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Drug and alcohol proof of concept evaluation, and wider approaches to supporting clients with a dependency

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Summary

In spring 2013, the Department for Work and Pensions (DWP) commissioned IFF Research Ltd to conduct a qualitative evaluation of two Work Programme (WP) proof of concepts (PoC), intended to better support individuals with a drug and/or alcohol dependency into employment. This report describes research covering the following two areas:

- 'Recovery Works' (RW) ran from April 2013 to March 2015 and sought to test the impact of awarding Work Programme Providers (WPPs) an additional job outcome payment of £2,500[1] per participant achieving sustained employment; and
- 'Recovery and Employment' (R&E) ran from April 2013 to March 2016 and sought to test the impact of the DWP encouraging closer working relationships between WPPs and treatment providers.

In addition, in summer 2014 the DWP commissioned further research in non-proof of concept areas to obtain a broader, national picture of relationships between employment support and treatment providers; and of approaches to supporting clients with a dependency. This report therefore brings together the findings from these studies.

[1] This was increased to £5,000 per participant in one of the contract areas.

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Acknowledgements

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The Authors

Lorna Adams and Angus Tindle, Directors, headed up the IFF team responsible for evaluating the two drug and alcohol proof of concepts. Both have considerable experience in conducting evaluations and in researching employment support and welfare issues, particularly in relation to vulnerable client groups.

Anna Ponomarenko and Sarah Coburn, Research Managers, also work within IFF's Employment and Benefits team. Anna and Sarah are highly experienced qualitative researchers and have had key roles in the delivery and analysis of this study.

List of abbreviations

DWP	The Department for Work and Pensions
ESA	Employment and Support Allowance
IB	Incapacity Benefit
JSA	Jobseeker's Allowance
PHE	Public Health England
PoC	Proof of concept(s)
R&E	Recovery and Employment
RW	Recovery Works
WP	Work Programme
WPP	Work Programme Provider

Glossary of terms

Distance travelled	Clients with dependencies making progress towards overcoming their dependency and/or towards becoming ready for employment.
Job outcome	Job outcomes are where an individual enters sustained employment in a job of a minimum of 16 hours per week. For employment to be 'sustained', they must remain in employment for either 13 or 26 weeks (the number of weeks varies, according to the type of Work Programme participant).
Job outcome payment	This is a payment made from the DWP to a Work Programme Provider on achievement of sustained employment.
Specialist Treatment Provider	Specialist treatment provider deliver a package of support to clients relating to their drug or alcohol dependency specifically.
Stakeholders	Where we use the term 'stakeholders', we mean all of the organisation types involved in the study, i.e. Work Programme Providers, Treatment Providers, representatives of Local Authorities and of Public Health England.
Structured treatment	Structured drug and alcohol treatment consists of a comprehensive package of pharmacological and psychosocial interventions provided as part of key-working or case management. Structured treatment requires a comprehensive assessment of need, and is delivered according to a recovery care plan, which is regularly reviewed with the client. The plan sets out clear goals which include change to substance use, and how other client needs will be addressed in one or more of the following domains: physical health; psychological health; social well-being; and, when appropriate, criminal involvement and offending.
Three-way case conferencing	A discussion between the Work Programme Provider and the Support Provider regarding an individual client's circumstances, with the client also present.
The Treatment Outcomes Profile	This system uses 20 questions to measure progress in individuals being treated by drug and alcohol services.

Treatment Providers	Treatment Providers deliver support to clients relating to their drug or alcohol dependency, and can also provide a range of psychosocial and pharmacological interventions. (In this report, treatment and specialist treatment providers are at times referred to collectively as support providers).
TPR1	This is a referral and consent form sent to Treatment Providers by Jobcentre Plus or Work Programme Providers when a client is referred to structured treatment. The Treatment Provider returns the form to confirm that the client has attended their initial treatment appointment.

Executive summary

Introduction

In spring 2013, DWP commissioned IFF Research Ltd to conduct a qualitative evaluation of two Work Programme (WP) proof of concepts (PoC) intended to better support individuals with a drug and/or alcohol dependency into employment. This report describes research covering the following two areas:

- 'Recovery Works' (RW) ran from April 2013 to March 2015 and sought to test the impact of awarding Work Programme Providers (WPPs) an additional job outcome payment of £2,500[2] per participant achieving sustained employment; and
- 'Recovery and Employment' (R&E) ran from April 2013 to March 2016 and sought to test the impact of the DWP encouraging closer working relationships between WPPs and Support Providers (both Treatment Providers and Specialist Treatment Providers).

In addition, in summer 2014 the DWP commissioned further research in non-proof of concept areas to obtain a broader, national picture of relationships between employment support and treatment providers; and of approaches to supporting clients with a dependency.

This was achieved by interviewing a range of stakeholders – WPPs, Treatment Providers, Local Authorities and Public Health England (PHE) representatives.

This report brings together the findings from the studies.

The drug and alcohol proof of concept evaluation – Key findings

There were instances of the proof of concepts drawing attention to a 'hard to help' client group and creating scope for the WPPs and Support Providers to speak to each other about clients. Where increased communication about the client was adopted, it:

- Reduced clashes between WP activity and treatment and/or helped avoid directing clients towards inappropriate job roles (which could have jeopardised their recoveries).
- Allowed the WPP to reach out via the Treatment Provider to re-engage disengaged clients.

In addition, trialling co-location on WPP and Treatment Provider premises led to increased client referrals.

Overall levels of participant referrals to the PoC were low, and consequently job starts and sustained employment outcomes were also low. There were a number of lessons learnt from this:

- **Relationships between WPPs and Treatment Providers were critical in delivering the PoC**. It was challenging to initiate constructive working relationships when existing relationships were mixed, and on occasion did not exist at all, when the PoC were introduced.

[2] This was increased to £5,000 per participant in one of the contract areas.

- **Personal motivation and quality of relationships were more effective in driving PoC activity than financial incentives**. Incentives based on additional job outcome payments had made little difference, because achieving job outcomes with this client group was felt to be too remote for enhanced payments to be motivating. The R&E concept (encouraging closer working relationships) was therefore more effective in driving collaboration than the RW payment-based model.
- **Diagnostic interviews by Work Programme providers at the start of engagement are not always reliable in identifying dependency: building trust is critical to identifying dependency-related needs, while improved data sharing would assist with identification and remove the need for clients to broach a difficult subject**. Jobcentre Plus, WPPs and Treatment Providers tended not to systematically share this data when referring clients on to each other, and clients were initially reluctant to disclose their dependency to a stranger.
- **Where adopted, a 'default' referral model[3] led to increased referrals**.
- **Ideally WPPs would be better equipped to articulate the benefits of participation**. Once eligible participants were identified, it was difficult to 'sell' the idea of participating in the PoC because the intended benefits were too intangible/subtle.
- **There is a need for clarity around who is responsible for delivery**. WPP proof of concept leads and PHE representatives felt unclear about who was accountable for delivering the PoC and there was a perception that more high-profile leadership across Jobcentre Plus and Work Programme providers might have helped sustain joint working to deliver the proof of concepts.

Understanding wider approaches to supporting clients with a dependency – Key findings

Most stakeholders thought supporting clients with a drug/alcohol dependency into employment was a high priority for their organisation. There were very mixed views regarding whether this client group was being effectively supported into employment in practice: some felt these clients were being effectively supported; others did not.

