

# **Employing drug users**

**Individual and systemic barriers to  
rehabilitation**

**Hilary Klee, Iain McLean and Christian Yavorsky**

The **Joseph Rowntree Foundation** has supported this project as part of its programme of research and innovative development projects, which it hopes will be of value to policy makers, practitioners and service users. The facts presented and views expressed in this report are, however, those of the authors and not necessarily those of the Foundation.

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Published for the Joseph Rowntree Foundation by YPS

ISBN 1 84263 053 9 (paperback)

ISBN 1 84263 083 0 (pdf: available at [www.jrf.org.uk](http://www.jrf.org.uk))

**Work and Opportunity Series No. 29**

Cover design by Adkins Design

Prepared and printed by:

York Publishing Services Ltd

64 Hallfield Road

Layerthorpe

York YO31 7ZQ

Tel: 01904 430033; Fax: 01904 430868; E-mail: [orders@yps-publishing.co.uk](mailto:orders@yps-publishing.co.uk)

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# Acknowledgements

We are grateful to the clients of Education, Training and Employment (ETE) services in the North West of England for their contribution to this project. Their willingness to disclose experiences from childhood to the present day, and also to discuss their hopes and aspirations for the future, has given us many insights into the problems they face. We hope they will lead to improvements in employment services for people with drug problems. We are also indebted to the professionals who not only spared the time to be interviewed, but also in

many cases mediated contact with their clients, and then found space for us on their own premises. Samantha Wright devised and carried out the pilot study for this research. Thanks are due also to members of the Advisory Group: Samantha Wright, Malcolm Craven, Jaqui Nayansungh, Ian Smith, Jan Southworth and Mike Hindson. We thank the Joseph Rowntree Foundation for funding the research and Mark Hinman, Senior Research Manager, for his help and support.

# Summary

Recovering drug users and ex-users face considerable barriers when they attempt to abandon the drug-oriented lifestyle and look for work. They are often hampered by the consequences of events in their early history at home and at school that have led to their use of drugs and their subsequent dependence on them. The decline into social exclusion brings with it further disadvantage if they resort to crime to fund their drug habit. A criminal record adds another barrier to social acceptance that is equally difficult to overcome. Unemployment for months or years brings with it financial deprivation, poor living conditions and a further lowering of self-esteem. Lack of school qualifications, training and work experience then become obvious when they are faced with the prospect of active job-seeking. Support at this time is critical to their ability to overcome the multiple disadvantages and gain success.

## The study

This study examines barriers that can start in the childhood home, continue and increase through school and result in social isolation and a dysfunctional lifestyle in adulthood. These barriers were revealed through extended interviews with problem drug users who presented to Education, Training and Employment (ETE) services in the North West of England. Their accounts are balanced by interviews with ETE professional groups: advisers, educators and trainers. Employers were also interviewed and identified the barriers facing problem drug users from their perspectives.

There was great diversity in the services that were available to problem drug users. However,

they can be categorised into three main groups: the Community Drug Teams, some of them offering ETE advice delivered on site by other agencies; specialist ETE services dedicated to drug users and/or other disadvantaged people, which were largely run by non-governmental organisations (NGOs) or commercial consultancies; and mainstream ETE services operating out of Job Centres. All but the mainstream services were involved in a free market based on competitive bidding for short-term funds.

## Family and school experiences

There are many childhood experiences that give rise to later emotional and behavioural problems, including the use of illegal drugs. Four categories of such experience were identified among the clients: lone-parent families, divorced parents and stepfathers, families with drug-using members and being placed in care. Many were members of more than one group. The parenting by lone parents, all mothers, was characterised by overwork and lack of control over their children. None of these clients had kept in touch with the absent father. Research shows that lack of such contact is often associated with emotional and behavioural problems, difficulties with anger management and under-achievement at school. A similar pattern was seen among clients of separated families where contact with the father was broken. For those whose father was replaced, there were additional problems particularly for the male clients. A high proportion of clients had been in care; they were more likely to have lost contact with the mother than any other group.

Many clients had serious problems at school: truancy, aggressive behaviour and exclusion. The majority of clients had moved house and a quarter of them found it difficult to make new friends at school. Bullying was common and some clients devised protective mechanisms to avoid being a target. The consequences of such disruption were apparent in their academic development. There was an increased likelihood of leaving school early with few or no qualifications.

### Current lifestyle

Many clients were living in deprived or low-grade accommodation. Over a third were in hostels, temporary accommodation or supported housing and some were living in areas known for the prevalence of illicit drugs use. Although some parents were supportive, the influence of partners appeared to be stronger. Non-drug-using partners were focused on getting clients to control their use of drugs. Health and drugs generated concern; clients reported current health problems and the majority were still using street drugs, mostly cannabis. A number of those who were in treatment and receiving a methadone (heroin substitute) prescription had used heroin in the previous month. The clients had funded their drugs from a variety of activities that included legitimate work and unofficial work as well as crime. However, three-quarters had a criminal record.

### Clients' views of services

Most clients did not aim to get a job immediately on joining a scheme. Though they

had reached a point in their lives where they wanted to change their lifestyle, most felt they were not ready. There was a strong fear of relapse. This would be a serious setback if their Social Security benefits had been terminated and they had to renegotiate their finances. It would be at a time when they were facing failure and were low in confidence. The preferred option for many was to go for educational courses, mostly non-vocational and aimed at self-improvement. However, there was a realisation among those who had left school with no qualifications that these were important. Those that completed courses, exerting the discipline required to attend regularly, reported a real sense of achievement.

Their evaluations of the ETE services were mostly positive. The advisers at services dedicated to the needs of drug users were particularly praised. However, there were frustrating difficulties and delays when there were no places on a course, or the course did not start for several weeks, or it meant travelling long distances to attend. There were also fears that, ultimately, they would fail because of their criminal record. There was a mix of views about introducing schemes in the New Deal specifically for drug users. This might require them to go back into settings where drug users collected and this could undermine their resolve. Others were still at a stage where they preferred to be with people with a similar history.

### ETE workers' views of their service

ETE professionals identified serious barriers that faced problem drug users getting into work. The problematic personal characteristics

were their lack of commitment, a chaotic lifestyle and lack of confidence. Others were a lack of qualifications and a criminal record. ETE professionals acknowledged that these clients were multiply disadvantaged. Many felt they should not probe too deeply into the clients' histories since this could damage the rapport necessary to arrive at a good assessment. The mainstream ETE advisers were particularly hampered since they had no certain way of identifying clients who had a drug history. The assessment and referral system varied in its effectiveness. Ideally, knowledge of drug problems and a criminal record should inform the assessment, but these were not easy to obtain. Referral systems were criticised for their lack of co-ordination and problems resulting from waiting lists for treatment and educational/training courses.

There was concern among professionals that the service was not user-friendly and was unattractive to drug users. In some cases it was the run-down area and accommodation, in others it was the formal and defensive exterior with locked door and screens between reception staff and clients. They also feared that clients were being pushed towards options of no interest or for which they were not ready.

Communications both within and between agencies were also subject to criticism. A major barrier to inter-agency collaboration was that agencies were often in competition with each other to attract clients. This tended to stifle progress towards service improvement through learning from others. Another problem, particularly when wishing to liaise with drug treatment agencies, was confidentiality. In addition, the ethos and procedures of some ETE services tended to be oriented more directly

towards getting clients into work and did not necessarily agree with the view that this would involve a long preparation time. There was some support for a neutral co-ordinator to develop links across the services.

The definition of success across all specialist ETE services was to meet the requirements of their funders in terms of the agreed target outcomes. In some cases this was no more than the number of referrals each month. There was pressure for a fast throughput to achieve the targets since time-limited grants might not be renewed. Most advisers disliked this pressure and believed that 'softer' targets were more appropriate, such as improving the clients' quality of life, self-discipline, time management and bringing about a more positive sense of self-worth and confidence.

The Social Security benefits received by clients were also seen as a barrier. Many were on Sickness, Incapacity or Disability allowances and the income derived from benefits was not likely to be matched by a low-paid job. This was largely because the work available to this group was poorly paid and tended to be rejected by other job-seekers who were not so disadvantaged.

### Employers

There were very few ETE advisers who approached employers directly on their clients' behalf. Rather, there was help for clients with decisions on which jobs to apply for, filling in application forms, writing a curriculum vitae and interviewing skills. Advisers were unanimous in their belief that employer prejudice was a barrier that was difficult to overcome.

Employers' views of drug users was that they were more likely to be unreliable, untrustworthy and unsafe. The use of soft drugs was not a serious problem and largely to be expected of some younger employees. However, problem drug users were not likely to make good employees and should be placed in low-risk work. There were policy differences between companies and employers depending on the size of the business; the larger companies that had occupational health departments were more likely to have standard recruitment and disciplinary procedures that dealt with employment of drug users and ex-offenders. The US practice of drug testing was rare among employers and not popular with management. However, it was still under consideration by several large companies.

### Key issues and their implications for policy

An examination of the legacy of emotional, behavioural and educational problems that affected the client sample, and also the barriers endemic in the ETE service, exposed many issues that needed attention. The main ones were: client employability, the nature of rehabilitation, funding issues and competition, support for ETE staff and employer participation:

- A debate on the meaning of 'readiness' for work could clarify the criteria to be used in identifying the current needs of clients. An understanding among ETE workers of the role of treatment in the process of rehabilitation would help to establish a working relationship with treatment agencies. This could lead to collaboration in developing appropriate

action plans for clients. Confidentiality issues would need to be addressed first, however, and ways of reconciling the different aims and speed of working in different agencies should be sought.

- Rehabilitation: achieving a state of readiness was seen as a gradual process that could involve many stages and different types of experiences, and could require various kinds of support. There seem to be several options that include 'through-care' as an integrated system of life skills, non-vocational skills and training delivered either as a 'package' or through a system of referrals. Relapse prevention should be an essential feature, and identifying risk factors for relapse an important element in a system of after-care. The fear of a drop in income from a poorly paid job when compared with Social Security benefits increases reluctance to seek work. Similarly, relapse once in work could mean renegotiating the benefits. Some modifications to the rules governing benefits should encourage problem drug users to engage fully in ETE schemes.
- Short-term funding with the need for fast throughput increased time pressure. Simplistic targets are at odds with the need to incorporate lengthy therapeutic interventions for problem drug users. Outcomes governed by sensible criteria are needed that will not further disadvantage problem drug users. Competitive funding also leads to an unwillingness to reveal ways of working that attract and benefit the clients. The

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impact of such funding arrangements on the quality of the service deserves investigation.

