug/alcohol addictions?
- What can we say quantitatively and qualitatively about the prevalence of other characteristics of disadvantage among these groups, and how they might interact to compound an addiction or block off work as a viable option?
- What types of addiction are prevalent among clients and how do they affect job-search?
- What kind of help would clients value most from DWP, and do they ‘trust’ DWP to deliver this kind of assistance?
- In what ways and at which stages in clients’ recovery can the *progress2work* pilots and Jobcentre Plus hope to make a difference to employment placement and retention?

DWP were also interested in how urban or rural location might effect drug and alcohol users’ barriers to employment, for instance, as a result of differential or inequitable access to support services or employment opportunities. This dimension was explored in the interviews with alcohol and drug users.

### **1.3 Research methods**

The research included three distinct, but inter-related activities: first, a review of national and international literature; secondly, a secondary analysis of the British Crime Survey (BCS) and the General Household Survey of Great Britain (GHS); and thirdly, a series of interviews with key representatives of organisations providing support services and rehabilitation treatment to drug and alcohol users, as well as interviews with some of their clients.

### **1.3.1 Literature review<sup>2</sup>**

The aim of the literature review was to identify national and international research, which has investigated the barriers that drug and alcohol users face in entering or re-entering the labour market. In addition, the review identified a number of national and international programmes, which assist or assisted drug and alcohol users in finding and obtaining employment. Where available, evaluations of such programmes were obtained and reviewed, and their findings will be summarised in this report.

Relevant literature was identified through internet searches and searches of indices of publications, including unpublished but circulated reports and papers provided by organisations not primarily concerned with publishing and typically referred to as ‘grey literature’. Seventeen providers of rehabilitation and employment placement service for drug and alcohol users, and researchers with special interest in this field were contacted and asked for guidance and advice about relevant literature, programme descriptions or programme evaluations. About half of the providers and researchers who were contacted were located in Great Britain, while the remainder were based in the United States, New Zealand and countries across Europe.

The literature review specifically sought to collect existing evidence with respect to:

- the effect on jobseeking and job retention of the misuse of different types of drugs;
- the need to distinguish between different age groups;
- the relatedness of drug and alcohol abuse, and the need to distinguish between multiple forms of dependency; and
- the relationship between drug and alcohol abuse and socio-economic characteristics or forms of socio-economic disadvantage.

### **1.3.2 Secondary quantitative analysis**

The original aims of this part of the study were, for people living in private households,:

- to analyse the job-search behaviour of self-reported drug and alcohol users (and to compare this with other jobseekers);

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<sup>2</sup> The literature and support scheme review is published as a separate report (Sutton et al., 2004). Its findings, however, will be reported here as appropriate.

- to estimate the proportion of self-reported drug and alcohol users amongst benefit clients and to describe their characteristics and types of addictions; and
- to explore the extent of coincidence and correlation of drug and alcohol misuse and other forms of social and economic disadvantage, and their cumulative effect, if any.

The General Household Survey (GHS) and the British Crime Survey (BCS) were used to analyse and estimate, respectively, the use of alcohol and drugs among individuals living in private households in Britain. In both instances, the most recent survey available at the time of the study was used for analysis. For the British Crime Survey, this was the survey conducted in 2000; with respect to the General Household Survey, this was the survey conducted in 1998.

### Caveats

Neither the GHS nor the BCS lends itself to an analysis of job-search behaviour. The quantitative analysis, therefore, focussed solely on estimating the number of self-reported drug and alcohol users among the benefit population, describing their characteristics and looking for evidence of multiple social disadvantage.

The BCS provides information about respondents' knowledge and use of drugs and more limited information about respondents' drinking behaviour. The GHS, in contrast, contains no information about respondents' drug use, but a detailed account of their drinking behaviour, which also seeks to be more accurate than the survey participants' self-reported estimates of the BCS. For these reasons, the GHS was used to estimate the number of alcohol users and to describe their characteristics, while the BCS was used for estimating, and describing the characteristics of, drug users. A further analysis to quantify and describe individuals who use both drugs and alcohol was also based on the BCS.

Although working-age recipients of social security benefits, that is, people aged between 18 and 64 (men) or 18 to 59 (women)<sup>3</sup>, were the main focus of this study; this group could only be identified from the GHS. The BCS only records the employment status of respondents, but not whether unemployed respondents or economically inactive respondents, who are not currently looking for work or are not immediately available for work, also receive social

security benefits. Although many of the unemployed or inactive respondents might have been in receipt of social security benefits, the extent to which this was, in fact, the case could not be determined from the data.

In summary, the study used two definitions to identify the substance user groups: (a) benefit recipients who use alcohol and (b) unemployed or inactive people who use drugs or drugs and alcohol.<sup>4</sup> Using different definitions ruled out any direct comparisons of, on the one hand, drug users and, on the other hand, alcohol, or drug and alcohol users.

A further aim of the study was to ascertain the extent to which drug and alcohol users suffered forms of social disadvantage. Beside income data, only the GHS provided information, which could be used as indicators of forms of material deprivation. Neither survey included data relevant to determining the extent to which substance users might suffer other forms of social disadvantage, such as social networks, which are known to affect employment chances (Hannan, 1999). The GHS indicators on deprivation related to bedroom standard and the possession of durable goods.

Bedroom standard is the occupancy ratio of persons per room (not counting kitchens and bathrooms) and is considered above (below) standard, if the ratio is less (more) than one person per room. 'Standard' bedroom standard equals one person per room. The indicator is therefore a proxy measure of overcrowding or over/under-occupancy.

The possession of durable goods (including colour or black-and-white television, telephone and home computers) is an indicator of the relative material prosperity of individuals and their households (cp. Gordon et al., 2000). In this study, a simple index counting the number of items owned by respondents was constructed and the number of possessions compared between the alcohol user and non-users.

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<sup>3</sup> The lower bound of the working age was defined as 18 rather than 16 because only those aged 18 or over are independently eligible for social security benefits.

<sup>4</sup> Further details of the definitions of the benefit and employment status of respondents and of the definition of drug and alcohol use applied in this study are presented in the relevant chapters dealing with these user groups (Chapters 3-5).

## Data Selection and Preparation

The findings from the secondary analyses will be presented in separate chapters below, each dealing with one of the three drug, alcohol, and drug and alcohol user groups. Each chapter will follow a similar structure, reporting first the population estimates, followed by descriptive data about the user group and, finally, the results of one or more logistic regression analyses, designed to draw out the key differences between substance users and non-users (see below).

Neither the GHS nor the BCS is specifically designed to capture the population of benefit recipients or people looking for work. As a result, the number of cases available for analysis is typically small and further reduced when the focus, as in this study, is much more narrowly on a minority group of ‘hard’ drug or heavy alcohol users. In order to boost case numbers and thus improve the robustness of some of the analyses, two surveys of adjacent years were combined into one large dataset<sup>5</sup>, thus increasing the number of cases available for analysis (Table 1.1). In the case of the GHS, the survey conducted in 2000, which had become available in the course of the study, was combined with the GHS of 1998. Similarly, the BCS 2000 was merged with the BCS 1998.

**Table 1.1      Surveys used in the analyses**

	<b>Alcohol Users</b>	<b>Drug Users</b>	<b>Alcohol and Drug Users</b>
Estimates	GHS 1998	BCS 2000	BCS 2000
Descriptive data	GHS 1998	BCS 1998 + BCS 2000	BCS 1998 + BCS 2000
Logistic regression	GHS 1998 + GHS 2000	BCS 1998 + BCS 2000	BCS 1998 + BCS 2000

The merged datasets were used when small case numbers would otherwise have severely weakened the analyses or, indeed, would have rendered them impossible. The merging of the datasets led to the loss of a few variables reported in one, but not the other survey year, or of variables whose coding had changed from one year to the other and could not be reconciled. The omission, however, had no major adverse effect on the scope of the analyses. Despite

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<sup>5</sup> As the datasets of the same source, i.e. GHS or BCS, contained, with the noted exceptions, largely identical variables, they could be combined by simply appending one year’s dataset to the other’s.



the merging of two survey years, the data analyses still required substantial aggregation of variables that described the characteristics of participants, because individual cell numbers would have been too small and, thus, unreliable for reporting.

Issues relating to the weighting of the survey data are discussed in Annex A.

### Logistic regression

Logistic regression analysis is a statistical tool by which the key characteristics that distinguished drug and/or alcohol users from non-users and other user groups among the sample population could be identified. It compares the likelihood (or odds) that known characteristics, described by the variables in the datasets, distinguish one group from another, and estimates the statistical significance of these differences. At the same time, it controls for other characteristics captured by other variables, which are included in the analysis model. Logistic regression is, therefore, different from descriptive statistics, also presented in each relevant chapter in the form of frequency distributions, in so far as the latter only list the characteristics of group members, but do not compare them, in a standardised format, with those of members of other groups. Further details of the method of logistic regression analysis are provided in Annex A.

### **1.3.3 In-depth interviews**

The qualitative part of this study included interviews with key personnel of providers of rehabilitation and/or employment services, providers for drug and alcohol users and their clients. In total, representatives of ten support organisations were interviewed; these included six drug user and four alcohol user support organisations, placed in London and the Midlands. In addition, 23 drug users and 11 alcohol users were interviewed<sup>6</sup>, based at five of the ten support organisations, two of which were in heavily built up urban areas, while the others were in smaller urban centres or semi-urban areas, catering also for clients resident in less densely populated, sometimes distinctly rural areas in the vicinity.

In all instances, the support organisations agreed for flyers to be exhibited in their premises (typically the reception area) to ‘advertise’ the research. The support organisations gave handouts to clients who expressed an interest in participating in the research. The hand-outs

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<sup>6</sup> In the end, only 20 drug user and ten alcohol user interviews were analysed. For details, see Chapter 8.

included a one-page letter drafted and signed by the DWP, which explained the aims and objectives of the study. It invited drug and alcohol users on benefits to participate in the research and, in accordance with the ethical principles set out by the Social Research Association, emphasised that participation was voluntary and all information given to the interviewers would be treated as confidential.

CRSP interviewers visited the support organisations on days previously agreed with them and indicated on the flyers. Interviews took place in offices provided by the support organisations and, in one instance, hired elsewhere by the researchers, because no spare room was available on the support organisation's premises. In order to maintain the anonymity of research participants, interviews had not been pre-arranged with individuals. It was therefore left to the drug or alcohol users to visit the organisation by his or her own volition if he or she wished to participate in the study. Others volunteered for the interview following a counselling or drop-in session they had visited.

The interviews with support organisations were conducted in August and September 2002; the interviews with client/drug or alcohol users in September and November 2002.

#### **1.4 Structure of the report**

The report is divided into eight chapters. Following this introductory chapter, Chapter 2 summarises existing evidence of drug and alcohol use in Britain. In the following three chapters, the results of the secondary quantitative analyses of the GHS and BCS are presented for alcohol users (Chapter 3), drug users (Chapter 4) and drug and alcohol users (Chapter 5).

In Chapter 6, the report moves on to discuss the findings from the in-depth interviews with support organisation, while Chapter 7 analyses the interviews with drug or alcohol using clients.

Chapter 8 draws together the key findings from the three main elements of the study, the literature review, and the quantitative and the qualitative analyses, and implications for policy are discussed.

## 2 DRUG AND ALCOHOL USE IN BRITAIN – BACKGROUND AND DEFINITIONS

### SUMMARY

Various surveys and analyses of surveys have captured and estimated the number of substance users in private households:

- ❖ British Crime Survey data suggests that between one and three per cent of adults aged 16 to 59 years had used Class A drugs in the month or the year before the survey conducted in 2000.
- ❖ The Survey of Psychiatric Morbidity estimated that one adult aged 16 to 74 years per thousand was *dependent* on one or more opiates.
- ❖ Estimates derived from treatment register data for the period from October 1999 to September 2000 put the number of opiate and cocaine users at between 280,000 and 500,000, while studies of alcohol consumption found that, in 2000, 29 per cent of men and 17 per cent women drank in excess of the recommended maximum weekly amount.
- ❖ High and problematic substance use is more frequent encountered among younger rather than older age groups.
- ❖ There is little evidence of an association between drug use and socio-economic deprivation, while alcohol use tends to increase with income.

This chapter provides a brief overview of some of the empirical evidence of problematic drug and alcohol use in Britain. The main sources of information about drug and alcohol use in Great Britain are the Survey of Psychiatric Morbidity (SPM), the British Crime Survey (BCS) and the General Household Survey of Great Britain (GHS). The GHS and the BCS are both biennial surveys. The GHS records data about the health of men and women aged 16 to 64 years in Britain, including the extent of alcohol consumption, while the BCS surveys matters related to crime, policing and victimisation among the adult population living in private households in England and Wales. The BCS also records drug awareness and drug use. A parallel Scottish Crime Survey covers Scotland. Both surveys produce the most regular accounts of drug and alcohol use in the general population. The SPM, in contrast, is a series of national surveys conducted during the last decade, which has covered different population groups and, in 2000, surveyed adults aged 16 to 64 living in private households. Other groups have included residents of institutions, the homeless and prisoners. The main aim of the SPM is to record the prevalence of mental illness in the populations. As part of this it records drug and alcohol addiction.

In this chapter, the definitions of problematic alcohol use and classified drugs used in the three surveys and the study's own analyses of the GHS and BCS (Chapters 3-5) are

summarised. The methods of recording drug and alcohol use in the two surveys and their coverage are also noted.

## **2.1 Drug use**

In the United Kingdom (UK), drugs are described as either Class A, Class B or Class C, based on ‘*an assessment of their relative harmfulness with penalties attached*’ (JRF, 2000, p. 13). The distribution and possession of classified drugs are a criminal offence, which may incur prison sentences or fines, the severity of which varies with the class of the drug used and is highest for Class A drugs. Classifications can be and, in fact, have been changed, as in a recent case when cannabis was reclassified from a Class B to a Class C drug. Currently, Class A drugs are heroin, methadone, cocaine, LSD, cannabinoids and ecstasy. Class B covers amphetamines<sup>7</sup> and cannabis; Class C, benzodiazepines (tranquilliser) and buprenorphine (synthetic opiate) (JRF, 2000).

The BCS records the use of cocaine, crack, ecstasy, heroin, LSD and methadone (Class A) and amphetamines and cannabis (Class B, since 2002 Class C). However, it only records the prevalence of drug use, not the quantity or the frequency of use.

The latest BCS was conducted in 2000. An analysis of that survey calculated that about 11 per cent of the population aged 16 to 59 had used Class A or Class B drugs in the last year, and six per cent in the last month (Ramsay et al., 2001). The prevalence of the ‘harder’ Class A drug alone was, however, considerably lower. About one per cent of 16 to 59 year olds had used this type of drug in the last month and three per cent had used it in the last year. Class A drug use was highest amongst those aged 16 to 29 years, eight per cent of whom had used one or more of these drugs in the last year (approx. 763,000 individuals) and four per cent in the last month (approx. 373,000). Drug use tailed off markedly in older age groups.

Scottish Crime Survey (SCS) data show a similar pattern of a higher level of ‘hard’ drug use among young people. According to the SCS 2000, about one per cent of the Scottish population aged 16 to 59 years had used one or more of what the report refers to as “opiates +”, i.e. cocaine, crack, heroin or methadone<sup>8</sup>, in the last year (Fraser, 2002). The prevalence of opiate taking, however, was about twice as high among young people aged 16 to 19 or 25

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<sup>7</sup> If amphetamines are injected, they are considered Class A drugs.

to 29, and five times this level among 20 to 24 year olds. It was below average for those aged 30 years or older.

Neither the BCS nor the SCS indicate whether drug use has resulted in addiction or is predominantly recreational and, at least in part, controlled by the drug user. This detail is provided by the Survey of Psychiatric Morbidity in Private Households in Great Britain (SPM) conducted by the Office for National Statistics (ONS). The last survey conducted two years ago (2000) covered a representative sample of people aged 16 to 74 years living in England, Scotland and Wales, and assessed drug dependence through a series of five questions. The questions were designed to elicit information about the frequency of drug use; respondents' feeling as to whether they needed, or depended on, the drug; their (in)ability to cut down consumption; their need for larger amounts; and the experience of withdrawal symptoms. A positive response to any one of these questions indicated drug dependence.

Survey findings<sup>9</sup> indicate that between one per cent and two per cent of respondents had used one or more Class A drugs in the last year (Singleton et al., 2001). Although this estimate was lower than that produced by Ramsay et al. (2001) using the BCS, closer examination of use estimates for individual drugs showed only small variations in these estimates between the two surveys. The difference in the use estimates for the two populations was probably the result of the inclusion in the SPM of people aged 60 to 74 years, not covered in the BCS. Very few respondents in this age group admitted the use of Class A drugs, which would have depressed the use estimate in the SPM.

The SPM also revealed that about one respondent per thousand was currently *dependent* on one or more opiates, i.e. heroin or methadone, while two in a thousand were dependent on cocaine or tranquillisers. Including other drugs, but not cannabis, dependency increased to 12 per thousand individuals. It was highest among 16-19 and 20-24 years olds (44 per thousand and 45 per thousand respectively), and 25-29 years olds (27 per thousand), but declined to single-digit figures thereafter. Since not all drug use leads to dependence and some drug use recorded in the SPM was committed in the past, estimates of *current* drug dependence were lower than estimates of drug use.

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<sup>8</sup> Only heroin and methadone are opiates.

<sup>9</sup> At the time of commissioning, the SPM survey data had not yet been lodged with the Essex DataArchive and was, therefore, not available to this study.

### 2.1.1 Additional estimates

A different approach to estimating drug use in Britain has been proposed by Godfrey et al. (2002), largely building on work done by Frischer et al. (2001). Godfrey et al. summarise different estimation methods using different types of administrative data and grossing-up procedures. The methods produce highly variable results, placing the estimate of the total number of Class A drug users in England and Wales in 2000, itself based on a mix of estimation procedures, at between 1.7m and 3.5m.

The more narrowly defined '*problem use*' of Class A drugs covered only opiates and cocaine use and included opiate users at risk of death and injecting drug users, that is, use of drugs most immediately associated with damage to the users' health. Problem use was estimated to have extended to between 281,125 and 506,025 drug users during the period between October 1999 and September 2000.<sup>10</sup>

Godfrey et al. (2002, p. 9) acknowledge that their estimates of problem Class A drug users (1.7m - 3.5m) '*were higher than the estimate of all users of these drugs based on population survey*'<sup>11</sup>. The authors also produced an estimate of the number of problematic drug users, who received state benefits. As will be seen in Chapter 5, this estimate was also substantially higher than that produced by the present study, which likely reflected the different populations captured by the estimation methods (cp. Chapter 5).

A further estimate released by the Department of Health (DoH, 2001a) suggests that between April 2000 and March 2001, there were 118,500 drug users reported as being in treatment with drug treatment agencies or General Practitioners in England. This compared to a separate estimate, provided by Godfrey et al. (2002, p. 11), of 168,675 individuals in treatment in England and Wales between October 1999 and September 2000.

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<sup>10</sup> Based on these figures, the Government's recent Updated Drug Strategy document *reports* 'around 250,000 problematic drug users in England and Wales' (Home Office, 2002, p. 51).

<sup>11</sup> As noted earlier, based on the BCS 2000, Ramsay et al. (2001) estimated about 763,000 people aged 16 to 29 years, who constitute the majority of drug users, to have used Class A drugs in the last year.

## 2.2 Alcohol use

Studies of the consumption of alcoholic drink in Britain have recorded, both the frequency and the amount of alcohol consumed. Until 1998, the common method of estimating alcohol use in the UK was based on the maximum recommended weekly amount of alcohol consumed. This asks individuals, how often they had drunk different types of alcohol over the last year, and how much they usually drank on any one day. This information allows the weekly alcohol consumption, measured in units of alcohol, to be estimated. The maximum recommended weekly amount of alcohol is 21 units for men and 14 units for women. Heavy drinking is defined as drinking more than 50 (men) or 35 units (women) of alcohol per week.

In 1998, a new method of estimation based on daily rather than weekly consumption was introduced. The change followed an inter-departmental review of the effects of drinking, which had concluded that even irregular, but heavy drinking might damage a person's health. Subsequent advice suggested that men restrict their daily alcohol consumption to four units of alcohol, and women to three units of alcohol (DoH, 1995). In this instance, heavy drinking is defined as drinking more than eight (men) or six (women) units of alcohol.

Patterns of daily and weekly alcohol consumption are recorded in the General Household Survey of Great Britain. For 2000, it has been estimated that 39 per cent of men and 23 per cent of women had exceeded the maximum recommended number of *daily* units on at least one occasion during the previous week (Walker et al., 2001). Almost half of young people aged 16 to 24 had exceeded these levels. In fact, 37 per cent of 16-24 year old men and 27 per cent of women in the same age bracket had engaged in heavy drinking, i.e. the consumption of more than eight (men) or six (women) units of alcohol in one day. Whereas heavy drinking decreased with age, all drinking exceeding the lower recommended amount of daily units of alcohol fluctuated with age and only dropped off markedly among people aged 65 years or older.

With respect to the *weekly* consumption of alcohol, Walker et al. (2001) show that 29 per cent of men and 17 per cent of women had drunk more than the recommended maximum amount of 21 or 14 units of alcohol. Moreover, seven per cent of men and three per cent of women had exceeded the heavy-drinking benchmarks of 50 or 35 units of alcohol. The estimates of the extent of weekly consumption of alcohol in excess of the recommended limit, or in excess

of the heavy-drinking benchmark, were thus lower than the equivalent estimates based on daily consumption.

An alternative method of recording alcohol consumption and, in particular, of identifying problematic drinking is the World Health Organisation's Alcohol Use Disorders Identification Test (AUDIT), which was used in the Psychiatric Morbidity Survey (SPM). The SPM asked people about their drinking behaviour in the last six months, but also about signs of alcohol dependence, including alcohol-related injuries. Scoring high on just two of ten indicators suggested *hazardous* drinking behaviour, which referred to cases of mild alcohol dependency and was defined as:

*'an established pattern of drinking which brings the risk of physical and psychological harm now or in the future.'*

(ibid., p. 27)

More severe cases of alcohol *dependence* were subsequently identified from among those scoring 10 points or more in the AUDIT. This exercise used the Severity of Alcohol Dependence questionnaire (SAD-Q), which asked individuals about a range of likely symptoms of dependence. The resultant scores were then added to indicate no, mild, moderate or severe alcohol dependence (for details, cp. Singleton et al., 2002).

Like the use of Class A drugs, the prevalence of hazardous drinking was particularly high amongst younger age groups and declined steadily amongst people aged 30 or older (Singleton et al., 2001). In total, about 26 per cent of the surveyed population displayed signs of hazardous drinking. At 32 per cent, the hazardous drinking rate was highest among 16-19 years old, declining to 29 per cent among 20-24 year olds and 23 per cent among 25-29 year olds. It further decreased to 17 per cent amongst 30-35 year olds and was lowest amongst 70-74 year old respondents, of whom just five per cent had drunk alcohol to a level that might incur physical or psychological harm (Singleton et al., 2001, p.45).

The risk of alcohol *dependency* was markedly lower than the prevalence of hazardous drinking. About five per thousand of the population aged between 16 and 74 years displayed signs of moderate or severe alcohol dependency (Singleton et al., 2001, p.48), which was also more evenly spread across age groups. Highest amongst 16-19 year olds (14 per cent)



moderate or severe dependency effected between two and five per thousand of all other age groups, including nine per thousand 40-44 year olds (Singleton et al., 2001, p.48).

### **2.3 Combined drug and alcohol use**

Surveys and secondary studies provide little insight into the coincidence of combined drug and alcohol. The only recent survey evidence of combined drug and alcohol use is available from Ramsay et al's (2001) analysis of the BCS. They found that the more young people (aged 16 to 29 years) drank, the more they were also likely to be taking drugs. While four per cent of young people drinking two or three times a month, or less, reported to have used a Class A drug in the last year, this rose to 16 per cent for those drinking three or more days a week (Ramsay et al., 2001, p.28).

### **2.4 Economic status, social disadvantage and substance use**

Several studies have explored the link between the consumption of drugs or alcohol and social disadvantage. The evidence suggests that drug and alcohol use and dependence vary with the economic status of the drug user. But this evidence is stronger for drug use than for alcohol use.

#### **2.4.1 Drug use**

Both the BCS and the SPM found an association between drug use or drug dependency, and economic status. Ramsay et al's analysis of the BCS 2000 calculated that about 12 per cent of unemployed respondents had used Class A drugs in the last year, compared to just eight per cent of the employed and eight per cent of the economically inactive sample population (Ramsay et al., 2001, p.26). The SPM similarly encountered a higher prevalence of unemployment amongst people with signs of drug dependence: about ten per cent of dependent drug users were unemployed, compared to three per cent of respondents not dependent on drugs (Singleton et al., 2001, p.85).

Social deprivation among substance users was also the subject of a study reported by the Advisory Council on the Misuse of Drugs (1998). The study found a strong positive correlation between the risk of drug dependency and a person's deprivation score (Advisory Council, 1998, pp.109/10). The score was composed of indicators of recorded unemployment, tenure (living in rented accommodation), car ownership, and manual work

status. A person scoring highest on the deprivation score was almost ten times as likely to be drug dependent as a person scoring lowest, that is, someone not deprived on this scale.

There appears to be little evidence of other forms of socio-economic disadvantage amongst drug users. The SPM showed that drug users were not necessarily educationally less qualified than others who did not use drugs. Where they appeared to be, this likely reflected their younger age or ethnic status rather than lower achievement (Singleton et al., 2001). Similarly, the BCS analysis concluded that Class A Drug use peaked amongst individuals with no educational qualifications and those with higher academic qualifications, and was lowest amongst individuals with intermediate levels of qualification (Ramsay et al., 2001). Ramsay et al. found a similar pattern for household income: Class A drug use was highest amongst individuals living in households with a combined income of below £5,000 or above £29,999, and lowest amongst those living in households with intermediate incomes (£5,000-£29,999). On other words, drug use was most prevalent among the least and the most advantaged social groups.

#### **2.4.2 Alcohol use**

In contrast, there was a much clearer association between a person's income and other indicators of social and economic position, and his or her consumption of alcohol. However, the use of alcohol tended to be associated with higher rather than lower socio-economic status. Whereas, in 2000, 13 per cent of men living in households with a gross weekly income of £150 or less drank more than the recommended maximum amount of eight units of alcohol on at least one day during the previous week, this rose to 26 per cent of men living in households with a gross weekly income of over £500 (Walker et al., 2001). In the same income groups, the proportion of women who drank more than the maximum amount recommended for women of six units of alcohol at least once during the previous week, increased from six per cent to 12 per cent.