Stakeholders cited the following as examples of 'what currently works':

- Early signposting of individual clients to other agencies, and formulating a tailored action plan for the individual.
- Use of one-to-one sessions to encourage client candour in a more private setting, as well as group work to promote client social skills and reduce isolation.
- Reducing clashes between employment support and dependency support – this is consistent with the proof of concept findings.
- Using volunteering and work experience to build client self-esteem, confidence and routines.

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[3] This involved clients identified as having a dependency being directed towards participating by default, with the ability to 'opt out', rather than being asked if they wished to 'opt in'.

There were mixed views regarding contact and collaboration between the employment support and dependency support sectors and most felt that barriers exist between the two organisations. Most Employment Support Providers attempted to track client dependency and most Treatment Providers attempted to track engagement with the employment support sector.

The ability of Employment Support Providers to tailor their support to clients with dependencies was perceived to be severely limited by a lack of client willingness to disclose their dependency – with stigma being the key perceived barrier.

Stakeholders suggested that future delivery should involve increased:

- **Use of co-location** of employment support and treatment services and increased ability to have specialist staff on site.
- **Recognition of distance travelled** in commissioning and performance monitoring of services.

Conclusions

The key conclusions that can be drawn from these two strands of research are:

- Close collaboration between providers in the employment support and dependency support sectors can bring positive outcomes for clients by helping to ensure that their preparation for employment does not adversely impact on their treatment/recovery from addiction and vice versa.
- Personal motivation and quality of relationships were more effective in driving joint-working between the employment support and specialist support sectors activity than financial incentives. Enhanced job outcome payments to WPPs alone (whether the ‘standard’ £2,500 or the increased £5,000 additional payments achieved on securing job outcomes) are not sufficiently motivating to achieve employment outcomes, or sustain joint-working between the employment support and specialist support sectors.
- Some of the challenges for employment and treatment services building up constructive working relationships with each other, and with clients, were attributed to staff turnover within Work Programme providers and dispersion of claimants across Work Coaches and WPP teams. Therefore there may be an argument for more widespread use of ‘expert’ teams within the WP to assist clients with Drug and Alcohol dependency issues. This would reduce the numbers of staff that need to be equipped with the skills to offer suitable support to these claimants.
- Encouraging clients to disclose their dependency is a challenge. Clearer guidance over the data protection issues around disclosing that clients have dependencies could prevent the need for clients to repeatedly disclose their situation.

About this report

This remainder of this report describes the findings from these two related strands of research; firstly detailing the findings of the evaluation of the two drug and alcohol PoC before exploring the findings of the research into the broader, national picture of approaches to supporting clients with a dependency across England.

1 Introduction

1.1 The drug and alcohol proof of concept evaluation

The negative consequences of addiction to drugs and alcohol are felt at every level of society – in terms of crime, and impacts on health services, children and families.

In 2010 the Government launched its five-year drugs strategy, setting out three strands of work that would address dependency issues in England through reducing demand, restricting supply and building recovery. The key role employment plays in supporting long-term recovery from dependency is recognised in the 'building recovery' strand of the strategy.

The Department for Work and Pensions (DWP) and Public Health England (PHE) acknowledge that Jobcentre Plus, Work Programme Providers (WPPs) and Treatment Providers have to work together to provide tailored support for individuals in treatment so they can fully recover from their dependency and find employment. Historically there have been relationships between Jobcentre Plus and PHE at local and regional levels. The introduction of the Work Programme (WP) in 2011 led the DWP and PHE officials to explore how to bring together WPPs and Treatment Providers. Two proof of concept (PoC) trials were designed to test ways of encouraging WPPs and Treatment Providers to work together for the mutual benefit of the people they were both supporting.

Making full use of 'black box' principles and making allowances for differences in local practice and structures, DWP gave providers the freedom to decide how they would work with the treatment sector, setting two overarching frameworks – one PoC would have no financial incentives whereas the other one would.

The use of the black box approach, and gathering of feedback from providers also meant there was more scope to make adjustments to the PoC as they progressed. Changes made included interventions from DWP officials to bring the two sets of providers together through regular meetings, and establishing regular contact with providers along account management principles. Adjustments were made to the amount of financial incentive offered and to the basis for referral to the trial. The evolution of the PoC was captured during the ongoing qualitative evaluation, and provided DWP with further evidence on ways of supporting those with addictions into employment.

1.1.1 Background

In spring 2013, the DWP commissioned IFF research to conduct this qualitative evaluation of 'Recovery Works' (RW) and 'Recovery and Employment' (R&E) – the two WP PoC intended to better support individuals with a drug and/or alcohol dependency back into work:

- RW sought to test the impact of awarding WPPs an additional job outcome payment of £2,500 per participant achieving sustained employment. This approach was trialled in

West Yorkshire and the East of England. Proof of concept referral was voluntary[4];

- R&E sought to test the impact of the DWP encouraging closer working relationships between WPPs and Support Providers within existing funding arrangements. This approach was trialled in Coventry and Warwickshire, and Birmingham. PoC referral was also voluntary.

Variations on these two core aims were also tested:

- an increased job outcome payment of £5,000 in one RW area;[5] and
- a 'default' referral approach in some areas delivering RW and R&E, whereby clients identified as having a dependency were directed towards participating by default, with the ability to 'opt out' rather than being asked if they wished to 'opt in'.[6]

Aside from this, the DWP gave WPPs the autonomy to decide how the proof of concepts would be delivered in their area. The underlying purpose was to explore how WPPs and Treatment Providers could be encouraged to better assist clients with drug/alcohol dependencies into employment.

Individuals were eligible to take part in the proof of concepts if they were WP participants who had been referred to the WP on or after 2 April 2013 and:

- were undertaking structured drug or alcohol treatment,[7] or
- had been in structured drug or alcohol treatment at any point during the six months prior to their referral to the WP, or
- were referred to structured treatment by the WPP and then confirmed to be receiving structured treatment by the Treatment Provider – using a TPR1 form[8].

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4 WPPs were given autonomy in deciding how to deliver the proof of concepts in their area – and this extended to how referral was introduced and explained to participants. WPPs reported that, once a dependency had been identified, conversations about the PoC might typically involve an advisor checking whether the individual is in treatment and, if not, offering to refer them to treatment. It also involved checking whether the dependency is a barrier to work and, if so, offering to refer them to other specialist support and explaining that taking part would allow sharing of their information between the WPP and the Treatment Provider to allow the WPP to be more flexible in how they work with the individual.

5 A higher additional outcome payment of £5,000 was offered to one of the two WPPs operating in the East of England (with the other WPP still being offered the original £2,500 additional payment for securing a job outcome).

6 Both of the two WPPs operating in West Yorkshire were asked to adopt a 'default' referral approach, while in the East of England, only one WPP was asked to adopt 'default' referral (the organisation still in receipt of the original £2,500 outcome payment).

7 See definition in the Glossary.

8 The TPR1 is a referral and consent form sent to Treatment Providers by Jobcentre Plus or WPPs when a client is referred to structured treatment. The Treatment Provider returns the form to confirm that the client has attended their initial treatment appointment.

To be eligible to participate, individuals also had to agree to data sharing between the WPP, the Treatment Provider, and the DWP.

This is a summary. The eligibility criteria are detailed in Appendix A.

1.1.2 Methodology

The evaluation consisted of qualitative, in-depth interviews, with:

- Stakeholders, comprising representatives of:
  - WPPs;
  - Treatment Providers (sometimes referred to as Specialist Treatment Providers or collectively as 'Support Providers');
  - Local authorities; and
  - Public Health England (referred to as 'PHE').
- Proof of concept participants, i.e. clients of WPPs who were identified as having a drug and/or alcohol dependency and who were referred to the PoC.

