

Research report

# Alcohol misusers' experiences of employment and the benefit system

by Linda Bauld, Colin Carroll, Gordon Hay,  
Jennifer McKell, Claire Novak, Karin Silver  
and Lorna Templeton

Department for Work and Pensions

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# **Alcohol misusers' experiences of employment and the benefit system**

Linda Bauld, Colin Carroll, Gordon Hay, Jennifer McKell, Claire Novak, Karin Silver and Lorna Templeton

A report of research carried out by the University of Bath and the University of Glasgow on behalf of the Department for Work and Pensions

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# Glossary of benefits

|  |  |
|--|--|
| Disability Living Allowance (DLA)      | People may be eligible for DLA if they have a physical or mental disability severe enough to require someone to help care for them, someone to supervise them, or to cause walking difficulties. Individuals can claim DLA if they fulfil these criteria whether or not they are in work.  |
| Employment and Support Allowance (ESA) | ESA was introduced in October 2008 to replace Income Support, Incapacity Benefit and Severe Disablement Allowance for new claimants. Individuals who cannot work because of illness or disability and are under State Pension age may be eligible for ESA. Drug or alcohol dependency does not of itself confer entitlement – to qualify, claimants have to undertake a medical assessment of incapacity for work called the Work Capability Assessment. This assesses the effects of a person's condition on their ability to carry out a number of everyday activities relevant to work. People with a recorded diagnosis of alcohol or drug dependency may have other diagnoses, for example mental illness, which result in their incapacity for work. |
| Incapacity Benefit (IB)                | This benefit is payable to individuals who cannot work due to illness or disability and are under State Pension age. It was replaced for new claimants in 2008 by ESA. As with ESA, individuals are not awarded the benefit on the basis of a particular condition, but on the basis of the effects that the condition has on the individual's ability to carry out a range of everyday tasks relevant to work. These effects are assessed in a medical assessment called the Personal Capability Assessment.  |
| Income Support (IS)                    | Income Support is a benefit for people on a low income who work less than 16 hours a week, but do not have to sign on as unemployed. Lone parents may also be eligible for IS.   |
| Jobseeker's Allowance (JSA)            | This is the main benefit for people of working age who are out of work but available for, capable of and actively seeking work, or for those who work less than 16 hours a week on average. In order to keep receiving the benefit, JSA recipients are required to attend regular, usually fortnightly, jobsearch reviews at their jobcentre to demonstrate that they are actively looking for work.   |

# Summary

## Introduction

This study was commissioned by the Department for Work and Pensions (DWP) to explore the experiences of adults with alcohol misuse problems in the UK in relation to employment, unemployment and benefit uptake. A separate report contains the findings of a study to estimate the number of people who are accessing DWP benefits and who have a problematic relationship with alcohol (Hay *et al.*, 2010).

The Coalition Government has stated that it is committed to tackling drug and alcohol addiction, which is one of the most damaging root causes of poverty. The Government has also stated that it advocates an approach to addressing addiction that is firmly rooted in the concept of recovery and reintegration; a process through which an individual is enabled to overcome the symptoms and causes of their dependency, and reintegrate back into society. DWP have responsibility for the 'recovery and reintegration' strand of the 2010 Drug Strategy. This strand acknowledges that recovery does not begin or end with treatment, but encompasses employment, education and skills, family support, probation and wider health services around treatment in an holistic fashion to support sustained recovery. The information contained in this report will inform the development of this strand of the strategy.

The report has two main elements – a systematic review of the literature on alcohol misuse, employment and benefits, and a qualitative study involving depth interviews with 53 problem drinkers and 12 professionals working in or with treatment agencies in five study areas in England, Scotland and Wales. Key findings are summarised here.

## Literature review

A systematic review of the literature was conducted that identified 93 relevant articles and reports. The search was conducted between October and December 2009 and limited to studies published from 1990 onwards.

## Alcohol misuse

The 2007 Adult Psychiatric Morbidity Survey showed that just under a quarter (24 per cent) of the adult population in England could be classified as hazardous drinkers, of which four per cent are harmful drinkers. The survey also found that six per cent of the population aged 16-74 could be classed as dependent drinkers (McManus *et al.*, 2009). The 2008 General Lifestyle Survey (GLF) suggests that those employed in managerial and professional roles exhibit the highest levels of weekly alcohol consumption, with the lowest consumption seen in routine and manual worker households. The report also notes that the economically inactive tend to drink less than those who are working (Office for National Statistics (ONS), 2008). A 1990 study found that fewer unemployed men drink alcohol than employed men, but there are more moderate and heavy drinkers amongst the unemployed. (Lee *et al.*, 1990). Men are more likely than women to become problem or excessive drinkers whereas women are more likely to suffer drink-related problems, relative to their level of use (Bongers *et al.*, 1997). Mortality from alcohol-related conditions is associated with increasing age, being male, unemployment and previous employment in an alcohol-related business (Feuerlein *et al.*, 1994).

## **Welfare, employment and alcohol misuse**

Literature from the US suggests that the receipt of benefits does not encourage or increase drug or alcohol dependence, and recommends that alcoholism and drug addiction be considered a serious limitation on employment (Stevenson, 2002). UK literature flags up the lack of availability of suitable treatment programmes and support services, especially for those with multiple and complex needs including drug as well as alcohol misuse problems and/or additional health issues (Alcohol Concern, 2009a). UK studies highlight the need for alcohol users to address their other co-occurring problems, including housing and health issues, before attempting to (re-)enter employment, despite identifying a strong desire amongst many to return to the labour market (Spencer, 2008; Dean, 2003).

## **Alcohol misuse, health and unemployment**

Significant negative health impacts can arise as a result of unemployment, both for the unemployed and their families, and this impact is exacerbated when alcohol misuse is also involved (Wilson and Walker, 1993). Poor health behaviours, such as high alcohol consumption, are exacerbated by unemployment (Montgomery *et al.*, 1998). Research suggests that the prevalence of mental health problems for those dependent on alcohol is more than double that of the general population (Jane-Llopis and Matysina, 2006). However, specialist treatment for clients with dual diagnosis is not always available, and cross-referral between mental health and substance misuse treatment services is low (Menezes *et al.*, 1996; Hilarski and Wodarski, 2001). The evidence suggests that mental health problems and alcohol misuse are not always a barrier to finding work, but they can make it harder to sustain employment (Dooley and Prause, 2002; Zabkiewicz and Schmidt, 2007).

## **Employment, unemployment and alcohol**

Socio-economic factors both influence the onset and continuation of alcohol misuse, and can be influenced by it (Romelsjo *et al.*, 2004; Hemmingsson *et al.*, 1998). The level of impact of alcohol misuse on employment varies, and can be contradictory. There is evidence that the quantity of consumption and the extent of physical symptoms affect employment (Morgernstern *et al.*, 2003; Booth and Feng, 2002; Bray *et al.*, 2000; Mullahy and Sindelar, 1996). A number of studies, including two from the UK, have identified a negative relationship between alcohol dependence and employment (MacDonald and Shields, 2004; Sutton *et al.*, 2004). However, two US studies found alcohol misuse had no impact on employment (Schmidt *et al.*, 2007; Feng *et al.*, 2001). There is also some evidence that moderate alcohol consumption may have benefits for some people in terms of job attainment and remuneration (MacDonald and Shields, 2001).

Studies from Europe and the US conclude that there is a negative correlation between problem drinking and unemployment, suggesting that alcohol misuse (particularly binge drinking) is more likely to start or escalate after unemployment begins (Claussen, 1999; Ettner, 1997; Catalano *et al.*, 1993; Janlert and Hammerstrom, 1992; Dee, 2001).

The relationship between alcohol dependence and other factors (such as education) and barriers to employment has been explored in various studies (Schmidt *et al.*, 2007; Morgernstern *et al.*, 2003; Bush and Kraft, 2001; Sutton 2004; Cebulla, 2004). Research with both substance users and service providers found that they advocate a 'step-wise' (re-)integration into the labour market, involving voluntary, part-time, and short-term work (Cebulla *et al.*, 2004). The importance of support programmes employing staff with an understanding of local labour markets and close links with employers, so that they can successfully match clients to job opportunities in their areas, was also highlighted (Sutton *et al.*, 2004).

## Alcohol misuse and benefits

Almost all the identified literature on alcohol misuse and benefits comes from the US, with just two studies coming from the UK. One of the US studies aimed to determine whether the receipt of benefits was associated with increased drug or alcohol use. It found that new benefit recipients showed reduced levels of alcohol use and concluded that being on benefits did not trigger substance misuse (Rosen *et al.*, 2006). Alcohol misuse was found by another study to be a predictor of longer-term benefit receipt in the case of some benefits, but not others (Schmidt *et al.*, 1998). This suggests that the relationship between benefit use and alcohol misuse may vary depending not only on the characteristics of recipients, but also the form of benefit received.

## Employment-related interventions

Those seeking treatment for alcohol misuse are more likely to have taken this step only after experiencing other problems in their lives, including family breakdown, and mental health problems (Proudfoot and Teeson, 2002; Hajema *et al.*, 1999). Substance abuse treatment alone can result in positive employment-related outcomes. Treatment completion and length of time in treatment are good predictors of positive employment-related outcomes (Metsch *et al.*, 2003; Zarkin *et al.*, 2002; Moos *et al.*, 1999).

Some studies indicate that employment programmes (on their own or part of substance abuse treatment) which are intensive and offer a structured approach, but can also be flexibly adapted to meet individual need, have promise in terms of a range of outcomes. Intensive individual case management support seems to be important (Morgenstern *et al.*, 2009; Diver and Dickson, 2006; McLellan *et al.*, 2003) as does vocational rehabilitation and a focus on developing an individual's 'employability skills' (Diver and Dickson, 2006; South *et al.*, 2001). Predictors of an individual being able to return to work include employment history, employment immediately prior to treatment entry and the proximity of clients to the services available to them (Metsch *et al.*, 2003).

For programmes to meet multiple needs, a strong degree of inter-agency communication and collaboration is necessary between alcohol treatment and employment services (Sutton *et al.*, 2004; South *et al.*, 2001; Gossop and Birkin, 1994). However, overall there is a lack of robust research in the area of employment-related interventions and little evaluation of programmes in the UK (South *et al.*, 2001; Sutton *et al.*, 2004; Cebulla *et al.*, 2004). More evidence is therefore needed in this area.

## Views of alcohol misusers

### Childhood and education

Participants reported mixed experiences in terms of childhood, family life and education, but problems during childhood, for example family break-up or bereavement, living with parental alcohol problems, bullying, truanting or other problems at school, were common characteristics across the sample. Many participants discussed gaining multiple qualifications at school but many others left with none. On leaving school, most participants went on to either further education, employment or an apprenticeship, although not all interviewees were able to sustain these long-term.

### Employment

Although all but one interviewee was unemployed at the time of the study, their previous work experience was extensive and varied. Some had worked for very long periods in the same job or industry, whilst others had had a variety of different jobs. The types of jobs undertaken ranged from

unskilled to semi-skilled and very high skilled occupations. Few interviewees had little or no work experience.

The most common reason cited by participants for leaving previous employment was problems with alcohol, though some had also lost jobs due to ill health or becoming redundant. Most participants conveyed a positive work ethic, although many reported that ongoing physical and mental health problems prevented them from seeking work at the time of interview. Some participants admitted that they had previously done cash in hand, casual work in addition to receiving benefits.

### Alcohol use

Two broad groups emerged from the interview data. For the first group, alcohol problems developed during their younger years, sometimes as a result of exposure to parental drinking problems or workplace alcohol culture. For the other group, alcohol problems developed over longer periods of time, or in response to a particular trigger, such as bereavement, redundancy or unemployment, or mental health problems. Interviewees talked about the breakdown of significant relationships, often related to their alcohol misuse and other problems. As a result, many of the study participants were single and lived alone, often in rented or supported accommodation.

Most of the sample were abstinent at the time of their interview; some had been abstinent for a while, whilst others had very recently entered alcohol treatment. Almost all interviewees said that they had experienced at least one, and usually several, relapses in their attempts to stop drinking.

### Benefits

Interviewees were in receipt of, or in the process of applying for, a number of benefits, including Incapacity Benefit and/or Disability Living Allowance (DLA), Income Support (IS), Employment and Support Allowance (ESA) and Jobseeker's Allowance (JSA). Some interviewees had only become unemployed for the first time, or first significant amount of time, recently because of their alcohol misuse. Others had a long benefit history, with only sporadic periods of employment. A number of clients were claiming benefits for reasons of co-existing mental health issues or other health problems, and only in some cases was alcohol the primary reason for claiming<sup>1</sup>.

Sources of advice on benefits came from benefits advisers and jobcentre staff, health care professionals, support agencies and in some cases other clients, friends or relatives. Staff in alcohol treatment and other support services were a valued source of help in relation to benefits, particularly with form-filling and other forms of practical help.

Experiences of the benefit system generally were mixed, with some clients reporting very positive interactions with staff, and others expressing frustration with staff and systems. These included having to deal with more than one adviser and repeat the same information about their situation each time they saw someone different. A number of clients described negative, even distressing, experiences of medical assessment and subsequent appeals. To many the process seemed opaque and the outcomes arbitrary, and several felt that their assessments focused on their physical rather than mental health issues.

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<sup>1</sup> Alcohol (or drug) dependency does not of itself confer entitlement to disability-related benefits including IB and ESA. To qualify for these benefits claimants have to undertake a medical assessment of incapacity which assesses the effects of their condition on their ability to carry out a number of everyday activities relevant to work. People with alcohol or drug dependency may have other diagnoses, for example mental illness, which result in their incapacity for work.

## Facilitators and barriers to work

Many respondents were personally motivated to return to work and could identify the benefits of returning to employment. However, they were also keen to highlight that they saw this as something which could not happen overnight and that needed to be a gradual process. Others were quite fearful of returning to work, worrying that going back too quickly or taking the wrong kind of job might jeopardise their recovery. Generally, interviewees wanted to take their time to consider what returning to work meant for them. Many wished to try and engage with ‘meaningful’ employment rather than returning to the types of job they had had in the past. Some respondents felt that they lacked the necessary skills and qualifications to regain employment. Training and education opportunities, along with voluntary work, were seen as important stepping stones in the return to work.

Individual barriers to returning to work included wanting more time to deal with their alcohol problems, and fear of the stigma they may face as a result of their alcohol or mental health problems if they had to reveal them to a prospective employer. Significantly, many respondents indicated that they would be worse off financially if they returned to work. Some were concerned that they would be unable to earn sufficient money in a low paid job to cover all their living costs as they would lose the financial support of benefits such as housing and council tax. This was a particular concern for those in supported accommodation.

## Views of professionals

### Engagement, recovery and relapse

Most clients seen by these professionals had long-standing problems with alcohol. Some were in employment, or had been until a recent crisis or escalation in their drinking; others had a limited work history. Some were also drug users (including prescription drugs). Most were described as socially isolated. Female clients often had particular issues and needs including childcare, fear of losing their children, or over time, the loss of family life triggering alcohol misuse.

Professionals identified financial instability as a major barrier to engaging with support and treatment services either caused or exacerbated by issues around benefit claims, household budgeting and debt. Other barriers cited by professionals included the fear of losing benefits; chaotic lifestyles and mental health issues; difficulties with social interaction; denial of the seriousness of their alcohol misuse; pride or stigma; or simply not knowing that help is available.

Feeling positive, motivated and wanting to change is essential for recovery; a negative state of mind is a significant barrier. All the professionals stressed that recovery can take a long time, up to three years or more for those with more complex needs. Some professionals felt that clients would benefit from continuity of support from a treatment professional during this period. Several emphasised that coercion and compulsion were counterproductive; recovery primarily requires self-motivation. People have to want to engage with services, become abstinent and return to work. In addition to treatment needs clients had a wide range of economic, social and practical support needs. Professionals stressed the importance of dealing with these complex ‘life issues’ as part of recovery and before a return to employment.

Relapse is common if not inevitable. Potential triggers include the threat of or actual loss of benefits; financial and housing issues; stress around returning to work too soon; bereavement; family problems; the availability of alcohol and the lack of an (alcohol-free) social life.



## **Interaction with the benefits system**

Professionals helped clients with benefit forms but did not feel knowledgeable about benefits, and usually referred clients on to specialist advice services. Most described positive experiences of jobcentre services, although some acknowledged that clients' experiences were less positive. They reported clients' misconceptions of the benefit system and entitlements, and difficulties caused by their alcohol problems and stress/anxiety. Some benefit requirements (eg. job-search activities for JSA recipients) were seen to potentially hinder recovery and return to work. Some negative experiences of the ESA medical assessment were reported, particularly for clients with mental health issues and chaotic lifestyles.

Withdrawal of benefits was seen as particularly problematic for those with alcohol misuse problems, as the loss of benefits could lead to health problems, disengagement from treatment, and relapse. In addition, the payment of backdated benefits in a lump sum was identified as an issue for some recipients, for whom it may trigger episodes of binge drinking.

## **Employment**

Most professionals felt it was important for clients to 'do something' and to be socialised back into a work environment, even if employment was not initially paid. However, they felt it was unlikely that some clients would return to work as their problems were too complex, or their mental health issues were too great.

Facilitators to a return to work included a positive state of mind and social support, access to appropriate support services, retraining, and a staged return to the workplace, including 'bridging' services and voluntary work. Barriers to employment described by professionals included a lack of financial stability, confidence and motivation, and social support. Additional barriers included time out of employment, lack of appropriate work experience and skills, concerns over a criminal record, a 'culture' of not working within the family or locality, and alcohol misuse itself.

For some clients being on benefits can be a motivator to return to employment, but for others it can be a barrier. This is particularly the case for older clients, or in areas where employment opportunities are limited or inappropriate, and clients are reluctant to leave the 'safety net' of benefits as the alternative may be seen as significantly worse. It was felt that being 'pushed' into returning to work too soon was likely to be counterproductive, with a high chance of relapse.

## **Gaps and issues in service provision**

Most professionals were generally positive about integrated working with other services, the voluntary sector, benefit agencies and jobcentres. Some felt more targeted provision of benefits advice would be helpful. Concerns were expressed about the perceived lack of services for adults with alcohol misuse problems. Specific gaps identified included outreach, aftercare, out of hours services, family therapy, and services targeted at binge drinkers and young people. Most argued for a wider view of treatment, to include social support and help with living an alcohol-free life.

## Conclusions and recommendations

A number of key themes and issues emerge from the study and there is a clear relationship between the literature and the empirical findings, as well as important gaps where more research is needed. In particular, there are a number of potential recommendations for policy and practice. These recommendations are intended to provide some practical suggestions for solutions to issues identified within the report. The current uncertainties about cost reductions within the public services may affect what can be implemented.

**Treatment, recovery and employment** – Findings demonstrate that engagement with and completion of treatment is an important first step on the route to employment. However it is recovery (involving the resolution of other life issues and stresses such as housing problems) rather than treatment completion that is a key component of coming off benefits and securing employment. Interventions and policies need to recognise this distinction. A recovery allowance involving a relaxation of benefit conditionality that could be accessed by those who are undertaking or have recently completed a treatment course for alcohol or drug addiction would assist individuals in focusing on recovery and moving forward with more confidence and less fear of financial hardship.

A step-wise approach starting with voluntary work, part-time work or work experience to provide a gradual reintegration to the workplace, and ensuring that individuals are better off in work than they would be on benefits, would help this group make the transition to employment.

Further evidence is needed around longer-term employment outcomes from programmes, and the role that abstinence plays in helping those leaving treatment to gain and sustain employment.

**Additional support from Jobcentre Plus staff** – Alcohol misusers face a number of barriers to both accessing appropriate benefits and moving off them and into employment, and some reported feeling that they didn't receive the support they felt they needed from Jobcentre Plus staff. They would benefit from better access to those with specialist knowledge in order to negotiate the benefit system. A caseloading system in which alcohol misusing customers see the same Jobcentre Plus adviser every time they visit may help to improve the experience for this group by removing the need for them to repeat often sensitive and difficult personal information to different advisers.

**Mandation to treatment** – The literature suggests that the receipt of benefits does not encourage or increase alcohol dependency. Alcohol misuse can cause unemployment which may result in being on benefits, but it is not the benefit receipt in itself that causes or escalates alcohol misuse. In our view there is inadequate evidence from either the literature or qualitative research that making treatment a condition of benefit receipt would improve treatment outcomes for clients or result in more alcohol misusers re-entering employment.

**Interagency working** – One of the clearest findings from our study is that interagency working can result in better support for adults with alcohol misuse problems and better access to future training and employment opportunities. The clients interviewed in our study expressed frustration about having to deal with multiple agencies and individuals and having to provide the same information repeatedly. They also reported that Jobcentre Plus staff were not always responsive to their needs, particularly when these were related to substance misuse. The professionals we interviewed also identified a need for benefit and employment advice for their clients in the context of some understanding of alcohol misuse. One model for increasing interagency working would be the introduction of Jobcentre Plus outreach sessions in treatment provider premises.

# 1 Introduction

This study was commissioned by the Department for Work and Pensions (DWP) to explore the issues surrounding employment, unemployment and benefit uptake amongst adults with alcohol misuse problems in the UK. A separate report contains the findings of a study to estimate the number of people who are accessing DWP benefits and who have a problematic relationship with alcohol (Hay and Bauld, 2010).

The Coalition Government has stated that it is committed to tackling drug and alcohol addiction, which is one of the most damaging root causes of poverty. The Government has also stated that it advocates an approach to addressing addiction that is firmly rooted in the concept of recovery and reintegration; a process through which an individual is enabled to overcome the symptoms and causes of their dependency, and reintegrate back into society. DWP have responsibility for the 'recovery and reintegration' strand of the 2010 Drug Strategy. This strand acknowledges that recovery does not begin or end with treatment, but encompasses employment, education and skills, family support, probation and wider health services around treatment in an holistic fashion to support sustained recovery. The information contained in this report will inform the development of this strand of the strategy.

This study aimed to:

- review UK and international literature on the relationship between alcohol misuse, unemployment, benefit receipt and routes back to work;
- explore the views of adults with alcohol misuse problems regarding employment, unemployment and benefits;
- examine the perceptions of professionals working with, or in, alcohol treatment agencies regarding the needs of their clients, particularly in relation to benefits and work.

The report has two main elements – a systematic review of the literature on alcohol misuse, employment and benefits and a qualitative study exploring the views of problem drinkers and professionals working in or with treatment agencies in five study areas in England, Scotland and Wales. The study was conducted by a team of researchers from the Department of Social and Policy Sciences at the University of Bath and the Centre for Drug Misuse at the University of Glasgow. The team has also conducted a study to estimate the size of the population of individuals in receipt of benefits who have alcohol misuse issues (Hay *et al.*, 2010). These reports are complementary to two previous studies conducted for the DWP by the same team, focusing on problem drug use and benefits (Bauld *et al.*, 2010; Hay and Bauld, 2008).

It is widely acknowledged that excessive consumption of alcohol can cause a range of health and social problems. The UK has what has been described as a heavy drinking culture (Institute of Alcohol Studies, 2009) and UK governments have a long history of attempts to control heavy drinking (Alcohol Concern, 2009b). The World Health Organisation (WHO) has defined the harm caused by alcohol consumption as the third highest preventable public health problem facing the world (WHO, 2008). In the UK, alcohol misuse costs the NHS £2.7 billion each year to address alcohol-related health problems (Department of Health, 2008). Alcohol misuse is estimated to cause over 30,000 deaths per year (Balakrishnan *et al.*, 2009).

Alcohol misuse is defined in a range of ways that are discussed later in this report. Many countries have set sensible drinking guidelines. In the UK these are defined as no more than three to four units per day for men and two to three units per day for women on a regular basis (Department of

Health, 2004). It is estimated that around one in three men and one in six women drink above the recommended guidelines. Excessive drinking is associated with being older, living alone and living in urban areas (MacDonald and Shields, 2004). The relationship between problem drinking and social class is complex, but the risk of experiencing the physical symptoms of alcohol misuse is highest in more disadvantaged groups. The link between alcohol misuse, unemployment and benefit uptake is explored further in this report.

The report has five main sections: First, we outline the research methods we employed. This is followed by findings from the systematic review of the literature on alcohol misuse, benefits and employment. We then describe findings from interviews with adults with alcohol misuse problems and professionals who work in, or with, treatment agencies. The report concludes with a discussion section that links our interview findings with the literature and outlines recommendations for policy and future research.

## 2 Methods

This study includes two elements: a literature review, drawing on systematic review methodology, followed by fieldwork with adults with alcohol misuse problems who were in contact with treatment agencies and with professionals working in, or with, treatment agencies from five research sites across England, Wales and Scotland. This section of the report describes our approach to the literature review and to the qualitative study. Both parts of the study followed similar methods to a recently completed study undertaken by the authors for the DWP with problem drug users (Bauld *et al.*, 2010).

### 2.1 Literature review methods

The literature review component of this study aimed to examine available evidence on the relationship between alcohol misuse and benefit uptake, employment and unemployment.

#### 2.1.1 Literature search

We adopted a systematic approach to this literature review. This was informed by the systematic review methodology recommended by the National Institute of Health and Clinical Excellence in their *Methods for the development of NICE public health guidance* (NICE, 2006). The same approach has been used by the authors in other recent studies (Bauld *et al.*, 2009a; Bauld *et al.* 2009b; Bauld *et al.* 2009c; Murray *et al.*, 2009). The following types of literature were targeted:

- primary studies located via searches of bibliographic databases;
- primary studies identified from references in existing reviews and articles;
- studies obtained via public health and other appropriate websites.

The searches of bibliographic databases involved: (1) an initial scoping search primarily using study titles during which key references were identified and search strategies were refined; (2) a main search using the agreed key word search strategies to identify potentially relevant studies.

#### 2.1.2 Search process

A search strategy was developed and tested during the initial scoping search and then refined by the research team.

The main search strategy used the key words detailed in Box 2.1.

##### Box 2.1 Search terms

|                |     |                   |      |               |
|----------------|-----|-------------------|------|---------------|
| alcohol *use*  | and | benefit           | plus | mental health |
| abuse          |     | welfare           |      | disab*        |
| problem drink* |     | social assistance |      | incapacity    |
|                |     | insurance         |      |               |
|                |     | and               |      |               |
|                |     | training          |      |               |
|                |     | work*             |      |               |
|                |     | (un)employ*       |      |               |

The search was conducted between October and December 2009 and limited to studies published from 1990 onwards.

The search process has been clearly documented (databases searched, time span searched, results of individual searches) to ensure it is transparent and repeatable. Search results have been saved as Endnote databases and as text files. The electronic databases that were searched included:

- Web of Knowledge (includes MEDLINE);
- EMBASE (Ovid);
- Cochrane Library (Wiley);
- SIGLE (grey literature);
- Project Cork.

The database search was supplemented by a search of two relevant websites: Social Care Online and Drug and Alcohol Findings. Finally, hand searching of Addiction Abstracts from 1996 was conducted to ensure no key recent studies had been missed. As the searches sought to retrieve both quantitative and qualitative studies, no study design filter was employed; i.e. no studies were omitted from the review on the basis of the research methods used.

### 2.1.3 Selection of studies for inclusion

The initial database search produced more than 20,000 records but a significant number of these were duplicates that were removed when the records were imported into Endnote. The title of the remaining records was screened by one reviewer to identify potentially relevant studies of any design. Three hundred and ninety-two records were considered potentially relevant and were then screened on the basis of title and abstract. These abstracts were divided up amongst the research team and all abstracts were screened by at least two reviewers, with a third reviewer consulted to resolve any disagreement. Of these abstracts, 108 publications were considered potentially relevant and full papers for these records were ordered. Of these, 68 were included following final screening on the basis of full papers. An additional 25 relevant papers were identified from references. Overall, therefore, 93 articles/reports were examined in detail in this review.

### 2.1.4 Critical appraisal and synthesis

The studies that met the inclusion criteria were grouped into a series of themes based on the main focus of the article/report. Themes were allocated to different members of the research team who then read all the papers relating to that theme. The themes were: prevalence of alcohol misuse; alcohol use, welfare and employment; alcohol misuse and other diagnoses; employment and alcohol; unemployment and alcohol; alcohol and benefits; and interventions.

In discussion with the research funders it was agreed that the findings from the literature review would be organised under a number of headings:

- alcohol misuse
- welfare, employment and alcohol misuse;
- alcohol misuse, health and unemployment;
- employment, unemployment and alcohol;
- alcohol and benefits;
- employment-related interventions.

Following the grouping of studies into themes, each article/report was then read by the relevant research team member and summarised in the form of an evidence table. Data was extracted from each study and included in the table. The evidence tables were then used as the basis for drafting the thematic sections listed, with cross-referral to the original studies and reports for additional detail when required.

### 2.1.5 Quality of the literature and limitations

In the critical appraisal stage of the review 40 studies were rejected because of a lack of relevance, or a lack of empirical findings. A few general sources (i.e. those which were not research reports or academic papers) were included where they were felt to be particularly relevant to the research topic. The remaining studies were assessed for their methodological rigour and quality and any limitations were noted in the evidence tables. Of the 94 papers in the review, the majority of the papers included were published in peer-reviewed journals. Sixteen were from other sources including reports produced for, or by, government departments or non-governmental organisations and commentary articles. Secondary sources mentioned in the text are referenced in footnotes.

The empirical studies included in this review used a variety of research designs and sample sizes, which were detailed in the evidence table and noted in the text or in footnotes where appropriate. The time periods over which data were collected, analysed and reported on, also varied greatly. Because of the variation in methods, sampling and analysis it is not always possible to make meaningful comparisons between study findings, except in the case of a few similar studies. Connections between study findings, and between the literature and the findings of this study are highlighted in the discussion section of this report. Where the term 'review' is used in the text, this refers to a paper published in a peer-reviewed journal, which reviews previous work (although this will not all necessarily have been peer-reviewed).

We identified a number of limitations which were common to several studies, which are summarised below. Limitations specific to particular studies have been noted in the text where relevant.

There was a problem with comparability across studies due to the diversity of definitions and measures used (for alcohol use or misuse<sup>2</sup>; and employment<sup>3</sup>). There was also wide variation in sampling approaches; some studies were specific to certain types of welfare, or to certain demographics, or a limited geographical area (in some cases with particular employment profiles). There was an overall lack of studies comparing alcohol misusers receiving welfare and the general population, and a lack of pre- and post-welfare reform studies in the US (and longitudinal work generally). In terms of reliability virtually all studies relied on self-reported levels and frequency of alcohol use, and several studies mention the likelihood of under-reporting.

There was a clear lack of UK research and evaluation, particularly relating to alcohol use and benefit take up, and treatment outcomes relating to employment, and much of the evidence came from the US. The US studies tended to focus on veterans and lone mothers, while European studies tended to focus on men. Our search, conducted in 2009, was only able to identify two UK reports that were directly relevant to the theme of alcohol misuse and benefit uptake (Cebulla *et al.*, 2004; Sutton *et al.*, 2004). We did identify at least one commentary piece on this issue (Hunter, 2009, from the magazine *Community Care*) but only one empirical study (Cebulla *et al.*, 2004). This is a severe limitation as some aspects of the US context and American social policy are not relevant to the UK.

<sup>2</sup> See Appendix B for a summary of measures used, with example studies from this and other sections.

<sup>3</sup> See Section 2.1.6.

A further limitation is that a number of the studies in this section were conducted in the late 1980s and early 90s (pre-US welfare reform), although the articles themselves often appeared some years later. Among other changes, patterns of alcohol use are likely to have changed since then, especially among women. In addition the focus in some US studies on the issues around treatment cost and employment-based medical insurance is not directly relevant to the UK.

A major limitation when considering alcohol misuse was that the majority of studies we identified looked at substance misuse in general, and it was not always possible to separate out data for study participants (or outcomes for study participants) who only used alcohol. In addition there were few studies looking at the complexity of issues facing those with alcohol misuse problems and other health and social needs.<sup>4</sup> There was also an issue with the age of some data sets as cross-sectional studies may not take into account changes in the economic context, benefits or levels of substance use and the availability of treatment.

### **2.1.6    Terminology**

In the studies we reviewed a variety of terms were used to describe the use and misuse of alcohol including ‘abuse’, ‘dependence’, ‘alcoholism’ and ‘problem drinking’. There are some standard definitions of these terms (see table of definitions in Appendix A and table of measures in Appendix B) but these have evolved over time and a full consensus on definitions and measurement has not yet emerged in the literature. In the descriptions of the studies and their findings that follow we have used the authors’ terms wherever possible. Consequently, the use of the various terms is not consistent across studies, and any comparisons between studies should be made with caution. In our narrative we have used the term ‘alcohol misuse’.

## **2.2    Qualitative study**

This research included a qualitative study. Qualitative methods were employed because they provide a means of exploring individuals’ experiences and perspectives in depth. In previous research with problem drug users we found that semi-structured interviews provided the best way of capturing service users’ views on the support they had received, the benefits system and routes into employment. We also found that semi-structured interviews were an effective way of exploring the perspectives of professionals working with adults with substance misuse problems. As a result we adopted a similar research design in this study focusing on alcohol misuse.

### **2.2.1    Fieldwork**

Interviews with 53 alcohol users who were clients of alcohol treatment agencies and 12 professionals were conducted in five areas. These study sites were selected in consultation with colleagues from the DWP and personal contacts which members of the research team had with Drug (and Alcohol) Action Teams (D[A]ATs) and other treatment providers across England, Scotland and Wales. The study sites were chosen to give diversity to the overall sample, including urban and semi-rural areas. Clients and professional interviewees were recruited via the organisations in each area. All of the organisations delivered treatment and support to adults with alcohol misuse problems. A brief description of the study sites, and the nature and role treatment service providers worked with in each site, can be found below.

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<sup>4</sup> One exception is Dean (2003) in Section 3.2.2.



## Study sites

**Area A** is a largely rural county in the South West of England. The collaborating organisation is the sole provider of drug and alcohol treatment services for the county. In both towns client interviewees were recruited via the intensive structured group programme; all clients were therefore abstinent at the time of the interviews and had been engaged with treatment for a while.

**Area B** is a seaside town around seven miles from a large city in Wales. The research team collaborated with the local Alcohol and Drug Team, which also provides non-NHS treatment services. Client interviewees were recruited via the counselling service. One member of the counselling service team was an Independent Living Adviser who works with clients who have concerns about their benefits. Interviewees here tended to be at different stages in their treatment, with some having been abstinent for a while but others were new to treatment or had recently relapsed.

**Area C** is a London borough. At this site, the study team collaborated with a local service user organisation that had established a weekend service to meet some of the social as well as support needs of drug and alcohol service users within the area. In this environment, service users are able to socialise with peers and engage in a number of sporting, artistic and therapeutic activities. The service also provides some substance-related support, for example, provision of a needle exchange and referral to other agencies.

**Area D** is a large town situated in the North West of England within ten miles of a large city. At this research site, the study collaborated with a voluntary organisation that provides services related to drug and alcohol addiction, at multiple locations, across the north of England. As an organisation, one of their main objectives is to provide '*evidence-based solutions...based on cognitive behavioural and motivational models of intervention*'. At their facility based in the centre of town, staff provide clients with a range of services including counselling, motivational work and alternative therapies, such as acupuncture. Staff also provide support for individuals through shared care arrangements with the NHS and the criminal justice system.

**Area E** is a local authority area in Scotland that combines both urban and rural settlements. Interviews in this area were conducted within this area's largest town. In this area, the study team collaborated with a voluntary organisation which provides services to individuals with problems related to alcohol, drugs and gambling. The range of services provided include information and advice; counselling, group work and training as well as supported accommodation and tenancies. Most of the people interviewed were drawn from the service's supported accommodation and tenancy programme. To qualify for supported accommodation, clients are required to be abstinent from alcohol for six weeks prior to entry. Once admitted to supported accommodation, staff work with clients to address their addiction problems and develop their ability to handle everyday tasks. In recent years, this service has received deprived area funding from Jobcentre Plus to work on issues related to alcohol misuse and employability with claimants of Incapacity Benefit (IB).

More information on the study areas can be found in Appendix A, including mortality figures; estimates of the prevalence of alcohol misuse; unemployment rates and the numbers of people claiming IB in those areas.

Once potential study sites had been identified, contact was initiated by a member of the research team to explain the research and to ask if the site wished to participate in the study. Study information sheets were used where necessary to provide further information which could be disseminated about the study, for example, to members of staff teams. Once agreement had been secured each case study site agreed to identify and approach clients about the study, and to assist researchers with making arrangements for site visits. At this stage a small number of professionals who worked for, or with, each treatment agency were also identified and arrangements were made to interview them face-to-face or by telephone. Five members of the research team conducted the fieldwork in the five case study sites between November 2009 and March 2010.

### **2.2.2 Research ethics**

The study obtained ethical approval from the Faculty of Humanities and Social Sciences Research Ethics Committee at the University of Bath. All participants, both alcohol users and professionals, gave informed consent to be interviewed. In addition, because one member of the research team was employed by an NHS Trust, additional research approval was needed, and secured, for her involvement in the study.

### **2.2.3 Interviews with alcohol users**

The research team accessed problem alcohol users in each of the five study areas through professionals at each service. In some cases the professionals were working directly with potential participants; in a small number of cases the professionals had a specific remit to focus on employment-related issues. Professionals assisted the researchers to arrange the site visits for the interviews to be conducted, and a member of staff was available when site visits took place, to assist the researchers and also to ensure that someone was available should any of the interviewees require any additional support. A total of fifty three interviews were conducted with clients (38 men and 15 women. See Appendix D for a table summarising gender and age for each study site)

At the start of each interview the researcher explained the study to the interviewee, provided an information sheet and sought written informed consent. The interview then proceeded using a semi-structured topic guide which was designed to include key areas of interest and was agreed in advance with colleagues at the DWP (see Appendix E). Interviews lasted between 15 minutes and just over an hour. All interviews were audio-recorded and the recordings were supplemented by detailed notes taken by the interviewers.

After the interviews at the first two study sites the interviewers wrote brief notes summarising the interviews and these were circulated to the research team. This allowed for discussion about the interviews and some minor changes were made to the interview topic guide as a result. In this way, the work at the first two case study sites also served as a natural pilot for the study.

### **2.2.4 Interviews with professionals**

Twelve professionals who worked for, or closely with, treatment agencies were interviewed as part of the study. No DWP or Jobcentre Plus staff were interviewed. The aim was to interview two professionals at each study site, although in two sites three professionals were interviewed. The professionals were all individuals who had direct contact with alcohol users, usually in a supportive capacity and in some cases with a specific remit for assisting with benefits or employment issues (the topic guide for these interviews can be found in Appendix F). Most of the interviews with professionals were conducted face to face, with four completed by phone. The interviews lasted between 35 minutes and one hour.

### **2.2.5 Analysis**

All interviews were audio recorded using a digital recorder and transcribed in full. These transcripts were then analysed using the Framework approach, which is a qualitative analysis approach commonly employed in applied policy research (Ritchie and Lewis, 2003; Ritchie, Spencer & O'Connor, 2004). Where relevant, observations from interview notes were used to provide a context for the analysis. The same process of analysis was undertaken for both the alcohol misuser and professional interviews. Analysis of the data from the alcohol misusers and the professionals was undertaken independently with the research team subsequently discussing the findings in preparing the report.

The transcripts were initially divided by case study area due to the large number of interviews. Analysis began with members of the research team reading through the transcripts. At least two members of the research team read through the transcripts for each area. On the basis of this initial reading, a number of key themes were identified. These themes then served as the basis for developing a series of frameworks for each theme. The themes dovetailed with the structure of the interview topic-guide. A re-reading of the transcripts then produced sub-themes which were then added to the framework. A final coding framework was then agreed by the research team and an Excel Spreadsheet developed to facilitate ordering of the data. Members of the research team then coded the data and entered the relevant parts of the transcripts into the appropriate parts of the framework. One researcher led on this for each case study site area, with at least one other member of the team checking the frameworks, usually by independently coding and entering some of the data. Once this process had been completed a resource document was produced that included a narrative that explored the main themes and sub themes with key quotes – this served as the basis for drafting the findings section for the report, with members of the research team taking responsibility for drafting different parts of the findings section. One member of the research team took the lead with drafting the professionals' findings section. Draft findings were reviewed and discussed by other team members to ensure that the reporting was comprehensive and accurate.

In the findings sections of the report we protect the anonymity of both the alcohol users and the professionals by making no reference to name, occupation or area. Instead we outline key themes and illustrate these where relevant with verbatim quotes without attributing these to particular interviewees. This approach means that any potential differences between case study areas may be difficult to distinguish. However, where these differences were apparent we have highlighted them in the text while retaining the anonymity of our interviewees. With regards to the professionals, it may mean that it is difficult to identify where the views of interviewees have been shaped or influenced by their professional background. However, as this study did not set out to represent the views of any particular group of professionals in relation to alcohol misuse and the benefits system, we believe that these limitations do not undermine the value of the information provided.

# 3 Literature review

This chapter sets out the findings from a systematic review of the literature relevant to alcohol misuse and benefits, which was conducted between October and December 2009. For details of the methodology used to conduct this review please see Section 2.1.

The papers selected for inclusion in the review are organised under six headings as follows:

- alcohol misuse (18 papers);
- welfare, employment and alcohol misuse (6 papers);
- alcohol misuse, health and unemployment (12 papers);
- employment, unemployment and alcohol (24 papers);
- alcohol and benefits (20 papers);
- employment-related interventions (12 papers).

For the purposes of the critical appraisal and evidence synthesis stage of the review, no articles were included in more than one theme. This, however, does place artificial distinctions around individual studies which may be relevant to more than one theme. Any overlap is addressed by cross-referencing where appropriate.<sup>5</sup>

Throughout the review we begin each subsection with a summary of key messages from the literature, and then move on to discuss individual studies or groups of studies.

## Limitations of the data

As noted above in the methods section of this report there were some limitations to the literature identified, which are summarised again here. A major limitation is the general lack of relevant UK research, and that a considerable number of the US studies pre-date welfare reform. For a number of reasons relating to study design (the range of definitions and measures used, variation in sampling, and demographic differences) it is hard to make comparisons across the studies and there is a general reliance on self-reporting of alcohol use. In addition many of the studies in the review look at substance use in general rather than focusing specifically on alcohol misuse.

For more detailed discussion of the limitations of this review please see Section 2.1.5.

## 3.1 Alcohol misuse

In the course of conducting the review of the literature we identified a number of papers which provide background information on alcohol misuse, and therefore a context for the study.

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<sup>5</sup> For example the two reports by Sutton, Cebulla and colleagues (Department for Work and Pensions (DWP), 2004) are referred to in several sections of this report, but are only included in the total for Section 3.4.

### Summary

- Although UK survey data exist on the prevalence of alcohol misuse (most notably through General Lifestyle (previously Household) Survey), the peer-reviewed literature relating to the prevalence of alcohol misuse in the general population or in subgroups is extremely limited.
- The *2007 Adult Psychiatric Morbidity Survey* showed that just under a quarter (24 per cent) of the adult population in England could be classified as hazardous drinkers, of which four per cent are harmful drinkers (McManus *et al.*, 2009). The survey also found that six per cent of the population aged 16-74 could be classed as dependent drinkers. Rates of harmful, hazardous and dependent drinking were all higher amongst men than women.
- The *2008 General Lifestyle Survey* in the UK suggests that those employed in managerial and professional roles exhibit the highest levels of weekly alcohol consumption, with the lowest consumption seen in routine and manual worker households. The report also notes that the economically inactive tend to drink less than those who are working (Office for National Statistics (ONS), 2008).
- One 1990 study found that fewer unemployed men drink alcohol than employed men, but there are more moderate and heavy drinkers amongst the unemployed (Lee *et al.*, 1990).
- Men are more likely than women to become problem or excessive drinkers, whereas women are more likely to suffer drink-related problems, relative to their level of use (Bongers *et al.*, 1997).
- Mortality from alcohol-related conditions is associated with increasing age, being male, unemployment and previous employment in an alcohol-related business (Feuerlein *et al.*, 1994).
- The cost of alcohol misuse to society, though based on a number of assumptions, is substantial. The Cabinet Office estimated that alcohol misuse in England cost between £18 billion and £20 billion over the year 2001 (and in 2001 prices), as a result of (amongst other things) increased health care, lost productivity and crime. Estimates from Scotland in particular highlight the significant cost to the economy in terms of alcohol-related unemployment due to lost productivity (Cabinet Office Strategy Unit, 2003; Scottish Executive, 2001; Varney and Guest, 2002; York Health Economics Consortium, 2010).
- There is some evidence available from the Alcohol Needs Assessment Research Project (ANARP, 2005) on the treatment needs of those who misuse alcohol, the proportion that access treatment, and the gap between needs and access. However, ANARP does not assess the availability and effectiveness of treatment programmes generally, or employment-related interventions specifically. There is also a lack of research on the impact on UK employers of alcohol abuse and/or any existing employee support programmes.