Walker et al. also found that heavy drinking was more frequent among the working than the inactive or unemployed population, at least as far as men were concerned. While 27 per cent of employed or self-employed men had drunk more than eight units of alcohol on at least one day in the previous week, this was true for 24 per cent of unemployed men and 16 per cent of men who were economically inactive. The respective figures for women drinking more than six units of alcohol on at least one day during the previous week were 14 per cent of working

or unemployed women and eight per cent of economically inactive women (Walker et al., 2001, p.143).

Singleton et al's analysis of the SPM (Singleton et al., 2001) confirmed these findings for hazardous drinking. Both reports emphasised that differences in the consumption of alcohol between economic activity groups, to a large extent, reflected concurrent age differentials, in particular, amongst the economically inactive group, which included a large proportion of men aged 60 and over.

## **2.5 Summary**

The BCS, GHS and SPM, together with the SCS, are the principal population surveys, which have been used for estimating alcohol and drug use, including substance addiction, in Britain. The surveys use different methods of measuring the extent and intensity of substance use, including problematic use or dependent use and, as a result, their estimates can differ.

According to the BCS, about three per cent of adults in England and Wales aged 16 to 59 years had used a Class A drug in the last year, while in Scotland, using a narrower definition of types of drug, about one per cent of the adult population had used one or more opiates over the same time period. Estimates of the use of Class A drugs based on the SPM were lower owing to the inclusion of older age groups and suggested that between one and two per cent of the adult population had used one or more Class A drugs in the last year. Estimates of drug dependency, derived from the SPM, tended to be yet lower again, with one person in a thousand assumed to be dependent on one or more opiates.

The highest relative prevalence of problematic drug use is concentrated among younger age groups and use tends to decline with age. Estimates of the number of drug users, derived from the BCS 2000, have suggested that some 763,000 young people aged 16 to 29 had used Class A drugs in the last year, including 373,000, who had used these drugs in the last month (Ramsay et al., 2001). These estimates included recreational as well as problematic use, i.e. use assumed to have led to addiction.

Substantially higher drug user estimates have been derived from administrative statistics. Between 1.7m and 3.5m individuals in England and Wales have thus been estimated to be using Class A drugs in 2000, including between 280,000 and 500,000, whose drug use was

causing, or risked causing, severe damage to their health (Godfrey et al., 2002). As yet, no attempt has been made to reconcile these administrative estimates with the estimates from population surveys. In Chapter 5, estimates of the number of Class A drug users in receipt of social security benefit estimated by the present study and those derived from administrative data will be compared, and differentials in estimation explored.

Studies of alcohol use in Britain have used two different definitions to benchmark alcohol consumption, using estimates either of the *daily* or the *weekly* number of units of alcohol. Estimates of alcohol use exceeding the recommended maximum number of units using the daily method of estimation tend to be higher than estimates using the weekly method. Thus, for 2000, it was estimated that about 39 per cent of men and 23 per cent of women had exceeded the daily recommended amount of alcohol on at least one occasion during the previous week, compared to 29 per cent of men and 17 per cent of women, who had exceeded the maximum recommended weekly number of units of alcohol. But survey results also suggest that only about five per thousand of the adult population suffer from moderate or severe alcohol dependency (Singleton et al., 2001, p.48).

Alcohol use, including problematic use, is typically highest among younger age groups and declines with age. Only the prevalence of alcohol dependency, while much lower than alcohol use, holds comparatively steady across age groups, although peaking among young people and the group of 40 to 44-year olds.

There is some, but limited, evidence of all substance use being linked to economic status. Unemployed and inactive people are more likely to be substance users than people in employment. However, other socio-economic indicators suggest an increased risk of problematic substance use among individuals with higher as well as lower educational or academic qualifications, and with higher as well as lower household incomes. If substance use were thus driven by socio-economic factors, such as income or education, their effects would appear to vary internally or be compounded by other factors.

### 3 ALCOHOL USERS

#### SUMMARY

- ❖ In 1998, approximately 120,000 claimants of Jobseeker's Allowance or Income Support and about 150,000 claimants of sickness or disability benefits living in private households engaged in *problematic* drinking, i.e. consumed over 50 units of alcohol (men) or over 35 units of alcohol (women) per week.
- ❖ Higher-bound estimates suggest that up to 170,000 JSA/IS recipients and up to 195,000 Sickness or Disability Benefit recipients might be heavy drinkers.
- ❖ Heavy drinkers in both benefit groups were more often male, young(er) and single people living alone than non-drinkers on benefits.
- ❖ Socio-economic differences, such as in occupation, income or the possession of durable goods, tended to be smaller between heavy drinkers and others who did not drink than between different benefit groups.
- ❖ In comparison to heavy drinkers who worked, heavy drinkers who did not work were older, more likely to be live in rented accommodation in the social sector and to be on lower income. They were also more likely to consider their health as 'not good'.

This chapter presents the findings of the analyses of alcohol users identified in the General Household Survey (GHS), a survey of private households in England, Scotland and Wales. For the main part, the analyses were conducted using the GHS of 1998. It was already noted in the introductory chapter that the survey included only a small number of cases of alcohol users in receipt of one or more social security benefits, whose drinking pattern could be described as problematic or hazardous. In order to increase their numbers in the logistic regression analyses, the GHS 1998 was combined with the GHS 2000.

The merging of the two datasets was unlikely to have distorted the results of the GHS data analyses. Between 1998 and 2000, abstinence from alcohol decreased from 19.4 per cent of the working-age population to 18 per cent (GHS' own calculations). The weekly consumption of moderate amounts of alcohol (men: up to 21 units; women, 14 units) decreased from 57.2 per cent to 56.9 per cent of people of working age, while the consumption of larger amounts increased from 23.4 per cent to 25.1 per cent. The demographic and socio-economic composition of moderate and other drinkers appeared to be little affected by these changes.

## 3.1 Definitions

### 3.1.1 Alcohol consumption

The aim of the analyses was to record the prevalence and characteristics of benefit recipients in living private households whose drinking behaviour would be considered problematic because it poses a risk to the person's health. The GHS does not record the prevalence of alcohol dependency, but its records of consumption can be used to identify problematic or *heavy* drinking. The indicator chosen for this task was the weekly amount of units of alcohol consumed. Although the alternative definition based on the daily alcohol consumption is currently considered the more appropriate (see Section 2.1), it only records the estimated maximum that survey participants drank on any one day and may include occasional or one-off as well as regular drinking of potentially health-threatening amounts of alcohol. The weekly definition of alcohol consumption is more likely to capture regular or repeated, heavy drinking and, for this reason, was preferred to the daily-amount measure.

The benchmark for defining heavy drinkers was the weekly consumption of 50 or more (men) or 35 or more (women) units of alcohol. These cut-off points have previously been used in government statistics on drinking behaviour. The selection of the consumption benchmark in this study was also guided by Walker et al's (2001) point that the consumption of eight (men) or six (women) units per day indicated heavy drinking and increased the risk of intoxication and dependency. The present definition required individuals to be drinking this amount, on average, six days a week.

Although this benchmark captures the consumption of unusually large amounts of alcohol, it provides no immediate indication as to the likely effects that drinking might have on an individual. Different people display different propensities to intoxication, and drinking habits, drinking patterns and personal constitution might lead to different outcomes in terms of drunkenness or addiction. It cannot, therefore, be assumed that everyone drinking in excess of these amounts suffers intoxication. However, given the longer time period covered by this weekly definition, intoxication and addiction are more likely than if the daily-consumption definition was used.

### 3.1.2 Definition of benefit groups

The Department for Work and Pension expressed a particular interest in evidence of heavy drinking among five benefit client groups:

- recipients of Jobseeker's Allowance (JSA) only;
- recipients of Income Support (IS) only;
- sick or disabled people in receipt of:
  - Incapacity Benefit (IB), including the Income Support Disability Premium;
  - Severe Disability Allowance (SDA);
  - Disability Living Allowance (DLA; Care and Mobility components);
  - Statutory Sick Pay (SSP);
  - Industrial Injuries Disablement Benefit (IIDB);
- lone parents in receipt of IS; and
- recipients of Invalid Care Allowance<sup>12</sup> (ICA), Windows Benefit (WB), War Disablement Pension (WDP) and/or Housing Benefit (HB), unless when claimed in conjunction with any of the benefits named above.

With the exception of JSA and recipients of IS, the client group categories are not mutually exclusive and benefit recipients could belong to, and be counted in, more than one category.

Estimates of the prevalence of heavy drinking in each of the five categories will be presented below. However, these estimates proved unreliable because of the small number of cases they were based upon. Small numbers also prevented a detailed analysis of those groups of benefit recipients, who also drank heavily. For this purpose, the five groups were combined into two larger groups. The group of recipients of *JSA/IS recipients* (JSA/IS) included both recipients of JSA or IS, including lone parents in receipt of IS, while the groups of recipients of *sickness or disability benefits* (SDB) covered all other benefit recipients, with the exception of ICA, WB, WDP and HB, which were no longer considered as a separate benefit group and were excluded from the subsequent analysis.

In the following sections, estimates of the number of heavily-drinking benefit recipients are presented first, before their characteristics of recipients of JSA/IS and SRB are described.

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<sup>12</sup> To be renamed Carers Allowance.

### 3.2 Estimates of alcohol users amongst benefit recipients

The proportion of heavy drinkers amongst recipients of social security benefits living in private households ranged from about three per cent for lone parents on Income Support to over six per cent for claimants of JSA or IS (Table 3.1).<sup>13</sup> In virtually all instances, these figures were based on small case numbers. For instance, the estimate for lone parents in receipt of IS was based on 293 claimants<sup>14</sup>, of whom only eight were found to be heavy drinkers. Similarly, only 15 of the 233 JSA recipients in the survey were heavy drinkers.

**Table 3.1 Heavy drinkers – benefit claimants and non-claimants, Great Britain (Summer 1998), unweighted, private households**

	<b>Non- Claimants</b>	<b>JSA Only</b>	<b>Lone Parents on IS Only</b>	<b>Others on IS Only</b>	<b>Sickness Benefits*</b>	<b>Other Benefits**</b>
Male	300	14	3	7	23	12
Female	109	1	5	3	8	12
All	409	15	8	10	31	24
% (of all claimants)	4.7	6.4	2.7	6.4	5.6	4.3
No. (all claimants)	8646	233	293	157	556	646
95% confidence interval	4.2-5.1	3.2-9.5	0.8-4.5	2.6-10.2	3.7-7.5	2.7-5.9

Note: \* IB, SDA, IB&IS; \*\* ICA, WB, WDP, HB. Number of male, female and all cases refer to those identified in the GHS.

Source: GHS 1998.

Small sample numbers reduce the accuracy of statistical estimates that are derived from them. It is important this is acknowledged and, in order to illustrate the limited accuracy of some of the estimates, 95 per cent confidence intervals have been calculated. The intervals indicate that the *true* value of an estimate had a 95 per cent chance of falling within the indicated ranges.

The true value of the proportion of heavy drinkers among lone parents was thus estimated to lie between 0.8 per cent and 4.5 per cent; for JSA recipients, the true value was estimated to

<sup>13</sup> These estimates were based on unweighted data. Weighted data was used when analysing the social, economic and demographic characteristics of substance users in order to take account of the distribution of these characteristics. Data is typically weighted to ensure that the sample appropriately represents the population from which it is drawn, correcting for, for instance, non-participation in the survey.

<sup>14</sup> 'Claimant' and 'recipient' are used interchangeably in this report.



range from 3.2 per cent to 9.5 per cent. Because of the larger number of cases in the sample, the confidence interval was narrowest for the estimate of the proportion of heavy drinkers amongst non-claimants (4.2 per cent - 5.1 per cent). The mean estimate for this group (4.7 per cent) was also considerably more accurate than the estimates calculated for the smaller claimant groups.

Based on these estimates, lone parents were least likely and recipients of JSA only or IS only were most likely to be heavy drinkers. In all instances, however, heavy drinkers only accounted for a small proportion of benefit recipients or client groups. Moreover, the overlap of the confidence intervals for these groups indicates that differences in the prevalence of heavy drinking between the groups were unlikely to be statistically significant.

Because of the limited accuracy of the five group estimates indicated by their large confidence intervals, the estimation of the *number* of heavily-drinking benefit claimants was restricted to the two aggregate benefit groups, which covered recipients of JSA/IS and SDB (Table 3.2). At the 95 per cent confidence interval, between three per cent and 6.4 per cent of recipients of JSA/IS and between 3.8 per cent and 6.8 per cent of recipients of sickness-related benefits were heavy drinkers.

In August 1998, when the GHS was conducted, some 2.6m individuals were claiming JSA or IS (statistics provided by DWP). In addition, some 2.8m individuals were claiming one or more of the sickness or disability benefits that were included in this analysis (DSS, 1999). An estimate of the *number* of benefit claimants who also drank was calculated by applying the estimates of the *proportion* of alcohol using recipients derived from the GHS to these claimant figures. Thus, **between 78,000 and 170,000 JSA/IS claimants were heavy drinkers, as were between 110,000 and 195,000 SDB claimants.** The mean estimates were 120,000 JSA/IS and 150,000 SDB claimants, who drank heavily.

**Table 3.2      Estimate of the number of heavy drinkers – JSA/IS and SDB claimants, Great Britain (Summer 1998), unweighted**

	<b>Claimants of JSA/IS</b>	<b>Claimants of Sickness or Disability Benefit</b>
Male	22	32
Female	9	13
Total	31	45
% (of all claimants)	4.7	5.3
No. (all claimants)	658	844
<b>95% confidence interval</b>	<b>3.0 – 6.4</b>	<b>3.8 – 6.8</b>
Claimant Population (August 1998)	2,602,100	2,847,000
<b>Population estimate (mean)</b>	<b>120,000</b>	<b>150,000</b>
<b>Population estimate (95%-confidence interval)</b>	<b>78,000-170,000</b>	<b>110,000-195,000</b>

Note: all estimates rounded to the nearest 5,000, or the nearest 1,000 for figures below 100,000. Number of male, female and all cases refer to those identified in the GHS.  
Source: after GHS 1998 – own calculations.

It is important to emphasise again that these estimates are based on analyses of a survey of people living in private households and do not include those who, perhaps because of their alcohol use, live in communal establishments, such as treatment centres. The estimate of the number of alcohol users is, therefore, a lower-end estimate, which is likely to increase if individuals living in other than private households are included. The number or the proportion of alcohol users among those living in other than private households, however, are as yet unknown, although estimates may become available in the near future.

### **3.3      Characteristics of heavily-drinking benefit recipients**

This section moves on to the analysis of the JSA/IS and SDB recipient groups (in private households) and the comparison of those who drank or those who did not drink heavily. It begins with general descriptive data, including some comparative data referring to the total working age population. The subsequent section reports the results of a series of logistic regression analyses, which were conducted to extract the key characteristics that

distinguished heavily-drinking JSA/IS and SDB recipients from those that did not drink heavily.

JSA/IS and SDA recipients who drank heavily shared a number of characteristics that set them apart from recipients who did not drink heavily, while in most instances, JSA/IS and SDB recipients also differed from one another.

### 3.3.1 Demographics

The clearest marker between benefit recipients who drank heavily and others who did not was their gender. This was the case for both groups of benefit recipients. The majority of heavily-drinking benefit recipients in both groups were **male** (Table 3.3).<sup>15</sup> They also tended to be **younger** and more likely to be **single and living alone**, often **in social sector housing**. This was particularly the case for JSA/IS recipients. In direct comparison of heavy drinkers, 12 of the 33 JSA/IS recipients were aged 18 to 24 years, whereas this was true for only three of the 45 SDB recipients. Twice as many heavily-drinking JSA/IS recipients were single (18) than was the case for heavily-drinking SDB recipients (9). Most of the 33 JSA/IS recipients who drank heavily either lived alone or as lone parents (20), compared to a minority of heavily-drinking SDB recipients (17).

Most JSA/IS recipients lived in social rented accommodation, and this was also true for 21 of the 33 heavy drinkers among them. SDB recipients also rented, mostly in the social rented sector (20 of 45). Both recipient groups were over-represented in the North of England and in Scotland. This was particularly the case for heavy drinkers (JSA/IS: 17 of 33; SDB: 21 of 45).

Most of these differences between benefit recipients who drank and others who did not also held for comparisons with the total working-age population, including both heavy drinkers and others not drinking heavily. This was particularly the case with respect to household type, tenure and region of residence. Compared to the total working-age population, heavy drinkers in both benefit groups were more frequently living alone, in social sector housing and in the North of England or Scotland.

### **3.3.2 Socio-economic data**

Compared to the average working-age population, benefit recipients were more likely to have been in manual rather than non-manual occupations in the past. Twenty two of the 33 heavily-drinking JSA/IS recipients and 27 of the 45 SDB recipients, who drank, had worked in manual occupations.

Whereas many JSA/IS recipients (16 of 33) described themselves as unemployed, few SDB recipients (2 of 45) did so. A majority of JSA/IS recipients who drank heavily had also been unemployed for only a short period, including seven of the 16 self-described unemployed claimants for no more than three months. Eleven were looking for or wanted a job. In contrast, most SRB recipients were inactive, most likely due to illness. Thirty nine of the 45 SDB recipients who drank heavily reported a long standing illness or restricted activity. Only 15 were looking for or wanted a job.

A sizeable minority of JSA/IS or SDB recipients had no educational qualifications, and this was true for those drinking heavily and those who did not. In the case of heavily-drinking JSA/IS recipients, 14 had no qualifications, as did 20 heavily-drinking SDB recipients. In contrast, eleven heavily-drinking JSA/IS recipients and fifteen heavily-drinking SDB recipients had obtained educational qualifications at A-level or higher.

### **3.3.3 Social disadvantage**

The GHS covers only a limited range of indicators of social disadvantage, recording the bedroom standard of respondents' accommodation and the possession of a range of consumer goods, including items such as colour television or video recorders (see also 1.4.2). In both instances, SDB recipients were less likely to be disadvantaged than JSA/IS recipients. Thus, only about one-third of SDB recipients who also drank heavily (16 of 45) lived in accommodation with one or more persons per bedroom ('standard' bedroom standard or below), compared to two-thirds of heavily-drinking JSA/IS recipients (22 of 33). Similarly, out of a total of 11 items, while the majority of heavily drinking SDB recipients claimed to possess eight or more consumer goods (25 of 45), only about half of the group of heavily-drinking JSA/IS recipients did so (16 of 33). For both benefit groups, differences between those drinking heavily and others who did not appeared small, if not negligible.

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<sup>15</sup> Because the sample base for heavy drinkers in both benefit groups is below 50, only absolute frequencies are

SDB recipients also tended to be financially better off. Only seven of the 45 drinking heavily reported a gross weekly household income of £100 or less, compared to 16 of 33 heavily drinking JSA/IS recipients. In both benefit groups, heavy drinkers appeared more likely to claim household incomes of £100 or less than were those not drinking heavily.

Income differences between JSA/IS and SDB recipients, whether heavily-drinking or not, could have been the result of the higher incomes typically accruing from sickness or disability benefits when compared to JSA or IS. The former increases with the size of the household, which tended to be greater among SDB recipients since, compared to JSA/IS recipients, fewer lived in single person and lone parent households. SRB recipient incomes might also be higher owing to their receiving occupational pensions. Other factors might have included the presence of earners in households, but JSA/IS and SDB recipients were, similarly, likely to report at least one worker in their households, although the number of workers and their earnings are unknown.

### **3.3.4 Summary**

Heavy drinkers in both benefit groups, thus, differed from those not drinking heavily in a number of demographic and economic characteristics. In particular, they were more often male, young(er) and single people living alone. This was particularly the case for JSA/IS recipients. In comparison to the total working population, all four groups of benefit recipients but, in particular, JSA/IS recipients (heavily-drinking and those not drinking heavily), appeared more socially and economically disadvantaged with respect to their occupation, income and possession of durable goods. However, differences between heavy drinkers and other benefit recipients were often small.

## **3.4 Logistic regression analyses**

Personal characteristics, such as those just described, might be closely associated with one another and, in statistical terms, correlated. For instance, the high prevalence of single people among JSA/IS recipients or the low prevalence of them living alone might merely have reflected the younger average age of this group. Logistic regression analyses, which are reported in this section, served to disentangle these relationships and to determine the key

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reported for these two groups. All other figures shown in Table 4.3 are percentages.

features that distinguished heavy drinkers from others in both benefit groups (for a general note, see Section 1.3.2 or Annex A).

### 3.4.1 JSA/IS recipients

For recipients of JSA or IS, the logistic regression identified gender, age and region of residence as the key characteristics that distinguished heavy drinkers from other JSA/IS recipients who did not drink heavily (Table 3.4). Heavily-drinking JSA/IS recipients were nearly four times more likely to be **male rather than female**, about twice as likely to be **very young**, i.e. aged 18 to 24 than to belong to any of the other age groups, and over three times as **likely to live in the North of England or Scotland** than in any of the other two aggregated regions.

**Table 3.4 Best fitting predictions of odds of heavy drinking recipients of JSA/IS**

Statistically Significant Variables	Odds Ratio
<b>Gender</b>	
Female	1.0
Male	3.8***
<b>Age</b>	
25-34	1.0
18-24	1.9**
35-44	0.9
45+	0.8
<b>Government Offices for the Regions</b>	
Yorkshire, Midlands, East	1.0
North of England, Scotland	3.3***
London, South, Wales	1.7

Note: significance levels: \* 10% \*\* 5% \*\*\*1%.

Source: GHS 1998 and GHS 2000 combined – own calculation.

### 3.4.2 Sickness or disability benefit recipients

Like JSA/IS recipients, recipients of sickness or disability benefits, who drank heavily, were also significantly **more likely to be male than female** (2.3 times) (Table 3.5). They were also more likely than SDB recipients who did not drink heavily to **live in ‘other’ households**,

i.e. households with multiple, but not related members (4.1 times) than in households where they were part of a couple with no children, or any other type of household. Heavy drinkers were also more likely to be **smokers** than to be non- or ex-smokers (4.9 times).

**Table 3.5 Best fitting predictions of odds of heavy drinking among recipients of sickness or disability benefits**

Statistically Significant Variables	Odds Ratio
<b>Gender</b>	
Female	1.0
Male	2.3**
<b>Household Type</b>	
Couple, no children	1.0
Single person or lone parent	0.9
Couple with children	0.6
Other	4.1**
<b>Current Smoker Status</b>	
Ex-smoker or never smoked	1.0
Current cigarette smoker	4.9***

Note: significance levels: \* 10% \*\* 5% \*\*\*1%

Source: GHS 1998 and GHS 2000 combined – own calculation.

### 3.5 Summary

To summarise, it is estimated that, in August 1998, between three per cent and just over six per cent of JSA/IS recipients, and between about four per cent and nearly seven per cent of SDB recipients were heavy drinkers, i.e. consumed more than 50 units (men) or 35 units (women) of alcohol in a week. This was equivalent to between 78,000 and 170,000 JSA/IS and 110,000 and 195,000 SDB recipients living in private households.

Heavy drinkers in both recipient groups included a disproportionate number of men. In addition, heavy drinkers on JSA/IS were younger than those on JSA/IS who did not engage in heavy drinking, and a disproportionate number lived in the North of England or Scotland. More often than those not drinking heavily, heavy drinkers on SDB lived in households with more than one person, to whom they were not related. Many were also cigarette smokers.

In terms of their social and economic characteristics, there were few substantial differences between heavy drinkers and others not drinking heavily. However, the group of benefit recipients, drinkers and non-drinkers alike, was materially disadvantaged (in terms of consumer goods, bedroom standard, income) when compared to the working-age population as a whole. JSA/IS recipients had become unemployed more recently than SDB recipients, a majority of whom described themselves as inactive, and more JSA/IS recipients were looking for or wanted employment. JSA/IS recipients who drank heavily were particularly likely to have become unemployed only recently.

Statistical analyses of the GHS data, using logistic regression analysis, helped to draw out the key characteristics that differentiated heavily-drinking benefit recipients from those recipients who did not drink heavily. Compared to non- or moderately drinking claimants, heavily-drinking recipients of JSA or IS were, thus, found to be significantly more likely to be:

- male;
- aged 18-24; and
- living in the North of England and Scotland.

Similarly, compared to non- or moderately drinking recipients of SDB, heavily-drinking recipients of the same benefits were significantly more likely to be:

- male;
- living in 'other' households with multiple, but not related members; and
- cigarette smokers.

### **3.6 Addendum: working and not-working heavy drinkers**

Additional analysis was conducted to ascertain the key differences between heavy drinkers who worked and those who did not. Because case numbers for these two groups were sufficiently large, no merging of datasets was necessary for this exercise and the analysis was, therefore, based on data from only the GHS 1998. As before, heavy drinkers were defined as not working if they were, or declared themselves to be:

- unemployed (according to the ILO definition);
- permanently unable to work;
- retired;



- keeping the house; or
- inactive for any other, unspecified reason.

Logistic regression analysis was again used to determine how the two groups of heavy drinkers, apart from their consumption of alcohol, differed from one another. It revealed that heavy drinkers who did not work were twice as likely to be aged 45 or over (as to be aged 25 to 34 years), over three times more likely to be renting in the social sector (than owning their property) and over five times as likely to describe their health as '*not good*' as to describe it as '*fairly good*' (Table 3.6). Their gross weekly incomes were between five and over seven times more likely to be up to £200 or between £200 and £300 than to be more than £300; while, finally, heavy drinkers who did not work were between 2.5 and 3.5 times more likely to live either in the Southern/South-Eastern (London, South, Wales) or the Northern/Scottish (North-East, North-West, Merseyside, Scotland) parts of Britain.

The subjectively poorer health of non-working heavy drinkers frequently coincided with long-standing or recent illnesses or injuries; specific illness, such as hearing difficulties; smoking and more frequent visit to General Practitioners (Table 3.7). The lower household income was reflected in the lower prevalence in ownership of eight or more durable goods. Because these conditions were strongly correlated with the subjective health assessment (and the age variable), they did not show as independently significant in the logistic regression analysis.

**Table 3.6      Best fitting predictions of odds of heavy drinkers not working**

<b>Statistically significant variables</b>	<b>Odds Ratio</b>
<b>Age</b>	
25-34	1.0
18-24	0.7
35-44	0.7
45-64	2.3*
<b>Tenure</b>	
Owner	1.0
Social sector tenant	3.5**
Private sector tenant	1.1
<b>Health in last 12 months</b>	
Fairly good	1.0
Good	0.6
Not good	5.4***
<b>Gross weekly household income</b>	
Over £300	1.0
Up to £200	7.5***
£200.01-£300.00	5.0***
<b>Region</b>	
Yorkshire, Midlands, Eastern	1.0
North of England, Scotland	3.4**
London, South, Wales	2.5*

Note: significance levels: \* 10% \*\* 5% \*\*\*1%

Source: GHS 1998 – own calculation.