The evaluation fieldwork was divided into three stages:

- 14 initial exploratory interviews conducted with key stakeholders between 23 September and 22 October 2013, to identify any early implementation issues;
- 31 in-depth interviews conducted with stakeholders between 3 April and 21 May 2014 to explore how the proof of concepts were operating once they had 'bedded in';
- 23 in-depth interviews with stakeholders, from 13 February to 2 July 2015, and 21 in-depth interviews with proof of concept participants, from 11 September 2014 to 23 March 2015. These were to obtain a final picture of PoC delivery, from both the stakeholder and participant perspective.

A full breakdown of these interviews is provided in Appendix B.

1.2 Understanding wider approaches to supporting clients with a dependency

1.2.1 Background

To build on the findings from the PoC research, the DWP commissioned further research in non-proof of concept areas to obtain a broader, national picture of the ways in which individuals with drug/alcohol dependencies are currently supported towards or into employment. They also wanted to better understand the relationships between the WPPs and the treatment/specialist drug and alcohol dependency support sectors.

1.2.2 Methodology

Semi-structured qualitative interviews were used to capture stakeholder views.

A small-scale pilot was conducted in June 2015. The results from this were taken into account in the final questionnaire design.

Mainstage fieldwork was conducted between 22 June and 1 September 2015. In total, 73 interviews were conducted across England with:

- WPPs and sub-contractors (referred to throughout this chapter as 'Employment Support Providers');
- Treatment Providers and Specialist Treatment Providers (collectively referred to throughout this chapter as 'Support Providers');
- Public Health England (PHE); and
- Local authorities.

A full breakdown of these interviews is provided in Appendix C.

1.3 Structure of the report

The remainder of this report is structured as follows:

- Chapter 2 describes the findings of the stakeholder interviews regarding the two PoC;
- Chapter 3 describes the findings of interviews with participants in the two PoC;
- Chapter 4 describes the findings of the stakeholder interviews in non-proof of concept areas, regarding wider approaches to supporting clients with a dependency;
- Chapter 5 draws together conclusions from both strands of the evaluation, i.e. the PoC research and the research into wider approaches to supporting clients with a dependency.

2 Proof of concept stakeholder findings

2.1 Stakeholder roles

The stakeholders involved in delivering the proof of concepts (PoC) were:

- Work Programme Providers (WPPs) who are contracted to the Department for Work and Pensions (DWP) to deliver employment-related activity and support to clients, either directly or via subcontractors;
- Treatment Providers and Specialist Treatment Providers, who deliver a package of support to clients relating to their drug or alcohol dependency. They can also provide a range of psychosocial and pharmacological interventions;
- Local authorities who commission drug and alcohol dependency support services; and
- Public Health England (referred to as 'PHE'), who had a role in supporting the proof of concept activity.

2.2 The proof of concept delivery models

Aside from applying the core aims (reiterated in brief below), the DWP gave WPPs the autonomy to decide how the PoC would be delivered in practice. Stakeholders described how the PoC were being delivered in their area.

For Recovery Works (awarding WPPs a financial incentive per participant achieving sustained employment) delivery was summarised as follows:

- Jobcentre Plus occasionally flagged that clients had a dependency at the point of their referral to the Work Programme (WP). However, in most instances the client's dependency was instead either identified in an initial diagnostic interview (conducted by the WPP with every client) or emerged at a later date in the course of the client working with their WP advisor;
- The WPP then delivered 'business as usual' support to the client. As with all WP clients this support was tailored to the individual client's barriers to entering employment;
- In working with the individual client, the WPP sometimes referred them to Treatment Providers who offer support relating specifically to dependency. These were not contracted to the WP and did not receive any additional payments for working with these clients: they simply delivered the support that they would have anyway;
- In theory, communication between the WPP and the Treatment Providers about individual clients would be more 'joined-up'.

For Recovery and Employment (encouraging closer working relationships between WPPs and Treatment Providers) delivery was as follows:

- As seen in Recovery Works (RW) the WPP identified a client's drug or alcohol dependency;
- Where a dependency was identified, the client was referred to a Treatment Provider that offered support with dependency issues. This Provider was contracted to the proof of concept and, as a result, received a share of the job outcome payment, a sum of money paid by DWP to the WPP for each client who entered employment and remained in it for 13 or 26 weeks;[9]
- In **Birmingham**, the Treatment Provider delivered supplementary specialist support to the client, and the client would often have interacted with an advisor working for the Treatment Provider. The WPP would, however, retain primary responsibility for the overall package of support delivered to the client;
- In **Coventry and Warwickshire**, the Treatment Provider would take over the overall package of support delivered to the client.

2.3 Perceptions of the proof of concept purpose

Stakeholders perceived the purpose of the PoC to be to incentivise WPPs to give more attention to a 'hard-to-help' client group and to direct individuals not in treatment towards treatment provision. They also recognised the intention to create scope for WPPs and Treatment Providers to talk to each other about individual clients. This would ensure that provision is joined up and WP activities do not counter-productively clash with treatment, ideally through three-way case conferencing[10]. It would also avoid clients being able to tell their WPP and their Treatment Provider different things, for example, to avoid engaging fully with employment support and/or treatment; and would allow WPPs to recommend a more lenient approach to making activities mandatory, so as to avoid sanctions being issued for not completing activities where this was deemed appropriate. This joined-up communication was perceived to be the key difference to the 'client experience'.

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9 For a definition of job outcomes and job outcome payments see the glossary at the beginning of this report. These were 'business as usual payments' to the WPP for a client achieving sustained employment, as opposed to any additional sums of money for achieving an employment outcome with a client with a dependency in the context of the PoC (it is only the other PoC model, RW, in which additional outcome payments were made). This Specialist Treatment Provider was also contracted by the local authority to provide this support to local residents in general (i.e. regardless of whether or not they were part of the WP).

10 A discussion between the WPP and the Treatment Provider regarding an individual's client circumstances, with the client also present.

2.4 What has worked well?

The PoC produced some positive outcomes:

- **Normalising discussions of dependency and treatment**: In a handful of cases, just mentioning to the client the idea that taking part would permit communication between the WPP and the Treatment Provider had made a subtle difference by sending a signal to the client that dependency and treatment could be discussed openly with their WPP. This openness in turn enabled the WPP to more appropriately schedule WP activities, so as not to interfere with the client's treatment. It also enabled the WPP to direct their client towards more appropriate job searches, avoiding inappropriate roles, i.e. job roles that would clash with treatment or be inappropriate for someone with a dependency.
- **Increasing dialogue between the WPP and the treatment provider**: In some cases, there was direct contact between the WPP and the Treatment Provider[11]. This sometimes resulted in reductions in the number of client appointments and/or the number of mandated job searches with the WPP, to 'reduce the pressure' on the client. It also gave WPPs a means of re-engaging clients who were at risk of sanctions. In this situation the WPP had contacted the client's Treatment Provider so they could urge the client to re-engage with the WP activities, therefore avoiding withdrawal of benefits.
- **Increasing the co-location of services**: This was implemented in some areas with a degree of success although the sustainability of this model was ultimately impaired by resourcing constraints. Where this was adopted, the perceived benefits were that it facilitated referrals between organisations by making WP staff more aware of the support available to those with dependencies, and that it helped to maintain the PoC profile among WP staff. Some 'spikes' in referrals were evident where co-location was trialled.
- **Generating additional 'default' referrals**: Where a 'default referral approach' was implemented it was perceived to have generated additional referrals to the PoC as well as helping WPP frontline advisors to overcome their wariness about mentioning the PoC to clients.[12] A lack of awareness of default referral among PoC leads meant this had no impact on RW.