- Support for ETE staff was often poor. The work was demanding and could be stressful. Most complaints were about inter-agency communication systems and management. The referral system was complex and involved many delays that slowed throughput and caused frustration among the clients. There was a high staff turnover in some agencies. Faster access to information is needed, for example, through computer databases of educational and training courses, and job opportunities. Monitoring outcomes of courses in terms of completion rates and student satisfaction would yield information that could guide clients and contribute to a view of 'what works'. Similarly, access to treatment options and

waiting lists for Community Drug Team (CDT) places should be available. Inter-agency communication could be initiated through informal gatherings or conferences that would support staff morale and lead to the sharing of experiences.

- There seems to be little enthusiasm among employers to participate in the New Deal. Large companies are better equipped to respond to their needs but the nature of the work sets limits on the jobs they are prepared to offer. Problem drug users with a criminal record are likely to be the most unwelcome applicants. Although the prejudice attributed to employers was not extreme, special measures aimed at reassuring them should be developed that allow for supervision and monitoring of progress.

# 1 Introduction

## Developments in government policy on employment

There are several schemes currently operating in the UK that aim to improve the employment prospects for those who are out of work. The overall aim of government is to increase financial incentives to workers that can compete with the range of Social Security benefits available to the unemployed. The education and training of unemployed people is part of this incentive and the Green Paper *Towards Full Employment in a Modern Society* (Department for Education and Employment, 2001) addresses issues that relate to drug users. Economic recovery in the second half of the 1990s and initiatives by the Employment Service have gradually reduced the unemployed population to a 'hardcore' of people with exceptional difficulties. They are people 'with multiple barriers' (Department for Education and Employment, 2001, p. 24), and drug users are included along with other disadvantaged groups such as the homeless and people with mental health problems. Forty million pounds will be available over three years for mentoring and training programmes aimed at 30,000 benefit claimants which will help them deal with their drug problems and enter the workforce. A cost-benefit analysis predicts that this investment will lead to proportionately greater savings from an associated reduction in crime.

Tighter focusing of the programmes such as the New Deal (see Appendix 1) and specialised training for the personal advisers is one aspect of the improvements planned in the Green Paper and the need for effective co-ordination between agencies is emphasised. A programme

already under way is aimed at young people (Connexions; see Appendix 1). Other recommendations for service development include: the need to relate social to business benefits when recruiting employers to the schemes; the development of users' self-esteem and motivation; and the flexibility to keep in contact which extends beyond the period of engagement of the client with the service.

A variation is being introduced in Scotland where there will be 'employment and training measures in support of the Scottish Executive drugs strategy' (Department for Education and Employment, 2001, p. 21). This will include an employment dimension to drug rehabilitation projects and the remit of Drug Action Teams (DATs). Details are included in the report *Moving on: Education, Training and Employment for Recovering Drug Users* by the Effective Interventions Unit (Richards and Morrison, 2001).

## Developments in government policy on drugs

The acceleration of drug problems has led to major impacts on levels of crime and strain on health services. The last decade has seen changes in policy as the proportions of drug users in the populace have grown and the effects in terms of social isolation, deprivation and crime have become more apparent. There have been marked contrasts internationally in the way these problems have been addressed. In the United States, the control of drug use in the workplace is increasingly through drug testing and drug programmes for employees on work sites. In contrast, attention in Western Europe

and Australia is now on rehabilitation in conjunction with treatment that will produce positive lifestyle change.

In 1998, the British Government published its ten-year strategy for tackling drugs misuse (Central Drugs Co-ordination Unit, 1998). Its implementation was to be achieved through setting up local DATs, comprising members from local agencies and commercial concerns, which would lead and co-ordinate local efforts to tackle drug use. Drug-related crime was a major theme and DATs were to aim 'at increasing take-up rates for further education and employment for former addicted criminals through the Welfare to Work, New Deal and other means'.

The deployment of funds outlined in the Green Paper includes measures that are designed to improve the take-up rates of drug-using offenders to Education, Training and Employment (ETE) schemes. This was identified as necessary in meeting two of the drug strategy's four main aims, which were to protect communities from drug-related crime, and make treatment more available to drug users. Currently, the DATs are in the best position to co-ordinate efforts to assist drug users to access treatment and increase their numbers in employment.

A new service that will affect drug users seeking work is now available to employers. Developed from the 1997 Police Act to protect vulnerable people from various types of abuse, the Criminal Records Bureau will offer its Disclosure Service to employers (Criminal Records Bureau, 2001). This will give information about the convictions of job applicants at three levels of detail depending on the nature of the work and the contact with

vulnerable groups. Employers will be required to inform candidates of their intention to seek disclosure in their advertising and application forms. There are implications here, not yet clarified, for ETE programmes aimed at drug users that may affect current legal requirements and processes of disclosure to employers.

### Current ETE services

There is great diversity in the services that are available to drug users in the UK. This has arisen largely through the number of different providers involved: statutory bodies, non-governmental organisations (NGOs) and private companies. Statutory bodies include various departments of the National Health Service (NHS), Social Services, the Employment Service (ES), local education authority establishments such as colleges, police and probation, and local government (council) projects. NGOs include voluntary agencies, charities, trusts and not-for-profit organisations. In this free market, partnerships or networks of agencies from all these categories can join together to address a particular need or seek a particular form of funding. Alternatively, one agency may employ another to provide a specific service within its wider service provision; an example in the North West is the ETE guidance that Greater Manchester Probation Service (GMPS) provides at its offices across the county but which is delivered under contract by local independent commercial agencies.

Community Drugs Teams (CDTs) exist across the UK with a clientele mostly comprising heroin users. Some drug agencies buy in ETE provision and some drug workers in CDTs provide individual ETE assistance to their clients if

resources allow and the client requests help.

The Employment Service, through its Job Centres, is the only service that is available in a form that is standard across the country. The various schemes available to the unemployed, such as New Deal, are the only ETE schemes available nationwide and are open to a wide range of eligible clients. The awareness and training of ES staff about drug issues vary between regions, as do the number of training agencies and types of employers who participate in schemes such as New Deal. The services that are available in any given area also vary. Inner-city areas have the widest range and many outlets. Urban areas with large rural hinterlands and rural areas are not so well served. Since private commercial companies operate side by side with statutory services or NGOs, in many instances they are in direct competition with them.

Services are funded in various ways and the nature of the financial arrangements plays a major role in dictating policy and procedures. Statutory services may receive their funding directly from central government and/or locally from Council Tax and may additionally 'top up' with funds obtained competitively from sources such as the European Social Fund, Single Regeneration Budget, charities and the National Lottery. For CDTs, these can enhance or increase the range of services on offer; for NGOs dedicated to specialist services for disadvantaged people, they may be the only sources of funding. These grants are time-limited and hence require regular and sometimes frequent reapplications if the service is to continue. There are also problems in meeting the outcomes set as a condition of the grant. Funders require that the projects they

support demonstrate their success through meeting specific targets. These vary in detail to the extent that some will be limited to little more than the number of referrals on to other agencies.

Independently of the providers and their clients, there is also diversity in the nature and content of the services, which address specific client needs and can be accessible through different paths. If the path is successfully negotiated and the services are accessible, a client may progress from a primary level of education and other forms of help to more advanced courses through a process of inter-agency referral.

In summary, the nature and distribution of ETE services yields a complex picture of what is available to a problem drug user seeking a job. Agencies offer different services, may have different target groups and their own systems of referral. Outcomes are dictated by funding requirements that also vary. If an agency does not provide a service then attempts are made to refer clients to those that do, a process that depends for its success on co-operation and co-ordination between them. (See Appendix 2 for further details of services participating in this study.)

### **The source and nature of barriers to the employment of problem drug users**

There is concern that anti-social activities may be encouraged if there are barriers to the rewards that can be achieved through employment (Baker, 1997; British Medical Association, 1997, Pearson, 1995). A review of vocational rehabilitation among drug misusers (Platt, 1995) clearly showed that employment

was a critical feature in success in achieving a return to mainstream culture. More generally, drugs need to be replaced with alternative interests and occupations (Robson, 1994). An association between unemployment and drugs was confirmed more recently by the *British Crime Survey* (2001) which showed that unemployed 16–29 year olds had higher rates for most drugs, including heroin. In 1998, it was estimated that over 75 per cent of drug users in treatment in England and Wales were unemployed (Gossop *et al.*, 1998).

There are well-established links between crime and drug use (Edmunds *et al.*, 1999; Hough, 1996) and drug use is common among offenders. A study of drug use among arrestees in the UK (Bennet, 1998) found that nearly two-thirds had recently used drugs, and almost half of these said their drug use and crime were connected.

Drug inebriation or dependence can have profound effects on work performance. Cognitive, perceptual, emotional, motivational, physical and social changes are common but there are other factors associated with drug use that are just as important to an understanding of the range of barriers affecting those drug users seeking work. These are the ‘risk’ factors that led them to use drugs – in childhood, adolescence and adulthood (see Lloyd, 1998 for a review of the literature). Some are particularly at risk because they are unable to cope with rejection, physical pain, social isolation, grief, depression and so on. Other barriers to employment appear if the use of drugs becomes associated with anti-social patterns of behaviour: delinquency at school, crime and a prison record. All of these help to perpetuate social dysfunction if they increase a need for yet

more drugs to provide relief from a deteriorating lifestyle.

### Negative stereotypes

Stereotypes of drug users in society are a major barrier to them returning to working life. In general, they are seen as deviant, dishonest, unreliable, manipulative individuals prone to poor health and self-neglect who are alienated from their families and prioritise drugs above all else. These stereotypes influence their interactions with members of the general public that include not only potential employers but also professionals in public health services (Klee *et al.*, 2002). As a result, it is to be expected that a major priority for drug users is to avoid exposure of their drug dependence.

### ETE: a path to rehabilitation?

According to Buchanan and Young (2000), problem drug users tend to have suffered marginalisation and exclusion by conventional society and they recognise the benefits of education and training that will enhance their job prospects and may facilitate access to support networks of non-drug users. However, drug services that include programmes designed to get them into jobs are rare. It could be argued that the development of ETE schemes that are able to meet their needs are important not only for individual self-development, but also for diminishing social exclusion and for strengthening the cohesiveness of local communities. For drug users, such schemes could offer, for the first time, real opportunities for them to build a fulfilling and productive lifestyle.

Dependent drug users devote much of their time to raising money to buy drugs and to gaining access to them (Bennet, 1998). They are rewarded with immediate gratification of their need when the drugs take effect. By comparison, the rewards associated with a programme of drug reduction and abstinence are more abstract, more uncertain and slower to appear. This suggests a need for a strategy that reduces access to drugs and increases the availability of alternative sources of gratification, and also the promise and proximity of the delayed rewards (Bickel *et al.*, 1998).