The 18 papers in this section are organised under the following two headings:

- prevalence of alcohol misuse;
- the risks and costs associated with alcohol misuse.

Studies relating to patterns and trends in alcohol misuse relating to benefits, employment and treatment interventions can be found in later sections of the literature review.

### 3.1.1 Prevalence of alcohol misuse

Searches of the literature produced very limited results with regard to peer-reviewed research into the prevalence of alcohol misuse, particularly amongst the groups of interest to this research such as the unemployed. Only two directly relevant papers were found, one 1990 UK study focused on older unemployed men, the other with a limited geographical focus (Rotterdam). Because of the lack of peer-reviewed papers we include here, by way of context, a summary of key information relating to alcohol misuse at the international level (from the World Health Organisation (WHO)) and the national level (from the Information Centre and ONS).

The WHO's *Global Status Report on Alcohol* (WHO, 2004) provides an overview of drinking patterns and the effects on health world-wide. The report, the culmination of work done over a three year period, involved a summary of peer-reviewed and grey literature that discussed various aspects of alcohol use with reference to each world region. The report stated that there are 76.3 million people in the world with disorders related to an alcohol diagnosis; and that there have been 1.8 million alcohol-related deaths, accounting for 3.2 per cent of total deaths across the world. The report also highlighted a finding from the work of Rehm and Eschmann (2002)<sup>6</sup> that showed that, in Europe in 1999, 55,000 individuals aged 15 to 29 died due to alcohol use.

The *2007 Adult Psychiatric Morbidity Survey* (McManus et al., 2009) found that just under a quarter (24 per cent) of the adult population in England could be classified as hazardous drinkers, of which four per cent are harmful drinkers. Men were twice as likely as women to be hazardous drinkers (33 per cent compared with 16 per cent) and three times as likely to be harmful drinkers (six per cent compared with two per cent). Rates of hazardous and harmful drinking were higher amongst the younger age groups. The survey also found that six per cent of the population aged 16-74 could be classed as dependent drinkers, of which the majority were mildly rather than moderately or severely dependent. As with hazardous and harmful drinking, prevalence rates were higher amongst men than women (nine per cent of men compared to four per cent of women classed as alcohol dependent).

The ONS report, based on findings from the *2008 General Lifestyle Survey* (ONS, 2010)<sup>7</sup>, details frequency of alcohol consumption, amounts consumed, and average weekly consumption<sup>8</sup>. It also presents data on the association between consumption and characteristics such as gender, age, socio-economic classification, and region. It is important to note that the survey methodology changed in 2006, and this needs to be taken into account when looking at trends in alcohol consumption. The general trend identified by this survey is a steady increase in average weekly consumption from 1998 to 2002, followed by a decline of about 15 per cent to 2006. However, the authors note the possibility of under-reporting, as well changes in glass sizes (and therefore the survey methodology) and the strength of alcoholic drinks over this period, which makes comparison across survey data less reliable. They also note that the greater fall in consumption for young people may be partially explained by their reduced participation in the survey. In 2008 the average alcohol consumption was around 13 units a week, although it was about a third lower for those aged 65 and over (8.5 units per week). The average consumption for men was about double that of women (16.6 units to 8.4), and triple that of women when looking solely at the older age group (65+).

<sup>6</sup> Rehm J., Eschmann, S. (2002). 'Global monitoring of average volume of alcohol consumption'. *SozialundPräventivmedizin*, 47(1):48-58. In WHO (2004) *Global Status Report on Alcohol*, Geneva: WHO.

<sup>7</sup> ONS General Lifestyle Survey (GLF, previously General Household Survey) report: *Smoking and drinking among adults*, 2010.

<sup>8</sup> See Appendix C for measures used.

In terms of socio-economic status, the GLF reports that average weekly consumption was highest (13.8 units) for those in the managerial and professional group, and lowest (10.6 units) among those in routine and manual worker households, with the difference particularly pronounced for women (10.2 to 6.5 units per week respectively). Similarly, the report notes generally higher consumption among men and women in high income households, with those who are economically inactive tending to drink less than those who are working. Average weekly consumption varied across the countries and regions of the UK, with consumption in England highest at 12.4 units (16.8 for men and 8.6 for women); 12.4 in Wales (17.3 for men, 7.8 for women) and lower in Scotland at 10.1 units per week (14.3 for men, 6.5 for women). The region with highest weekly consumption was Yorkshire and the Humber (15.3 units) and the Midlands was the lowest (10.7 units).

In terms of heavy drinking (defined for men as drinking more than eight units on at least one day during the previous week, six for women) there was variation according to gender (21 per cent of men and 14 per cent of women) and age group: 30 per cent for men (24 per cent for women) aged 16 to 24; 27 per cent for men (20 per cent for women) aged 25-44; 21 per cent for both men and women aged 45-64; and seven per cent for men (two per cent for women) aged 65 or over. There was also variation in amounts drunk for men and women in different socio-economic groups. However, there were notably higher rates of heavy drinking among women in large employer/higher managerial households than those in the 'routine and manual' group (38 per cent to 21 per cent for drinking more than three units on any one day; 18 to 10 per cent for drinking heavily in the previous week). Those in employment were more likely to have drunk alcohol during the previous week (76 per cent for men, 64 per cent for women) than the unemployed (58 per cent and 48 per cent) and economically inactive (56 per cent and 45 per cent). A similar pattern emerged for heavy drinking: 27 per cent for the employed compared to 16 per cent for the unemployed (women 20 per cent compared to 11 per cent for economically inactive, based on drinking more than 6 units per day).

The 2008 GLF also reports alcohol consumption by region. People in England were more likely to have drunk alcohol on at least five days in the previous week (20 per cent of men, and 12 per cent of women) than those living in Scotland or Wales (around 14 per cent of men and eight to nine per cent of women). Heavy drinking appears more common in England (18 per cent) than it is in Wales (14 per cent), and the regions associated with higher and heavy drinking were the North West, and Yorkshire and the Humber (ONS, 2010).

Moving to the limited peer-reviewed research on the prevalence of alcohol misuse, a cross-sectional study by Lee and colleagues (1990) used Scottish Heart Health Study data from men and women aged 40-59 years. Owing to the low numbers of unemployed women included in the study and the differences in their drinking behaviour their data were not included. Comparison of the data for employed and unemployed men demonstrated that amongst the unemployed, fewer men drank alcohol than the employed but also that there were more moderate and heavy drinkers amongst the unemployed. Of those who drank heavily, their drinking was more frequent, in greater quantity and they were more likely to binge drink. What was not clear was whether the style of drinking was influenced by the loss of employment or by pre-existing drinking patterns. Blood tests (GGT<sup>9</sup>) confirmed the self-reported higher consumption rates amongst the unemployed heavy drinkers in comparison with the employed drinkers. It had also been suggested that the non-drinkers in the unemployed group may have been ex-drinkers, however, the tests showed that these men were actually low or non-drinkers<sup>10</sup>.

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<sup>9</sup> Serum gamma-glutamyltransferase. See Appendix C for details.

<sup>10</sup> Elevated GGT levels can indicate the existence of liver disease and other alcohol related health problems, even after someone has stopped drinking. This group had GGT levels lower than the employed non-drinkers indicating that they were unlikely to have been heavy drinkers in the past.

In a more recent Dutch study Bongers and colleagues (1997) conducted a cross-sectional survey that examined alcohol use and levels of problem drinking amongst the population of Rotterdam in 1994 (n=3,537). They found that the majority of the population were 'light' to 'moderate' drinkers (neither defined here); 18 per cent were abstinent; eight per cent were 'excessive' drinkers and nine per cent were 'problem' drinkers (see Appendix C for measures used). Looking more closely at drinking patterns, the researchers found that men were more likely than women to become problem or excessive drinkers whereas women were more likely to suffer drink-related problems, relative to their level of use. The authors also found that factors such as being single, unemployed and unfit to work (men only) were associated with problem drinking. This appears to contradict the GLF data which found lower levels of drinking and heavy drinking amongst the economically inactive.

### 3.1.2 The risks and costs associated with alcohol misuse

In this section we summarise studies investigating the risks associated with alcohol misuse in terms of mortality, and the social and economic costs to society in general, and to employers specifically. We have included nine journal articles, three from the UK and the others from the US, New Zealand and Germany. We also include four UK government reports (three from Scotland). It is important to note that the literature on costs to employers mainly originates from the US and is less relevant to the situation in the UK<sup>11</sup>.

#### *Mortality estimates*

Britton and McPherson (2001) produced estimates of the numbers of deaths and years of life lost for alcohol-related conditions in England as well as the health benefits of moderate drinking. They found a maximum benefit of a 20 per cent reduction of Coronary Heart Disease (CHD) risk at ten grammes per day (1.25 units)<sup>12</sup> for women and 25 grammes (approximately three units) per day for men. Harmful effects of alcohol on CHD risk arose at 40 grammes per day (five units) for women and 120 grammes (15 units) per day for men, although the authors noted that the majority of the population do not drink at these levels. They estimated approximately 1.8 per cent fewer deaths annually than would be expected in a non-drinking population (2.8 per cent for men; 0.9 per cent for women). If prevented deaths are ignored, 2.0 per cent of all mortality would be attributable to current alcohol consumption levels. The authors note that these estimates are lower than other studies (which ignore protective effects) and that the cardio-protective properties of alcohol lead to a net favourable mortality balance only for men aged 55+ and women 65+.

Alcohol attributable deaths for women are mainly from falls, liver cirrhosis, breast cancer, haemorrhagic stroke and colon cancer. For men the main causes are liver cirrhosis, colon cancer, oesophageal cancer, suicide, and road traffic accidents (RTAs). For the young, deaths are mainly from injuries (RTAs and suicide) plus liver disease. Britton and MacPherson conclude that, in England, approximately 75,000 years of life lost prematurely are attributable to alcohol consumption. It is important to note that this study is based on 1996/1998 figures, and we are not aware of a more recent comparable study. The focus is on current, rather than previous, consumption, and the analysis does not take account of the risk factors associated with a combination of several diseases (Britton and MacPherson, p.385).

An earlier European study provided some detail on mortality rates for specific groups. In a longitudinal study in Germany, Feuerlein and colleagues (1994) looked at mortality rates amongst

<sup>11</sup> For an early review of this literature see Gill (1994) below.

<sup>12</sup> Britton and McPherson converted units to grammes assuming one unit = eight grammes of alcohol.



a sample of patients previously treated for alcoholism within an inpatient setting ( $n=1,410^{13}$ ). The overall mortality rate for this sample was 7.6 per cent, breaking down into a mortality rate of 9.8 per cent for men, and 4.8 per cent for women. The authors found that a higher mortality rate was associated with age; being male; not being fit to work; being retired at the start of treatment and previous employment in an alcohol-related business.

### *Estimating costs to the economy and society*

In recent years, research into the cost implications of substance use and misuse for societies and economies has become a highly salient issue. The Cabinet Office Strategy Unit produced a report in 2003 outlining cost estimates relating to death and illness due to alcohol misuse in England. Included in these estimates were costs associated with health care; injuries due to traffic accidents and crime and also lost productivity. The report concluded that costs due to alcohol misuse for the year 2001 ranged between £18 billion and £20 billion (based on 2001 prices). Moreover, the researchers stated that £4.7 million of the larger estimate (£20 billion) was attributable to external intangible costs incurred by the emotional impact upon victims of crime.<sup>14</sup>

In 2001 a study carried out by health economists for the Scottish Executive (Scottish Executive, 2001; Varney and Guest, 2002<sup>15</sup>) estimated the total social and economic cost of alcohol misuse to Scottish society, and also the specific cost components, such as spending within the NHS and the cost to the economy of lost productivity. They estimated that alcohol misuse cost Scottish society £1,071 million in 2001/02 (at 2001/02 prices) with alcohol-related unemployment costing an estimated £84 million due to lost productivity. Alcohol misuse was said to have cost NHS Scotland £95.6 million; the criminal justice system and emergency services £267.9 million; and they put the human cost in terms of premature mortality at £216.7 million. However, as the authors highlight, many of the estimates were based on assumptions drawn from the conclusions of other studies. For example they quote a Home Office study<sup>16</sup> which found that 25 per cent of people arrested had been using alcohol, but Varney and Guest point out that the presence of alcohol does not necessarily account for criminal activity, and in turn this undermines the assumption that the cost of such arrests can be attributed to alcohol misuse. In 2005 the Scottish Executive updated the figure for the cost of alcohol misuse in 2002/03 to £1,125.5 million (an increase of more than £50 million), although it is acknowledged that this is a nominal figure as, due to difficulties costing other areas, it was only possible to provide estimates of current costs to the NHS, and other estimates were simply increased by the rate of inflation (Scottish Executive, 2005). The costs of alcohol misuse to the NHS included a 16 per cent rise in real terms above the previous estimate. This total figure was again updated in 2008 to £2.25 billion for the year 2006/07, once again with the caveat that, for the same reasons above, these figures were indicative. The report also explains that, unlike the Cabinet Office Strategy Unit figure, the estimate does not include intangible costs, such as the emotional impact on those families living with a relative who has an alcohol problem (Scottish Government, 2008).

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<sup>13</sup> Data collected at admission to treatment and then at three follow-up points over four years.

<sup>14</sup> A more recent estimate appears in the *Impact Assessment for the Policing and Crime Bill* (2009). The costs of alcohol-related crime is estimated at £8 billion to £13 billion, based on 2005 findings from the 2005 Offending, Crime and Justice Survey. <http://www.ialibrary.berr.gov.uk/uploaded/IA%20Alcohol%20Mandatory%20Code.pdf>

<sup>15</sup> Journal paper.

<sup>16</sup> Bennett T. (1998). *Drugs and crime: the results of research on drug testing and interviewing arrestees*. London: Home Office Research and Statistics Directorate.

A more recent study was carried out by researchers at the University of York, published in a report for the Scottish Government (York Health Economics Consortium, 2010). The researchers investigated the societal costs relating to alcohol misuse in Scotland for 2007; and also examined the methodology relating to this type of study. They estimated that, during 2007, alcohol misuse cost Scottish society between £2.47 billion and £4.63 billion, representing the lowest and highest cost estimates. As in the Scottish Executive reports the researchers highlight the levels of uncertainty that relate to the calculation of certain costs (such as of absenteeism, child and family social work and alcohol-related crime), resulting in estimates that again should only be considered indicative. However in this study intangible costs relating to wider society were also included in the overall estimate. These costs included the value of life lost to premature mortality, in terms of paid and unpaid work, and indirect costs incurred by alcohol-related fires, road traffic accidents and homicide.

Similar estimates of the costs of alcohol misuse have been produced in other countries. For example, in New Zealand in the 1990s Devlin and colleagues (1997) looked at the direct and indirect costs to society of alcohol misuse. Direct costs were considered to include those incurred by the health service, the police and criminal justice system. Indirect costs related to lost work productivity as result of such issues as premature death, sickness and reduced performance. Devlin and colleagues estimated that in 1991 alcohol misuse cost New Zealand's society between one and four billion dollars. Jones and colleagues (1995) estimated that the costs of lost productivity due to absenteeism were \$15.4 million annually, and the costs of reduced work performance were \$41.7 million.<sup>17</sup>

### *Costs to employers*

A review conducted by Gill in 1994 looked at earlier work on alcohol use in relation to employment up to 1993 in the US and the UK, but found few relevant UK studies and very little quantitative data, a situation which does not seem to have changed a great deal since then. Gill looked at (the mainly US) literature around costs in the workplace, and to the economy, of alcohol misuse; alcohol-related problems among workers; and responses to alcohol problems in employment, including referrals by supervisors and comparison of in-patient and out-patient treatment programmes. Gill makes reference to UK education campaigns in the workplace in the late 1980's (Health Education Authority (HEA), 1991)<sup>18</sup> but notes the lack of a widespread adoption of alcohol policies by employers at that time. He also notes that in the UK the existence of the NHS reduces the incentive for employer-run programmes, as the issue of reducing employers' health insurance costs does not arise. We could not find more recent findings in this area.

More recently Foster and Vaughan (2005) aimed to find out whether the cost to US employers of employee absenteeism is such that it is cost effective to implement programs to assist employees in overcoming their substance misuse. They extracted data from the National Household Survey on Drug Abuse in 2000 relating to all full- and part-time workers aged over 16, working in the private sector<sup>19</sup>, and calculated the level of absenteeism due to workers who met the criteria for a substance misuse problem (no separate calculation was made for alcohol misuse). The authors found that this group of workers were absent from work 1.4 days per month compared to the 0.89 days per month of those who did not meet the criteria. This meant that overall, 0.51 extra days per month were attributable to substance misuse problems accounting for 0.2 per cent of the payroll

<sup>17</sup> In this study costs were extrapolated from a sample drawn from Auckland, New Zealand's largest city, which may not be representative of New Zealand's population as a whole.

<sup>18</sup> *Evaluation of the HEA Alcohol Awareness at Work Campaign*. (1991) HEA, Research Department, Public Health Division, London.

<sup>19</sup> Excluding those working in agriculture, forestry, fisheries or hunting professions.

and 4.5 per cent of wages lost due to absence. On this basis, Foster and Vaughan conclude that the case for employee assistance to combat absenteeism due to substance misuse is unconvincing, although employers' desire to tackle substance use amongst their employees may be motivated by factors other than the cost of absenteeism, including health and safety risks.

An earlier US study also investigated the impact on employers of employee alcohol misuse. Holder and Blose (1991) outline their study of work absences among the mostly male employees at a large manufacturing company in the American mid-west in the late 1980s. Comparing a sample of workers with a primary or secondary diagnosis<sup>20</sup> of a chronic drinking problem with a group of employees without alcohol problems (both n=1,828), the researchers sought to ascertain whether those with an alcohol diagnosis were absent from work more frequently, and received more disability payments, than those without such a diagnosis. They found that there was a statistical difference in the average annual indemnity cost between the two groups and that the costs for those with alcohol problems were almost double that of the comparison group. The researchers also found that this difference was due to non-occupational absences, that is those not attributable to accident or injury in the workplace

In the course of this review we also identified a study by French and colleagues (1997) which examined the cost of Employee Assistance Programs set up to address substance misuse issues amongst employees in the US. However, the findings were of limited relevance to our research questions and thus we do not detail them here.

We were not able to identify studies looking at the impact of alcohol abuse on UK employers. Neither were we able to find any reports or papers that evaluated any existing employee support programmes in the UK. It appears that this is a gap in the literature, although in the case of the latter this could also reflect a possible lack of such support services.

### 3.1.3 Alcohol treatment

Although this study did not aim to assess general demand for treatment services or their availability in the UK we did take into account the findings of the 2004 ANARP (cited as a secondary source in Section 3.2.1)<sup>21</sup>. This study, conducted for the Department of Health, identified a high level of need across different categories of drinkers in England, and low levels of identification, treatment and referral by GPs, particularly for younger patients. The study highlighted a large gap between the need for and access to treatment, with only 5.6 per cent of those with an alcohol dependency accessing specialist treatment in England annually. They also noted a lack of consensus on what should be the goal for access to treatment (10 per cent is deemed 'low' in the US) and that access to treatment could be improved; only a third of those who are referred actually access treatment, and a third who do access treatment are self-referrals. However they also emphasise the need to look at the supply side of alcohol treatment services: '*consideration also needs to be given to the capacity of specialist treatment services to meet any increase in demand*' (ANARP, 2005, p.23). The ANARP report is concerned with the alcohol treatment needs of the general population and not on programmes aimed at moving people towards employment, which we cover in more detail in Section 3.6.

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<sup>20</sup> International Classification of Diseases (ICD-9) diagnosis.

<sup>21</sup> ANARP (2005) *The Alcohol Needs Assessment Research Project*, for the Department of Health. <http://www.nwph.net/alcohol/anarp.aspx>

## 3.2 Welfare, employment and alcohol misuse

### Summary

- Literature from the US highlights some of the issues around welfare reform for those with alcohol and other substance misuse problems, including the impact of conditionality of benefits on treatment (Brucker, 2007; Stevenson, 2002) and the provision (or lack) of treatment programs and services.
- Evidence from the US suggests that the receipt of benefits does not encourage or increase drug or alcohol dependence, and recommends that alcoholism and drug addiction to be considered a serious limitation on employment (Stevenson, 2002).
- These issues are also of concern to agencies in the UK, particularly the lack of availability of suitable treatment programmes and support services (Alcohol Concern, 2009a).
- The literature points to concerns for those with multiple and complex needs, including those with drug misuse problems and/or health issues as well as alcohol misuse. UK studies (Spencer, 2008; Dean, 2003) highlight the need for alcohol users to address their other co-occurring problems, including housing and health issues, before attempting to return to or enter employment, despite identifying a strong desire amongst many to return to the labour market (Dean, 2003).

The six papers in this section help to set the policy context for this study, and for the more detailed section that follows on alcohol and benefits which includes studies conducted before and after welfare reform in the US, and subsequent sections on alcohol misuse and other diagnoses and interventions respectively.

These papers are organised under the following headings:

- welfare reform;
- complex needs and employment.

### 3.2.1 Welfare reform

On the second reading of the Welfare Reform Bill in the UK, which subsequently became the 2009 Welfare Reform Act, Alcohol Concern published a briefing paper that outlined the reasons why they believe there should not be an assessment/treatment requirement as a condition of receiving benefits (Alcohol Concern, 2009a). They highlight issues relating to the complexity of alcohol addiction; the high risk of relapse; the availability and affordability of alcohol; the nature of long-term incremental treatment, which is not a 'cure'<sup>22</sup>; the need for a 'staged' move to employment; the lack of employment opportunities and employer support<sup>23</sup>; and barriers to treatment, including stigma, access to resources and childcare<sup>24</sup>. They argue that demand for treatment services is

<sup>22</sup> 'Treatment, as for other chronic disorders, takes time and may be a lifelong process. Dependence cannot be cured in the sense that some illnesses may be cured and treatment should therefore be viewed in terms of degrees of improvement, steps towards abstinence/moderation, and improved health and social functioning...' (Alcohol Concern, 2009a: 1.2)

<sup>23</sup> Quoting a 2007 survey report by the Chartered Institute of Personnel and Development: *Managing Drug and Alcohol Misuse at Work*.

<sup>24</sup> Grant, B.F (1997) 'Barriers to alcoholism treatment: Reasons for Not Seeking Treatment in a General Population Sample'. *Journal of Studies on Alcohol*, Vol 58, No. 4.

already greater than supply<sup>25</sup>; and that there is a general lack of funding, wide regional variation and a lack of specialist services.

There is a large body of literature from the US both before and after welfare reform in 1996, some of which is included in this review. It is important to understand the nature of the reforms in order to interpret the applicability of the individual studies to the UK. Here we outline the context of US welfare reform in the mid-1990s as described by Gensenz and colleagues (1998). We also include relevant contextual information from four other papers which are detailed in the subsequent section of this review on alcohol misuse and benefits (Swartz *et al.*, 2004; Brucker, 2007; Meara, 2008; Schmidt *et al.*, 1998).

The US federal government introduced the Personal Responsibility and Work Opportunity Act (PRWOA) in 1996 to reform welfare programs, and this included redefining eligibility for those with substance abuse problems. The Supplemental Security Income (SSI) programme which had been available to those with drug addiction or alcoholism as their primary disabling condition was terminated. SSI recipients could reapply to the Social Security Administration (SSA) for Social Security Disability Insurance (SSDI), and nearly three quarters did so. One-third of those requalified for SSDI as a result of different disabilities, such as mental illness (Gresenz *et al.*, 1998). This benefit provides a temporary income to those unable to work until their condition improves, or an income top-up to those whose condition does not improve. The remaining two-thirds of recipients of SSI who reapplied did not requalify for SSDI and were therefore unable to access benefits. Prior to the change in the law an estimated 53 per cent of alcohol misusers were in receipt of SSI, 29 per cent of whom were dependent on both alcohol and drugs (Gresenz *et al.*, 1998, citing Barber, 1995<sup>26</sup>).

Prior to 1996 those receiving SSI under the Drug Addiction and Alcoholism (DA&A) program were required to attend treatment as a condition of benefit receipt. With the treatment mandate came access to referral and monitoring services. Benefit recipients were expected to access public treatment programmes, paid for by Medicaid insurance (for which SSI recipients were eligible). If recipients were deemed ineligible for SSDI, they would also have become ineligible for insurance to pay for treatment. Recipients were also required to have a 'representative payee' to receive benefits on their behalf. This may also be the case for some in receipt of SSDI, for example in the case of severe psychiatric disorder (Swartz *et al.*, 2004<sup>27</sup>).

There is little data available on the effectiveness of the US approach pre-PRWOA reforms to the treatment of alcoholics in particular and substance users in general. Brucker (2007) notes that *'In addition to the limitations inherent in existing state treatment systems, the actual monitoring of this treatment requirement for SSI recipients by SSA was quite lax, and few recipients complied. Furthermore, no records of outcomes for persons who did participate in treatment were kept'*. When the SSI DA&A program was terminated the requirement to access treatment disappeared at the same time, leading to a fall in treatment uptake by those who were no longer in receipt of those benefits (Swartz *et al.*, 2004). There is some evidence that those who continued to receive disability benefits were more likely to access treatment than those whose benefits were terminated (Brucker, 2007).

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<sup>25</sup> Citing ANARP (2005). *The Alcohol Needs Assessment Research Project*, for the Department of Health. <http://www.nwph.net/alcohol/anarp.aspx>

<sup>26</sup> Barber, S. L. (1996). *Supplemental Security Income Recipients for Whom the Alcoholism and Drug Addiction Provisions Apply (DA&A Recipients)*, December 1995. Office of Program Benefits Policy, SSA.

<sup>27</sup> Detailed in Section 3.5.4.

Under PRWORA Aid to Families with Dependent Children (AFDC, a federal assistance program which ran from 1935 to 1996, providing financial assistance to children whose families had low or no income) was also abolished and replaced with the much more restricted Temporary Assistance for Needy Families (TANF), with the intention of reducing welfare dependency and poverty. The abolition of AFDC reduced the number of people receiving welfare, and the number of previous recipients entering the workforce increased (although as Meara, 2006, notes this was during a period when the US economy was booming).

General Assistance (GA) is a benefit available to 'able bodied' adults. This most commonly includes food stamps, and housing relief, with few if any states giving cash (as of 2005 only New Jersey and Utah did so). It was suggested that reduced access to federal welfare (SSI) for substance users may have led to an increase in those accessing support through the (less visible) safety net of GA and other local relief programmes (Schmidt *et al.*, 1998), although in our review we did not find further evidence to either support or refute this theory.

A review conducted by Stevenson in 2002 looked at the history of US benefit rules<sup>28</sup>; the effects of policy change; and analysed arguments for and against providing disability benefits to alcoholics and drug users. He notes that since 1996 a number of studies have shown that a large number of addicts were dropped from treatment programs, with some becoming homeless, and few re-enrolling for other benefits or entering the workforce. He states that the '*best research indicates that the receipt of public benefits does not encourage or increase drug and alcohol dependency*' (p.219) and he therefore refutes 'moral hazard' arguments: '*the rehabilitation approach is the most consistent with empirical studies of the results of recent policies*' (Stevenson, 2002, p.228). Stevenson recommends less punitive treatment in eligibility decisions and argues that the government should '*allow alcoholism and drug addiction to be considered a serious limitation on employment, weighed with other factor in the Social Security 'Grid', or viewed as one factor like obesity*' (Stevenson, 2002, p.240).

There is also some literature from the US around legal definitions of disability, which while based on US case law may have some interest or relevance for assessments of ability to work in the UK. Massengill (2005) noted that courts have used varying standards in deciding whether alcoholism should be considered a disability under the Americans with Disabilities Act, from accepting alcoholism as a disability, per se, to requiring extensive evidence of substantial limitation on a major life activity. He notes that 'required accommodations' (changes to be made by employers to accommodate the disabled employee) are minimal (mostly an allowance of time off for rehabilitation) and that employers have been permitted to hold alcoholics to the same standards of performance and behaviour as non-alcoholics. He notes that there is a difference between being able to perform work tasks, and being able to turn up for and be fit for work, and also discusses the issue of 'reasonable accommodation' to enable a return to work, including requirements on employers to release staff for treatment; back to work contract conditions; disciplinary procedures and termination of employment (Massengill, 2005).

### 3.2.2 Complex needs and employment

Issues around employment are more complicated for those alcohol misusers who also misuse drugs and/or have mental health problems, and consequently support needs may be much greater. Here we provide two general papers as background for the sections that follow on alcohol misuse and health (Section 3.3) and employment and alcohol (Section 3.4). Both papers are empirical UK studies: the first on barriers to employment for problem drug users (who may also misuse alcohol); the second on adults with multiple and complex needs.

<sup>28</sup> Stevenson, D (2002). 'Should addicts get welfare? Addiction and SSI/SSDI'. *Brooklyn Law Review*, 68 (Fall): 185-240.

A recent qualitative study conducted for the UK Drug Policy Commission found that high levels of alcohol consumption were highlighted by many service providers as common among Problem Drug Users (PDUs) in recovery, and a significant hindrance to their ability to obtain or keep a job (Spencer *et al.*, 2008). They found that the main barriers were getting drug users 'job ready' and confronting their complex 'primary issues' (including motivation, accommodation problems and health issues), and the support required to do this. They also found that although work was a key objective of treatment, there were a variety of myths reported by employers, along with perceived problems around employing PDUs. While it cannot be assumed that all these barriers are experienced by all those who misuse alcohol alone, it does give an indication of the range and complexity of issues faced by those who are users of alcohol and drugs (see Section 3.4.3 for details on alcohol use and barriers to employment).

A qualitative cross-sectional study conducted by Dean (2003) in England looked at the issue of welfare to work in respect of those with complex needs amongst a sample which included 34 with substance abuse problems. He conducted in-depth interviews with participants in two urban areas in the north and south of England. All participants had experienced unemployment and had a sporadic employment history. Many also had experiences of homelessness; the criminal justice system; and violent, abusive or disruptive family or personal relationships. Although Dean found that *'by and large participants embraced a desire – often a strong desire – to access the labour market, many were also conscious of the need to address their other problems and needs, including and particularly needs for housing, medical treatment or health care'* (Dean, 2003, p.444). Dean advocates a 'life-first' approach to enable people to deal with problems, before entering employment.

The findings detailed here are specific to those with complex needs, including polydrug use, but are also relevant to the section on barriers to employment (Section 3.4.4). Studies addressing the issue of complex needs can also be found in Section 3.3.2. However, we found limited UK research in this area.

### 3.3 Alcohol misuse, health and unemployment

#### Summary

- There are significant negative health impacts that can arise as a result of unemployment, both for the unemployed and their families, and this impact is exacerbated when alcohol misuse is also involved (Wilson and Walker, 1993).
- People with the poorest health behaviours (including smoking and high alcohol consumption) were more likely to be unemployed, and the experience of being unemployed led to a worsening of poor health behaviours, particularly in the case of recent or accumulated unemployment (Montgomery *et al.*, 1998).
- The prevalence of mental health problems for those dependent on alcohol is likely to be more than double that of the general population (Jane-Llopis and Matysina, 2006).
- Poor mental health is associated with high levels of alcohol consumption. A high proportion of those people engaged in alcohol treatment services also have mental health issues, including undiagnosed psychosis (Barnett *et al.*, 2007; Weaver *et al.*, 2003).
- Specialist treatment for clients with dual diagnosis is not always available, and the level of identification of substance misuse by mental health services and of mental health problems by substance misuse services is low. Therefore, referral between services is not common. Greater training for workers in both types of services in relation to dual diagnosis is needed to help combat this (Menezes *et al.*, 1996; Hilariski and Wodarski, 2001).

- Being on benefits may be associated with higher risk of depression and alcohol consumption, but does not necessarily exclude people from seeking or obtaining work (Zabkiewicz and Schmidt, 2007; Dooley and Prause, 2002).
- The evidence suggests that mental health problems and alcohol misuse are not always a barrier to finding work, but they can make it harder to sustain employment (Dooley and Prause, 2002; Zabkiewicz and Schmidt, 2007).

Among the unemployed alcohol misuse problems often co-exist with other diagnoses, particularly mental health problems. Although only a small number of papers on this subject are included in this section they demonstrate some of the complex interactions between alcohol consumption, unemployment, mental health and well-being

Of the 13 relevant papers in this theme, eight are from the UK, three are from the US, one is from Australia, and one is an international review<sup>29</sup>. Seven papers, five from the UK, report study findings on comorbidity and substance use, including alcohol consumption. We also include a report by the UK Mental Health Foundation which summarises a range of research on alcohol and mental health problems. One UK paper looks at the health impacts of high alcohol consumption and unemployment (Montgomery *et al.*, 1998) whilst another reviews existing literature on the impact of unemployment on the health of individuals at the time of the widespread closure of coal mines in the Midlands (Wilson and Walker, 1993). Two more papers consider possible barriers to transitions from 'welfare to work' in the US.

The findings from the literature in this area can be grouped into the following three inter-related themes:

- alcohol, unemployment and health;
- the co-existence of alcohol misuse and mental health problems (comorbidity);
- mental health, alcohol misuse and welfare exit.

### 3.3.1 Alcohol, unemployment and health

The adverse impact of unemployment on the physical health of individuals has been acknowledged in the literature for many years. More recently the links between hazardous behaviours, including alcohol consumption, health and unemployment have been explored.

In a review of the evidence of the health impacts of unemployment on individuals and their families in the UK, Wilson and Walker (1993) found that unemployed men experienced higher rates of premature mortality, reduced psychological well-being including higher incidence of suicide, parasuicide<sup>30</sup> (age- and gender-related), depression and anxiety disorders. Their families were likely to experience increased levels of depression, increased mortality rates including perinatal and infant mortality. The authors found that rates of poor health behaviours, including high alcohol consumption, were higher among the unemployed compared with the employed (see Lee *et al.*, 1990) and that smoking and alcohol consumption often increased after the onset of unemployment. There were higher rates of family breakdown, for children in care or on the Child Protection Register among the unemployed.

<sup>29</sup> Jane-Llopis and Matysina (2006).

<sup>30</sup> Attempted suicide or instance of self-harm. A predictor of future suicide attempts.



Montgomery and colleagues (1998) used data from a longitudinal study of young men in the UK<sup>31</sup> to compare the health of those who had never been unemployed and those who had experienced unemployment. An association between higher levels of accumulated unemployment, lower social class at 16 years of age and lower educational levels was identified. It was found that those people with the poorest health behaviours (including smoking and excessive alcohol consumption) were more likely to be unemployed than others and that the experience of being unemployed led to a worsening of poor health behaviours. Higher numbers of non-drinkers were found in the accumulated unemployment group at age 33 years compared with those who had never been unemployed. However, high alcohol consumption was also common at age 33 years. A high CAGE<sup>32</sup> score and high level of alcohol consumption were significantly associated with recent unemployment. Accumulated unemployment was also associated with problem drinking (Montgomery *et al.*, 1998).

### **3.3.2 The co-existence of alcohol misuse and mental health problems (comorbidity)**

The UK Mental Health Foundation produced a report in 2006 on the relationship between alcohol and mental health (Mental Health Foundation, 2006). It summarises a range of research on alcohol and mental health problems, general prevalence, drinking habits, and policy and alcohol treatment, or rather the lack of treatment, especially for those with mental health problems. In addition, their own survey of the general public found that those who say alcohol reduces their level of anxiety or depression are those who drink nearly every day, and also those who state that they would find it difficult to give up.

We identified one fairly recent journal paper which reviewed 20 studies relating to the prevalence of co-occurring mental health and substance use disorders within general population surveys (Jane-Llopis and Matysina, 2006<sup>33</sup>) conducted in several different countries, and reported between 1998 and 2005. This review included reference to a 2001 paper based on The British Adult Psychiatric Morbidity Survey (BAPMS)<sup>34</sup>. They found that people with a substance use disorder had higher comorbid rates of mental disorders than vice versa (although the highest rates were among those with illicit drug disorders<sup>35</sup>) and a strong direct association between the magnitude of comorbidity and the severity of alcohol use disorders. They also highlighted that 30 per cent of those dependent on alcohol had mental health problems, compared to 12 per cent of the general population. They noted evidence that alcohol is a casual factor for depression; in the group of Northern and Southern European countries (including the UK) over seven per cent of depressive illness in men is alcohol-related.

In three UK studies the incidence and prevalence of substance use in mental health patients were assessed. They were conducted in inner-city London, Sheffield, Nottingham (Weaver *et al.*, 2003), south London (Menezes *et al.*, 1996) and south Cambridgeshire (Barnett *et al.*, 2007). Each study

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<sup>31</sup> National Child Development Study 1958.

<sup>32</sup> The screening tool uses four questions to identify problem drinking. A high CAGE score is defined here as three or more positive answers. See Appendix C for details.

<sup>33</sup> Mental Health Programme, WHO Regional Office for Europe.

<sup>34</sup> Farrell *et al.* (2001). 'Nicotine, alcohol and drug dependence and psychiatric comorbidity: Results of a national household survey'. *British Journal of Psychiatry*, 179: 432-437. NB The date of the BAPMS is not given in this paper, but presumed to be 1999.

<sup>35</sup> The data for drug use was analysed separately from the data for alcohol use so it is not possible to say whether this holds true for drug disorders alone, or in addition to alcohol problems.

used a defined group of patients who were already in touch with mental health services and used validated tools for the assessments. One US study conducted by McKay and colleagues in 1998 found high levels of depression and mental health problems among recipients of welfare benefits targeted at alcohol misusers and drug users. Details can be found in Section 3.6.5.

Weaver and colleagues (2003) compared the comorbid status of Community Mental Health Team (CMHT) clients and people engaged with substance misuse services. It was found that 25 per cent of CMHT clients reported harmful alcohol use with about a tenth of the sample reporting severe alcohol misuse. Conversely, 85 per cent of alcohol service clients also had a psychiatric disorder in the past year. The prevalence rate for psychosis in this group (19 per cent) was much higher (24 times) than in the UK urban population generally (0.8 per cent), (Jenkins *et al.*, 1998).

Menezes and colleagues (1996) found that 31.6 per cent of severely mentally ill patients had concurrent alcohol problems. Young male clients were most at risk of having substance use problems. Clients with comorbidity in relation to substance use made greater use of services. This is also supported by findings from an Australian national survey (Burns and Teeson, 2002). Barnett and colleagues (2007) identified that the rate of substance use among those with first-episode psychosis was twice that of their peers in the general population (from the British Crime Survey<sup>36</sup>). Only one of the 123 clients sampled had never used alcohol. Nearly half of the sample (43 per cent) had drunk at the level described as dependence or abuse (DSM IV) at some point in their life. Poly-substance use including alcohol was common amongst these clients.

Weaver and colleagues (2003) found there was little cross-referral between psychiatric and substance misuse services in their study in three cities in England. Many clients were not identified as having substance misuse issues by CMHT workers or psychiatric problems by substance misuse services and were not therefore given access to specialist services. These findings are supported by an American review, Hilarski and Wodarski (2001), who also identified the training needs for both types of services in relation to comorbidity issues and treatment.

### 3.3.3 Mental health, alcohol misuse and welfare exit

Two recent studies have explored how mental health problems interact with alcohol misuse problems and can act as a barrier to work, in the context of the American welfare reforms of the late 1990s.

In a quantitative study based on secondary analysis of panel data, Dooley and Prause (2002) explored alcohol abuse and other 'behavioural dysfunctions' that might cause women to seek welfare support, and those aspects which might prevent them from leaving welfare. They also considered aspects of mental health problems which may constitute barriers to returning to work after a period on welfare benefits. Drawing on data from the National Longitudinal Survey of Youth from 1992-1994<sup>37</sup>, prior to welfare reform, they found that entering welfare was associated with depression and alcohol consumption, and that this seemed to be due more to social causation than selection (i.e. that entry into welfare led to depression, and for some also to increased alcohol consumption, rather than that an increased propensity to depression and alcohol misuse made people more likely to enter into welfare). Those who had a diagnosis of depression were more likely to be on welfare. Being on welfare benefits had a negative impact on well-being. One of their hypotheses, that women would not be able to leave welfare due to personal barriers such as

<sup>36</sup> Condon, J. and Smith, N. (2003). *Prevalence of drug use: key findings from the British Crime Survey*. Home Office [www.homeoffice.gov.uk/rds/crimeew0203.html](http://www.homeoffice.gov.uk/rds/crimeew0203.html)

<sup>37</sup> Sample made up of female respondents to the 1992-94 surveys with data describing depression, alcohol use, and receipt of AFDC (n=3,678).

depression and high alcohol consumption, was not supported by their findings. Being in employment was found to reduce the symptoms of high level alcohol use but not of binge drinking or depression. However they also noted that '*confidence in an apparent beneficial effect on alcohol symptoms of leaving welfare for employment was limited by small sample sizes*' (p.787). The authors also note that their correlational research design limits conclusions about causality, and that the restricted age range of the sample could also be considered a limitation.

Zabkiewicz and Schmidt (2007) used data from the Welfare Client Longitudinal Study in a six-year period prior to the US welfare reforms to investigate how behavioural health problems such as alcohol misuse might affect the process of seeking work whilst in receipt of benefits, within a two-year timescale, and the ability to remain employed. The study found prior and recent work experiences and education were consistent predictors of seeking and obtaining work. Having a young child made seeking work difficult but did not prevent transition from welfare to work. Behavioural health problems, apart from depression, did not prevent active jobseeking but appeared to prevent exit from welfare. The conclusions drawn were that other external factors influence the success, or not, of active jobseeking. However, for those who made a successful transition it was found that mental health and substance misuse issues did not impact on hours worked, but on the person's ability to sustain employment.

From the studies identified in this review it is not possible to unpick the extent to which mental health problems pre-date alcohol misuse for the unemployed, or the extent to which alcohol misuse initiates or exacerbates mental health problems. It is well known that excessive alcohol consumption in the both short and longer term can cause poor physical health and problems with finding and sustaining employment. However, additional problems with psychosis or other mental health issues create even greater challenges to both client and professional, both in mental health and specialist treatment services. There is clearly a need for further research into the most effective way of dealing with dual-diagnosis. There is also a need, once established, to provide training for staff in both services in the identification of psychosis and substance misuse. Ways of sustaining employment and supporting individuals with alcohol and comorbidity issues and their families to achieve better health outcomes would also bear further research and development.

### 3.4 Employment, unemployment and alcohol

#### Summary

- Socio-economic factors influence the onset and continuation of alcohol misuse. In turn, socio-economic status can also be influenced by alcohol use (Romelsjo *et al.*, 2004; Hemmingsson *et al.*, 1998)
- A number of studies, including one UK paper and one review have identified a negative relationship between alcohol dependence and employment (MacDonald and Shields, 2004, Sutton *et al.*, 2004).
- The reported impact of alcohol misuse on employment varies, and can be contradictory. The research included here uses a range of definitions of alcohol misuse. There is evidence that the quantity of consumption and the extent of physical symptoms affect employment (Morgernstern *et al.*, 2003; Booth and Feng, 2002; Bray *et al.*, 2000; Mullahy and Sindelar, 1996).
- Two American studies found no impact of alcohol misuse (Schmidt *et al.*, 2007; Feng *et al.*, 2001) on employment. There is also some evidence that moderate alcohol consumption may have benefits for some people in terms of work attainment and remuneration (MacDonald and Shields, 2001).