2.5 Challenges with the proof of concepts

Levels of referrals to the PoC were low, and consequently job starts and sustained employment outcomes were also low. Stakeholders felt there were a number of lessons learnt from this. These are grouped into primary, secondary and tertiary learnings according to their perceived potential impact:

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[11] On a few occasions, this had involved the intended three-way case conferencing between the client, the WPP and the Treatment Provider, but more often it was communication just between the WPP and the Treatment Provider.

[12] The adoption of 'default' referral within the R&E PoC was not related to the requested adoption of this (at the DWP's instigation) within RW. The R&E PoC providers adopted this as their own innovation since the DWP had given WPPs the autonomy to decide how the PoC would be delivered in their area.

2.5.1 Primary challenges

Personal motivation and quality of relationships were more effective in sustaining joint working between the employment and specialist support sectors than financial incentives. The overall consensus among WPPs interviewed was that incentives based on job outcome payments had made little difference because the chances of achieving sustained job outcomes with this client group felt too remote for payments to be motivating.[13] Across all of the RW WPPs, frontline advisors appear to have been motivated by their ability to have more joined-up, open conversations with clients rather than by securing additional funds.

> *'Our staff aren't actually told of the* [financial] *uplift that's there, it's only the… management…I don't promote it to my staff, it becomes a case of "these customers are …in need of specialist assistance, this is what we can do for them, let's do whatever it needs to be"…the monetary side of things doesn't really come into it.'*
>
> (WPP, RW, West Yorkshire)

There is a need for clarity around who is responsible for delivery, and individual personalities are critical in driving successful joint working between the sectors. WPP proof of concept leads and PHE representatives felt that a lack of clarity about who was responsible for PoC delivery and to whom they were accountable led to a widespread perception that "everyone is responsible and so no-one is". As a result, the level of activity was strongly influenced by individual personalities at local level. In some areas, individuals informally adopted a leadership role, driven by a personal desire to take the PoC and 'make something of it'. As a consequence the PoC varied considerably both by area and by WPP. In some cases they were slow to gain traction and progress.

> *'It's never had a champion…behind it, there's no government targets behind it, it's not linked into anything else, it's not like when you read anything else about employment, it also says "and the Government's* [drug and alcohol] *pilot's on the end of it" because it doesn't'.*
>
> (Stakeholder)[14]

There was, therefore, a perception among WPPs and PHE representatives that more high-profile leadership might have helped sustain joint working to deliver the PoC. Stakeholders suggested that, in future, accountability/leadership could be enhanced by: the PoC being embedded in wider strategies for employment or dependency support services; their being built into an individual's job descriptions and increased use of 'soft influence' (e.g. exerted through contact between the DWP and WPPs).

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[13] Participants included both Jobseeker's Allowance (JSA) and Employment and Support Allowance (ESA) claimants. While ESA claimants are only expected to become job ready, not apply for work, the purpose of the PoC was to support participants towards employment, and in practice a few job outcomes were achieved among both ESA and JSA claimants.

[14] The stakeholder type and location have deliberately been omitted to protect the anonymity of the research participants.

Diagnostic interviews at the start of engagement are not always reliable in identifying dependency: building trust is critical to identifying dependency-related needs. Identifying eligible pilot participants was felt to be challenging for WPPs, because clients were initially reluctant to disclose their dependency to a stranger, meaning that WPPs' attempts to use diagnostic interviews to identify dependency at the start of a client's engagement with the WP were not consistently effective. Clients were more likely to disclose dependency as trust between them and their WP advisor built over time, but by this point there would be less time in which the support could be tailored to the dependency.

Improved data sharing would assist with identification and remove the need for clients to broach a difficult subject. Ideally, some WPPs and PHE representatives felt that Jobcentre Plus staff should notify WPPs when referring a client known to have a dependency, to avoid clients having to broach a 'difficult' subject again and to avoid a situation in which a dependency already known about by Jobcentre Plus only emerges later in the relationship with the WPP.[15] This process did not happen systematically however and even when organisations tried to transfer information, they often encountered issues sharing the data.

2.5.2 Secondary challenges

There may be an argument for more widespread use of a separate stream of clients with dependency issues within the WP. WPPs reported it was difficult to maintain focus on the PoC because they were overloaded with other competing WP initiatives. Given that the PoC were introduced mid-way through the lifetime of current WP contracts, participating clients had often been assigned to different teams and coaches, which made it difficult to communicate effectively with staff involved in delivery. The PoC sometimes became 'lost' due to turnover in WPP management and frontline staff. At management level this was because it was not a high priority when handing over and/or because incoming management felt it was difficult to grasp its purpose.

Ideally WPPs would be better equipped to articulate the benefits of participation. Some WPPs and Treatment Providers perceived the offer to the client to be relatively subtle/ intangible, reflecting the fact that the DWP had given WPPs the autonomy to decide how the PoC would be delivered in their area. This made it more difficult for frontline staff to grasp and more difficult to 'sell' participation to clients.

> *'The recovery workers are aware they are able to refer, but it's not something I ever believe has been discussed with clients and I think that comes down to recovery workers not feeling confident in knowing what the benefits might be to the client apart from sharing information.'*
>
> (Treatment Provider, RW, East of England)

[15] See the Joint-Working Protocol between Jobcentre Plus and Treatment Providers (http://www.nta.nhs.uk/uploads/joint-workingprotocolwithjcp.pdf) for a suggested 'ideal' process.

2.5.3 Tertiary challenges

Relationships between WPPs and Treatment Providers were critical in delivering the PoC. It was challenging to initiate constructive working relationships when existing relationships were mixed, and on occasion did not exist at all, when the PoC were introduced. Treatment Providers could initially be concerned that, in the context of a 'payment by results' model, WPPs might be driven to overlook clients' best interests in pursuit of profit, while WPPs reported that they were not always knowledgeable about either the type of work the Treatment Providers carried out, or to whom in this sector they should refer their clients with dependencies. Launch and re-launch events and catch-ups between stakeholders were used to build relationships and identify points of contact between the sectors, with varying degrees of success.

Clearer guidance over the data protection issues around disclosing that clients have dependencies could help remove the barriers to data sharing and referrals between organisations. WPPs reported that Treatment Providers were slow to return completed TPR1 data sharing agreements,[16] while Treatment Providers did not always understand the form's purpose or have an identifiable WPP point of contact to return forms to. There was confusion about what the TPR1 data sharing agreement permitted. Some WPPs and Treatment Providers believed they could only discuss the client if the client themselves were present, while WPPs hypothesised that Treatment Providers were reluctant to case conference[17] due to fear of undermining the trust they had built up with their client. Moreover, WPPs' IT systems did not always allow dependency 'markers' to be added to individuals' case files.

Increasing support for co-location would be beneficial. Some WPPs and Treatment Providers believed the proof of concepts would be more effective if Treatment Providers were co-located on WPPs' premises (see 'what has worked well', above). The ability to do this in practice was curtailed by physical space and resources.

It is important to maintain momentum and to address any challenges early. Stakeholders reported that over time 'fatigue' had set in. The proof of concepts had been slow to gain traction due to the need to forge relationships 'from scratch' and the lack of clear accountability among stakeholders. Low levels of referrals, job starts and sustained employment outcomes meant the PoC slipped down stakeholders' priorities. All this led to numerous catch-ups and relaunches among stakeholders, which gradually eroded their goodwill.