The benefits of employment to clients through diverting their energies away from drugs are mirrored by the benefits to society through a simultaneous reduction in crime. The

cost–benefit advantage in spending £1 on drug treatment which then saves £3 in averted crime is clear (Gossop *et al.*, 1998). The effects of unemployment on drug use and health are also very clear; Neale (1998) reported that unemployed drug users had poor physical health, poor concentration and a reduced ability to function effectively and safely. Working drug users felt that the time when they were working was a positive feature of their lives. However, although the income work generated was an alternative to crime, it could also be used to buy drugs. Income from work, or from Social Security benefits, was not seen by the unemployed users to be as important to them as the need to fill their time with non-drug activities that would avert boredom.

## 2 The study

### Aims and objectives

The aims of this project were to reveal the support needs of drug users participating in ETE schemes and to record the barriers encountered by them and by those who attempt to help them. In this study, the term 'drug users' encompasses a variety of associations with illicit drugs that are known to lead to health and/or social problems for them. These are: ex-users who may have been free from drugs for some time; recovering users who are currently abstinent and may be in treatment; clients of treatment agencies who are prescribed a drug substitute; and those who are still dependent on street drugs. Occasional, non-problematic drug users were not a part of the sample; they did not volunteer for the study and none was identified by the agency personnel that provided access to their clients.

There were six main objectives:

- to provide insights into the problems faced by drug users participating in ETE schemes, their aspirations and their experiences
- to identify the problems faced by the professionals running ETE schemes for drug users
- to record the experiences of education/training providers who are working with drug users
- to reveal the attitudes of employers towards managing drug users in the workplace
- to uncover the barriers to effective policy implementation and make recommendations for the development and refinement of social policy
- to inform the development of local ETE services for drug users.

### Location

The area targeted was the North West of England with a focus on the Greater Manchester area.

According to regional statistics (Drug Misuse Research Unit, 2001), 83 per cent of users currently in treatment in the North West were unemployed. In order to cover a broad range of ETE services and the different drug-using clients they may attract, 18 different agencies were sampled. In addition, an advertisement was placed in an agency magazine that is aimed at heavily dependent drug users.

### The services

(For more details see Appendix 2.)

The diverse nature of services across the North West means that the overlapping profiles of strategies, procedures, funding arrangements, target client groups and underlying philosophies result in agencies that to some extent are unique.

Three categories of support were identified, two of them aimed at problem drug users and/or other disadvantaged groups:

- Treatment and rehabilitation services that could be statutory (Community Drug Teams) or NGOs. Most focus on fundamental health issues and drug dependence. Some 'buy in' ETE services; others assign these to a particular member of staff. Referrals are made to other agencies.
- Specialist employability projects for drug users often operating with short-term funding acquired in open competition with other NGOs, private companies and statutory services. These agencies receive referrals from CDTs and employment services and many allow self-referral.
- Mainstream ETE services are delivered through Job Centres that assess and allocate clients to appropriate programmes in New Deal that will continue their preparation for work through education and training or assist clients in job-seeking.

### Samples

#### Drug users

The sample of 70 ETE clients with current or recent drug problems was divided into three groups:

- 20 who did not pursue the scheme offered or withdrew later
  - 20 currently participating in education or training through an ETE scheme
  - 30 newly presenting to an ETE scheme who were later followed up in order to assess progress.
- Eighty-three per cent of the sample was male and 96 per cent white British. Mean age was 31 years with a range of 16–46 years. The profile of white British males in this age range reflects to some extent the clientele of treatment agencies, which is to be expected in a sample of problem drug users. Women are under-represented, however, since the expected proportion would be about 30 per cent of drug agency clients. The reduced number may be due to an unwillingness to take part in the research when approached by ETE staff, but may also reflect a reluctance to use the service. Half of the sample lived in rented accommodation, 20 per cent were homeless, mostly staying in hostels, 19 per cent lived with a parent, 8 per cent in supported housing and three people had their own home.

#### Professionals

The sample of 40 professionals working in ETE services were divided into two groups:

- 20 ETE advisers
- 20 course teachers or training instructors, referred to here as 'trainers'.

In addition, 20 employers were interviewed. These were managers and personnel workers from a range of small and large, public and private companies engaged in different manufacturing and service sectors. The companies were: a DIY store, a food production company, a food retailer, a men's clothing

retailer, a graphic design company, an engineering firm, a haulage firm, a hospital, a financial institution, a home shopping company, a public transport company, a broadcast media company, a local council, a building firm, a higher education establishment, a car spares shop, a public house, a city centre bar and two non-statutory drug agencies.

### Procedures

Interviews with drug-using clients were mostly conducted on the premises of ETE services, but sometimes at clients' homes or at the research offices. They lasted between 45 and 75 minutes and were recorded on audiotapes, which were subsequently transcribed for numerical data coding and entry onto computer databases. Second interviews were conducted with the third group of respondents between four and six weeks after the first. Some could not be recontacted at this stage for various reasons; having left the scheme, moved away or did not wish to be interviewed. This left 20 participants in the group in which progress could be compared over time. Taped interviews with professional groups and the employers were held in their offices.

### Interview schedules

The interview schedules were developed from pilot study data (Wright, 2000) conducted on 40 drug-using clients attending the Manchester Drug Service in 1999. The schedule for the main study incorporated both closed and open questions. Closed questions were used where previous research or pilot data allowed a range of responses to be identified in advance. These yielded quantifiable data for computer coding. Open questions allowed greater exploration of respondents' attitudes and experiences. The interview schedules with ETE workers and employers mostly comprised open questions.

### Analyses

Statistical analyses were conducted on quantitative data to provide background and profile of the ETE clients in the sample. Qualitative data from the transcripts provided supportive thematic data and verbatim accounts were selected to illustrate key issues in this report.

### 3 Family and school experiences

There were very few respondents who did not report home circumstances that are commonly associated with risk factors for later social or psychological disturbance. Intact families were rare. Twenty per cent of respondents grew up in families in which the father was never known, or had left soon after the birth, after a divorce, or was absent for long periods because of work demands. This chapter deals with the ways that family structures and dynamics affect early development in the growing child in ways that are relevant to their educational and employment opportunities later in life. Four primary risk categories were identified: children in single-parent families; children of divorced parents; children who had been in care; and children from families that included drug-using members. Many respondents were members of more than one group.

#### Single-parent families

In the UK, there has been considerable growth in single-parent families over the last 25 years (Office for National Statistics, 1997). This trend is almost wholly due to a rise in the numbers of lone mothers, since the proportion of lone fathers has remained about the same.

There are many factors associated with lone parenting that are said to contribute to family dysfunction, for example: lone parents generally have much lower incomes; they depend more on state benefits; and 'tend to be more likely to be living in overcrowded and poorer quality accommodation than other families'.

In this study, while some fathers were replaced by stepfathers, home life for single mothers, particularly in households with other children, was characterised by overwork and

problems in controlling the children in their adolescent years:

*My mum and dad split up when I was about two, and I lived with my mum. She wasn't bothered about me going to school. She used to follow me to school, but I was out of control when I was young, about 12.  
(Chas, 25 years)*

Single mothers may develop close relationships with their daughters, while those with sons tend to experience greater child-rearing stress and exert poor maternal control (Belle, 1994). However, the histories of women respondents in this sample were no less traumatic, rebellious or disturbed than the men:

*Interviewer: Did you ever argue with her about school?*

*Yeah. But me mum didn't really have that much control over me so it must've been quite frustrating for her because she would tell me till she was blue in the face that I was going in school the next day and if I didn't want to go I wouldn't go, or I'd pretend to go, and she was working so she wouldn't have known the difference any way.  
(Linda, 24 years)*

Research has shown that children of single-parent families are more likely to have difficulties with emotional and psychological adjustment, school performance and educational attainment, and more likely to have behavioural problems than children of two-parent families and exhibit 'depressive symptoms, high levels of smoking and drinking and drug use during adolescence and adulthood' (Rodgers and Pryor, 1998). Similar

patterns can be seen in drug-using families (Reder and Lucey, 1995) and, in particular, that the children are at risk for later substance misuse themselves (Tarter and Mezzick, 1992). A higher proportion of teenage children from lone-parent families report having offended, and problems such as child custody and children being taken into care are particularly pronounced.

In this study, one-fifth of clients were from single-parent families, all of them headed by mothers. Comparisons were made between them and those from two-parent families. The major difference was that none in the single-parent group had maintained contact with the absent father after leaving home though high proportions in both groups had kept in touch with the mother.

The absent father has been much researched (Abramovitch, 1997; Biller and Trotter, 1994; Pirani, 1989) and a number of negative outcomes for the child have been revealed. Fathers play a major role in the lives of their children and the lack of contact may impair their academic performance in comparison with father-present households. With the father absent, some research suggests that sons may be more likely to experience emotional disorders and depression, and to have behavioural problems, particularly aggression control. However, other research suggests that it is the closeness of the relationship as distinct from contact that is associated with achievement. The earlier the father leaves (under five), the greater the degree of under-achievement since progress at school in maths and reading may be impaired.

The style of parenting by fathers of boys is said to be more physical than nurturing, often

with an emphasis on sports, though more recent research on contemporary fatherhood has revealed this to be an over-simplification. Nonetheless, the model available to the boy seems highly important to an unambiguous path towards conventional expectations of manhood. It is interesting in this study that no male respondent in a single-parent family chose sport as their favourite subject, in contrast to father-present families where a quarter chose this subject. The overwhelming majority of the respondents in the sample were male and these issues may be of particular relevance to an understanding of the patterns of development that emerge later.

### Divorce and stepfathers

Research has established that, if the mother remarries after a divorce, a continuing warm and supportive relationship between the biological father and the child is a highly effective protective factor against damaging emotional disturbance. A review of a number of research reports (Rodgers and Pryor, 1998) found that continuing contact with the absent parent was likely to help the child's adjustment following separation. A father's sudden absence and continuing lack of contact can give rise to feelings of rejection and even self-blame in younger children. Divorce proceedings are rarely without acrimony and conflict that can put pressure on the child to take sides. Often there is a fairly extended period in which the family environment becomes chaotic 'as the household routines and roles break down and are re-constructed' (Hetherington and Stanley-Hagen, 1997). Children exposed to these changes exhibit a wide range of emotional and

behavioural disorders, particularly if they witness hostility between their parents (Harold *et al.*, 2001). In the overwhelming number of cases, the mother is awarded custody and, if there is no replacement father, this often means financial hardship, a decline in the standard of living and other stressors such as assuming most of the responsibility for the rearing of the child.