- The relationship between unemployment and alcohol misuse is complex and, as with all unemployment, is influenced by economic conditions (Mossakowski, 2008; Dee, 2001).
- Studies from Europe and the US conclude that there is a negative correlation between problem drinking and unemployment, suggesting that alcohol misuse (particularly binge drinking) is more likely to start or escalate after unemployment begins (Claussen, 1999; Ettner, 1997; Catalano *et al.*, 1993; Janlert and Hammerstrom, 1992, Dee, 2001). However we were not able to identify any similar studies (either more recent or based on work in the UK) which might support these findings.<sup>38</sup>
- Poverty needs to be considered as a factor independently of unemployment in considering the needs of those with alcohol misuse problems (Mossakowski, 2008; Khan *et al.*, 2002).
- The relationship between alcohol dependence and other factors (such as education) and barriers to employment was explored in two quantitative studies looking at mothers receiving TANF in the USA (Schmidt *et al.*, 2007; Morgernstern *et al.*, 2003) and one qualitative study (Bush and Kraft, 2001). Similar findings on these links were highlighted in the UK Sutton review and Cebulla report (both 2004).
- Research with both substance users and service providers advocated a 'step-wise' (re-) integration into the labour market, involving voluntary, part-time, and short-term work (Cebulla *et al.*, 2004).
- The importance of support programmes employing staff with an understanding of local labour markets and close links with employers in order to successfully match clients to job opportunities in their areas, was also highlighted (Sutton *et al.*, 2004).

This section includes studies which investigate the relationships between socio-economic factors and alcohol use, how alcohol misuse impacts on employment, and the effect on drinking behaviours of becoming unemployed. It also includes studies which focus on the barriers to employment specifically for those who misuse alcohol (rather than for poly-drug users and those with mental health issues and complex needs; these groups are covered by studies elsewhere in this review). Finally it details a study looking at the effect of job change on alcohol consumption, including reference to underemployment and binge drinking.

A total of 24 papers are included in this section. Only four are based on UK studies (MacDonald and Shields, 2001; MacDonald and Shields, 2004; Sutton *et al.*, 2004; Cebulla *et al.*, 2004) with the remainder being from Scandinavia, Canada, and the US. Therefore, the findings in this section are of limited applicability to the UK. Another limitation is that, while there is some consensus in the findings, many of the studies relate to data gathered pre-1995. This is problematic because several authors note the influence of the changing economic climate on alcohol misuse (Dee, 2001 and Mossakowski, 2008) the latter noting that this may have affected results of a study conducted in the 1980s. This is likely to be the case for other studies using data from this period. There is a clear lack of recent research in this area, particularly in the UK.

Some of the studies looking at changes in alcohol consumption in relation to employment status used longitudinal survey methods, allowing exploration of this relationship across time. However, it is difficult to make comparisons between these studies because of a lack of consistency in the measures and definitions used. A wide range of definitions were used for alcohol use with some studies only using quantity-based definitions, and others extending to physical symptoms of alcohol

<sup>38</sup> See also Sutton *et al.*, (2004).

use (most commonly DSM-IV<sup>39</sup>). Similarly, the studies presented differing definitions of employment and past employment, with only some specifying that ‘out of the labour market’ (i.e. unemployed but not seeking work) was included. Additionally, definitions of ‘employment’ varied, from ‘working at any time in the past 52 weeks’ (for example, Feng *et al.*, 2001) to current status of employment (for example, MacDonald and Shields, 2004). As there are inconsistencies between papers, comparisons should be made with caution.

This section includes a review by Sutton and colleagues (2004) which looked at evidence around barriers to employment for substance users. The same authors produced a research report for the DWP which included an element of qualitative research (Cebulla *et al.*, 2004) and their findings are also detailed here. As Sutton and colleagues note, most of the relevant literature around employment does not distinguish between types of substance users, and there is limited research looking only at those who use alcohol. Most of the papers in this section focus on alcohol use to at least some extent. However, six studies (including the Sutton and Cebulla reports) consider substance use in general.

The findings from the literature in this area are organised under the following headings:

- the relationship between socio-economic factors and alcohol use;
- the impact of alcohol misuse on employment;
- the effect of unemployment on alcohol consumption;
- alcohol use and barriers to employment;
- the effect of favourable job change on levels of alcohol consumption.

### **3.4.1 The relationship between socio-economic factors, employment and alcohol use**

Two studies from Sweden drew on national surveys, cross-referenced with other large data sets, to track the life outcomes of study participants. Both focus on the influence of socio-economic factors on alcohol use and the impact of alcohol use upon socio-economic status. In a secondary analysis of survey data (n=49,321) collected between the 70s and 80s<sup>40</sup> Hemmingsson and colleagues (1998) considered the influence of risky alcohol use in late adolescence in predicting later alcohol problems and socio-economic grouping (classified in terms of occupation: unskilled, skilled and non-manual employees, assistant and senior). The authors found that young men who had demonstrated risky use of alcohol at recruitment, as well as other risk factors, such as limited social network and previous contact with police or childcare authorities, were more likely to be in a lower socio-economic group (no employment or unskilled work) five years later. However, the strongest predictor of later socio-economic group was level of school achievement. Moreover, those participants who were unemployed or working in unskilled occupations were also at higher relative risk of receiving an alcohol-related diagnosis.

In the second Swedish study identified, Romelsjö and colleagues (2004) presented findings from a study over a similar period which considered the relative risk for individuals with alcohol problems in relation to leaving, or downward mobility within, the workforce, according to socio-economic status.

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<sup>39</sup> Diagnostic and Statistical Manual of Mental Disorders of the American Psychological Association. See Appendix C for details.

<sup>40</sup> Data taken from a survey of 49,321 young Swedish men, conscripted to Military Service in the years 1969/70 linked with records of socio-economic-grouping from the 1975 Census, and alcoholism diagnoses within the National Inpatient Care Register 1976-1983.

The sample was drawn from the whole population of Stockholm county aged 20-49 in 1970 (using census data), who remained in the same socio-economic grouping between 1970 and 1975, and had been hospitalised with an alcohol-related diagnosis<sup>41</sup> (n=1,579). As in the Hemmingsson study the researchers employed socio-economic groupings based upon an individual's occupation. They found that there was a greater likelihood of employment loss for individuals with an alcohol-related diagnosis who worked in manual occupations compared to those in non-manual occupations at medium and high levels. Furthermore, despite the finding that individuals with an alcohol diagnosis were more likely to leave employment than experience a downward shift, two categories of non-manual male employees were at increased relative risk of downward mobility. One limitation of this study design (secondary analysis) is that pertinent information, such as the reasons why participants left the workforce, was not collected.

A cross-sectional Canadian study conducted by Marchand (2008) also discusses the importance of environment and socio-economic factors upon alcohol use, presenting findings from a large-scale survey involving random sampling of the population of Quebec<sup>42</sup>. Marchand examined whether work conditions and structure influence alcohol use; whether position in the organisational structure ameliorates the influence of work conditions; and whether personality and support from family and others can help individuals deal with work-related stress. He found that being in a position of authority led to high-risk drinking whilst being in a position that involved prestige and the use of skills was associated with low-risk drinking. Marchand also found that personality and relationships outside the workplace help people to combat stress, but there was no evidence to suggest that position in the workplace structure had a similar positive effect. Marchand acknowledges that this study does not consider the possible influence of workplace culture on alcohol use, and that the cross-sectional nature of the study does not allow for investigation of how factors might change over time.

### 3.4.2 The impact of alcohol misuse on employment

This section contains ten papers. The first six (one from the UK, one from Finland and four from the US) focus on the impact of alcohol misuse on the probability of employment, and have broadly similar findings – the main one being that alcohol dependence significantly reduces the probability of being in work. The following two papers look at the same topic, but use different approaches and produce some contradictory findings. In addition we include a brief summary of a paper which highlights the effects of alcohol on occupational attainment in the UK, and we make reference to the qualitative study conducted by Cebulla and colleagues in the UK, which looked, in part, at the impact of alcohol misuse on the working life of participants (further findings from this study are summarised in Sections 3.4.4 and 3.5.1).

In a large cross-sectional study of men in the UK (n=6,644<sup>43</sup>) MacDonald and Shields (2004) found that treating alcohol consumption as an independent variable in their analysis resulted in a weak association between problem drinking and working status. However, more detailed analysis using a range of definitions and more complex models (using a range of dependent variables) revealed a more significant relationship: depending on which of four definitions of problem drinking was used, being a problem drinker reduced the probability of working by seven to 31 per cent. For comparison seven per cent was roughly the same positive effect on employment of having a degree, relative to

<sup>41</sup> Authors referred to an AAA diagnosis, representing alcoholism, alcohol psychosis or alcohol intoxication.

<sup>42</sup> Participants aged fifteen and over: effective sample n=5,992.

<sup>43</sup> Health Survey for England (HSE), aged 22-64, analysed using univariate and bivariate probit models.

having no qualifications. In this study employment was defined by current status: in work (employed and self employed) and out of work (unemployed and non participants). In a similar study in Finland, Johansson and colleagues (2007) found that when treated as an independent variable, alcohol dependence was found to decrease the probability of employment by 14 per cent for men and 11 per cent for women<sup>44</sup>. The relevancy of this study to the UK context is limited, and the authors note the unique unemployment levels in Finland at the time, as well as generous unemployment benefit in Finland compared to the UK and US.

Four US studies had similar results. An early study by Mullahy and Sindelar (1996<sup>45</sup>) found that for both men and women problem drinking results in lower employment levels and higher unemployment. Building on this work, Bray and colleagues (2000) found that for males, substance use with physical symptoms is associated with lower employment and fewer hours of work. For women, substance use with symptoms is associated with lower employment, but there is no evidence of a relationship to hours worked. Although looking at substance abuse the authors defined problem drinking separately through quantity-based and symptom-based measures.

The other two US studies are slightly different in approach. Booth and Feng (2002) conducted a longitudinal study looking at 'at risk drinkers'<sup>46</sup> in six southern states. The study found that when controlling for previous employment prior to baseline, drinking seven drinks or more on an average day significantly increased the likelihood of not working and reduced the number of weeks in work for those employed. While the strongest predictor of employment was previous employment, at risk drinkers who drank more than seven drinks a day were six times more likely not to be employed six months after baseline (note the focus on short-term employment). Similarly to MacDonalds and Shields (2004), Booth and Feng found the effect of high consumption of alcohol is as important as the impact of education. Morgernstern and colleagues (2003) looked at substance abusing women (using the DSM-IV criteria) receiving TANF in the US, and found that substance dependent women reported significantly lower scores on every employment indicator, than the non-dependent group.

We identified two peer-reviewed studies which report findings that would seem to challenge the consensus presented by the studies detailed above. In a random sample of women and men in six southern states, Feng and colleagues (2001) used their own screening criteria (tied to DSM-IV) and did not find a negative or significant relationship between problem drinking and employment. Depending on the estimator used, and gender, they argue that problem drinking may even show a positive association with employment. However the authors identify some limitations of their own study: that they use a potentially non-representative sample, and that there are problems with phone interviews as data collection methods. The study also used as a measure of employment 'working at any time in the past 52 weeks', which is arguably non-specific and ignores length of time in employment. In a quantitative longitudinal study of welfare mothers receiving TANF in the US, Schmidt and colleagues (2007) found no evidence that substance use operates as a barrier to work, independently of other factors, and did not directly predict transitions from welfare to work and back again for welfare mothers. However, as the authors point out, given the low paid, short-term employment experienced by most of the women, substance use may have had little time to make an impact on employment. In this study problem drinking is not analysed separately, but included in 'substance misuse'.

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<sup>44</sup> The study used data from the Health 2000 survey in Finland, the sample of which contained 16 per cent of men and four per cent of women as alcohol dependent.

<sup>45</sup> From the 1988 Alcohol supplement of the National Health Interview Survey.

<sup>46</sup> Meeting only one of the DSM-IV criteria for dependence.

One UK study looked at the positive and negative effects of alcohol on occupational attainment (MacDonald and Shields, 2001). It used mean hourly wage as a measure of occupational attainment, and found positive and significant returns to moderate levels of drinking for male and female employees which drop off rapidly as consumption increases (15 per cent lower wages for men at either end of the spectrum). It appears that there may be an ‘occupational’ protective effect of moderate alcohol consumption.

In addition to estimating the numbers of substance users who were actual or potential recipients of benefits in private households in 1998<sup>47</sup>, Cebulla and colleagues (2004) report findings on the impact of alcohol use on employment in the UK. They conducted in-depth qualitative research with 23 drug users and ten alcohol users (five of whom were abstinent and five still using alcohol at the time of the study). They also conducted interviews with ten ‘key personnel’ from rehabilitation and/or employment service provider for people with drug and alcohol addiction, including representatives from a community alcohol team, an alcohol counselling service for ex-offenders, and an alcohol advice centre (see Section 3.6.2 for more details on these programmes). They found that the alcohol using group were generally older than drug users (mostly 40-60), and about half were perceived as ‘middle class’, including some professionals. Many had previously been employed, and owned property, and for most heavy drinking had been part of their lives for some time. They described it only becoming a problem because of a significant life event leading to increased drinking, leading in turn to negative impacts on work, their relationships or family life. Their alcohol misuse tended to have a cumulative effect in the workplace, gradually affecting punctuality and attendance; performance (including acting appropriately with colleagues); and safety (for themselves and others). Many were able to hide their use of alcohol, even those needing to drink at work to prevent withdrawal. For most their alcohol problems led to eventually losing their jobs, in some cases because of breakdowns triggered by divorce, stress, or depression. Support workers noted a ‘*general reluctance of people with alcohol problems to seek help*’ (more so than drug users), especially women (p.67).

### 3.4.3 The effect of unemployment on alcohol consumption

A number of studies from Europe and America investigated the relationship between unemployment and alcohol consumption, with most suggesting at least some causal relationship.

In an early longitudinal study in the US conducted by Catalano and colleagues (1993) 10,000 adults were given two face-to-face interviews at one-year intervals. They found that those who reported no alcohol abuse and were employed at the first interview were more likely to report alcohol disorder (DSM-III) if laid off<sup>48</sup> before the second interview. Being male, married or having a past history of alcohol disorder increased the chances of alcohol disorder at the second interview, but having a lower income at the second interview was not statistically significant in predicting alcohol disorder for those that remained employed.

Ettner (1997) used data gathered as part of the US National Health Interview Survey (n=32,012) to consider average daily consumption and dependence in the context of not working (involuntary unemployment and non-participation in the labour market) and, separately, involuntary unemployment. The study demonstrated that both alcohol consumption and symptoms of dependence were significantly associated with involuntary unemployment. However, there was no significant relationship between alcohol use and dependence and not working generally.

<sup>47</sup> See Section 3.5.1 for details.

<sup>48</sup> Note that ‘laid off’ refers to those who were claiming unemployment allowance, discounting those who voluntarily left employment, suffered a disability or retired against their will.



Three Scandinavian studies produced differing results. In a longitudinal study in Sweden 1,000 pupils aged 16 were followed up after five years to investigate the effect of unemployment<sup>49</sup> on alcohol consumption (Janlert and Hammerstrom, 1992). They found that for men there was a positive correlation between unemployment and alcohol consumption at the beginning and end of the study, even when previous consumption and other socio-economic variables were controlled for. The same was true for women, but the correlation was only positive between unemployment and change in consumption when motherhood and alcohol intake prior to the study were controlled for (i.e. if women were mothers they were less likely to increase their alcohol consumption when unemployed). It is worth noting that the area in which the study took place had long-standing unemployment problems.

Claussen (1999) concluded that there is a causal relationship between unemployment and high levels of harmful drinking in Norway. The study was longitudinal and followed up a small number of unemployed people (n=228 at the start of the study). At a five-year follow-up, respondents who were still unemployed had double the prevalence of alcohol disorders compared to the re-employed. However, this study has limitations due to the initial gender imbalance in the sample (it included a higher number of young females) and attrition bias (the majority of those who dropped out were men). Conversely, another longitudinal study also carried out in Norway (tracking 2,000 17-20 year olds) and looking at alcohol use in the immediate aftermath of job loss, found that unemployment did not appear to influence alcohol use (Hammer, 1992). The author explained that participants did not seem to view alcohol use as a way of handling stress and therefore did not increase consumption. Moreover, Hammer claimed that even those who were involved in heavy alcohol use reported a fall in consumption after losing employment.

In a large-scale quantitative study using secondary analysis Dee (2001) looked at the impact of changing unemployment rates upon alcohol consumption in the US, taking account of chronic and binge drinking patterns. He extracted data relating to over 700,000 participants surveyed as part of the Behavioural Risk Factor Surveillance System (BRFSS, 1984-95). Dee found that alcohol use was pro-cyclical, meaning that consumption tended to follow the direction of economic conditions. High unemployment rates, which generally indicate an economic slowdown, tended to reduce levels of alcohol purchasing and consumption overall. In contrast, binge drinking was counter-cyclical and tended to increase in times of high unemployment and therefore increased economic hardship. Citing evidence that binge drinking also increases amongst the employed during economic slowdown, Dee concluded that binge drinking was not solely attributable to more free time amongst the unemployed but may be explained by increased financial stress.

A longitudinal study from Canada examined the impact of unemployment on alcohol use (Khan *et al.*, 2002). The authors were particularly keen to include poverty as a variable, alongside unemployment, in order to take into account the view that unemployment does not necessarily mean economic hardship. Although unemployment tends to involve a significant fall in income, in some cases individuals have other sources of financial support, such as savings. Khan and colleagues found that poverty, in both the short and long term, had a positive and significant relationship with alcohol use, problems and dependence (i.e. that increased poverty leads to increased alcohol use and alcohol problems). They also found that in the short term unemployment appears to reduce alcohol use, only for consumption to increase in the long term. The authors noted that to gain a better understanding of any relationship between unemployment and alcohol misuse longitudinal data would be required. It is worth noting that this study was based on survey data from 1989-1991, and so its findings may not be comparable to the more recent economic context in the UK.

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<sup>49</sup> Defined as being unemployed for more than 20 weeks.

The most recent paper by Mosskowsky (2008), again from the US, used secondary analysis of longitudinal datasets (1979-92). The author found that longer durations of poverty (3 or more years) and involuntary spans of unemployment significantly predict being a heavy drinker and more frequent drinker at the ages of 27-35 yrs old<sup>50</sup>. Additionally, the duration of involuntary unemployment has a significant relationship with being a heavy drinker<sup>51</sup>, although there is no significant association with the duration out of the labour market.

### 3.4.4 Alcohol use and barriers to employment

Two studies described under the sections above (Schmidt *et al.*, 2007 and Morgerstern *et al.*, 2003) look at welfare mothers receiving TANF in the US. The 2007 Schmidt study found that substance use does not predict work status, but it is strongly associated with the practical problems that prevent transitions from welfare to work. Thus, substance use is linked indirectly, via practical problems, to employment. Factors such as level of education (substance users being significantly less likely to hold diplomas) were key in women's capacity to stay off welfare over time. Similarly, the earlier Morgerstern study found that substance dependent welfare mothers had significantly more barriers to employability, than those who were not dependent. On average they experienced five of the following barriers: educational barriers; low work experience; housing; transportation; childcare; physical health; child's mental health; legal; mental health (depression and Post Traumatic Stress Disorder (PTSD)); domestic violence; and child welfare. The authors do not state which barriers were more frequently experienced by substance using women, but they emphasise the prevalence of multiple barriers, the rates of co-occurring problems being two or three times greater than for non-substance users.

Bush and Kraft (2001) ran focus groups with substance<sup>52</sup> abusing women receiving welfare in New Jersey (n=58), in order to understand their experiences and perceptions of barriers to self-sufficiency, recovery and (re)entry to employment. Psychosocial barriers included issues such as low self-esteem and self-efficacy, and a lack of recognition of the work ethic and willingness to work. Structural barriers included stigma, lack of treatment options, childcare services, and a lack of safe environments in which to live.

In their review of evidence from the UK, Europe and the US, Sutton and colleagues (2004) found that research on alcohol users' barriers to employment is limited and of variable quality. They found relatively little information on the specific barriers faced by problem drinkers, as most of the research they reviewed looked at substance abuse more generally<sup>53</sup>. They identified six key barriers to substance users' (re)entry into employment: *'low education or skills; poor physical or mental health; evidence of multiple forms of deprivation; gaps in the provision of support services; personal and presentational barriers; and inter-personal barriers'* (Sutton *et al.*, 2004, p.5). The latter included stigma, fear of losing custody of children, and domestic violence. They emphasise that substance users experience 'substantial mental and physical health problems, which limit their job-readiness and slow their entry or return to work during and after recovery' (p.i). They also highlight the finding from a Scottish study<sup>54</sup> that even those who are capable of working face barriers, including the

<sup>50</sup> Data from the US National Longitudinal Survey of Youth, 1979-1992.

<sup>51</sup> Heavy drinker is defined as drinking five or more drinks consumed on a drinking day.

<sup>52</sup> This study does not look at alcohol use separately from drug use.

<sup>53</sup> Key UK studies on drug users included: Effective Interventions Unit (2001), *Moving On: Education, training and employment for recovering drug users*; Klee *et al.*, (2002), *Employing Drug Users: Individual and systemic barriers to rehabilitation*. York Publishing Services; CESI (2002), *Barriers to work for drug misusers*. Working Brief.

<sup>54</sup> NFFI (2000), *Barriers to Employment, Education and Training Facing NFFI Clients*. New Futures Fund Initiative Summary Paper.

difficulty of reconciling work and treatment requirements. In their discussion Sutton and colleagues note the importance of successful support programmes having well trained staff, and that this included an understanding of local labour markets and close links with employers, in order to successfully match clients to job opportunities in their areas. They also state that employers need to be made aware of the problems substance users might have in adjusting to employment, including additional support with practical issues such as childcare and transport. The authors emphasise that the studies in the review contained little in terms of robust evaluation, and no data on outcomes for those who misuse only alcohol (see Section 3.6.2 for more details on the UK interventions they reviewed).

In a qualitative study in the UK the same authors identified barriers to work for substance users that they interviewed (Cebulla et al., 2004). Some of these barriers were specific to alcohol users. Health problems were found to be the most immediate barrier for substance users, with deep-seated psychological problems more often cited by alcohol users. Other perceived barriers were ‘eroding’ social networks, homelessness, adverse social environments<sup>55</sup>, low confidence, and fluctuating motivation. They found that educational and occupational qualifications could be low, although this was more so for young drug users as most alcohol users hoped to return to the kind of work they had held previously. A further barrier for all substance users was perceived interrupted work histories, gaps in CVs, and the need to disclose health problems to employers. In terms of support to return to work, Cebulla and colleagues noted a general lack of trust in government services but greater trust in treatment providers who were seen to understand the ‘*multiplicity and diversity of problems faced by (former) substance users and the benefits of case management*’ (p.vi). They also identified a need for integration in service provision, improved awareness training for jobcentre staff, and the provision of more information on support for education and training, and financial support. Both substance users and service providers advocated a ‘step-wise’ (re)integration into the labour market, involving voluntary, part-time, and short-term work. The authors emphasised the need for employers to be willing to support this type of working for substance users, for example by accepting a ‘waiver’ so that users could avoid declaration of prior substance use. All interviewees agreed that in order to enter and sustain employment, substance users needed to be abstinent, commonly citing safety reasons, although some thought that certain types of employment might be feasible for those who had reduced their usage. The potential for relapse was another issue of concern to all.

There is a developing literature on substance users’ barriers to employment, but a dearth of literature on the barriers faced specifically by those who misuse alcohol as distinct from other drugs. The literature that does exist uses different measures of both alcohol misuse and employment, with a full consensus on suitable measures yet to emerge. Papers detailed elsewhere in this report look at the complex relationship between substance misuse, including polydrug use, mental health and unemployment (see Sections 3.2.2 and 3.3.3). These findings are helpful in understanding barriers to employment for these specific groups, but there is clearly potential for research targeted specifically at alcohol users in order to develop a better understanding of this area.

### **3.4.5 The effect of favourable job change on alcohol consumption**

Dooley and Prause (1997) conducted secondary analysis on data from the US National Longitudinal Survey of Youth from 1984, 1985 and 1989. The study, which focused on binge drinking, investigated whether positive employment change affects alcohol abuse, and whether different types of employment change make any difference. Whilst this study is about job change and not solely

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<sup>55</sup> Described by the authors as deprived neighbourhoods ‘*where people go their own way*’ (p.112) or ‘*areas of high unemployment and in some cases high levels of drug use and trafficking*’ (p.113).

unemployment it is still relevant to both this section and the previous section on employment. The authors distinguish between unemployment and underemployment, the latter being involuntary part-time work or 'poverty wage work', both of which are defined as inadequate employment. Thus, the different types of employment change are defined as unemployment to underemployment, unemployment to adequate employment, and underemployment to adequate employment. Results show that among prior binge drinkers, favourable job change decreases the odds of later binge drinking. In the short term (one year) favourable job change (all types) was associated with a decrease in binge drinking but only in those who were high binge drinkers at the start of the study. Limitations of this study include the focus on binge drinking, in addition to the data being rather out of date.

We were not able to identify other papers that support the findings of this particular study. While this topic is somewhat outside the scope of this review, it is relevant to the issue of sustaining employment. There may be a considerable research gap in this area in respect of binge drinkers, and others who misuse alcohol.

### 3.5 Alcohol misuse and benefits

#### Summary

This section describes findings from 20 studies on alcohol misuse and benefits, with all but six of the studies taking place in the US and just two from the UK. The majority of these American studies were conducted in the years leading up to or just after the 1996 PRWOA welfare reforms, which tightened benefit eligibility and terminated a benefit (SSI) that has been targeted at those with drug and alcohol misuse problems. SSI had required recipients to attend substance misuse treatment as a condition of benefit receipt, and unsurprisingly, after this benefit was terminated, treatment uptake in the US fell.

A number of studies examined the prevalence and severity of alcohol misuse amongst adults accessing a range of benefits although findings from these studies were not always consistent.

- One large-scale study concluded that rates of heavy drinking were low amongst welfare recipients and were comparable to the population not receiving benefits (Grant and Dawson, 1996); another found no association between not being employed (with or without benefits) and heavy drinking (Rodriguez and Chandra, 2006).
- A study focusing on low income women found that alcohol dependence was higher among single women receiving welfare than among other single mothers (Meara, 2006).

Studies focusing on SSI recipients prior to the reforms found that this group experienced a range of other problems in addition to alcohol and/or drug misuse including mental and physical ill-health.

- McKay and colleagues (1998) found that few of the 2,500 SSI recipients in their study had worked at all in the past three years with only 12 per cent in full- or part-time employment during that period.

Other studies looked at treatment uptake amongst benefit recipients and whether or not benefit uptake affected alcohol use.

- Alterman and colleagues (2000) studied a small sample of SSI recipients and found that even when that benefit, which was treatment contingent, was in place, treatment was often coerced and the severity of the problems faced by recipients limited treatment efficacy.

- Ries and colleagues (2004) trialled contingent and non-contingent payment of benefits on the basis of treatment uptake and found that alcohol and drug use did decrease amongst the contingent management group, although this was a pilot study with only 22 clients in the intervention group.
- Rosen and colleagues (2006) aimed to determine whether receipt of benefits (specifically SSI or SSDI) was associated with increased drug or alcohol use. They found that new benefit recipients showed reduced levels of alcohol use and concluded that the political focus in the US on receipt of benefits triggering increase substance misuse was unwarranted.

US studies shed some light on the impact of alcohol misuse on welfare dependency or entry to employment.

- One study found that the extent to which substance misuse was a determinant of longer-term use of benefits varied depending on the benefit received (Schmidt *et al.*, 1998). Amongst those receiving one form of welfare in the USA (Aid to Families with Dependent Children), substance misuse, including alcohol misuse, was not a determinant of long welfare stays, repeat welfare use or the total time spent on welfare.
- In contrast the same study found that among recipients of General Assistance (non-cash benefit) substance misuse was a strong predictor of repeat welfare use. This suggests that the relationship between benefit use and alcohol misuse may vary depending not only on the characteristics of recipients but also the form of benefit received.

These studies highlight the finding that barriers to employment as a result of drug and alcohol misuse were higher for people in receipt of GA than for other forms of assistance, where the rates of alcohol misuse were comparable to the general public. The results indicate that the impacts of drug and alcohol misuse are amplified because people in receipt of GA are more likely to be repeat welfare recipients.

Two Scandinavian studies looked at disability pensions and alcohol misuse :

- Individuals who consumed alcohol (at any level) were more likely to be receiving a disability pension than abstainers (Mansson *et al.*, 1999).
- Upmark and colleagues (1999) found higher levels of sickness absence amongst those with indications of problem drinking who were still in work at the time of the study.

Finally, we reviewed three US studies that examined the effect of terminating or withdrawing benefits from adults with substance misuse problems.

- Swartz and colleagues (2004) summarise findings from a series of studies on this topic. Within two years of SSI being terminated, less than half of recipients had re-qualified for another form of benefit (usually disability benefits) and substance misuse treatment participation had declined. Around one third had no consistent source of income over those two years and earnings from sporadic employment did not offset the loss of cash benefits.
- A number of housing problems were identified (Anderson *et al.*, 2002) although housing and hunger improved after a peak of hardship at one year.

Evidence about the impact of SSI withdrawal is of limited applicability to the UK context. Exceptions, perhaps, are the lessons it provides about reduced levels of treatment uptake when contingent benefits are stopped, and the type of hardship that can be experienced as a result of the loss of benefits, even in the short term.

Twenty papers directly relevant to the topic of alcohol misuse and benefit uptake are included here. Sixteen are US studies, and four are from Scandinavia (all relating to disability pensions). We have also included the only other UK study we identified which was of relevance to this topic (Brown *et al.*, 2008) looking at benefit uptake on the grounds of alcoholism in Scotland. In addition to these 20 papers we make reference to Cebulla and colleagues (2004), which we included in the previous section on alcohol and employment. They produced estimates of the prevalence of drug and alcohol misuse among benefit recipients in the UK, and we have included these here.

The vast bulk of identified papers on alcohol and benefits are from US studies conducted just before or after welfare reform. An overview of US welfare reform can be found in Section 2.3.

The findings from the literature in this area can be grouped into the following themes:

- the prevalence and/or severity of alcohol use among benefit recipients;
- benefit receipt, treatment and effects on alcohol use;
- the impact of alcohol use on welfare dependency and/or entry to employment;
- the effects of termination of benefits.

### 3.5.1 The prevalence and/or severity of alcohol use among benefit recipients

Cebulla and colleagues (2004) estimated the numbers of substance users (including alcohol users) who were actual or potential recipients of benefits in private households in the UK in 1998. They estimated that for ‘problematic drinkers’<sup>56</sup> there were at least 120,000 people on Jobseeker’s Allowance (JSA) or Income Support (IS) (with 170,000 being the top estimate) and 150,000 on sickness or disability benefits (top estimate of 195,000). Those with problematic drug and alcohol use were estimated to make up 51,000 ‘potential’ claimants.

Although not focusing on prevalence and severity of alcohol use we did identify one other UK study relating to alcohol misuse and benefits, with a significant gender difference in their findings. Brown and colleagues (2008) looked at the reasons why individuals were claiming IB<sup>57</sup> in Glasgow and Scotland between 2000 and 2007. Their study was focused on mental health but they classed alcoholism<sup>58</sup> as a mental health or behavioural disorder. They found that during that period of study there was an increase in the number of people claiming IB due to mental health problems, and that men living in Scotland are far more likely than women to claim IB on the grounds of alcoholism (85 per cent for men; 15 per cent for women in 2000). They also noted that this gender gap appears to be narrowing slightly as the number of women claiming IB because of alcoholism increased over the seven-year period to 16.7 per cent, while the number of men claiming fell to 83.3 per cent.

Four studies from the US examined the prevalence and severity of alcohol misuse amongst adults accessing a range of benefits<sup>59</sup>. Findings from these studies were not consistent, or comparable, and only the evidence review (Meara, 2006) makes comparisons pre- and post-welfare reform, and then only for women. Studies in this and other sub-sections note that those receiving welfare benefits pre-reform experienced a range of other problems in addition to alcohol and/or drug misuse, including mental and physical ill-health.

<sup>56</sup> See Appendix B.

<sup>57</sup> Using data supplied by DWP.

<sup>58</sup> The term ‘alcoholism’ is not defined by Brown and colleagues.

<sup>59</sup> AFDC, SSI, Food stamps, Medicaid and the Special Supplemental Food Program for Women.

Secondary analysis of the 1992 US National Longitudinal Alcohol Epidemiologic Survey, combined with a national cross-sectional survey (n=42,862) estimated the prevalence of heavy alcohol use, drug use, and alcohol and drug abuse and dependence among recipients on five welfare programs, and found that rates of heavy drinking and alcohol abuse/dependence were low among welfare recipients, and comparable to the population not receiving benefits (Grant and Dawson, 1996). We are not aware of a more recent, comparable study. Secondary analysis of the US National Survey of Families and Households (1987/88;1991/92) conducted in 2006 (Rodriguez and Chandra) found no association between not being employed (with or without benefits) and a greater likelihood of engaging in heavy drinking behaviours, and drinking levels among other employment groups were not significantly different. However, the study did find that employed welfare recipient women have a greater likelihood of heavy drinking<sup>60</sup> than other full-time employed (26 per cent compared to 11 per cent) and this was especially true for those with more children. The authors cite issues of low income employment, childcare and resulting stress as possible explanations. Again, similar data post-welfare reform is not available for comparison.

A review of evidence on employment patterns before and after 1996 welfare reform, focusing on drug and alcohol use among low income women (Meara, 2006) found that alcohol dependence was higher among single mothers receiving welfare (nine per cent) than among other single mothers (five per cent), and that since 1996, women with substance use disorders (SUDs) had increased their employment and earnings, but by less than similar women without SUDs. This study focused on drug and alcohol use, however, and provided little data relevant to alcohol use and employment.<sup>61</sup> A cross-sectional study conducted prior to welfare reform (McKay et al., 1998) included some detail on employment. Data from structured interviews with a sample of 2,500 recipients of SSI benefits for drug addicts and alcoholics (DA&A), assessed at the point in which they were to be referred for treatment services, showed that only 12 per cent had worked full or part-time over the previous three years; 68 per cent were usually not working; and the longest full-time job averaged four years. The principal drug of abuse was alcohol<sup>62</sup>, with the sample averaging 3.4 prior treatments for alcoholism. The study found high levels of depression and other mental health issues (more than 30 per cent had reported attempting suicide; 40 per cent had been prescribed psychiatric medication). Sixty-three per cent had a chronic medical problem, and 73 per cent had been in prison at some time, with a significant minority having experienced physical and/or sexual abuse. As benefit entitlements and requirements changed after this study, there is no more recent comparable data on this client group.

### 3.5.2 Benefit receipt, treatment and effects on alcohol use

Two of the three US studies detailed here looked at treatment uptake amongst benefit recipients, and the other whether or not, and to what degree, benefit uptake affected alcohol use.

A cross-sectional interview-based study with a small sample (n=237) of recipients of SSI (DA&A) benefits pre-reform, who had been assigned and entered into substance abuse treatment, was conducted with the aim of describing for a smaller sub-sample the treatment services received, and assessing whether such provision was appropriate (Alterman et al., 2000). The authors concluded that *'the treatments received by these patients were often coerced and that many of these clients exhibited multiple, serious problems'* (p.209). The sample (which was 68 per cent male) had little or no work history, 64 per cent had chronic medical problems, and most had various psychiatric problems (77 per cent serious depression). Again incarceration (61 per cent), and abuse featured.

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<sup>60</sup> See Appendix B for a summary of measures used, with example studies from this and other sections.

<sup>61</sup> See McLellan and colleagues (2003) in Section 3.6.3 for details of the CASAWORKS for Families pilot project which aimed to support the co-ordination of services to tackle multiple barriers to employment, including substance abuse and childcare.

<sup>62</sup> See Appendix B for a summary of measures used, with example studies from this and other sections.

Alcoholics and cocaine users were combined into one group for the analysis, making it hard to extract meaningful data for alcohol use alone. This sub-group averaged 18 years of alcohol use, and 2.8 times treated, with 14 being the mean number of services received (including group therapy, 12-step programmes, or drug/alcohol education). The mean figure for the use of medical services was low (1.8), with the average for other services (psychiatric, employment, legal, and family/social) being very low to non-existent.

Two studies focused on benefit recipients with specific or complex needs. One small-scale pilot study, running over a two year period, involved a trial of contingent and non-contingent payment of SSDI benefits to 41 patients with severe and persistent mental illness and co-occurring substance dependence (Ries *et al.*, 2004). Although the findings were reported for alcohol and drugs combined, the most used substance was alcohol (61 per cent). The authors found that those with contingent management used significantly less alcohol and drugs, and for fewer weeks and also showed much better money management than the 19 with non-contingent management. Half of the group received benefits contingent on an assessment of substance use, money management, and treatment follow-through, along with active case management and screening for drugs and alcohol. The authors found few differences in adverse outcomes, but as the two groups were more alike than different, they also state that it was hard to isolate effects of contingent management intervention. In this sample group the urban mental health centre they were attending was also the 'representative payee' for SSDI benefits.

Secondary analysis of longitudinal data generated from a sample of 6,000 homeless and mentally ill participants<sup>63</sup> over a four-year period, to determine whether receipt of SSI/ SSDI disability payments was associated with increased drug and alcohol use (Rosen *et al.*, 2006). The study analysed four sub-groups: those on SSI/SSDI; those newly awarded benefits, those recently awarded and those without benefits. The main findings of this study were that those not receiving benefits significantly reduced substance use over time, although this must be qualified with the fact that they also started with the highest levels of use. Those newly receiving benefits showed no greater drug use, and alcohol use reduced (the opposite of an hypothesised 'spike'<sup>64</sup>) but had more days housed and fewer days employed (although this may have stabilised over time). The authors also found that receipt of SSA payments '*facilitates exit from homelessness*'. They conclude that the political focus in the US on receipt of benefits triggering increased substance use has largely been shown not to be the case, and that causes of substance use 'lie elsewhere'.

### 3.5.3 The impact of alcohol use on welfare dependency and/or entry to employment

The five US studies in this section, and four longitudinal studies from Scandinavia, look at the relationship between alcohol use, welfare dependency and employment, and at the differences between those receiving different forms of benefits. These include including those targeted at people with dependent children, non-cash assistance and disability benefits.

One longitudinal study conducted prior to welfare reform (Schmidt *et al.*, 1998) analysed data from two different groups over six years, initially on application for benefits (1989 n=606; 1995 n=411)<sup>65</sup>. One group were receiving AFDC (94 per cent women, 61 per cent single parents); the other group were on local General Assistance programmes (61 per cent male, eight per cent single parents). The authors identified problem drinkers at baseline (see Appendix B for details). They found that GA recipients were three times more likely to be problem drinkers than those in receipt of AFDC (38.4

<sup>63</sup> Access to Community Care and Effective Social Supports and Services demonstration.

<sup>64</sup> Participants awarded benefits between months 4 and 12 had over time less clinician-rated alcohol use than those without benefits.

<sup>65</sup> This sample was drawn in one state in California, and is not nationally representative, although the study used a general population survey (n=3,069) for comparison.



per cent compared to 12.2 per cent), whereas rates for AFDC recipients were comparable with the general population. GA recipients were also more likely to be problem drug users, and substance dependent. The authors found that for AFDC recipients substance abuse was not a significant determinant of long welfare stays, repeat welfare use, or the total time a person remained on welfare. For these welfare recipients background and family-related factors were stronger determinants. However, GA was a strong predictor of repeat welfare (a four-fold increased risk) and they identified a 'revolving door' pattern. Reasons substance abusers gave for leaving welfare were: being cut off for failure to comply with treatment or benefit requirements 43 per cent (compared to 23 per cent for other welfare recipients); getting a job 36 per cent (47 per cent); transferring to a different programme 26 per cent (32 per cent); changing residence 21 per cent (11 per cent); and being incarcerated 16 per cent (seven per cent). Although the authors note a potential risk of recipients being pushed from national programmes of support to local 'safety nets', there is no data presented on this here.

A cross-sectional study of low income, substance abusing women who had recently been discharged after treatment in 'Village' residential programmes (n=7266) found that 36 per cent of the sample had used alcohol in last 30 days (Metsch et al., 1999, using the Addiction Severity Index (ASI)). The study looked at welfare status, work status, and barriers and facilitators to gaining and maintaining employment, and found that women who had used substances in the past 30 days were less likely to be working than those who had not used since leaving, or used more than 30 days ago (five per cent compared to 29 per cent,  $p=0.004$ ). Barriers to employment cited by participants were childcare (21 per cent), including cost, and lack of job flexibility; involvement in illegal activities or incarceration (20 per cent); a perception that jobs were not available (16 per cent); inadequate job skills (nine per cent); and other commitments and/or responsibilities (nine per cent). Only four per cent cited health reasons. Those in work were associated with having a higher level of education and having received job training; being drug free; programme completion; close relationship with friends (but not family) possibly for social support, and practical help with transport and childcare. The authors found three variables independently associated with work status: a high school education; longer duration in treatment (12 months +); and programme aftercare.

A (post-reform) cross-sectional study of applicants for TANF benefits (n=8,797 screened) found there was very little difference with regard to employment and earnings, or use of Food Stamps, cash assistance, and Medicaid, between those who screened positively for substance abuse (n=6,462) and those who did not. However, they did not collect data for alcohol use specifically (Crew and Davis, 2003).

Secondary analysis of the 2002 and 2003 US Surveys on Drug Abuse and Health (n=73,396) assessed the relative impact of disability benefit receipt on participation in substance abuse treatment and the labour force (Brucker, 2007). An analysis of treatment used a sub-set of 11,076 of individuals with any alcohol or drug abuse (n=5,371) or dependence (n=3,873) using criteria mirroring the DSM-IV. The study found that disability beneficiaries with substance use disorders are more likely to access treatment than those who are not beneficiaries. Of those who participated in treatment (in the previous year) for 8.5 per cent this was with alcohol abuse or dependence, 14.8 per cent with any abuse or dependence and 16.7 per cent were disabled. Thirty-two per cent of alcohol abusers and dependants worked in last week (the figure was 30.2 per cent for drug users). The study could not confirm however that those who accessed treatment were more likely to return to employment than those who did not (they found only a three per cent higher chance of being employed, and this was not statistically significant).

In a longitudinal, mixed methods study conducted in California, between the late 80s and early 90s,

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<sup>66</sup> Conducted in Miami. Seventy-three per cent of the sample were African American; 67 per cent were parents, mostly lone parents.

Mulia and Schmidt examined the relationship between substance-using welfare recipients, their wider social network and the welfare system (Mulia and Schmidt, 2003), focusing in the qualitative part of the study on reasons for welfare exit.<sup>67</sup> They found that where alcohol or drug use was involved, administrative exits from welfare were more likely (almost a quarter of overall exits for alcohol and drug users), as well as imprisonment, while the non-substance using group were more likely to leave welfare for employment. The authors noted that dealing with an addiction can impair an individual's ability to comply with administrative procedures; and that family difficulties can lead to problems with eligibility (for example substance-using individuals who may put their children into care in order to improve their safety, but then lose their right to welfare benefits because they no longer have parental responsibilities). Mulia and Schmidt conclude that the difficulties of handling substance use in the welfare system encompasses interaction between clients, the welfare system and the client's wider social environment. The researchers emphasised the importance of taking into account the wider complexities associated with a substance-using lifestyle, although no distinctions are made here between drug use and alcohol use.