2.6 Summary of chapter

- Personal motivation and quality of relationships were more effective in sustaining joint working between the employment and specialist support sectors than financial incentives. This was primarily because achieving job outcomes with this client group was felt to be too remote for these payments to be motivating. The R&E concept, of encouraging closer working relationships, was therefore more effective than the RW payment-based model.

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16 For an explanation of the TPR1, see the Glossary earlier in this report.

17 A discussion between the Work Programme Provider and the Treatment Provider regarding an individual's client circumstances, sometimes with the client also present.

Drug and alcohol proof of concept evaluation, and wider approaches to supporting clients with a dependency

- There is a need for clarity around who is responsible for delivery, and individual personalities are critical in driving successful joint working between the sectors.
- Diagnostic interviews at the start of engagement are not always reliable in identifying dependency: building trust is critical to identifying dependency-related needs.
- Improved data sharing would assist with identification and remove the need for clients to broach a difficult subject. Clearer guidance over the data protection issues around disclosing that clients have dependencies could help remove the barriers to data sharing and referrals between organisations.

3 Proof of concept participant findings

3.1 What are the backgrounds and situations of proof of concept participants?

Most participants had a complex and longstanding history with either drugs and/or alcohol. Many had difficult and complicated home lives which involved multiple issues including debt, leaving prison, relationship breakdowns, death of family members or having their children taken into care. Some mentioned they were frequently in contact with multiple agencies (e.g. social services, probation).

All participants were in receipt of benefits and many had been in receipt of both Employment and Support Allowance (ESA) and Incapacity Benefit (IB) at some point, although there was a mix of those who had been in receipt of benefits long term and those who had started claiming more recently (i.e. within the last one to two years).[18]

Taking drugs or drinking had for some, been the reason why they had lost their job (although in a small number of cases, participants reported that their dependency had been prompted by job loss). All had been unemployed for a least 18 months; some due to their having been in prison for a period.

Some participants had been employed at some point in the past (either long- or short-term). While a few had a substantial employment history, for the most part employment had been shorter and more sporadic.

The majority of participants said that they would like to find employment, although a few said they did not feel 'work ready'. A few had signed up for training courses or volunteering or had been actively pursuing jobs prior to joining the Work Programme (WP).

3.2 What has worked well?

In some instances, participants had received support that they felt was appropriately tailored to their dependency, including:

- Work Programme Provider (WPP) advice and training on how to become self-employed. Self-employment was a motivating goal and was positively received by participants in the context of their fear of experiencing dependency 'stigma' and/or being subjected to criminal record checks when joining a new employer.

[18] As noted earlier, participants included both Jobseeker's Allowance (JSA) and ESA claimants. While ESA claimants are only expected to become job ready, not apply for work, the purpose of the proof of concepts was to support participants towards employment, and in practice a few job outcomes were achieved among both ESA and JSA claimants.

- WPPs allowing participants time either to collect prescriptions or to receive counselling support from Treatment Providers. Participants considered the medication, counselling – and the weekly routines built around accessing these – to be vital to avoid destabilising their recovery (particularly for those with the most severe dependencies).

  'It would have been more difficult without my medication. I have had to learn that I need to keep taking it if I am to remain in control.'

  (Participant, Recovery Works (RW), East of England)

- Where WPPs were able to vary mandation,[19] participants felt that this reduced the 'pressure' and 'stress' associated with the WP.

- Being allocated a WP advisor who had previously had a dependency or fully understood their situation. This had helped participants to form relationships with their advisor, which in turn made participants more receptive to the advisor's guidance as they felt the advisor understood their situation. These advisors were also felt to have had a good grasp of the issues underlying the dependency (e.g. anxiety, depression) so the client was referred to better targeted support.

  'My first adviser was an ex-addict and we discussed the use of anti-depressants … and [he] *referred me onto an alcohol project. He understood … depression … came first, followed by agoraphobia and then the use of alcohol to dampen these down.'*

  (Participant, RW, East of England)

It is extremely difficult to discern exactly how much of this support was related to the proof of concepts (PoC) – but at the very least, communication between WPPs and Treatment Providers leading to sensitive appointment scheduling and a more individually-tailored approach to making activities mandatory, can be attributed to them.

3.3 What outcomes were achieved for participants?

Participants reported a range of outcomes. Most commonly these were 'soft' outcomes – for example, increased confidence; improved structure and routine; increased engagement with other people; and the opportunity to build up their skills for seeking employment (e.g. improving CV and letter writing skills, or building skills in how to perform a job search).

'[I've gained] *self-confidence in getting out there…in terms of functioning around people…branching out, mixing with new people. It taught punctuality; I have to stick to a timetable and keep appointment times.'*

(Participant, RW, West Yorkshire)

[19] Enforcing WP activities as compulsory, which can in turn lead to the use of sanctions by Jobcentre Plus, i.e. suspending benefit payments if activities were missed without good cause.

A few participants also reported that the PoC had prompted a positive change in their attitude which had consequently increased their willingness to become employed and/or tackle their dependency.

> *'It helped me to come out of me house and go up on the training to get my fork lift licence…that is something I did want for a long time.'*
>
> (Participant, R&E, Birmingham)

In a minority of cases, participants reported they had managed to find employment, even if they hadn't managed to sustain this long term. Some participants felt their WP advisor had been instrumental in them achieving this, for example, by providing access to IT facilities and a loan to purchase tools, by encouraging them to pursue roles better suited to their health conditions or capabilities, or by directing them to an 'exclusive' opportunity.

3.4 Lessons learnt from the proof of concepts

Participant feedback also pointed towards a number of lessons learnt related to their support provision:

- Most commonly, participants emphasised that their WP advisor understanding dependency and the wider complications often associated with it would help create a more positive WP experience. Some felt that their WP advisors had lacked this understanding of dependency, for example, advisors did not always acknowledge that client mood and physical health could fluctuate and that tasks appropriate on a 'good day' should not necessarily be enforced on a 'bad day'; or that the complexity of participants' wider situations meant there was sometimes a need for appointments with other agencies to take precedence over WP commitments (e.g. social services regarding child protection issues).

  > *'She* [the WP advisor] *knows that if I don't have my methadone script, I will be poorly, but she doesn't fully understand the initial process building up to that; starting to feel sick, mood swings.'*
  >
  > (Participant, RW, West Yorkshire)

- Much less commonly, participants suggested that:
  - Having increased opportunities for privacy on WPP premises would support them in more openly discussing their dependency.

    > *'It's all open plan. They ask all these personal questions…and all the other clients are in there … They can all hear everything. You don't exactly feel confident to talk.'*
    >
    > (Participant, RW, East of England)

  - Increased consistency in the WP advisors seen would remove the need for clients to repeatedly broach a difficult subject. Seeing multiple WP advisors left participants unsure of which advisors were aware of their dependency issue and which were not, leading to them feeling that they would need to broach this 'difficult' subject again.

> *'I talk to one advisor, I open up a bit, I tell you my problems and then you swap with another one* [and] *I've got to do it all again. I'm sick of talking to people and telling them about myself.'*
>
> (Participant, RW, East of England)

- Ensuring training courses, job search goals or support were always appropriate, would avoid undermining the relationships between the WP advisor and the participant. For example, one participant's dependency was triggered by stress but they were directed toward a role with 'pressured' targets (which then triggered a relapse); another was sober and was signposted to support sessions with other people who were still drinking. In other cases inappropriate job settings were also suggested.
- WP advisors being consistently sensitive to the client's dependency would also avoid these relationships being undermined. For instance, one participant had felt humiliated after being asked to leave WPP premises for smelling of alcohol.