A third of the respondents were children of divorced parents. While there was no significant difference in the proportions in current contact with their mothers whether the parents were divorced or not, contact with their fathers was significantly less for those with divorced parents, a pattern similar to that of single parents. The only factor that distinguished this group from others was the use of drugs with friends at school, which was much higher for children of separated families.

Although offering a possible solution to the lack of support for the mother, her remarriage and the introduction of a stepfather may be even more problematic for the child than an absent father. There is evidence that the abrupt and restricted contact with the natural father after divorce tends to reduce further with a replacement father on the scene. Research suggests that most stepfathers do not attend to their stepchildren as they do their biological children. According to Rodgers and Pryor (1998), the stepchildren in these families may do less well than those in lone-parent families. If the relationships are poor, the stepchild's academic performance and social relationships may be affected. Some research has suggested that this is particularly the case for boys and more so if they are already approaching adolescence, though Rodgers and Pryor point

out that distress among girls may be different and perhaps less easily detectable.

Twelve respondents were brought up by stepfathers after divorce, nine men and three women. Only one male respondent reported a good relationship with the replacement father, but the three women reported no problems, which may represent a gender difference, but could also reflect the timing of the remarriage, which occurred when they were very young (Rodgers and Pryor, 1998). The men not only complained about discrimination in favour of their half- or step-brothers or sisters but also physical attacks. With some there were additional complications arising from the relationship between the mother and her new husband. One man who had retained a good relationship with his natural father was suspended from school:

*I was out of control by that time. I got sent to me dad's, sent to live there for a couple of weeks, but that was more because of me step-dad ... he was dead violent, he used to beat the shit out of me mum.*

(Brian, 20 years)

Several others talked of beatings and hostility but one respondent acknowledged that these might have been provoked. In this case he had assumed the stepfather was his natural father and reacted badly:

*As a child he always put me down ... he always said I'd never get anywhere and I'd be a road sweeper because I wouldn't do my homework. I was quite a rebellious child once I found out he wasn't my real father – I only found that out when I was nine.*

(Stephen, 28 years)

Another said simply 'I hate him'.

### Children in care

Approaching a third of the total sample had been in care, some of them for many years (range one month to 12 years). There was great variety in their backgrounds but all reported behavioural problems that resulted in some form of educational and social disadvantage. In a few cases these appeared early and no information was offered to relate this to childhood events. In many there was a direct link with dysfunctional relationships with parents and/or living in a poor and crime-oriented urban area. Some were in and out of care because the mother could not adequately look after the child or cope with the child's delinquent behaviour; some had attended a series of approved schools; others had been fostered or adopted.

Whereas the damage to parental relationships in the divorced and single-parent families focused on the father, those who had been in care were significantly less likely to have maintained contact with their mother and currently had a poor relationship with her. Many had a very unforgiving attitude towards their mothers:

*I hate them, well I get on with me dad but I don't like me mum.*

*Interviewer: What about her job, do you think she enjoys that?*

*I don't really care. I'm not being funny but we don't get on at all, I have nothing to do with her.*  
(Dave, 34 years)

In some cases more than one child was taken into care at the same time and the sense of family was restricted to that generation. Five women came from a care background, none had a close relationship with their mothers and two were particularly hostile:

*I've been in care from about nine.*

*Interviewer: So do you have much contact with your mother?*

*None at all.*

*Interviewer: And your father?*

*We speak on the phone but that's about it. The only person I'm close to is my twin who I go and see every weekend.*

*(Karen, 16 years)*

The problems of being in care were compounded by other related factors; those with a history of care were more likely to have moved schools and to have truanted, both of these leading to disrupted education. These observations are supported by other research, for example: Lakey *et al.* (2001) in their study of multiply disadvantaged young people found that such children were less likely to have taken exams when leaving secondary school, and Ward (1998) found a greater incidence of drug use and mental health problems.

These results support observations made on the educational potential of 'looked after' children by Barnado's (2001). Their research revealed that such children are 'ten times more likely to have been excluded from school than their classmates', and reported that very high proportions (70–80 per cent) leave school with no qualifications and that fewer than 20 per cent stay on in education after 16 years.

### Drug-using families

There was a wide range of family sizes reported by the respondents, from one to 11 children. Three-quarters of them came from families in which one or more members used drugs (see Table 1):

*Interviewer: So your father's been long-term unemployed.*

*Yeah.*

*Interviewer: How long was that for?*

*All his life, I don't think he's ever had a job.*

*Interviewer: You mentioned your father was an addict?*

*Yeah.*

*Interviewer: Do any other family members use drugs?*

*All me dad's family do, all ten of them.  
(Jan, 24 years)*

Half of all these family members used 'hard' drugs such as heroin, or the stimulants, amphetamine or cocaine. Several reported the death of a sibling through overdose.

There can be serious implications for children growing up in drug-using families, which may be chaotic and dysfunctional. Research suggests that the children are prone to stressful life events, poor emotional attachment with parents and greater involvement with drug-using peers. Much research in the UK (Buchanan and Young, 2002; LGDF/SCODA, 1997; Mounteney, 1999) and in the US (Reid *et al.*, 1999) shows that children reared in such families are at greater risk of being taken into

**Table 1 Childhood home: risk factors**

	%
Single parent	20
In care	28
Divorced parents	17
Family member using drugs	76
Brother(s)	57*
Family member long-term unemployed	37

*n* = 70

\*Of those reporting drugs used by a family member.

care. The impact of sibling drug use in particular has been noted in a Home Office report on drug use by vulnerable young people interviewed in the Youth Lifestyles Survey (Goulden and Sondhi, 2001).

### Educational disruption

The years spent in the educational system are as influential in shaping children's social identities, self-esteem and aspirations as their home environments. School can perpetuate and increase dysfunction that starts in the home and may contribute to a move into psychoactive drugs to help them deal with the problems they face.

The majority of respondents had a variety of experiences during their school years that were liable to affect their education. Sixty per cent moved house and school and nearly half of them reported relocation problems such as finding new friends, missing old friends and settling in to an unfamiliar environment. There were consequences to this disruption; the more

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moves to different locations, the more respondents were likely to leave school before completing their secondary education:

*I had to settle in again, I was doing really well at the first school and doing all my exams, and when I moved to S [name of place] I just started to mess around to fit in, and me education just went downhill. I became a person that just clowned about.*

(Trev, 36 years)

Over a third left school early. Analyses showed that this was related to coming from a family with a background of drug use, using drugs with friends and truanting.

The major form of disruption was in staying away from school. Over a third truanted frequently and regularly. Only just over a quarter said they had never truanted. Crises caused by violent acts, aggression and sustained bad behaviour in school were common. Nearly half were suspended or expelled, half of these because of violence towards a teacher or another pupil. Truanting and exclusion have been associated with offending and are predictors of problem drug use (Lloyd, 1998; Miller and Plant, 1999). These effects of exclusion have been noted but remedial interventions have not yet been found (Powis and Griffiths, 2001).

There were many reasons given by respondents in this study for their outbreaks of aggression, some of them understandable when the context was known. Just over a quarter said that teachers used physical punishment:

*... just pushing me around and giving me the slipper and the cane and strap. They thought that was the answer to all the problems instead of sitting down and talking with you.*

(Keith, 39 years)

The pupils' reactions were sometimes remarkable for their explosive and uncontrollable nature. This man was suspended for attacking his teacher:

Interviewer: *Why did you do that?*

*We had a disagreement over a bike shed. This teacher said that if I cleaned the bike shed up I could have the parts in the bike shed, so I cleaned the bike shed and made myself this top BMX. I wanted to take it home with me and he wouldn't let me. We started arguing and I just picked a crowbar up and twatted him with it.*

(Phil, 37 years)

## Bullying

Bullying between pupils was very common. Over a third admitted that they bullied their peers at school and nearly half were bullied by them. Some had devised strategies to avoid bullying by peers that found disfavour among teachers:

Interviewer: *When you were at school were you bullied by anybody?*

*I'd say I was bullied off one of the teachers – I used to have really long hair and he was one of these teachers that was, like military – short hair, top button done and all that. I was one of those that could always get round without being bullied. It was, 'oh he's funny him, he doesn't half make me laugh'. I think it's because I wanted to be liked, you know, to be part of the crowd.*

(Mark, 27 years)

Research on delinquent youth and bullying offers some insights into the social dynamics during adolescence (Carroll *et al.*, 2001; Ireland, 2001). At this time of maximum peer influence

and the search for a social identity, it is argued that young people choose to develop a particular identity and then work towards enhancing their reputations in the context of a reference group with similar values. Some choose to conform to social norms of academic achievement and they develop their self-esteem through the positive responses of like-minded peers, their parents, teachers and conventional society. For others who come from a background of poverty, neglect, psychological stress and emotional damage, the opportunities may be restricted and available mainly through non-conformist behaviour. These are children whose self-esteem is low, possibly because of poor relationships at home. According to Emler (2001) in his review of the causes of low self-worth, 'the simple answer is: parents'.

One solution to being bullied is to present an image to peers as tough and 'cool', reject the rules imposed by authority figures and avoid being 'teacher's pet'. This has the added advantage of achieving acceptance among their peers:

*We went to an all girls school and it was quite a posh school really, I suppose I was a bit of an outsider 'cos I was a bit poorer and I came from a different area, and me friend Debbie she was sort of in the same boat ... she was a bit not the same as everybody else. But we didn't bully people ... well, I suppose we did really, but now looking back on it we didn't really mean to do that, but that was the way we used to act, you know, act like it didn't bother us. So we had people who tended to want to be our friends 'cos we were a bit naughtier than everybody else.*

(Jackie, 24 years)

### Academic performance

The proportion of ETE clients that sat for GCSE examinations before leaving school was higher than one might predict given their early histories. There were a number of factors implicated in poor performance: taking drugs with school friends was associated with failure to achieve any passes and, predictably, those truanting frequently were more likely not to sit the exams and passed few subjects if they did. There was often some pressure to get reluctant pupils to take the exams:

*Interviewer: What age did you stop going to school?*

*It was halfway through the fourth year – then the school inspector came round and they dragged me in for me last week of the year. They tried getting me in for the fifth year but I got suspended for a piece of artwork so then they got me a home tutor.*

*Interviewer: Did you take any exams with the home tutor?*

*No. I only seen him one day and then I just avoided him.*

(John, 25 years)

Those who said they had been bullied were more likely to take exams. These tended to be the more retiring respondents who liked school more, making them potential targets for their peers.

The majority of the respondents' parents thought education was very important. About a quarter of the clients could be described as from middle-class families, that is, the family had no history of unemployment or of economic hardship, and parents' occupations were in

professional or management categories. Almost all of them took their exams, compared with less than half of those with a background in other employment groups. Nearly half of them passed four or more GCSEs and several passed A levels. Typically, they stayed on at school at or beyond 16 years.