Four longitudinal studies from Scandinavia relate to the relationship between alcohol consumption and disability pension. A study of middle-aged men in Sweden<sup>68</sup> found a cumulative incidence of disability pension of 19 per cent among teetotallers, 12 per cent for those with low consumption, and 16 per cent for those with high consumption (Mansson et al., 1999, using a modified MAST (Michigan Alcohol Screening Test)). A similar study<sup>69</sup> in Denmark (Upmark et al., 1999) using CAGE and consumption measures<sup>70</sup> found a consistent pattern of increased sickness absence for high consumers and for those with indications of problem drinking. They conclude that their data suggests there is an effect on working incapacity independent of baseline health status, smoking, and socio-economic group. As in the Swedish study the authors note the relatively higher risks for abstainers and speculate that there could be an unidentified sub-group with specific problems (for example recovering alcoholics or those with other health issues not picked up by the survey). An earlier longitudinal study by Upmark and colleagues (1997) based on a survey of Swedish conscripts in 1969/70 found factors such as early unemployment and a father's low socio-economic status were strong predictors of such a disability pension. However, the strongest predictor of a pension was previous involvement with police or child welfare authorities. A more recent study (Upmark et al., 2002) found that strong predictors of receiving a disability pension among a sample of Swedish women (n=284), included experience of living in a children's home; having one or both parents with an alcohol problem; problems at school; early drug use and experience of shoplifting. As only a fairly small proportion of the initial sample (28 women, less than ten per cent) was in receipt of a disability pension by the end of the study, these findings are arguably less robust than the earlier study. We were not able to find a comparable study with a larger female sample.

### 3.5.4 The effects of termination of benefits

Three US papers report findings around the effects of terminating or withdrawing benefits (i.e. during welfare reform) from adults with alcohol and drug misuse problems.

<sup>67</sup> Two waves over six years, from recipients of AFDC and GA, in one county of California (n=411).

<sup>68</sup> n=3,751, 13.3 per cent of the sample (n=498) were granted disability pension after screening. 7% of this sub-group had a medical diagnosis of alcohol dependence (although the authors suspect the true figure was higher).

<sup>69</sup> Sample from four primary care districts in Stockholm county (n=985 women; n=870 men) who were 'fit for work' in 1984.

<sup>70</sup> Two or more positive answers to the four CAGE screening questions plus usual alcohol consumption, and consumption during the previous week. See Appendix C for further details.

A two-year multi-site cohort study<sup>71</sup>, reviewed by Swartz and colleagues (2004), looked at the effects of terminating SSI for drug addiction and alcoholism. An average of 33 per cent of the sample were addicted to alcohol, and 50 per cent to alcohol and drugs, with 16 per cent reported daily or more frequent alcohol use, although the findings reported here are for substance users in general (using ASI). The study established that within two years of programme termination, 35-43 per cent of recipients had requalified for disability benefits; substance abuse treatment participation declined and illegal drug use was prevalent. Twenty per cent 'secured income assistance from other sources' (from other benefits but also from family members and from crime). Thirty-seven per cent had no consistent source of income over two years, and earnings from sporadic employment rarely offset loss of cash benefits. They found higher rates of 'doubling up' in housing, although housing and hunger appeared to improve after a one-year peak of hardship (the authors concede that some whose circumstances may have worsened had dropped out of the study). They noted low treatment participation (either through loss of the mandate, or completion of treatment), but had no information to report on substance use rates pre- and post-treatment. They found that 21 per cent of the sample drank to intoxication in the month prior to the two-year follow up. Generally, quality of life worsened for those not replacing income lost, plus those with higher use at baseline. The authors conclude that there was some increase in 'resilience' in the sample, although it is unclear how this was defined (except in terms of people finding other sources of income, including crime, and solutions to housing, including doubling up).

There were a number of individual papers arising from this study each exploring different aspects of the loss of DA&A benefits<sup>72</sup>, and others on sub-sets of the same sample, or closely related samples<sup>73</sup>. Anderson and colleagues (2002) used mixed method interviews to investigate the effect of the removal of SSDI on housing status among a sample of former recipients (n=101<sup>74</sup>). The authors found that termination of benefits, combined with a housing market explosion, increased homelessness and dependency on family and friends ('doubling up'), or problematic state-provided housing. This in turn increased risk of drug and alcohol use, criminal participation, and victimisation. They found that housing was the most important expense and concern for participants. Although data on alcohol use is not generally separated out (all reported use 'ever'; average recency 2.3 years previously), and there is no data on level of use/abuse, of the 41 per cent currently needing treatment, for 21 per cent this was for alcohol treatment, 30 per cent for alcohol and other substances. Over half (n=52) had been in a drug or alcohol treatment programme once, and some had been treated several times.

One more recent study used secondary analysis of five waves of interview data, looked at a very specific group affected by welfare reform: women who were 'chronically disconnected' from both employment and cash welfare (Turner *et al.*, 2006). The sample consisted of single mothers

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<sup>71</sup> Nine sites (five in California, two in the Midwest and two in the Northwest). Not nationally representative, with variation in sampling and recruitment. Average of 62 per cent male; 50 per cent African American; 87 per cent single, divorced or separated; 79 per cent had two or more medical problems; 72 per cent had psychiatric problems; 27 per cent reported committing a crime in the preceding six months.

<sup>72</sup> Including Campbell *et al.*, 2003; Guydish *et al.*, 2003; Norris *et al.*, 2003; Speigman *et al.*, 2003; Swartz and Martinovich, 2003.

<sup>73</sup> Goldstein *et al.*, , 2000; Swartz *et al.*, , 2000; Watkins *et al.*, , 2001; Anderson *et al.*, 2002; Swartz *et al.*, 2003.

<sup>74</sup> Chicago: non-randomly selected. Seventy-four per cent male, 82 per cent black, 86 per cent never married/divorced/ separated, 72 per cent had children. Forty-five per cent were employed (all on a low wage).

receiving cash welfare in February 1997 ( $n=853^{75}$ ). The authors found that most single mothers became disconnected from work and cash welfare (including support from a partner) at some point. Nine per cent became ‘chronically disconnected’ from both, and that they were disconnected for substantial periods and/or multiple spells. The authors identified statistically significant increases in the number disconnected in the study period, while the number working increased from 21.6 per cent to 61.3 per cent. The correlates for chronic disconnection were physical limitation; learning disability; and having no car or driver’s licence; but also using illegal drugs or meeting the diagnostic screening criteria for alcohol dependence (22.5 per cent, see Appendix B for measures). They also found that this sample were more likely to have lost a job than to have lost welfare benefits.

### 3.6 Employment-related interventions

#### Summary

This section of the review summarises findings from studies that described interventions intended to treat those with alcohol problems and support them to find employment and/or training. In addition to DWP reports included in previous sections (Sutton *et al.*, 2004; Cebulla *et al.*, 2004) we identified a further 12 studies which described several features and facilitators of returning to work.

- Those seeking treatment for alcohol misuse are more likely to have taken this step only after experiencing other problems in their lives, including family breakdown, and mental health problems (Proudfoot and Teeson, 2002; Hajema *et al.*, 1999).
- Substance abuse treatment alone can result in positive employment-related outcomes. For example, treatment completion and length of time in treatment are believed to be good predictors of positive employment related outcomes. (Metsch *et al.*, 2003; Zarkin *et al.*, 2002; Moos *et al.*, 1999).
- Some of the studies summarised here indicate that employment programmes (on their own or part of substance abuse treatment) which are intensive and offer a structured approach, which can also be flexibly adapted to meet individual need, have promise in terms of a range of outcomes. Offering intensive individual case management support seems to be important. (Morgenstern *et al.*, 2009; Diver and Dickson, 2006; McLellan *et al.*, 2003). Vocational rehabilitation and ‘employability skills’ are also believed to be important (Diver and Dickson, 2006; South *et al.*, 2001).
- Some studies have demonstrated positive outcomes in wider areas of personal, family and social functioning, indicating that interventions in this area can usefully involve a more holistic response rather than focusing too narrowly on alcohol misuse and employment (McLellan *et al.*, 2003).
- Some of the studies reviewed indicate other predictors of being able to return to work when someone engages with substance abuse treatment and/or an employment intervention. This includes employment history, employment immediately prior to treatment entry (Metsch *et al.*, 2003) and the proximity of clients to the services available to them.
- For programmes to meet multiple needs a strong degree of inter-agency communication and collaboration is necessary, between alcohol treatment and employment services (Sutton *et al.*, 2004; South *et al.*, 2001; Gossop and Birkin, 1994).
- There is a lack of robust research in the area of employment-related interventions and little evaluation of programmes in the UK (South *et al.*, 2001; Sutton *et al.*, 2004; Cebulla *et al.*, 2004).

<sup>75</sup> Women’s Employment Study (1997-2003), in one urban county of Michigan. 749 at first wave; 503 at the fifth.

This section of the review includes papers that examine interventions to treat alcohol misuse, in particular programmes that include a component that aims to support clients to find training and/or employment opportunities. A varied group of 12 papers are included in this section. Two non-UK papers (one from the Netherlands and one from Australia) look at patterns and predictors of help-seeking behaviour, but these may be of limited applicability to the UK. Only two of the papers on interventions described UK studies, one of which is more than ten years old. A third UK article, whilst not a research study, was included because it did discuss, albeit in limited detail, issues related to this theme (South *et al.*, 2001). The relevant sections of the reports on drug and alcohol use as barriers to employment, produced in 2004 for the DWP (Sutton *et al.*, 2004 and Cebulla *et al.*, 2004) are also included in this section.<sup>76</sup>

The literature search clearly did not identify many articles in this theme, and little research, particularly in the UK has apparently been conducted and published in this area (South *et al.*, 2001; Sutton *et al.*, 2004). However, the number of projects outlined in some literature reviews in this area (South *et al.*, 2001; Sutton *et al.*, 2004) indicates that the work is there, but that it is not adequately supported by a strong enough research and dissemination agenda. South *et al.*, (2001) argue that one reason for this gap is that addiction treatment simply does not sufficiently consider employment as part of its treatment programmes. Nonetheless the findings from many of these studies demonstrate positive outcomes from a small number of interventions in terms of substance abuse, employment and other areas of functioning.

It should be noted that only one article included in this section of the review considered interventions for alcohol use alone, which makes it hard to consider how findings from the included studies could be applied to alcohol specifically (studies which considered both drugs and alcohol had to be included in this theme because of the lack of research in this area). Generalisation of study findings is further confounded because many of the studies focused on specific populations. For example, in the US studies tend to focus on women with children on welfare or veterans. The main conclusion from this group of papers is that there is a general lack of research on interventions for alcohol misuse, and an urgent need for this gap to be rectified. The UK and US studies which have been summarised give useful indications of lines of inquiry for further research in this area.

### 3.6.1 Help-seeking

Two studies looked at factors that predict an individual's decision to seek help for alcohol use problems. In the Netherlands, Hajema and colleagues (1999) compared self-reported data collected from male outpatients of a treatment centre (collected in 1993 and 1994, n=129) with that of male problem drinkers, identified from a survey of the general population (1980-89, n=89). Hajema and colleagues found that age, unemployment and disability increased the likelihood of an individual seeking help for alcohol problems. They also found evidence to confirm the hypothesis that the negative impact of alcohol problems upon an individual's health and personal relationships had a greater influence over their decision to seek help than any recognition of problem drinking. Apart from the limitations of this study in terms of the focus on male problem drinking, small sample size and self-reported data, it is also important to highlight the different time periods in which the data was collected; and the fact that the outpatient data-set was sampled from only one treatment centre.

A cross-sectional study conducted in Australia in 1997 examined the predictors of help-seeking for alcohol problems amongst a random population sample (n=10,641) found that receiving a diagnosis of alcohol dependency did not indicate an individual's use of services (Proudfoot and Teeson, 2002). As in the work of Hajema and colleagues, this study demonstrated that other factors appeared

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<sup>76</sup> These reports are not included in the total for this section. See Section 3.4.

to intervene in influencing the decision to seek help. Proudfoot and Teeson found that the co-occurrence of mental health problems amongst those with an alcohol dependency was associated with seeking help from alcohol services. The researchers also found that women were far more likely than men to seek help.

No similar studies on help-seeking were identified in the UK.

### 3.6.2 Employment-related interventions in the UK

Two very different studies were included here. The first trained 145 staff in employment services in one area of England to provide a better response to those with alcohol and drug problems (Gossop and Birkin, 1994). Following delivery of a specifically designed two day training course a random sample of 50 per cent of those trained were followed up<sup>77</sup>. The results showed that many staff felt more confident, able and willing to deal with clients who presented with alcohol or drug problems with improvements reported in the areas of problem recognition, assessment, counselling and referral. The review by Sutton and colleagues (2004) also summarised that, *'employment service providers had in-depth knowledge of drug- or alcohol-related issues (including health and behaviour), as well as close links with the local labour market'* (pg. i). Unfortunately, a major limitation to this study was that no data were collected from the clients themselves so there is no way of knowing if the training course ultimately benefited them through their being better able to access treatment or regain employment.

The other UK study was a largely descriptive study of a therapeutic community in one area of England (Diver and Dickson, 2006). Whilst virtually no research data are presented this paper is useful in describing in quite some detail the intense programme available to residents and when and how issues relevant to employment are considered. The programme lasts 12-15 months with six main stages. The paper focuses on Stages 4 and 5, the most relevant stages in terms of employment and community integration. The Stage 4 're-engagement' process usually begins at approximately nine months. During Stage 4 clients are able to get involved with voluntary work placements and workshops and talk to a career guidance officer. Clients need to be able to understand that a return to previous careers might not be possible because of work-related triggers to substance misuse, whilst others need guidance and support with things like writing a CV or attending a job interview. A client has completed Stage 4 when they have a job, and an employment contract and bank account associated with the job. Clients then progress to Stage 5 where they must sustain employment for 12 weeks whilst adjusting to community living. At the end of their paper the authors conclude that, *'obtaining and maintaining full-time employment is crucial. In the first six months of 2005-2006, 43 per cent<sup>78</sup> of residents...left into planned accommodation having been in full-time employment, obtained on the open job market, for three months. This provides a really firm basis for ongoing recovery'* (Diver and Dickson, 2006, p.106). Whilst this study discusses a very specific programme, the detail of some elements of the programme can be usefully extracted and compared to, for example, the principles of the intensive and case management models summarised in the US (see below).

In the absence of much research in this area, other literature reviews offer further insight in UK based research in this area. South and colleagues (2001) identified 28 local projects across England which involved partnerships between substance abuse and employment/training (whilst more focused on drugs, the issues discussed can be equally applied to alcohol). They summarised the key features of a very diverse range of projects, but did not present any specific research or evaluation data. The projects include, for example, those which encourage residents in residential communities

<sup>77</sup> Response rate of 83 per cent.

<sup>78</sup> Forty-three per cent amounts to about 28 people.

to engage with the running upkeep of the community, an employment specialist to develop 'employability skills', back to work courses and workshops, and 'sheltered employment' schemes where *'work experience and confidence can be gained while the client receives the kind of the support unavailable in normal employment'* (South et al., p.28).

Sutton and colleagues (2004) reviewed a number of studies relating to intervention programmes for substance users in the UK, Europe and the US. They found very little in the way of robust evaluation of these programmes, particularly in the UK, with most reports describing throughput rather than outcomes or programme effectiveness. Seven of the papers they reviewed described UK projects, but only three of these contained any data. One project (funded by the Single Regeneration Budget) involved the location of two employment placement workers within community drug team offices<sup>79</sup>, who provided help with writing CVs and job applications. They recorded that of the 161 substance users who accessed the service, 30 moved into full- or part-time employment and 24 into education. There is no information on outcomes for the remaining 107, or how many were alcohol users. Another programme for alcohol and drug users consisted of a 12-week course using a therapeutic approach to achieve a return to 'meaningful work' and long-term abstinence. However, the project report contained no information on outcomes, and it is not known if this programme was repeated<sup>80</sup>. The other evaluated programme, in Scotland, was targeted at drug users, and so is of limited relevance. This focus on substance use means that the key findings of the Sutton review can only be applied with caution to those who misuse alcohol. The authors found that successful programmes attempted to meet the needs of individual substance users, through one-to-one support and a wide range of support services. Success also depended on trust between support workers and substance users, and good communication between workers in treatment services and those providing employment support. Expertise in substance misuse and close links with the labour market were also important for successful intervention (see Section 3.4.4 for findings on barriers to employment). The authors conclude that *'all programmes emphasised the need, first of all, to help clients to rebuild social and personal communication and life-planning skills before moving them onto active job search and job preparation courses.'* (p.25-26).

The same authors conducted a qualitative study (Cebulla et al., 2004) which again looked at substance users in general rather than alcohol misuse alone. In addition to research with individual substance users (see 3.4.2 and 3.4.3) they interviewed professionals working in ten treatment organisations, with the aim of exploring their views on employment support needs of their clients. Four of these were organisations working to support alcohol users: two community alcohol teams funded by the NHS; one alcohol counselling service for ex-offenders (part funded under the dependency2work programme); and an alcohol advice centre funded by a community trust. All four services provided counselling and advice, but only one (the ex-offenders programme) offered access to education, training and employment support, although the authors add that *'all would refer clients to local Jobcentres, if so asked'* (Cebulla et al., p.67). The alcohol advice centre also offered daycare. As this part of the study focused on client support needs the authors do not provide any information on treatment and employment outcomes for any of these projects, and do not comment on the success of these interventions.

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<sup>79</sup> 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).

<sup>80</sup> Lygo-Baker (2000). *Employment Project for the Rehabilitation of Alcoholics and Other Addicts* (EPRA), Guildford.

### 3.6.3 Employment-related interventions in the US

The majority of the included research from the US concentrated around interventions in light of the major welfare reform which took place in the mid 1990s, largely for substance dependent women with children and on welfare, specifically TANF. Two particular interventions were involved in the studies; Intensive Case Management (ICM) (Morgenstern *et al.*, 2009, 2006) and the CASAWORKS for Families model (McLellan *et al.*, 2003. The CASAWORKS model is also discussed in the UK Sutton *et al.*, 2004 review). Both interventions involve intensive support to clients coupled with a case management approach to allow a fundamentally structured intervention to be flexibly tailored to meet individual need. The findings from studies of both interventions showed reduced substance abuse and dependence on welfare and improved post-treatment employment rates coupled with, for the CASAWORKS intervention, improvement in other domains of social and family functioning. The findings were maintained and/or extended at 12-month (for CASAWORKS) and 24-month follow-ups (for ICM). The results for ICM were better than the comparison intervention which was simplistic 'screen and refer' usual care. Another study (Siegal *et al.*, 1996) compared a strengths-based case management approach to substance abuse treatment only with 632 mostly male veterans in substance abuse treatment (it should be noted that cocaine was the dominant problem, although over half of the sample also reported alcohol problems). Whilst there were improved substance abuse and employment outcomes in both groups, additional improvement was seen in the case-management group, with enhanced outcomes in key dimensions of employment, namely days employed and employment problems as well as improved functioning in other areas.

Another US study (Moos *et al.*, 1999) conducted a multi-site evaluation of substance abuse treatment programs for veterans, involving over 3,000 veterans, 40 per cent of whom were alcohol dependent and 43 per cent alcohol and drug dependent. Follow-up data collected at 12 months showed that those who engaged with 12-step self-help programmes were most likely to be both abstinent and employed.

Another study (Metsch *et al.*, 2003) collated data on over 4,000 women who were receiving both welfare and substance abuse treatment from three databases in one state of the USA (about 26 per cent of the sample were primary alcohol abusers). Analysis highlighted a significant increase in women who moved from welfare to work, with the key predictors of this shift identified as demographics (arrest history, age, education level and marital status), treatment-related characteristics (including treatment completion and length of time in treatment) and working during the month of admission to treatment. Another USA study reported on the importance of both length of stay in treatment and treatment correlation as significant predictors of post-treatment employment (Zarkin *et al.*, 2002).

An additional paper presented a 'supported employment model' (Harley and Maxwell, 1994) to assist recovering alcoholics in employment in the US, although this is not detailed here as the content is not directly relevant to this study.

For programs to meet multiple needs a strong degree of inter-agency communication and collaboration is necessary. The study in English employment services further highlights the potential benefits of considering interventions/the response beyond alcohol and drug treatment services themselves. Gossop and Birkin (1994) highlight that '*a comprehensive and effective national response to drug and alcohol problems must extend beyond the health care sector*' (p.127). This conclusion is supported by the review conducted by South and colleagues (2001), which calls for the need for better links and partnership working between the treatment and employment sectors.



In addition to the CASAWORKS program described already Sutton and colleagues (2004) reviewed 15 international projects aimed at supporting substance users towards recovery and employment. Only five of these projects were evaluated, and the authors include a short summary of each. However these interventions are of limited relevance: two focused on specific communities of substance users in New Zealand in the late 1990s; two were targeted solely at drug users; and the other US study, looking at a program for TANF recipients in 1999, contained no information on outcomes. This again underlines the need for more robust research and evaluation of these types of programmes.

## 4 Views of alcohol misusers

This chapter presents the findings from qualitative research conducted with clients of the alcohol treatment services in the five study areas. The sample is a convenience sample, chosen to ensure that a range of views and experiences were captured, and should not be taken to be representative of the whole population of alcohol misusers. Any figures given in the text aim to give a better understanding of the make-up of the sample groups in each study area, and to aid comparison between them, but it should not be assumed that these figures can be extrapolated to the wider population.

Fifty-three clients of treatment agencies, 15 of whom were women and 38 men, participated in semi-structured interviews as part of this study. The study recruited a diverse range of interviewees from the five research sites. The age of participants ranged from 22 to 63, though the majority of participants were over 40 years old. This gender and age profile broadly reflects that of alcohol treatment service clients nationally, although specific attention was given to recruiting younger clients (defined here as those in their 20s and 30s), who are rarer within treatment services as the average age of alcohol treatment uptake in the UK is 41 (Department of Health, 2010). Interviews with seven participants aged under thirty took place.

Participants were recruited from three areas in England, one area in Wales and one area in Scotland. Twenty-seven people were interviewed in the English research sites; while 14 and 12 people were interviewed in Scotland and Wales, respectively.

About one-third of the participants were currently abstaining from alcohol use as part of a treatment programme when they were interviewed. Periods of sobriety ranged from three weeks to two years. The remaining interviewees were also engaging with treatment but were not abstinent at the time of the fieldwork. Ten of the interviewees stated that they were, or had been, binge drinkers. Fourteen participants revealed that they had started drinking either 'at an early age' or in their teens.

Almost all the sample was unemployed at the time of interview, with only two being currently employed. Approximately one-third of the participants had been unemployed for over five years, but others had only recently become unemployed and moved onto benefits after a period of employment (not all interviewees stated how long they had been unemployed). Many interviewees reported that ongoing mental and physical health problems prevented them from seeking work at this time.

In the interviews, participants were asked a range of questions about their background, the treatment they had received and employment and benefits issues. Findings from the interviews are grouped into seven themes:

- family and childhood;
- education;
- employment;
- alcohol use;
- health;
- benefits;
- facilitators and barriers to work.

## 4.1 Family and childhood

### Summary

- Interviewees discussed a range of issues relating to their family and childhood. They talked about the breakdown of significant relationships, often related to their alcohol misuse and other problems. As a result, many of the sample were single and lived alone, often in some type of rented or supported accommodation.
- There were mixed experiences in terms of childhood, family life and education, but experiencing problems during childhood or at school (for example, family break-up or bereavement, living with parental alcohol problems, or bullying or other problems at school) were common characteristics across the sample.

### 4.1.1 Family life and relationships

During the interviews, treatment service clients were asked about their personal circumstances and family life. Fewer respondents from one site talked about significant relationships/marriage or children; this may be a reflection of the lower age range of the sample at this site. Aside from this, many of the overall sample were currently not in a relationship. However, many of the respondents said that they had had a significant relationship or marriage in the past which had broken down. Some indicated that their alcohol problem had played a major role in the breakdown of this relationship, with a small minority expressing hope that they might be able to repair this relationship once they had resolved their alcohol problem. Those who were in a current relationship also talked about the negative impact that their alcohol problem was having.

A number of the respondents had children and the majority of the female interviewees had current or past childcare responsibilities. However, many of the respondents talked about adult children who lived away from home; this is not surprising given the age range of the sample. One respondent spoke particularly of his worry that one of his sons was developing a problem with alcohol.

For those of the sample who talked about younger children there was little mention of the involvement of Children & Families Services<sup>81</sup> (but this was an area which was not a specific focus of attention during the interviews) and, at least in one site, the participants who had young children said that they did not necessarily live in the same house as those children but had good access to them and were working hard to repair delicate relationships.

*‘...and then you get a phone call from your kids or whatever and life’s worth living again... because my kids are talking to me, and other times you feel as though what’s the point.’*

(Male, 44)

*‘For years and years I missed her growing up, she’s 20 years of age, I basically never seen her from when she was a wean, and I’ve got the ability to catch up with that now, I can’t make up for the past, I’ll never be able to do that, but I can make sure the day that it’s no like it was, I can let her know that I’m here.’*

(Male, 53)

Few of the sample lived with a ‘significant other’ and/or children and there were generally low levels of current home ownership across the research sites. The interview data indicated a strong

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<sup>81</sup> Formally Social Services.

association between these lower levels of current home ownership and the respondents' alcohol problem and/or unemployment, as well as associated other problems such as the breakdown of a significant relationship or financial problems. Across the research sites the majority of the respondents lived in local authority housing or rented property or in other types of accommodation such as a charity-run dry house, a hostel, supported accommodation or a bed and breakfast. Some respondents said that they had experienced periods of homelessness. At one site most of the participants said that they lived alone in supported accommodation provided by the organisation which facilitated study recruitment. Respondents at another site spoke much less about current or previous home ownership, despite the fact that most clients in this sample were in their late 30s and 40s.

#### 4.1.2 Childhood

Many of the respondents across the research sites reported that they had happy and stable childhoods supported by good relationships with their parents, siblings and others. One respondent said that they had been placed in foster care from birth but that they had stayed with that family throughout their childhood.

*'Idyllic...a fantastic childhood...couldn't have had better.'*

(Female, 62)

*'I had a fantastic childhood...my parents were excellent.'*

(Female, 56)

*'I had the best parents anybody would ever want. I was brought up on a very large council estate. They didn't have the same problems in those days as they've got now... Yes, so I had no problems as a child at all.'*

(Male, 55)

However, some respondents did reflect that, despite a stable childhood, there had been difficult or traumatic events, things which they linked to troubles later in life, including their alcohol problems. For example, the death of a parent or sibling appeared to have been a trauma which affected quite a large number of the respondents.

Some respondents talked about difficult and troubled childhoods, highlighting divorce/family break-up, disruption caused by moving around a lot, being in care, bereavement or other trauma, and parental alcohol problems. Others mentioned violence and abuse in their childhoods.

*'[I was] brought up in millions of different places because my dad was in the Navy and we were always moving. He was always posted to X...or here or Y...or Z...or wherever.'*

(Female, 52)

*'[I had a] big family...alcoholic father...mother had alcohol problems...but due to ill health she stopped drinking, stopped smoking, most of me family, elder sisters, no brothers, elder sisters, they all drank, all the extended family, the uncles, the cousins, all...heavy drinkers.'*

(Male, 55)

*'I was in children's homes, I left when I was, just before me 16th birthday. I went in when I was eight. I went straight out of there straight into foster care which I then left when I was about going on 17.'*

*(Female, 38)*

## 4.2 Education

In this section, we summarise details of participants' educational backgrounds including their experience of school, whether or not they left with qualifications; and what they did after leaving school, including training, further education or employment.

### Summary

- Participants reported very different experiences of school; whilst some looked favourably on their school days, others related more negative experiences, or viewed their time spent at school as unremarkable. Many of the interview participants said that they had been bullied at school and many had played truant.
- Although many participants discussed gaining multiple qualifications at school there were many others who left school with none.
- Most participants left school at an age that was appropriate to the time in which they were schooled, but a minority left early due to particular circumstances, including mental health problems or being expelled, but also to take up apprenticeships.
- Experiences of the period following school appeared to be more positive. On leaving school, most participants went on to either further education, employment or an apprenticeship, although not all interviewees were able to sustain these long term.

### 4.2.1 Experience of school

Participants reported very mixed school experiences. Some participants discussed an indifferent school career that was 'average' or 'alright'; whilst others spoke of enjoying their school days, in terms of both school work and the activities that school offered.

*'School – I loved school, I was a wee swot. Basically loved high school. Left high school because I didn't know what to do with myself.'*

*(Female, 43)*

*'Nice. Good days. I just got on with what I needed to get on with. Was on the football team, the cricket team.'*

*(Male, 30)*

However, those participants who described a negative school experience mentioned various issues including, learning difficulties; bullying; disruptive behaviour; a lack of engagement and truancy.

Some of those interviewees who described struggling with their school work attributed this to dyslexia. One participant said that their dyslexia had only been discovered towards the end of their school career, and another said that he found out that he had dyslexia after leaving school.

*'Sixteen, but I found out when I was just 16 when I was doing the exams, you sit prelims a few months before your exams, kinda fake exams, and they told me I was dyslexic...I done no bad but I should've been getting more help throughout the school you know what I mean.'*

(Male, 22)

*'School was all right, a lot of fun but I kind of struggled with a lot of things, I was dyslexic and never found that out till I left school, the teachers used to say I was a bright kid they didn't understand how I wasn't doing as well as, I could do great with numbers and all that stuff, but English and even putting things down on a bit of paper just now even emails are just illegible to a lot of people.'*

(Male, 33)

Many of the interview participants said that they had been bullied at school. Most bullying mentioned related to interviewees' school peers but some also said they were bullied by teaching staff.

*'I hated it, bullied, plus because my eyes are weak I had to wear glasses which I hated doing, most of the time I'd go to school without them, so that sort of held me back in that I couldn't, if I had to take homework home I'd copy not the answers but the questions off my friend, I couldn't see the blackboard.'*

(Female, 48)

*'School was difficult, I got bullied at school.'*

(Female, 54)

In contrast, other interviewees spoke of their own disruptive behaviour at school.

*'I got asked to leave there because I was always getting into fights.'*

(Male, 33)

One participant described a particularly turbulent school career where he was expelled twice and also convicted of setting fire to his school.

*'I enjoyed school, but then when I got to about 13 I suppose I just started misbehaving and being a pain, got expelled twice, tried to burn school down, ended up in court and me dad had to pay the fine and everything...I loved the notoriety that they gave me...I just remember being rebellious.'*

(Male, 42)

Other interview participants admitted taking little interest in school, or their school work.

*'[At] school I was a bit of the clown, I wasn't too bad but I was always mucking around, you know, and again wanted to be seen, wanted to be liked I suppose...'*

(Female, 47)

*'I was terrible, I was a nightmare in school...I had no interest, I thought I knew better than the teachers...I tended to bunk off more than I'd go, I always had something better to do than get an education.'*

(Male, 53)

In one case, an interviewee spoke of being keen to leave school and find a job.

*'I had a fairly good education – I was quite clever, although it didn't appear that way. I didn't pursue my academic side. I just wanted to get out of school and into the shipyards.'*

(Male, 53)

Truancy was also mentioned by interviewees, with some citing at least one of the difficulties outlined above as the reason that they missed school. For example, while one participant played truant to avoid bullying, another interviewee missed school because they had difficulties engaging with their school work.

*'So yeah I was bullied a lot at school, that's why I never went.'*

(Male, 42)

*'...if the teachers would of made it more interesting, the learning process, I probably would have gone, "cos I did go to lessons where the teachers were alright, and they took an interest you know, but eh, I'm really interested in history but me history teacher, well, he was cr\*p you know, so, I've learnt more since leaving school than I did at school.'*

(Male, 43)

#### 4.2.2 Qualifications

A large number of interviewees left school with no qualifications, yet there were many others who had achieved multiple qualifications. The range of qualifications amongst the interview participants varied substantially. However, certain qualifications were more common than others. Although, one of the participants had a university degree and some had A-levels, the majority of those with qualifications had obtained basic school level certificates including O grades, GCSEs and Standard Grades. Some of those achieving these certificates had been successful in a number of subjects.

*'Yes I left with my Standard Grades: English, Maths, History, Computing, Craft and Design, Biology.'*

(Male, 36)

*'O grade art and technical drawing that's it and woodwork, three, I got three.'*

(Male, 43)

It appeared that many participants had left school at 15 or 16, having completed compulsory education. However, some disclosed leaving school early due to particular circumstances. One participant left school early because of mental health problems.

*'I didn't really finish school properly...I didn't participate in any exams because I'd had a nervous breakdown to do with my parent's situation.'*

(Female, 47)

A couple of interviewees spoke of leaving school early to take up apprenticeships.

*'They let me leave early 'cos I was just, eh, I had an apprenticeship to go to.'*

(Male, 33)

*'And I got offered an apprenticeship as a pipe-fitter welder, so I left school at Easter but I didn't take me exams.'*

(Male, 49)

#### 4.2.3 Leaving school for work, training or further/higher education

On leaving school, most participants quickly became engaged in employment, training or further or higher education. In terms of education, a couple of participants said that they left school to go to university but more participants attended vocational college courses, involving, in some cases, achievement of an NVQ or SVQ. Certain interviewees also said that this education later enabled them to obtain relevant employment.

*'Then I went to \*\*\*\*\* College day release when I started a YTS Business SVQ, levels 1 and 2. So I did them.'*

(Male, 36)

*'I did that 'cos...I was working for me grandpa and he sent me to college like you know, to get something you know get a trade under your belt.'*

(Male, 43)

A couple of participants reported dropping out of further education, before gaining any qualifications, and deciding to find a job.

*'Then I left [school] and I went to college for a couple of years, didn't take any exams or anything because I messed up, because I'd been in boarding school for so many years I thought whoopee I'm at college now so I didn't go to many lectures or anything like that, so I gave that up and I got a job.'*

(Female, 52)

*'I had a chance to retake them but when I went to six form college I was sort of ostracised because I was using drugs then, and drugs weren't like cool back then, so I didn't last long at college, went and tried to find work.'*

(Male, 42)

A number of participants managed to obtain apprenticeships for skilled employment straight from school. Although some of this group did not finish their training, most were successful and were engaged in relevant employment for a long time after completing their apprenticeship.

*'Got an apprenticeship installing alarms. I was getting paid a whole lot of money for – I mean, 220 quid when you're 16 years old which is quite a lot.'*

(Male, 30)

*'Left school at 16 done my five years' training, then became a fully time served welder.'*

(Male, 33)

*'...but I was lucky enough to go into the building trade...I'm still in contact with the man who taught me...so a bricklayer by trade.'*

(Male, 52)



Other participants said that they moved straight into employment after leaving school, mainly involving retail or factory jobs. Some interviewees were able to sustain this initial employment for a long period, others were less successful.

*'The first job I got was a baker; I was working in a bakery, Jewish bakery funny enough, kosher bakery when I was 16.'*

(Male, 42)

*'I had a job in a, as a sewing machinist that didn't last long, and little bits of hairdressing.'*

(Female, 38)

*'I worked in sales, I worked from the haberdashery department selling luggage.'*

(Male, 37)

## 4.3 Employment

In relation to employment, participants were asked about the types of jobs they had held; how long they had been employed and the reasons why they had left previous employment. Interviews also covered participants' attitudes to working and any informal work they had done.

### Summary

- Although most of the people interviewed in this study were unemployed, their previous work experience was extensive and varied. Some had worked for very long periods in the same job or industry, whilst others had had a variety of different jobs. Few interviewees had little or no work experience.
- The types of jobs undertaken by participants were also mixed in terms of the skills required. While certain participants had mainly worked in unskilled jobs, other participants had been involved in semi-skilled or very high skilled occupations.
- The most common reason cited by participants for leaving previous employment was problems with alcohol, though some had also lost jobs due to ill health or financial difficulties faced by a previous employer.
- Most participants conveyed a positive work ethic, as demonstrated by their desire to find work in the future. However, some participants admitted that they had previously done cash in hand, casual work in addition to receiving benefits.

### 4.3.1 Work experience

A large majority of the people interviewed at the time of the study were unemployed, yet previous work experience was common. A number of participants spoke of being employed for a long period of time in the same job or organisation, in some cases for decades. It appeared that most of this group had worked in an unskilled or semi-skilled position but one interviewee said that he had worked as a barrister.

*'I didn't have many qualifications. I left school at 16 and went straight into a job. I worked there for 20 odd years.'*

(Male, 47)

*'...after that I worked for another local company...that made made-to-measure bed-linen for any shape and size of bed, and I'd been working for that, I've been working for that guy on and off for 20 odd years.'*

(Male, 42)

*'I was in the RAF for nine years...mainly [based in] Scotland. I've been to Falklands, America-Arizona, Australia twice, New Zealand once, Basra three times, Cyprus, Italy, Reykjavik in Iceland.'*

(Male, 30)

*'As soon as I left university got a pupillage which is an apprenticeship for being a barrister, straight away I was taken on and I've been at the same desk for 17 years.'*

(Male, 37)

In contrast, the work histories of other participants were substantially varied, involving many different changes of employment, sometimes within a particular industry but also between industries. Some of this group of participants had had multiple unskilled jobs such as factory work, packing, cleaning, labouring, retail and warehouse work.

*'I'm in the building game... I run the luggage department for them from when I was 16 I run the whole department myself...I was working...I had a couple of jobs, I was in construction...I was doing a little couriering and...you know I just you know odd jobs I suppose, I was doing a little painting...I worked for a cleansing company... I've worked in retail, I've worked in the food and beverage industry, construction.'*

(Male, 37)

*'Warehouse packing, unpacking, loading, general labouring, tarot reading,...I've done bar work.'*

(Male, 27)

Other participants had moved from one skilled job to another. These jobs involved administration, catering, driving, social care and technical trades.

*'I've had care jobs like care work. Most of them care work, worked with the elderly. Worked in \*\*\*\*\*, I done a placement with them when I did my SVQ, and I loved it in there. I've worked with the council, and I've worked in a couple of care homes.'*

(Female, 27)

*'I had a job in \*\*\*\*\* for council, loft installation and draft proofing, that was a contract job that was only for six month... Then I got the job with, there was two companies in one group, it was welding and central heating, they were both owned by \*\*\*\*\*, so there were two firms in one building, under same roof. So when the \*\*\*\*\* job run out, that was not a contract job, that was another six months, I got a job at \*\*\*\*\*, that was full-time.'*

(Male, 49)

Another female participant's experiences, however, went against the employment patterns set out above, as demonstrated by her movement from a highly skilled to unskilled job. This participant worked as a staff nurse for a number of years before giving up work due to ill health (depression).

After recovering, the participant then returned to work in a book-maker's, part-time.

*'I was a nurse for ten years. A staff nurse...And then left that, was off work for a couple of years with depression...got over my depression, but it took a while. Then I worked for the bookies for a while.'*

(Female, 43 )

A small number of participants had very little experience of working, in addition to not having worked for many years. Some female participants in this group said that family responsibilities had previously affected their ability to work.

*'I was working for a while yes, I was doing a little bit of office work but then I found it very difficult because of the childcare, so...I stopped and went on to benefits because I couldn't afford basic care.'*

(Female, 54)

*'I got a job in a children's clothes shop... then my mum died, I was 18 then, so I left there to sort of take on her role because my dad and my brother were working, my sister was only, she was 12. I think I was 19 then I got a job on the post for the Christmas, I think it was like ten days' work.'*

(Female, 48)

As demonstrated by interviewees such as the former nurse and former barrister, a number of participants had previously successful working lives, involving positions of responsibility and status, or had been self-employed and/or owned their own business.

*'All my jobs have really been in retail, worked for \*\*\*\*\*, went in as a cashier and got up to supervisor. So pretty much, not being bigheaded or anything but every job I've had I've gone in as a sales assistant or whatever and been really lucky to get to assistant manager or supervisor. So I've been really lucky with that.'*

(Female, 47)

*'I bought a business, bought my own business. It was a dairy business and milk delivery business. I employed two or three people. I sold that and took a year out, and then started another business, I did a sort of a carpet and upholstery cleaning.'*

(Male, 58)

Some participants also explained why they left previous jobs, most commonly because of their problems with alcohol. A number of the interviewees said that they had been sacked because they had been turning up to work drunk or proved themselves unreliable.

*'Sadly one day I went into work on me day off, but I went into work totally p\*\*\*\*d up and went through a public area, so it was a serious offence.'*

(Male, 55)

*'I kind of felt as if I was pushed out the door, I did actually get suspended for not opening the shop, aye, failure to open the shop, and it was two days in a row, that was really it, they suspended us and then, when they suspended us I went like that "I'll tell you what – f\*\*\* your job".'*

(Male, 33)

For a few of the individuals interviewed, loss of employment related to the possible impact of their alcohol use on health and safety in the workplace. In particular, one interviewee highlighted the concerns of his previous employer.

*'Because I were steaming [drunk]...but another thing was it's only five minutes round the corner from where I live, so at dinner time I'd go home and have a drink and then go back, 'cos I were rattling and I were shaking. And that went on for about six, seven months, they knew, and the guy, the owner, he's a recovering alcoholic as well, so he knew what I were going through. I respected him in that way, that he actually fired me like he did because I was using blades and scissors and sewing machines and it was, I was just putting myself and other people at risk.'*

(Male, 42)

Finally, one participant described how his alcohol problems had lost him more than one job.

*'Came back to Manchester worked in a \*\*\*\*\* in \*\*\*\*\*, got sacked there in, got sacked for drinking in July of '97. Worked at a restaurant in Manchester from about August '98, eh '97, to September '98. Moved down to London to start a degree in psychology, messed that up within three months, started drinking. Got a job working in a hotel in August '99, got sacked from there in June 2000 for drinking.'*

(Male, 42)

A number of interviewees said they had lost their jobs, because their previous employer had run into financial or other difficulties. Similarly, another participant spoke of losing his job when his business went bankrupt.

*'\*\*\*\*\* went bust. They ran before they could walk – started expanding too fast and the money just dried up.'*

(Male, 36)

*'Well they took me on full-time, at first I went on as you know what's it called eh, wasn't a proper job at first, through agency, and they said there's a position going, who wanted them, so I put in and I applied, they accepted and then laid us all off at Christmas.'*

(Female, 38)

Finally, some participants attributed the loss of previous employment to poor mental or physical health, due, in some cases, to alcohol misuse.

*'I was running a taxi company, running the office in the harbour in \*\*\*\*\*, that was my last job. That was about ten years ago, I was about 43, 44 I think, yeah, about nine years ago, something like that. I couldn't take the, with the diabetes, the drinking, depression, I just couldn't do the job to my satisfaction. I wasn't asked to leave, but I couldn't cope so I knew I had to leave because I couldn't do the job that I was being paid for, so I was wasting their time basically.'*

(Male, 53)

*'Because I had been drinking quite heavily even when I wasn't working, I had taken a seizure, so unfortunately I was forced to stop working again.'*

(Male, 36)

#### **4.3.2 Attitudes to working**

In terms of attitudes to working, most interviewees appeared to possess a positive work ethic. Many of those participants who were unemployed at the time of interview expressed a desire to return to work in the future, and some had recently been looking for a job.

*'The company that I was with suggested ill health retirement which I didn't take because...I'm not ready to retire yet. I want to go back to work.'*

(Female, 56)

*'I'm doing the right things and looking up employment down at the jobcentre, always on the job search computers, always sending my CV off.'*

(Male, 27)

Additionally, some participants discussed what they perceived were the advantages of working. One interviewee spoke of how he felt that work would not only improve his financial situation but that it would also improve his self-esteem. Another participant appeared keen to return to work in order to escape benefits which he viewed negatively.

*'I agree with working, I agree that you should work...it's a bloody struggle living [on benefits], I'm not complaining because you don't deserve to live any better than that really, but it's hand to mouth...but when you're working you've got a bit more consistency in your income and you can do more, and you also feel better about yourself, fighting depression.'*

(Male, 53)

*'I hate benefits, I'm ready now to go out and face the deep wide big bad world... I would rather get up in the morning have a bath and shave and go to work.'*

(Male, 42)

A small minority of participants said that they had no plans to return to work. In at least one case this was due to the combined problem of alcohol and illegal drug use.