**Table 3.7      Selected characteristics of heavy drinkers, by work status (in %)**

	Multiple responses	
	Not Working	Working
Has long-standing illness or disability	60.2	27.2
Illness/injury in last 2 weeks reduce activity	36.5	11.8
Difficulty with hearing	24.0	13.7
Current cigarette smoker	71.2	50.0
Time from waking to smoking first cigarette: within 29 minutes*	74.3	42.9
One or more GP consultations in last week	27.9	10.1
Eight or more durable goods	55.8	72.9
N	104 (74)	364 (182)

Note: \* only asked from current cigarette smokers (numbers in ( )).

**Table 3.3 Heavy drinkers: JSA/IS and sickness or disability benefit claimants (in % and No.)**

		Income-replacement benefit		Sickness or disability benefit		Working-age population
		Heavy drinker <sup>1</sup>	Not heavy drinker	Heavy Drinker <sup>1</sup>	Not Heavy Drinker	All
<b>DEMOGRAPHICS</b>						
Gender	Male	24	38.7	32	52.7	50.3
Age	18-24	12	20.9	3	2.8	12.1
	25-34	9	35.5	8	13.4	25.4
Marital Status	Single	18	46.7	9	18.3	27.5
	Married	5	13.4	18	56.7	57.6
	Divorced	4	24.2	10	17.2	9.7
Household Type	One person (excl. lone parents)	8	16.0	14	20.7	10.2
	Lone parents (with dep. or non-dependent children)	12	50.8	3	10.1	9.2
Tenure	Social sector tenants	21	59.9	20	37.2	16.5
Government Offices for the Regions	North of England, Scotland	17	30.2	21	37.2	26.2
	Yorkshire, Midlands, Eastern counties	6	34.5	10	31.5	35.0
	London, South, Wales	10	35.3	14	31.3	38.8
<b>SOCIO-ECONOMIC</b>						
SEG (1)	Manual	22	69.1	27	65.1	47.4
Ever had a paid job	Yes	28	83.9	38	93.7	84.8
Economic Status	Unemployed	16	31.4	2	1.6	4.0
	Inactive	15	52.9	38	80.3	22.4
Time unemployed (2)	Up to 3 months	7	13.2	2	12.1	21.9
Limiting long standing illness or restricted activity	Yes	13	31.6	39	86.9	24.9
Looking for or wanting a job (3)	Yes	16	54.4	2	2.8	6.1
Highest qualification	A-Level or higher	11	32.2	15	26.2	43.4
	No qualification	14	37.8	20	40.1	20.2
<b>SOCIAL DISADVANTAGE</b>						
Bedroom standard	Below or standard	22	60.2	16	35.8	31.8
Number of durable goods (4)	8 or more	16	42.5	25	60.7	71.9
Household gross weekly income	Up to £100	15	43.1	7	11.5	6.5
Work status of household	Workers in household	13	27.9	19	48.3	86.1
N		33	569	45	799	11633

Note: <sup>1</sup> Because of reporting restrictions on population bases of less than 50, figures are absolute frequencies. Valid Responses only. (1) married & cohabiting women take partner's SEG; (2) JSA/IS: ILO unemployed persons only/Sickness and Disability Benefits: all respondents; (3) all respondents; (4) total: 11 listed items, incl. colour TV, video etc., (5) current smokers only. Source: GHS 1998.

### SUMMARY

- ❖ Estimates of the number of drug users were derived for individuals potentially claiming benefits in England and Wales rather than actual benefit claimants, which the BCS does not specifically identify.
- ❖ Approximately 39,500 individuals potentially claiming benefits and living in private households had been using Class A drugs in the month before the interview.
- ❖ Among this group, 27,500 individuals potentially claiming benefits had been using one or more of the Class A drugs heroin, cocaine, crack and methadone.
- ❖ Home Office estimates suggest some 270,000 problematic drug users, most of whom would not be living in private households or for other reasons not be captured by the BCS.
- ❖ The two estimates should be seen as complementary, although partly overlapping.
- ❖ Drug users tended to be male, young and possibly transient. In comparison to non-users, they were very likely to have had contact with the police, courts or probation service.

This chapter introduces the findings of the secondary analyses of the British Crime Survey (BCS) of drug use among unemployed and economically inactive individuals living in private households in England and Wales. Estimates of the size of the drug-using population and the basic descriptive data about drug users were derived from the BCS 2000. For the logistic regression analyses, which were conducted to extract information about the key characteristics of drug users and will be reported towards the end of the chapter, the BCS 2000 was combined with the BCS 1998. This increased the number of cases ready for analysis and thereby enhanced its robustness. As in the case of the GHS analysis, the merging led to the loss of some variables, reported in one, but not the other BCS dataset. Most variables that were lost, however, had been derived from other variables present in both datasets and could be replicated, where necessary.

Merging the two datasets did not risk distorting the analyses, but formed the basis for a more detailed account than would otherwise have been possible. Between 1998 and 2000, self-reported use of Class A or Class B drugs rose from four per cent to 4.1 per cent of the total working-age population, although the use of ‘harder’ Class A drugs, in conjunction with Class B drugs, or on their own, increased somewhat more from 0.9 per cent to 1.1 per cent of cases (BCS, own calculations). The prevalence of Class B-only drug use declined from 3.1 per cent to 2.9 per cent. The composition of drug users, however, had changed little.

## 4.1 Definitions

### 4.1.1 Drug use

The BCS records respondents' knowledge and consumption of eight Class A or Class B drugs. These are:

Class A drugs:

- cocaine;
- crack;
- ecstasy;
- heroin;
- LSD; and
- methadone.

Class B drugs:

- amphetamines; and
- cannabis (now re-classed as Class C).

Participants are asked whether they have used any of these drugs within the last year and, if so, whether they had also used them in the last month. It has already been pointed out in Chapter 2 that the survey does not ask participants about the quantity of drugs used, or the frequency of their consumption.

Although the BCS does not contain information about the prevalence of drug dependence, the drug classification scheme implicitly grades individual drugs by their addictive properties. However, without additional detail about user habits, including the ability to control intake and to manage the drugs' effect on the individual's life, it cannot be concluded that the consumption of drugs categorically implies addiction or is, in social, psychological, physical, physiological or legal terms (DrugScope, 2001), *problematic* rather than recreational, irregular or an isolated event. This caveat applies to 'soft' Class B and to 'hard' Class A drugs. Thus, for instance, although ecstasy is a Class A drug for the health risks it poses, it is more frequently used as a recreational drug that can become a habit, but need not lead to

addiction and '*physical dependence is not [considered] a problem*' ([www.drugscope.org.uk](http://www.drugscope.org.uk)), although psychological dependence might be.

In order to focus on the most likely addictive drugs and to reduce the cases of recreational, non-addictive use, the study focussed primarily on Class A drugs, but excluded the Class A drugs ecstasy, LSD and magic mushrooms from some of the analyses. Furthermore, only drug use recorded *in the last month* before the survey was used in the analysis. In the absence of a measure recording drug use patterns, recent use was the most appropriate indicator for identifying mainly acute, rather than distant, instances of drug dependency or individuals at risk of becoming drug dependent. In the following sections, this group of Class A drugs, now including only crack, cocaine, heroin and Methadone, will be referred to as the 'Class A core' category. Class A and Class A core users included some who also used Class B drugs; but Class B users used only this type of drug and *not* also Class A drugs.

#### **4.1.2 Definition of the client group**

As in the case of the analysis of drinking behaviour (Chapter 4), the main objective of the analysis of drug consumption was to explore its prevalence amongst recipients of social security benefits. Because the BCS does not specifically identify this group, an alternative definition was sought that most closely approximated this population. This was taken to be all individuals aged 18-59 (women) or 18-64 (men) who were defined as unemployed or economically inactive, but including only individuals:

- looking for paid work or a government training scheme;
- intending to look for work but prevented by temporary sickness or injury;
- permanently unable to work because of long-term sickness or disability;
- retired from paid work (but below the age from which the state pension can be drawn); or
- looking after the home or family.

Participants on government schemes or waiting to take up employment, full-time students and those engaged in other unspecified activities, were excluded. Retired people and people looking after the home or family were included at the outset because they might become available for work (again) in the future, as might people who described themselves as temporarily sick. In fact, none of the drug users were eventually found to be retired, and only

a small number was looking after the home or family. The permanently sick were included because, at least for some, their sickness would be related to their drug use. The group of people included in this definition will be referred to as *individuals potentially claiming benefit*.

Although it was the closest attainable approximation, the definition of the sample group was an imperfect one. It covered people with variable degrees of labour market attachment, but could not distinguish between those seeking work and others who did not. Although the BCS contains a variable that indicates whether inactive respondents wanted to work, its application as a further identifier would have greatly reduced the number of cases available for analysis. Instead, this variable was used alongside others in the descriptive and the logistic regression analyses.

## **4.2 Drug use in England and Wales**

Over five per cent of the *working-age population* in private households in England and Wales reported the use of Class A or Class B drug in the month prior to the 2000 BCS (Table 4.1). With four per cent of respondents, **individuals potentially claiming benefit were less likely than the total working-age population to have used Class A or Class B drugs during this period**. In the majority of cases, drug use was limited to Class B drugs, as 4.2 per cent of the total working-age population and 2.9 per cent of the population of individuals potentially claiming benefit reported to have used them in the last month. Just over one per cent of either group had used Class A drugs (1.1 per cent). **However, individuals potentially claiming benefit were more likely than the average working-age population to have used one or more of the ‘harder’ Class A core drugs** (crack, cocaine, heroin, or Methadone; 0.9 per cent vs. 0.7 per cent) than any one of the other Class A drugs (ecstasy, LSD or magic mushrooms).



**Table 4.1      Prevalence of drug use in England and Wales in last month, by population group, private households (percentages)**

	<b>Working-age Population</b>	<b>Individuals Potentially Claiming Benefit</b>
Class A (all)	1.1	1.1
Class A core	0.7	0.9
Class B only	4.2	2.9
Class A or Class B	5.3	4.0
Non-Users	94.6	95.9
N (unweighted)	13629	2560

Note: percentages may not add to 100 due to rounding.

Source: BCS 2000 dataset - own calculations.

On closer inspection, drug users among the individuals potentially claiming benefit appeared more likely than the average working-age population to have taken any one of the ‘harder’ Class A core drugs, with the exception of cocaine (Table 4.2). From among the four Class A core drugs, the most frequently drug used by the 18 individuals potentially claiming benefit was heroin (used by nine individuals), followed by cocaine (eight) and crack and Methadone (five each). Relatively more individuals potentially claiming benefit appeared to use Methadone than was the case in the total working-age population. It is possible that this group of Methadone users included some who were undergoing drug rehabilitation treatment, during which methadone is frequently used as a heroin substitute.

**Table 4.2**      **Type of drug consumed in last month – (in % and No.)**

	Class A (All)		Class A Core	
	Total Working-Age Population	Individuals Potentially Claiming Benefit*	Total Working-Age Population	Individuals Potentially Claiming Benefit*
	(%)	(N)	(%)	(N)
Cocaine	51.6	8	87.3	8
Crack	8.7	5	14.8	5
Heroin	9.8	9	16.7	9
Methadone	3.2	5	5.4	5
Ecstasy	59.2	12	N/A	N/A
LSD/A	7.4	0	N/A	N/A
Magic Mushrooms	12.0	3	N/A	N/A
N (valid cases, unweighted)	137	27	86	18

Note: \* Due to reporting restrictions on base populations below 50, only absolute case numbers are shown.

N/A = not applicable.

Source: after BCS 2000 – own calculations; multiple responses.

### **4.3      Estimate of drug use among individuals potentially claiming benefit**

The small number of drug users among individuals potentially claiming benefit in the BCS calls for caution when extrapolating the survey statistics to the total population. As in the case of estimates of alcohol use (cp. Section 4.2), estimates of drug users among the total population of individuals potentially claiming benefit are, therefore, presented using 95 per cent confidence intervals. These suggest that between 0.6 per cent and 1.4 per cent of individuals potentially claiming benefit in England and Wales had used one or more Class A drugs, including between 0.4 per cent and one per cent who had used one or more of the Class A core drugs in the last month. The use of Class B drugs in the last month extended to between 2.6 per cent and four per cent of likely claimants.

In Spring 2000, when the BCS 2000 was conducted, some 8m people in England and Wales were economically inactive or unemployed. Of these, approximately 4m fell into the unemployment or inactivity groups used here to define individuals potentially claiming benefit (cp. 7.1.2). Applying the percentages of the confidence intervals to this number,

between 24,000 and 54,500 individuals potentially claiming benefit are estimated to have used one or more of Class A drugs in the last month. Between 15,000 and 40,000 potential benefit claimants had used one of the four Class A core drugs in the last month, while 103,000 to 157,000 had used only Class B drugs (Table 4.3).

**Table 4.3 Estimate of the number of drug users among individuals potentially claiming benefit, last month, private households, England and Wales (Spring 2000), unweighted**

	<b>Class A (All)</b>	<b>Class A (Core)</b>	<b>Class B Only</b>
Male (N)	18	14	61
Female (N)	7	8	24
All (N)	25	18	85
% (all)	1.0	0.7	3.3
No. (all cases)	2560	2560	2560
<b>95% confidence interval (%)</b>	<b>0.6-1.4</b>	<b>0.4-1.0</b>	<b>2.6-4.0</b>
Unemployed and inactive population (Spring 2000)	3.93m	3.93m	3.93m
<b>Population estimate (mean, N)</b>	<b>39,500</b>	<b>27,500</b>	<b>130,000</b>
<b>Population estimate (95%-confidence interval, N)</b>	<b>24,000-54,500</b>	<b>15,000-40,000</b>	<b>103,000-157,000</b>

Note: Class A (core) includes heroin, crack, cocaine and methadone users only. For definition of inactive population, see text. Figures rounded to nearest 500 or 1,000, if greater than 100,000. Number of male, female and all cases refer to those identified in the BCS.

Source: after BCS 2000 – own calculations.

## **4.4 Additional estimates**

### **4.4.1 The Home Office estimate**

In their study for the Home Office (HO), Godfrey et al. (2002) produced an estimate of the number of Class A drug users who are in receipt of state benefits based on the number of drug users registered for treatment. As already noted in Section 2.1.1, the authors estimated that between 281,125 and 506,025 individuals were using opiates or cocaine between October

1999 and September 2000. Their medium estimate was 337,350 drug users. Godfrey et al. used this medium estimate to calculate the number of drug users on state benefit. To do so, they referred to the findings of the National Treatment Outcome Research Study (Gossop et al., 1998), which tracks over 1,000 drug users through various treatment and rehabilitation programmes. It has found that, among the cohort of clients prior to intake into treatment:

*'During the previous two years, the majority (81%) reported being 'mostly unemployed.'*

(ibid, Section 2.1)

Godfrey et al. noted that, more precisely, the rate of unemployment among drug users *currently in community-based treatment* was somewhat lower at 79 per cent (Godfrey et al., 2002, p. 38). Using either percentage figure for people in treatment and not (yet) in treatment, Godfrey et al. estimated that 271,005 opiate and cocaine users were on some type of state benefit (ibid., Table 2.7). This estimate was substantially higher than the present estimate of approximately 27,000 Class A core users potentially claiming benefit.

The principal reason for this difference is most likely that the two estimates were, in fact, derived from different base populations. As already repeatedly pointed out, **the BCS surveys people living in private households, but does not cover people living in communal establishments**, including hospitals, treatment centres or prisons. Godfrey et al.'s estimate, on the other hand, was based on registration data, which mainly – although not exclusively - capture people who do not or no longer living in private households. This includes individuals living in communal establishments, such as hostels, or homeless people.

The two estimates should, therefore, be seen as complimentary, although overlapping, the degree of which is difficult to quantify. Godfrey et al.'s estimate of the number of benefit claimants who use opiates or cocaine is based on the Treatment Coverage Method (TCM) of estimation, to which they apply the 80 per cent-rate of assumed benefit claimants. TCM uses administrative data of *new entrants*, of all ages, to drug treatment programmes recorded on the Regional Drug Misuse Database (RDMD) (DoH, 2001b). The data is then extrapolated, based on the assumptions that new entrants represent about one-third of all drug users in treatment and that 50 per cent of all drug users are, in fact, in treatment. In other words, the number of new entrants is multiplied by six (3x2) in order to adjust for the suspected under-recording of drug users in the database. This leads to an estimate of 337,350 problem Class

A drug users in England and Wales, of whom 80 per cent are assumed to be receiving state benefits.<sup>16</sup> In applying this multiplier, Godfrey et al.'s estimate is likely to capture at least some drug users (still) living in private households, although the extent to which this might be the case is uncertain.

By comparison, the BCS-derived estimate is likely, at the same time, to understate and to overstate the extent to drug use among benefit recipients in private households, some of whom may be captured by the register-derived estimate. It is likely to overstate drug use because of the definition of use that it applies, which takes no account of the frequency or the intensity of drug use and permits no conclusion as to the addictive nature of the use. This type of definition might, in fact, record many recreational users. On the other hand, it is prone to understating the extent of drug use because drug users, in particular problematic users, would be likely to refuse participation in household surveys, such as the BCS.

A qualitative follow-up study of the BCS also found that respondents

*“would more readily report ever having taken drugs than they would admit to using them in the last 12 months”* (White et al., 1998, p. 41).

In other words, drug use is underreported, and this underreporting might be greater where, as in the present study, yet more recent time periods ('the last month') are chosen for recording drug use. Reporting past drug use might appear socially more acceptable than reporting current or recent use. Similarly, the greater social acceptability of some drugs over others might help explain BCS respondents' greater propensity to report the use of cocaine, which contrasts with data contained in the RDMD register and an earlier Home Office statistical report on drug use (Table 4.4). Both latter sources identified heroin as the most frequently used Class A drug. In summary, this suggests that the BCS may fail to capture significant section of the drug-using population, i.e. of heroin users, either because it is restricted to private households, where heroin use is less prevalent, or because surveys participants do not volunteer the information.

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<sup>16</sup> Assumed lower coverage of treatment leads to the higher estimate of 506,025 problem Class A drug users.

**Table 4.4      Types of drug consumed – BCS, RDMD and Home Office Statistics compared (in % and No.)**

	Multiple response			
	BCS Class A core drug users		RDMD	Home Office
	Working-age population, 2000  (%)	Individuals potentially claiming benefit, 2000**  (N)	Drugs used by users starting treatment in six months to 30 September 2000  (%)	All drug addicts notified (new and re-notified; main drug only), 1996  (%)
Cocaine	87.3	8	21	8
Crack*	14.8	5	6	N/a
Heroin	16.7	9	71	70
Methadone	5.4	5	18	43
N (valid cases, unweighted)	86	18	33,093	43,372

Note: \* ‘other opiates’ in RDMD. \*\* Due to reporting restrictions on base populations below 50, only absolute case numbers are shown.

Source: BCS 2000 – own calculation; DoH (2001b), Table 7a.; Corkery (1997), Table c.

#### **4.4.2 The DoH estimate**

The 79 per cent rate of unemployment among (former) substance users currently in treatment can also be applied to the Department of Health estimate of 118,500 of drug users in treatment in England between April 2000 and March 2001 (DoH, 2001a; see 2.1.1).

Accordingly, some 93,615 individuals, who were in drug treatment, were out of work and, therefore, potentially receiving state benefits in England during that time.

Again, this estimate is substantially higher than the one produced in the present study, although the former covers a smaller area (England, instead of England and Wales) and only people in treatment, who are assumed to make up no more than one third of all substance users. The reasons for the larger size of the DoH estimate which, like Godfrey et al’s estimate, is based to a large extent on data from the RDMD, although omitting the grossing-up procedures, are likely to be similar to those reported above for the HO estimate. In particular, they include: differences in drug use and user definitions and differences in base

populations. Although only about four per cent of registered drug users in England recorded on the RDMD were inpatients or in residential rehabilitation, while 94 per cent received treatment in the community through specialist services or general practitioners, it is assumed that few of the drug users in treatment lived independently. They would, therefore, not have been captured by a private household survey, such as the BCS.

#### **4.4.3 Summary**

The present study's estimate of approximately 27,500 drug users among individuals potentially claiming benefit should be considered in conjunction with Godfrey et al.'s estimate of some 270,000 unemployed opiate and cocaine users and the DoH estimate of approximately 118,000 drug users in treatment in England (about 93,000 of whom would be unemployed). The number of problematic drug users among the population of benefit recipients is, therefore, likely to be around 270,000 or more.

Annex B highlights, in tabular form, further detail of the data sources and of the estimation methods used in this study and by Godfrey et al.

#### **4.5 Characteristics of potential benefit claimants who use Class A drugs**

In this section, demographic and socio-economic characteristics of drug users are presented alongside information about their drinking behaviour and encounters with the police and the criminal justice system. The statistics are now based on the combined BCS 1998 and BCS 2000 dataset. Despite the merger, small case numbers required considerable aggregation of the variables used to describe drug users' characteristics.

The BCS does not record indicators of social disadvantage beyond the conventional range of economic (incl. income) and educational information. For instance, unlike the GHS, it does not include data on the possession of consumer goods or the quality of accommodation (bedroom standards). The extent of deprivation or multiple deprivation among drug users could, therefore, not be investigated.

##### **4.5.1 Demographics**

Drug users among individuals potentially claiming benefit, whether they used Class A or any of the more narrowly defined Class A core drugs, were disproportionately male and young, with about half of the drug users aged between 18 and 24 years (Table 4.5). Reflecting the

young age distribution of this group, the majority of drug users was single and had never been married. Although more drug users than non-users lived alone, many also lived in households with three or more members. Few of these households included any dependent children, i.e. aged 16 or under.

Nearly half of drug users among individuals potentially claiming benefit also lived in private rented accommodation, compared to only about one-in-ten of individuals potentially claiming benefit who did not take any Class A or Class B drugs. They were less likely to have lived at their address for long: between a quarter (Class A core users) and one-third (all Class A users) had moved into their home within the last year. Nine in ten drug users lived in the North or the South of England, while less than eight per cent lived in the Midlands, Eastern counties of England, or Wales. This contrasted starkly with non-users, who were almost evenly distributed across the three broad regions, with approximately one-third living in either the North or the South of England, or in the Midlands, the Eastern counties or Wales.

#### **4.5.2 Socio-economics**

Drug users tended to have attained educational qualifications broadly similar to those attained by non-users, although users of Class A core drugs were less likely to have qualifications of A-level standard or higher (9 of 38 individuals). About two-thirds of drug users had previously been in manual occupations, compared to about one half of non-users.

The majority of drug users (55.8 per cent of all Class A; 24 of 38 Class A core users) were also looking for work or were only temporarily prevented from looking for work due to short-term illness. This was a substantially higher proportion than among non-users (13.6 per cent). Unlike the drug user group, the group of non-users included many who described themselves as retired, and proportionately more were looking after the home or family. This was likely to explain the comparatively smaller proportion of non-users looking for work or only temporarily prevented from doing so because of illness.

Approximately 40 per cent of drug users and non-users (17 of 38 Class A core users) reported a limiting long-standing illness, disability or infirmity. Perhaps curiously, however, more Class A core drug users claimed a limiting long-standing illness or impairment (17) than had described themselves as permanently unable to work or looking after the home (14). Either their illness or impairment were not considered long-standing after all, or they did not prevent



them from looking for work or intending to do so in the near future. In contrast to this group, the reporting of long-standing illness by all Class A users and non-users was reflected in a greater proportion also describing their activity status as permanently unable to work, or looking after the home or retired.

About half of all drug users (all Class A users: 50 per cent; Class A core users: 13 of 29 disclosing their income) reported an annual household income before tax and other deductions not exceeding £5,000, compared to just one-fifth of non-users (19.4 per cent). Although this might suggest that drug users, on average, were poorer than non-users, this was not necessarily the case, because disproportionately more drug users lived alone and would not have had to share their income.

#### **4.5.3 Alcohol use**

Drug users tended to consume more alcohol when drinking than non-users of drugs, but they did not necessarily do so more often. About a third of Class A and Class A core drug users would, typically, drink more than eight units of alcohol, i.e. in excess of the recommended maximum amount, on any one drinking occasion, compared to a quarter of non-users (24.4 per cent). Approximately one-fifth would do so on three or more days a week, as did non-users (22.5 per cent). Finally, about half of drug users and non-users drank less than once a week or, indeed, not at all.

#### **4.5.4 Police**

Finally, drug users were also likely to have been stopped by the police in the past. Sixteen of the 22 Class A and nine of the 11 Class A core users<sup>17</sup> had been stopped when travelling in a car, while 13 of the Class A users and, again, nine of 12 Class A core users had been stopped while on foot. Because the question referred to respondents *ever* having been stopped by the police, in the case of drug users, these instance might include those that took place before the individuals started to use drugs, and might be unrelated to drug use. The general observation that drug users were likely to have been stopped by the police, nonetheless, remains true.

In 2000, the BSC introduced a new set of questions concerning respondents' encounters with the police or judicial system, including as victims or (suspected) perpetrators of crime. These

and other crime-related questions were only put to a random half of survey participants. This further reduced the already small number of cases available to this study (for instance, to 13 Class A drug users) and rendered detailed analysis unreliable. As broad indicators, the survey responses suggested that Class A drug users were more likely than non-users (possibly up to five times) to have experienced arrests, court action or contact with the Probation Service.

#### **4.5.5 Summary**

In summary, a disproportionate number of drug users were male, young and possibly transient, having only recently moved to their present address. Many had worked in manual occupations and were now looking for work. The clearest distinction between drug users and non-users was the contact that they had with the police. Other statistics relating to the preparation of crime, or the accusation of having committed a crime, indicate a similarly high chance that drug users have had contact with the judicial system.

It was not possible in either instance to ascertain a direct association between drug use and crime, which would confirm that both activities, typically, occurred concurrently. The findings, nevertheless, correspond with those of other studies, which have shown that drug use often temporally coincides with crime, in particular, acquisitional crime. However, this association is not inevitable and it is unclear whether there is a causal link between the two activities (Lawless and Cox, 2000).

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<sup>17</sup> Questions relating to encounters with the police were only put to a random half of the sample; in total, 38 Class A and between 11 and 12 Class A core drug users answered these questions.