### Subject choice

Of particular relevance to career goals is the choice of a favourite subject at school. This was not only instructive in identifying their preferred style of educational content and delivery at the time, but also offered insights into the perceived negative aspects of training and jobs that can set limits on their options. The subject at school that was top of the list across the whole sample was art and technical drawing (37 per cent). The most frequent reason given for most subject choices was that they were good at it (69 per cent), but the next most frequent reason for this subject was that they could see an end product.

Such choices have implications for ideas of aptitude and perceived success that persist when faced with the subjects on offer to those entering ETE schemes. What is it about these subjects that make them preferable?

*I liked art. It wasn't like the other lessons where there was loads of discussion going on – there was no talking, it was quiet and everyone just got on with it.*

(Mark, 24 years)

It emerged from an examination of themes derived from qualitative analyses of transcripts

**Table 2 School: risk factors**

	%
<b>Age left school:</b>	
Before 16 years	39
16 years	56
17 or 18 years	5
<b>GCSEs or equivalent:</b>	
None	40
1–5	30
6 or more	29
Moved house	60
House/school relocation problems	27
Member of a group/gang	64
Used drugs with friends	47
Bullied others	37
Bullied by others	46
Both bully and bullied	17
Frequent truanting	34
Suspended or excluded	43
<i>n</i> = 70	

that the delivery of instruction was quite dissimilar to other subjects: the student was left to his or her own devices for much of the time; the tuition was not public but on a one-to-one basis, ensuring that any difficulties would not be revealed to peers; progress was more likely to be self-paced; and the level achieved (in art and design) could not be measured as precisely as in more formal subjects. In addition, the teachers' approach tended to be much more about self-expression. Some of these factors have appeared in other research as recommendations for education and training among, for example, the homeless (Randall and Brown, 1999) and drug users (Richards and Morrison, 2001).

## 4 Current lifestyle

### Environment, parents and partners

The local environment in which drugs users live is often critical to successful rehabilitation. They and the professionals treating them believe that relapse is highly likely if the recovering drug user is surrounded by drug-related cues associated with other users and the places where drugs are obtainable. For nearly a third of the sample their surroundings were poor and offered depressing prospects:

*I think it's Vietnam for gear and rock. Ten to 15 years ago, or whenever it was built, all brand new but now it's all wrecked, half of it's knocked down, you know, people just like abuse the flats, you know it's like drug den city really.*  
(Keith, 32 years)

Over a third were currently living in hostels or supported housing and some intermittently on the streets. Homelessness is associated with a past history of negative childhood experiences, low educational attainment, psychiatric disorder, antisocial behaviour and crime (Craig and Hodson, 1998).

Support from their family was important to many clients. Approximately three-quarters were currently in contact with their mothers and just over half with their fathers. The quality of their relationships varied. It was diminished by several factors: those who had been in care were less likely to be in contact with parents and reported poor relationships with them; those who had funded their drug use through crime reported less contact with both parents. It is known that drug users with serious dependency problems sometimes steal from their families and criminal activity brings with it the attentions of the police, the associated stress of

court cases and shame before neighbours and friends. Those who had been in prison reported a poor relationship with the mother in particular.

The parents generally offered a good example to their children about attitudes to work, although nearly half the families had a member of the family who had been long-term unemployed. Of those from families with working parents, the vast majority of parents were said to be positive about their work. However there were differences between parents:

*Well, me dad was very much anything for nothing, you know, try and get by on as little as possible and me mum was the total opposite, 'you don't get anything without a hard day's graft, stand on your own two feet' you know, she had to do everything the hard way, the same as everybody else.*  
(George, 33 years)

Well over half the respondents had been influenced or helped by their parents in getting work in the past. For some, there was proactive help and assistance in getting a job, particularly on leaving school, and others were given advice on how to behave and present themselves.

There is much evidence that partners of drug users can have considerable influence on their behaviour. The dynamics are different depending on whether they also use drugs. Women drug users are rarely found with a non-drug-using partner (Klee *et al.* 1990; McKeganey and Barnard, 1992) but there are many women that remain attached to a drug-using man. A non-drug-using partner can be a powerful force towards abstinence and rehabilitation, a using

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partner sustains the dependence. An attempt to get off drugs with a partner who is also using them often requires an agreement for both to abstain (Klee *et al.*, 2002). The presence of children is also a critical factor in restraining drug use by parents.

Over a third of the sample, 18 male and seven female, had a current regular partner and 17 were living with the partner. Only two partners did not know of the respondent's use of drugs and, of the rest, just over half objected and had been applying pressure towards abstinence:

*Well she tries to keep me in, I've been using heroin so she'd go and buy me cannabis. She knew people who sold it so she'd go and buy me cannabis hoping that I'd smoke enough spliffs and then be too knackered to go out really and buy any.*

(Chris, 20 years)

The health of this man's partner had been affected and she had threatened to leave:

*She's getting counselling at the moment. I've got to stop or she's going basically. In the last few weeks we've built a home together so we are looking at staying together. But there's been points where, like, she was in hospital for two weeks with an infection. I mean I'm not blaming myself but I believe I've run her down you know, ground her down with my drug problem.*

Interviewer: *What does she do to try and help you come off?*

*She makes me go to the meetings [substance abuse] on a regular basis. Like she's on at me all the time if I don't go to a meeting. But I'm coming here for myself ... if she walked out*

*tomorrow I'd be really sad and upset but I'm doing this for myself, I'm trying to get clean for myself. And then she'll reap the rewards from me being clean.*

(Rob, 27 years)

The majority of partners who did not object were using drugs themselves, though these were mostly 'soft' drugs. Several clients reported relationships that had ended recently, perhaps suggesting that this may have been associated with the desire for a change to their lifestyle, noted in research on amphetamine users entering treatment (Klee and Wright, 1999).

Just over half of the respondents had children, and nearly a third were living with their children. Half of the partners were themselves unemployed. There was a strong association between having been in care and not having a regular partner. Twenty-one who had not been in care had a regular partner, compared with only three of those who had been in care. Although more research is needed to evaluate this observation, it may be that the legacy of a history in care can have implications for later personal relationships.

## Health, drugs and drug treatment

In reporting recent mental health symptoms the most common was depression. Over a quarter were currently prescribed anti-depressants. A similar proportion said they had experienced paranoid delusions. The origins of these were unknown since many were still using drugs (which, in the case of amphetamine, can have persisting effects) and there were others for whom endemic mental health disorders were

suspected by the interviewer, though not corroborated by the respondent. Half of the sample reported hepatitis B or C and 12 people reported thrombosis induced by drug injecting. A wide range of general health problems of a more minor and temporary nature were also mentioned. The prospects of drugs interfering with performance on a course or while working could be high. In the previous month, three-quarters had used street drugs (see Table 3).

The respondents' health problems were reflected in their Social Security benefits. Well over a third were receiving Sickness or Incapacity benefit and another 13 per cent were on Disability benefit.

A third of the respondents were currently prescribed methadone by a drug agency. Many more of those prescribed methadone (64 per cent) had used heroin than those not prescribed methadone (20 per cent). A prescription indicates heavy opiate dependence. The occasional use of street heroin, though fairly common among drug agency clients in the early phase of treatment, means that there is contact with drug-using networks that is likely to impede progress towards rehabilitation. Data from research in Scotland (Richards and Morrison, 2001) reports that only a fifth of those prescribed methadone said they were ready to look for a job.

**Table 3 Current context: partners, drugs, health and finances**

	%
Regular partner	36
Living with a partner	24
Partner disapproved of drugs	52
Accommodation in drugs area	23
Clients who used street drugs in past month:	73
Cannabis	66
Heroin	31
Cocaine or crack	30
Prescribed methadone	33
Mental health problems:	
Depression	31
Paranoid delusions	17
Social Security benefits:	
Sickness/Incapacity	34
Income Support	23
Job Seekers' Allowance	16
Disability	13

*n* = 70

### Crime and drugs

Current or past drug use was not always or comprehensively funded by crime. A third of the clients obtained the money through legitimate work and another third through unregistered work. Some had never resorted to crime; others only funded drugs in this way; and some combined crime with work.

In line with research on ex-offenders (Fletcher *et al.*, 1998), three-quarters of these problem drug users faced a double disadvantage in getting work because of their criminal records. For over half, this was for a property crime: 31 per cent theft or shoplifting and about a quarter for burglary. Similar proportions reported drug dealing and acts of violence. One-fifth were currently on probation. While in prison, over three-quarters were offered educational or training courses and almost all took them up, though not always for the best reasons:

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Interviewer: *When you were in prison did you do any education or training courses?*

*I did a bit of education. I just did it to get me out of a cell.*

(Rob, 22 years)

Others felt that prison was an opportunity, not only to use the time in getting qualifications, but in ‘self-improvement’, frequently cited as a motive for training across the sample as a whole:

Interviewer: *What [training] did you do?*

*City and Guilds. I got myself a basic education that I missed out on, so I did it in Maths and English, and I did a lot of social and life-skills courses.*

(Ian, 28 years)

*They taught me to take responsibility for myself.*

(Simon, 32 years)

For another respondent, the courses on drug use were the most valued and made an impact on his attitude:

*A lot of Maths, a lot of English, a lot of drugs courses – you know, rehabilitation, thinking skills, family relationships. And then just odd things, like woodwork, drama, cookery. I was on a lengthy sentence so I knew I just had to get as many certificates as I could.*

Interviewer: *Were any of those helpful would you say?*

*The drug ones were helpful because they looked at it from our point of view. We managed to sit down and talk. Even if it was alcohol, gambling or*

*drugs like, it all comes down to one addiction – it’s all the same. It’s a lot easier to talk between yourselves ... it knocked me off drugs, I don’t take drugs now apart from weed.*

(Mike, 20 years)

The majority believed that their criminal record would make it difficult to get a job and nearly half of those who had filled in forms when applying tended not to declare this. While most did not reveal their use of drugs voluntarily, if their ETE adviser was from probation or an agency specifically dealing with drug users, this would be a signal to any potential employer. It is easy to understand why exposure was avoided; over a third said they had lost a job through drugs, mostly a result of the effects on performance such as lack of concentration but also poor timekeeping and absenteeism.