*'I don't want to go back to work...Most of my money goes on drugs, I can't really afford to get a job.'*

(Male, 43)

#### **4.3.3 Informal employment**

Some of the interviewees mentioned that they had experience of doing undeclared casual work.

*'I was wheeling and dealing a little bit, promotions for clubs, making a little bit of money.'*

(Male, 37)

In most cases, participants said they received cash in hand payment for this work but one interviewee said that they were generally paid in kind.

*'Oh yeah, I've fiddled here and there definitely...it makes life more bearable. I do things more on a favours basis...so like if I fix someone's computer then they'll take me shopping because they've got a car.'*

(Male, 53)

Participants with experience of casual work were not specifically asked why they became involved in casual work but one interviewee suggested that they occasionally worked as a way of occupying their day.

*'I did work on and off you know, a day here and a day there, odd couple of days here...I'd be lying if I said no ...to get me out of the house,...[relieve the] boredom.'*

(Male, 52)

It seemed other participants had worked in order to supplement their income from benefits.

*'You know I get £93 a week and you know I'm quite fine with that and I have done some work,... I've received payment for doing cooking classes, and I got a cheque for 250 quid.'*

(Male, 42)

## 4.4 Alcohol use

In this section we describe what interviewees told us about their alcohol use. This included outlining how and why their problem drinking started, their current drinking status and their experience of using treatment services.

### Summary

- Two broad alcohol misuse career trajectories emerged from the interview data.
- For the first group, alcohol problems developed during their younger years. Some of this group had started drinking normally and experimentally, whilst others developed problems as a result of exposure to alcohol problems, usually as a result of parental drinking or workplace alcohol culture.
- For the other group, alcohol problems developed over longer periods of time, or in response to a particular trigger. Key triggers were bereavement, redundancy or unemployment, and mental health problems.
- Most of the sample were abstinent at the time of their interview and were engaged with a range of treatment services. Some of the respondents had been abstinent for a while whilst others had very recently entered alcohol treatment. Across the research sites the participants were receiving a range of interventions and support.
- Some participants gave positive accounts of intensive and structured treatment programmes, and those which gave them respite from their alcohol problem. Some were also critical of short-term treatment programmes which provided more limited structure and support. 12-step support groups (such as Alcoholics Anonymous) were said to be helpful in providing structure and social support.
- A significant finding which emerged from the interview data was that almost all of the sample said that they had experienced at least one, and usually several, relapses in their attempts to stop drinking. Many, therefore, described the difficulties in staying abstinent.

#### 4.4.1 Early drinking history

Many of the respondents had started drinking alcohol at a young age and said that their use of alcohol at this time was normal and youthful experimentation. However, some clients said that they began drinking before the age of ten. A number of clients also said that their alcohol use became problematic in their teens. Many of the respondents who reported drinking from a young age made connections with their parent's drinking behaviour (including where a parent had an alcohol problem) and, for example, being taken regularly to the pub by a parent. For others more serious problems with alcohol emerged later in life, usually as a response to a particular trigger, such as financial difficulties, isolation/loneliness, unemployment/redundancy, bereavement or illness (see below).

*'[I was] still at junior school, [I was] eight, nine years old...Whenever any uncles came round, I can remember sitting on [their] laps and [they] let...me drink, I was regularly outside the pub if not inside the pub with my dad and he'd be nipping out to the betting shop back into the pub and every time he did that that was another glass of shandy. Certainly by the age of 14 [or] 15 I was drinking quite a lot.'*

(Male, 55)

*'Home brew yeah, and when he went to bed at night I snuck down and wanted a taste...there was always alcohol round the house, because I was watching them do it, I had a tippie and they got sick of carrying me up the stairs basically and put a big padlock on the door.'*

(Female, 38)

Quite a few of the sample said that their drinking increased or worsened directly through the nature of their employment, when (excessive) alcohol consumption was an expected part of the work culture (for example, the Armed Services or the leisure industry), or because of the availability, often for the first time, of disposable income.

*'I've always had [problems with alcohol] but it went a bit excessive about ten years ago. I drank a hell of a lot night and day. Thirty years ago we used to go to the pub to get work...that's how we [builders] used to communicate.'*

(Male, 52)

*'I was working in a bar and I didn't drink when I started working there, I was 30 and, yeah and then over a period of seven years sort of daily drinking it took its toll.'*

(Male, 42)

*As soon as you get there [RAF] the induction...It's how you meet people – an ice breaker. Every week there was someone new at base, so you were part of the ice breaking team...it was basically [drinking] every night.'*

(Male, 30)

*'Every Friday, pay night. Just got your pay packet and straight to the pub, it was just next door... my first couple of weeks at work, the week ends – I don't remember them. Black outs right away. I went home drunk. One of the men used to put my wage packet down my sock. So when I got home, my dad would take my wage packet out of my sock.'*

(Male, 54)

*'Then I was a staff nurse in the \*\*\*\*\* for a while. I didn't have any alcohol problems then, but we always drank. Every night out involved getting steaming.'*

(Female, 43)

#### 4.4.2 Triggers for alcohol misuse

As indicated above, for many of the respondents there was at least one identifiable trigger which they associated with the progression of their alcohol problem. Sometimes this stemmed from childhood or from the nature of the employment that they were involved with. Other respondents had a variety of reasons for drinking, including relationship breakdown, financial problems or boredom. Across the board, however, it seemed that the two most significant triggers which emerged from the interview data were bereavement and redundancy/unemployment and from associated problems such as depression (see Section 4.5.1).

*'I had two brothers...when I was 11 they both died. My parents thought the best thing was to send me away. My husband was killed in a road accident [when children were two and five years] and a week after my sister's daughter died.'*

(Female, 56)

*'At the time a lot of people died around me in the family, aunties, uncles friends...this is a particularly bad time...Christmas...[my] nephew committed suicide this year...me and the wife have ended up with the eldest daughter.'*

(Male, 52)

*'...[my] mother died in about 2002, about the same time as [I was] made redundant.'*

(Male, 47)

*'I went straight into a job when I left school at 16 and worked there for 20 odd years, [then I] was then made redundant...then [I] worked in a sorting office [over Christmas]...the redundancy and the redundancy money triggered drinking.'*

(Male, 47)

Although one participant had discussed having long-term problems with drinking, he felt that his alcohol use became worse after leaving his job in the RAF. Unemployed for a period of three to four weeks after leaving the RAF, the participant said that boredom led him to drink more and more:

*'Yes, because for the first three/four weeks I was unemployed...I wasn't working but got paid leave money, I had a lot of money...so I was bored.'*

(Male, 30)

#### 4.4.3 Current drinking status

Most of the sample were abstinent at the time of their interview and were engaged with a range of treatment services. Some of the respondents had been abstinent for a while, whilst others had very recently entered alcohol treatment. A significant finding which emerged from the interview data was that almost all of the sample said that they had experienced at least one, and usually several, relapses in their attempts to stop drinking. Many, therefore, described the difficulties in staying abstinent and how their commitment to alcohol treatment needed to be prioritised before they



could engage with employment (see Section 4.7). Unsurprisingly, all but two of the sample were currently unemployed although some were engaged with training or voluntary work, or with a back to work programme (see Section 4.3 for more detail).

*'I've stopped for a while and then I started again and now I'm on the verge of stopping again. I'm finding it hard to stay stopped...if they gave out prizes for stopping I'd have a gold medal but if they gave out prizes for sustaining it I wouldn't even be in the race.'*

(Male 53)

*'I got complacent...that was my first experience of any sort of treatment really, and I suppose I thought I had it all buttoned up really, because I'd had I suppose 13/14 months of abstinence from all sort of chemicals and that, and then I felt good in myself and I came back to [treatment service]. I stopped doing AA meetings and didn't follow the basic suggestions really and I relapsed...I think this time it's a couple of months...I mean I had a month off then relapsed for a day and then had another couple of months off and relapsed for a day...but this time it's like about...two months.'*

(Male 42)

#### 4.4.4 Alcohol treatment

Across the research sites the participants were receiving a range of interventions and support. Some were waiting for a medical detoxification from alcohol or a place at a residential rehabilitation centre for alcohol treatment; several were on prescribed Antabuse<sup>82</sup>. Many were receiving counselling and at some sites were engaged with an intensive group programme. From the interviews it appeared that the intensive support received by individuals offered opportunities for a variety of treatments that aimed to address many of their needs. Participants seemed very positive about this type of treatment. In particular, some suggested such treatment gave them some respite from their alcohol problem, and gave them some structure which they found helpful.

*'I did go into treatment again for a six-week period...that was really good...because it was [a] very institutionalised treatment centre, but very nicely institutionalised, good food and everything and it gave me plenty of time to learn to be with myself...because as somebody who's been in violent relationships...somebody who's taken drugs, somebody who's drunk lots of alcohol you know I'm very used to a very chaotic life, and it's very difficult to adjust to non chaos...it was nice...to be able to sit with myself relax and, you know, to actually relax is very difficult to do as an alcoholic, so just even to do that is an accomplishment.'*

(Female, 40)

*'...a rehab, I went in there, you do six weeks intensive care...on paper the schedule looks really full...you know you've got something to do almost every hour...I done that but halfway through the thing...I was like going and sleeping...a couple of times during the day for like an hour, and I think it was just my body...I mean I'd been in psychiatric hospitals and stuff like that but...it had finally come home to me that it just wasn't going to work you know, so for me I needed the break.'*

(Male, 33)

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<sup>82</sup> Antabuse, or Disulfiram, is a drug which is commonly used in alcohol treatment. Its main function is to promote chronic sensitivity to alcohol, thereby aiding patients to abstain.

In contrast to these accounts, some participants described more negative experiences of treatment which provided limited structure and support.

*'But to me, they take you for two weeks and then they send you home again which I don't think is long enough...you don't do anything because there's no workshops or...or anything to do. So what you do is get up, get your medication, watch TV... I was down there with recovering alcoholics for two weeks... the people weren't drinking, some of them were taking drugs and unfortunately there was a shop not half a mile away that sold alcohol, so people were able to sneak out and buy their own alcohol.... So you would come in and do your two-week stint and straight back out again. For most people it was like going down there and getting a free feed.'*

(Male, 36)

*'It's meant to be your detox...so you go up there, take your tablets, blah, blah, blah and then they kick you out, or else they keep you there to the first six weeks, between ten and two, that's your detox, and then they show you a couple of videos – really to tell you the truth it's not very good... you get a lot better support in [the service] here than what you ever got in [hospital clinic]....'*

(Male, 44)

Participants at some of the research sites talked about involvement with AA (and sometimes other 12-step groups), usually reporting that they found them a helpful part of their treatment, giving them social support and a structure or simply keeping them occupied.

*'I wouldn't ask for any more, it's nice to know that I've got somewhere to go...and everybody's been through it, and meeting people, and a different set of people.'*

(Female, 38)

*'I go to AA four, five times a week, when I've got more in my life I think I can put it down to two times a week, 'cos sometimes it's a chore. But for me 'cos I've not got that much on I like to be kept busy, I'm not someone that wants to be in the house all the time.'*

(Male, 33)

## 4.5 Health

Interviewees were also asked about their past and current health. Many more talked about mental health problems than physical health problems, and also saw clear associations between their health problems, their alcohol problem and their current inability to work. Interviewees were asked about their use of alcohol and other drugs; some volunteered information on their drug use and this was included in the analysis, however, the issue of drug misuse was not probed.

### Summary

- The majority of the interviewees talked about both mental health and physical health problems. Many more talked about mental health problems, often seeing clear associations between their health problems, their alcohol problem and their current inability to work.
- Interviewees at all the research sites talked about common mental health problems. Depression and anxiety disorders were most prevalent, with some interviewees indicating that these problems were related to specific life triggers, such as a close family bereavement.
- The respondents talked about a range of physical health problems that they experienced, usually linked to their drinking and sometimes related to attempts to withdraw from alcohol.
- Some of the interviewees also talked about a range of non-alcohol-related health problems that were affecting them.

#### 4.5.1 Mental health

Interviewees at all the research sites talked about common mental health problems. Depression and anxiety disorders were most prevalent, with some interviewees indicating that these problems were related to specific life triggers, such as a close family bereavement.

*'I didn't realise I was suffering from post-natal depression, lasted for about three months.'*

(Female, 48)

*'When my mum passed away I got ill, I got depression.'*

(Male, 39)

*'I go into a deep depression every six months something like that, might be less, might be more, for about five or six weeks where I just isolate myself, I don't talk to anybody, I don't go out, I don't do anything.'*

(Male, 49)

*'I had a panic attack on the way to work one day and I just burst out crying in the taxi. I was in floods of tears, my boyfriend phoned up for me and I cried non-stop for about six months and didn't know what was wrong with me.'*

(Female, 43)

*'I get panic attacks and stuff, I don't know how it works, I can't explain what happens to me – I freak out.'*

(Male, 43)

*'I had a breakdown 4 years ago... I finished work in August this year due to work-related stress and depression.'*

(Female, 56)

Some respondents talked about these problems and how they might be connected to their alcohol problem, or in some cases, drug use.

*'I never had a doctor, my depression was when I was drinking, I thought I was at a right low time especially when I was sitting in the house myself.'*

(Male, 33)

*'I've suffered from depression anyway so when I drank I got more depressed, and I'd end up self-harming myself, always punching myself for one thing after another.'*

(Female, 38)

*'I suffer from depression and, I think that's stopped me getting a job, but I think it's drug induced depression.'*

(Male, 43)

A small number had other mental health problems, whilst some had multiple mental health problems and a small number had severe mental health difficulties such as psychosis, self-harm (including suicide attempts) or obsessive compulsive disorders. Often it seemed that these problems had been present for some time and all required intervention to aid recovery.

*'...severe depression...anxiety, panic attacks, social phobia, agoraphobia, you name it, everything, and my husband now is officially my carer.'*

(Female, 47)

*'I was doing it [courses] to get me out of the house...because I was locked away for two years like, I didn't go anywhere.'*

(Male, 49)

*'[I] went a bit mental. Drinking a lot, trying to commit suicide, jumping off a bridge, hit a tree on the way down, my luck. That saved me, but did me a lot of damage.'*

(Male, 30)

*'I do strange things – I get carried away a lot, talk to myself. You know, one of the things, I'm making weird sounds and pulling faces, and fighting myself, thinking I'm fighting other people, you know what I mean?'*

(Male, 27)

*'Well I'm a complicated character...I really see it all started when I was about nine or ten, well not drug use but with obsessive compulsive disorders. And then I had a huge obsession with drinking before I'd even drunk, you know like collecting beer mats and bar towels and bottle labels, write to every brewery in the world when I was 12/13 and I'd never sort of touched drink then, and then my OCD got into like, that was the collecting and then it went into exercise, going the gym for six hours a day.'*

(Male, 42)

### 4.5.2 Physical health

The respondents talked about a range of physical health problems that they experienced, usually linked to their drinking. The problems mentioned included, diabetes, blood pressure, pneumonia, memory problems<sup>83</sup> and seizures. Many had experienced hospitalisation as a result of these health problems. One respondent said that he had recently been diagnosed with Hepatitis C, as a result of previous illegal drug use.

*'Then I started having fits, my first fit [I] was just [about] to leave for Sunday lunch [with my] daughters, I said "I don't feel right", next thing I knew is two paramedics waking me up.'*

(Female, 48)

*'I've got liver disease...The consultant said "you got to get your life sorted man, you got to get off the drink, it's like you will die, you will die".'*

(Male, 39)

*'You name it, the whole package that comes along with drinking too much, it's all there.'*

(Male 53)

*'Alcohol's given me...I've inherited some of these things from it: diabetes, neuropathy, which is nerve ending damage in hands and feet...acute pancreatitis. I've only got about 20 per cent of my pancreas left. Of all the organs in the body that cannot repair itself, it had to hit that one.'*

(Male, 54)

*'My body just stopped working, it was because I was working in a bar, and I didn't drink, when I started working there I was 30 and, yeah and then over a period of seven years sort of daily drinking it took its toll...it sort of culminated really I was having fits and seizures and I was admitted to hospital.'*

(Male 42)

Some of the sample had been hospitalised as a result of serious alcohol-related injuries such as head injury, violence and seizures.

*'There was five of them lined up...smashing my face through a car windscreen...battered my legs with whatever they could find.... But now I go to physiotherapy...and I'm on the list for the operation for my legs.'*

(Male, 41)

*'I had pneumonia...I spent three weeks in [hospital]...I came out and I must admit I did start drinking again shortly afterwards. ....I was blacking out. I started having accidents in the home, falling down the stairs. I broke my ribs, I broke my collar bone. I cracked my chest bone, things like this, accidents, I banged my head quite badly, and basically it's been in and out of the doctor's and the hospital as well.'*

(Male, 52)

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<sup>83</sup> Alcohol can cause neurological damage leading to problems such as memory loss and, in severe cases, alcohol dementia.

In addition some mentioned health problems arising from their attempts to withdraw from alcohol.

*'But as soon as I stopped drinking, started to come off it, it was like the people who take heroin, my brain was just shutting down. There were no tell tale signs and I would just take a seizure.'*

(Male, 36)

*'...when I started, it started when I started coming off the drink and I was at an AA meeting when I took my first seizure.'*

(Female, 27)

Some of the interviewees also talked about a range of non-alcohol-related health problems that were affecting them. This included, for example, diabetes, varicose veins, joint problems/osteoporosis, prostate trouble and Crohn's disease.

## 4.6 Benefits

This section contains findings from client interviews on the benefits received and applied for; benefit histories; reasons for claiming benefit; information and advice; sources of practical help and support; the application process and medical assessments; and experiences of the benefit system and jobcentres. For estimates of the size of the alcohol misusing population in receipt of each of the DWP's main benefits please see Hay *et al.*, 2010.

### Summary

- Clients were in receipt of a number, and in some cases multiple, benefits. These included Incapacity Benefit (IB) and/or Disability Living Allowance (DLA), and Income Support (IS) (in some case all three). Some were in receipt of Employment and Support Allowance (ESA) (as new claimants or having been transferred from other benefits) and others were in the process of applying for, or appealing against the removal or refusal of, this benefit<sup>84</sup>. Additionally, some were in receipt of Jobseeker's Allowance (JSA).
- Benefit histories were mixed, with some clients only having become unemployed recently or for the first significant amount of time because of their alcohol misuse. Others had a long benefit history, with periods of employment sporadic or non-existent.
- A number of clients were claiming benefits for reasons of co-existing mental health issues or other health problems, and only in some cases was alcohol the primary reason for claiming.
- Sources of advice on benefits came from benefits advisers and jobcentre staff, health care professionals, support agencies and in some cases other patients, friends or relatives.
- Staff in alcohol treatment and other support services were a valued source of help in relation to benefits, particularly with form-filling and other forms of practical help.
- A number of clients described negative, even distressing, experiences of medical assessment and subsequent appeals. To many the process seemed opaque and the outcomes arbitrary, and several felt that their assessments focused on their physical rather than mental health issues and were unhappy about this.

<sup>84</sup> Alcohol (or drug) dependency does not of itself confer entitlement to disability-related benefits including IB and ESA. To qualify for these benefits claimants have to undertake a medical assessment of incapacity which assesses the effects of their condition on their ability to carry out a number of everyday activities relevant to work. People with alcohol or drug dependency may have other diagnoses, for example mental illness, which result in their incapacity for work.

- Experiences of the benefits system were very mixed, with some clients reporting very positive interactions with staff, and others expressing frustration with staff and systems. These included having to deal with more than one adviser and repeating the same information about their situation each time they saw someone different.
- Particular issues were raised by those in supported accommodation. These clients could find themselves in a benefit trap, meaning that it was difficult for them to work while still being able to afford to pay rent, and to access treatment and support services.

Included in this section is discussion of the helpful and not so helpful factors that were important in influencing clients' access to benefits. Table 4.1 highlights the facilitators and barriers to benefit uptake, with reference to the relevant sub-sections. Note that only some sub-sections focus on facilitators and barriers, and that this section is therefore not organised in the same way as Section 4.7.

**Table 4.1 Facilitators and barriers to benefit uptake**

| <b>Facilitators</b>  | <b>Barriers</b>   |
|--|---|
| <b>4.6.4 Information and advice</b><br>Receiving advice from Benefit Advisers; Jobcentre Plus staff; health workers; treatment agency staff; friends/relatives and fellow clients.   | <b>4.6.4 Information and advice</b><br>Difficulties accessing Jobcentre Plus due to lack of transport or money for fares.<br>Lacking the confidence to ask for help.  |
| <b>4.6.5 Help and support</b><br>Receiving support to fill in application forms, deal with correspondence and attend appointments at the jobcentre.  | <b>4.6.5 Help and support</b><br>Difficulties filling out application forms.<br>Problems communicating with Jobcentre Plus staff.   |
| <b>4.6.7 Experiences of the benefit system</b><br>Having a dedicated member of Jobcentre Plus staff who clients can contact/meet to discuss circumstances.<br>Jobcentre staff being approachable, sympathetic and 'not patronising'. | <b>4.6.7 Experiences of the benefit system</b><br>Clients having to deal with different staff every time they are in contact with Jobcentre Plus and having to explain their situation repeatedly.<br>Delays in clients' receipt of benefits, particularly whilst claims are being processed.<br>Staff who do not engage with clients but direct them towards using a telephone helpline or computer within Jobcentre Plus.<br>Difficulties understanding the benefit system. |

### **4.6.1 Summary of benefits received**

Clients in all areas were in receipt of a range of benefits. The main benefits mentioned were IB, ESA (although not all clients identified this by the correct name), DLA, IS and in a few cases Jobseeker's Allowance. Some clients received IS in addition to other benefits, and therefore were able to access other indirect benefits such as free prescriptions, glasses and sports centre entry. Housing Benefit and Council Tax Benefit were also mentioned by many, as were Child Benefit and Child Tax Credit for those with the care of children. We do not focus on these latter benefits here, although they clearly make up a significant proportion of income for clients, and their loss (or threat of loss) can cause anxiety and financial hardship.

### **4.6.2 Clients' benefits history**

The benefit history and experiences of clients varied between, as well as within, the research sites. In site A only a few were long-term claimants of IB and/or IS. The rest of the participants at site

A had either never claimed or only for short periods in the past. In site B several clients had been claiming benefits for a long period (between six and 15 years). A couple had claimed in the past, in one case when her children were young. The rest had received benefits for two years or less, and had no previous experiences of claiming benefits. In site C many of the interviewees had received their current benefit for a number of years, and in some cases they had been in receipt of benefits for more than a decade. A similar picture emerged in site D, with those currently in receipt of IB being most likely to have received this benefit continuously for a long period of time. However two participants in this area had begun claiming in the last year for the first time. In site E most participants had received benefits prior to their current claim. Some of those now claiming IB, IS or ESA had previously claimed JSA. Although many participants in this area had been claiming one or more benefits for a long period of time, in some cases, years, at the time of interview, this receipt had often followed long spells of employment. Participants' previous involvement with the benefit system had, therefore, been intermittent.

When comparing findings across the research sites two groups emerge. The first is those who had only recently claimed benefits for the first time or after a long period, or periods, of employment. This included clients who had received some benefits, or Working Tax Credit, in the past when their children were young.

*'There might have been just a few weeks in my 20s or something where, I had, there would be Housing Benefit at some point, but no I pretty much generally always worked.'*

(Male, 42)

*'I was on Income Support when I had my son because I was on my own...never been on Jobseeker's, I'd always worked.'*

(Female, 27)

The other group that emerges is those clients who had claimed benefits almost continuously for a number of years, mainly IB.

*'I'm on Incapacity Benefit, have been for about six year seven years.'*

(Male, 42)

*'Incapacity Benefit I'd say in total ten years apart from a period of a few months round about the end of 2004.'*

(Male, 42)

Participants who had received different benefits after a certain period mainly talked of being moved from IB or ESA to JSA but some had moved from JSA to disability benefits.

*'When I had me accident I was on Incapacity for about two year, and while I've been in [the area, for three years] I've been on Jobseeker's.'*

(Male, 49)

*'I was, eh, four or five months I was on this sickness and now I'm getting employment, eh, Jobseeker's Allowance.'*

(Male, 26)



*'Yes until I told them about me drug use and I was on prescriptions, they said "you're on the wrong benefit, you need to..." and they referred me to [service] and then I got put on incapacity.'*

(Male, 43)

#### **4.6.3 Reasons for claiming benefits**

Interviewees' reasons for claiming IB, and in some cases IS, included physical health issues such as problems with mobility; and mental health issues, primarily depression and substance misuse.

*'My condition, the doctor's diagnosed it as substance misuse.'*

(Male, 37)

*'I spoke to the doctor, I said "I'm suffering from depression, I've got this awful depression", and she, I'd been with her for two years and she knows me, and that I'd changed and that, and she said "I suggest you put [that] in your form".'*

(Female, 38)

*'I have osteoporosis and I've had it really since I were born but didn't find out till later on..., I bent over to pick something up and broke me back, two vertebrae just crushed, I've done it twice now...so due to something I was born with which I only found out 18 months ago that I had it... that's why I'm on the low rate of DLA.'*

(Male, 42)

In some cases clients were claiming benefits (or intending to) for a combination of reasons. For many clients, the primary reason stated for claiming, or attempting to claim, benefits was not alcohol misuse but depression, or another serious mental health problem.

*'At the time it was through, it would've been through my depression, yes my depression yeah, not through addiction.'*

(Male, 42)

*'I'm only on Child Tax Credits at the moment and Child Benefit...went to Citizens Advice to see what I was entitled to, like just to say "look I'm going on Income Support", but because of the bipolar and having a drink problem, an alcoholic, they tried to get me E...ESA or disability because I don't do my own tablets, I'm not allowed...it has to go through a responsible adult – 30 years old but I'm pleased with that though because it takes the pressure off, the worry off me...because the overdose was accidental...I didn't want to kill myself, I was so drunk.'*

(Female, 30)

Some clients who described having a physical health problem said that they also received DLA or a disability premium as part of another benefit.

#### **4.6.4 Information and advice**

Some clients noted that access to information about benefits can vary according to location, transport and resources, both financial and individual.

*'It's harder for people now they're closing some of the local centres; harder for people if they can't travel or can't afford to travel to a jobcentre or whatever in another town or they can't access a computer.'*

(Male, 53)

*'Nobody gives you any information unless you've got enough about you to ask...some people are so stressed out...what am I going to do?.'*

(Female, 56)

Clients had been advised on benefits by a range of people and services. Some received advice from benefits advisers or Jobcentre Plus staff. This included advice on the type of benefits which would be most suitable for them.

*'...she [Jobcentre Plus adviser] tried to get me on this DLA thing, so I can actually work so many hours and I don't lose any benefits.'*

(Male, 49)

*'Yeah, I rely on the people at the benefits office to tell me.'*

(Male, 43)

One person described how he approached the jobcentre himself to ask for help, on account of his problems with alcohol.

*'I went to jobcentre and just tried to get something 'cos I said to them "I got problem with drinking", and they gave me this [application form] 'cos I was seeing my doctor.'*

(Male, 26)

Those participants currently receiving IB were mainly recommended to apply for this benefit by their GP, or another health worker. However, one individual said that it was a worker from a specialist alcohol treatment agency that encouraged them to apply for this benefit.

*'It was my doctor, he said, 'cos I went to my doctor and I said what was happening to me in the work and that.'*

(Male, 22)

*'I think it might have been my community alcohol worker, 'cos I did see her I think for a few months in 2000. I think she might have mentioned something to me about getting on to the sick.'*

(Male, 42)

Some of the individuals interviewed said they had received advice about applying for benefits from the treatment support agency they were attending. Participants in one site also mentioned a separate agency, operated by their local council, which specialises in providing advice about the benefit system.

*'They [support agency] advised me what to go for and how to go about it and all that and what I was entitled to and all that.'*

(Male, 53)

*'They'll help you fill out your forms, claim forms and all that... They're good it's just a free thing you know, they're supposed to help you with council tax or...Housing Benefit and all that.'*

(Male, 33)

One client described how he had received information from fellow clients in a rehabilitation centre, who felt that he was not receiving the appropriate benefit.

*'There was people in [rehabilitation centre] that were getting upwards of £190 a week DLA invalidity – all these things...they were telling me how to do all this for when I come out.'*

(Male, 33)

Sometimes the recipient or a relative had researched the appropriate benefit. In one case, a client's daughter had made phone calls while her father was in hospital and filled in forms on his behalf, and then accompanied him to the jobcentre and council offices.

*'I was in hospital...my daughter did on the telephone for me...the Housing Benefit we went to the offices to fill in forms, but the ESA was done on the telephone. It seemed really weird that you could do it on the telephone. She marched me around [town] all day, she took me to the jobcentre, she brought me here, she took me to the council offices, and she took me to the place where the AA meets now, the NA meetings. She had a big pack with her, she'd written it all out before she came, bless her.'*

(Male, 58)

#### **4.6.5 Help and support**

Many clients received help with benefits from staff in alcohol treatment and other support services, particularly with filling in benefit application forms, but also answering questions and helping them to deal with the practical problems they face day to day.

*'I ended up coming to see the independent living adviser here, she said "we'll deal with it [paperwork] together" which was a real help.'*

(Female, 56)

*'I had a lot of help off [treatment service]. ...they helped me fill in the forms and get me a care worker to sort out the rent. I've learned a lot from [them].'*

(Male, 52)

*'When I'm getting my first benefit she [alcohol worker] wrote me a letter with some explanations [about] what's happened with me. I think that was really helpful.'*

(Male, 26)

One participant also spoke about having staff from the support agency to accompany them to Jobcentre Plus to help them discuss their problems and ask for support. He described his mounting frustration caused by him not knowing what he was entitled to, and feeling that the jobcentre was not telling him what he needed to know, or deliberately not dealing with his claim.

*'They were basically telling me I was getting nothing because I'd sold the big house and there was no way I'd went through that amount of money in that short time, so I was getting nothing, just "go away sonny" and whatever, and it was frustrating, and I came in and spoke about it and I got the help I needed, so I took people [from the support agency] up with me and they explained it because I couldn't do that, the steam was coming out my ears when I seen them, there was no..., I felt like you were getting treated like a number.'*

(Male, 53)

One individual spoke of their regret in not asking the Citizens Advice Bureau or another agency to help him fill out an application for DLA, which was turned down. In contrast, another participant felt he needed no help filling in application forms.

*'Yeah, the mistake I made was I filled the form in on my own without getting any help through Citizens Advice or one of the other agencies. I still think possibly I've got a case for eligibility.'*

(Male, 55)

*'I'm all right filling out forms. I...made sure everything was sorted.'*

(Male, 30)

#### 4.6.6 Experiences of assessment

Most clients felt that they were on the right benefit, although several were in dispute with Jobcentre Plus following unfavourable assessment and withdrawal of their benefit. Some interviewees recounted, in detail, their experiences of being assessed for their eligibility. Although some clients had fairly positive experiences of claiming benefits, many of these accounts were more negative. One client who also had a gambling problem, reported that he did not get benefits for a year, because Jobcentre Plus were aware of the large sum of money he had received from the sale of his house, and did not appear to believe that he had spent it. He described how he eventually won his appeal.

*'I was living on fresh air for a year, but eventually I won my appeal when they realised I had a gambling problem and the money wasn't there and it wasn't stashed under the bed, that I was skint...but eventually I got benefits, I got Income Support.'*

(Male, 53)

Several participants recounted their experiences claiming DLA. One described multiple application attempts for DLA, focusing on one application process which she had found particularly unpleasant.

*'...when I went for the DLA about, that was about two years ago I got turned down at the appeal, even a man from the DWP actually came along, which is quite unusual...there was a woman there that was a benefits expert, was supposed to be...I felt quite intimidated in the room, it was quite sort of, I felt rather threatened as well.'*

(Female, 54)

The same participant also mentioned that she had previously gone through an appeal for IS and had been successful. Another spoke of the delays she experienced in receiving her claim for DLA.

*'About eight months by the time it all got sorted out, there was a big delay in the process.'*

(Female, 27)

One participant was not successful in his application for DLA, a benefit to which he felt entitled not only because of his disability, but also because he had paid a large amount of tax over his working

life in the building trade. Although he was aware that others were being turned down or removed from this benefit, he felt that, by being refused DLA, he was effectively being pushed back into work before he was ready.

*'I'm a wee bit frustrated about the DLA you know, 'cos I thought I would have got something from that, but I'm hearing that they are taking everyone off it...I've got a thing in my head that I'm due this 'cos I've paid it in the first place...I've had quite a cr\*p time and I'm coming out of it but because I can string sentences together doesn't mean I'm ready to go out and get straight back to work, I need to try and get myself as level footing as possible and take the next step, and it's frustrated me a bit how I just get knocked back.'*

(Male, 33)

A number of interviewees described the process of moving onto ESA from JSA, which some found hard to understand and led to anxiety and even in some cases, time without benefits. One described how she had her JSA stopped before being able to claim ESA, even though she already had a certificate from her doctor signing her off sick for three months to attend rehabilitation.

*'So I went to the jobcentre and told them about this, and they stopped my Jobseeker's Allowance and they gave me a leaflet and referred me to ring up for ESA – that's an 0800 number...it's actually written on the certificate, reason for signing off alcohol problems, is attending rehab.'*

(Female, 52)

The experience of the medical assessment process (in some cases repeated assessment) was described in depth by a number of clients and was clearly problematic for many of them. Some found the whole experience very unpleasant, especially when they felt that it was assumed they were lying. Others were surprised or upset by some of the questions asked, or by the manner of the person conducting the assessment. In some cases the final decisions made after assessment appeared arbitrary to those involved, or the process itself seemed opaque.

*'...when I went for the DLA I had to go in front of four people..., one was a doctor, one was a judge or something...and you had to convince them that you were entitled...it was nightmare. They never believe you, they always think you're lying.'*

(Male, 49)

*'I know after a certain time on ESA I had to go to this horrible medical...it wasn't very nice at all. I think once you're on benefit for eight weeks I think you get called for a medical...if you score 15 points or over you get the higher rate which is £80 a week – I scored nought...he wasn't a very nice chap...one of the questions was..."do you keep your room tidy?" Well, if it had been a tip I'd have said yes to that wouldn't I? Most people would wouldn't they, would have said "of course I do"? But I do actually. He said have you got a television in your room, and I said "yeah". He said have you smashed the screen or broken it in any way? I said no. And at that point I asked him, "can I ask you why you're asking me these questions?" And he just put his head down and he wouldn't answer me. And I found it pretty odd that.'*

(Male, 58)

The main complaint was that, in their view, the assessment tool was focused on physical ability and was inappropriate for someone with addiction and mental health issues. They felt that the fact that they had managed to attend the interview did not mean that they were therefore able to work. In some cases they felt that they were being penalised for being able to attend the interview. In others they felt that the interviewers were not well equipped to conduct this kind of assessment.

*'I've been for assessments five, six, seven times. Once a friend was going to drive me...at the last minute he couldn't...so I drove myself. Because I did they knocked me off the system...another day I wouldn't have been able to [drive].'*

(Male, 63)

*'...it was a tick box [exercise].The whole lot was totally irrelevant because I wasn't there for a physical disability [but] for a mental health difficulty. The score was nil...'*

(Female, 56)

*'I think just somebody you don't know – and obviously they don't take your own doctor into consideration – and it was just like a guy that turns round and says look if you can put a jacket on you're fit to work...he could hardly speak English, pardon me,...I felt the communication part was quite important to me because I was needing support...Somebody that could communicate better would have been a lot better.'*

(Male, 44)

Some participants described losing their benefits after undergoing a medical assessment, and then having them reinstated on appeal. For some this caused them a great deal of distress, in addition to the financial difficulties it led to.

*'They stopped my money. I got in touch with Jobcentre Plus...She said "If you're appealing I'll send you a form and the minute we get it back your money will be reinstated". It's been a real nightmare...the stress and confusion it's caused. It has nearly tipped me over the top.'*

(Female, 56)

*'I got taken off it [IB] maybe about a year or a year and a half after I had been on it, I had to appeal it, had to live on £25 a week, aye, £25 a week for six months, until the appeal got dealt with.'*

(Male, 22)

One participant gave a more positive account of the assessment process, although he did not seem to have a clear understanding of the process or know why this decision went in his favour.

*'I had a medical two or three weeks ago and I don't have to get a certificate now until next year, next January...I went to some; social medical – they assess – and I passed it. I didn't really do nothing, I didn't pretend I was mad or nothing I just told her what it was and that was it.'*

(Male, 43)

#### 4.6.7 Experiences of the benefits system

Comments on the benefit system as a whole were mixed. Some recipients were positive about the procedures involved and the services offered.

*'Oh, I think there's a lot on offer at the jobcentre, when I'm ready I'm going to go and see them because they do do training courses don't they.'*

(Male, 37)

*'Personally I found it straightforward, positive. Yes, I was homeless for seven months a couple of years ago now...I dealt with them via a post office address, I was living in a...there were no problems at all. The mail would get there, I'd get replies.'*

(Male, 57)

Some participants were aware that, although they did not have a problem with their own benefits, others had experienced difficulties with the benefits system, particularly those on lower rates of benefit.

*'On the whole I find it very good. I feel that that's because it's, a few years where it's been settled so to speak, whereas I know there are two people within the Dry House are that on a Jobseeker's type thing and they are struggling with finances because they're only getting their minimum Jobseeker's Allowance and they haven't got any top ups out of that...I know that all week they don't have a pound between them...it's not like that with me but, you know, that means I've always got to buy the milk and the coffee.... They struggle with benefits, but because I get the DLA and stuff it's not so bad for me.'*

(Male, 42)

Negative accounts of experiences of the benefit system mostly related to delays in benefits being received and inconsistent service in terms of having to deal with more than one person, and the need to give the same information repeatedly. This was particularly challenging for a client for whom English was not his first language.

*'Over Christmas and I was supposed to get paid and I didn't. They said "your money's not been issued" I said "why". "I don't know"...'*

(Male, 30)

*'I've been seeing this woman now for nearly 12 months every time I go and she's all right, but before like you'd be seeing someone different every week.'*

(Male, 49)

*'It was really stressful for me when I need to ring them 'cos I was waiting for my benefit for almost eight weeks, so it was, I was almost thinking I didn't get any money and to get a new job and now I became homeless, so I was really frustrated because of this...every time when I ring them you need to speak with different person and explain everything from the beginning.'*

(Male, 26)

One interviewee also described being investigated for working whilst claiming benefits, and the impact of having his IB stopped whilst waiting for the investigation to come to an end.

*'There was a mistake and I went three and a half months without any money, they stopped my money while they were looking into something...they found out I've done a bit of work but it was under so many hours – while they were looking into it the previous employer wouldn't give them any information, so for three and a half months I was living on forty pounds a week, thirty pounds a week or whatever, crisis loans.'*

(Male, 42)

*'Views on jobcentre and Jobcentre Plus staff and their helpfulness varied. Some people had found that individual staff were helpful, understood their problems and were responsive to their needs, whether these were related to their alcohol misuse or other problems, including health issues. Clients spoke of the importance of staff being approachable, sympathetic, and 'not patronising'.'*

(Female, 27)

*'Well she knows I've had issues, she knows I've had problems, I told her I had problems...she knows I'm getting out of it...but she had been really good.'*

(Male, 30)

*'They're alright, I've just been truthful with them... They understand.... I think they're doing the best they can.'*

(Female, 38)

*'I do, I go and see a lassie and she's brilliant, and we're actually talking about me getting into some sort of work soon... Brilliant, she's excellent, I think she's on my wavelength, she doesn't sit there and talk too stupid, she's normal, which I quite like, she's a good laugh.'*

(Female, 27)

Some had a more mixed or negative experience, and felt that Jobcentre staff were not very helpful. Some felt that the self-service approach (being directed to phones or computers) was inappropriate for people who might need some extra support or explanation of how things worked. Others described frustration with the way in which they perceived the system to work, whether because things were not clear, or because they were not being offered the kind of information or advice they thought they should be (for example on training opportunities). In one case a client felt that he should have been offered more of a 'push' towards education or training to enable him to change career from his previous job in catering, rather than being urged to return to it.

*'They're not very helpful. Like I went in there saying I need to cancel my Child Tax Credit, "oh go and use that phone". Not only am I bipolar, I'm dyslexic, and there was loads of numbers there and it wouldn't be hurtful just to...say "look this is what number you need to phone and this is the procedure", not just "there's the phone there ring it"..., the phone actually was broke and I thought, and it made me not want to go back...you need someone who's working in that environment to be approachable.'*

(Female, 30)



*'I don't really know what they can do to make it better because eh, there's no empathy, there's no nothing, you're treated by the rules, there's no grey areas in it, there's no grey areas whatsoever, so there's no room for any permutation of any kind...there's no room for manoeuvrability with individual circumstances, you're just black or white, and I think that's why most people get frustrated with them, but eh, it's the system.'*

(Male, 53)

*'...they don't give you any support... There's been nothing really, I would like it if they got in contact and said to me "right you're on return to work benefit" and say "right we've got courses here we've got courses there", but there's nothing.'*

(Male, 44)

Some participants also felt frustrated that due to the fact that they live in supported accommodation they are effectively prevented from working. Most of the people interviewed at one research site lived in supported accommodation involving a substantial level of rent to cover the costs of the support provided by agency staff. In circumstances where clients are receiving benefits, this rent is manageable due to the simultaneous receipt of Housing Benefit and Council Tax Benefit. However, if a client wanted to find employment and therefore move off benefits, they would likely find it difficult to pay this rent and maintain the support they receive.

*'I couldn't work in the homeless unit because of the amount of rent, there's a serious flaw in the system there, there's a serious flaw, because I was in a situation where I wanted to work but couldn't afford to work, and there's something seriously not right there.'*

(Male, 33)

For one of these participants, this situation appeared to be compounded by a lack of available information from Jobcentre Plus regarding financial support.

*'If they decide I have to go onto jobseekers, I obviously have to be seen to be looking for a job or they don't pay me any money. If I have to start working, I can't afford to keep the flat on. And the fact that I work...I don't get my SAT worker because, depending on whether I'm doing a day shift/night shift or what type of work I'm doing then I won't be able to see [him/her]....You're in a Catch 22. I don't want to be living off state benefits either. You can't really survive on what they are giving you. So you've got to look at the bigger picture. Do I put myself straight back into work again or do I try and hang off as long as possible.'*

(Male, 36)

This client was willing to work, and was prepared to take a low paid job for more than 16 hours a week if he knew that he would be able to access additional benefits to support him. However he felt that nobody could tell him how he could sustain himself financially in work, whilst maintaining himself in supported accommodation with continued access to treatment.

## 4.7 Facilitators and barriers to work

In this section we cover the facilitators and barriers to moving off benefit and back into employment that the respondents discussed.

### Summary

- Many respondents were personally motivated to return to work and could identify many benefits to returning to employment.
- However, many were keen to highlight that they saw this as something which could not happen overnight and that their return to work was a gradual process.
- Others were quite fearful of returning to work, worrying that they were going back to work too quickly or that taking the wrong kind of job might jeopardise their recovery. Others were simply anxious about returning to work, particularly if they had not worked for a while.
- Training and education opportunities, along with voluntary work, were seen as important facilitators to returning to work. Many respondents felt that they lacked the necessary skills and qualifications for going back to work.
- Generally, many interviewees wanted to take their time to consider what returning to work meant for them. Many wished to try and engage with 'meaningful' employment rather than returning to the types of job they had had in the past.
- Individual barriers to returning to work included wanting more time to deal with their alcohol problems, and fear of the stigma they may face as a result of their alcohol or mental health problems if they had to reveal them to a prospective employer.
- Significantly, many respondents indicated that they would be worse off financially if they returned to work. Some were concerned that they would be unable to earn sufficient money in a low paid job to cover all their living costs as they would lose the financial support of benefits such as Housing Benefit and Council Tax Benefit.