**Table 4.5 Characteristics of individuals potentially claiming benefit using Class A drugs, and non-users (in % and *No.*)**

		Class A Users (all)	Class A Users (core) <sup>1</sup>	Non-Users	Working-Age Population
DEMOGRAPHICS					
Gender	Male	74.5	30	35.5	49.1
Age	18-24	46.2	19	6.7	12.0
	25-34	36.5	11	19.2	24.0
Marital status	Single, never married	76.5	31	13.1	20.0
Number of adults in household	1	33.3	12	16.1	13.2
	2	25.5	8	59.7	56.4
	3 or more	41.2	18	24.2	30.4
Number of children in household	None	74.5	32	57.9	60.4
Tenure	Social sector tenants	34.0	9	29.2	14.8
	Private sector tenants	46.0	18	10.7	13.5
Years at address	Less than 1 year	36.5	14	10.9	13.2
Government Offices for the Regions	North	44.2	17	35.1	30.8
	Midlands, Eastern, Wales	7.7	3	32.6	33.9
	South	48.1	18	32.3	35.2
SOCIO-ECONOMIC					
Highest qualification	A-levels or trade apprenticeship or higher	34.9	9	35.8	53.1
SEG	Non-manual	32.6	11	48.9	57.6
	Manual	67.4	20	51.1	42.4
Activity last week	Looking for paid work, temp sick	55.8	24	13.6	15.2
	Perm. unable to work, looking after home, retired	44.2	14	86.4	84.8
Limiting long-standing illness, disability or infirmity	Yes	44.2	17	43.2	22.0
Total household income (annual)	Nothing/under £5,000	50.0	13	19.4	7.5
	£5,000-£15,000	26.2	7	40.2	22.7
	£15,000 or more	23.8	9	40.4	69.8
DRINK AND CRIME					
How often usually drink?	3 or 4 days a week, or more often	21.6	8	22.5	31.5
	1 or 2 days a week	29.4	12	25.6	32.0
	Less often, or never	49.0	18	52.0	36.6
How much drink when drinking	1-4 units	43.1	17	62.6	64.6
	4-8 units	23.5	8	13.0	17.4
	More than 8 units	33.3	13	24.4	18.0
Ever been in car approached or stopped by police officer?*	Yes	16	9	43.9	59.9
Ever been stopped and questioned by police officer when on foot?*	Yes	13	9	9.7	14.1
N		51 (22)	38 (11-12)	5102 (2587)	24175 (11962)

Note: <sup>1</sup> Because of reporting restrictions on population bases of less than 50, figures are absolute frequencies. \* question asked of a random half of the core sample. N in () refer to this random half. All percentages based on valid responses.

Source: after BCS 1998 and BCS 2000 (combined) – own calculations.

## 4.6 Logistic regression

In order to determine which characteristics genuinely distinguished drug users from non-users among the sample of individuals potentially claiming benefit, two logistic regression<sup>18</sup> analyses were conducted; the first, involving Class A drug users, the second only Class A core users. Both analyses identified the same characteristics to distinguish Class A or Class A core drug users from non-users (Table 4.6). Crime-related data were omitted from the logistic regression analyses because only half of survey participants had been asked about their experience of, or involvement in, crime. The data's inclusion would have reduced the number of cases used in the analyses and, thus, reduced the robustness of the derived models.

Both logistic regression models identified drug users as significantly more likely to be male, young and single rather than female, of older age, and married, separated, divorced or widowed. For instance, Class A drug users were nearly six times more likely to be male than female; while Class A core drug users were over seven times more likely to be male than female.

Class A drug users were also twice as likely to live in private rented accommodation as in the social sector or in owned property, and were three times as likely to have moved into their accommodation fairly recently (rather than two or more years ago). Similarly, Class A core drug users were over three times as likely to live in private rented accommodation as to live in the social sector or in owned property, and were nearly five times more likely to have moved into their accommodation fairly recently.

Finally, Class A drug users were nearly four times as likely to live in the North of England and were almost six times as likely to live in the South of England as in the English Midlands, Eastern counties or Wales. Similarly, Class A core drug users were between four and five times more likely to live in the North and about seven times more likely to live in South of England than in the Midlands, Eastern counties or Wales.

Although the odds reported for the two groups differed for each characteristic, this did not, necessarily, indicate significant differences between these groups, because significance levels are sensitive to case numbers and the distribution of cases.

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<sup>18</sup> For details about logistic regression, see Annex A or section 1.3.2 in the Introduction.

**Table 4.6 Best fitting prediction of Class A drug use: individuals potentially claiming benefit (weighted), odds ratios**

	Class A	Class A Core
<b>Statistically significant variables</b>		
<b>Gender</b>		
Female	1.0	1.0
Male	5.7***	7.3***
<b>Age</b>		
35 or over	1.0	1.0
18-24	8.7***	7.0***
25-34	4.3***	2.3
<b>Marital status</b>		
Other	1.0	1.0
Single	5.8***	8.7***
<b>Tenure</b>		
Social rented sector	1.0	1.0
Owner	0.9	2.0
Private Rented Sector	2.0*	3.3***
<b>Years at address</b>		
More than 2 years	1.0	1.0
Less than 1 year	3.1***	4.8***
1-2 years	3.9***	6.8***
<b>Government Offices for the Regions</b>		
Midlands, Eastern, Wales	1.0	1.0
North	3.7**	4.5**
South	5.8***	7.1***

Note: significance levels: \* 10% \*\* 5% \*\*\*1%

Source: after BCS 1998 and BCS 2000 (combined) – own calculations.

## 4.7 Summary

The BCS provided the basis for an estimate of the number of Class A and Class A core users among individuals potentially claiming benefit. This group of jobseekers included (self-reported) unemployed and inactive people, with the exception of full-time students, individuals on government schemes or waiting to take up employment, or engaged in other, unspecified activities. The narrow definition of Class A core drugs used for most of the study

to focus on the most likely addictive drugs covered cocaine, crack, heroin, and Methadone, but excluded the other Class A drugs ecstasy, LSD and magic mushrooms.

Between 0.6 and 1.4 per cent, and 0.4 per cent and one per cent of individuals potentially claiming benefit declared to have used Class A or Class A core drugs within a month of being interviewed for the BCS in 2000. This was equivalent to approximately 24,000 to 54,500 Class A drug users and 15,000 to 40,000 Class A core drugs among individuals potentially claiming benefit in England and Wales.

The estimate of Class A core drug users potentially claiming benefit was substantially below an alternative estimate by Godfrey et al. (2002) based on extrapolating administrative data, which concluded that over 270,000 problem drug users were in receipt of state benefits. A comparison of the methods used for producing the two estimates suggested that the BCS-based estimate of the present study might have omitted a large proportion of heroin users. On the other hand, the alternative estimate was based on numerous, only partially substantiated assumptions, which require further testing.

Drug users were significantly distinguished from non-users by their gender (male), age (under 35) and marital status (single). They were also more likely to live in private sector accommodation, to have moved into their accommodation within the last year or two, and to be resident in the North or the South of England.

A majority of drug users had in the past been stopped and questioned by the police. They were more likely to have done so than others not using drugs. There was further, but statistically less reliable evidence that disproportionately more drug users than non-users had in the past been arrested, taken to court or been in contact with the Probation Service.

## 5 DRUG AND ALCOHOL USERS

### SUMMARY

- ❖ In the year 2000, approximately 51,000 potential benefit claimants in private households were heavy drinkers who also consumed Class A or Class B drugs.
- ❖ In terms of their demographic and socio-economic characteristics, heavily drinking drug users who were also potentially claiming benefits more closely resembled the profile of other drug users than that of other heavy drinkers.
- ❖ The only characteristic that significantly distinguished heavily-drinking drug users from other drug users was their greater propensity to live in socially and economically disadvantaged areas.
- ❖ In comparison to other heavy drinkers, heavily-drinking drug users were younger, more transient and, potentially, more socially isolated.

The final section reporting the findings of the secondary analyses turns to the group of individuals who use both drugs and higher than recommended amounts of alcohol. Data about the prevalence of drug taking and of alcohol consumption are collected in the BCS, which was, therefore, used again for this analysis. As in the case of drug users, described in the previous chapter (4.1.2), the analysis focused on individuals potentially claiming benefit and living in private households.

### 5.1 Definitions

Unlike the GHS, which estimates both the weekly and daily consumption of alcohol, the BCS only records weekly consumption. Moreover, whereas the GHS derives its consumption estimates from a detailed account of the type and the quantities of alcoholic drink consumed by survey participants within the last week and on the day they drank most, the BCS only asks respondents to indicate, when they drink, '*on average how many units of alcohol do you have in a day*'. The BCS and GHS estimates of alcohol consumption are, consequently, not immediately comparable. The BCS estimate of alcohol consumption might also be less accurate.

As in the case of benefit recipients who use alcohol (Chapter 4), the definition of heavy drinking used in this analysis is that of consumption exceeding eight units of alcohol per day for men and six units for women.

In the previous chapter, it was noted that about one-third of Class A drug users typically drank more than eight units of alcohol on any one drinking occasion (Table 4.5). Such low percentages meant that small case numbers in the BCS once again hampered subsequent analyses. Although merging the two datasets of the BCS 1998 and the BCS 2000 increased these numbers, they were still insufficient to facilitate a detailed and reliable analysis. It was, therefore, necessary to include both Class A and Class B drug users, in this analysis of heavy drinkers. This created a sufficient number of cases for only the BCS 2000 to be used in the analyses.

## 5.2 Drug and alcohol use among individuals potentially claiming benefit

In 2000, heavily drinking Class A and/or Class B drug users accounted for 1.6 per cent of the working-age population and **1.3 per cent of individuals potentially claiming benefit** according to calculations using the BCS (Table 5.1). These estimates are based on actual responses. Because between one-tenth and nearly one-fifth of survey participants did not, or could not, answer the question about alcohol consumption, the data contains a high proportion of missing values. The estimates are, therefore, **lower-bound estimates** and the real values may, in fact, be higher if some, or all, of the missing cases involved heavily-drinking drug users.

**Table 5.1 Drinkers and drug users, living in private households, England and Wales (Spring 2000)**

	Column percentages	
	Working-Age Population	Individuals Potentially Claiming Benefit
Heavily-drinking drug users	1.6	1.3
Heavy drinkers only	9.8	7.4
Drug users only	3.6	2.3
Neither/nor	75.7	70.8
Missing	9.4	18.3
Total	100	100
N (unweighted)	13629	2560

Note: Percentages may not add to 100 due to rounding.

Source: after BCS 2000 – own calculations.



The 95 per-cent confidence interval of the proportion of heavily-drinking drug users among individuals potentially claiming benefit living in private households in England and Wales is 0.9 per cent to 1.7 per cent (Table 5.2). Based on the total number of individuals potentially claiming benefit in August 2000 of approximately 4m, it is estimated that **between 34,000 and 68,500 potential benefit claimants were drug users, who also drank heavily**. As before (see Chapters 4 and 5), it must be emphasised that this estimate only refers to **individuals living in private households**. As many heavy drug and alcohol users may not live in private households, but in communal establishments, the estimate is likely to understate the true number of problematic drug and alcohol users potentially claiming benefit.

**Table 5.2      Estimate of the number of heavily-drinking drug users, individuals potentially claiming benefit, living in private households, England and Wales (Spring 2000), unweighted**

Male	30
Female	3
All	33
% (all)	1.3
No. (all cases)	2560
<b>95% confidence interval (%)</b>	<b>0.9-1.7</b>
Unemployed and inactive population (Spring 2000)	3.9m
<b>Population estimate (mean)</b>	<b>51,000</b>
<b>Population estimate (95%-confidence interval)</b>	<b>34,000-68,500</b>

Note: Population estimates rounded to the nearest 500. Number of male, female and all cases refer to those identified in the BCS.

Source: after BCS 2000 – own calculations.

### **5.3      Heavily-drinking drug users**

About 15 per cent of heavily-drinking drug users had used Class A drugs in the previous month. This compared to nearly a fifth (24.2 per cent) of drug users, who did not also drink heavily. Besides this instance of the less frequent use of Class A drugs, heavily-drinking drug users were a group clearly distinguishable from other drug- or alcohol- using individuals potentially claiming benefit on the basis of their demographic and socio-economic

characteristics, and the extent to which they had been in contact with the legal and justice systems.

### 5.3.1 Demographics

Most heavily-drinking drug users were **male** (69.1 per cent), **young** (46.1 per cent aged 18-24) and **single** (56.2 per cent) - all characteristics they shared with Class A drug users (cp. Chapter 5). Many **lived alone** (37.3 per cent), and most had **no children** (56.5 per cent).

The largest group of heavily-drinking drug users lived in the North of England (38.5 per cent) but, of all substance users, they were most likely to live in the English Midlands, the eastern counties or Wales (27.7 per cent). Heavily-drinking drug users were least likely to own their home (25.1 per cent) and most likely to live in the **social rented sector** (57.0 per cent). Over one-third of heavily-drinking drug users had moved to their present address within the previous 12 months (37.1 per cent), which was probably a reflection of younger age and, therefore, more transient lifestyle of this group.

Information about the type of areas or neighbourhoods that drug and alcohol users lived in, was obtained from two variables. The 'Acorn Category' classifies neighbourhoods according to a range of socio-economic and environmental areas. 'Striving' and 'aspiring' areas are high-unemployment areas with households, typically, on low incomes (striving) or slightly better-off areas characterised by low- and high-rise estates, including council areas, occupied by white collar and skilled workers. Nearly two-thirds of heavily-drinking drug users (65.4 per cent) lived in these types of area as, also, did many heavy drinkers (59.9 per cent).

Moreover, about three-quarters heavily-drinking drug users (74.7 per cent) described their neighbourhood as a place where people tended to '*go their own way*' rather than where they '*do things together and try to help each other*'. This was a markedly higher percentage than among heavy drinkers (56.6 per cent), drug users (61.6 per cent), or the average of all individuals potentially claiming benefit (49.2 per cent).

Drug and alcohol users, thus, appeared more likely to be living in neighbourhoods with few social and inter-personal networks. It may, however, also have been the case that their description of the neighbourhood, above all, reflected the respondents', perhaps, more

isolated position within the area. In either case, the neighbourhood appeared to offer this group of substance users few apparent means of social support.

### **5.3.2 Socio-economics**

Further, in part tentative, evidence of greater social disadvantage of drug and alcohol users emerged from the socio-economic data included in the BCS. Drugs and alcohol users were less educationally qualified than drug-only users, although not less qualified than the total population of potential benefit claimants. Other indicators also pointed to drug and alcohol users taking up a weaker position in the labour market.

Fewer drug and alcohol users have had jobs in the past (84.8 per cent) than any other substance user group (heavy drinkers: 94.9 per cent; drug users: 93.7 per cent), although the percentage rate would still be judged to be high. Among those who had worked in the past, heavily-drinking drug users were most likely to have worked in manual occupations (77.4 per cent). Long-standing illness, disability or infirmity affected about half of all drug and alcohol users (48.5 per cent), which was a higher proportion than found for other substance users.

Drug and alcohol users were also most likely to report low annual household incomes. Two-fifths of drug and alcohol users claimed a gross annual household income of up to £5,000 (42.5 per cent), compared to about one-third (30.2 per cent) of heavy drinkers and those using only Class A or Class B drugs (35.8 per cent). Because proportionately more drug and alcohol users lived alone, lower incomes might, in part, be compensated for by the absence of other household members with whom income might be shared.

### **5.3.3 Police and crime**

The clearest indication of the precarious nature of drug and alcohol user's lifestyles emerged from BCS data about the experience, or suspected perpetration, of crime. This information was only recorded for a random half of participants in the BCS 2000, which resulted in smaller case numbers. Because of restrictions on reporting percentages for base population smaller than 50, only actual frequencies can be reported for heavily-drinking drug users and some of the data available for drugs-only users.

On most indicators, drug and alcohol users were more - sometimes considerably more - likely to have had some contact with the police or the criminal justice system, mostly as suspected

perpetrators of criminal acts. In fact, eight of 16 respondents who were drug and alcohol users, had been inside a prison ‘for any reason’, as were 13 of 34 drugs-only users. This compared to about one-third of heavy drinkers (29.1 per cent) and one-fifth of all potential benefit claimants (20.4 per cent). Because the survey question is somewhat openly, or ambiguously phrased, it cannot be concluded that time spent inside a prison was always, and necessarily, time spent serving a court sentence. But the drug and alcohol users’ responses to the questions concerning arrests and court actions suggest that imprisonment could have been one reason.

Many substance users among those potentially claiming benefits had been victims of crime. Thus, 11 of 16 drug and alcohol users reported to having been victims of crime, as did 22 of 34 drugs-only users and 70 per cent of heavy drinkers. By comparison, just under 60 per cent (59.2 per cent) of all potential claimants stated that they had been victims of crime at some point in the past. Since only crimes reported to the police were queried, the statistic probably under-recorded the full extent to which respondents had been victims of crime. If their already frequent encounters with the criminal justice system, or other reasons, discouraged drug and alcohol users from reporting crimes to the police, the underestimate would have been particularly large for this group of substance users.

**Table 5.3**      **Characteristics of heavily-drinking drug users potentially claiming benefit (Class A or B), England and Wales (in % and No.)**

		Heavily- Drinking Drug Users	Heavy Drinkers	Drug Users Only	All Individuals Potentially Claiming Benefit
Class A drug user		15.1	0	24.2	1.0
<b>DEMOGRAPHICS</b>					
Gender	Male	69.1	59.3	54.4	36.4
Age	18-24	46.1	12.9	38.8	8.0
	25-34	33.7	26.6	35.8	20.0
Marital status	Married/cohabiting	32.8	54.2	33.3	71.3
	Single	56.2	26.0	50.0	14.6
Number of adults in household	1	37.3	28.8	34.8	16.9
Number of children in household	None	56.5	54.9	63.3	58.0
Government Offices for the Regions	North	38.5	57.0	34.0	35.2
	Midlands, Eastern, Wales	27.7	20.4	20.6	32.2
	South	33.8	22.6	45.4	32.6
Tenure	Owners	25.1	42.1	26.1	58.6
	Social sector tenants	57.0	46.0	37.2	29.8
	Private sector tenants	17.9	11.9	36.7	11.6
Years at address	Less than 1 year	37.1	14.4	31.7	11.8
Vandalism a problem in area	Yes	51.3	33.3	44.0	32.8
Type of neighbourhood	Go own way	74.7	56.6	61.6	49.2
Acorn category	Striving or aspiring	65.4	59.9	45.2	42.0
<b>SOCIO-ECONOMIC</b>					
Highest qualification	A-Level or higher	29.9	22.2	39.0	30.6
SEG	Manual	77.4	73.8	56.4	51.4
Activity last week	Looking for paid work	41.7	20.8	51.9	12.6
	Intending to look for work, but temporarily sick	3.7	4.8	4.6	2.6
Ever worked in the past?	Job in past	84.8	94.9	93.7	90.4
Limiting long-standing illness, disability or infirmity	Yes	48.5	43.3	32.5	43.1
Total household income (annual)	Nothing/up to £5,000	42.5	30.2	35.8	20.3
<b>CRIME</b>					
Ever been victim of crime reported to police*	Yes	11	70.1	22	59.2
Ever been arrested by the police for any reason*	Yes	11	37.4	18	14.8
Ever been in court as person accused of a crime*	Yes	7	29.1	11	12.0
Ever been in contact with Probation Service*	Yes	6	14.1	9	11.4
Ever been inside a prison for any reason*	Yes	8	29.1	13	20.4
N (unweighted)		64 (16)	422 (92)	148 (34)	3729 (1259)

Note: \*\* From BCS 2000. N (unweighted) of BCS 2000 in (). Respondents only.

Source: BCS 1998 and BCS 2000 – own calculations.

## 5.4 Logistic regression

Logistic regression analyses identified features that distinguished heavily-drinking drug users among individuals potentially claiming benefit from other groups, that is, non-users, other heavy drinkers and other drug users (see also Annex A or section 1.3.2 in the Introduction). The comparisons of drug and alcohol users and non-users *all* refer to individuals potentially claiming social security benefits.

The characteristics that distinguished heavily-drinking drug users who might claim benefits from non-users and heavy drinkers potentially on benefits were rather similar. Drug and alcohol users were about 36 times more likely than non-users, and ten times more likely than other heavy drinkers to be aged 18 to 24 years than to be aged 35 or over.<sup>19</sup> They were still ten times more likely than non-users and nearly four times more likely than other heavy drinkers to be aged 25 to 34 years.

Drug and alcohol users potentially claiming benefits were also nearly three times as likely as non-users or heavy drinkers to be living at their address for less than one year. Similarly, they were about twice as likely as non-users or heavy drinkers to describe their neighbourhood as an area in which people ‘went their own way’ rather than helping each other (or doing neither).

In addition, drug and alcohol users were three times as likely to live alone and eight times more likely to be male than non-users, but neither characteristic significantly distinguished drug and alcohol users from heavy drinkers.

In contrast, there was only one statistically significant difference between drug and alcohol users, who might be claiming benefits, and other drug users potentially on benefits, which was their area of residence. The former were significantly more likely to be living in areas classified by ACORN as ‘striving’ or ‘aspiring’, that is, being typically low-income and high-unemployment or low- and high-rise, white collar and skilled worker estates.

The logistic regression excluded statistics about respondents’ **encounters with the criminal justice system**, because their inclusion would have halved the number of cases available to

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<sup>19</sup> The figures are in part a reflection of the small number of cases available to the analyses and should be read as indicators of difference, not necessarily measuring the magnitude of difference.

the regression. A separate logistic regression analysis of the smaller sample of drug and alcohol users and non-users potentially claiming benefits who answered survey questions relating to crime did, however, confirm that all crime-related indicators, with the exception of the variable ‘ever having been the victim of a crime’, significantly distinguished the former group from the latter group.

**Table 5.4 Best fitting prediction of heavily-drinking drug users potentially claiming benefit, odds ratios**

Statistically significant variables	Comparison with		
	Non-users	Other Heavy Drinkers	Other Drug Users
<b>Gender</b>		n.s.	n.s.
Female	1.0		
Male	8.3***		
<b>Age</b>			n.s.
35 or over	1.0	1.0	
18-24	35.6***	10.0***	
25-34	10.1***	3.9***	
<b>Number of adults in household</b>		n.s.	n.s.
2 or more	1.0		
1	3.0***		
<b>Years at address</b>			n.s.
1-5 years	1.0	1.0	
Less than 1 year	2.7**	2.7**	
5 years or more	1.3	1.8	
<b>Neighbourhood type</b>			n.s.
Place where people help each other or ‘neither/nor’	1.0	1.0	
Place where people go their own way	2.3**	2.1**	
<b>Acorn category</b>	n.s.	n.s.	
Thriving, expanding, rising, settling			1.0
Aspiring, striving			2.3**

Note: significance levels: \* 10% \*\* 5% \*\*\*1%; n.s.: not significant.

Source: BCS 2000 – own calculations.

## 5.5 Summary

In August 2000, between 34,000 and 68,500 individuals potentially claiming benefit and living in private households took Class A or Class B drugs and also drank heavily. The data used for this estimate contained a large number of missing values, some of which might have related to other drug-taking heavy-drinkers. The range is, therefore, likely to underestimate the actual number of drug users who drank heavily, whose true value might be closer to the upper bound of the estimate range. Moreover, the true number of problematic drug and alcohol users in receipt of state benefit is likely to be higher as it would include many who do not or do no longer live in private households.

In terms of demographic and socio-economic characteristics, drug and alcohol users who were also potentially claiming benefits and living in private households were closer to other drug users than to other heavy drinkers or non-users of either drugs or alcohol. This was highlighted by the logistic regression analysis, which showed that the only characteristic, which significantly distinguished drug users who drank heavily from others who only used drugs, was their place of residence. Heavily-drinking drug users potentially claiming benefits were significantly more likely than other drug users to live in often socially and economically disadvantaged areas, comprising low-income and high-unemployment or low- and high-rise, white collar and skilled worker estates. Heavily-drinking drug users are, therefore, disproportionately spatially clustered, although this concentration does not imply that they live exclusively in these disadvantaged areas.

In comparison to other heavy drinkers, heavily-drinking drug users among those potentially claiming benefits were younger, more transient and, possibly, more socially isolated, living in places which they described as areas '*where people go their own way*'. The same characteristics distinguished heavily-drinking drug users from non-users but, in comparison to the latter group, they were also significantly more likely to be male and to be living alone.

Heavily-drinking drug users potentially on benefits were less likely to have been using Class A drugs than other drug users, who did not drink heavily. As a result, as a group, they might be less at risk of drug dependence or addiction than other drug users, although they were at greater risk of alcohol addiction. Both differential addiction risks, however, were compounded by a greater risk of social and economic disadvantage, which was reflected in where drinking drug users lived, and a greater risk of social isolation.



## 6 THE VIEWS OF DRUGS AND ALCOHOL SUPPORT ORGANISATIONS

### SUMMARY

- ❖ Telephone interviews were conducted with workers from ten substance user support organisations.
- ❖ Their clients were mainly male and of white ethnic background. Drug users were typically aged 20 to 35 years; alcohol users 40 to 60 years.
- ❖ Support workers stressed the need for rebuilding substance users' confidence, health and social network, and for creating better job opportunities while carefully managing former substance users' return to work.
- ❖ Benefits were perceived in co-ordinating or integrating rehabilitation and employment services, case management and involving the Intermediate Labour Market and voluntary work as interim stages of substance users' reintegration.
- ❖ The development of trust and understanding between rehabilitation services, employment support services and clients was seen as of paramount importance.

In this chapter, the findings of telephone interviews with ten drug and alcohol support organisations are reported. The interviews were conducted with support workers who were responsible for the social re-integration of clients as well as their detoxification treatment, and included a number of individuals who helped clients to find employment or to gain access to education or training courses. The support workers were asked about barriers to employment that (former) substance users typically encountered and the practical challenges of assisting unemployed drug and alcohol users in finding employment. The interviews also explored the issues that support workers thought Jobcentres and *progress2work* offices needed to address in order to ensure that employment services for drug and alcohol users are effective.

The chapter starts with a brief description of the organisations covered in this survey and of the types of service they provided (6.1). This is followed by a summary of some of the characteristics of substance users assisted by the organisations (6.2), while section 6.3 provides an account of substance users' employment barriers as identified by support workers. The penultimate section (6.4) brings together the support workers' views of the role of employment services in the rehabilitation of (former) substance users. It highlights support workers' concern that a deficiency of trust and understanding between substance users and Jobcentre/*progress2work* staff might undermine the effectiveness of employment service programmes for substance users. Section 7.5 briefly summarises the findings.

## **6.1 Drug and alcohol support organisations**

Telephone interviews were conducted with support workers from five drug support organisations, four alcohol support organisations and one organisation that provided support for both, drug and alcohol users<sup>20</sup> (Table 6.1). All organisations were located in London (2) or cities and larger towns in the English Midlands (8).<sup>21</sup> The two London-based organisations only provided services to drug or alcohol users who lived in the Borough, in which the organisation was located. By contrast, most Midland-based organisations made their services available to clients outside their towns or cities, operating outreach services to cover the semi-urban and rural hinterland. Some also reimbursed clients' travel expenses, but support workers remarked that poor public transport links with rural areas frequently continued to constrain access to these organisations.

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<sup>20</sup> To protect the anonymity of the drug and alcohol support organisation, it will be referred to as one of the alcohol support organisations.

<sup>21</sup> Several of the organisations later helped in the recruitment of drug and alcohol users for interview. Because of difficulties anticipated in recruiting substance users and the need to keep researchers' journey times to a minimum, client interviews were clustered in London and the Midlands. Areas were also selected to obtain a mix of locations with high and low levels of unemployment or deprivation.