**Table 4 Funding drug use, offences and prison**

	%
Funding drug use:	
Unofficial work	39
Legitimate employment	33
In prison or police custody:	77
For theft / shoplifting	31
For burglary	24
For drug dealing	24
For acts of violence	23
For drug possession	17
Currently on probation	21
Sacked because of drug use	36

*n* = 70

### Multiple disadvantages

Many respondents were subject to a disproportionately high number of risk factors for behavioural problems, drug dependence and criminality. Over three-quarters of them had a criminal record. According to Fletcher *et al.* (1998, 2001), ex-offenders are multiply disadvantaged, as are many homeless young people (Randall and Brown, 1999). A survey of young multiply disadvantaged New Deal entrants (Lakey *et al.*, 2001) confirmed that care leavers, ex-offenders, those with drug problems and those who had been homeless face barriers to employment. Added to these are people disaffected by or excluded from school, those with drug-using parents and those living in

problematic family circumstances (Goulden and Sondhi, 2001).

A summary of proportions of clients with two or more disadvantages can be seen in Table 5. They are: a history of care, a criminal record, no qualifications from school, suspended or excluded from school, family member(s) using drugs and current homelessness. Nearly a fifth were members of three disadvantaged groups.

When individuals were compared across these and additional current risk factors – that is: living in a deprived area, lack of parental support, living with a drug-using partner, reporting mental health problems and using street drugs – those who had been in care were at highest risk.

**Table 5 Clients with two or more disadvantages as proportions of the total sample (n = 70)**

Disadvantage	%	With	Frequency	%
Criminal record	77	Family use of drugs	36	52
		No qualifications	29	41
		Current homelessness	11	16
Family use of drugs	76	No qualifications	24	34
In care	28	No qualifications	15	21
		Family use of drugs	14	20
Current homelessness	20	Family use of drugs	13	18
		No qualifications	9	13
No qualifications	52	Suspended from school: 37%	16	23

## 5 Clients' views of services

### Joining a scheme

When asked why they had joined an ETE scheme, only one-fifth of the clients identified getting a job immediately as their main reason. For many people they felt they had reached a point in their lives when they needed to change:

*I was just sick of my lifestyle, sick of working crappy jobs and not getting good money, you know, you don't get anything without a degree or A levels or some kind of qualification, so I thought the time had come for me to do it.*

(Anne, 25 years)

For many others there were reservations:

*Interviewer: Would you go for any sort of training now at the moment?*

*I'd go to college on a part-time basis. I don't want to overdo it because I don't want to get stressed. If I get stressed it'll cause me to relapse.*

*Interviewer: How do you feel about your prospects for the future?*

*I don't really look too far into the future. I'm taking a day at a time – just concentrate on today and whatever happens tomorrow happens.*

(Martin, 32 years)

Some respondents believed it was necessary to come off drugs before looking for a course:

*... they haven't got the time ... they spend all their time robbing, thieving. They have to be clean first before they can go into education.*

(Phil, 28 years)

The most popular vocational courses were associated with a trade such as building, plumbing, decorating and electrical services.

This reflects not only the gender bias in the sample but possibly the absence of academic school qualifications that might lead to white-collar work. The attraction of non-vocational courses that were popular at school, such as art and wood-working, persisted and a high proportion chose computing which was available almost everywhere.

Another popular choice was drugs counselling. Fourteen clients chose this. A common view among drug users in treatment is that such counselling is best done by those with direct experience. Many clients had been counselled about their drugs and knew that there are genuine opportunities since ex-drug users are employed as counsellors, particularly in NGOs. Currently, there are no qualifications that determine entry into drugs counselling. This respondent already had a diploma in counselling:

*Well, what I would like to do I might not end up doing. But I would like to end up as a drug worker, because I'm an addict myself. I want to get back into care work and helping people but it's going to take a long time because I'm not 'clean' and my mind isn't healthy and I have a lot of work to do myself.*

(Paul, 35 years)

He believed that there were still dangers of being drawn back into drug use. Drug users consider themselves experts in this field and feel fairly confident that they can do the work. For people who lack formal qualifications and the self-confidence that goes with them, broadening their horizons is a risk; they would be less likely to fail in this occupation.

## Completing the course

Three-quarters of the respondents had failed to complete a course they had started. There were many reasons given: getting bored; not realising what it involved; long hours; and the distance to travel. However, half of them reported that a course had led to employment, although that work was not necessarily sustained. Others abandoned a course because they relapsed. This was a major concern of clients in the early months of abstaining from drugs:

*Interviewer: Do you feel pretty optimistic at this stage about finishing the course?*

*No, I feel a bit weak actually. I've been off it a couple of months and I had a relapse last week. One of the lads here, me and him went out for a drink, you know, at dinner time just for a pint, and we just got talking and then we just triggered each other and went and scored [obtained drugs]. I mean, I were that close to getting a habit again, it went on for three days. I don't think I'll get a habit again, but I don't know if I won't relapse again.*  
(Chas, 35 years)

Nearly three-quarters of clients who had completed a course felt they had benefited from it. Qualifications were important for those who had left school without them, but the majority described their reasons for taking them up as contributing to their self-development:

*Interviewer: So people made comments about the changes they saw in you?*

*Yeah. People that I work with on the course, people in this house, they've said that the course has made me do things differently, think of other*

*people and not myself all the time, to be responsible ... that's what it's made me do. They see that I'm getting up for college every single morning, coming back, you know, different. And I've cut down [drugs] an awful lot and I'm really proud of myself because I didn't think I could. The college is keeping me busy you see, that's the thing. And I've got to keep myself busy all the time now because I think if it stops then the drugs might come back.*

(Robert, 23 years)

For this woman, the support she had received from a specialist agency targeted at drug users helped her to manage her life, though it had not been easy:

*I feel stronger ... I can see a future for myself more now than I did then because I've been given the coping skills. And I didn't really have the support before and now I've got it. I'm six-and-a-half months clean and I spent 17 years using. I refused to get any help for a long time because it was like – the feeling wasn't there, but it was just ruining my life.*

(Angie, 35 years)

## Getting a job

Drug use is regarded as a chronically relapsing condition, partly because the causes have never been successfully addressed and partly because opportunities to 'escape' the lifestyle with its powerful associations are rare. The fear of relapse affected motivation and expectations of success in these respondents. When exploring their attitudes and aspirations one could not assume that their current ambitions were to get a job. Two-thirds said they would like to have a

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job in the future. However, many were not ready, either because of their unresolved drug use, mental state or the lack of qualifications:

*The way my head is at the minute, I'm not interested in work ... I just want to get better for now. A college course, couple of days part-time ... that'd be just enough for my head to take.*  
(Andy, 25 years)

In an open question that asked respondents to identify the positive aspects of getting a job, these were, in order: a higher income, greater respect from others, being more active, having a more interesting life and greater confidence. A question concerning drugs and employment revealed that just over half of the respondents believed that work would make it easier to get off or stay off drugs. When asked why, three-quarters of them said because their time would be occupied:

*I knew I had to fill my day up, I mean, I didn't really know what this was about but I knew it would fill my day up. That were basically it.*  
(Ian, 26 years)

When asked what sort of job they thought they would do eventually: a third named work of a skilled manual nature; approximately a quarter said counselling; and nearly one-fifth each said skilled non-manual or unskilled.

The other most influential factor undermining the desire to get a job was purely economic. Most drug-using respondents in this study were receiving Sickness or Incapacity benefits and this presented a problem that had to be negotiated with some skill if they were to be able to join a scheme of their choice without financial loss. Often their enthusiasm to work

was not in doubt, but their concerns were real enough; for this man it was a strain:

*The situation was – I had me Incapacity benefit and if I went to work they took that away and that was kind of like me prop if you know what I mean. So I was going to work and I was working on the side and getting me benefit – I knew that was wrong ... I was always looking over me shoulder and it made me a nervous wreck.*  
(Malcolm, 36 years)

## Clients' evaluations of the service

Evaluations of the service were mostly very positive. Nearly all said the staff were helpful. Three-quarters thought the premises were user-friendly; their main criterion being that it had a good atmosphere. The quality of the buildings and offices were often regarded as poor, but it seems they were acceptable and made up for by the quality of the care and attention they received.

Few Community Drug Teams offered ETE advice on the premises. If they did, while some clients were glad to be on familiar territory, there were complaints of relatively poor access to information about courses. There were other reasons for going elsewhere for this recovering drug user:

*If you've come off [drugs], the last thing you want is to be sat two hours while they're walking in and out picking prescriptions up, coming for needle exchange, or just coming in screaming and shouting because they've not got their script in the post or whatever. It's all that turmoil you've left behind, and if you're caught on a bad day, some people would start it off again. You're in a vulnerable position.*  
(George, 36 years)

Some advisers were particularly praised, particularly those based in specialist ETE agencies that helped drug users or other disadvantaged people:

*She helped me with all the forms to fill in and went through the courses with me, which ones I wanted to do, she was on the phone talking to people at the college. She virtually did it all and I just put my name on the paperwork.*

(Keith, 31 years)

Almost all assessments were in the form of a single interview and most were happy with the advice they were given. There were a few exceptions however, this from a client of a mainstream agency:

Interviewer: *What did you think of that [the assessment process]?*

*I had to ring back on several occasions just to check up on things. I did feel as though the people were just trying to fill the places on a course rather than interview you to see if you were capable of doing the course.*

(Mark, 41 years)

Having become enthused about the choice of course, there was frequently another hurdle to surmount while the adviser enquired when this started and whether there were places available:

*The waiting times, I mean, I generally want to do something at one time but then you have to wait four to six weeks for a course. But, by the time I've put my name down for it and the time it's come, I won't go. Sometimes I feel dead positive but I've got to do it then, I can't wait six weeks 'cos I might change me mind in six weeks.*

(Dave, 26 years)

For those not immediately seeking to work their aim was to make a step on the way:

Interviewer: *What are the courses you're doing?*

*Pottery workshop, art workshop, the basic computers then progressing to IT skills, cookery and physical fitness. I chose two for therapeutic, one for fitness, two for future work, and business and the financial side.*

Interviewer: *Do you think these will improve your chances of a job?*

*I know the computers will, the others probably won't but I might be a better person for doing other things.*

(Keith, 31 years)

There were more pressing needs for self-improvement among those with learning or reading difficulties:

Interviewer: *How've you heard about them [ETE schemes]?*

*I went to like a class, you know, for me reading and writing and that, and I was a bit intimidated with some of the people about me. It just didn't feel right. If I do it, I'd like it on a one-to-one basis or something like that.*

(Terry, 18 years)

For many respondents there were doubts about the ultimate outcome of their efforts in education and training because of their criminal record:

Interviewer: *For you personally how could the Government improve your prospects?*

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*Taking away me criminal record, giving me an equal opportunity, give me a chance to make something of myself. I know it's down to me this criminal record but at the same time I know I've changed, I know I can be responsible and trusted. Just to be given a chance to make something of myself without this prison sentence hanging over me head.*

(Brian, 33 years)

## Improving services

Most respondents were keen to say how services could be improved. An overwhelming majority believed that the Government was not doing enough for drug users and there were many views on the form that this should take.