A major part of the interviews focused on what the interviewees perceived as facilitators for change and for their return to work, and what they felt the barriers were to their return to work. Inevitably, the respondents were at all different stages of their recovery and this influenced what they had to say on this topic. A summary of the main facilitators and barriers as identified by the respondents is given in Table 4.2. It can be seen that facilitators and barriers operated at both the individual and the organisational/system level. The following sections will explore some of the major facilitators and barriers in more detail.

**Table 4.2 Facilitators and barriers to work**

| <b>Facilitators</b>  | <b>Barriers</b>  |
|--|--|
| <p><b>4.7.1 Personal motivation and being ready</b><br/>To change/return to work.<br/>Not wanting to be on benefits.<br/>Wanting a better quality of life through work and income.</p> <p><b>4.7.2 Alcohol consumption and abstinence</b><br/>Progress with alcohol treatment: sustained abstinence or reduced consumption.</p> <p><b>4.7.3 Training and voluntary work</b><br/>Access to training and education.<br/>Volunteering opportunities.<br/>Access to meaningful employment.</p> <p><b>4.7.4 Support from professionals and others</b><br/>Family support for change.<br/>Support from alcohol treatment services or other professional support.</p> | <p><b>4.7.5 Personal barriers</b><br/>Age and stage of life.<br/>Health problems.<br/>Feeling pushed back to work too quickly by the benefits system.<br/>Needing more time to tackle alcohol problem, any other co-existing problems and to have a sustained period of recovery.<br/>Facing stigma due to alcohol and other problems.<br/>Lack of skills and/or qualifications.<br/>Gaps in employment history, for example due to ill health, drinking or crime.<br/>Practical issues such childcare and transport.<br/>Feeling very hopeless about the future.</p> <p><b>4.7.6 The nature of employment</b><br/>Expectations regarding return to work.<br/>Fear of relapse caused by employment and potential impact on returning to work.<br/>Access to jobs – linked to concern that returning to ‘old’ type of work might trigger relapse and recurrence of other problems.</p> <p><b>4.7.7 Financial barriers</b><br/>Benefits trap: income gained through employment less than benefits.<br/>Facilitators to work.</p> |

The following sections look at the main facilitators which were identified by respondents as helping them tackle their challenges and actively focus on returning to work. It is important to note that at the time of interview only one client from the whole study was in employment, although some had previously been in employment, and then relapsed (see Section 4.7.6). Consequently the facilitators described in this section are those that interviewees perceived as aiding a return to work in the future. Most had not yet reached the stage of looking for employment.

### **4.7.1 Personal motivation and being ready**

Many respondents were personally motivated to return to work and could identify many benefits to returning to employment. Some said that they hated being on benefits and wanted to return to work to stop receiving benefits. For example, one respondent said that they felt they would have more ‘self-respect’ if they returned to work. Another said that they wanted the income so that they could stop ‘surviving and coping’ and have money for things like holidays, birthdays and Christmas. Other respondents said that returning to work would help them financially or that working and generally being occupied would reduce the risk of depression or other problems recurring.

*‘I hate benefits, I’m ready now to go out and face the big bad world.’*

(Male, 42)

*'All I've got in my head, all I've got in my mind, is that I want to earn money and I want to be successful. I want to just have a job...and I can come home knowing I'm earning money and I'm paying my way and I'm doing things.'*

(Male, 27)

*'...because...if I'm not doing something with my hands or moving around I'm sitting down...I'm getting depressed, so the aim is to get back up that ladder.'*

(Female, 38)

*'I'm getting to the stage that I'm getting restless now. For a while, the days and months were slipping past, it didn't just seem to matter. But now I'm getting to the stage [where] I want to change.'*

(Female, 43)

Many of the interviewees, therefore, were keen to get back to work and to focus their attention on the various stages of this journey. However, they were keen to highlight that they saw this as something which could not happen overnight and that their return to work was a gradual process. Many further emphasised that taking it slowly was necessary to maximise the likelihood of a positive outcome. Many were not sure what work they could, or wanted to, engage with, whilst others said that they wished to be able to be in a position to help others, who had faced similar difficulties, overcome their problems and returned to work.

*'I'm on a, what you call the beginning of the road to recovery, and I know it takes one step at a time but if you jump in head first you'll crash, and I don't want that to happen.'*

(Female, 38)

*'I'm going to ease myself back in just do something rather basic...just the type of work where I just have to do a bit of work and don't have to think.... I mean a part-time job, I have to do that at 16 hours a week, I can't work full-time.'*

(Male, 33)

*'I believe that that's why I personally need to get myself something, voluntary wise or part-time wise, I would rather ease myself in voluntary so that I'm not letting anyone down first off or anything, not that I intend to let anyone down but, you know, just to get back into the swing of it.'*

(Female, 40)

#### **4.7.2 Alcohol consumption and abstinence**

Inevitably, for many interviewees, their thoughts on their readiness for returning to work were closely associated with their recovery. Some individuals had made significant progress in terms of maintaining their abstinence and were now looking to the future, to re-training and finding employment. Others who were at an earlier stage in the process, however, were more tentative and therefore fearful of doing anything that might jeopardise their recovery (see Section 4.7.6).

*'I have to become sober to attend these courses, so you have to stay sober, if you've had a drink or injected anything you can't go. It's simple as that. The alcohol, I was on and off it for ten years plus and then to drying out clinics. For some reason this time there's something inside me head saying "come on you've had enough now".'*

(Male, 42)

Many interviewees were keen to return to work and were motivated to take the necessary actions for this to become a reality. However, many respondents wished to prioritise their alcohol treatment and their recovery and felt that they did not want to rush back into work and risk undoing all the good work they had been doing.

#### 4.7.3 Training and voluntary work

As was seen earlier many respondents had left school with few or no qualifications, and consequently been employed in menial or lower skilled jobs. While many had a more or less continuous employment history, some had not worked for many years. Many interviewees, therefore, were actively engaged in training courses or gaining qualifications that would facilitate their return to work. Some felt that they needed basic skills, such as computer skills, to help them find work whilst others were keen to re-train so that they could explore a range of options for returning to work or do something completely different, which usually involved a job in one of the caring professions to help other people. One respondent, from another European country, wanted to complete an English language course to help them find work.

*'I'm actually looking into working with old people like helping them get to bed or whatever, but that's the kind of thing I'd like to move into... I'd need to start part time I think, and then build my way back up again.'*

(Male, 44)

*'I did a 13-week course there at college which was through here as well, not through the jobcentre, and I totally enjoyed it.'*

(Male, 44)

*'I joined the CAPs group here which is the Community Access Programme...that would be some gardening or you'd go fishing perhaps, sometimes a bit of camping, that sort of thing, but I stuck with the allotment and [went] away on their residential [courses] which were about once a month, once every six weeks during the summer months...and doing conservation work.... I don't know how I'll stand once I start the NVQ which I can do two days a week minimum really. That's voluntary work and that will gain me the 450 hours needed in 12 months. So I would imagine I would be classed as fit for work. I'm not really sure, this I've got to find out, but they'll probably put me on Jobseeker's Allowance because I'm actually doing a course and it's voluntary so I'm not really sure what the outcome of that will be.'*

(Male, 57)

Many respondents were engaged in voluntary work, or felt that undertaking such work, would be beneficial to them, as a step on the way to paid employment. Some were doing this as part of their alcohol treatment programme. Some felt that it would provide opportunities for finding employment through channels other than the jobcentre, which they perceived as only advertising jobs in less meaningful occupations.

*'...a stepping stone to get me to a permanent job.'*

(Male, 43)

*'...well through there... I went for voluntary work, just to try and build my way back into work... you're working with old age pensioners and we just enjoy a laugh you know, that kind of thing, and it gets you to meet people, I really enjoy it.'*

(Male, 44)

*'I've been volunteering at this charity for 20 months and been helping a lot of people, homeless people, people on benefits, I do the soup run every Friday.'*

(Male, 42)

#### 4.7.4 Support from professionals and others

An important perceived facilitator for returning to work was the help and support from other people, although this was not something highlighted by many respondents as something which they had. For some of those who did have this support, it came from professionals, usually through the alcohol treatment service they were engaged with, whilst for others the support from family was important. One respondent mentioned that they had received help from an organisation that specifically addressed employability issues; and that they had heard of support provided by another organisation in relation to previous criminal convictions.

*'They help you do your CVs, work searches. It doesn't bother you...being on incapacity benefit... they're the ones that try to get you off it... Somebody was telling me about \*\*\*\*\* – you go down with your criminal convictions and they go through it all with you. If you go for a job...the Disclosure form...they can't hold that against you. If you've got convictions – they can't hold that against you. I've got it all planned out.'*

(Male, 28)

Another interviewee was positive about the support they were receiving from a local service user organisation, whose services seek to address a number of issues, but felt that there should be greater flexibility in terms of accessing services.

While not a direct focus of the interviews, many of the respondents mentioned the support that they did or did not receive from their family or wider support networks in relation to their alcohol misuse and other problems. As has already been seen many of the respondents had experienced the breakdown of a significant relationship and/or had family related problems during their childhood and adult lives. Many therefore reported poor support networks. In some cases the participant's family had broken ties with them as a result of their alcohol use. Nonetheless, some of the sample spoke about the positive support that they had received from family members or a wider support network. Sometimes this was confined to practical support such as accommodation or money but, in other cases, the support went further than this and included assistance with researching the intricacies of the benefits system or alcohol treatment. One respondent said that his parents had given him the incentive that if he stayed sober they would leave him their most treasured possessions in their wills.

*'There are good days and bad days...my neighbours bring me hot food on days when I can't get out of bed. They walk my dog and see to him...'*

(Female, 63)

*'I've always had the support...That's why I'm getting on well here now, you know because I've still got family and friends which have been around me, all the way...I've got a lot of friends...at the time I was drinking I wouldn't impose...they've got children...I wouldn't put my friendships through that.'*

(Male, 52)

In addition to facilitators, many respondents also identified significant barriers to returning to employment. These barriers will be explored in this section starting with personal barriers.

#### 4.7.5 Personal barriers to work

The respondents identified a number of barriers which they felt were delaying or preventing their successful return to work. Some felt that they just needed more time to be able to focus on their recovery from their alcohol problem and other problems that might also be present. Some wished to continue dealing with these issues without the pressure of returning to work and coming off benefits.

*'...all I want is, it's in my appeal letter...a bit of space, give me a little bit of breathing space. I feel that I'm begging. I've worked since I was 15 and I feel humiliated...you can't go from having a drug or alcohol, MH [mental health] problem...you've got people like myself who want a little bit of time to get myself back to some sort of stability who want to go back to work.'*

(Female, 56)

As was seen above many felt that taking time to train or do voluntary work would be to their longer-term benefit as they could engage with more meaningful employment which they felt would contribute to overall increased quality of life. Moreover, for some, they wished to have more time to resolve some of their basic needs, such as housing, which they felt needed to be in place before they could return to work.

*'As soon as I get a flat, I can start getting things done. But I need to get my own place, get that sorted out, and then basically, if I want to have money, I need to get a job and need to go out and work. Just like everybody else.'*

(Female, 43)

*'I don't really know my long term goals...I've got to get my short term goals right and the long term's really going to come into place...once I get my housing I'm going to build from there 'cos food and shelter are my two essentials, when I get them then I can look to better things.'*

(Male, 37)

Some interviewees described how their willingness or readiness to change was dependent upon what they wanted. There was a belief that they had to be willing and motivated to change before they could move on with their lives.

*'So I said "look I've stopped smoking weed and I've stopped drinking, don't come round you know what I mean, if you're gonna come round have cup of tea 'n that you know what I mean, play a game and that, don't come round just for a drink or a smoke, 'cos I don't want to do it any more".'*

(Male, 43)

*'It's very much down to myself to deal with the issues that I've got...there's only me that can say no...if I've made my mind up that I want to do something I'll do it.'*

(Male, 42)

Several respondents indicated that there were issues associated with their alcohol problem which were barriers to returning to work. These included the stigma that they would face as a result

of having an alcohol problem, being on prescribed medication for their alcohol or drug problem (including methadone), having a criminal record, prostitution, or having been in prison. However, involvement in criminal activity was uncommon amongst the clients interviewed. Some clients had a criminal record for disorder offences including being drunk and disorderly or breach of the peace. Other offences mentioned by clients included drink driving and possession of illicit drugs. A small minority of clients had been arrested and/or convicted and imprisoned for offences involving violence, theft and fraud. Drug use was mentioned by some of these interviewees in relation to their offending. One interviewee was on probation (with a drug treatment and testing order) at the time of the interview.

Some felt that gaps in their CVs, due to unemployment, imprisonment or ill health, would be of concern to potential employers.

*'I think if people know about someone's history I think it could affect their decision on their employment.'*

(Female, 54)

For many interviewees their mental or physical health problems (including things such as mobility) were major barriers delaying or preventing their return to work.

*'I go into a deep depression every six months something like that...for about five or six weeks where I just isolate myself, I don't talk to anybody I don't go out, I don't do anything. So I'm more worried about that really than the arm, if I got a job, nobody wants to be working with somebody like them for six weeks do they?'*

(Male, 49)

*'I struggle now with my motivation and with my physical tiredness and mental tiredness, I struggle with the day, just getting through a day, I struggle with getting out of bed in the morning, not through laziness...I have to drag myself out the bed, I struggle with sleeping, I don't sleep well at all, so...I'd be useless to somebody as an employee, if I went in and they said "right this is your job you got to do", I wouldn't be able to do it because it'd be too much for me.'*

(Male, 42)

*'I'm happy enough but I don't think I'm stable enough to hold a job down for the simple reason because I never know what I'm going to be like...although I feel guilty sometimes, I think to myself "well I'm not answerable to an employer"...I'm not quite stable enough to enter the workplace because it would be too much pressure at the moment as things are. I've got to make sure that I don't let my voluntary work and my classes interfere with my family...it's all about family and not tying myself down too much, but having my little bit of time as well, which helps with my mental health...because I think if I spend too much time at home rallying around just for the kids and grandchildren all the time.... I wouldn't have a purpose and my own identity.'*

(Female, 47)

Finally, a few interviewees felt that, ultimately, they would never be able to return to work, nor did some of them want to work. Some of the older respondents commented that as they were older they wanted to focus on other things in their lives, such as family, children, travel and other interests. Others just felt too hopeless and saw no change to their circumstances.

*'I don't want to go back to work.... I haven't got much in life that I want to live for, I haven't been with a woman in eight years, don't want it. I'm not happy with the way I am.... I just want to be*



*left alone.... I don't want help, I just want to be left alone, when the time comes the time comes. I tried to kill myself once and it didn't work, I made a balls of it, I tried to take an overdose and it didn't work...not a nice place to live either, especially if you haven't got money, you just survive, that's it.'*

(Male, 43)

#### **4.7.6 The nature of employment as a barrier**

Many interviewees talked about the type of employment that they wanted to do, and how they felt that the limited availability of suitable employment opportunities in their area was a barrier to them returning to (and staying in) work. Some did not want to go back to menial or low-skilled jobs, whilst others just wanted to do something different and take the time to work in more 'meaningful' areas of the job market. For some this was associated with a concern that returning to the work they had previously done might trigger a relapse or the recurrence of other problems. For example, one respondent was reluctant to return to work in the catering field because of the influence he felt it had on his drinking. Others, who perceived their previous jobs as having higher levels of responsibility, were concerned that returning to jobs involving high levels of stress might also increase the risk of a return to problem drinking.

*'I wouldn't want to do the staff nurse thing again. I don't think I could handle it now.'*

(Female, 54)

*'I want to be back in the workplace doing something. I would never go back into an office job...it would put me back in the same place I am in now.'*

(Female, 56)

Another area of concern expressed by a lot of the interviewees was that they felt they lacked the necessary skills or qualifications to be able to return to meaningful work. For some, this was associated with age, with older respondents feeling that their age made them unemployable. For some this was further associated with the concern that they would be unable to cope with how areas of industry had moved on and that they would be unable to undertake work in areas in which they had previously worked.

*'...not having any qualifications, I'm computer illiterate I've got this impression that I'm unemployable.'*

(Female, 48)

*'The way I see things today is that a company wants to employ younger people for less money.'*

(Male, 63)

*'My trade has changed so much that will be frightening...the materials have changed, different things, everything's coming out new.... I'd still be the old fashioned way.'*

(Male, 52)

In addition to the type of employment, some interviewees were concerned about the timing of a return to work, expressing a concern that entering employment at an early point in their recovery

could damage or seriously delay this process, and that a premature return to work might lead to relapse. Some had personal experience of this scenario; one client described having to return to a support organisation for help after being unable to sustain employment.

*'I've had to slow down because feeling better I've dived into something and burned myself out basically and I've just been told here several times at [support agency] "just slow down, don't rush in to get any job because you feel you must be earning to pay your way" and that sort of thing.... I think it's just taking the time, not jumping into something and rushing into it, finding it's not going to work and then thinking "oh God".'*

(Male, 57)

#### 4.7.7 Financial barriers

Significantly, many respondents indicated that they would be worse off financially if they returned to work. For some this was a major (or even the main) barrier which was preventing their return to work. Some were concerned that they would be unable to earn sufficient money in a low paid job to cover all their living costs as they would lose the financial support of benefits such as housing and council tax. Others were concerned that they would only be able to work a certain number of hours to be able to receive both income and benefits. For some, this barrier explained why they wanted to take time to train, gain qualifications or engage with voluntary work, because they felt that it would increase the likelihood of their getting a more meaningful and better paid job that would make it worthwhile coming off benefits.

*'I'm better off on benefits, I think most people are... but I think that most people say I'm better off on benefits than I am in full-time work because I don't get my income benefit, I don't get my Council Tax Benefit, and travel expenses as well if I come here.'*

(Male, 42)

*'If you go back to work for 16 hrs and you earn £30 they'll take your Housing and Council Tax Benefit off you...where's the incentive to work?'*

(Female, 56)

*'...sometimes you just can't take a job they give you, sometimes it's no good is it...I've got bills to pay and all that, it's different.'*

(Male, 46)

To conclude, whilst some of the respondents felt that would never return to work, for a range of reasons, many did want to return to work and many were actively taking steps to achieve this goal. Having a flexible system which provided time, support and opportunities to sustain their recovery from their alcohol problem and associated problems, and consider what returning to work meant for them. Nevertheless, the majority of respondents identified several key personal and organisational barriers to returning to work, not least the feeling that they would be financially worse off if they returned to work.

## 5 Views of professionals

Interviews were conducted with 12 professionals at the five research sites, with two to three interviewees per site. Their responses are clearly dependent on the type of service they operate in, the focus of their own work, and the profile of their clients. An overview of the five services and contextual information about the areas they operate in can be found in Chapter 2. In summary those interviewed were:

- a senior social worker;
- a care manager in a substance use team;
- two counsellors (one senior counsellor);
- five project workers (one senior and one an ex-service user);
- an independent living adviser;
- a support worker in accommodation services;
- a service development officer.

The findings from interviews with these professionals are organised under five main headings which correspond broadly to the higher level themes identified during analysis of the interviews:

- services and clients;
- engagement, recovery and relapse;
- interaction with the benefits system;
- employment;
- gaps and issues in service provision.

A short summary can be found at the start of each section.

### 5.1 Services and clients

#### Summary

- All services in the study sites offered clients assessment and support services, including provision of information, advocacy, and referral (or signposting) to other services. Some also provided access to treatment, and training (at colleges or from specialist providers) or employment placements (in voluntary organisations or within the service itself).
- Referrals came mainly from health professionals; social services, the probation service, jobcentres and other statutory services; and some were self-referrals.
- For more specialist support, clients were referred on to benefit advice services (particularly the Citizens Advice Bureau) and employment services; to legal, mental health, and housing services; and to Community Access Programmes (CAPs), local charities and volunteering agencies to support a return to employment. Some professionals referred clients to jobcentres, but professional contact with Jobcentre Plus or the Department for Work and Pensions (DWP) was generally limited.

- Most clients seen by these professionals had a long-standing problem with alcohol. Some were in employment, or had been until a recent crisis or escalation in their drinking. Others had a limited work history, and some were also drug users (including prescription drugs). Most were described as socially isolated.
- In addition to treatment needs clients had a wide range of economic, social and practical support needs. Professionals stressed the importance of dealing with these complex 'life issues' as part of recovery and before a return to employment.
- All stressed that recovery can take a long time; for some it may be a process lasting a few months; for others with more complex needs it may take three years or more.
- Some professionals stressed the importance of challenging 'stuck behaviours' or ways of thinking, and felt that clients may benefit from continuity of support from a treatment professional during this period.
- Several emphasised that coercion and compulsion were counterproductive; recovery primarily requires self-motivation. People have to want to engage with services, become abstinent and return to work.

### 5.1.1 Overview and referrals

Most services aimed to provide a supportive environment to encourage clients to engage with them, alcohol treatment and other services (including drug treatment). Services provided to clients included: assessment (care plans, assessment for residential or community detox/rehab); support prior to treatment (including practical support with finances and benefits, housing, police/probation); treatment and support services including therapeutic and motivational work (group and/or one-to-one), outreach, drop-ins and social activities; aftercare (including social support and relapse prevention); voluntary placements and training (mostly through referral, but in one service this was within the user-led organisation); the provision of information, advice and advocacy; and signposting other services.<sup>85</sup>

Some professionals worked with other statutory services including social services; police, court and probation services; and in one case directly with Jobcentre Plus Personal Advisers. Most referred on to other agencies including a number in the voluntary sector (see below). Referral sources mentioned included GPs, hospital staff, mental health professionals, community drug teams, and other health care professionals; social services; the probation service; jobcentres; rehab services; and housing services. In some cases clients self-referred.

We get about 60-odd referrals a month, drugs and alcohol; the vast majority though are alcohol.

*'...people can self-refer...they can actually just turn up on our doorstep...but people can also get referrals from their doctors or their psychiatrists or medical professionals or even from the housing...the Jobcentre have also referred people down here as well, because obviously people have got alcohol issues with pretty chaotic lifestyles.'*

Five of the professionals said that if clients had problems with benefits or other financial issues which they could not help with<sup>86</sup>, they would refer them to the Citizens Advice Bureau, or other local advice services. Three other professionals said they would refer to Jobcentre Plus, or the 'DSS' (as

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<sup>85</sup> Not all organisations provided all these services; some provided one or two, and some provided multiple services.

<sup>86</sup> See Section 5.1.3.

they referred to Jobcentre Plus). Other services mentioned were local law centres; housing advice services (specifically Shelter); and mental health teams. In terms of 'moving on' from treatment to employment, clients might be referred to CAPs teams and other training and employment services, including local charities running support programmes, and volunteering agencies finding placements.

*'They will work with people and aim to get them more integrated, back into...outside life really, so they get them involved with college courses...they have people go off on the local allotment...they'll take them away on residential weekends, conservation work. And then when they're ready they refer them on.'*

*There's definitely opportunities for them to go back and retrain, we link up with two or three different agencies...supporting clients who want to look at re-education.'*

*They are a charity that are independent from the Jobcentre but they do work closely with the Jobcentre ...they look at ways of getting them back into employment, maybe if they're lacking in certain skills, maybe helping them with courses and things like that.'*

They might also refer direct to jobcentres for support for clients with finding employment (although for some professionals contact with jobcentres was limited or a fairly recent development).

*'The DWP or Jobcentre Plus, I speak to them occasionally but not on a regular basis.'*

*We've just recently got funding from the jobcentre so we're going to be working more closely with them in future but that's a...new initiative that's just started.'*

One professional had set up a pilot service the previous year working closely with Jobcentre Plus, through a 'surgery' based at the Jobcentre:

*'I work with the Personal Advisers...their clients who were on Incapacity Benefit with alcohol related problems to try and see if we could help to assist them through their alcohol problems and possibly get them into a position of getting back to work.'*

This pilot project came about through the initiative of the interviewee who was encouraged to apply for Deprived Area Funding (DAF) to fund the post. The 'surgery' involved taking a personal history of alcohol use, and work on motivation :

*'My job is to motivate them and keep them motivated to make the changes, we use the Prochaska cycle of change, and then also we use some solution focus if they need some sort of solutions to their problems, we try and help them in that way too.'*

The pilot was deemed a success, although the take up was low (see Section 5.4.2 for more detailed information on outcomes), and further funding was accessed to expand the service.

*'The conclusion of it was that it demonstrated it was possible to develop a feasible service with Jobcentre Plus for their customers and in particular a productive working relationship we've established with the Jobcentre Plus Personal Advisers...a fast response service was available for the Jobcentre Plus customers and 50 per cent of those who attended the counselling for their alcohol use recorded a successful outcome.'*

### **5.1.2 Client characteristics**

Professionals explained that most of their clients had a long-standing problem with alcohol, and their alcohol misuse had built up over several years or even decades. Some were still in employment, or had been, but their drinking had worsened, in some cases as a result of an event or problem in their personal life.

*'The people I've been seeing recently ...have been people that have got existing jobs but have developed an alcohol issue and are now addressing it.'*

*I think there's a range of people and you've got the people who have worked in the past and have had regular jobs for a while, and maybe they're drinking or maybe they've been maybe heavy drinkers but something happens and it tips them to becoming dependent, so they stop working or they lose their jobs or something like that.'*

Others had never worked, or had only worked sporadically in informal, unskilled employment.

*'We have had the odd person who's come in who's not on benefits and they're actually paying the money up front...they have been in work, but that's few and far between...usually the people that come on they've maybe been on benefits for a few years.'*

*Most people have done work we call 'fiddle', where you do a bit on the side, and that's unskilled like painting or just helping friends, but no experience. And they're the ones that we keep focusing on, different governments saying they're the people we need to move on.'*

Some clients were also drug users, including those who may have become addicted to prescription drugs

*'People over the 35 group ...You get the clichés I suppose, people who are doing okay, hurt their back, went onto painkillers, started drinking, two years later it can be. That's when that de-motivation I think comes along.'*

*We have a lot of people that are using prescribed medication and alcohol and cannabis. And a lot of clients will just take whatever's there.'*

Clients were often described as experiencing social isolation, perhaps being alienated from their families because of their drinking, or increasingly drinking alone.

*'Not so much with drug dependency, more with alcohol dependency. They tend to, as they become more dependent, they become more withdrawn from society. It's not necessarily a social drug although we have pubs and clubs where it is predominantly a social setting, whereas in my experience, people taking drugs usually take drugs with other people, with alcohol dependency as they become more dependent, they tend to become more isolated.'*

### **5.1.3 Aims of services**

Some professionals were working with clients at the point of initial engagement with the service, others at a later stage when they had achieved abstinence. All stressed that the return to employment was at the end of a lengthy process.<sup>87</sup>

*'The group that I do is for when people are completely free of drugs or alcohol, so they're beginning to think about goals of what they'd like to do and whether they'd like to work again or maybe change a complete career or doing something different.'*

While some stressed the importance of challenging 'stuck behaviours' or ways of thinking, several stated that compulsion is likely to be counterproductive; people have to have the self-motivation to engage with services, to recover fully (in most cases to become abstinent)<sup>88</sup>, and to go (back) to work.

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<sup>87</sup> See Section 5.1.4.

<sup>88</sup> See Section 5.2.1.

*‘Quite often people are coerced into services, i.e. they’re on probation or their wife is complaining or their girlfriend has had enough of the drinking and you know, they are saying ‘get this sorted’ but the main golden rule of this is, you are not going to change unless you want to change... it’s better for us if they’re motivated...The client who are coerced in, quite often are not really getting a lot out of it because they already have that mindset that they don’t really want to be here in the first place. So, it’s like pushing water up hill a little bit with those clients.*

*I took his details...I said to him “did your PA railroad you up here?” and he said no, so he wanted to be there.’*

Several people said that their work involved supporting clients through the process of applying for benefits, often involving help with filling in forms, making phone calls to relevant agencies, or even in some cases going with clients to appointments at the Jobcentre. In some cases professionals supported clients through medical assessments (sometimes attending with the client) and subsequent appeals. However most of the professionals did not feel that this was an area in which they felt knowledgeable. They tended to deal with the issues that they could, and then referred clients on to other more specialist services such as the Citizens Advice Bureau, or other welfare rights and benefit advice services.

*‘We tend to sort of signpost people because there are so many different benefits.*

*I certainly don’t think I know everything about the benefits system and how it works, but I feel like I know enough to kind of have a good grounding you know to kind of know the basics...but if there’s anything I’m not sure of I don’t want to misinform people and I’ll say to them – you know obviously I’m not a welfare rights officer, I’m not a expert in this field, so you’re better getting the correct information...’cos if I give somebody a bum steer on anything you know it doesn’t reflect very well on the agency.’*

#### **5.1.4 Client needs**

Most professionals said that the services they provided were tailored to the needs of individual clients, and that these needs varied enormously. In addition to alcohol (and possibly also drug) treatment clients have a wide variety of economic, social and practical support needs (including specialist financial and benefit advice; legal advice; mental health treatment; basic skills training; social support and advocacy)

*‘With the alcohol comes lots of other thing behind it. You start peeling the onion away, and there’s lots of layers there, lots of things that are going on in their lives. Could be divorce, could be losing their job, could be not seeing their children. There’s lots and lots of things usually going on.*

*We do assessments, care plans, just help clients really any way we can. Focusing on the alcohol at first, but of course generally every part of a person’s life needs some kind of attention...So very often its mental health, physical health, dependency support, motivational issues, everything really.’*

Several stressed that these complex ‘life issues’ need to be sorted out before recovery and (return to) employment work is possible. They all note that recovery can take a very long time and that the length of the process varies greatly between clients, from a few months for some to three or more years for others (in the case of long term addiction, special needs or complex life issues).

*‘So until detox they wouldn’t be safe, either themselves or the public, to look at employment. Once they go through the system though and they stop drinking, or they go through residential rehab, that gets into the grey water of when are you ready, you know, is that months, weeks, years – it’s very difficult to know.*

*You can’t just expect people just to pick up...the whole culture and the whole way of operating, for an addict, is culturally very different from the culture of work. It’s almost like retraining – you’ve got to retrain behaviour – clients will benefit from CBT and that’s proving really quite helpful. But you can’t just send somebody out from treatment and say ‘right, go get a job’. It’s slow steps....I would say on average it’s about 2 years before somebody gets back to work. I think that would be a much more realistic aim..... for me what I’ve seen the most effective way is longer term working, working closely with someone, but doing it slowly.*

*Part of the problem for people is that there seems to be pressure to get people back into it too quickly...there needs to be a recognition that it’s a longer term process than perhaps some politicians would like to admit.’*

Some professionals were of the view that it is beneficial if clients have continuity of care and support throughout their treatment; individual treatment professionals who get to know them are better able to challenge ‘stuck’ behaviours and attitudes, and can more easily identify potential triggers for relapse.

## 5.2 Engagement, recovery and relapse

### Summary

- Professionals identified financial instability as a major barrier to engaging with support and treatment services either caused or exacerbated by issues around benefit claims, household budgeting and debt.
- Other barriers cited by professionals included the fear of losing benefits; chaotic lifestyles and mental health issues; difficulties with social interaction; denial of the seriousness of their alcohol misuse, pride or stigma; or simply not knowing that help is available.
- A requirement for abstinence might itself be a barrier to engaging with a service, though this was not the case for all the services in this study because abstinence was not necessarily an eligibility criterion for access to them.
- In a few cases clients experienced no significant barriers to engagement, recovery and re-entry into employment; the main facilitator being their own ‘internal resources’.
- Feeling positive, motivated and wanting to change is essential for recovery; a negative state of mind is a significant barrier. Some clients experience serious mental health problems, while others experience anxiety, or a lack of confidence. Mental health issues can also impact on the ability to perform simple everyday functions, which forms another barrier to engagement with services.
- Relapse is common if not inevitable. Potential triggers include the threat of or actual loss of benefits; financial and housing issues; stress around returning to work too soon; bereavement; family problems; the availability of alcohol and the lack of an (alcohol-free) social life.
- For some clients a lack of education, literacy or basic life skills learning difficulties or severe personality problems are risk factors for and barriers to engaging with services, and future employment.



- Women have particular issues and needs including childcare, fear of losing their children, or over time the loss of family life triggering alcohol misuse. Some women experience serious health effects from both their alcohol misuse and the risks associated with sexual coercion.

### 5.2.1 Barriers to engaging with services

Professionals identified a range of barriers to engaging with support and treatment services; some practical or structural (for example the lack of public transport), and some individual to the client. A significant barrier described by some professionals was around financial instability, which caused a great deal of anxiety to clients, and can be a trigger for relapse. Where they were able services helped clients with benefit claims and advice, trying to ensure that they had all that they were entitled to (including housing benefits and utility bill reductions); debt management; and day to day budgeting. For many clients sorting out their finances this was an almost insurmountable challenge, particularly in the case where they had previously been employed and never claimed benefits.

*‘Generally some of these benefits need to be stable and sorted before people actually feel confident to change. And if there’s a problem with benefits, you find that people are very focused on money and can’t look at anything else...most of them are very anxious over anything to do with money.’*

For those who had already been claiming benefits, fear of losing those benefits could be a barrier to engaging with the service.

*‘There’s people that don’t want to come off their benefits so they might think I’m a threat, but I did speak to the PAs and they said no they’ve made it quite clear that it is voluntary that they come [to a ‘surgery’ for alcohol users] it’s not mandatory.’*

(Professional working with Jobcentre Plus, pilot programme)

Other barriers to engaging with services mentioned included not knowing that help is available; chaotic lifestyles (particularly for those with mental health problems; co-existent drug use; or long-standing addiction); alcohol use causing anxiety and difficulties with social interaction; denial of the seriousness of their alcohol misuse, or a reluctance to ‘work on themselves’; pride and stigma.

*‘Some people are very proud and don’t want to get help...wouldn’t want to go to a community access programme. You know, they can do it themselves or should be able to do it themselves, and that can take them quite a long time to maybe work out they need some help, if they ever do.’*

Although the services in this study did not seem to require abstinence as a pre-requisite to engaging in the first instance, it became a requirement for certain services further down the line, for example in supported accommodation or intensive alcohol treatment programmes, and especially as clients moved closer to or into employment. Other services, however, might require abstinence from the outset. Only one of the professionals interviewed (in a user-led service) saw abstinence as an unrealistic expectation:

*‘I also think there are a lot of people who will never achieve the kind of government goal of being totally abstinent, and some people who will struggle substance use problems all their life, for whatever reason, and I think it’s wrong to discriminate against them too, actually they deserve as much a place as anybody else.’*

### 5.2.2 Recovery and the risk of relapse

In terms of recovery and an eventual return to employment it was noted that some clients experienced no significant barriers. In these (albeit rare) cases client's own 'internal resources' seemed to be the main facilitator.

*'And I've got other people, they come in and I see them once, and they're gone. Once I've given them advice about training or this or that, houses, they don't need to see me again because they're okay, they can manage it themselves.'*

All professionals noted the importance of a client's state of mind; they described feeling positive, motivated and wanting to change as essential for recovery, and a negative state of mind as a huge barrier. This might be because the client has a diagnosed mental health problem (including schizophrenia, a personality or social disorder, or more commonly depression) or because they are experiencing paranoia, acute anxiety, or a general lack of confidence. It might also be because a 'void' has developed in their life, through relationship breakdown, the loss of contact with family, loss of a job, or a lack of social contact. Mental health issues can then impact not only on recovery but also on the client's ability to perform simple everyday functions, adding practical barriers to engagement with treatment, benefits or employment services.

*'Anxiety and depression are two major things that end up being big issues for clients. I've seen people who you would imagine to be very confident in their life, but they're not. Even getting on a bus is a problem for them. That's quite common.'*

It may be that mental health problems, and other personality or social disorders, pre-date alcohol misuse, or are the result of (increasing) addiction, or a combination of the two.

*'A number of clients that suffer from depression or mental health related problems...I'd say quite a few, even if it's only mild depression...are they depressed because they're not working or they're drinking or...what comes first? – the chicken or the egg?'*

*'Substance misuse changes your personality – they tend to be more agitated so, they might well interpret what somebody is saying to them as negative and respond accordingly, so they can become aggressive or annoyed or they don't want to engage.'*

Professionals described a range of triggers which can cause panic and stress for clients, and in the worse case lead to a relapse. These included the threat of or actual loss of benefits; debts, housing problems and other financial issues; work issues or stress, particularly if they returned to work too soon; bereavement; family and relationship problems; returning to the same geographical location as pre-treatment; loneliness and lack of a social life; the generally wide availability of alcohol, and its connection with socialising; and previous relapses. Some noted that relapse is common if not inevitable.

*'People can relapse...because something goes wrong in their benefits and they go into debt and they haven't got any food.'*

*'I think there's a real big danger that if they are kind of pushed into going back to work simply full time, you know, too soon that they'll relapse.'*

*'In my experience it's something that people tend to revisit...alcohol is a legal substance. It can be bought pretty much anywhere, it's in your face every time you turn the TV on.'*

Clients who have been dependent on alcohol for a long time may lack 'skills for life' and struggle with day to day tasks which most people would take for granted, for example paying bills on time or eating properly, and they may find it hard to interact socially in appropriate ways, especially in situations where they would have previously used alcohol. Some may also lack a basic level of education or literacy.

*'We help them with basic living skills, there's a lot of people come in don't even know how to... boil an egg ...reading electricity or gas meters.*

*...how to talk to strangers, how to chat to people, you know, how to get by in the world.*

*A lot of clients who have issues with those particular things like literacy – reading, writing and maths – historically come from backgrounds where that runs right through the family...from chaotic backgrounds.'*

Some professionals mentioned their clients with learning difficulties, or severe personality problems, who were attending college, and they seemed to feel it was unlikely that they would enter paid employment:

*'It just gives them some sort of structure so that they have got something to turn up to each week.'*

Women have particular issues and needs: loss of family later in life can trigger or lead to increased alcohol misuse; fear of losing children can hinder engagement with services; childcare responsibilities can affect use of services and employment.

*'Women in their 40s and 50s who have drunk a long time, I have noticed a trend of women that have very good educations, have had careers, but have had a lot of family problems and starting drinking. The family dissolves, there's no longer a career, there's no role in life anymore, and they tend not to do so well...You know, they've had it all. They've also lost it all. They tend to be harder to work with, the underlying belief, you know, what's the point of life.'*

One professional noted that alcohol misuse can have a direct impact on children:

*'A lot of that is safe guarding simply because they are alcohol dependent pretty much throughout the day. You know, they might well be driving the kids to school under the influence, they're not getting up in the morning, the kids are not getting to school, there's not enough money in the house to feed them.'*

Another noted that some women are at risk of serious health effects not only from alcohol, but also from sexual coercion (drug taking, rape and enforced prostitution) when drunk. However crime was not raised as a major issue by the professionals, except in reference to criminal records being a barrier to employment (see section 5.4.1). When prompted on this topic, one explained that in this respect alcohol users differed from drug users:

*'The offending I suppose might well be domestic violence, sexual deviance of some kind, drink driving, fighting outside pubs and clubs...When you're alcohol dependent, your confidence is not that great, so walking into a shop or shop lifting it or you know walking into somewhere and holding the place up at gun point or anything like that, doesn't happen much with that client group. They tend to end up financially in a bad place, you know, they end up where they're not paying their rent, they're not paying out for this, they're not paying out for that, because they just haven't got the money for it. But they haven't got the drive to go out and commit crime.'*

### 5.3 Interaction with the benefits system

#### Summary

- Most clients seen by the professionals interviewed were believed to be in receipt of Incapacity Benefit (IB)/Employment and Support (ESA) or Disability Living Allowance (DLA), with a minority on Jobseeker's Allowance (JSA). Professionals helped clients with benefit forms but did not feel knowledgeable about benefits, and usually referred clients on to specialist advice services.
- Most professionals described positive experiences of jobcentre services, although some acknowledged that clients' experiences were less positive. They reported clients' misconceptions of the benefit system and entitlements, and difficulties caused by their alcohol problems and stress/anxiety.
- Some benefit requirements (including availability, working hours, and levels of benefits) were seen to potentially hinder recovery and return to work
- Most professionals had limited experience of ESA, or knowledge of its impact, although most were positive about its aims. Some negative experiences of the medical assessment were reported, particularly for clients with mental health issues and chaotic lifestyles.
- Withdrawal of benefits was seen as particularly problematic for those with alcohol misuse problems, as the loss of benefits could lead to health problems, disengagement from treatment, and relapse. In addition the payment of backdated benefits in a lump sum was identified as an issue for some recipients, for whom it may trigger episodes of binge drinking.

Only some professionals knew offhand the proportion or number of their clients on benefits, and which benefits. Most of their clients were in receipt of IB/ESA or DLA, with a minority on JSA. Housing Benefit was mentioned by some, usually in relation to its withdrawal. One person mentioned tax credits in relation to a woman with dependent children. A separate DWP report contains estimates of the number of alcohol misusers on benefits (Hay and Bauld, 2010). Benefits issues were described as complex and most professionals refer on to others with specialist knowledge (especially the Citizens Advice Bureau which is praised highly, but overstretched; also jobcentres, and other voluntary agencies such as Shelter). However, many of them said that they would help clients with benefit forms if asked.

Of those who had direct experience of jobcentres, most made generally positive comments about services, and that staff have, in their experience, been quite understanding of clients' needs and circumstances, once these have been explained by the substance use professional. However, they also acknowledge that clients are generally less positive – describing issues with forms, benefit requirements when attending treatment (for example, not being available for work whilst claiming JSA due to treatment commitments) and loss of benefits.

*'They don't understand the forms. I look at the forms sometimes and think what the hell are they trying to say here, and I work with them all the time. ...especially when the majority of the people have got alcohol, because of their life circumstances some of them have got mental health problems too, which include depression and anxiety. And even to read a simple letter doesn't make sense to them sometimes.'*

*If people are thinking of coming onto...a programme like ours, which is a big commitment because it's every day for three hours, they need to be free of any kind of pressures really... Jobseeker's Allowance, they're sort of expected to be there and be available for work or signing on or however they do it.'*

Some said that clients tend to have a lot of misconceptions around the benefits system and entitlements (which is not helped by some unpredictable/variable outcomes).

*'...if you're on incapacity there tends to be a shortfall in your Housing Benefit...a lot of people don't understand that they just seem to assume that if you're on benefit you just get Housing Benefit automatically...you don't have to pay any rent or council tax, there's a kind of misconception that we come across all the time from people.'*

There were also reports of clients' concerns about the rate of benefits they would receive if they returned to work, with some thinking they would be financially worse off. One service felt that although jobcentres could help with this assessment, they might be better placed to do this with their own clients:

*'One of the first things we do, is do a budgeting plan with them, we show them how much they've got coming in and going out, the jobcentre does that with them to as well, but they're maybe not as open with people at the jobcentre about certain things that they're buying (laughs) for instance, and they can be so, you know, we can kind of build up a more accurate picture and usually what you find after you've done that is "wait a minute I've got a wee bit more money than I thought I was going to get".'*

Two professionals noted that clients with alcohol problems may feel negative about these services because of their alcohol use and the effect it has on their state of mind, whether this negativity is warranted or not. Clients can also have an unrealistic expectation about how quickly problems can be sorted out and may not always deal very well with bureaucratic processes (which in turn may lead to increased stress and increase their chances of relapse).

*'It's a bureaucratic system and very often with that client group people want stuff yesterday anyway. So the patience is something which we try and work with....I'll do everything I can to facilitate them going through that system. If I can make a phone call then it will get them through quicker, just to have that conversation, fine. It's a system we live in. It's not just about the benefits system is it? I think that's a fact of life.'*

*We have had cases where clients become frustrated but usually it's because...a client [has] lost benefit or they're not getting benefit, they panic and a lot of clients responses to that are to get frustrated or angry...we can speak on their behalf and get things sorted out as opposed to someone picking up the phone and then slamming it down and not getting anything done.'*

Some benefit requirements were seen to potentially hinder recovery and return to work (for example JSA work availability requirements; minimum working hours for tax credits). Several mentioned clients moving from JSA to IB/ESA, or encouraging them to see their GP in order to do so. One mentioned problems experienced by under 25s in treatment as they receive a lower rate of benefit. One professional also felt that the higher rate of DLA compared to Income Support (IS) would mean that there would be a temptation to spend more money on alcohol (or stronger alcohol).