**Table 6.1 Drug and alcohol support organisations participating in study**

Organisation	Location	Funded by	Service provided
Community Drug Team	Midlands	NHS	Drug treatment & assessment; information & advice; prescribed treatment; motivation interviewing
Community Drug Team (targeting under 19s)	Midlands	NHS	Drug treatment & assessment; information & advice; prescribed treatment; motivation interviewing
Community Drug Team	Midlands	NHS	Drug treatment & assessment; information & advice; outreach
Community Drug Team	London	Local Authority	Drug treatment & assessment; information & advice; prescribed treatment
Drug Advice Team	Midlands	Parent organisation funded by European Social Fund, Jobcentre Plus, and Learning and Skills Council	Help in overcoming barriers to work; post detoxification (one-to-one) support; outreach
Drug and Alcohol Team (focus on drugs)	Midlands	NHS	Therapy and detoxification; access to education and training; introduction to employers/co-attending clients' job interviews
Community Alcohol Team	Midlands	NHS	Counselling, advice, information and outreach
Community Alcohol Team	Midlands	NHS	Counselling; information & advice; detoxification; outreach.
Alcohol Counselling Service (for ex-offenders)	London	Part-funded under dependency2work programme	Treatment; information & advice; mentoring; access to education and training; employment support
Alcohol Advice Centre	Midlands	Community Projects Trust	Daycare; counselling; group sessions.

The majority of the organisations (6) were funded by the National Health Service (NHS), while the others received funding from their local authority (1), a regional Community Projects Trust (1), or were funded under the Government's dependency2work programme for ex-offenders (1) or by several different organisations, including the European Social Fund (1).

The support organisations provided a range of services, including drug and/or alcohol treatment, counselling, client assessment and general advice. Few organisations provided direct jobsearch or employment placement services. However, all would refer clients to local Jobcentres, if so asked, while some liaised directly with the Centres' specialist staff, such as Disability Resettlement Officers or New Deal Advisers, in order to help former substance users to access training and employment opportunities. One drug support organisation employed an Employment, Education and Training (ETE) worker, based in the local Jobcentre, whose main task was to research issues surrounding the return to work of former substance users, but who provided no direct client support.

A second drug support organisation, part-funded under Jobcentre Plus, conducted their outreach work in local Jobcentres. This organisation also enjoyed good formal links with training providers and employers in the area and was the only one to do so. Its main support activities were one-to-one mentoring for drug users to help them regain a steady life balance, referrals for detoxification, and post-detoxification mentoring. As a next step, the team's regional parent organisation provided access to the New Deal programme and offered basic skills assessment tests for 18 to 24 year-olds as well as basic employability skills training (e.g. time-keeping).

A third drug support organisation, also based in the Midlands, focussed on helping clients select and attend basic education and F.E. college courses and training programmes. Upon clients' request, team members would also accompany clients to job interviews and related appointments, and would continue to liaise with employers after clients had taken up employment.

## **6.2 The clients of the support organisations**

In most drug and alcohol support organisations, the majority of clients was male. This was particularly the case in former mining areas in the Midlands. Alcohol support workers noted a general reluctance of people with alcohol problems to seek help, which appeared to be

greater than among drug users. Women were typically more reluctant to admit their substance misuse than were men, and fewer women than men would, as a result, attend support organisations:

*‘Men might say “I’m drinking too much”, but women have often internalised the problem.’*

(Alcohol support worker)

The number of male clients also tended to be higher than that of female clients because non-addicted woman had often encouraged male partners with alcohol problems to seek specialist advice and support. By contrast, men were seen to be less likely to try and persuade female partners, who were addicted or on the brink of addiction, to seek support.

Most clients were of white ethnic background, largely reflecting the population in the support organisations’ catchment areas. Only one drug support organisation catered for a majority Asian client group, while another organisation provided support for a mixed ethnic group, including Asian language counselling for clients with little or no knowledge of English.

Support organisations’ clients with drug problems tended to be younger than did clients with alcohol problems. Drug users were typically aged between 20 and 35 years of age, whereas the alcohol users were more likely to be aged 40 to 60 years. Some drug and one of the alcohol support organisations noted that, in recent years, the average age of their clients had been declining and they had treated more younger substance users.

In part, as a result of their young age, but also reflecting their economic activity and occupation, in particular in the Midlands’ former mining areas, many of the drug and alcohol users had few formal educational qualifications. Some had dropped out of school or had been excluded from school. However, clients also included many with higher educational attainment, including some clients who had just completed secondary education. Drug support workers remarked that there was often a surge in demand for drug support services after the announcement of A-Level results, because school leavers wanted to get *‘sorted out’* before they started higher education.

In fact, both drug and alcohol support workers described about half of their clients as *‘middle class’*, at least as far as their educational attainment was concerned. Alcohol support

organisations also pointed out that many of their clients were professionals, for instance GPs or police officers, including some in employment. In fact, in two instances, more than half the clients of alcohol support organisations were in employment. In all other cases, however, the majority of alcohol and drug users were out of work.

Most clients of the support organisations now lived in local authority or housing association accommodation, or rented in the private sector. Some clients had no fixed abode. However, unlike most drug users, many alcohol users and addicts had previously been employed or had owned property, both of which they lost as their addiction developed:

*'They've had it all, the job, the family, the house, and they've blown it.'*

(Alcohol support worker)

There was some concern, among the alcohol support organisations in particular, that long episodes of drinking would cause physical disability and would eventually force alcohol users, who were currently working, out of their jobs.

### **6.3 Client barriers to work**

According to the support workers, substance users faced a number of concurrent disadvantages besides their addiction. These included housing problems, including homelessness; low levels of education; medical and emotional problems, including mental health; financial debt; and the lack of family support.

All these disadvantages could potentially represent major barriers to the employment of (former) substance users. In essence, support workers argued that substance users needed to recover some form of stability and regularity in their lives and that employment could form part of efforts to achieve this. Many of the support workers' clients, in particular former alcohol users, wanted to return to '*a stable, natural life*' (alcohol support worker) and, as part of their re-adjustment, were already undertaking some type of paid work, while others had indicated that they would like to go back to work. One alcohol support worker pointed out that clients who felt ready to work often wanted to go into training or join a college course first. Such courses were seen to increase clients' chances of obtaining a job of their choice and to reduce the risk of having to accept what was seen as '*dead-end*' jobs.

On a cautionary note, drug and alcohol workers emphasised that the substance users' transition into the labour market needed careful case management. Work was not every substance users' realistic option and could be '*a bridge too far*' (drug support worker) for some, especially those who had been out of work for some time:

*'It is a huge thing going back into work – clients need some kind of confidence and assertiveness-building before they can think about work.'*

(Alcohol support worker)

The intermediate labour market, voluntary or part-time work were often seen as useful, if not important, interim stages during substance users' return to paid work. They were seen to offer less stressful and sometimes less demanding environments, in which former substance users could explore their job readiness and ability to hold down a job.

First, however, clients would have to control, if not completely stop, their drug or alcohol use. In the view of drug support workers, clients would find it difficult, if not impossible, to maintain employment as long as they remained dependent on drugs. Clients' need '*to get a fix*' each day would stand in the way of keeping a regular pattern of work. In order to obtain the substitute drug, Methadone, clients had to attend clinics, normally during their working hours, which some employers (and even other employees) might find hard to understand or accept. Employers' attitudes towards drug users, and their readiness to accept and to accommodate their special needs, were, as a result, crucial to the successful integration of drug users into the labour market.

Support workers perceived a lack of public understanding of the difficult process of rehabilitation, which posed a major obstacle to the social re-integration of substance users. Employers in particular, were seen to lack trust in former substance users and their reliability, and for this reason were unwilling to consider substance users for employment. To counteract the risk of prejudice, substance users often hid their history of addiction from employers for fear that disclosure might have detrimental effects on their chances of obtaining employment or would subject them to greater scrutiny, and suspicion, on the job.

This fear was yet greater if clients also had a criminal record which, according to the support workers, many substance users also preferred to hide from employers:

*'A criminal record increases the negativity of the perception of the client, so they are doubly damned ... And then they enter into the realm of hopelessness, which is difficult for both us and the client to deal with.'*

(Alcohol support worker)

Support workers acknowledged that employers' concerns about the reliability of (former) substance users were not entirely unfounded. Yet, for many substance users, the entry into rehabilitation signalled a determination on their part to address not only their addiction, but also the personal and inter-personal barriers that had built up in the course of their substance misuse.

Support workers stressed that drug and alcohol users needed to develop a genuine, independently nurtured desire and motivation to work, overcome personal anxieties and improve their self-confidence. Part of the rehabilitation process was for substance users to learn to adopt more responsible attitudes and behaviours and, once again, to structure their days and develop routines. Support workers frequently saw their role as facilitating this process by way of re-building clients' confidence. One alcohol support worker pointed out that he could often tell that clients had reached the point of a stepwise return to conventional and regular forms of living and working, when they displayed visible changes in their demeanour and dress.

A return to work would be difficult without regaining confidence in one's abilities, in particular, since many clients felt they had nothing to offer an employer and the prospect of being in employment was regularly perceived as an *'insurmountable [psychological] barrier'*. As a result, any incentive to look for work subsided. In the words of one drug support worker:

*'A lot of the barriers they [the clients] face they create themselves ... for example they say "I can't do this" ... it's a lack of confidence or inertia with regard to change and the need for direction.'*

(Drug support worker)

But not all support workers agreed with this analysis of substance users' self-perception and low self-esteem. Some workers, typically those more concerned with the re-integration rather than treatment and rehabilitation of substance users, pointed out that substance users



exploring opportunities for employment could also be prone to over-estimating their ability to work and the type of work they are capable of doing. As one advice worker noted, '*[some clients] have ideas above their station*'. Lacking a realistic sense of achievability, they would misjudge the change that employment would bring to their lives. Unrealistic earnings expectation would later add to disappointment and frustration.

The transition to work, therefore, needed careful management in order to avoid the experience being '*demotivating*' (alcohol support worker) for the client. One important factor in this respect was clearly to distinguish between the medical judgement of a GP who might declare a former substance user fit for work and the user's continued experience of anxiety or depression. Labour market attachment activities should accept both perceptions as independently valid and be designed accordingly.

In contrast to psychological and motivational disadvantages, support workers considered substance users' practical skills and educational or occupational qualifications much less of a barrier to work. The main exceptions were young substance users who, according to some drug support workers, not only frequently lacked basic levels of education (numeracy and literacy), but also the desire to attain them. This lack of interest was particularly strong among drug users who were also involved in drug dealing:

*'Most kids don't get any GCSEs ... they aim for jobs like waiter or a checkout operator, whereas drugs (dealing) means a lot of money and flash cars.'*

(Drug support worker)

The financial rewards that could be gained from drug dealing and other illicit activities, thus, undermined incentives to pursue regular, legal employment opportunities.

#### **6.4 Improving employment services for substance users**

As has already been noted, few of the organisations covered by these interviews provided direct employment services for their clients, although two had direct contact with *progress2work* co-ordinators and most others had some contact with relevant local support organisations, including Jobcentres, and referred clients to them. Their principal emphasis, however, was to provide addiction treatment and rehabilitation, or early guidance to help clients to return their lives to some level of 'normality'.

This said, since support workers were acutely aware of the barriers that substance users faced in everyday situations, including the return to work, most had suggestions as to how substance users' chances of a successful return to work could be increased. General concerns included the financial disincentives to work that rehabilitating substance users faced, both owing to their low earnings potential and the comparatively higher earnings-replacement rate of some of the social security benefits that substance users were receiving.<sup>22</sup>

A drug support worker felt some clients should be more rigorously checked for abusing the system by falsely claiming sickness benefits. Others suggested that the emphasis should be on increasing financial incentives to work, in particular by giving substance users the chance to undertake voluntary work without risking the withdrawal of their benefits. As already mentioned earlier, the Intermediate Labour Market and the voluntary sector in particular, were often seen as useful areas in which substance users could test their ability to sustain work.

Rules governing the receipt of JSA, IS and IB already allow claimants to undertake voluntary work as long as it remains unpaid, although expenses may be covered, and claimants continue actively to seek work and are available to take up paid work within a week of it being offered. Not all support workers might have been aware of these rules. However, their principle argument was that, to assist (former) substance users, voluntary work should be considered as a 'testing ground' for substance users before they might contemplate regular, paid work in the primary labour market. Currently, benefit rules considered voluntary work secondary to paid work, which was not compatible with the important transitional role that voluntary work can and, in support workers' views, should play in the (re)integration of (former) substance users.

At the same time, most support workers also felt that private sector employers needed more encouragement to take on rehabilitating and former substance users. There was scepticism among support workers, however, as to whether, even under tight labour market conditions, employers could ever be convinced of the benefits of employing former substance users.

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<sup>22</sup> The Department for Work and Pensions offers a number of financial and practical aids to assist transitions between welfare and work. The research did not investigate whether support workers were not aware of these aids or, if they were aware of them, whether they rated them as ineffective or insufficient. It is known, however, that, in the general population, awareness of financial and practical forms of assistance is low.

#### 6.4.1 Co-ordination of activities and promoting understanding

Support workers saw considerable scope and, indeed, need for greater co-operation and collaboration between drug and alcohol treatment providers and employment service providers. Many would also welcome greater strategic co-ordination of service provision, since no one organisation was capable of providing the full range of services that is typically required to rehabilitate substance users. Most support workers argued for improved referral services at different stages during clients' rehabilitation and social integration processes. One drug support worker felt particularly strongly about the need to co-ordinate services, and suggested their integration *'under one roof'*.

Support workers would generally welcome, and acknowledged the potential benefits of, working with or alongside employment service providers, including Jobcentre staff, to improve referral services between the service providers. In addition, co-operation could set into place specialist treatment and employment service skills, which would complement each other and thus enhance rehabilitation and integration support for substance users. Greater co-ordination was seen to improve the monitoring of clients' progress throughout all stages of rehabilitation and reintegration, which currently was not always happening:

*'... some clients drift in and out of contact with services and are not chased or contacted ... they need monitoring but it's difficult because many people on benefits aren't chased up, and then it's all a missed opportunity.'*

(Drug support worker)

But substance user support workers were concerned that, without proper induction and training, employment service staff might not have the necessary depth of understanding of the personal and inter-personal barriers that former substance users face when they prepare to return to work. Some felt that Jobcentre staff could misjudge their clients' behaviour as 'laziness' and rejection of the work option when, in fact, their clients had withdrawn from much of social interaction and lacked the confidence to engage even in basic social activities. In their view, all involved need to understand that:

*'[The difficulty is that] a lot of people who want to work have just had the wind battered out of them and they need a take-off pad.'*

(Drug support worker)

Some support workers already gave presentations to Jobcentre staff to promote greater understanding and awareness, but at least one drug support worker felt that it was still

difficult to get the support workers' message across. Support workers appeared to sense that mutual, only slightly formalised consultation was the right way forward, at least in the initial stages. There was a wide-spread feeling that contacts between rehabilitation and employment service providers should become more frequent:

*'We ourselves should go in and work on a consultancy basis so that we can transfer our skills on to them [Jobcentre staff] so that they become specialists themselves. We're not precious about it; there are too many people with too many problems for that.'*

(Alcohol support worker)

#### **6.4.2 Issues of trust**

Support workers were also concerned that, in some cases, there was a lack of trust between their clients and Jobcentre (and social security office) staff and their mutual 'good will'. However, clients' perceptions of Jobcentre and social security office staff could be diverse and swing between trust and mistrust, and it was difficult to make any kind of generalisation.

Some substance users were described as lacking faith in public services and officialdom in general. This could be both a sign of opposition and of resignation:

*'... they feel that the government doesn't care, the government doesn't know they exist.'*

(Drug support worker)

More specifically, substance users often doubted the Jobcentre's ability to help them to find employment, in particular, employment, which they considered 'worthwhile' and 'rewarding'. Substance users were worried about being pushed into '*dead end jobs just to make the figures look better*' (alcohol support worker) and felt that low-paid jobs they saw advertised in the Jobcentre would not cover the loss of their social security benefits.

While low-paid jobs were a general concern, not all clients apparently rejected Jobcentres' efforts to place those who were deemed job-ready in employment. More positive attitudes towards Jobcentre staff had often been formed on the basis of positive personal experience.

Substance users' trust in Jobcentres, services appeared finely balanced by, on the one hand, the extent to which they felt accepted and treated with respect by case managers and other Jobcentre staff and, on the other hand, the extent to which Jobcentres were considered a threat to individuals' benefit income:

*'It's not just about getting clients into work but about getting them suitable jobs. Clients feel they have a lot to lose, financially. It's a big step going into employment and losing all their benefits.'*

(Drug support worker)

*'I've seen those who've left Jobcentres with hope and have positive expectations. Then again some perceive job services, Jobcentres, as those with the means to take benefits away from them.'*

(Alcohol support worker)

It was not uncommon for support workers to be told that their clients felt social security office staff had treated them like '*lower class citizens*'. In many instances, these remarks were based on clients experiencing inconvenience when visiting social security offices or Jobcentres where facilities were outdated and staff over-stretched who, as a result, were seen to be '*unhelpful, judgemental*' (drug support worker). However, these experiences were not unique to substance users, although the fact that they were substance users exacerbated problems:

*'The problems arise if [social security and Jobcentre staff] know it's a drug or alcohol client. They perceive them as a potential threat and the client can be threatening. But it's usually because they are fed up with files being lost and information going missing and the general bureaucracy of it.'*

(Alcohol support worker)

However, some support workers did wonder whether Jobcentre or social security office staff would know at all whether any of their customers were substance users, since many were quite determined to hide this fact from others. Overall, support workers were less critical of Jobcentre and social security office staff than their clients reportedly were. Referring to drug users' complaints of being treated disrespectfully, some drug support workers pointed out that this was as much part of substance users' everyday experience as it was a reflection of their own poor self-image and low self-esteem:

*'Some will be perceived as a 'useless junkie' – but it is more about the state of the mind of the client – they will feel this anywhere they go ... There is no evidence to say clients are treated worse than anyone else.'*

(Drug support worker)

This point was further elaborated by one alcohol support worker, who noted that many clients had had ‘*a really good talk*’ with Jobcentre advisers, while others had felt that advisers had been ‘*hostile*’ towards them. In the view of the support worker, this was not uncommon and quite possibly owing to some clients’ behaviour and mannerism, to which Jobcentre staff did not know how to respond:

*‘There is a need to improve awareness and understanding. There is a misconception about users – they are seen as aggressive and manipulative, and this is not always the case.’*

(Drug support worker)

Some support workers felt that case management had helped to improve relationships between substance users and Jobcentre staff, in particular:

*‘New Deal staff appear to have more understanding of clients’ needs than do front line staff who are often frightened by substance misuse clients. [Clients] see the same Personal Advisers a lot and some are very good and “bend over backwards” to try and help clients. Some are a bit “jobsworth” and misjudge the clients; they have no time for them.’*

(Drug support worker)

This view, however, was not shared by all support workers, and a few remained aggrieved by an apparent lack of understanding that New Deal caseworkers appeared to have for the special needs of (former) substance users. More personalised, one-to-one casework was generally favoured by support workers, who were concerned that Jobcentre and social security office staff understood the difficult circumstances and language of substance users, and learned to empathise with the individual. Ultimately, many support workers felt, caseworkers would be best placed to gain a proper understanding of the complexity of problems that many (former) substance users face and then to develop adequate work strategies:

*‘Clients with alcohol problems are not necessarily identified by staff. I think that it’s useful to identify drug/alcohol issues with them sensitively and confidentially. I know some clients get into problems with paying their rent and are threatened by the Council with eviction and things like that don’t help. Staff need training. The fact that they’ve got to be actively pursuing jobs means a dilemma for clients with serious problems.’*

(Alcohol support worker)

### 6.4.3 The potential of progress2work

Support workers generally believed that *progress2work* could be an important tool in helping to ‘*bridge the gap*’ (alcohol support worker) between basic integration services provided for people not yet ready for work and the generalist services of Jobcentres targeted at all jobseekers. However, some were concerned that this gap was already too wide and that, for *progress2work* to be successful, the initiative needed to follow on seamlessly from rehabilitation or, preferably, commence before rehabilitation was completed. Importantly, the initiative needed to acknowledge the primary importance of full rehabilitation before labour market integration:

*‘Yes, [progress2work co-ordinators] can set up interviews and hand-holding is very important as [substance users] lack confidence and skills. [But] Addicts cannot go straight into work, they need confidence building, any little set back will knock them back.’*

(Drug support worker)

Most support workers found it conceivable that *progress2work* ‘*will help some clients who want to work*’ (drug support worker) but before this point was reached, in their view, more should be done to address and improve clients’ motivation as ‘*some have excluded themselves and they feel employment is unobtainable*’ (ibid.). Support workers frequently felt that they, themselves, were under-resourced to accomplish this task fully, but that *progress2work* could greatly enhance re-integration services, if it worked with clients before they become job-ready, as is envisaged under current proposals.

Adequate funding for *progress2work* remained one of the support workers’ principal concerns. Few had any precise knowledge of the scale of the initiative, but most noted that treatment and rehabilitation services were currently inadequate in their areas. Although multiple services might operate there, they would lack co-ordination or financial strength. Many could not meet local demand and there was concern among support workers that *progress2work* be of sufficient scale to provide a reliable support service interlocking with traditional rehabilitation services while, effectively, helping substance users to (re)connect with the labour market:

*‘I know it’s not the only project that is running or has been tried, but there is a huge hole in the support given to customers. What we don’t need is some Mickey Mouse scheme that isn’t adequately funded, staffed and organised. [Drug users] need real training opportunities and real jobs at the end of it.’*

(Alcohol support worker)

Some support workers acknowledged that their own support activities were often too isolated and not sufficiently linked to those of other service providers. For them, *progress2work* was seen as an opportunity to develop, expand and integrate existing support services for the benefit of substance users:

*'It's easy to get bogged down in your own work. We need to share and communicate.'*

(Alcohol support worker)

Communication was particularly important to ensure that the addition of *progress2work* services would not lead to duplication of effort or, as in this case, 'competition':

*'We were phoned up by the progress2work people and I was quite miffed because I said we already have an organisation [dependency2work] coming in that deals with work. They are fighting over the same people.'*

(Drug support worker)

## **6.5 Conclusion**

In summary, the interviews with support workers in drug and alcohol centres drew out specific concerns about the needs of substance users and the type and arrangement of help that they should be offered. Key suggestions included:

- recognising the importance of rehabilitation as a pre-requisite to labour market integration, and the need for a carefully managed return to work;
- co-ordinating or, in fact, integrating rehabilitation and employment services to facilitate transitions between them, to match substance users' multiplicity of problems and to enhance mutual understanding between support service providers;
- ensuring that duplication of provisions is avoided and competition between providers limited;
- developing case management as a means to improving support staff's understanding of the multiplicity of problems faced by (former) substance users, and to enhancing mutual trust;
- ensuring initiatives, such as *progress2work*, are adequately funded; and
- using the Intermediate Labour Market and voluntary work as interim stages in the process of substance users' reintegration.



## 7 INTERVIEWS WITH DRUG AND ALCOHOL USERS

### SUMMARY

- ❖ Face-to-face interviews were conducted with 30 substance users to gather their views on their barriers to work and their perception of the role of the Department for Work and Pensions and the Jobcentre Plus network as providers of employment support services.
- ❖ Substance users emphasised that they often encountered deep-seated psychological problems, which coincided with, or even had triggered, their addiction and needed to be addressed first.
- ❖ Work was perceived to offer an avenue to return to a more 'normal' and patterned way of life that they had lost or given up as a result of their addiction.
- ❖ Substance users were aware of the problems they faced or might face if they were to take up or to consider taking up employment. These included not only deficiencies in numeracy and literacy, but also limited job information networks, homelessness, debt, poor past employment records, recent criminal records and, in particular for drug users, continued treatment with substitute drugs.
- ❖ Substance users had mixed views as to the services provided by Jobcentres and many felt that more needed to be done to improve understanding and develop trust between themselves and Jobcentre staff. Involving trusted treatment support service staff was seen as a means of achieving this.

### 7.1 Introduction

This chapter reports the findings from the face-to-face interviews conducted with drug (mainly heroin) and alcohol users, the majority of whom were currently out of work and receiving social security benefits.

The objective of these interviews was to identify substance users' support needs and their perceptions of the role of the Department for Work and Pensions (DWP) - via Jobcentre Plus services - in assisting users' (re)integration into the labour market. The objective was also to investigate at which stage of a user's recovery from addiction this support might be most effective.

In total, 30<sup>23</sup> individual, face-to-face interviews with drug and alcohol users were undertaken and used in this study. Respondents were recruited via drug and alcohol support organisations. Interviews were steered by topic guides and lasted about 40 minutes on average. They were tape-recorded and, later, transcribed verbatim.

The chapter is divided into six parts. The following section (7.2) gives a brief description of drug and alcohol users' personal characteristics. This is followed by an account of their substance dependency, illustrating the effects it has had on their lives, at home and at work (7.3). Section 7.4 gives examples of substance use's effects on the users' physical well-being and social interactions, while section 7.5 focuses specifically on substance users' experience of employment during their addiction. The subsequent section, 7.6, explores in greater depth the substance users' perceptions of their barriers to work, before Section 7.7 lists the users' suggestions for the type of employment services, which they would like to see implemented, and for their delivery.

## **7.2 Background**

All but one of the drug users was, or had been, heroin-dependent. Typically, drug users had tried a number of different drugs and alcohol. The un-prescribed drugs included crack cocaine and 'speed balls' (heroin and cocaine), speed, acid, solvents, ecstasy and cannabis. Heroin, however, was the main drug, which users had become addicted to.

Three of the drug group were former users, without recent relapses, who also no longer used prescribed opiate-substitute drugs. Five were no longer using heroin, but received treatment involving opiate-substitutes (e.g. methadone) or other drugs to help during detoxification (e.g. Subutex). Twelve individuals were current users, most of whom were relapsing and looking to break their addiction; all but one attended drug support services.

Alcohol users were more likely to have been addicted to only alcohol, but at least three of the ten respondents in the alcohol group had also used un-prescribed drugs. At least six

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<sup>23</sup> Thirty-four people were interviewed. Twenty-three interviews with drug users resulted in twenty usable cases; three were excluded from analysis. Two of these included the same respondent who attended two interviews (with different researchers), giving conflicting details in the interviews presumably in an attempt to pass himself off as two separate identities. The other interview was excluded owing to the poor quality of the recorded material. In total, 11 interviews were conducted with alcohol users. One interview was excluded from analysis, again because of the low quality of data due to the respondent's poor/damaged memory and extremely agitated state.

individuals used anti-depressants which, in two cases, was described as long-term use and in one case as an ‘*addiction*’. In all cases, however, alcohol was the main source of users’ dependency.