The most frequent were: increasing the number of schemes, increasing funding and changing the rules on benefits. The value of a specialist ETE provision for drug users within New Deal was mentioned by only six respondents. This suggests that such a move would not be universally welcomed. Those who had successfully abstained and had more confidence were keener to disassociate themselves from the drug sub-culture and put it behind them:

*I think if you put too many drug-heads together you wouldn't see much get done.*

*Interviewer: So is that a problem then, that you're surrounded by people with similar problems?*

*Yeah, I'd prefer not to be.*

(Simon, 32 years)

## 6 ETE workers' views of their service

### The knowledge base of ETE staff

ETE professionals identified what they considered were the major barriers to clients gaining entry to the workforce that were associated with their personal characteristics. In order of mention, they were: lack of commitment by the client, their chaotic lifestyles, a criminal record, a higher income derived from benefits, lack of confidence and lack of qualifications:

*They might never have worked at all, it might be their lifestyle is totally chaotic because the drug use is their priority, they might not have settled accommodation, they might be in such a state they're just totally unaware of how they present themselves physically. Their social skills might be just totally lacking or inappropriate or have never been used.*

(Harriet, Probation ETE Adviser)

Certain jobs could not be considered because of the nature of the clients' criminal convictions. These mostly depended on the type of job: for example, serious driving offences would rule out most transport work. A wide variety of more idiosyncratic barriers were mentioned including collecting a daily prescription of methadone in business hours, a fear of using public transport, being unable to get a bank account to receive wages, lack of affordable childcare, poor presentation skills and attitude to authority. In particular, a very common problem was a reluctance to travel to courses or jobs outside their own neighbourhood. For those with serious disabilities, the options were very limited:

*Interviewer: Would you say that some of your clients are unsuitable for education and training?*

*Yes I do. Some clients with mental health problems. The only bit of advice that I thought would be suitable for one particular client was for him to buy a dog for therapy, to take it for a walk, stroking it, and so on. He lived on his own, he was suicidal.*

(Janet, Probation ETE Adviser)

The view of most professionals was that their drug-using clients had a range of problems. Many ETE advisers were reluctant to probe into personal histories since this might be seen as invasive and undermine the rapport that was needed to be able to assess and advise them. When asked what were the important items of information they needed to be able to work with their clients, family background was rarely mentioned. The level of awareness of critical factors that might be implicated, such as being in care, was low. This observation was an exception:

*In the hostels particularly, there's a lot of them that from the age of 12 they've been in and out of homes, if not before. A lot of them have been abused as well, either in the homes or in their own home.*

(Jane, Probation ETE Adviser)

However, the client's educational level was regarded as very important by just over a quarter of ETE workers. Enquiries tended to be restricted to basic skill levels and the qualifications achieved. When ETE professionals were asked to describe their drug-using clients, the profile that emerged was:

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mostly males, between 16 and 35 years, and 'disadvantaged'. Half of the professionals believed that problem drug users were 'mostly without qualifications'. However, some professionals qualified their view with reasons for their low achievement:

*They are largely of low educational attainment ... that's not to say we don't have the odd one or two with degrees and A levels and professional qualifications, but they appear disaffected through the educational system. Maybe some of them tend to be a little on the aggressive side or impatient and perhaps a little lacking in certain social skills.*

(David, Probation ETE Adviser)

When asked what they thought were the positive aspects of drugs for such clients, 'escape' was the main perceived benefit, followed by pleasure, and then the cohesiveness of the drug-using social network. One adviser noted a similarity between employment and drug-related activities:

*One positive thing that people get out of their drug use, a strange thing to say, but actually selling drugs ... it gives them an entrepreneurial sort of flair, they know how to sell things, and they actually do make money and gain confidence from doing that. I don't like saying that to be honest, but it's true.*

(Dave, Probation ETE Adviser)

A question on what was needed to replace drugs gave rise to suggestions of an alternative reward system through education, training or employment, an increase in self-awareness and personal development, and entry into a non-using social network. This trainer was mindful

of the need for careful progression in rehabilitative interventions:

*Interviewer: How might their goals be achieved?*

*I think by giving targets that are achievable, which would raise self-esteem. I think the difficulty is that all of those take time, whereas the drug is an instant thing. And that is the biggest step, having to be patient and waiting for things to come.*

(Mary, Trainer)

Knowledge of a criminal record was regarded as critically important by ETE advisers though often the most difficult to obtain from the client. This was easier for Probation ETE advisers since they have access to information about their clients' crimes. ETE workers outside the Criminal Justice System had to rely on their clients' honesty. Getting ex-offenders into work was difficult and often disappointing for the adviser as well as for the client:

*This guy actually had skills – catering skills. I managed to get him to apply successfully for a job in a local pub as the chef. He was clean, he was thrilled to bits and then ... I'm not sure if somebody came in the pub and shopped him ... but he lost the job. He's ended up slipping back into using, lost that accommodation. He's now in different supported housing, but it's not as good. He's got another court case coming up ... I think he's been caught shoplifting again. I think he's on the slippery slope.*

(Helen, Probation ETE Adviser)

## Assessment and referral

The importance of assessment has been stressed elsewhere in research on disadvantaged groups

seeking employment (Fletcher *et al.*, 1998). In Scotland (Richards and Morrison, 2001), a study of drug users led to the observation that initial assessment is 'critical in deciding on an individual support and action plan'. This assumes that a drug problem has already been identified. For most ETE professionals in the North West the assessment or referral procedures might indicate whether clients were using drugs, but this was not predictable. Many mainstream ETE services relied on clients volunteering the information or their own intuition. A study of ETE workers in Leicestershire and Rutland (Meier, 2001) also revealed that there was no standard assessment that could surface drug-use problems among their clients. Some workers, keen to avoid alienation with clients, had devised a strategy of embedding drug use within the context of enquiring about potential barriers to employment such as health concerns.

It was acknowledged by a very high proportion of mainstream ETE services in the North West of England that clients with drug problems had needs that their service could not meet, concerning, for example: accommodation; mental and physical health; and the need for detoxification, rehabilitation or some other form of drug treatment. If these were surfaced at interview they were addressed through referral to other agencies. This was not always successful, however, and most professionals said their referral system could be improved. The most common suggestions for improvement were: better co-ordination of referrals between and within agencies; persuading other agencies to refer more often; and for staff to travel to other sites in order to

encourage self-referral among users. The main problem that all professionals reported in accessing other agencies for their clients was the length of waiting lists for courses and treatment.

ETE professionals and their clients did not always agree on the most appropriate plan of action. Clients' aims were said to be 'usually realistic' by nearly half of the professionals, 'over-optimistic' by another third and over-pessimistic by the rest. Clients were encouraged to identify realistic aims by offering alternatives to them that were realistic, talking the client through the development of aims in stages, or describing what is needed to achieve that aim in order to demonstrate that it was not possible.

### Training problem drug users

There were relatively few services providing education and training specifically for drug users. Some of the trainers were dealing with the more basic needs of clients, for example: literacy, numeracy, job seeking, writing a CV, interview skills, and a variety of courses were aimed at confidence building. Others taught on popular educational courses, such as IT and art, which were widely available at local colleges and adult education centres, statutory and voluntary drug service offices, and some non-governmental training centres.

Half the trainers felt that most of their drug-using students were motivated to join their course by a desire for self-improvement rather than to get a job; some needed to show a commitment to change when a court case loomed, or to avert a threat to their Social Security benefits. When discussing the training needs of drug-using clients, trainers referred to

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a combination of the physical effects of drug use and the associated lifestyle. Their needs were accommodated where possible by fostering an informal atmosphere, flexible session times and individually tailored learning plans. Some trainers believed that it was important to show users that they were valued as students and to break sessions up so as not to lose the group's attention. In other respects, trainers felt that client drug use was of little relevance to their teaching sessions. Most of them taught mixed groups of users and non-users and they reported that the users and non-users generally got on well together. There was little evidence of stereotyping among trainers:

*Well, drug users are no different from anybody else. They're just people who've tried something and maybe liked it and do it more than they should, and it happens to be illegal. I have more trouble with alcoholics than I do with drug users because most drug users keep it to themselves.*  
(Jean, Trainer)

Over half the trainers felt that working with drug-using clients had changed their attitudes towards them and their training needs. Through personal contact they had a better understanding of the nature of any limitations and also their potential for success.

### The image of the service

Most clients were very positive about the services and some descriptions of the interviews were overwhelmingly complimentary. Although premises were subject to some criticism, this was well tolerated. It was surprising, therefore, that most professionals felt that there were aspects of their service that actively discouraged

users from accessing it. The reasons given for these were many and varied, but two aspects stood out. One was the building itself, which could be alienating; for example, access to the premises could be through locked doors using an intercom and, in some, the reception staff were sealed behind a glass screen:

*Structurally wise – as they come in, it's just a small reception room, locked doors, glass or perspex at the front, it could make them feel a bit uncomfortable straight away.*  
(Seb, Probation ETE Adviser)

Such security measures may be necessary given the nature of the service, its clients and sometimes the location, but they are, nonetheless, barriers that anxious clients may not have the confidence to surmount. The other problem was that services were often located in run-down and poorer areas, which were sometimes a distance out of town and involved travel and its associated costs.

However, the buildings and location were not as off-putting to these clients as the ETE advisers thought. This is probably because each group worked to different standards in terms of accommodation. Many current or recovering drug users live in areas that are not often salubrious and welcoming. They are also familiar with services, such as Social Security, where there is physical protection against the clients. That ETE professionals were sensitive to the comfort of their clients was a feature of the quality of the staff that was appreciated by many of their clients.

A variety of other perceived barriers emerged from interviews with professionals: that drug-using clients fear being pushed towards options of no interest to them or for

which they are not ready; they fear breaches in confidentiality; they dislike mixing with other users when trying to stay off drugs; and they dislike being in classes with people from other disadvantaged groups, such as people with learning difficulties or mental health problems. The profile of clients seen in agencies was another issue; the dominance of male staff and clients might deter women from presenting, and many professionals said they saw very few drug-using clients from minority ethnic groups.

### Communication and co-ordination between professionals

ETE workers were asked to rate the quality of communication within their agencies. In general, advisers rated their own standards of communication significantly more favourably than did their Probation colleagues who were sub-contracted to work within the Probation system but were not part of it. They were least likely to feel part of a team and more likely to complain of feeling isolated. However, significantly more of them said that overall management was an aspect of the organisation that did work well.