*'Whatever level of benefit a substance misuser is on, the money will go on the substance.'*

Most made positive comments about aims of ESA, for example for those who were wanting to work and were moving towards it, but not yet in a position to do so, and who would have previously cycled on and off other benefits.

*'There seems to be more emphasis on let's see, obviously, what they can do rather than what they can't do.'*

Several said that as it was 'early days' in relation to the introduction of ESA they had little experience of the new system, or an opinion on its impact.

Professionals also reported that the way individual clients approach and experience the medical assessment (for IB or ESA) varies widely, with some 'taking it in their stride' and others finding it very difficult and upsetting, and that sometimes the outcomes can seem rather arbitrary.

*'It's not really for me to say how ill they are or how ill they aren't, but I thought they've had a fairly good chance at continuing with Incapacity or ESA, but I've been surprised when some of them have come out with me and like a couple of weeks later they've been turned down.'*

Some concerns were expressed around medical assessment in relation to addiction and mental health issues, for example, in the case of clients who present as 'well' on a good day and are deemed able to work; or of those who fail to turn up because of their addiction, their anxiety, or their chaotic lifestyle (or in some cases difficulties with public transport), and then have their benefits cut, leading to anxiety and relapse.

A few professionals noted problems caused by the withdrawal of awards followed by the need to appeal (in one case in respect of a client in treatment who should not have had the benefit withdrawn in the first place).

*'A lot of people don't attend and then get struck off, and then have to go through the whole tribunal thing and then get it backdated, which is never a good thing to have a lot of money in one go for the majority of our clients.'*

One professional gave a detailed account of the impact loss of benefits can have on a client with alcohol misuse problems:

*'Their money gets stopped when they don't go to the...medical assessment. And it's very hard once it's stopped to get it reinstated...the appeal system is harder, especially...they couldn't go to their medical today because they'd been drinking and they'd forgot about it. They didn't even forget about it because they didn't even look at their letter to say that they had this appointment.... When the benefit stops it's a knock-on effect ...Housing Benefit and everything else. And then that takes ages, the letters getting there, then they go to decision makers, then it's this, then it's that, then they get back to them. And this could go, and then they'd have to go to a tribunal which could be three/four months down the line, so say they're on Incapacity Benefit...they've gone on Income Support at 20 per cent reduced rates, and they just can't afford to be living because that gets them back into debt, which means their mental health [gets worse]...so it's a knock-on effect to everything.'*

Some felt that withdrawing benefits or imposing benefit sanctions was particularly unhelpful in the case of those with substance misuse problems:

*'Cutting your benefits because you can't work doesn't seem to work, doesn't motivate somebody to go and get a job, they just put up with less money...it doesn't have the therapy side then because they always feel unsettled and they can get money somewhere...you might do sort of like the last three days before you go to the Post Office you don't drink as much, but then you have a huge binge once you do...so there's that pattern.'*

*If you really hassle people into it, [and] you can do by consistently pulling benefits when they've got no choice, they will go and find some sort of work but the chances of them relapsing is now so much higher, and then you've got to pay for them to go through the treatment system all over again, and with a lower chance of success, you know the more times you kind of relapse and fall apart the less likely you are to kind of complete in some cases 'cos people give up.'*

## 5.4 Employment

### Summary

- Barriers to employment described by professionals included a lack of financial stability, confidence and motivation, and social support. These were also identified as barriers to engaging with services.
- Additional barriers to employment included time out of employment, lack of appropriate work experience and skills, concerns over a criminal record, a 'culture' of not working within the family or locality, and alcohol misuse itself.
- For some being on benefits can be a motivator to return to employment, but for others it can be a barrier. This is particularly the case for older clients, or in areas where employment opportunities are limited or inappropriate, and clients are reluctant to leave the 'safety net' of benefits, as the alternative may be seen as significantly worse.
- It was felt that being 'pushed' into returning to work too soon was likely to be counterproductive, with a high chance of relapse.
- Facilitators to a return to work included a positive state of mind and social support; access to appropriate support services; retraining; and a staged return to the workplace, including 'bridging' services and voluntary work.
- Most professionals felt it was important for clients to 'do something' and to be socialised back into a work environment, even if employment was not initially paid.
- Some clients were seen as unlikely to return to work as their problems were too complex, or their mental health issues were too great.
- Professionals generally had little robust evidence of employment outcomes, apart from one service working closely with Jobcentre Plus. Some gave accounts of clients who had either passed from the service into employment, or had difficulty sustaining themselves in work (see the case examples in Section 5.4.2).

### 5.4.1 Barriers to employment

Many barriers/facilitators to recovery are also barriers/facilitators to a return to work (including the time needed for recovery, financial stability, individual motivation and social support). Other barriers include the length of time out of employment, the lack of substantive work experience, and the need to update skills. There are also some types of employment which may not be possible or appropriate for people to go back to (for example, bar work, teaching or high stress careers).

Most described alcohol misuse itself as a barrier to employment and thought that clients needed to recover from addiction first, before even attempting to return to work. They described this as a lengthy process, in which abstinence is the initial step.

*'I think there is a misconception perhaps amongst the general public and amongst politicians sometimes that all you need to do is stop the alcohol or the drugs and you're finished, actually that's the first part of the process.'*

Professionals described their clients' anxieties about employment and reluctance to return to work, or start working for the first time. This may be because they lack confidence (for example, having a fear of interviews, or anxiety over actually being able to do the work required or the pressure that they would be under); do not see themselves as able to work because of their drinking or ill health;

come from an area where few people work or there is a lack of family or community support; or are likely to relapse due to the prevalence of cheap alcohol and the lack of alcohol-free social activities.

*'A lot of clients, they don't want to work...nobody in their family works, they've never worked, and can't imagine working...and that could be a difficult client group to move on because they're frightened of it.'*

*They say "I'm not strong enough" "I can't work until I get my strength back, stop drinking". It's almost like this hamster wheel going round really.'*

*People living in deprived areas and you say to them "here's your money, don't come back for another two years" and on the way home there's the shop that sells alcohol cheaper than water and they're living a miserable life...And I think that depression, anxiety, alcohol misuse, drug misuse is a kind of natural reaction to that environment, sociologically. There's also the element of, repetition over generations...communities where large percentages of people in families are on these benefits and have been, it's a case of "why should he get it, why shouldn't I?" All that mixed in, it's unrealistic to just accept, in the middle of all that to turn themselves around of their own accord.'*

Some professionals noted that a criminal record can be an additional barrier to employment. However, they did not talk about this in detail, or describe the extent to which this was a barrier for specific clients, and this was not probed. (See the comments in Section 5.2.2 which notes the difference between alcohol and drug users in respect of criminal activity. Section 4.7.5 briefly summarises findings from client interviews relevant to the subject of crime.)

*'They've had huge chunks of time off work, maybe even never worked in their lives. Then of course you've many with possibly criminal records'*

*...you've lost your job, and you've committed some silly criminal offence, and now you've got a criminal record, got trouble getting a new job...'*

For some clients who have previously been employed, being on benefits can be a motivator to returning to employment, but for others it is perceived as an insurmountable barrier. Older clients were felt to be facing a particular challenge.

*'You feel that more if you've worked, so not only can't I work but I'm on benefits and that's wholly how I've gone. So for some people it's an incentive and some people think well there's too much of a wall to climb back up and I might as well not even try.'*

*I think in some people's heads they think that, they just resigned themselves that they're not going to go back to work, and it's really they're own kind of feeling about that stopping them.'*

*So I think, let's be realistic here. I think people in their late 40s/50s are going to struggle [to find a job].'*

Several professionals described how they felt clients saw their opportunities for employment locally as being very limited, and professionals had some sympathy with this view.

*'...the preconception that "I'll be cleaning the streets"...*

*...they've got to do jobs that they see as menial jobs...*

*...the work that might be on offer will be so kind of soul destroying...'*

It was clear that most of the professionals felt that the lack of local employment opportunities was not just a perceived barrier but an actual one in the areas these services operated in. The recession was, not surprisingly, seen to have been compounding existing problems.



*'They're going to have to look for a job, they get fed up doing it because there isn't that many opportunities, there's not that many jobs here.'*

*Where are the jobs? ...if you've got a population of say 50,000 people who have an alcohol or drug issue, we're sobering up those people, but there's only 20,000 jobs – what are the other 30,000 people going to do? I think that that's in any town/city that you go to in Britain at the moment.'*

Some clients were felt to be reluctant to leave the 'safety net' of benefits (particularly DLA), even if they were motivated to go into employment. One professional described the dilemma of a client currently in receipt of DLA.

*'I know someone at the moment who's on DLA and she could get a job, wants to get a job, but because she's never sort of like worked without the safety net of DLA she could give it up and yet she'd get Jobseeker's again but that's half the amount of DLA, and she's sort of umming and erring about it...she would lose Housing Benefit, Community Tax Benefit and the Council Tax stuff, and then if she couldn't actually physically keep the job going then because she never has worked 37 hours a week...and she'd be back then on Jobseeker's, and whereas now she's on, I think it's £210 a fortnight, she gets plus her rent, and if she goes onto Jobseeker's she'd be getting £100 a fortnight and her rent, and that's a bit of a drop isn't it.'*

Aside from financial considerations some professionals expressed concern that available jobs might not be suitable for those who have had substance misuse problems. The type of jobs that were available locally tended to be low-paid and unskilled (several cited supermarket work), and this was seen as a risk for some clients, particularly those with experience of work or qualifications, who might become stressed, frustrated or depressed and resume drinking.

*'A lot of the [traditional] employment these days is gone...so if I put myself in a client role...“I've just sorted out my drinking problem and now I've got my first job working in Asda stacking alcohol on shelves”, do you know what I mean? “How do I get round that?” I think it's a big issue for clients.'*

*They're worried about being stuck in a job where it's going to put a lot of pressure on them and they're not really interested in doing that job, and then they're basically going to end up back to where they started, I think that's the big thing, there's a big fear of failure.'*

Some local employers were mentioned as being supportive of employing recovering clients, but this was not probed in the interviews. Some identified a need for ongoing support for those in employment, including drop-in services but also financial incentives for employers, for example to support a mentoring scheme.

Some felt clients were pushed (or in some cases pushed themselves) to return to work too soon, and that this was counterproductive if it then led to relapse. Professionals stressed that for most clients their alcohol misuse had developed over a long period of time, and that it was therefore unrealistic to expect them to be able to recover quickly.

*'...not overstretching yourself. Because I've had clients go straight back into a job and relapse. And that actually negates everything.'*

*Some people have been doing it since they were teenagers and they're now in their 40s, you know, 12 weeks of key working and a bit of motivational interviewing isn't really going to sort that out, it's going to be a long-term project.'*

There were some accounts of clients' anxiety about returning to work too soon, and strategies they might use to try to manage this pressure:

*‘One of the weird side effects of that is that people go and grossly exaggerate their problems, and I have heard, you know, stories of people not bathing for a week and growing their fingernails and breaking down in tears and twitching and all sorts of stuff, in order to hang on to benefits they need, because they’re not given time to finish the process.’*

Some also gave accounts of clients who had themselves attempted to return to work too soon, in some cases whilst still drinking, and this was generally felt to be risky with regard to the potential for relapse.

*‘Their motivation to get into employment straight away will be financial, or supporting a family or debt or that kind of thing. But they might still be relapsing, drinking, might have just stopped drinking. Very often people when they’ve just stopped drinking they have all the confidence in the world. We know, workers, what can happen...motivation is only part of it.’*

## 5.4.2 Facilitators to gaining and sustaining employment

Some of the perceived facilitators to a return to work were similar to those for engagement with services and recovery from addiction, especially state of mind, social support, and the provision of or referral to appropriate support services.

Additional facilitators identified included (re)training and a staged return to the workplace. Several professionals described a range of education and training opportunities available locally to their clients, including college courses, the progress2work<sup>89</sup> programme and permitted work accessed through the jobcentre. However, they noted that formal training courses needed to be appropriate to clients’ needs, and clients themselves needed to be motivated to take up training, and capable of actually attending.

*‘There’s quite a few things people can access if they really want to.’*

*They have college courses that are specifically for ex-addicts to reintegrate. They start off with something basic – reading and writing – some people hate those courses and other people quite like them*

*I think it’s really really important that they’ve got the support there to do it because I think if they’re on their own there’s a tendency to kind of just give up...because you know they’ve felt “oh I’m ok to do it on my own, I’m feeling independent enough to do it on my own”, but then when they do it the reality is slightly different.’*

Most stressed the importance of ‘bridging’ services, and a staged return to employment, citing part-time voluntary work as being especially appropriate and useful, particularly for those with long-standing addictions and/or chaotic lives. This was seen as helping to build clients’ confidence, improve their social skills, and learn better financial and life skills, which could help to sustain work in the longer term.

*‘You get some experience of working in a structured environment, maybe a day a week, it’s a gradual thing.’*

*They get talking to people who are out of their sub culture ...no one’s been nice to them for so long ...treat them like just a human being again and even that is a big change for them.*

*If they do do part-time work it can also teach them to budget better and manage their money better, so that when they do go into their own tenancy it’s not a case of “I’ve been on benefits for so long so I can only exist on benefits”.’*

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<sup>89</sup> progress2work (and progress2work-LinkUP) are the DWP-funded employment programmes aimed respectively at stabilised drug misusers; and stabilised alcohol misusers, offenders and ex-offenders, and the homeless.

Voluntary placements and training courses were also seen as important for getting clients into a structure of routine. Most thought that it was important that the client 'did something', to enable them to develop a 'more normal rhythm of life' and be socialised back into the workplace.

*'If you start doing more, you get more interested in life itself, and take the substance away then human instinct kicks back in. But I think doing something has got to be the goal.'*

However, one professional acknowledged that some clients are not willing to do voluntary work because it is unpaid, or are unable to because their lives are so chaotic that they cannot get themselves to appointments, or fail to return phone calls.

Success amongst providers in getting their clients back into work will clearly vary according to the client profile for a particular service. Some clients were seen as being highly likely to return to work, with the appropriate support, while others might never do so because their problems were too complex to resolve, or their mental health issues were too great to overcome. In these cases it was felt that neither incentives nor the removal of benefits (or the threat of their removal) were likely to make any difference.

*'Most of the people I've met just have a willingness to go back to work...it might not be in the short term, it might be in the long term before they go back to work, but I've never thought that there's anybody that's come through that there's any reason why they shouldn't be working.'*

*...but others they'll never go back to work, they'll never go back to work because of their situation, because they're just not, they've got mental health problems, they are involved in the community mental health team, they're on DLA. You know, they might, they go to train, I send them to courses or training, they might do that for a week or two but find it too much.'*

The employment outcomes of clients were not probed during interviews so this report contains limited information on that topic, however, the evidence that was collected suggests that the professionals' experiences were mixed.

*'When you think about how many people have actually gone into employment, it's going to be very small.'*

*We've had people that have been referred to [another service] and then have actually got jobs...I don't really have much experience of how they're getting their jobs.'*

*it's surprising how many people have volunteered for us and gone to college, done basic counselling skills course or a drugs awareness course, a few of our training workshops – have gone out and got jobs, I think people can be helped back.'*

*We've had quite a few people go on to get full-time jobs from supported accommodation, so, that's quite good, we've had a few people who haven't as well.'*

One professional who did talk in more depth about employment outcomes was a senior counsellor who had run a pilot project working with Jobcentre Plus Personal Advisers providing a voluntary drop-in 'surgery' at the Jobcentre Plus premises. This involved weekly one-to-one counselling sessions and motivational work with clients, who had come voluntarily on the suggestion of their Personal Advisers.

*'Once we kind of thought that they were kind of in a stable way we would then go back and have a three-way appointment with the Personal Adviser, just to see what was an option for them, and to see how they could get into employment.'*

The professional had personally initiated this pilot, partially out of frustration at the lack of services available for alcohol users, and had been awarded DAF. Out of the 19 clients targeted, nine did not attend for assessment and five relapsed to drinking. The remaining five had successful outcomes (although they were not tracked at the end of the project so it is not known how many sustained employment).

*'The conclusion of it was that it demonstrated it was possible to develop a feasible service with Jobcentre Plus for their customers and in particular a productive working relationship with the Jobcentre Plus Personal Advisers. We've got a fast response service available for the Jobcentre Plus customers and 50 per cent of those who attended the counselling for their alcohol use recorded a successful outcome.'*

Although the professional concerned had been awarded funding to support an extended project for a further year, it was unclear what would happen after that, as the DAF would no longer be available.

Some interviewees used extended examples of one or more individuals who had been through their service, or that they had personally helped to achieve abstinence and employment. Some of these are included here as short case examples. These should not be taken to be representative of their clients or the outcomes of the service, but serve as illustrations of perceived successes.

#### Case example 1:

*'Someone I'd worked with before was a radiographer, married, got into problems, she moved, was isolated, started drinking and...was drunk at work and lost her job. And ...three episodes here, she relapsed after the first two. But after the second one ...she kind of worked out what she needed to do more. Well sometimes [you] can suggest things and people don't take it on board but she kind of put a lot more things to her life and did get a part-time job at a local school doing admin. I think she is doing well and a mixture of classroom support, and she...probably did that for about a year and has now been offered a job as a radiographer with the NHS.'*

#### Case example 2:

*'One of the guys that I've been working with – I would consider him to be a success story because when he came to us he'd been homeless for quite some time, he was of no fixed address for about maybe six years and he'd been sleeping on the street and sleeping on people's couches... we were able to get him on benefits, get him sorted out and get him tied into...various other services, and once he'd been with us for a while and he'd been stable for a while we were able to get him [on a training] course ...he did that for about ten months, and he did a stress management course with them as well to help him deal better with his obsessions, and after he'd done that he tracked down the girl [in the employability service] and he told her that he really wanted to work with computers...he's only finished that, and he's looking from there to go to university to do a librarianship, because he had a degree already in English...and [the employability service] are helping him set all that up...so as far as a plan for like grants or loans and all that – they're going to help him through every stage of that, so that's one of the ones we would consider to be a success story because he's kind of trying to further himself and get out the situation that he's in, get back to work.'*

**Case example 3:**

*'Another one of my women decided, because she had a child, she was going to remain under the day programme. She had a long-standing alcohol problem and the child was at risk of being taken away. She is now a qualified midwife – she chose to go to university and we supported her through some dips – because she was back in the community....She had a bit of a dip – not a relapse – but emotional dip and she phoned me and I just saw her a couple of times and talked about other things she could link into community wise and that really helped her.'*

**Case example 4:**

*'Someone that we had that had been homeless, and he came through our agency and we helped him basically facilitate everything in terms of his move, filling in the forms for a community care grant, making sure that he had his tenancy furnished, making sure that his Housing Benefit was sorted out, but once he'd been in his tenancy, I think he'd only been in his new tenancy about two weeks when he got a job interview and he got a job...so what we did was we went to the jobcentre...[who helped with benefit entitlements]...it's like a one stop shop basically 'cos we got everything done that day, the woman dealt with everything and got it done, she was really good, [the service supported him through sorting out his rent]...he started originally working like 22 hours a week but he's now working full time, and he's getting along great, I think he's just about ready to be promoted, he still keeps in touch with the agency and lets us know how he's getting on.'*

**Case example 5:**

*'I've noticed a big difference in people. The guy that I was talking about earlier on, that I took to the jobcentre to fill out everything so that before he went to his work, the kind of confidence that he's got, he's almost kind of cocky now. Whereas before he was quite a shy kind of retiring guy that wouldn't say boo to a goose, but [getting a job] really has helped him leaps and bounds with his confidence. Also his social circle as well, he's got more friends, like before he was quite isolated, and also money wise, you know, he is managing his money really really well, and he's taking a pride in his house. He's actually doing really well, he's not been drinking and all that as well, so I think it's gave him focus as well. So it's like loads of different things, you could actually say getting a job helps, and people just sometimes look at the financial side of things, but it's other things that you get from it. I think he just has a respect for himself now that he didn't have before.'*

Professionals also gave examples of clients who had returned to work, but who they felt might struggle to stay in employment, or had not been able to do so.

**Case example 6:**

*'I've got one who just started a job...and I've got significant concerns about how she's going to cope with that. But she's determined to do it, so...she's not demonstrated that she can stay sober for more than a week for a start...But she is absolutely determined to go through with it, so I'll support her with it and then be there when, if and when, things happen.'*

Interviewer: *'Is her employer aware of her [alcohol problem]?'*

*'I don't think she mentioned it at the interview, no!'*

**Case example 7:**

*'He struggled a bit...because he was having problems with his relationship at the time as well, and also because of that he was homeless...so he came into one of our supported accommodation flats and we worked with him, but...where he was quite happy to be driving around and doing the [driving] job and doing the deliveries and things like that, it became a bit too much pressure for him, he was getting asked to be here and be there in a shorter time, he could do that in half an hour where maybe he was taking 45 minutes, I did speak to him afterwards and he kind of did really have a bad relapse, and then that's when we got him into one of our flats and worked with him and got him sober again, he's now in his own accommodation.'*

*[So did he give up that job?]*

*'Yes, well he had to give it up because the employer was 'no alcohol'...he actually gave the guy a chance, he normally wouldn't take anybody that had an alcohol problem, because the guy was so good at what he was talking about and things like that he says "ok I'm willing to give you a chance", I don't think he'll be willing to give anybody else a chance after that.'*

**Case example 8:**

*'One guy a while back, he'd relapsed quite a few times, just after moving into his own tenancy and he was applying for jobs and he wasn't getting them, and he eventually got a job and you know he was doing a lot of shift work and when he wasn't working he was kind of drinking, and I'd actually questioned him "are you sure you're ready to do this because, obviously with driving any machinery...because it's going to take it's toll on you eventually, it might not be right now but eventually it is going to start taking it's toll on you", and it ended up that he did have to kind of take time off work, he went back, he eventually went through a detox again, I think he took some time off work but not a lot, and he ended up going back to work...he's still somebody that gets in touch with the agency from time to time, as far as I'm led to believe it's been a kind of pattern with him, the drinking tends to get in the way, and it might be that that guy actually needs to take a step back just now, but I'm not the one to say that to him, he's got to decide that for himself.'*

Most professionals stressed how it is extremely hard for some clients to recover and regain a 'normal life' when they are facing multiple, complex problems, of which their alcohol use is both catalyst and a compounding factor. Some used hypothetical scenarios as illustration:

*'I've often asked people "imagine yourself for a moment, that you have had a problem, and so you become divorced and your partner won't allow you access to your kids, and you've lost your job, and you've committed some silly criminal offence, and now you've got a criminal record, got trouble getting a new job, you need to find somewhere to live, your family aren't talking to you because you've annoyed them, you're quite isolated, and imagine the effort it would take to put, to sort that out in your life, put all those things back together, so you've got your self esteem back and you've got a functional life, and now add a serious substance misuse issue on top of that", it's not a bad generic example of where most people are when they enter the system, because for me there's a simple truth, you know, people like drugs and alcohol, they don't access treatment until they're in real trouble, no one does it until...they stop having fun.'*

## 5.5 Gaps and issues in service provision

### Summary

- Most professionals were generally positive about their own services, and about integrated working with other services, the voluntary sector, benefit agencies and jobcentres. Some felt more targeted provision of benefits advice would be helpful.
- Some highlighted a lack of information and awareness of other services among professionals and clients. Concerns were expressed around planned reorganisation of services, and the general lack of resources hampering provision of extended services.
- Professionals generally felt there was a lack of alcohol services. Specific gaps included outreach; aftercare; out of hours services; family therapy; and services targeted at binge drinkers and young people.
- Some also raised the issue of a lack of early intervention and ongoing support in the workplace.
- Most argued for a wider view of treatment, to include social support and help with living an alcohol-free life.

During the interviews professionals were asked if they felt there were any gaps in services, or anything that they felt could be improved. Most were very positive about their own services, particularly where they were able to offer an innovative service, or fill a gap in local provision.

*'I don't think there are any problems with the current service...I think it's fantastic that we're able to offer...the intensive day programme. It's the first time there's ever been anything like this in [this district], an abstinence programme.'*

Many were also positive about integrated working with other services, the voluntary sector and jobcentres. Most felt that those working in jobcentres tended to be understanding of clients' issues, once they had been explained to them (for example by the substance misuse service). Some felt there was a shortage of benefit advice services in their area, with many services having long waiting lists, and suggested that it would be useful to have advisers come to their service on a regular basis to provide information to themselves and their clients, and an opportunity to ask questions. One service had done just this:

*'She's actually came out to this office and done presentations for staff and also for some of the clients, we've invited a kind of open meeting sort of thing, we've invited some of the clients in to kind of give them like an open forum to ask questions about benefits and stuff like that so that's been quite useful as well.'*

Some comments were made about there being a lack of 'joined-up' services, or an awareness of what was available locally (to clients and professionals). In some cases integrated working seemed fairly new, and although welcomed it was unclear what specific benefits had been identified.

*'It's only just really starting to come together, things like our weekend stuff, like education training in employment departments, like definite links with housing, social housing, supported housing, rent deposit schemes.'*

Concerns were expressed by some over recent or planned changes arising from the reorganisation and amalgamation of services. Some felt there was a general lack of resources, time and staff capacity in their own service and in others (including rehab services). One professional felt that the quality of services might be compromised, for example, with the use of under-qualified staff. Others

felt they were restricted in extent (for example, the ability to offer one-to-one services) or reach (for example, outreach or preventative work).

*'We don't have the time or room to do drop-ins, and some people need to engage on an informal basis because they're so chaotic but there just aren't the resources. And there's a huge unmet demand for alcohol, and we're only able to give them six sessions, unless they're prepared to join the group...brief intervention, and we've got a long waiting list...we don't really go and do any outreach.'*

Some specific gaps were identified in services generally, including aftercare and services in evenings and at weekends (one service provided weekend support, and this was 'peer-running designed'); family therapy; specific services for binge drinkers; and appropriate services for young people. Several expressed a need for more alcohol treatment services generally, which is perceived as a bigger problem than drug use (some examples were given by one professional of people who could sustain work while using prescribed methadone or even heroin, but the consensus among the professionals interviewed seemed to be that alcohol users needed to be alcohol-free to sustain employment. (See Section 5.2.1.)

*'I'd almost start a whole new service around alcohol if I could because I think it's such a massive problem...and you can work with people here for three months, but meanwhile you've also got all the other family members at home, you've got the children...we just need more, it's just scratching the surface of treatment for alcohol. Family therapy, all of that kind of stuff, I think there should be so much more help. I mean I don't think it's just that there's a gap here, there's a gap absolutely everywhere now.'*

*Traditionally weekend services don't exist because they're expensive and time consuming to run, it's never made much sense to me that the standard treatment system work nine to five Monday to Friday, as if there's no need for support advice help or information at any other time, so if you like we fill in that gap, especially the weekend...the drug treatment system doesn't work very well, the first part is brilliant but there's no aftercare...on-going support...we cut people loose a bit early I think. And it needs to be a lot more intensive than it is.'*

Some professionals noted a lack of preventative early intervention in the workplace, and the danger of a 'revolving door' situation, where clients relapse, cannot sustain employment and move back onto benefits or into treatment. Others mentioned that clients were often unsure what to do when dealing with their employer over their alcohol problems, and might benefit from advice or support at this stage.

*'Usually I'm seeing [the client] at that point where their manager's found out or [they are] at the stage of "should I tell him?"'*

*Well they're, maybe it's the absence, absence management that are finding it out, if they're having lots of days off or things like that, for whatever reason they seem to think if they put their hands up to an alcohol problem that's going to save their job.'*

Most professionals expressed a need for a wider view of treatment, to include more social support and development of the skill of living without alcohol whilst also surrounded by it.

*'So there needs to be a, not only a, refocusing perhaps of government monies to increase treatment services but also to have a much broader view of how you deal with someone who has, whose life has revolved around a substance, what do you do then when they don't have that anymore.'*



## 6 Conclusions and recommendations

This report has reviewed the literature on alcohol misuse, employment and benefit uptake and explored the views of clients of alcohol treatment services and professionals working with these services. A number of key themes and issues emerge from the study and there is a clear relationship between the literature and our empirical findings, as well as important gaps where more research is needed. In this section of the report we reflect on these issues under three broad headings:

- the profile of alcohol misusers;
- alcohol misuse, unemployment and the benefit system;
- the transition from benefits to employment.

We conclude the section with recommendations for policy and practice.

### 6.1 The profile of alcohol misusers

The qualitative study recruited a diverse range of alcohol treatment service clients from five research sites across England, Scotland and Wales. Of the 53 individuals interviewed 38 were male and 15 were female. The age range of the sample was broad, from 22-63 years of age, with the majority being over 40 years of age. The achieved sample reflects the gender and age profile of alcohol treatment service clients in the UK, where the average age of treatment uptake is 41 (ANARP, 2005, Department of Health, 2010). However, participants in this study were not necessarily representative of all alcohol treatment service clients in the UK.

All the study participants were engaged with treatment services at the time they were interviewed. Length of time in treatment varied and approximately one-third of the sample was abstinent at the time of interview. Whilst there was a great deal of diversity across the sample there were also key areas where certain characteristics were more prevalent. Almost all interviewees were unemployed at the time of interview, with many having been unemployed for long periods of time. The relationship between alcohol misuse and unemployment in our study is supported by much of the literature that we reviewed (Moskowsky, 2008; MacDonald and Shields, 2004; Sutton *et al.*, 2004). Despite their current unemployed status, many of the interviewees had long and varied employment careers, often spanning many years, and expressed a positive attitude towards work. Alcohol misuse was often the main reason for unemployment, although it also sometimes escalated after redundancy. Interviewees talked about the breakdown of significant relationships, often as a result of their alcohol misuse and other problems. Many of the sample were single and lived alone, often in some type of rented or supported accommodation. There were mixed experiences in terms of childhood, family life and education, but experiencing problems during childhood or whilst at school (for example, family break-up or bereavement, living with parental alcohol problems, or bullying or other problems at school), and leaving school with few or no qualifications, were common characteristics across the sample. However, some interviewees were highly qualified.

Two broad alcohol misuse trajectories can be identified from the testimonies of the interviewees. The first group are those whose alcohol problem developed during their younger years. Some of this group had started drinking normally and experimentally, whilst others developed problems as a result of exposure to alcohol problems, for example parental drinking or workplace alcohol

culture. The other group developed their alcohol problems over much longer periods of time, or had alcohol problems heighten in response to a particular trigger, or series of events, when much older. Sometimes this later development of an alcohol problem was linked to a workplace alcohol culture, but other common influences included bereavement (sometimes multiple bereavements), redundancy or unemployment, marriage breakdown and mental health problems. This is consistent with findings from the literature which suggests that those seeking help for alcohol problems are more likely to have taken this step after experiencing a range of other problems in their lives (Proudfoot and Teeson, 2002, Hajema *et al.*, 1999). The complex links between alcohol misuse and other problems, particularly mental health problems, was also highlighted in interviews and is apparent in the literature identified in our review (Barnett *et al.*, 2007; Zabkiewicz and Schmidt, 2007, Weaver *et al.*, 2003; Menezes *et al.*, 1996).

Overall, the problem drinkers that we interviewed appeared to have had similar experiences to other alcohol misusers described in the studies we reviewed (Jane-Llopis and Matysina, 2006; Bongers *et al.*, 1997; Feuerlein *et al.* 1994). A complex picture emerged of individuals facing problems in a range of domains, ultimately dominated by their alcohol misuse, which had prevented them from returning to work.

## 6.2 Alcohol misuse, unemployment and the benefit system

All but one of the treatment service clients that we interviewed for this study was accessing Department for Work and Pensions (DWP) benefits. However, the length and nature of respondents' periods of unemployment and benefit uptake did differ. The professionals that we interviewed confirmed a varied pattern of work and worklessness amongst service clients, with some accessing treatment while in work, or working successfully (often in professional or senior positions) for a number of years whilst coping with their alcohol misuse problem, and then eventually losing their employment. The relationship between job loss or absence from work and alcohol misuse is confirmed in some of the literature we reviewed, with alcohol misuse having a negative relationship with employment (Hoder and Blose, 1991; Montgomery *et al.*, 1998; MacDonald and Shields, 2004). Other interviewees had been unemployed for long periods, or had worked sporadically in informal, unskilled employment and had accessed benefits over a number of years.

Interviewees in the study were in receipt of a range of benefits, including Incapacity Benefit (IB), Disability Living Allowance (DLA), Income Support (IS) and Jobseeker's Allowance (JSA). A few interviewees were in receipt of the new benefit, ESA or were in the process of applying for it, or appealing against the decision from their medical assessment. Clients identified a number of reasons for why they were claiming particular benefits, not all of which were alcohol-related, with mental and physical health problems playing a prominent role.

Our study explored, in some detail, people's experiences of claiming and receiving benefits, from the perspective of treatment clients and professionals. Clients had been directed towards particular benefits by a range of sources including family, treatment service staff, GPs, support agencies such as Citizens Advice Bureau and also through Jobcentre Plus. At least one client had gone directly to Jobcentre Plus and discussed their drinking with staff there, explaining their need to access benefits as a result of it. Treatment agency staff and other individuals working with these agencies had an important role to play in assisting their clients in making enquiries concerning benefits, filling in forms, attending interviews and assessments, and supporting clients when problems accessing benefits occurred. Clients had encountered a number of challenges in 'negotiating' the benefit system, in line with the small number of UK studies that have examined this issue in relation to adults with substance misuse problems (Bauld *et al.*, 2009a; Sutton *et al.*, 2004; Cebulla *et al.*, 2004). Problems included delays in moving from one benefit to another (for example from JSA to ESA), problems with medical assessments for eligibility for ESA or IB, delays in appeals, and issues

to do with completing forms and obtaining information over the telephone. Professionals reported that delays or appeals concerning their benefits had contributed to some of their clients relapsing to alcohol use as a means to cope with the stress resulting from the financial uncertainty they experienced. However, the adults with alcohol misuse problems who participated in this research were generally positive about Jobcentre Plus, perhaps more so than the problem drug users from our previous study (Bauld *et al.*, 2010). A number had received helpful support and advice from Jobcentre Plus staff, and the professionals interviewed also noted good relationships between Jobcentre Plus and treatment agencies, although closer working was recommended, a point to which we return in Section 6.4.

### 6.3 The transition from benefits to employment

Despite the fact that the clients interviewed in this study were almost all unemployed, the majority were eager to return to work in the future. Their aspirations to re-enter the labour market were, in general, stronger than those expressed by the problem drug users we interviewed in our previous research (Bauld *et al.*, 2010). The exception to this was some older treatment service clients who were not confident that they would be in a position to find work again in the future. Their hesitancy was related at least in part to health issues, and/or prioritising spending time with or supporting other family members.

Despite their desire to return to work, however, the clients we interviewed also expressed concern about a number of problems they had encountered or felt they would encounter when moving off benefits and into work. These concerns and those expressed by the professional interviewees are not dissimilar to those identified in the literature. Studies have found that adults with alcohol misuse problems face more barriers to moving off benefits and returning to employment than those who are not dependent (Morgernstern *et al.*, 2003). Studies in the USA have identified educational barriers, low work experience, housing, transportation, childcare, physical and mental health, domestic violence, legal problems and child welfare issues as barriers, and research in the UK has identified similar issues (Morgernstern, 2003; Cebulla *et al.*, 2004).

What was clear from our qualitative research was that alcohol treatment service clients and the professionals who supported them agreed that completing treatment was a necessary first step on the route back towards employment. However, even with positive treatment outcomes there were a range of other issues that clients needed to address before they were in a position to move towards re-entering the labour market. As Dean found in his study of welfare to work for those with complex needs (including some alcohol users): *'by and large participants embraced a desire – often a strong desire – to access the labour market. However, many were also conscious of the need to address their other problems and needs, including and particularly needs for housing, medical treatment or health care'* (Dean, 2003, p.444). Dean advocates a 'life first' approach to employment-related interventions. This requires effective cross-referral and good working relationships between a range of agencies (South *et al.*, 2001; Gossop and Birkin, 1994). The professionals we interviewed were positive about the benefits of closer working relationships between Jobcentre Plus and treatment services, but further research is required to examine how this is working in practice, and, where it is not currently taking place, how best to facilitate it.

The clients and professionals we interviewed also pointed out that training and voluntary work were important steps towards future employment. This echoes findings from other studies (Bauld *et al.*, 2009a; Sutton *et al.*, 2004; Spencer *et al.*, 2008). The professionals we interviewed emphasised the importance of a staged return to employment that could involve voluntary work and then, if available, appropriate part-time work. Some concern was expressed about the lack of employment opportunities in some of the areas in which our research took place, where unemployment rates

were high. Clients also pointed out that the benefit system could serve as a financial disincentive to re-enter work, with fear of the 'benefit trap' (benefit payments being higher than household income in employment), a feature for some interviewees, particularly those in supported accommodation.

Research has also shown the adults with alcohol misuse problems, once in work, are less able than others to sustain employment (Zabkiewicz and Schmidt, 2007). Thus, access to longer-term support is likely to be important for alcohol misusers who are re-entering (or entering for the first time) the world of work. During the course of our research we were unable to identify any studies that had explored longer-term employment outcomes for adults with alcohol misuse problems after leaving treatment and accessing work. In our view this is an important research gap and future work on this issue could provide valuable lessons for policy and practice.

### 6.4 Recommendations

A number of potential recommendations for policy and practice emerge from this study. These relate to the following issues:

- treatment, recovery and employment;
- additional support from Jobcentre Plus staff;
- mandation to treatment;
- interagency working.

The recommendations are intended to provide some practical suggestions for solutions to issues identified within the report. The current uncertainties about cost reductions within the public services may impact upon what can be implemented. Jobcentre Plus have been developing a range of initiatives to support this group. This includes Developing our Advisory Service, which has been tasked with delivering a strategy to enable all advisers to work with as wide a group of individuals as possible, including those with substance misuse issues.

#### 6.4.1 Treatment, recovery and employment

A finding from our qualitative study and the literature we reviewed is that engagement with and completion of treatment is an important first step on the route back to employment. Successfully abstaining from drinking is an important outcome of most treatment programmes. In many cases abstinence can facilitate an eventual return to work (although there is an evidence gap in relation to the longer-term outcomes for clients who complete a treatment programme). However, the distinction between 'completion' of treatment and 'recovery' (which is a much longer process) is not clear and varies between individuals. The professionals we interviewed reported that recovery can take a few months for some clients and several years for others. It is recovery, rather than treatment completion, that is a key component of coming off benefits and securing employment. Recovery involves having other life issues, such as housing, and mental and physical health problems, addressed in combination with alcohol misuse. Interventions and policies need to recognise this distinction.

In relation to benefits, some of the studies we reviewed found that dealing with an addiction can impair an individual's ability to comply with administrative procedures (Mulia and Schmidt, 2003). Our qualitative research also found that fear of or actually losing their benefits can cause stress and, in some cases, cause relapse to drinking.

A recommendation from the research, therefore, is to consider a recovery allowance that could be accessed by those who are undertaking or have recently completed a treatment course for

alcohol or drug addiction and are preparing for a return to training or employment. This should involve a relaxation of benefit conditionality, and would assist individuals in focusing on recovery and moving forward with more confidence and less fear of hardship. When a return to employment looks possible, the alcohol users and professionals we interviewed advocated a step-wise approach starting with voluntary work, part-time work or work experience to provide a gradual reintegration to the workplace.

Some interviewees in our study were reluctant to leave the ‘safety net’ of benefits even if they were motivated to go into employment. This was particularly an issue for those accessing DLA who were concerned about moving onto JSA and losing access to the other related benefits (such as Housing Benefit) that accompany DLA. An issue for policy, therefore, is to consider how to incentivise individuals to aim for employment by providing a better transition to work than JSA currently offers for those moving off longer-term benefits.

As noted above, studies are needed that explore what happens after treatment and, in particular, what role abstinence plays in helping those leaving treatment to gain and sustain employment.

#### **6.4.2 Additional support from Jobcentre Plus staff**

Our research identified a number of barriers to both accessing appropriate benefits for treatment service clients and moving off benefits. The professionals we interviewed, in particular, felt that alcohol treatment clients needed better access to those with specialist knowledge (Citizens Advice Bureau or Jobcentre Plus staff, for example) in order to help them successfully negotiate the benefit system and access the most appropriate benefits and employment support.

Sources of stress that were identified by the treatment service clients in our study included dealing with different individuals each time they visit the jobcentre and having to explain their circumstances repeatedly. Dealing with staff who they perceived did not have sufficient understanding of, or empathy with, their situation to be able to provide them with the advice and support they felt they needed was also mentioned as a source of stress. It is our view that more could be done to ensure that advisers working with this client group have the necessary skills and knowledge to be able to respond to their needs and support them effectively during their journey back to employment. One model of working could be a caseload system in which alcohol misusing customers see the same Jobcentre Plus adviser every time they visit. This would help to improve the experience for this group by removing the need for them to repeat often sensitive and difficult information about their circumstances to different advisers.

#### **6.4.3 Mandation to treatment**

Findings regarding the merits of linking benefit receipt to engagement with treatment were varied. We identified a small amount of relevant evidence on this issue from the literature, all of it from the US. What this literature tells us is that firstly, the receipt of benefits does not encourage or increase alcohol dependency (Stevenson, 2002). Alcohol misuse can cause unemployment which may result in being on benefits, but it is not the benefit receipt in itself that causes or escalates alcohol misuse. Secondly, the US experience suggests that when treatment is a mandated part of welfare receipt, more adults with substance misuse problems do engage with it than would otherwise be the case (Schwartz *et al.*, 2004). However, termination of benefits for those who fail to comply with a treatment regime can have negative consequences (in terms of health and homelessness, for example) particularly in the short term (Schwartz *et al.*, 2004).

Findings from our qualitative research suggest that mandating treatment as a condition of benefit receipt may be counterproductive. The professionals we interviewed stated that the threat or actual loss of benefits (i.e. moving from one benefit to another, appealing a decision about eligibility) was

a trigger to relapse for some of their clients. They and clients felt that compulsion was likely to be counterproductive. Individuals need to be motivated to engage with services and motivation is an important determinant of successfully completing treatment. In our view, therefore, there is inadequate evidence from either the literature or qualitative research to support the view that making treatment a condition of benefit receipt would improve treatment outcomes for clients or result in more alcohol misusers re-entering employment.

#### **6.4.4 Interagency working**

One of the clearest findings from our study is that interagency working can result in better support for adults with alcohol misuse problems and better access to future training and employment opportunities. Findings from our literature review and interviews are consistent on this point. Adults with alcohol misuse problems have multiple needs and as Gossop and Birkin (1994) point out ‘*a comprehensive and effective national response to drug and alcohol problems must extend beyond the health care sector.*’ A previous review commissioned by the DWP highlighted that much more could be done to improve links and partnership working between treatment and employment agencies (Sutton *et al.*, 2004). Findings from our qualitative research suggest that some progress has been made in this regard – with professionals in particular highlighting recent improvements in joint working between Jobcentre Plus and treatment agencies. However, problems were still evident with clients and professionals indicating a lack of awareness of what employment-related services were available locally.

One model for consideration for increasing interagency working is the introduction of regular Jobcentre Plus outreach sessions in treatment provider premises, possibly undertaken by dedicated advisers who have a remit to work with adults with substance misuse problems. Some of the professionals interviewed suggested that the introduction of such services, in which both treatment professionals and clients could ask questions of Jobcentre Plus staff, would be valuable. There is some additional evidence from the literature that offering intensive case management that combines treatment with other support to improve access to a range of other services can improve outcomes (including employment-related outcomes) for adults with alcohol misuse problems (Morgenstern *et al.*, 2009; Diver and Dickson, 2006, McLellan *et al.*, 2003). By bringing Jobcentre Plus services to adults with substance misuse problems in a familiar environment, the chances of them accessing this support and engaging with it in a positive way could be increased.