Five of this group were former alcohol users, who were now entirely abstinent. The remaining five were current users. One alcohol user reported that he was working towards total abstinence through controlled reduction of his alcohol use, while another two attempted to maintain controlled, reduced alcohol use. One of the latter aimed to reach and maintain the level of a ‘*social drinker*’ rather than striving for abstinence. Two individuals were currently relapsing.

The gender, age and economic status of both the drug and alcohol groups reflected the make-up of the general population of drug and alcohol users respectively (see previous chapters). In both groups, there were more men than women, and drug users were younger than alcohol users (Table 7.1).

**Table 7.1      Gender, age and economic status of respondents**

	(Numbers)	
	Drug group	Alcohol group
<i>Gender</i>		
Male	16	7
Female	4	3
<i>Age</i>		
18-19	1	0
20-29	11	0
30-39	6	2
40-49	2	6
50-59	0	2
<i>Economic Status</i>		
Waged employment	2	1
Long-term sick leave from waged employment	0	2
Voluntary work	1	2
Un employed and receiving Jobseeker’s Allowance	4	1
‘Sickness benefit’: Incapacity Benefit or Income Support	14	6

Three respondents were in waged employment: one ex-drug user was employed as a drug and alcohol service outreach worker; a current drug user assisted with the fitting of air-conditioning systems; and a current alcohol user was working as a barman and cleaner. Two ex-alcohol users were on extended sick leave from employment in education.

Three respondents were doing voluntary work: one ex-drug user was setting up a relapse prevention project while claiming Jobseeker's Allowance (JSA); a current alcohol user on Income Support (IS) worked voluntarily for a community furniture scheme; and a former alcohol user on Incapacity Benefit (IB) was a volunteer teaching assistant in a special needs school.

Most respondents claimed what they typically described as 'sickness benefits', which included IS (9 cases), IB (4), or a combination of both (1). Six respondents could not specify the name of the 'sickness benefit' they received. In most cases, benefits were claimed on grounds of substance dependency or for reasons related to dependency (e.g. mental health problems). Details on duration of benefit receipt were unclear, though some respondents had been claiming benefits because of substance dependency for as much as ten years.

A 41 year old male, current alcohol user was about to start a New Deal programme, while a current drug user had just undertaken three months of an education and training option under the New Deal for Young People (NDYP). Upon disclosing his heroin addiction, however, he had left the programme and was now claiming 'sickness benefit'. At least two other current drug users had signed off JSA to avoid having to take part in the New Deal. One had moved from JSA to 'sickness benefit' and the other moved between JSA and temporary employment.

The drug group included a mix of those with and without educational or vocational qualifications. Seven respondents had GCSEs, including one who also held an Ordinary National Diploma (OND) in engineering and another who had obtained a BTEC National Diploma in travel and tourism, an NVQ in warehouse skills and a Computer Literacy and Information Technology (CLAIT) certificate. Those without qualifications had left school by or at age 16. Seven respondents had left prior to 16, including two as young as 13.

Most alcohol users had left school between ages 14 and 16. Only one respondent had continued education into his twenties, achieving a degree in nursing, a Master's Degree and a teaching certificate. At least five individuals had left school without any qualifications, including two who later returned to education: one to undertake a City and Guilds course in community care work and another to study for a non-graduate special needs teaching qualification. Three alcohol users had GCSEs, one of whom later attained a City and Guilds qualification in electronics servicing.

Most respondents lived in urban locales: Chesterfield, Leicester, London and Peterborough. Four of the drug group and three of the alcohol group lived or had lived in rural areas, mainly villages in Leicestershire, Nottinghamshire and Cambridgeshire.

Seven of the drug users were accommodated in homeless shelters, two in night shelters and one man was 'sleeping rough' while waiting to be housed in a hostel. Six individuals lived with their parents and four had their own homes, of which at least three were council or housing association stock. In contrast, all alcohol users had their own homes, of which at least two were rented from housing associations, two from councils, and two were mortgaged to the occupier.

Most members of both groups were articulate and motivated in their participation in the interviews. One exception to this was a current heroin user who was 'gouching' during the interview. 'Gouching' happens soon after heroin has been taken when the user appears to be dropping to sleep. The gouching user in the interview appeared to be falling asleep yet continued to respond to questions accurately, even though responses tended to be delayed and curtailed<sup>24</sup>.

### **7.3 Dependency**

The interviews with substance users revealed different routes by which heroin and alcohol dependencies emerged and developed.

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<sup>24</sup> Despite the physical reaction of gouching, it was evident that the respondent was willing and able to participate, without distress, and that the interview did not contravene principles of ethical research.

### 7.3.1 Heroin dependency

Heroin dependency without exception developed rapidly as casual use became chronic dependency. A typical case was that of a current heroin user, who was introduced to the drug by friends and began using it without comprehending the consequences:

*'I used to like my beer from the age of 18 to 25, then one night I went out as normal, got invited to a party afterwards and was smoking this sh\*t on foil. So I thought I'll just do that, as you do when you're pissed. ... they said it was heroin, but I didn't know what heroin was or what it does.'*

(30 year old male, ex-heroin user)

Prior to heroin, many drug users had tried other un-prescribed drugs. Some had started using one or more types of illicit substance while still at school, including cannabis, amphetamines, or solvents. Only two respondents said that they had been dependent on other drugs, and both referred to amphetamines.

Some members of the group explained that they had first begun to use heroin to relieve some personal trauma, including: being bullied or unfairly treated in school; failing to get a desired job; death of a close family member; and being victims of crimes, including rape and physical attacks. While such trauma was cited as the reason why respondents first used heroin, the highly addictive nature of the drug was the cause for its continued use.

The drug group reported that their heroin habit had cost them a minimum of £10 per day. Three drug group users, all now confining their use to methadone or prescribed opiate-substitutes, used to spend up to £100 per day on heroin and several other respondents stressed that they would spend most, if not all, of their incomes on the drug:

*'Say, if I were on a job now and I were getting £350 that would never last a week. It would last three or four days or something. ... some days I might have £40 and I know I haven't got a penny to come the next day but I will still spend that £40 and then I'll be running about panicking the next day for money.'*

(30 year old male, current heroin user)

Most respondents had been using heroin, at least intermittently, for between two and nine years, but two had been dependent for 19 years and another for 29 years. Several of the drug group had been using heroin since before age 20, including five who had first used heroin when aged between 14 and 16.

The length of time during which respondents had been seeking the help of drug support services also varied widely. Most users or former users had been registered with a service for one or two years, while some had accessed support services for ten or more years.

All respondents had either stopped using heroin or aspired to stop, because: *‘that’s my dream to get off heroin, that’s all I want in my life’* (current drug user). However, they also emphasised that the resolve to stop taking drugs was a struggle to maintain. At least ten respondents had relapsed after previous attempts to break dependency. A current user described having relapsed after each of 17 prescribed detoxification programmes, while a former user explained that she only overcame her heroin dependency on her eighteenth attempt.

### **7.3.2 Alcohol dependency**

Unlike heroin, alcohol can be used without entailing physical dependency. The alcohol group had started using alcohol between their early teens and early twenties, yet only one felt that alcohol had been problematic since first use. For others, there was no clear point at which they became substance-dependent.

Alcohol users tended not to define their addiction on the basis of the amount of alcohol they were or had been consuming. Rather, high levels of alcohol consumption had been recognised as excessive or problematic only when they coincided with other personally traumatic events. Several alcohol users had been heavy drinkers for long periods, but their addiction to alcohol only became apparent when it began to cause or contribute to problems at work or in family relationships.

For example, a 44 year old current drinker explained that heavy drinking had been *‘part and parcel’* of his lifestyle for 29 years when he served in the Royal Air Force (RAF). Although he was aware of his alcohol problem during this time, and once received medical advice to cut down, he never missed work because of alcohol use, which was never identified as substantially problematic. After leaving the RAF, he and his wife took work as assistants on a country estate. Six years later and having received two warnings from his employers, he was made redundant because of his alcohol dependency, triggering the break-up of his marriage and subsequent loss of his home. Despite heavy alcohol use for some 35 years, it

was only when it interfered with his performance at work that the respondent and others around him realised the full extent of his alcohol dependency.

In other instances, it was routine medical check-ups that led to the identification of the alcohol problem, as in the case of a 42-year old man who had started drinking aged 14 and, by age 16, was drinking half a bottle of whisky each day. He continued to drink heavily for the next 24 years, during which time he was in stable employment, and married with family:

*'I was very good at hiding it ... It was controlled drinking. I would not drink during the day, I would not drink and drive obviously for safety reasons and I wouldn't drink around my children if I was out with them [but then] ... I used to stay up all night drinking, middle of the night still drinking.'*

(42 year old male, ex-alcohol user)

His alcoholism remained concealed despite the fact that, between ages 33 and 40, his marriage collapsed, he received treatment for depression and experienced increasing difficulties coping with work. It was only when he reached 40 that his alcoholism was diagnosed during a routine appointment with an occupational health doctor.

More often than was the case with drug use, problematic alcohol use was perceived to have been triggered by traumatic events, which ranged from the death of a parent during a person's childhood, or stress at work, to divorce or relationship problems. Frequently, it was a combination of events, and changes in a person's life, which eventually led the individual to drink excessively. In other instances, more deep-rooted psychological problems were noted:

*'I have always been a drinker but it has been worse in the last five years and I am sure it was induced by depression. ... the stuff I did in Rehab has been useful, some of the realisations about my childhood, relationship with my parents ... I have got to learn to love myself.'*

(42 year old male, ex-alcohol user)

Most of the alcohol group had been accessing alcohol support services for up to two years. One had been using services for more than five years and another for about ten years. Many had relapsed once or twice since attempting to stop drinking. One respondent had stopped drinking for a month and had not relapsed. While most of the current users aspired to stop



drinking, as noted above, two respondents, instead, aimed to reduce and control their alcohol consumption.

#### **7.4 Personal and social effects of substance use**

Respondents reported how substance use had adversely affected their physical and mental health and their social networks. For most heroin users interviewed in the course of this study, their addiction involved an obsessive structuring of lifestyle, which was constructed around the need to obtain and consume the drug. This obsessive focus on heroin, in many cases, resulted in estrangement from parents, partners and children, and loss of friends:

*'I'm the black sheep of the family and they don't want anything to do with me ... My Mum was the only one who, whenever I was in trouble, would stick up for me. And now there is no one. ... she used to lend us money whenever we were in trouble ... She was always there for me, for me to stay there and things like that.'*

(19 year old male, current heroin user)

Associated with the lack of formal and informal support networks, most of the drug group had, at some point during their addiction, become homeless, sometimes for several years. At least two of the group had accrued substantial rent arrears - £1,000 and £2,000 - in respect to former council housing, while another two had substantial debts (£800 and £2,000) after using credit cards to fund their heroin habits. Most of the group had, at some point, funded their addiction through illegal activities, mainly shoplifting and, to a lesser extent, burglary and drug dealing. Nearly all drug users had criminal records and many had served custodial sentences.

Apart from the physical symptoms of withdrawal, few users noted health problems associated with heroin dependency, although some mentioned weight-loss, general self-neglect, or epilepsy. Similarly, only a few of the drug group had suffered mental health problems caused, or made worse, by drug use. Some suggested that dependency eroded confidence, self-esteem, motivation or the ability to interact socially with non-users. However, overall, psychological and emotional concerns were presented as peripheral to addiction.

Most drug users strongly believed that, if only they could beat their dependency, other personal and inter-personal problems would also be resolved.

Like the drug group, the alcohol group had experienced estrangement from parents, partners and children, and loss of friends:

*'I have had loads of friends, but one of the beasts about alcohol is that they drift away and you can't blame them. Nobody wants to be with somebody who is permanently drunk.'*

(45 year old male, ex-alcohol user)

In contrast to drug users, past or present homelessness was the exception among alcohol users, with only one user reporting sleeping rough in the past. Alcohol users were also less likely to have had a criminal record; none had received custodial sentences.

Few alcohol users commented on the effects which the heavy use of alcohol had on their health, although some had previously been hospitalised or suffered physically as a result of their long-term problematic drinking. However, much more so than drug users, alcohol users emphasised psychological problems associated with their dependency. Several respondents had experienced periods of depression and severe stress:

*'There is this chicken-and-egg situation with alcohol because alcohol makes you think that you feel good ... But, in fact, it is quite the opposite. Alcohol induces depression, so if you are depressed you just get more depressed.'*

(45 year old male, ex-alcohol user)

In summary, substance use frequently entails the collapse of friendships and social networks culminating, in the case of drug users, in homelessness or the accumulation of debt. Poor health related to substance use was also reported, in particular, psychological problems experienced by alcohol users.

## **7.5 Substance users' experience of employment and addiction**

Most respondents had entered employment immediately on leaving education and alcohol users' first jobs tended to be more secure and lasted longer than those of drug users.<sup>25</sup> As noted earlier, at the time of the interview, three respondents were still in waged employment, two of whom had been continuously in some type of employment since leaving school; another three were now doing voluntary work.

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<sup>25</sup> This could reflect the fact that the alcohol group was older. At the time they were leaving school, there was a stronger youth labour market than at the time the drug group were leaving school.

Three types of employment histories were identified from the interviews. Some respondents have had solid periods of continuous employment, which were sharply curtailed with the onset of substance problems, resulting in long periods of unemployment. This type of history was more prevalent among the alcohol group. For example, one former alcohol user had worked for 30 years as a skilled engineer, when his alcoholism became too severe to retain work, and he had been out of work for the last decade.

Other respondents – mostly drug users – had been in waged employment for only scarce periods. For example, a 43-year old current heroin user had been in waged employment for only two years during her life.

The third type of employment history included those who had worked in a string of temporary jobs. This was especially the case for younger drug users. Often temporary employment involved working through agencies and entailed low paid, unskilled labouring, often on a day-to-day basis, typically based in warehouses and factories. Episodes of work were interspersed with patches of unemployment.

### **7.5.1 Heroin use and employment**

Drug users typically agreed that, in their experience, employment and the continued use of heroin were difficult, if not impossible, to reconcile. Only in exceptional instances had heroin users managed to keep working by restricting the use of heroin to off-work periods. Given that the availability of heroin, though widespread, is unreliable, the routine task of finding and buying heroin often interfered with being at work:

*'If I was to say to my dealer at night, "Listen, I'm at work at 8.00am, yes, I'll be around at 7.30am and I want to buy some heroin", get there at half seven and he says "I haven't got none", you aren't going to get to work for 8.00am, are you? ... You end up getting to work at 10.00am in the morning or end up not going.'*  
(30 year old male, current heroin user)

Respondents also reported the problem of managing increasing addiction during the working day. When available, heroin would be used at regular intervals, during the day as well as in the morning and at night. Obvious, practical difficulties were associated with injecting or smoking heroin at work:

*'Being at work's like a long, dragging process. I had to take stuff in ... in the toilet. But sometimes it's hard because, if you do too much, you go to sleep or they notice.'*  
(25 year old male, current heroin user)

A few drug users hypothesised that it should be possible for heroin users to hold down a job if they had a reliable, sufficient supply of the drug and employers permitted, and provided a space for, the drug to be used in the workplace. Others noted that a drug users' ability to retain work depended on their discipline and skill in using just enough of the drug to alleviate withdrawal symptoms, without inducing sleepiness ('gouching'). However, most respondents were eventually unable to continue working because of the physical side effects of heroin and had resigned before their erratic attendance record at work could lead to their 'sacking'.

The few drug users, who did retain their job, at least for a while, had managed successfully to hide their drug use from employers and colleagues at the workplace. They also felt that the use of heroin had not necessarily adversely affected their performance at work. Some, indeed, argued that it lent them extra stamina and made them work harder:

*'I can work harder than you after I've been taking heroin, faster, harder and keep going and going ... the pain and everything goes away and you get faster, better.'*  
(21 year old male, current heroin user)

For those who could not hold down their regular job, temporary, short-term work offered through employment agencies enabled them to maintain some connection with the labour market and to earn an income. Importantly, it allowed users to move from job to job before employers became aware of their addiction:

*'This is why I've stuck to agency rather than full time work. Because knowing that there's a possibility I might let them down at some point, there's no point me going for a full-time job because they'll just sack me.'*  
(23 year old male, current heroin user)

However, for many, the motivation required even for short-term work was eroded by the poor quality of jobs that appeared to be available for them, the physical effects of heroin addiction, and the likelihood that large parts of their earnings would be spent on buying drugs, leaving little additional income. In some instances, drug users had turned to drug dealing and other illicit activities to finance their lifestyle.

### 7.5.2 Alcohol and employment

Compared with heroin dependency, the accounts of alcohol users suggested that alcohol dependency had a less immediate, but more cumulative impact on users' performance in the workplace. Like heroin, alcohol withdrawal causes painful physical reactions:

*'Your body has got the dependency ... If you haven't got a certain amount of alcohol in your system, your system starts giving you absolute hell. You hurt all over, you get the shakes, you get the vomiting. As soon as you get a quantity of alcohol in your system that goes away ... You can actually get through the day without being in absolute pain.'*

(41 year old male, current alcohol user)

However, in comparison to heroin users, alcohol users reported, more often, being able either to restrict their use to off-work periods (evenings, lunchtime and sometimes to the mornings before work) or to be able to hide their drinking at work:

*'Alcoholics are very clever people, they can conceal anything at the end of the day, they can lie about anything when you get the craving. ... what's actually in that bottle? It's Tizer. Really it's half a bottle of whiskey or vodka inside it, very easily done.'*

(42 year old male, ex-alcohol user)

Although alcohol users were able to work for sustained periods while drinking heavily, most eventually left or lost jobs because of alcohol use. Respondents reported three types of behavioural effects of excessive alcohol, which eventually cause them to lose their jobs.

First, alcohol users' attendance and punctuality at work faltered because of alcohol use:

*'With the job with London Transport, I used to be away for 16 hours a day, used to drink myself to sleep and did not have time to wake up and get it out of my system, so I used to turn up late ... I had a few written warnings and verbals. So, indirectly, I had no choice but to go for other work.'*

(41 year old male, current alcohol user)

Second, dependency resulted in a deterioration of users' performance at work, in particular their ability to interact appropriately with colleagues:

*'I could not actually hold a conversation. So, I am working in a factory environment and I'm running away from people in embarrassment because my nervous system is so shot ... You are just waiting for the time that you can have some alcohol, so that you can loosen off the effect of the up-tightness and stressed feeling. It took about three pints, where I could start holding a conversation.'*

(56 year old male, ex-alcohol user)

A number of respondents explained that alcohol use caused them to pose a health and safety risk at work. However, only a few respondents remarked that alcohol had diminished the quality of their work; others, in fact, felt that it was questionable whether alcohol had affected their performance at work at all.

Third, some alcohol users had lost, or had been suspended from, their jobs when they had breakdowns, caused or fuelled by long-term alcohol dependency. Breakdowns had been triggered by divorce, stress at work and sudden withdrawal from anti-depressants. Untreated, breakdowns entailed uncontrolled and extremely heavy drinking, withdrawal from work and social networks, and emotional distress and depression:

*'I would actually pass out for a few days. ...I would spend a few days at home just drinking myself silly ... [with the] usual effects with drink, vomiting, diarrhoea, not eating ... having the shakes, tremors, hot and cold sweats, all the works. ... I did have a couple of jobs, but it got to the point, where I wouldn't turn up for work because I would be either too ill or I had drunk too much.'*

(41 year old male, current alcohol user)

One of the alcohol group had been able to maintain her job as a cleaner even during her period of personal crisis and problematic alcohol use, because she could work in isolation and avoid contact with her employers:

*'Some mornings, I would have a hangover. I would keep myself to myself during the course of the houses, because it is houses that I clean in. I would just disappear.'*

(46 year old female, current alcohol user)

## **7.6 Users' perceptions of their barriers to work**

Substance users explored the opportunities and challenges, which they faced when seeking and obtaining work.

### **7.6.1 Aspirations**

Drug and alcohol users alike, in particular those already in waged employment or doing voluntary work, acknowledged the social as well as the material benefits of work.

Employment was seen to confer 'normality', provide identity, and may help former users, once again, to 'get on with life'. Work was also perceived to have a preventative and therapeutic quality: people could afford to move from their present neighbourhoods to other areas and thus avoid former fellow addicts and the associated temptation to use substances;

work filled time and distracted recovering addicts from the physical and emotional symptoms of withdrawal; and work provided new goals, self-esteem and self-respect. Furthermore, work was seen as a means for developing new social networks with people who were not substance-dependent:

*‘[What would you get out of working?] My life back, some independence, learning new skills at work, getting away from my old life, be a normal person. That’s what I want. I feel like I’m being treated like I’m scum and I am scum - that’s how I feel.’*  
(29 year old male, current methadone user)

Drug and alcohol users’ job aspirations were often modest, reflecting their current level of skills. Respondents in the drug group wanted to go either to college for vocational training or to take up unskilled or semi-skilled manual work (retail-assistant, cleaning, shop security, bar work, heavy plant machinery driver/operator). Respondents in the alcohol group tended to aspire to return to the jobs or the type of jobs they had left when their addiction was diagnosed.

### **7.6.2 Job-seeking**

Most of the drug group not already employed and not on extended sick leave were currently looking for work. In contrast, however, only one of the alcohol users was currently looking for work. In neither user group was job-seeking a constant, regular activity. Some respondents had recently started, but then stopped a period of job seeking. Decisions to stop and start job searches were often taken abruptly and reflected users’ volatile motivation and fragile outlook on life. However, they were also largely unrelated to whether or not respondents were currently using substances.. Nor were these decisions determined by the type of benefit which substance users received, or the job search requirement, which are attached to them: some respondents on ‘sickness benefit’ were looking for work, while some on JSA were not.

Respondents’ perceptions and experiences of job seeking varied. Some believed that it was easy to find employment and - were it not that their motivation towards independent and ‘purposeful’ living had been eroded by substance dependency- they felt they could find a job without delay:

*‘If I weren’t on drugs I believe, if I started looking for work today, I’m sure I would have a job by next Wednesday ... For people, if they want it, there’s plenty of jobs.’*  
(30 year old male, current heroin user)

While some substance users believed that work would be readily available through employment agencies, others argued they would rely on personal social networks to find a job. In fact, about a third of the respondents had gained work via friends and family in the past:

*'I went to London Transport, my brother got [me] the job ... With the security work, it was a mate of mine; with care work, it was a friend of mine; when I moved from London Transport to [unskilled engineering], that was my sister-in-law. It's always someone else that's got to give me the push ... it's all been down to family and friends.'*

(41 year old male, current alcohol user)

However, as many substance users' social networks had eroded in the course of their dependency, finding a job could prove difficult because information about job opportunities was scarce and personal contacts, who could help to identify these opportunities or even recommend individuals to employers, were not available:

*'A lot of people, they're not advertising for jobs ... pulling relatives in or a mate they know and that and if you're not in the network - I mean, I've a very, very small social circle of about one, so I mean, I've no chance of hearing about a job that's going from any mates.'*

(23 year old male, current heroin user)

Previous sections in this chapter (8.5.1 and 8.5.2) have already illustrated how substance use and the physical pain caused by dependency had made it impossible for many users to retain their employment. Similarly, users pointed out that this same physical pain often prevented them from making sustained efforts to look for employment.

### **7.6.3 Job-readiness**

Respondents in both the drug and alcohol groups asserted that there were no generalisable criteria to determine when someone recovering from a dependency problem would be ready to return to work. Job-readiness, instead, depended on individual motivation, commitment and confidence. Many argued that it should be left to the (former) substance users to decide when the time was right for taking first steps towards seeking employment. However, respondents were also aware that substance users might not be able to judge their job-readiness accurately. For this reason, some argued that substance users' commitment to job-seeking and working would need to be independently tested.

Drug users expressed contrasting views about whether users of methadone, or other drugs designed to help in the stabilisation of drug users could, or indeed should, be offered



employment. Some felt that drug users could work, as long as, and only if, they were solely relying on the substitute drug to control their dependency, and providing this did not significantly impair their performance at the workplace. The greatest concern amongst drug users was that methadone made them feel drowsy which, in turn, led to an increased risk of accidents at the workplace. However, not everyone shared this view and some felt that, in their personal experience, this risk had been exaggerated, which prevented them from taking up work:

*'Unfortunately you can't work. You've got to be on the sick to get the methadone ... I probably could work ... They say methadone, when you take it, it's supposed to make you drowsy, sleepy. I don't find it does.'*

(30 year old male, current methadone user)

Similarly, there were contrasting views in the alcohol group as to whether people with alcohol problems could or should be working. The general view was that alcohol dependency would impair performance at work and, for this reason, people with alcohol problems should not be allowed or be expected to work. A former alcohol user, who felt it important to recognise the 'therapeutic' value of work, qualified this view. He argued that users should be given the opportunity to work even if they had not yet overcome their addiction. However, in such cases, work should be restricted to less demanding, low-responsibility and less 'risky' tasks and to jobs which did not involve driving or operating machinery. At the same time, substance users should have markedly reduced the level of their consumption before taking on any employment:

*'I think a Jobcentre should be involved at the point when the person who's drinking says, "Right, I have got a drink problem, but I think I can handle a job" ... If you're trying to stop drinking, but are out on the streets, it is a damn sight harder, because you have nothing to do but drink. ... if you cut down, like I have, to three-quarters of the amount I used to drink, I'm now looking for work as I feel that is going to give me more incentive to finish it completely.'*

(41 year old male, current alcohol user)

#### **7.6.4 Barriers to obtaining work**

Substance users identified their frequently interrupted work histories, poor health and criminal records as their main barriers to obtaining work. Queried routinely on job applications and during job interviews, respondents argued that these immediately weakened their chances of gaining employment over other job contenders. Having to explain gaps in their employment records, disclosing health problems, above their (former) addiction and admitting a criminal conviction had discouraged several substance users from applying for jobs:

*'I got myself two application forms ... I get so far and then comes the question your last employer, why did you leave? Now do I lie - which I can't see the point - to say you've lost your job through alcohol? So I haven't filled them in.'*

(54 year old male, current alcohol user)

Some substance users felt inclined to hide, and in fact had hidden, their addiction or their criminal record from employers, or had otherwise 'embellished' their CVs in an effort to obtain employment. Most, however, feared they would eventually be found out, and indeed some were.

Drug users also deplored that some employers failed to differentiate between past heroin addiction and current use of methadone as part of a stabilisation and rehabilitation programme. Drug users experienced rejection in job interviews, because taking methadone was equated with taking heroin:

*'I told them that I wasn't actually using the heroin any more and was on a methadone programme but the actual bloke said it was the same thing as doing drugs.'*

(29 year old male, current methadone user)

Many substance users interviewed for this study had left school early and had obtained few, if any, vocational qualifications thereafter. The lack or low level of occupational skills was not necessarily considered a disadvantage when seeking employment, because of the low-skill type work that substance users typically sought. However, deficiencies in numeracy and literacy and in the knowledge of modern technology were repeatedly acknowledged. Unfamiliarity with, and lack of access to, technology could prevent substance users from applying for jobs, for which they appeared otherwise suitably qualified:

*'A while back I got an application form for driving a fork truck, but it's all computerised, I don't know how to turn a computer on, let alone use one. ... anything that involves writing or spelling, or computers, I don't bother looking for that type of work.'*

(41 year old male, current alcohol user)

The final barrier to obtaining work, which was specifically identified by the drug group, was homelessness. Without a permanent address, respondents argued, employers would not take them on. Even where homeless hostels provided a quasi-permanent address, residents felt that they would not be able to afford the cost of the accommodation, which included full-board and was paid via Housing Benefit, if they were to take up work and lose part or all of

their social security benefits. Instead, those affected preferred to wait until they were rehoused in public housing.