3.5 Summary of chapter

- Most participants had a complex and longstanding history with either drugs and/or alcohol, often accompanied by difficult and complicated home lives involving multiple issues such as debt, leaving prison, relationship breakdowns, or having their children taken into care.
- The following aspects of support delivered within the proof of concepts were positively received, i.e. self-employment support; the WPP creating flexibility to allow participants to maintain existing routines around collecting prescriptions or receiving dependency counselling; and being allocated a WP advisor with empathy who understands dependency and the wider complications often associated with it helping to develop strong advisor-participant relationships.
- A minority of the PoC participants had managed to enter employment, even if this was not ultimately sustained. More commonly, they had not entered employment, but had achieved other, less measurable outcomes such as increased confidence; improved structure and routine; increased engagement with other people; and improved skills for seeking employment.
- Participant feedback also pointed towards a number of lessons learnt – most commonly, that the WP advisor understanding dependency and the wider complications often associated with it would help create a more positive WP experience, and would avoid relationships being undermined by 'inappropriate' or unsympathetic WP interactions and activities. A few also felt that increased opportunities for privacy on WPP premises would help them to discuss dependency openly, and increased consistency in the WP advisors seen would remove the need for clients to repeatedly broach a difficult subject.

To build on these findings from the PoC evaluation, in summer 2014 the Department for Work and Pensions (DWP) commissioned further research in non-proof of concept areas to obtain a broader, national picture of approaches to supporting clients with a dependency. The findings of this research are discussed in the next chapter.

4 Wider approaches to supporting clients with dependencies

This chapter describes the findings of research in non-proof of concept areas to obtain a broader, national picture of approaches to supporting clients with a dependency.

4.1 Degree of priority given to supporting this client group

Most stakeholders thought supporting clients with drug and/or alcohol problems into employment was a high priority for their organisation. Some felt it had become more important in the past five years with an increased focus on the role of employment in recovery in the National Drugs Strategy for England typically being cited as the main reason for this.[20] Support Providers also cited an increased recognition that this client group can be 'good employees', while Employment Support Providers also cited increased volumes of clients with dependencies in their caseload (related to increased volumes of Employment and Support Allowance (ESA) claimants).

Only a minority, believed it had become less of a priority in the past five years – the main reason given being that government has placed greater emphasis on addressing wider public health issues in recent years, with a corresponding reduced focus on dependency[21].

4.2 Perceived efficacy of support for this client group

Despite the high priority some felt to be given to this client group, stakeholder views were very mixed regarding whether or not they think that this client group is currently supported into employment effectively.

The proof of concept (PoC) findings demonstrate the importance of good relationships, joined-up referral systems and the need for sensitive handling of this client group.

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20 For details of the National Drugs Strategy see: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118336/drug-strategy-2010.pdf. Note that responsibility for drugs policy area is now devolved outside England.

21 For instance, a few reported that encouraging employment among this client group has less prominence now that drug and alcohol dependency has been absorbed into a wider public health agenda. There is also a view that government priorities change frequently and this detracts from a consistent focus on the employment support for this client group.

Stakeholders who held the view that current support is effective attributed this to:

- The availability of joined up and holistic services in the local area;
- Good provider relationships and referral systems between the treatment and employment support sectors; and
- Employment Support Provider willingness to engage with this client group.

Stakeholders who held the view that current support is ineffective highlighted the following as issues that needed to be addressed:

- Organisations failing to cater for the length of time and level of support required to attain employment outcomes;
- Employment Support Provider staff not always being sensitive/committed to a stigmatised client group;
- A lack of joined-up services – particularly at an operational level;
- Treatment Providers struggling to cope with demand; and
- This client group not always being at the forefront of Employment Support Providers' agendas.

4.3 Contact between employment support and treatment providers

There were mixed views regarding contact and collaboration between Employment Support Providers and Treatment Providers, including frequency of contact.

Where there was more regular contact, clearer referral processes and systems to share client data had often been established, employees from respective organisations knew each other's names and, in the best examples, representatives of the two sectors would regularly phone or meet to refer clients to treatment, ensure clients had honoured appointments, or to discuss how employment support could best be adapted to compliment clients' treatment.

In some areas, there was co-location of services (e.g. running 'Job Clubs' on Treatment Providers' premises).

> *'We attend monthly meetings at Pathways who are a drug and alcohol dependency provider. They provide doctors, detox, support workers, community placements and employment links. We've all got our customers to sign a TPR1, so we're able to share information.'*
>
> (Employment Support Provider, Manchester)

In instances where there was less contact between the sectors, this tended to be limited to signposting clients between organisations.

4.4 Relationship building between organisations

Although contact between the two sectors was limited in some areas, most felt that there had been recent relationship building. Often this had been local authority substance misuse commissioner-led, sometimes leading to contractual arrangements between parties, or at the very least, to opening discussions between organisations.

Where collaboration had been most effective, there was evidence to suggest that it had reinforced closer working in a 'virtuous circle'. For instance, in some cases where strong relationships between the Employment Support and treatment sectors had been built, client referrals had increased which in turn brought the two sectors into more regular contact.

On the other hand, most stakeholders believed there were barriers to building closer working relationships. This pointed to a number of potential improvements: most commonly, a need to improve the understanding of the support provided by the other to build relationships between organisations, or to address data sharing issues. Many of these were also potential improvements identified by stakeholders involved in the PoC. The reasons for the lack of mutual understanding and lack of relationships were varied. They included: high staff turnover in the employment support sector, leading to comprehension of the treatment system and cross-sector relationships being lost when individuals moved on; large numbers of providers being involved in the local treatment system making it hard for Employment Support Providers to understand and navigate provision; and a reluctance among Employment Support Providers to invest time in building relationships with the treatment sector in order to help clients for whom the chances of securing Job Outcome Payments were perceived to be remote. The data sharing issues raised were that:

- managing data protection issues was time consuming;
- employees, particularly at Employment Support Providers, feared breaching data protection legislation, which had sometimes led to decisions not to identify drug or alcohol problems on Employment Support Provider data systems;
- clients were unwilling to give consent because they didn't understand how and why information would be shared; and
- it was felt that the Government/DWP could have given more guidance on the handling of sensitive data.

4.5 Perceived differences in approach between organisations

Most stakeholders thought that approaches to employment support for this client group differed between the employment support and the treatment providers. Treatment providers were more likely to say this than Employment Support Providers.

- Employment Support Providers were commonly perceived to 'push' clients harder to try to secure work. Some stakeholders, particularly in the Treatment Provider sector, commented that this pressure could cause clients to relapse.

- Treatment Providers were commonly felt to adopt a 'softer' approach by offering bespoke support and only encouraging those perceived as 'ready' to start looking at employment options. Some felt that treatment providers were not always aspirational in terms of promoting employment and that as a result clients could be dissuaded from seeking a job, even when beneficial to their recovery.[22] This points towards a need to ensure the two sectors are working together to address any concerns about overly-pressured or insufficiently aspirational employment support.

4.6 Employment Support Provider tailoring to this client group

Regarding how Employment Support Providers tailor their service to this client group:

- Nearly all mentioned increased communication with other organisations to try to balance employment support with treatment.
- Many also reported simply offering their service more flexibly – for example, by avoiding clashes with treatment appointments or by scheduling sessions in the morning when clients with complex substance misuse related problems may be easier to engage.
- Less commonly, they mentioned offering tailored support – for instance by creating a specialist internal team to work with clients with dependency issues, by referring clients to Support Providers or by using Support Providers to upskill the Employment Support Providers' own staff.