# **Appendix A**

## **Prevalence of alcohol misuse, unemployment and benefit claimants, by study area**

**Table A.1** Prevalence of alcohol misuse, unemployment and benefit claimants, by study area

| Region     | Study area     | Mortality: alcohol related 2009 <sup>1</sup> (per 100,000) |        | Mortality: alcohol attributable 2009 (per 100,000) |        | Hazardous drinking (synthetic estimates) 2009 <sup>2</sup> | Harmful drinking (synthetic estimates) 2009 | Unemployment rates (modelled) 2007/08 <sup>3</sup> | Incapacity Benefit/ Severe Disablement Allowance recipients Aug 2008 |
|------------|----------------|--|--------|--|--------|--|---|--|--|
|            |                | Male   | Female | Male   | Female |  |   |  |  |
| Wales      | A              | 15.0   | 7.6    | 37.0   | 14.5   | n/a  | n/a   | 5.3%   | 4.7%   |
| South West | B (1)          | 8.4  | 4.0    | 31.5   | 10.8   | 19.3%  | 3.9%  | 3.0%   | 3.1%   |
|            | B (2)          | 9.6  | 3.1    | 29.5   | 14.3   | 19.1%  | 4.0%  | 3.3%   | 3.8 per cent   |
| South East | C              | 8.3  | 3.0    | 25.2   | 12.1   | 22.9%  | 5.5%  | 5.4%   | 3.6%   |
| North West | D              | 19.1   | 11.9   | 50.8   | 23.6   | 22.4%  | 7.2%  | 6.7%   | 6.9%   |
| Scotland   | E <sup>4</sup> | 23.5   | 10.7   | n/a  | n/a    | n/a  | n/a   | 5.0%   | 6.3%   |

n/a = figures not available.

<sup>1</sup> Source: *Local Alcohol Profiles for England*, North West Public Health Observatory, December 2009. <http://www.nwph.net/alcohol/lape/> and *A profile of alcohol and health in Wales*, National Public Health Service for Wales, March 2010. [http://www2.nphs.wales.nhs.uk:8080/ProjDocs.nsf/1f8687d8da97650980256fa30051b0be/0400558233b1c95c802576ea00407a33/\\$FILE/Alcohol%20and%20health%20in%20Wales\\_WebFinal\\_E.pdf](http://www2.nphs.wales.nhs.uk:8080/ProjDocs.nsf/1f8687d8da97650980256fa30051b0be/0400558233b1c95c802576ea00407a33/$FILE/Alcohol%20and%20health%20in%20Wales_WebFinal_E.pdf)

Welsh mortality figures are approximate as the source data is not available, and represent averages for 2002-2006.

<sup>2</sup> Based on 2005 figures, source: *Local Alcohol Profiles for England*, December 2009. <http://www.nwph.net/alcohol/lape/>

<sup>3</sup> 'Synthetic estimate of the proportion (%) of adults who consume at least twice the daily recommended amount of alcohol in a single drinking session (that is, 8 or more units for men and 6 or more units for women). Estimates originally produced for the Department of Health (2003-2005).'

<sup>4</sup> Source: Office of National Statistics: Regional trends, March 2010. [http://www.statistics.gov.uk/downloads/theme\\_compensia/RegionalSnapshot/Directory.pdf](http://www.statistics.gov.uk/downloads/theme_compensia/RegionalSnapshot/Directory.pdf)

IB percentages calculated from UK population statistics.

[http://www.statistics.gov.uk/downloads/theme\\_population/mid-2008-improved-migration-revised-13-05-10.zip](http://www.statistics.gov.uk/downloads/theme_population/mid-2008-improved-migration-revised-13-05-10.zip)

<sup>4</sup> For area E alcohol related mortality is calculated from UK population statistics (169,800, source as note 3) and number of deaths (58, for men and women = 34.2 per 100,000, adjusted in same gender proportions as for Scottish total, source: General Register Office for Scotland. <http://www.gro-scotland.gov.uk/statistics/deaths/alcohol-related-deaths/index.html>)



# Appendix B

## Comparison of definitions for alcohol misuse

**Table B.1 Comparison of definitions for alcohol misuse**

| Source  | Definitions used   |
|---|--|
| World Health Organisation (1994). <i>Lexicon of alcohol and drug terms</i>  | <p><b>Hazardous drinking:</b> people drinking above recognised ‘sensible’ levels but not yet experiencing harm.</p> <p><b>Harmful drinking:</b> people drinking above ‘sensible’ levels and experiencing harm.</p> <p><b>Alcohol dependence:</b> people drinking above ‘sensible’ levels and experiencing harm and symptoms of dependence.</p>   |
| Department of Health (2005). Alcohol Needs Assessment Research Project (ANARP)  | <p>Recommended daily limits in terms of units of alcohol:</p> <p>3-4 units per day regularly for men (21-28 per average week)</p> <p>2-3 units per day regularly for women (14-21 per average week)</p>  |
| Cebulla, A. et al. (2004). <i>Drug and Alcohol Use as Barriers to Employment</i> . DWP research report W193   | <p><b>‘Problematic drinking’:</b> 50+ units for men, 35+ for women. (Executive Summary pg iv.)</p>   |
| ONS UK General Lifestyle Survey: Smoking and drinking among adults, 2008  | <p><b>Measure for alcohol consumption used:</b></p> <ul style="list-style-type: none"> <li>• average weekly alcohol consumption</li> <li>• maximum amount drunk on any one day in the previous seven days</li> </ul> <p>Maximum recommended weekly amounts = 21 units for men and 14 units for women.</p> <p><b>Two levels of consumption reported:</b></p> <p>Those exceeding 4 units (men) or 3 units (women) on their heaviest drinking day.</p> <p><b>Heavy drinking:</b> more than 8 units (men) or 6 units (women) on at least one day during the previous week.</p>   |
| Drinkaware (2008). <i>Alcohol and your health</i>   | <p><b>Binge drinking</b> a sub-category of hazardous drinking</p> <p>8 units for men and 6 units for women on any one occasion (Drinkaware, 2008).</p>   |
| Midanik, L (1999). ‘Drunkenness, feeling the effects and 5+ measures’. <i>Addiction</i> 94 (6) 887-897  | <p>Most common definition of <b>binge drinking</b> used by alcohol researchers: 5 or more drinks in one sitting.</p> <p>Midanik:</p> <p>Impossible to identify the source of this definition. Not a good predictor of social consequences and alcohol-related harm – too many variables (body mass, tolerance and hereditary factors) determine how the individual is affected by alcohol not just units of alcohol consumed. (Frequency of drunkenness probably more accurate).</p>   |
| McManus, S., Meltzer, H., Brugha, T., Bebbington, P., and Jenkins, R. (2009). <i>Adult Psychiatric Morbidity Survey, 2007</i> . The NHS Information Centre. | <p><b>Hazardous drinking:</b> an established pattern of drinking which brings the risk of physical and psychological harm. Measured using AUDIT (score of 8 or more).</p> <p><b>Harmful drinking:</b> those with the most hazardous use of alcohol, where damage to health is likely. Measured using AUDIT (score of 16 or more).</p> <p><b>Alcohol dependence:</b> defined by the International Classification of Diseases (10th edition) as a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use. Measured using AUDIT (score of 10 or more) and SADQ (score of 4 or</p> |

# Appendix C

## Measures of alcohol misuse

**Table C.1 Measures of alcohol misuse**

| Measure   |  | Version                                     | Studies using this measure (or combined measures)   |
|-----------|--|---|---|
| DSM       | <i>Diagnostic and Statistical Manual of Mental Disorders of the American Psychological Association</i><br>Diagnoses of ‘abuse’ or ‘dependence’   | DSM-III                                     | Catalano <i>et al.</i> (1993). US.<br>Mullahy and Sindelar (1996) US (revised version using 3 of nine symptoms, also measure of ‘heavy drinking’ noted above).<br>Claussen (1999) Norway (+ AUDIT).   |
|           |  | DSM-IV                                      | Burns and Teeson (2002). Australia.<br>Booth and Feng (2002) US (Fulfilling only one of the DSM-IV criteria for dependence; also used measure for number of drinks on an average drinking day).<br>Morgernstern <i>et al.</i> (2003). US.<br>Ries <i>et al.</i> (2004). US (also active substance use in last 6 months).<br>Turner <i>et al.</i> (2006). US.<br>Barnett <i>et al.</i> (2007). UK.<br>Johansson <i>et al.</i> (2007). Finland. |
|           | Problem drinking screener developed by the authors.  | ‘Tied to’ DSM-IV                            | Feng <i>et al.</i> (2001). US.  |
|           | National Survey of Drug Use and Health (NSDUH) questions   | ‘Mirror’ criteria listed in DSM-IV          | Brucker (2007). US.   |
| GGT*      | Serum Gamma-glutamyl transpeptidase (also Gamma-glutamyl transferase)<br>Levels used as a marker of alcohol-related health problems. Raised serum GGT can be indicative of factors such as some medications or neurological disorders. Also indicates pancreatic and liver disease associated with longer-term heavy use of alcohol. |   | Lee <i>et al.</i> (1990). Scotland.   |
| ASI (US)  | <i>Addiction Severity Index</i><br>Measures ‘level of discomfort’ in 7 problem areas, including alcohol use. The categories are ‘rated for severity’   | 5th edition<br>(none given)<br>(none given) | McKay <i>et al.</i> (1998). US.<br>Metsch <i>et al.</i> (1999). US (plus whether used >30 days ago; no use; or used in past 30 days).<br>Swartz <i>et al.</i> (2004). US (‘addiction’ and ‘drinking to intoxication’).  |
| Continued |  |   |   |

Table C.1 Continued

| Measure      |  | Version  | Studies using this measure (or combined measures)  |
|--------------|--|--|--|
| AUDIT* (WHO) | <i>Alcohol Use and Disorder Identification Test</i><br>10 question test covering frequency of drinking, dependence symptoms and signs of hazardous and harmful consumption.  |  | Claussen (1999) Norway (a score of 10 or more indicated problem drinking. Also used DSM-IV).<br>McManus (2009) England (a score of 8 or more equalled hazardous use, and a score of 16 or more equalled harmful use).  |
| MAST (US)    | <i>Michigan Alcohol Screening Test</i><br>24 scored items assess symptoms and consequences of alcohol abuse.<br>Also bMAst (Brief Mast).   | Modified version of 'Brief Mast'<br>(9 questions High MAST = 'Yes' to 2 + questions) | Mansson <i>et al.</i> (1999). Sweden (also 'are you teetotal?').   |
| CAGE*        | Screening tool using four questions to help diagnose problem drinking<br><br><i>CAGE=Acronym of key words</i><br>1. Have you ever felt you should Cut down on your drinking?<br>2. Have people Annoyed you by criticising your drinking?<br>3. Have you ever felt bad or Guilty about your drinking?<br>4. Have you ever had a drink in the morning to get rid of a hangover (Eye opener)?   |  | Montgomery <i>et al.</i> (1998). UK.<br>Upmark <i>et al.</i> (1999). Denmark.<br>Two or more positive answers to CAGE questions plus usual alcohol consumption, and consumption during the previous week (converted to grams of 100% ethanol. High = 35 g per day for men and 25g per day for women).<br>MacDonald and Shields (2004) UK. (plus in the top decile of the quantity distribution – more than 45.3 units per week; drinks alcohol every day). |
| SADQ (WHO)   | <i>Severity of Alcohol Dependence Questionnaire</i><br>Screening tool consisting of 20 questions covering a range of dependence symptoms, using the six months before the interview as the reference period. Answers to all questions are scored from zero to three, and summed to give a total score ranging from zero to 60.<br>Established thresholds indicating different levels of alcohol dependence are:<br>No dependence (scores of three or less);<br>Mild dependence (scores ranging from four to 19);<br>Moderate dependence (scores ranging from 20 to 34);<br>Severe dependence (scores ranging from 35 to 60). |  | McManus (2009). England (asked of all respondents who scored 10 or more in the AUDIT).   |

\*For more details on these measures see the NHS Clinical Knowledge Summaries: [http://www.cks.nhs.uk/alcohol\\_problem\\_drinking/making\\_a\\_diagnosis/confirming\\_diagnosis/cage\\_questionnaire#-265702](http://www.cks.nhs.uk/alcohol_problem_drinking/making_a_diagnosis/confirming_diagnosis/cage_questionnaire#-265702)

# Appendix D

## Summary of gender and ages of clients interviewed, by study area

**Table D.1 Gender and ages of clients interviewed, by study area**

| Area  | Interviews | Men | Age range | Women | Age range |
|-------|------------|-----|-----------|-------|-----------|
| A     | 8          | 4   | 42-58     | 4     | 30-52     |
| B     | 12         | 7   | 44-63     | 5     | 34-57     |
| C     | 9          | 6   | 37-47     | 3     | 40-54     |
| D     | 10         | 9   | 26-55     | 1     | 38        |
| E     | 14         | 12  | 22-54     | 2     | 27/43     |
| Total | 53         | 38  | 22-63     | 15    | 27-57     |

# Appendix E

## Client interview topic guide

### 1. Interviewee profile

Record basic demographic information about the interviewee including: age, gender, housing and employment status and caring responsibilities, ethnicity.

### 2. Education and employment history

The interviewee will be asked to describe their experience of education including where they attended school, how long they attended, qualifications gained at school, any difficulties they experienced and where they were living (with parents, other family members, looked after and accommodated, etc.) when they were attending school.

The interviewer will then ask about any experience of further or higher education and qualifications obtained, as well as any experience of other training courses or programmes.

Employment (or lack of employment) following education and up to present day will then be discussed where relevant, including brief questioning about the interviewees' last job and reasons for leaving the job [this is covered in more detail later (see section 7)].

### 3. Alcohol use history

Interviewees will then be asked to briefly describe their previous and current use of alcohol and/or any other drugs, including levels of consumption before entering treatment and current level of consumption; experience of relapse; and their perceptions regarding when their alcohol use became a problem; what the key reasons were for this (if any) and their experience of treatment to date.

How their history of alcohol-use fits in with their employment history should also be explored. Did the lack of job cause alcohol misuse from the interviewees' perspective or did alcohol cause the lack of employment or were both because of something else?

### 4. Benefits history

This part of the interview will focus on the clients' experience of the benefit system, which benefits they have accessed in the past, at what point they first started receiving benefits and what the reasons were for this. A particular focus will be on the transition between an employment-seeking related benefit (such as Jobseeker's Allowance) and a disability or incapacity benefit, where relevant.

### 5. Current benefits

Interviewees will be asked about the benefits they currently receive. The interviewer will probe the reasons why the client receives these benefits, including who suggested they may be eligible for each benefit (GP, other health professional, friends/family, etc.), how suitable they think they are for their current situation (e.g. if on JSA do they really feel capable of holding down a job at the moment) whether anyone has discussed switching to a different benefit (e.g. JSA if they are on IB/ESA and vice versa) with them since they started receiving the current one?

## **6. Barriers and facilitators to benefit uptake**

Any perceived problems or issues relating to benefit uptake will be explored with the interviewee including lack of knowledge about benefits entitlement, lack of advice, difficulties filling out application forms and attending appointments, problems with Jobcentre Plus facilities and stigmatisation (or fear of it) by staff and other claimants.

Any specific facilitators to benefit uptake that have worked for them?

## **7. Barriers to employment**

Interviewees will be asked about current and previous barriers to them entering or remaining in employment. Alcohol use will be addressed but other potential barriers that will be probed include:

- physical health;
- mental health;
- willingness to work (attitudes towards work and general motivation, including any financial incentives or disincentives);
- transport;
- stigma;
- obtaining references;
- driving;
- relapse;
- general presentation;
- lack of confidence;
- lack of qualifications and/or relevant experience;
- affordable childcare;
- availability of suitable jobs.

In particular, interviewees' most recent jobs should be discussed, including the reasons their employment came to an end, details of any support they received to help them to try and remain in their job, why this support ultimately failed and what kind of support might have been successful in helping them to retain their employment.

## **8. Facilitators to employment**

Interviewees will be asked what has helped them currently or in the past to secure employment/move into a job and retain that job. Probe regarding family and service support, levels of motivation, easy application, type of work available, flexibility within the job, understanding manager and colleagues, etc.

## **9. Financial Difficulties**

This part of the interview will ask about current or previous periods of financial difficulty the client has experienced. Have they ever had to seek alternative sources of income (informal sources rather than formal employment – this could include criminal activity) to make ends meet?

## **10. Support services**

Interviewees will be asked about the support services they are in contact with currently (and briefly those they have had experience of in the past) and their perceptions regarding the role of that support in maintaining their participation in treatment and/or current or future attempts to enter employment. Also probe about the services that have been most effective for them in the past, and what kind of support they ideally would want to receive?

## **11. Aspirations**

This final part of the interview will focus on the clients' aspirations for the future, as well as whether they think these aspirations are likely or realistic, and what support they would have to receive to help them achieve them. Specific issues to be explored include:

- alcohol-free/alcohol-controlled;
- employment aspirations;
- what is more important – sorting out alcohol use or sorting out employment?

# Appendix F

## Professionals interview topic guide

This interview will explore the following themes:

- Brief description of the service the interviewee works for and their role within it.
- The role of employment and benefit system in alcohol treatment in their local area.
- Links the service has with jobcentres/training providers locally.
- Referral pathways to other relevant support agencies (including links to family and other supportive networks for the client).
- Any advice or support regarding employment or benefits they [or other professionals in the centre] provide to clients.
- Barriers to benefit uptake, including lack of knowledge about benefits entitlement, lack of advice, difficulties filling out application forms and attending appointments, problems with Jobcentre Plus facilities and stigmatisation (or fear of it) by staff and other claimants.
- Any specific facilitators to benefit uptake that have worked in this area?
- Perceptions of employability of those in treatment, whether they are on the right benefits (e.g. not able to work but on JSA).
- Barriers to entering employment and training, including:
  - alcohol use;
  - physical health;
  - mental health;
  - willingness to work (attitudes towards work & general motivation, including any financial incentives or disincentives);
  - transport;
  - stigma;
  - obtaining references;
  - driving;
  - relapse;
  - general presentation;
  - lack of confidence;
  - lack of qualifications and/or relevant experience;
  - affordable childcare;
  - availability of suitable jobs/training opportunities (including mentoring and voluntary work) in the local area.



- Barriers to retaining employment and training.
- Facilitators to finding and retaining employment, including family and service support, levels of motivation, easy application, type of work available, flexibility within the job, understanding manager and colleagues, etc.
- How active and effective are the service they work for in helping their clients get back into employment/reach the point at which they are able to find or hold down a job?
- Views on what kind of support they feel is most effective in helping to get people with alcohol problems back into the workforce and remain in the workforce.
- Views on how any recent organisational changes have affected their work.
- Any issues that they think are particularly relevant to their local area.

# References

- Alcohol Concern (2009a). *Welfare Reform Bill: Briefing for House of Lords 2nd Reading*, 29 January 2009.  
URL: <http://www.alcoholconcern.org.uk/alcohol-concern-in-action/parliament/parliamentary-briefings/welfare-reform-bill-2009>
- Alcohol Concern (2009b). *Future proof: can we afford the cost of drinking too much?*. Alcohol Concern, London. URL: <http://www.alcoholconcern.org.uk/publications/policy-reports/item-2>
- Alterman, A. I., Shen, Q. S., Merrill, J.C., McLellan, T. et al. (2000). 'Treatment services received by Supplemental Security Income drug and alcoholic clients'. *Journal of Substance Abuse Treatment*, 18(3):209-215.
- Anderson, T. L., Shannon C., Schyb, I. and Goldstein, P. (2002). 'Welfare reform and housing: Assessing the impact to substance abusers'. *Journal of Drug Issues*, 32(1):265-295.
- Balakrishnan, R., Allender, S., Scarborough, P., Webster, P. and Rayner, M. (2009). 'The burden of alcohol-related ill health in the United Kingdom'. *Journal of Public Health*, 31(3):366-373.
- Barnett, J.H., Werners, U., Secher, S.M. et al. (2007). 'Substance use in a population-based clinic sample of people with first-episode psychosis'. *British Journal of Psychiatry*, 190:515-520.
- Bauld, L., Hay, G., McKell, J. and Carroll, C. (2010). *Problem drug users experiences of employment and the benefit system*. DWP Research Report No. 640. Department for Work and Pensions.  
URL: <http://research.dwp.gov.uk/asd/asd5/rports2009-2010/rrep640.pdf>
- Bauld, L., Brandling, J. and Templeton, L. (2009b). *School-based interventions for smoking prevention: a qualitative systematic review*. National Institute for Health and Clinical Excellence (NICE), London  
URL: <http://www.nice.org.uk/guidance/index.jsp?action=download&o=44027>.
- Bauld, L., Bell, K., McCullough, L., Richardson, L. and Greaves L. (2009c). 'The effectiveness of NHS smoking cessation services: a systematic review'. *Journal of Public Health*, 32(1):71-82.  
doi:10.1093/pubmed/fdp074
- Bongers, I. M. B., van Oers, H. A. M., van de Goor, L. A. M. and Garretsen, Henk F. L. (1997). 'Alcohol Use and Problem Drinking: Prevalences in the General Rotterdam Population'. *Substance Use and Misuse*, 32(11):1491-1512
- Booth, B.M. and Feng, W. (2002). 'The impact of drinking and drinking consequences on short-term employment outcomes in at-risk drinkers in six southern states'. *Journal of Behavioural Health Services and Research*, 29(2):157-166
- Bray, J. W., Zarkin, G. A., Dennis, M. L. et al. (2000). 'Symptoms of Dependence, Multiple Substance Use, and Labor Market Outcomes'. *The American Journal of Drug and Alcohol Abuse*, 26:1, 77-95.
- Britton, A. and McPherson, K. (2001). 'Mortality in England and Wales attributable to current alcohol consumption'. *Journal of Epidemiology and Community Health*, 55(6):383-388.
- Brown, J., Hanlon, P., Turok, I et al. (2008). 'Mental health as a reason for claiming incapacity benefit: a comparison of national and local trends'. *Journal of Public Health*, 31(1):74-80
- Brucker, D.L. (2007). 'Substance Abuse Treatment Participation and Employment Outcomes for Public Disability Beneficiaries with Substance Use Disorders'. *The Journal of Behavioral Health Services and Research*, 34(3):290-308.

- Burns, L. and Teeson, M. (2002). 'Alcohol use disorders comorbid with anxiety, depression and drug use disorders: Findings from the Australian National Survey of Mental Health and Well Being'. *Drug and Alcohol Dependence*, 68:299-307
- Bush, I.R. and Kraft, M.K. (2001). 'Self-Sufficiency and Sobriety: Substance-Abusing Women and Welfare Reform'. *Journal of Social Work Practice in the Addictions*, 1(1):41-64
- Cabinet Office Strategy Unit (2003). *Alcohol misuse: How much does it cost?* London: The Stationery Office. URL: [http://sia.dfc.unifi.it/costi\\_per\\_cent20uk.pdf](http://sia.dfc.unifi.it/costi_per_cent20uk.pdf)
- Catalano, R., Dooley, D., Wilson, G. et al. (1993). 'Job Loss and Alcohol Abuse: A Test Using Data from the Epidemiologic Catchment Area Project'. *Journal of Health and Social Behavior*, 34(3):215-225
- Cebulla, A., Heaver, C., Smith, N. and Sutton, L (2004). *Drug and Alcohol Use as Barriers to Employment*. DWP Research Report No. W193. Sheffield: Department for Work and Pensions. URL: [http://research.dwp.gov.uk/asd/asd5/working\\_age/wa2004/w193rep.pdf](http://research.dwp.gov.uk/asd/asd5/working_age/wa2004/w193rep.pdf)
- Claussen, B. (1999). 'Alcohol disorders and re-employment in a 5-year follow-up of long-term unemployed'. *Addiction*, 94(1):133-138
- Crew Jr., R. E. and Davis, B. C. (2003). 'Assessing the Effects of Substance Abuse Among Applicants for TANF Benefits: The Outcome of a Demonstration Project in Florida'. *Journal of Health and Social Policy*, 17(1):39-53.
- Dean, H. (2003). 'Re-conceptualising Welfare-To-Work for People with Multiple Problems and Needs'. *Journal of Social Policy*, 32(3):441-459.
- Dee, T.S. (2001). 'Alcohol Abuse And Economic Conditions: Evidence From Repeated Cross-Sections Of Individual-Level Data'. *Health Economics*, 10:257-270.
- Department of Health (2009). *The cost of alcohol harm to the NHS in England: An update to the Cabinet Office (2003) study July 2008*. Health Improvement Analytical Team, Department of Health. URL: <http://www.lho.org.uk/viewResource.aspx?id=13594>
- Department of Health (2010). *Statistics from the National Alcohol Treatment Monitoring System (NATMS) 1st April 2008 – 31st March 2009*. Department of Health/National Treatment Agency for Substance Misuse. URL: [http://www.nta.nhs.uk/uploads/natms\\_annual\\_statistics\\_report\\_2008\\_2009.pdf](http://www.nta.nhs.uk/uploads/natms_annual_statistics_report_2008_2009.pdf)
- Devlin, N.J., Scuffham, P.A. and Bunt, L.J. (1997). 'The social costs of alcohol abuse in New Zealand'. *Addiction*, 92(11): 1491-1505
- Diver, K. and Dickson, N. (2006). 'Managing the Transition from Treatment in a Therapeutic Community to Successful Integration Back into Society'. *Therapeutic communities*, 27(1).
- Dooley, D. and Prause, J. (1997). 'Effect of Favorable Employment Change on Alcohol Abuse: One- and Five-Year Follow-Ups in the National Longitudinal Survey of Youth'. *American Journal of Community Psychology*, 25(6):787-807.
- Dooley, D. and Prause, J. (2002) 'Mental Health and Welfare Transitions: Depression and Alcohol Abuse in AFDC Women'. *American Journal of Community Psychology*, 30(6):787-813.
- Ettner S.L. (1997). 'Measuring the human cost of a weak economy: Does unemployment lead to alcohol abuse?' *Social Science and Medicine*, 44(2):251-260.
- Feng, W., Zhou, W., Butler, J.S. et al. (2001). 'The Impact Of Problem Drinking On Employment'. *Health Economics*, 10:509-521.

- Feuerlein, W., Kljener, H. and Flohrschutz, T. (1994). 'Mortality in alcoholic patients given inpatient treatment'. *Addiction*, 89:841-849.
- Foster, W.H. and Vaughan, R.D. (2005). 'Absenteeism and business costs: Does substance abuse matter?' *Journal of Substance Abuse Treatment*, 28:27-33.
- French, M.T., Zarkin, T.A., Bray, J.W. et al. (1997). 'Costs of Employee Assistance Programmes: Findings from a National Survey'. *American Journal of Health Promotion*, 11(3):219-222.
- Gill, J. (1994). 'Alcohol-Problems In Employment – Epidemiology And Responses'. *Alcohol and Alcoholism*, 29(3):233-248.
- Grant, B. F. and Dawson D. A. (1996). 'Alcohol and drug use, abuse, and dependence among welfare recipients'. *American Journal of Public Health*, 86(10):1450-1454.
- Gresenz, C. R., Watkins, K. and Podus, D. (1998). 'Supplemental Security Income (SSI), Disability Insurance (DI), and substance abusers'. *Community Mental Health Journal*, 34(4): 337-350.
- Gossop, M. and Birkin, R. (1994). 'Training Employment Service Staff To Recognise And Respond To Clients With Drug And Alcohol Problems'. *Addictive Behaviors*, 19(2):127-134.
- Hajema, K-J, Knibbe, R.A. and Drop, M.J. (1999). 'Social Resources and Alcohol-Related Losses as Predictors of Help Seeking among Male Problem Drinkers'. *Journal of Studies on Alcohol*, 60 (1):120.
- Hammer, T. (1992). 'Unemployment and use of drug and alcohol among young people: a longitudinal study in the general population'. *British Journal of Addiction*, 87:1571-1581
- Harley, D.A. and Hanley-Maxwell, C. (1994). 'Improving Employment Outcomes for Chronic Alcoholics: Applying the Supported Employment Model'. *Substance Use and Misuse*, 29(5):667-673
- Hay, G., and Bauld, L. (2008). *Population estimates of problematic drug users in England who access DWP benefits: a feasibility study*. DWP Working Paper No. 46. Department for Work and Pensions. URL: <http://campaigns.dwp.gov.uk/asd/asd5/WP46.pdf>
- Hay, G. and Bauld, L. (2010). *Population estimates of problem alcohol misusers who access DWP benefits*. DWP Working Paper No. 94. Department for Work and Pensions.
- Hemmingson, T., Lundberg, I., Diderichsen, F. et al. (1998). 'Explanations Of Social Class Differences In Alcoholism Among Young Men'. *Social Science and Medicine*, 47 (10):1399-1405
- Hilarski, C. and Wodarski, J.S. (2001). 'Comorbid Substance Abuse and Mental Illness'. *Journal of Social Work Practice in the Addictions*, 1(1):105-119.
- Holder, H.D. and Blose, J.O. (1991). 'A Comparison of Occupational and Nonoccupational Disability Payments and Work Absences for Alcoholics and Nonalcoholics'. *Journal of Occupational Medicine*, 33(4): 453-457.
- Hunter, M (2009). 'Substance misuse professionals respond to benefit withdrawal idea'. *Community Care*, 11 May 2009. URL: <http://www.communitycare.co.uk/Articles/2009/05/11/111509/Welfare-reform-plans-to-remove-benefits-from-alcoholics.htm>
- Institute of Alcohol Studies (2009). *Alcohol consumption and harm in the UK and EU*. IAS Factsheet. URL: [http://www.ias.org.uk/resources/factsheets/harm\\_ukeu.pdf](http://www.ias.org.uk/resources/factsheets/harm_ukeu.pdf)
- Jané-Llopis, E. and Matytsina, I. (2006). 'Mental health and alcohol, drugs and tobacco: a review of the comorbidity between mental disorders and the use of alcohol, tobacco and illicit drugs'. *Drug and Alcohol Review*, 25(6): 515-536.

- Janlert, U. and Hammerstrom, A. (1992). 'Alcohol consumption among unemployed youths: results from a prospective study'. *British Journal of Addiction*, 87:703-714.
- Jenkins, R., Bebbington, P., Brugha, T.S. et al. (1998). 'British Psychiatric Morbidity Survey'. *British Journal of Psychiatry*, 173(7):4-7.
- Johansson, E., Alho, H., Kiiskinend, U. et al. (2007). 'The Association Of Alcohol Dependency With Employment Probability: Evidence From The Population Survey 'Health 2000 In Finland'. *Health Economics*, 16:739-754
- Jones, S., Casswell, S. and Zhang, J. (1995). 'The economic costs of alcohol-related absenteeism and reduced productivity among the working population of New Zealand'. *Addiction*, 90:1455-1461.
- Khan, S., Murray, R.P. and Barnes, G.E. (2002). 'A structural equation model of the effect of poverty and unemployment on alcohol abuse'. *Addictive Behaviors*, 27(3):405-423.
- Lee, A. J., Crombie, I.K., Smith, W.C.S. et al. (1990). 'Alcohol consumption and unemployment among men: the Scottish Heart Health Study'. *British Journal of Addiction*, 85: 1165-1170.
- MacDonald, Z and Shields, M (2001). 'The Impact of Alcohol Consumption on Occupational Attainment in England'. *Economica*, New Series, 68(271):427-453.
- MacDonald, Z. and Shields, M.A. (2004). 'Does problem drinking affect employment? Evidence from England'. *Health Economics*, 13: 139-155
- Mansson, N. O., Rastam, L., Eriksson, K.F. and Israelsson, B. (1999). 'Alcohol consumption and disability pension among middle-aged men'. *Annals of Epidemiology*, 9(6): 341-348.
- Marchand, A. (2008). 'Alcohol use and misuse: What are the contributions of occupation and work organization conditions?' *BMC Public Health*, 8:333.
- Massengill, D. (2005). 'Walking a straight (and fine) line: Alcoholism and the Americans with Disabilities Act'. *Public Personnel Management*, 34(3):283-297.
- McKay, J. R., McLellan A. T., Durell, J., Ruetsch, C et al. (1998). 'Characteristics of recipients of Supplemental Security Income (SSI) benefits for drug addicts and alcoholics'. *Journal of Nervous and Mental Disease*, 186(5):290-298.
- McLellan, A.T., Gutman, M., Lynch, K. et al. (2003). 'One-Year Outcomes from the Caseworks for Families Intervention for Substance-Abusing Women on welfare'. *Evaluation Review*, 27:656-680.
- McManus, S., Meltzer, H., Brugha, T., Bebbington, P. and Jenkins, R. (2009). *Adult Psychiatric Morbidity Survey, 2007*. The NHS Information Centre, Leeds.
- Meara, E. (2006). 'Welfare reform, employment, and drug and alcohol use among low-income women'. *Harvard Review of Psychiatry*, 14(4):223-232.
- Menezes, P., Johnson, S., Thornicroft, G. et al. (1996). 'Drug and Alcohol Problems among Individuals with Severe Mental Illnesses in South London'. *British Journal of Psychiatry*, 168: 612-619.
- Mental Health Foundation (2006). *Cheers?: Understanding the relationship between alcohol and mental health*. URL: <http://www.mentalhealth.org.uk/publications/?EntryId5=38566>
- Metsch, L. R., McCoy C. B., Miller, M., McAnany, H. et al. (1999). 'Moving substance-abusing women from welfare to work'. *Journal of Public Health Policy*, 20(1):36-55.
- Metsch, L.R., Pereyra, M., Miles, C.M. et al. (2003). 'Welfare and Work Outcomes after Substance Abuse Treatment'. *Social Service Review*, 77(2): 237-254.

- Montgomery, S.M., Cook, D.G., Bartley, M.J. et al. (1998). 'Unemployment, cigarette smoking, alcohol consumption and body weight in young British men'. *European Journal of Public Health*, 8:21-27.
- Moos, R.H., Finney, J.W., Ouirnette, P.C. et al. (1999). 'A Comparative Evaluation of Substance Abuse Treatment: I. Treatment Orientation, Amount of Care, and 1-Year Outcomes'. *Alcoholism: Clinical and Experimental Research*, 13(3): 521-536.
- Morgenstern J., McCrady B. S., Blanchard K. A. et al. (2003). 'Barriers to employability among substance dependent and non-substance-affected women on federal welfare: implications for program design'. *Journal of Studies on Alcohol*, 64:239-46.
- Morgenstern, J., Neighbors, C.J., Kuerbis, A. et al. (2009). 'Improving 24-Month Abstinence and Employment Outcomes for Substance-Dependent Women Receiving Temporary Assistance for Needy Families With Intensive Case Management'. *American Journal of Public Health*, 99(2): 328-333.
- Mossakowski, K.N. (2008). 'Is the duration of poverty and unemployment a risk factor for heavy drinking?' *Social Science and Medicine*, 67: 947-955.
- Mulia, N. and Schmidt, L.A (2003). 'Conflicts and trade-offs due to alcohol and drugs: Clients accounts of leaving welfare'. *Social Service Review*, December 2003:499 – 522
- Mullahy, J. and Sindelar, J. (1996). 'Employment, Unemployment and Problem Drinking'. *Journal of Health Economics*, 15:409-434.
- Murray, R., Bauld, L., Hackshaw, L. and McNeill, A. (2009). 'Improving access to smoking cessation services for disadvantaged groups: a systematic review'. *Journal of Public Health*, 31(2):258-277.
- NICE (2006). *Methods for the development of NICE public health guidance*. London: National Institute of Health and Clinical Excellence.  
URL: <http://www.nice.org.uk/guidance/index.jsp?action=download&r=true&o=31842>
- ONS/Robinson, S. and Bugler, C. (2010). *General Lifestyle Survey: Smoking and drinking among adults, 2008*. Newport: Office for National Statistics.  
URL: [http://www.statistics.gov.uk/downloads/theme\\_compedia/GLF08/GLFSmoking&DrinkingAmongAdults2008.pdf](http://www.statistics.gov.uk/downloads/theme_compedia/GLF08/GLFSmoking&DrinkingAmongAdults2008.pdf)
- Proudfoot, H. and Teesson, M. (2002). 'Who seeks treatment for alcohol dependence? Findings from the Australian National Survey of Mental Health and Well-being'. *Social Psychiatry and Psychiatric Epidemiology*, 37:451-456.
- Ries, R. K., Dyck D. G., Short, R., Srebnik, D. et al. (2004). 'Outcomes of managing disability benefits among patients with substance dependence and severe mental illness'. *Psychiatric Services*, 55(4): 445-447.
- Ritchie, J., Spencer, L. and O'Connor, W. (2004). 'Carrying out Qualitative Analysis'. In Ritchie, J. and Lewis, J. (Eds). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. (pp. 219-262). London; Sage Publications.
- Rodriguez, E. and Chandra, P. (2006). 'Alcohol, employment status, and social benefits: One more piece of the puzzle'. *American Journal of Drug and Alcohol Abuse*, 32(2):237-259.
- Romelsjö, A., Stenbacka, M., Lundberg, M. et al. (2004). 'A population study of the association between hospitalization for alcoholism among employees in different socio-economic classes and the risk of mobility out of, or within, the workforce'. *European Journal of Public Health*, 14: 53-57

- Rosen, M. I., McMahon, T.J. , Lin, H. Q. and Rosenheck, R. A. (2006). 'Effect of social security payments on substance abuse in a homeless mentally ill cohort'. *Health Services Research*, 41(1):173-191.
- Schmidt, L., Weisner, C. and Wiley, J. (1998). 'Substance abuse and the course of welfare dependency'. *American Journal of Public Health*, 88(11): 1616-1622.
- Schmidt, L., Zabkiewicz, D., Jacobs, L. et al. (2007). 'Substance Abuse and Employment Among Welfare Mothers: From Welfare to Work and Back Again?' *Substance Use and Misuse*, 42(7):1069-1087.
- Scottish Executive (2001). *Alcohol misuse in Scotland: Trends and Costs* – report by Catalyst Health Economics Consultants Ltd (The Catalyst Report). Scottish Executive: Edinburgh.  
URL: [http://www.alcoholinformation.isdscotland.org/alcohol\\_misuse/files/Catalyst\\_Full.pdf](http://www.alcoholinformation.isdscotland.org/alcohol_misuse/files/Catalyst_Full.pdf)
- Scottish Executive (2005). *Cost to Society of Alcohol Misuse in Scotland: An Update to Alcohol Misuse in Scotland Trends and Costs*. Scottish Executive: Edinburgh.  
<http://www.scotland.gov.uk/Publications/2005/01/20541/50225>
- Scottish Government (2008). *Costs of Alcohol Use and Misuse in Scotland*. Scottish Government: Edinburgh. URL: <http://www.scotland.gov.uk/Publications/2008/05/06091510/0>
- Siegal, H.A., Fisher, J.H., Rapp, R.C. et al. (1996). 'Enhancing Substance Abuse Treatment with Case Management: Its Impact on Employment'. *Journal of Substance Abuse Treatment*, 13(2):93-98.
- South, N., Akhtar, S., Nightingale, R. and Stewart, M. (2001). 'Idle Hands'. *Drug and Alcohol Findings*, 6:20-28. London: Alcohol Concern, DrugScope and the National Addiction Centre.  
URL: [http://www.findings.org.uk/docs/South\\_N\\_1.pdf](http://www.findings.org.uk/docs/South_N_1.pdf)
- Spencer, J., Deakin, J., Seddon, T. and Ralphs, R. (2008). *Getting Problem Drug Users (Back) Into Employment Part 2*. UK Drug Policy Commission.  
URL: [http://www.ukdpc.org.uk/resources/Part\\_Two\\_Background\\_Research.pdf](http://www.ukdpc.org.uk/resources/Part_Two_Background_Research.pdf)
- Stevenson, D (2002). 'Should addicts get welfare? Addiction and SSI/SSDI'. *Brooklyn Law Review*, 68 (Fall): 185-240.
- Sutton, L., Cebulla, A., Heaver, C. and Smith, N. (2004). *Drug and Alcohol Use as Barriers to Employment: Literature Review*. DWP Research Report No. 193a. Sheffield: Department for Work and Pensions. URL: [http://research.dwp.gov.uk/asd/asd5/working\\_age/wa2004/w193a\\_rep.pdf](http://research.dwp.gov.uk/asd/asd5/working_age/wa2004/w193a_rep.pdf)
- Swartz, J. A., Baumohl, A. and Lurigio, A. J. (2004). 'Termination of Supplemental Security Income benefits for drug addiction and alcoholism: Results of a longitudinal study of the effects on former beneficiaries'. *Social Service Review*, 78(1):96-124.
- Turner, L. J., Danziger, S. and Seefeldt, K. S. (2006). 'Failing the transition from welfare to work: Women chronically disconnected from employment and cash welfare'. *Social Science Quarterly*, 87(2): 227-249.
- Upmark, M., Hemmingsson, T., Romelsjö, A. et al. (1997). 'Predictors of disability pension among young men: The role of alcohol and psychosocial factors'. *European Journal of Public Health*, 7(1):20-28.
- Upmark, M., Möller, J. and Romelsjö, A. (1999). 'Longitudinal, population-based study of self-reported alcohol habits, high levels of sickness absence, and disability pensions'. *Journal of Epidemiology and Community Health*, 53:223-229
- Upmark, M. and Thundal, K. (2002). 'An explorative, population-based study of female disability pensioners: the role of childhood conditions and alcohol abuse/dependence'. *Scandinavian Journal of Public Health*, 30:191-199.

- Varney, S.J. and Guest, J.F. (2002). 'The Annual Societal Cost of Alcohol Misuse in Scotland'. *Pharmacoeconomics*, 20 (13): 891-907
- Weaver, T., Madden, P., Charles, V. et al. (2003). 'Comorbidity of substance misuse and mental illness in community mental health and substance misuse services'. *British Journal of Psychiatry*, 183: 304-313.
- Wilson, S.H. and Walker, G.M. (1993). 'Unemployment and Health: A Review'. *Public Health*, 107: 153-162
- World Health Organization, Department of Mental Health and Substance Abuse (2004). *Global Status Report on Alcohol*. Geneva: WHO.  
URL: [http://www.faslink.org/WHO\\_global\\_alcohol\\_status\\_report\\_2004.pdf](http://www.faslink.org/WHO_global_alcohol_status_report_2004.pdf)
- World Health Organisation (2008). *Strategies to reduce the harmful use of alcohol*. Geneva: WHO.  
URL: [http://apps.who.int/gb/ebwha/pdf\\_files/A61/A61\\_R4-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/A61/A61_R4-en.pdf)
- York Health Economics Consortium (2010). *The Societal Cost of Alcohol Misuse in Scotland for 2007*. Scottish Government: Edinburgh.  
URL: <http://www.scotland.gov.uk/Publications/2009/12/29122804/21>
- Zabkiewicz, D. and Schmidt, L.A. (2007). 'Behavioral Health Problems as Barriers to Work: Results from a 6-year Panel Study of Welfare Recipients'. *The Journal of Behavioral Health Services and Research*, 34(2):168-185.
- Zarkin, G.A., Dunlap, L.J., Bray, J.W. et al. (2002). 'The effect of treatment completion and length of stay on employment and crime in outpatient drug-free treatment'. *Journal of Substance Abuse Treatment*, 23: 261- 271.



This report presents the findings of a study commissioned by the Department for Work and Pensions (DWP) to explore the experiences of adults with alcohol misuse problems in the UK in relation to employment, unemployment and benefit uptake. In addressing these issues, the study also explores the wider context of education, training, alcohol misuse and treatment. The findings will inform the development of DWP policy to support individuals in overcoming their addiction and moving off benefits and into employment.

This report has two key elements: a review of the literature on alcohol misuse, employment/unemployment and benefit uptake, and a study involving depth interviews with 53 alcohol misusers and 12 professionals who work with alcohol misusers to explore specific issues in detail. The research was carried out by a team from the University of Bath and the University of Glasgow.

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