However, for some, this could lead to long delays if hostel residents had previously accumulated rent arrears while in council housing, which they were now expected to pay off before the Council would consider them for re-housing. As a result, they remained in the hostel, as this heroin user:

*‘So you are talking about maybe six months to pay my rent arrears off. Then I have to wait for the council to re-house me, so you are talking about a year. While all that was going on I would have to clean myself up, then I could start job hunting.’*  
(25 year old male, current heroin user)

In these circumstances, the combination of substance users’ fear of losing out financially (as wages might fail to meet the level of benefit assistance they received) and the real, or perceived, protractedness of their situation frustrated substance users and, ultimately, also diminished their motivation to seek work.

## **7.7 Employment Services for substance users**

Many substance users felt that more could and should be done to help their (re)integration into the labour market. Their views as to how this could best be achieved were strongly shaped by their experiences and attitudes towards DWP offices, above all Jobcentres, which will be reviewed in the first part of this penultimate section. Following this, users’ suggestions of the types of assistance, which they would like to receive to help them to find and obtain work, are summarised.

### **7.7.1 Experiences of DWP (Jobcentres)**

Most substance users had had experience with the Department for Work and Pensions (DWP) and its street-level services through contacts with the former Employment Service Jobcentres, the Benefits Agency and, in a few cases, New Deal providers. The extent of contact, however, varied and was particularly irregular among respondents who were in receipt of ‘sickness benefit’. Many respondents had either very recent or substantial previous experience of such agencies.

All respondents emphasised that they had never visited Jobcentres or benefit offices while under the influence of drugs or alcohol or, if they had, that this had not affected their

interaction with staff in the offices. Drug users, in particular, felt that Jobcentre or benefit office staff did not know that they were substance users, unless the users had themselves admitted their addiction. This, typically, happened when substance users sought to move from claiming Jobseeker's Allowance to claiming Incapacity Benefit.

Few drug users were concerned about disclosing their addiction, as most believed that Jobcentre and benefit office staff would not and did not differentiate in their attention and the assistance they offered, between people with drug problems and others without. However, drug users were worried about changes in staff's *attitude* if the respondents' addiction were discovered.

*'They sort of look down on you in a way, I suppose it's like they've got a bit of smell under their noses ... it makes you feel worthless in a way.'*

(21 year old male, current heroin user)

In many respects, this view was shared by other drug and also alcohol users, who felt that Jobcentre or benefit office staff were not always as '*polite*' or '*courteous*' or simply '*alright*' as they expected them to be.

However, one alcohol user<sup>26</sup> noted that, frequently, this alleged lack of politeness might only be imagined, in particular, where substance users believed that it was directed at them and their substance dependency:

*'It's hard to get a clear picture because, don't forget, while you're taking all these drugs you're not thinking clearly, you're suffering from paranoia ... A lot of people in a similar position to myself would say that they do not get a lot of help. They get a lot abuse and not a lot of understanding from some of the people that are in those jobs. I think if you're taking substances, then you're getting a distorted view.'*

(49 year old male, ex-alcohol user)

Substance users who, because of their dependency, felt unable to work, considered Jobcentres as a potential threat. In a few cases, this had triggered respondents to disclose their dependency problems, which subsequently allowed them to move from claiming JSA to claiming Income Support or Incapacity Benefit.

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<sup>26</sup> A similar point was made by an alcohol support worker (see Chapter 7).

*'Every time I went to sign on, they either had a job interview for me or some sort of sh\*t that I didn't want to do. So I went to see my doctor and I told him about it [drug use]. He said the best thing he could do is put me on the sick.'*

(30 year old male, current heroin user)

Although most substance users had fairly modest and perhaps realistic job aspirations (see above), they were, nevertheless, concerned with the lack of active help and, in particular, appropriate employment opportunities, which Jobcentre staff appeared to offer them. For this reason, some found it easier and just as quick to do their own searches.

*'Them two words strung together, 'Jobcentre' terrible, absolutely terrible, it's a farce. They're meant to help you back into work but it's pathetic ... They all want to save time, they're not that bothered about helping you. The jobs they have in there are crap anyway, they're either too far away or they're just stupid jobs that you wouldn't dream of doing.'*

(23 year old male, current heroin user)

There was no consensus as to whether DWP should have a role in addressing the specific needs of people with dependency problems, and aim to help (former) substance users to secure employment. Several respondents would welcome help with finding work. Many also shared the view of a current alcohol user who argued, referring to DWP and social security services in general, that *'they're not only there to dish out the benefits, they are there to help people back to work'*. Respondents specifically questioned the wisdom of allowing users to claim 'sickness benefits' on a long-term basis as this would further distance them from the labour market and entrench their situations. But others doubted that Jobcentres could help substance users to obtain 'decent' jobs, or believed that Jobcentres should not place substance users in work at all, because they would pose a risk at the workplace. Some substance users were also concerned that Jobcentre staff could not be trusted to keep details of users' dependency confidential. In one instance, a drug user feared information about drug use might be passed to the police.

### **7.7.2 Meeting need**

Despite these mixed views towards special employment services for substance users, a general consensus emerged as to what such service might entail. All respondents stressed the long-term nature of recovery from substance use and argued that services needed to take this into account and be planned accordingly. Under-resourcing of vital treatment services was a primary concern, in particular for drug users. Without these treatment services and the

substitute drugs they offered, it was felt that substance users would not be physically capable of taking up employment:

*'They need to realise that if they want drug users to go to work then they're going to have to make the programme for methadone more available ... The availability of substitutes is very, very poor. The reason the waiting list for [a community drug service] is so long is they haven't got enough funding to employ more people.'*

(28 year old female, current methadone user)

Respondents thought of employment services only in very general terms and their suggestions for the shape and form these services should take reflected this. In turn, this reflected their belief that, as long as employment services took account of the slow nature of recovery from addiction and any associated physical or psychological problems, substance users had few, if any, other requirements from employment services that would be unique to them.

Four specific suggestions were made. First, respondents argued that attitudes towards and perceptions of substance users needed to change. As noted earlier, substance users felt that, too often, Jobcentre staff attitudes were condescending or insensitive.

*'For a start, they could not take the drug issue into account and just look at you as if you are a human being. That would help.'*

(43 year old female, current heroin user)

However, substance users did not simply blame Jobcentre staff, but also acknowledged the role users themselves played in sustaining or perpetuating engrained adverse attitudes. Jobcentre staff, they felt, would need to be better equipped to understand substance users' needs, vulnerability and their own, often distorted, perception of themselves and their environment.

Jobcentre staff would also need to be able to help recovering users to appreciate the extent to which their histories of dependency might impact upon their employment opportunities. Substance users would need to be told and taught to keep expectations realistic. Most of all, Jobcentre staff needed to give substance users more personalised attention, for instance, to identify whether users have specific skill or literacy problems or to steer users to more targeted job-search.

*'If they actually took the time and effort and asked you a few personal questions ... and some of my disadvantages and advantages they'd be able to help you and say "Well, this job is going to be good for that person", or whatever, rather than saying, "Well yeah, check the board out, if like something go and pick it out", because half the time you don't really get nowhere.'*

(21 year old male, current heroin user)

Second, several respondents raised the possibility of an inter-agency approach, involving Jobcentres, substance support organisations and employers. Substance users reasoned that, with appropriate consent given, Jobcentre staff could liaise with support organisations to assess users' job-readiness and motivation towards employment during different stages of their recovery. This would allow resources to be targeted and prioritised, and would avoid including those who were not genuinely motivated and ready for work.

At the same time, Jobcentres should approach employers directly to encourage them to employ people with histories of substance dependency. Some respondents argued that involving treatment service providers in this process might help reassure (former) substance users, who otherwise did not trust Jobcentres to be able to help people with addiction problems.

*'The support worker could have a chat with the Jobcentre so they have a better idea of what sort of job the person might be capable of doing or have a better idea of how to choose employers to be more lenient or open minded towards somebody who has got a drink problem. ... that would make me comfortable if I was going to use the Jobcentre, if I could have my support team from here with me going through the process of jobs.'*

(41 year old male, current alcohol user)

One respondent would have liked a co-ordinated approach of treatment and employment services, which also involved support with housing, which would help users to move from their present home and break away from their present adverse social environment.

Third, substance users sought greater help with education and training, in terms of both accessing courses and receiving financial support whilst studying or (re)training. This was especially pertinent among drug users and reflected the number of respondents in this group who aspired to go to college for vocational training. Other more specific suggestions included help with mastering job interviews and advice on how to deal with employers' requirement to disclose health issues and criminal records on job applications.

Fourth, substance users suggested sheltered or ‘third-sector’ employment as a half-way house between complete recovery from substance use and full (re)integration into the labour market. Respondents felt that sheltered employment would improve their chances of gaining employment and opportunities to demonstrate their reliability and ability to hold-down a job.

*‘I think they should open some kind of work scheme where if you have got any problem work for them people, slot them into proper work and then move onto other jobs and get your life back again. At the end of it, I’m going to get a proper job: “he is capable of work, he is not going to slip back into his old ways”.’*

(29 year old male, current methadone user)

Respondents’ comments about the potential of sheltered employment also resonated with their views of the benefits of voluntary work as a means of enhancing CVs and for enjoying the sociability otherwise associated with employment.

## **7.8 Conclusion**

This chapter described substance users’ experiences of work, their support needs and perceptions of support service providers, above all of Jobcentres. It also discussed substance users’ views of when, during their recovery from addiction, employment support services might best be provided.

The interviews with substance users highlighted the protracted nature of their addiction and its diverse repercussions for users’ social networks, physical and mental health. In particular, alcohol users stressed that their addiction was frequently accompanied by deep-seated psychological problems, which they felt needed to be specifically addressed as part of their recovery from addiction. In contrast, drug users were more likely to argue that overcoming their addiction would, by itself, help them to overcome associated social and personal problems.

Relapse was a frequent problem.

Substance users’ difficulties with retaining work were, typically, reflections of their inability to maintain attendance (in particular, among drug users) or of their risking accidents at the workplace (alcohol users). In particular, drug users felt that they could best accommodate employment with their dependency, or their recovery through taking on short-term assignments, as arranged through temporary employment agencies.



Respondents found it difficult to determine when recovering addicts might be considered job-ready, which would depend on the individual's progress in breaking their addiction.

Substance users acknowledged the important life-structuring, 'therapeutic' value of work and, for this reason, many argued that employment could well form part of the recovery process.

Others, however, were sceptical as to whether substance users should be allowed, or even expected, to work before they had completely ceased taking drugs or alcohol. Evidence of a marked reduction in alcohol consumption or cessation of heroin use and sole reliance on methadone were seen as the minimum condition for (former) substance users' entry or return to work.

Substance users acknowledged that limited occupational as well as deficient literacy and numeracy skills might impede their chances of obtaining waged employment. However, job aspirations matched these perceptions and many (former) substance users considered job training or training as their preferred initial step into work.

Substance users, who were dissatisfied with services currently offered by Jobcentres, would like to see Jobcentre staff better appreciate substance users' physical and emotional problems. Specific barriers to finding and obtaining employment, which were mentioned, included:

- limited formal and informal job information network;
- homelessness and lacking a fixed address;
- debt, risk of loss of benefits, and associated disincentives to work; and
- interrupted work histories, health problems and criminal records, which needed to be disclosed in job applications and interviews.

Suggestions for improving or setting up specific employment services included:

- improved understanding between substance users and Jobcentre staff;
- close involvement of treatment support service providers (also as a trust-building measure), and collaboration between them, employment services and employers;
- better information about and support for training and education, and financial support; practical support with job applications; and

- providing a ‘half-way-house’ of employment opportunities through sheltered or voluntary employment and step-wise (re)introduction to the primary labour market at different stages of recovery.

## 7.9 Addendum

The interviews also sought to explore the extent to which living in urban or rural areas affected substance users’ experiences of work and their support needs. The majority of respondents lived in urban, built-up environments and only a small minority travelled from rural areas to the treatment service centres in urban areas, where the interviews were conducted and the respondents recruited.<sup>27</sup> Although the interviews highlighted some transportation problems that substance users encountered, most users were able to access support services in central locations, sometimes with the financial help of the service providers. The limited evidence that was available suggested that the extent of social isolation experienced by some substance users in urban and rural areas alike meant that for both groups there were few substantial differences in social networks. On the other hand, substance users with more extensive networks, including of drug suppliers, had been able to develop them either with the larger, urban location or across several villages in more rural places. Substance users in urban and rural locations also appeared to share similar experiences with respect to opportunities for obtaining employment.

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<sup>27</sup> Treatment service centre were based in larger populated areas. Outreach workers covered rural areas, from which they were able to help the researchers recruit a small number of substance users.

## 8 SUMMARY OF FINDINGS AND IMPLICATIONS FOR POLICY

### SUMMARY

- ❖ This chapter draws together the main findings of the research.
- ❖ The main policy implications include:
  - promoting close co-operation between treatment and employment service providers and, possibly, early joint intervention, including working with substance users' partners, family and friends;
  - co-ordinating the activities of treatment and employment service providers, including joint training of staff to provide a comprehensive understanding of substance users' personal, health and employment barriers;
  - timing intervention to include current as well as former substance users, where substance use is reasonably controlled; and
  - providing customised and flexible employment support services and a system of gradual re-entry of substance users to work.

This report has provided, (i) estimates of the number of drug and alcohol users in receipt of state benefits in Great Britain<sup>28</sup> and descriptions of their main characteristics, (ii) a review the national and international evidence-base of the support needs of and support programmes for substance users designed to help their (re-)integration into the labour market, and (iii) an account of treatment service providers' perceptions of substance users' barriers to work as well as users' personal experiences of work and obtaining work.

The principle aim of this report has been to scope the size of the problematic substance use among the population of benefit recipients and to explore the barriers to work this group might encounter. Also drawing on the findings of the literature review, the study sought to identify and present suggestions for the development of support services, which are designed to help substance users obtain or return to work, such as the Department for Work and Pensions' new initiative, *progress2work*, which specifically targets drug users. This final chapter summarises first, the key findings of this study before exploring their implications for policy-making.

### 8.1 Estimates of the number of substance users

The General Household Survey of Great Britain (GHS) and the British Crime Survey (BCS) were used for estimating the size of the alcohol- and drug-using population of benefit

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<sup>28</sup> Since the British Crime Survey, in fact, only covers England and Wales, drug user and drug and alcohol user estimates apply only to the two regions.

claimants or likely benefit claimants. Both surveys aim to record drug or alcohol use among the population living in private households and neither survey is specifically equipped to identify and study addicted substance users. The definitions of substance users adapted in this study reflected this (Table 8.1). Alcohol and drug users in this study were defined as (a) heavy consumers of alcohol or (b) recent users of Class A drugs.<sup>29</sup> In neither instance, however, should it be assumed that the user groups included only individuals addicted to drugs or alcohol. However, efforts were made to reduce the likely inclusion of casual, recreational and largely non-addicted users of substances. These included adopting a high benchmark of regular alcohol consumption ('heavy' or problematic drinking) and a focus on drugs known to be highly addictive.

A separate estimate of heavily drinking drug users, based on BCS data, was also produced. However, because case numbers would otherwise have been too small for analysis, this estimate included users of Class B drugs (cannabis and amphetamines) as well as of Class A drugs.

**Table 8.1**      **Definitions of alcohol and drug use**

<b>Alcohol use</b>	<b>Drug use/drug and alcohol use</b>
Men: 50 or more units of alcohol per week	Consumption in last month of one or more <i>Class A drugs</i> : cocaine, crack, ecstasy, heroin, LSD, Methadone
Women: 35 or more units of alcohol per week	Consumption in last month of one or more <i>Class A core drugs</i> : cocaine, crack, heroin, LSD  50 (men) or 35 (women) or more units of alcohol consumed on average in a week when respondents drink (drug and alcohol users only)

The study's principal focus was on substance users who were also social security benefit claimants. Only the GHS lends itself to identifying this group and analysis was undertaken for two specific sub-groups: claimants of Jobseeker's Allowance or Income Support and

<sup>29</sup> For definitions of Class A and Class B drugs, see Chapter 2.

claimants of sickness or disability benefits (SDB) (Table 8.2). The BCS does not identify whether survey participants receive state benefits. An alternative definition of unemployed or inactive individuals, who were deemed likely to be benefit claimants was, therefore, employed in the study of drug-users. In both cases, the populations of interest were of working age (aged 18-59/64 years). As a result of the different claimant definitions, the estimates of drug users and of alcohol users are not directly comparable. The estimates are, nevertheless, likely partially to overlap, as some drug users were also problematic alcohol users, and vice versa.

**Table 8.2 Definitions of claimant populations**

<b>Alcohol users</b>	<b>Drug users/drug and alcohol users</b>
(i) recipients of JSA or IS (ii) recipients of sickness or disability benefits* (IB, SDA, DLA, SSP, IIDB)	Individuals aged 18-59/64 who are: <ul style="list-style-type: none"> <li>• looking for paid work or a government training scheme;</li> <li>• intend to look for work but prevented by temporary sickness or injury;</li> <li>• permanently unable to work;</li> <li>• retired from paid work; or</li> <li>• looking after the home or family.</li> </ul>

Note: IB - Incapacity Benefit; SDA - Severe Disablement Allowance; DLA - Disability Living Allowance (care and mobility component); SSP - Statutory Sick Pay; IIDB - Industrial Injuries Disablement Benefit. \* Sickness and Disability Benefits - SDB.

Mean estimates of the number of drugs or alcohol users were:

- approx. 120,000 JSA or IS recipients; and
- approx. 150,000 SDB recipients who were heavy drinkers (both in 1998);
- approx. 39,500 potential benefit claimants used Class A drugs; including
- approx. 27,500 using Class A core drugs; and
- approx. 51,000 potential benefit claimants used Class A or Class B drugs and also drank heavily<sup>30</sup> (all three in 2000).

<sup>30</sup> About 15 per cent (or an estimated 7,650) of the potential benefit claimants who used drugs and alcohol in fact used Class A drugs.

These estimates were derived from very small case numbers identified in the respective surveys and are, therefore, not particularly robust. Range estimates, using 95 per cent confidence intervals are shown in Table 8.3 below.

All estimates also referred to individuals living in private households and did not capture other problematic users who might be living in communal establishments, such as hostels, treatment centres or prisons.

A further estimate recently produced in a report to the Home Office (Godfrey et al., 2002) concluded that, in 2000, some 271,005 opiate and cocaine users were in receipt of some type of state benefit. This estimate was derived from extrapolating the annual count of registered drug users entering treatment, contained in the Regional Drug Misuse Database (RDMD), to include other drug users not in treatment. Based on findings from the National Treatment Outcome Study, approximately 80 per cent of this total were thought to be out of work and, therefore, likely to be in receipt of one or more state benefits. The resulting estimate of opiate and cocaine users on benefit (271,005) was substantially higher than that produced by the present study (approx. 27,000). The discrepancy might have been due to a number of reasons, including different population basis, as the estimate by Godfrey et al. was likely to capture many individuals who did not or no longer live in private households. None of these would have been captured by the two surveys used to derive the estimate in the present study. Current or recent substance users are also known to deny their problematic use of drugs or alcohol or to refuse participation in household surveys. The BCS and the GHS are, therefore, likely to under-record problematic (as opposed to recreational) substance use.

For these reasons, all estimates produced for this study should be considered low-bound estimate and referring only to individuals living in private households. In the case of drug use, where additional estimates exist, the present estimate should be seen as complementary, although in part overlapping. The true number of problematic drug users potentially claiming state benefits is, therefore, likely to be closer to the number estimated by Godfrey et al. (270,000) or, indeed, higher.

**Table 8.3**      **Estimates of drug and alcohol users in Britain**

	<b>Alcohol users</b>		<b>Drug users</b>		<b>Drug and alcohol users</b>
	<b>JSA/IS</b>	<b>SDB claimants</b>	<b>Potential claimants – Class A</b>	<b>Potential claimants – Class A core</b>	<b>Potential claimants – Class A or B</b>
Percentage estimate (95% confidence interval)	3.0-6.4	3.8-6.8	0.6-1.4	0.4-1.0	0.9-1.7
Population estimate (mean)	120,000	150,000	39,500	27,500	51,000
Population estimate (95% confidence interval)	78,000-170,000	110,000-195,000	24,000-54,500	15,000-40,000	34,000-68,500

## **8.2 The characteristics of drug and alcohol users**

National surveys have found heavy drinkers and users of addictive drugs to include a disproportionate number of unemployed or economically inactive individuals (Singleton et al., 2001; Walker et al., 2001). However, socio-economic differences between substance users and non-users are rarely substantial and persistent, and are often explained by socio-demographic variables, such as age. The present study found that the prevalence of substance use among actual or potential benefit claimants living in private households was similar to that in the wider working-age population.

Within the same group of actual or potential benefit claimants, substance users, nevertheless, differed from non-users on a small number of socio-demographic and socio-economic characteristics (Table 8.4). With the exception of those receiving SDB, all substance users included a disproportionate number of men and young people, aged 18 to 24 or 18 to 34. Alcohol users also were significantly more likely to live in the North of England or in Scotland than elsewhere in Britain (JSA/IS recipients) or to live in households with two or more unrelated members and to be smokers (SDB claimants).

Drug or drug and alcohol users among potential benefit claimants often lived alone and/or were single and had resided at their address for only comparatively short periods of time. Drug users potentially claiming benefits tended to live in either the North or the South of England, while those using both drugs and alcohol frequently lived in neighbourhoods they described as places where people had little contact with each other.

Age, in particular, accounted for a number of other differences between substance users and non-users, including the formers' lower household income. However, other indicators of disadvantage or deprivation, which included the ownership of durable goods and the quality of accommodation (measured as bedroom standard), revealed no substantial differences between substance users and others. Nor did educational achievement differ significantly and consistently between substance users and non-users.



**Table 8.4      Characteristics of drug and alcohol users in Britain – summary of findings of logistic regression (comparison to non-users)**

Alcohol users		Drug users (Class A core)	Drug and alcohol users
JSA/IS	Sickness and disability benefit claimants	Potential claimants	Potential claimants
Male Age 18-24	Male 'Other' household type (multiple, unrelated members)	Male Age 18-24	Male 18-34
Living in North of England, Scotland	Current cigarette smokers	Single, never married Private rented sector Years at address < 2 years Living in North and South of England	One person household Years at address < 1 year Neighbourhood 'place where people go their own way'

Data from the BCS indicated a greater propensity of drug users to have been arrested, called before a court or been in contact with the Probation Service. This was also true for potential claimants who used drugs and alcohol. Together with their propensity to live in deprived environments and neighbourhoods 'where people go their own way', their encounters with the police and the criminal justice system marked this group as socially the most vulnerable of the three drug and/or alcohol user groups.

### **8.3      The effects of substance use**

The qualitative interviews with support organisations and drug and alcohol users highlighted a number of specific problems that substance users faced, which affected, and generally impeded, their ability to obtain or maintain regular employment (Table 9.5). **Physical and health problems** resulted from the immediate effects of substance use (addiction) and the use of substitute drugs or medication. Typical reactions to substance use or the use of medication

included the experience of withdrawal symptoms, including physical pain, or general tiredness and, in the case of drug users, of ‘gouching’, when users appear to be dropping to sleep.

Besides these physical effects of substance use, users often also suffered from psychological, emotional and associated personal problems, which either accompanied or resulted from their substance use, such as social isolation, or might have been one of its triggers. Psychological-emotional problems were, in particular, reported by alcohol users, who frequently related their increased consumption of alcohol to events, such as family death and relationship breakdown. In other instances, problematic alcohol consumption had led to the breakdown of friendships and family relationships rather than having been caused by it.

The experience of psychological-emotional problems can coincide with more serious mental health problems and distorted perceptions of reality including, in extreme cases, paranoia, anxiety and denial of substance dependency, and a generally low ability to manage stressful situations. These were reported to impede substance users’ ability to maintain personal relationships and collegial relationships at work, and have complicated interactions between substance users and support service providers, including Jobcentre staff.

Frequently related to these health and mental health problems are **practical constraints**, ranging from low motivation or confidence to poor focus and lack in concentration. All four impede the pursuance of regular activities, including work, as does any continued substance dependency and the need to ‘feed the habit’, which can dominate a substance users’ daily pattern of activities.

The erosion of support networks and living in social and physical environments typified by high levels of unemployment and, possibly, high levels of drug use and trafficking, further add to the substance users’ barriers to curtailing the use of drugs or alcohol. They also restrict users’ access to information about employment opportunities. Financial problems, including debt, can impede incentives to seeking employment because of fear of being financially worse off during and after the transition from ‘welfare to work’.

**Table 8.5 Effects of substance use on health, work and employment**

<b>Physical and health effects of substance use impacting on ability to work</b>	<b>Practical constraints impacting on ability to work/find work</b>	<b>Employment-related problems</b>	<b>Issues relating to treatment &amp; employment service provision</b>
Withdrawal symptoms, pain; tiredness; 'gouching'; medication	Low or fluctuating motivation/confidence/focus or concentration; activities dominated by continued substance dependency	Low educational and vocational skills/qualifications*; literacy and numeracy problems	Reluctance of substance users to come forward, esp. (women) alcohol users
Psychological-emotional and associated personal problems, esp. among alcohol users	Erosion of support/family/job information network; threatened or factual break-up of partnerships	Gaps in CV/employment histories	Addiction remains undiscovered
Paranoia, anxiety; self-denial; low stress management ability	Adverse social/physical environment (milieu); financial problems/reduced work incentives	Disclosure of health problems (or hiding addiction from employers); wish for anonymity; fear or experience of stigmatisation	Lack of trust in government services
	Need to collect prescriptions/take drug/alcohol/medication at work		

Note: \* typical for population at risk of unemployment.

In employment, the need to continue regular medication, involving temporarily leaving the workplace, is a further frequently encountered constraint on maintaining regular work or regular presence at work.

Other **employment-related problems**, which substance users face who are potential or actual benefit claimants, include low levels of educational and vocational qualifications or problems

with literacy and numeracy. These problems are however not peculiar to substance users on benefit, but shared with benefit recipients in general.