> *'Six months ago we created a team who only focus on those with drug or alcohol problems. We've created new checklists, we do our own induction, it's a much more understanding and inclusive approach.'*
>
> (Employment Support Provider, West of England)

4.7 Client disclosure of dependency

Stakeholders felt that building trust is critical to identifying dependency-related needs. They felt the ability of Employment Support Providers to tailor their services to this client group was severely limited by a lack of client willingness to disclose these issues and elicit information about barriers to employment. There was a general perception that clients were more likely to disclose information about their dependency once they trusted their advisor.

Few stakeholders believed that most clients disclosed their dependency to their Employment Support Provider – predominantly because of perceived stigma associated with dependency or fears it could jeopardise benefit claims. Jobcentre Plus sometimes flagged this on referral, but not consistently.

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[22] It is worth noting that these differences in approach could be related to differences in the profile of clients that each is working with (for instance, ESA claimants are not required to seek work until they feel ready to do so) and differences in payment arrangements (Work Programme Providers (WPPs) are paid by employment results achieved, while Treatment Providers contracted to them are typically paid for activity delivered, giving rise to perceptions of a 'softer' approach by the latter).

> *'I think it depends on the individual; how comfortable they are discussing it with new people. I think some people don't admit that they have a problem so they won't disclose it anyway. Sometimes it will be an embarrassment, sometimes it will be that they are not comfortable, sometimes they won't even acknowledge it to themselves.'*
>
> (Employment Support Provider, London)

Many Employment Support Providers were confident that their staff members were attempting to initiate conversations about dependencies with all or nearly all relevant clients. These providers felt that their staff understood this to be part of their remit and an established part of introductory conversations. In such cases it was sometimes reported that training had played a key role in instilling staff with confidence and the knowledge of how to conduct these conversations. In some instances Employment Support Providers reported that they would ask clients at certain intervals whether or not they had a dependency issue; this allowed clients multiple opportunities to disclose any information.

Most Treatment Providers reported that they always encouraged clients to disclose their dependency to those in the employment sector, to help ensure the clients received the best, most sensitive support possible.

4.8 Flagging and monitoring dependency

Most Employment Support Providers attempted to track volumes and progress of clients with dependencies through adding markers to their systems when clients were identified as having dependencies. The ability to better tailor support to the individual client was the main perceived benefit of this; another benefit was avoiding the client having to repeat previous conversations when allocated to a new advisor.

> *'So we can work with the customer and with the organisation concerned to help them in their journey towards rehabilitation or back into work. It's just making sure we have a joined-up approach. If a new* [advisor takes] *over that customer they'd be able to see the history.'*
>
> (Employment Support Provider, South East)

However, only half of Employment Support Providers monitored whether or not the client was in receipt of treatment. As noted above, Employment Support Providers that did not track dependency most commonly cited data protection concerns; some also expressed fears that the client may be discriminated against.

4.9 Measurement of distance travelled

Many Employment Support Providers and Treatment Providers had developed ways to measure 'distance travelled' towards employment by clients with dependencies, typically by assessing them against established frameworks or by gathering responses to a standardised set of questions at specific points in the client journey. In some cases this occurred in a systematic manner, particularly in the treatment sector where advisors frequently referred to the Treatment Outcome Profile system.[23]

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[23] The Treatment Outcomes Profile system uses 20 questions to measure progress in individuals being treated by drug and alcohol services.

> *'We rate a person in terms of their employability by a Steps To Work category, like what benefit are they on, are they mandated to be applying for work…as they progress then they progress up the Steps To Work and in effect become more employable.'*
>
> (Employment Support Provider, Cheshire and Merseyside)

Among stakeholders wishing to improve their support package, a better gauge of 'distance travelled' was often cited as a key means of achieving this improvement.

4.10 Examples of achieving long-term employment

Nearly all Employment Support Providers and Treatment Providers could think of examples where their clients with dependencies had managed to secure long-term employment, from working in warehouses to becoming peer mentors.

4.11 Which elements of support are most effective?

Stakeholders cited a range of different types of employment support that they perceived to be particularly effective in helping this client group.

- Early signposting of individual clients to other agencies, and formulating a tailored action plan for the individual client at an early stage.
- Use of one-to-one sessions to encourage client candour in a more private setting, as well as group work to allow scope for peer support and the development of social skills.
- Consistent with the PoC findings – reducing clashes between employment support and support with the dependency.
- Using volunteering and work experience to build client self-esteem, confidence and routines – with the ultimate goal of the client becoming employment-ready. On some occasions, work experience placements had led to offers of permanent employment and several stakeholders referenced the willingness of local employers to work with their clients as crucial in securing such opportunities.
- Where **employment had been secured**, stakeholders mentioned the value of in-work support and ongoing dialogue to ensure the continuity of employment.

4.12 How could support be improved?

Most Employment Support Providers and treatment providers felt that their current support package was as good as it could be. However, it was felt that if additional resource was available, the following would be welcome additions:

- Increased use of co-location of employment support and treatment providers on each other's premises; and increased ability to have specialist staff on site – for instance, by Work Programme Providers (WPPs) having staff trained in working with clients with dependencies.

- Increased recognition of distance travelled in commissioning and performance monitoring of services. In particular, there was call to review the WP payment by results model so that it recognises 'distance travelled' towards employment.

Less commonly, stakeholders also suggested that it would be beneficial to have more time with clients, to help to facilitate the formation of strong client-advisor relationships. One Employment Support Provider also argued it would be beneficial if a specific strand of the Work Programme (WP) were dedicated to supporting this client group.

4.13 Feasibility of achieving outcomes with these participants

The majority of both Employment Support Providers and Treatment Providers reported that the time it takes to achieve outcomes with this client group can vary hugely from individual to individual depending on attitudes and circumstances. The minimum amount of time needed to get an individual ready for employment ranged from 3 months to 5 years, according to the views of those interviewed.

Most stakeholders felt that their client base was very mixed, with a few ready for employment, and others needing more support first. Most maintained that there were some circumstances where it was reasonable for a client with a dependency to enter into employment while still in treatment, i.e. if the client:

- Were 'stable' (e.g. they were either no longer using, or stable on substitute medication);
- Were at the right point in their treatment journey to be seeking employment, training or education;
- had sufficient support from friends, family and support organisations; and
- were in control of other aspects of their life, for example, housing.

> *'It requires a significant degree of support and quite a specific approach from employers. I think it needs to be clients where they've made progress on their recovery. Trying to engage people with substance misuse at the very early stages of their recovery is probably on a hiding to nothing; there are clearly other things that you need to get in place first, there needs to be a degree of stability.'*
>
> (Stakeholder, Devon, Cornwall, Somerset)

Some stakeholders felt it was difficult and complex for clients to enter employment while still in treatment – since either the client would not be able to hold down the job, or the employer would be unwilling to take on a client at this stage of recovery. However, most maintained that there were some circumstances where it was reasonable for a client with a dependency to enter into employment while still in treatment.

4.14 Sustaining benefit claims

Treatment Providers tended to believe that at least three-quarters of their clients were claiming benefits. More so than Employment Support Providers, representatives from the treatment provider sector felt that drug or alcohol dependency was likely to have a profound effect on clients' abilities to sustain their benefit claims. Stakeholders felt clients' chaotic lifestyles could disrupt their benefit claims.