Drug and alcohol users interviewed for this study also found that their substance use and consequent health problems and erratic work patterns had left them with substantial gaps in their employment histories. These showed as ‘blank spaces’ on their curriculum vitae (CV) and, ultimately, on job applications, reducing their chances of obtaining employment in competition with co-applicants with more complete work histories. Again, this experience was not unique to substance users, but shared by others at the margins of the labour market, including many ex-offenders (Metcalf et al., 2001). As the BCS analysis suggested, drug users frequently had a criminal record.

An employment-related problem peculiar to substance users, at least in terms of its repercussions for obtaining employment, was the need to disclose on job application forms any health problems, including addictions, and criminal records. For most occupations, admitting an addiction problem or a criminal record bears a high risk of exclusion from recruitment for employment. This is because employers feel they cannot trust the applicant and fear employing a former or stabilised substance user might adversely affect relationships in the workplace.

Health problems and practical constraints can directly or indirectly impact of substance users’ **attitudes and behaviour towards employment service providers** and are, thus, likely to affect the effectiveness of service interventions. The effects include a reluctance of substance users to admit their dependence and to seek help. This is particularly the case for problematic alcohol users and, amongst them, women, but independent studies have also estimated that it can take drug users, on average, five years before they seek treatment. In other words, addiction frequently remains undiscovered. Added to this is a high level of mistrust towards government service providers uncovered by the interviews with substance users and confirmed in interviews with treatment organisations.

### **8.3.1 Drug users versus alcohol users**

Most problems faced by substance users and summarised above are shared by alcohol and drug users alike. However, psychological-emotional problems, occurring alongside the loss of confidence and self-motivation, can be particularly prevalent among alcohol users. At the

same time, alcohol users may be able to hide their addiction and maintain a regular working life more frequently than drug users can. As a result, their work histories may be more complete, yet still punctuated, than those of drug users. Both groups, however, face the problem of having to disclose and explain their health problems in the job application process.

## **8.4 Policy implications**

The information about the effects of substance use on users' health, work and employment, and the suggestions made by users and their support organisations provide indications of the range of support services that substance users require if they are to be helped (back) into work. Users' and organisations' accounts also suggest models for the delivery of these services. These issues will be discussed in the next sections covering four separate headings:

- the development of a broad framework for action;
- the co-ordination of treatment and employment services;
- the timing of interventions; and
- the customisation of employment services.

### **8.4.1 Developing a framework for action**

Substance users and support organisations repeatedly stressed that efforts to integrate or re-integrate (former) substance users into the labour market would take time and require patience and the careful management of expectations on the part of both the substance user and the service provider. Substance users' entry or return to work would take considerably longer than is typically the case for other groups of unemployed people. The failure rate of interventions might also be higher.

Support organisations suggested that employment support services take into account the added problems faced by substance users, and leave sufficient room for clients to pursue activities other than job-search or job preparation. This would help them deal with and sort out their personal and familial problems. Service providers may also be advised to offer a system of gradual (re-)attachment to the labour market. As will be further developed below, this may best be achieved in close co-operation with addiction treatment providers and may be facilitated by **early joint intervention**.

Substance users acknowledged the potentially beneficial effects of regular work, which can offer a daily pattern, a distraction from substance use and an opportunity to re-discover one's confidence. Employment services can, thus, play an important role in the **rehabilitation** of substance users. Given substance users' often poor social and job information network, employment services, such as *progress2work*, would benefit from performing a wider social function by offering (former) substance users a stable contact and reference point as well as a job preparation and placement service. This anchor point, as will be explained below, should be provided alongside that of treatment services and offered through case management.

Employment service providers might consider focussing on working with former substance users. However, the face-to-face interviews with substance users suggest that at least some users, mainly problematic drinkers, might not aim towards ceasing all substance use, but prefer to reduce or manage better their intake of the substance. This study could not judge whether this is a realistic objective on the part of the substance user. The finding nevertheless suggests that support systems might well be required to accommodate current as well as former substance users, to which must be added former users who relapse.

In the face-to-face interviews, substance users repeatedly deplored the breakdown of family relationships and losing touch with friends and neighbours. Such social networks are known to contribute to the psychological stability of substance users. For this reason, the role of treatment and employment services might also involve **working with the partner, family and with the friends** of substance users, to help to sustain stability in the substance users' home and outside his or her dealings with the service agencies.

The barriers to work faced by substance users, however, extend beyond the personal-psychological and the familial to include poor housing and living in disadvantaged environments. Both can add to the risk of continued substance use. Substance users also face financial debt, which can produce substantial disincentives to work and encourage involvement in illicit activities, such as dealing in drugs. Improving the milieu, in which substance users, in particular those using both drugs and alcohol, live - for instance, through relocation - and pro-actively assisting users in overcoming their financial problems, may be necessary **supplementary roles** for treatment and/or employment service providers.

National and international experience suggests the **personal advisor** model is best suited to fulfilling these roles and to achieving related programme tasks and objectives.

#### **8.4.2 Co-ordinating activities**

Initiatives for substance users, reviewed in Chapter 3, have highlighted the importance of the successful co-ordination of treatment and employment services. Employment service providers' understanding of treatment issues is as important as treatment service providers' understanding of employment and labour market issues. Comprehensive and, perhaps, joint training of treatment and employment service staff has been shown to be essential, not only for facilitating substance users' seamless transition between services, but also to add to the mutual understanding of the respective roles, responsibilities and capabilities of service providers.

Employment service staff will need to be made aware of **drug users' special needs** and their psychological and emotional problems, which may interfere with their interacting with the service providers. Managing the expectations of substance users, in particular, the potentially distorted self-assessment of their ability to obtain and retain employment, will be important, required skills of employment service providers when dealing with (former) substance users.

The co-ordination and, possibly, integration of treatment and employment services might also help to build **trust** and understanding between employment service providers and substance users. Many substance users interviewed in the course of this study expressed a marked mistrust towards Jobcentres and their staff's ability to provide access to employment, in particular, from the substance users' point of view, to 'meaningful' employment. In contrast, substance users, typically, trusted their treatment service providers. Combining the two services might not only help the mutual understanding between service providers, but also could be used to help to allay some of the fears and suspicions harboured by substance users towards Jobcentres and their staff.

#### **8.4.3 Timing effective intervention**

The frequently long process of substance users' (re-)integration into the labour market and the benefits of close co-operation between treatment and employment service providers make a strong case for early intervention, when substance users are still in treatment.

However, not all substance users will be in treatment, although the proportion who are is thought to have increased in recent years and resources made available under the government's anti-drug initiative is expected to further enhance access to treatment services (Home Office, 2002). Although not all substance users may need or want treatment, employment services providers would benefit from being able to refer users to treatment, where their own support services should prove insufficient.

Other substance users will, typically, be referred to employment service providers by treatment service providers, and other referral agencies such as the Probation Service. The point at which this happens, and at which employment services can most effectively be engaged is likely to vary with individual substance users. As noted above, not all substance users will have completely stopped their substance misuse, while others will receive substitute drugs (methadone) or drugs to alleviate the symptoms of substance use (Subutex). Moreover, many former substance users relapse, making drawing a definite line between former and current users difficult.

Although the provision of employment services would benefit from substance users having completely overcome their addiction, in reality, service might also be offered to current users. The present study interviewed a small number of current as well as former users who were undertaking voluntary or regular work. Continued substance use should, therefore, not be seen as a barrier to receiving employment services or, in fact, to working.

The study found no single criteria to describe when substance users might be ready to receive employment services. Employment service projects, nationally and internationally, have required a certain level of motivation (towards changing one's habits, pattern of living) on the part of the substance user and a certain amount of stabilisation of substance use before allowing (former) users onto their programmes.

For drug users, stabilisation, typically, involves the sole use of substitute drugs. A critical aspect of the use of substitute drugs on prescription is that it allows users to free themselves from the need to acquire illicit drugs, which can take over and dominate their daily activities and interfere with a return to a more regular lifestyle, including work. The face-to-face interviews with substance users suggested that users, who continue using the main drug (e.g. heroin) alongside the substitute drug, might not be able to sustain efforts to readjust their



lives. Moreover, the continued use of illicit drugs may force users to return to a social environment not conducive to rehabilitation.

Alcohol users, in contrast, may be less likely to be exposed to adverse social environments, but their alcohol use can, frequently, coincide with, indeed be caused by, psychologically and emotionally harmful events. In fact, the face-to-face interviews with alcohol users suggested that, in many instances, it was only when these events were identified that problematic alcohol use was also discovered. Before alcohol users can be expected to consider taking up employment, they will likely have received assistance in dealing with their personally damaging experiences.

#### **8.4.4 Customising effective intervention**

National and international employment service providers dealing with (former) substance users offered services, which could be described as either basic, intermediate/specialist or advanced (Table 8.6). In addition, and sometimes in co-operation with treatment service providers, they offered more general life skills training, which may be geared specifically towards facilitating (re-)employment. The latter included exercises designed to improve personal and time management skills (including hygiene), personal communication, and literacy and numeracy skills; to build up confidence; and to help users to regain a better and more realistic perception of themselves, their abilities and of others around them. Based on the evidence from interviews with substance users and their support organisations, stress or anger management training has been added to this list of services preparing substance users for employment.

Basic employment services included CV writing, developing interview skills and training in job-search techniques. Intermediate or specialist services included help with budgeting skills, the provision of legal and benefit advice, and auxiliary services, such as childcare and help with transport. Advanced services, finally, involved arranging short-term and long-term work placements; training and retraining courses, some of which allowed participants to ‘sample’ and, if necessary, switch between courses; direct liaison with employers, which could include attending job interviews with clients; and, exceptionally, post-employment services (see also Kellard et al., 2002).

**Table 8.6 Integrated employment and treatment services**

<b>Life Skills</b>	<b>Employment Services</b>		
	<b>Basic</b>	<b>Intermediate/Specialist</b>	<b>Advanced</b>
Life skills (time and personal management; self-presentation; focus) & personal communication; literacy and numeracy	CV writing	Budgeting skills	Work placements (short-term and long-term)
Confidence-building/individual or group counselling/stress management	Interview skills	Legal and benefit advice	Re-training (incl. 'samplers')
Self-perceptions/reality check & reconciliation	Job-search training	Auxiliary services: childcare, transport	Direct employer approach and liaison
Stress/anger management			Post-employment services

The national and international examples of employment services (see Chapter 3) were predominantly of sequential, but flexible programmes of assistance. Some of these allowed participants to re-consider and alter their choices and to move between courses of different duration and type. However, participants still needed to 'graduate' from introductory and less challenging to more demanding programmes, such as regulated training or re-training programmes.

Interviews with substance users and their support organisations suggested that a progression from less demanding to increasingly more demanding work placements and, ultimately, regular employment, might be best suited for re-introducing substance users to employment. Substance users and their organisations described themselves, and substance users in general, as highly vulnerable to stress-inducing situations. It was, amongst others, for this reason that some of the substance users interviewed for this study, who had taken up work, had chosen voluntary organisations, which they considered to offer less stressful and more 'understanding' work environments. A system of gradual (re-)introduction to work, with

entry-points at different levels, thus, appears to be an essential pre-requisite for a successful employment service programme.

Interview and case study evidence suggests that such a programme ought to involve the close co-operation of employers, who are aware that they are dealing with a group of individual with special support needs. Developing the ideas expressed by substance users and support workers, the employment service programme might, for instance, centre on a network of ‘friendly employers’ from the private, public and voluntary sectors, who accept substance users into their workforce on a trial or temporary basis, if not for open-ended or permanent employment. The process of integration would involve gradually increasing the job demands that substance users face, ranging from building up the hours worked and the duration of the placement to increasing the complexity of tasks and the level of responsibility on the job; if necessary, to do so, clients would move between employers. The programme would also involve basic job preparation courses, job (re)training and, if appropriate, assistance with improving or ‘regenerating’ social skills. Financial support would also need to be provided.

Substance users may be encouraged to accept irregular employment, or employment outside the primary labour market, if advancement opportunities, similar to the ‘job ladder’ model pioneered in the USA (Kellard et al., 2002) can be developed **by** and **between** employers. Employment service providers would work with employers and substance users towards the early identification and alleviation of any problems arising in the workplace or, indeed, the substance user’s home. A critical aspect of this model is that it would allow substance users not only to develop and regain an affinity to working, but also would help them to re-build their CV, which should later help them obtain regular employment.

Substance users might yet dislike the fact that under such a model their (former) addiction would inevitably be disclosed to employers, but a selective ‘waiver’ system, as suggested by the evaluators of the *progress2work* pilots (York Consulting, 2002), could be used to introduce substance users to a limited number of employers. The national and international experience indicates that, without the collaboration of at least some employers, employment service programmes have a much reduced chance of succeeding.

## REFERENCES

Advisory Council (1998), Drug Misuse and the Environment, A report by the Advisory Council on the Misuse of Drugs. London: The Stationery Office.

Alcohol Concern (2001), The State of the Nation. Britain's True Alcohol Bill. Downloaded from Alcohol Concern's website <http://www.alcoholconcern.org.uk/>

Alcohol Concern (2002), Your Very Good Health? Downloaded from Alcohol Concern's website <http://www.alcoholconcern.org.uk>

Atkinson, J., Lee D., Dayton-Shotts C., French C. (2001), 'Self-perceived job skills and employment barriers among non-drug using and chronic drug using welfare-to-work participants', *Journal of Drug Issues*, 31(3), 747-756.

Becker and Duffy (2002), Women Drug Users and Drugs Service Provision: service level responses to engagement and retention. Home Office DPAS Briefing Paper 17. London: Home Office.

Burrow, R. (1997), Contemporary Patterns of Residential Mobility in Relation to Social Housing in England. Centre for Housing Policy Research Report. York: Centre for Housing Policy.

Cabinet Office (1998), Tackling Drugs to Build a Better Britain. London: The Stationery Office.

CASA (2001), CASAWORKS for Families: A Promising Approach to Welfare Reform and Substance-Abusing Women. A CASA White Paper. Columbia, USA: The National Center on Addiction and Substance Abuse (Columbia University).

CESI (2002), Barriers to work for drug misusers. Working Brief. Downloaded from: [www.cesi.org.uk](http://www.cesi.org.uk)

Corkery, J. (1997), Statistics of Drug Addicts Notified to the Home Office, United Kingdom, 1996. Home Office Statistical Bulletin 22/97. London: Home Office.

Corkery, J. (2002), Drug seizure and offender statistics, United Kingdom, 2000, Supplementary tables. London: Home Office.

Craig, G. and Manthorpe, J. (2000), Fresh Fields: Rural social care – research, policy and practice agendas. York: York Publishing Services.

Davies, J.B., Wright L.B., Hutcheson, G.D., Henderson, M.M., Hepburn, A., McPherson, A. and Fox, A. (1997), Alcohol in the Workplace: results of an empirical study. HSE Contract Research Report 149/1997. Sudbury: HSE Books.

DoH (1995), Sensible Drinking: the report of an inter-departmental group. London: Department of Health.

DoH (2001a) Statistics from the Regional Drug Misuse Databases on drug misusers in treatment in England, 2000/01. London: Department of Health. Downloaded as [www.doh.gov.uk/public/sb0133.pdf](http://www.doh.gov.uk/public/sb0133.pdf)

DoH (2001b) Statistics from the Regional Drug Misuse Databases for six months ending September 2000. London: Department of Health.

Drogenberatung e.V. Bielefeld (2001), Drogenabhängige in Arbeit – November 1998-Dezember 2000. Bielefeld, Germany: Drogenberatung e.V.

DrugScope (2001), Annual Report on the UK Drug Situation 2001. London: DrugScope.

DSS (1999), Cross Benefit Analysis, Quarterly bulletin on the population of working age on key benefits. London: Department of Social Security.

Effective Interventions Unit (2001), Moving On: Education, training and employment for recovering drug users. Research Review downloaded from [www.drugmisuse.isdscotland.org/goodpractice/effectiveunit.htm](http://www.drugmisuse.isdscotland.org/goodpractice/effectiveunit.htm)

Fraser, F. (2002) Drug Misuse in Scotland: Findings from the 2000 Scottish Crime Survey. Scottish Executive Central Research Unit. Edinburgh: The Stationery Office Bookshop.

Fleischer, W., Dressner, J., Herzog, N., Hong, A. (2000), Keeping the Door Open: a Guide for Employment Programs Serving People with Drug Problems. New York: Corporation For Supportive Housing.

Frischer, M., Hickman, M., Kraus, L., Mariani F. and Wiessing, L. (2001), A Comparison of Different Methods for Estimating the Prevalence of Problematic Drug Misuse in Great Britain, *Addiction*, 96, 12265-1476.

Glasgow Street Intervention Group website address [www.gsig.org.uk/surveys/bte.html](http://www.gsig.org.uk/surveys/bte.html)

Godfrey, C., Eaton, G., McDougall, C., and Culyer, A. (2002) The economic and social costs of Class A drug use in England and Wales, 2000. Home Office Research Study 249. London: Home Office.

Gordon, D., Adelman, L., Ashworth, K., Bradshaw, J., Levitas, R., Middleton, S., Pantazis, C., Patsios, D., Payne, S., Townsend, P. and Williams, J. (2000), Poverty and Social Exclusion in Britain. York: Joseph Rowntree Foundation.

Gossop, M., Marsden, J. and Stewart, D. (1998) NTORS at one year. The National Treatment Outcome Research Study. Changes in Substance Use, Health and Criminal Behaviour one Year after Intake. Wetherby: Department of Health.

Hannan, C. (1999), Beyond networks: 'social cohesion' and unemployment exit rates. Working papers of the ESRC Research Centre on Micro-social Change. Paper 99-7. Colchester: University of Essex.

Home Office (2002) Updated Drug Strategy 2002. London: Home Office.

Hughes, D. and Westwood, S. (2001), Evaluation of Coventry & Warwickshire Substance Misuse Initiative Employment Support Project Centre for Guidance Studies. Derby: University of Derby (in partnership with Careers Consortium).

JRF (2000), Drugs – dilemmas, choices and the law. York: Joseph Rowntree Foundation.

Kellard, K., Adelman, L., Cebulla, A., and Heaver, C. (2002) From Job Seekers to Job Keepers: Job retention, advancement and the role of in-work support programmes, Department for Work and Pensions Research Report 170. Leeds: Corporate Document Services.

Kirby, G., Pavetti, L., Kauff, J., and Tapogna, J. (1999), Integrating Alcohol and Drug Treatment into a Work-Orientated Welfare Program: Lessons From Oregon. Princeton, NJ: Mathematica Policy Research Inc.

Klee, H., Mclean, I. and Yavorsky, C. (2002), Employing Drug Users: Individual and systemic barriers to rehabilitation. York: York Publishing Services.

Lawless, M. and Cox, G. (2000), From Residential Drug Treatment To Employment. Final Report. Dublin: The Merchant Quay Project.

LDRP Ltd. in association with Policy Research Institute and David Smart Consultancy Services (2002), New Futures Fund Initiative Evaluation of Management and Operation. Final Report. Volume I. London: LDRP.

Liddle, M., Feloy, M. and Solanki, AR. (2000), Offending and Employment in Greater London. A research report by NACRO on behalf of the London Offender Employment Network. London: NACRO.

Meier, P., (n.d) Opportunities for Change. Barriers to the utilisation of education, training and employment provision for people with drug problems in Leicester, Leicestershire and Rutland. Manchester: Drugs Misuse Research Unit, University of Manchester.

Metcalf, H, Anderson, T., and Rolfe, H. (2001) Barriers to employment for offenders and ex-offenders. Department for Work and Pensions Research Report No. 155. Leeds: Corporate Document Services.

Morgenstern, J., Riordan, A., McCrady, B., Blanchard, K., McVeigh, K., and Irwin, T. Barriers to Employability among Women on TANF with a Substance Abuse Problem National Center on Addiction and Substance Abuse at Columbia University (CASA) In press. Sent by e-mail correspondence 19<sup>th</sup> August 2002.

Neale, J. (1998), 'Drug Users aren't Working' DrugLink, March/April, 21-22.

New Futures Fund Initiative Summary Paper (2000), Barriers to Employment, Education and Training Facing NFFI Clients. Downloaded from <http://www.scottish-enterprise.com/skills/personal/futures/summarypaper.pdf> on 6th September 2002.

Purdon, S., Lessof, C., Woodfield K. and Bryson, C. (2001) Research Methods for Policy Evaluation. Department for Work and Pensions Research Working Paper No.2. London: Department for Work and Pensions.

Ramsay, M., Baker, P., Goulden, C., Sharp, C. and Sondhi, A. (2001), Drug Misuse Declared in 2000: Results from the British Crime Survey. London: Home Office.

Singleton, N., Bumpstead, R., O'Brien, M., Lee, A. and Meltzer, H. (2001), Psychiatric Morbidity among Adults Living in Private Households, 2000. London: The Stationery Office.

Singleton, N., Lee, A. and Meltzer, H. (2002), Psychiatric Morbidity Among Adults Living in Private Households, 2000: Technical Report. London: The Stationery Office.

SEU (2002), Reducing re-offending by ex-prisoners. London: Social Exclusion Unit. Downloaded from [www.socialexclusionunit.gov.uk](http://www.socialexclusionunit.gov.uk)

Sutton, L., Cebulla, A., Heaver, C., and Smith, N. (2004) Drug and Alcohol Use as Barriers to Employment. Literature Review. DWP Research Report No. W193a. Sheffield: Department for Work and Pensions.

Treatment Research Institute (2001), Final Evaluation Report. CASAWORKS for Families Pilot Demonstration. Mimeo. Philadelphia: Treatment Research Institute.

UKDAC (n.d.) Tackling Drugs to Build a Better Britain, Second National Plan 2000/2001. The United Kingdom Anti-Drugs Co-ordinator. London: Cabinet Office.

UKDAC Annual Report (2000/01) A report on progress since 2000 of the Government's ten-year anti-drugs strategy. London: Cabinet Office.

Walker, A., Maher, J., Coulthard, M., Goddard E. and Thomas M. (2001), Living in Britain – Results from the 2000/01 General Household Survey. London: The Stationery Office.

White, C. and Lewis, J. with Keegan, J. and Ward, K. (1998) Following up the British Crime Survey 1996. A qualitative study. London: Social & Community Planning Research.

York Consulting (2002) progress2work – Good Practice Guide. Draft 1. London: Department for Work and Pensions (unpublished).

## ANNEX A

### *Analyses and weighting*

Throughout the analyses, the BCS data was weighted, but the GHS was not. The GHS only began using weights in 2000. With no weights available for the 1998 dataset, the merged GHS file also remained unweighted.

The BCS weights principally adjust for non-response and skewed sampling, but generate substantially increased weighted sample sizes. In some statistical analyses, this can produce significant but, possibly, unreliable results based on a small number of cases. The researchers, therefore, created a new weight to scale down the weighted sample size of the combined 1998 and 2000 BCS to match the number of cases in the new dataset. Internal weights, that corrected for non-response and sampling bias, remained unaffected by this procedure.

### *Logistic regression*

The logistic regression analyses of the BCS and GHS data helped isolate those variables that, in statistical terms, significantly distinguished drug and/or alcohol users among benefit recipients and jobseekers from those that did not use any substances. Regression models, thus, typically retain fewer variables in the final model than are initially available for analysis, as non-significant variable drop out and significant variables enter the model. It is possible for two or more variables to be independently statistically significant but, when entered simultaneously into the model, turn non-significant. A choice is then to be made as to which variable to retain in the model, or whether interaction variables, which combine individual variables, should be created.

Creating interaction variables was not an option available to this study, because of the small number of cases in each regression. Therefore, whenever it was necessary to select one variable over another, preference was given to demographic variables (age, gender) and socio-economic variables indicating employment skills and labour market attachment. Preference was also given to descriptive variables, such as gender or socio-economic status, while attitudinal variables were eliminated. It was, thus, hoped to contribute to the development of a basic model amenable to the (early) identification of drug- or alcohol-using



benefit recipients based on more readily observable facts. Where drug or alcohol users' attitudes differed markedly from those of others not using drugs or alcohol, these could still be gleaned from the descriptive tables in each chapter.

The results of the regression analyses are presented in separate tables, which show the *increased* odds of drug or alcohol users displaying certain characteristics when compared to non-users of drugs or alcohol displaying these characteristics. For simplicity only, the odds are described as the greater likelihood of drug/alcohol users displaying these characteristics.

Logistic regression requires for each variable or person characteristic to have one of its values selected as the comparator. In the case of gender, for instance, this would be either *male* or *female* gender. The odds describe the greater or lesser likelihood of drug users being male (female) rather than female (male). The regressions sought to emphasise difference. Hence, the comparator chosen throughout was the characteristic least likely to describe substance users when compared to the total benefit, or unemployed or inactive sample population. In the regression tables, this characteristic is indicated by the odds value 1.0.

The tables show only the variables, or person characteristics, that were found to be statistically significant, after all other non-significant variables had been removed from the analyses. Given the small number of cases involved in the analyses, the reported odds are better understood as indications of the direction of statistically significant differences rather than as precise measures of the magnitude of that difference.

## **TECHNICAL ANNEX B**

### Comparison of BSC, RDMD and TDM drug user population estimates and estimation procedure

	British Crime Survey (BCS)	Regional Drug Misuse Database (RDMD)	Treatment Demographic Method (TDM)	Treatment Coverage Method
User number	15,000-40,000 Class A core users <i>potentially claiming benefits</i> (mean: 27,500) (e)	56,225 problem opiate users (r)	281,125 problem opiate users (e)	337,350-506,025 problem opiate users (e)
Method of estimate	BCS responses to 'use in last month'	New entrants to treatment reported	RDMD multiplied by 5 to account for users not in treatment, assuming it takes five years for problem users to enter treatment	RDMD multiplied by 3, assuming new entrants to treatment represent 1/3 of all in treatment. Product is multiplied by 2 or 3, assuming either 50% or 33% of problem drug users are receiving treatment
Basis of assumption	-/-	-/-	Case study	Expert opinion, "limited observational studies" (Godfrey et al., 2002, p. 11)
Base population	'Potential benefit claimants' in sample of private households in England and Wales	Registered problem opiate users entering drug treatment services, England and Wales	Registered problem opiate users entering drug treatment services, England and Wales	Registered problem opiate users entering drug treatment services, England and Wales
Data collection period	Months 1-2: 51.5% Months 1-4: 77.3% Months 1-6: 99.2%	New entrants between Oct 1999 and Sept 2000	New entrants Oct 1999-Sept 2000 (plus multiplier to represent drug users who have yet to seek treatment)	New entrants Oct 1999-Sept 2000 (plus multiplier to represent drug users who have yet to seek treatment)
Age group covered	18-59/64	All (>10% aged 19 or younger or aged 65 or over)	All (>10% aged 19 or younger or aged 65 or over)	All (>10% aged 19 or younger or aged 65 or over)
Type of data collection	Self-reported use	Administrative data	Extrapolation of administrative data	Extrapolation of administrative data

User number (e = estimate; r = recorded)