There may be a need for increased clarity regarding who is responsible for supporting clients to sustain their benefits claims. Most Treatment Providers felt that there was adequate support available to enable clients to sustain their benefits claims, although a common perception was that this support was offered principally by the Employment Support sector. Significantly, only half of Employment Support Providers maintained that clients with drug or alcohol dependencies received support to help them sustain their benefits, potentially indicating a gap between Support Providers' perceptions and reality.

4.15 Summary of chapter

- Most stakeholders thought supporting clients with a drug/alcohol dependency was a high priority for their organisation. There were, however, very mixed views regarding whether this client group was being effectively supported into employment in practice, and whether there was contact and collaboration between the employment support and treatment providers sectors currently.
- There is a need to overcome barriers between employment support providers and treatment providers, by improving understanding of the support each other are able to offer, building relationships and addressing data sharing issues. This will involve addressing varied underlying causes including: high staff turnover in the employment support sector; fragmented (and therefore difficult to navigate) treatment provider provision; and Employment Support Provider reluctance to invest time in building relationships with the treatment provider sector in order to help clients for whom the chances of securing Job Outcome Payments were perceived to be remote.
- Building trust is critical to identifying dependency-related needs: the ability of Employment Support Providers to tailor their support to clients with dependencies was perceived to be severely limited by a lack of client willingness to disclose their dependency and providers being able to elicit information on barriers to employment – with stigma being the key perceived barrier.
- Consistent with the PoC findings, reducing clashes between employment support and support with the dependency was perceived to be a key factor in delivering effective support to this client group. Using volunteering and work experience to build client self-esteem, confidence and routines was also felt to be key to the client becoming employment-ready. Stakeholders ideally wanted future delivery to involve increased use of co-location of employment support and treatment provider services on each other's premises; and greater recognition of distance travelled in service commissioning and performance monitoring.

5 Conclusions

It is clear from these two strands of research that close collaboration between providers in the employment support and treatment provider sectors can bring positive outcomes for clients. The key positive impact is that collaboration can help to ensure that clients' preparation for employment does not adversely impact on their treatment/recovery from addiction and vice versa.

Personal motivation and quality of relationships were more effective in driving this collaboration between sectors than financial incentives. Enhanced job outcome payments to WPPs alone (whether the 'standard' £2,500 or the increased £5,000 additional payments achieved on securing job outcomes) are not sufficiently motivating to achieve job outcomes or sustain joint-working between the employment support and treatment provider sectors.

Given the feedback from the wider employment support and treatment provider sectors that there should be increased recognition of distance travelled in commissioning and performance monitoring of services such incentives might be more effective if part-payment were made on achievement of distance travelled towards employment measures.

Encouraging clients to disclose dependency is a challenge. Diagnostic interviews at the start of engagement are not reliable in identifying dependency: building trust is critical to identifying wider dependency-related needs. Clearer guidance over the data protection issues around disclosing that clients have dependencies (between Jobcentre Plus and Employment Support Providers and between the Employment Support Providers and the Treatment Providers) could assist organisations in identifying client dependency at the point of referral and prevent the need for clients to have to repeatedly disclose their situation.

Some of the challenges for employment and treatment services building up constructive working relationships with each other, and with clients, were attributed to staff turnover and dispersion of claimants across Work Coaches and WPP teams.

Appendix A
Proof of concept: Detailed eligibility criteria

The full eligibility criteria for the proof of concepts (PoC) were as follows:

- The PoC were open to all Work Programme (WP) participants referred to the Work Programme Provider (WPP) on or after 2 April 2013.
- To be able to claim the RW Additional Job Outcome Payment, participants referred to the WPP must be undertaking structured recovery orientated drug or alcohol treatment at any point from 6 months prior to their referral, up to the day before their job start (whether treatment is successful is not a factor).
- Structured Recovery Orientated Drug or Alcohol Treatment is defined as treatment which is recorded on the PHE National Drug Treatment Monitoring System (NDTMS).
- If the participant has dependency issues with both drugs and alcohol the WPP will only be paid one additional job outcome payment, within RW.
- Participants returning to the WPP following a break in their claim remain eligible, provided their initial referral to the WP was on or after 2 April 2013 and the WPP has not already received an additional job outcome payment for them.
- Participants who are already on the WP and are identified as having dependency issues after 2 April 2013 are not eligible for the additional job outcome payment within RW.
- The participant must agree to data sharing between the WPP, the PHE treatment provider, and the Department for Work and Pensions (DWP). If consent is not given they will not be eligible for the pilot, and the WPP will not be able to claim the additional job outcome payment within RW.

Appendix B Proof of concept evaluation: Interviews achieved

A portion of the first wave of stakeholder fieldwork was brought forward to explore proof of concept progress and identify any issues in the early stages of implementation (14 in-depth interviews conducted from 23 September to 22 October 2013).

Table B.1 below provides a breakdown of interviews achieved.

Table B.1 Early Wave 1 interviews

	Recovery and Employment (R&E)		Recovery Works (RW)	
	Coventry and Warwickshire	**Birmingham**	**West Yorkshire**	**East of England**
PHE	1 (representing both areas)			
WPP	1	3	1	1
Treatment Provider	1	1	2	2
Local authority commissioner		1		
Total	**3**	**6**	**3**	**3**

Further wave 1 stakeholder fieldwork was conducted once the proof of concepts had ‘bedded in’ (31 in-depth interviews conducted from 3 April to 21 May 2014).

Table B.2 below provides a breakdown of interviews achieved.

Table B.2 Wave 1 interviews

	R&E		RW	
	Coventry and Warwickshire	**Birmingham**	**West Yorkshire**	**East of England**
PHE	1	1	1	1
WPP	1	3	2	2
Work Programme Subcontractors	2		2	2
Treatment Provider	1	1	3	3
Local authority commissioner	1	1	1	1
Jobcentre Plus				1
Total	**6**	**6**	**9**	**10**

Wave 1 findings were consolidated through a second wave of fieldwork with stakeholders (23 in-depth interviews, 13 February to 2 July 2015) and participants (21 in-depth interviews conducted from 11 September 2014 to 23 March 2015).

Table B.3 Wave 2 interviews

	R&E		RW	
	Coventry and Warwickshire	**Birmingham**	**West Yorkshire**	**East of England**
PHE	1 (representing both areas)		1	1
WPP	1	2	4	2
Treatment Provider	2	2	2	3
Local authority commissioner			1	
Jobcentre Plus				1
Total	**4**	**5**	**8**	**7**
Proof of concept participants		4	4	13

Appendix C Wider approaches research: Interviews achieved

Table C.1 below provides a breakdown of interviews achieved as part of the research into wider approaches to supporting clients with a dependency.

Table C.1 Wider approaches sample breakdown

	WPP/Sub-contractor	Public Health England	Local authority	Treatment Provider	Specialist Treatment Provider	Total
North East	1	1	1	2		**5**
Cumbria and Lancashire	2	1	1	1		**5**
Yorkshire and the Humber	2	1		1		**4**
Greater Manchester	3		1		2	**6**
Cheshire and Merseyside	2		1	1		**4**
Lincolnshire, Leicestershire, Nottinghamshire and Derbyshire	1	1			1	**3**
West Midlands	3					**3**
Bedfordshire, Hertfordshire, Northamptonshire	1		1	1		**3**
London	5	1				**6**
Sussex, Surrey and Kent	4	1		2	2	**9**
Thames Valley	2	1	1	1		**5**
Hampshire, Isle of Wight and Dorset	3	2	1	1		**7**
Devon, Cornwall and Somerset	3		1	1	1	**8**
Avon, Gloucestershire and Wiltshire	3		1	2	1	**9**
Total	**35**	**9**	**9**	**13**	**7**	**73**