The main methods of internal information sharing across ETE professionals were, first, team meetings, then memos and 'informal chats'. Only five workers said that computers were used. Limited resources meant that these were often shared and rapid access when dealing with clients was not possible.

Communication between agencies was generally acknowledged to be poor. A similar finding emerged from a study of employment and training for ex-offenders (Fletcher *et al.*, 1998). The term used by the researchers in 1998

was 'fragmentation'. Project development appeared to be ad hoc and 'related to the availability of funding rather than strategic development'. Though multi-agency partnerships are increasingly recommended, it appears that the effects of a 'contract culture' still persist. Only a third of the workers in the North West believed that ETE issues and aspects of good practice were shared between their employers and other agencies. Another third did not know whether or how it happened; the rest believed it did not happen. Staff were aware of the rivalry induced by competitive funding:

*I get the impression that because we're target-driven there's some competitiveness between the offices and a reluctance to give too much away of how they get their outcomes.*  
(Rachel, Probation ETE Adviser)

Despite the time-limited nature of funding and the need for continuity, little interest was shown in funding opportunities and how these could be shared between organisations. Confidentiality was a major concern when considering interagency communications about clients with drug problems.

Nonetheless, almost all professionals believed that co-ordination between ETE organisations dealing with drug-using clients should be improved: for example, by integrating projects and changing inter-agency referral systems.

They also identified as desirable the adoption of a common language between agencies, common policies, more inter-agency meetings and more time to attend them. Other ideas involved a centralised co-ordinator who should be responsible for pursuing these developments, not the agencies involved. These

observations are consistent with earlier research data on employment and training for offenders (Fletcher *et al.*, 1998) in which there were ‘considerable obstacles to co-operation’ in the system. The authors there concluded that ‘it may be necessary for national government to take a more proactive role’.

Professionals were frustrated by the lack of co-ordination and concerned about the range and diversity of services available regionally. Most of them wanted to learn from other agencies: about examples of good practice, about drug issues and services, and about their work in a way that would inform their referral decisions.

### Defining ‘success’: the nature of target outcomes

For many professionals, ‘success’ was reaching the targets set by their funders. They were seen as a form of quality assurance; a way for funders to check that agencies were allocating resources in the manner agreed. Some ETE advisers were passively hostile to the targets, seeing them as hurdles that had to be negotiated in order to stay in business; others were actively hostile and unable to see any reason for them. Targets were not a common feature in the training environment. Many ETE workers were subject to the additional stress of frequent review of their funding, which was on average about every three years but, for those operating on budgets from several sources, could be annual.

When asked if there were benefits in this form of funding, nearly half said there were none. Some admitted that: it allowed for some flexibility that was needed to develop new and

innovative services; it ensured value for money; enabled the agency to act independently; and motivated employees to work hard so that the funding would continue. Nonetheless, there were more disadvantages identified than benefits, the key one being that their service or their job would disappear if funding were not sustained. As one ETE worker said:

*It's like having a Sword of Damocles hanging over your head.*

(Derek, ETE worker)

Only eight of the 40 professionals saw the act of engaging in education, training and employment schemes as the primary definition of success for drug-dependent clients. The majority believed that any positive movement in their quality of life should be regarded as a success. While this could include attending a course, more potent would be evidence of improvements in their self-esteem or lifestyle. The critical factors for achieving success with clients were, in order of frequency: the client’s commitment and co-operation with services; the level and quality of input from the services involved; the quality of the client’s support network; and the client’s level of drug dependence.

Attributions by professionals of success were subtly in favour of the client. There was a tendency to attribute success to clients more than blame them for failure. Similarly with the capacity to keep drug use under control: it was worsening drug use that was blamed for failure more often than a client’s inability to reduce or abstain. However, advisers were understandably upset when their efforts were in vain:

*I had a client from a Homeless Offender's Unit and he was interested in a barber's course ... I got him in there, got him enrolled, paid the course fees, got him equipment like clippers and accessories. He got started, and then about three months later he sold all his gear and sold the accessories to fund his drug habit.*

(Brian, Probation ETE Adviser)

There was general acceptance that problem drug users are multiply disadvantaged and that 'hard outcomes' in terms of getting a job or formal qualifications may be appropriate for those who are 'job-ready' but not for many others. These observations have emerged strongly in other research and the growing consensus view seems to be that a more appropriate outcome for such clients would be based on a measure of 'distance travelled' (Richards and Morrison, 2001) with a focus on getting clients through a series of intermediate stages that could begin with help for drug dependence and improving basic skills.

### **Social Security and job opportunities**

It has been evident for some time that a way of balancing financial support through Social Security benefits with inducements to train and seek work has to be found. This is an important, and so far intractable, systemic barrier to successful entry into the workforce that has been noted in other research (Randall and Brown, 1999; Richards and Morrison, 2001).

A proportion of the clients were not only receiving Sickness, Incapacity or Disability

benefits, some were also topped up with additional allowances. Relatively few were receiving only a Job Seeker's Allowance. There were many genuine cases of continuing drug dependence and a correspondingly powerful fear of relapse that could bring about financial hardship if it occurred after starting work. Clients tended to believe they knew their own limitations. Some had tried jobs and had failed to adapt to the discipline of work. The jobs they described had aspects that would be unattractive to most employees: repetitive or shift work, long hours, low pay, no pride in the job and so on. For those clients with skills, this was underemployment, but it was the view of some professionals that they were offered these jobs because the better jobs needed someone who was more reliable.

There were differences between the advisers and trainers in how they felt about underemployment. ETE advisers thought that it was less damaging and less inevitable than the trainers, taking a more optimistic view of the individual's resilience. They agreed on one point: that underemployment could be a starting point and a foot on the ladder from which to gain a better position in the job market. However, some were sceptical, believing that many clients were stepping on and off the ladder rather than upwards; if the client was not very confident, the pressure of a better and perhaps challenging job could be a disincentive. A positive feature was that a criminal record might not be a barrier to these jobs and this critically influenced client choice.

# 7 Employers

## ETE advisers' views

Most ETE advisers did not approach employers directly on a client's behalf, or attempt to engage them in partnerships that could be sustained. The emphasis was more on equipping the client with the skills to job-hunt and make applications. Advisers were concerned about employer prejudice against problem drug users, which largely stemmed from an association with crime. This was seen as the most powerful barrier to these clients getting work. They could not be advised to avoid disclosure of their convictions on job application forms though some advisers observed that the jobs that attracted their clients did not involve application forms anyway. They were aware, however, that many of them did not disclose a record. A popular strategy was to write 'to be discussed at interview' on the application form so that it would not undermine the otherwise good aspects of their application. Describing the crime and convincing the employer that it was past history was also thought to be easier in person. Some professionals believed that unattainable standards were rigidly applied by the employers:

*I'm not a big fan of employers. Employers constantly moan that the workforce isn't suitable but when you ask them what they want, they always have completely unrealistic expectations.*  
(Mark, ETE Adviser)

Some ETE clients were aware of the implications and believed a more proactive approach should be adopted by service providers:

*I think there should be a liaison between business and somebody like S [adviser]. There should be a scheme where you get people that have fell off the conveyor belt back on it – but it doesn't seem to be like that. You're left high and dry and discriminated against forever, unless you can find some extra special motivation, you know, to put yourself back on it.*

(Mike, 37 years)

There have been attempts at engaging local employers in a dialogue about taking on recovering drug users. Meier (2001) found that employers had serious reservations about accepting any New Deal clients. ETE workers had little success with recruiting them to a list of those who would agree to employ people from disadvantaged groups.

## Employers' concerns

Twenty employers were interviewed in this study. They varied in the type of work, the size of the organisation and the level of management of the interviewee. The smaller the company, the higher the proportion of locally recruited employees. A specific drugs policy for recruitment existed only in larger companies with employees of more than 1,000. Four companies required candidates to have been drug free for the previous two years; the range across all employers was from six months to four years.

Employers were asked to list the ways in which a drug-using employee would be considered a threat to the company. The first concern was about their trustworthiness and the next most important was absenteeism. There

were many other problems that were assumed or had been observed: being a hazard to other workers and subject to disruptive moods swings, unreliability, lacking concentration, being aggressive and generally tarnishing the company's image. However, when asked about the employees who had subsequently become known as drug users, most felt they had got on with their colleagues as well or as badly as any other employee.

All large companies expected soft drugs to be fairly common among their employees, compared with less than half of the small companies. Larger companies were also more likely to have had heavy drug users on their staff. Soft drug use was not considered as serious a threat and most employers did not see recreational drug use as a problem.

Although they wanted to avoid recruiting drug users, most employers believed they could not avoid it entirely. Just under half expected recreational drug use. Various groups were nominated as likely to use recreational drugs: younger employees; 'creative' employees; temporary rather than permanent; academic rather than administrative; and those working in call centres rather than traditional offices open to the public.

Employers were asked what would make drug users acceptable employees. The response was that reassurance would be needed that they were not to be a risk to the company. This suggests that a more active and sustained role for ETE advisers might be needed in the first months of employment. Some were sure that abstinence from drugs was critical to such reassurance, an attitude that was significantly stronger among the smaller private businesses:

*We have a total 'no drugs' policy. Anyone with drugs on the premises will be removed, customer or member of staff. It's just not worth risking the licence and my job basically. The police are very tolerant of a lot of things you know, but we don't want to be known as a drugs den.*

(Mike, Bar Manager)

### A criminal record

A criminal record was regarded as a major handicap to getting a job by the ex-offenders in the client sample. ETE professionals felt that much of the employers' prejudice against their clients was caused by the association between crime and drugs. However, the prejudice seemed to be the result of the pragmatic requirements of their particular business rather than a moral stance:

*Interviewer: How would you know if people coming to you for a job had any criminal convictions?*

*If I knew them I suppose I would. If I didn't and if no one said anything bad to me about them, I wouldn't. It would depend what it was. I wouldn't want someone driving a van who was banned, or someone done for burglary. We're working in people's houses and people have got to trust you. (Eric, builder)*

*They have to be polite and well dressed, we're a clothes shop so people who want to work here usually dress well anyway. We've got a smart image, I'm not flogging tee shirts at the market, you know. I won't have drugs in the shop and I don't want staff coming in stoned either. Like, a spliff at lunchtime ... it chills you out too much.*

## Employing drug users

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Interviewer: *What about hard drugs?*

*Yeah, well that's different ... heroin turns you into a thieving sack of shit.*

(Jason, owner, menswear shop)

When asked how convictions that were disclosed on application forms were treated, nearly half of the employers said they were considered in the context of the rest of the application. Four pointed out that their job application forms did not require disclosure. Other procedures were to give the decision process over to a third party, such as the DVLA (Driving Vehicle Licensing Authority) for transport companies, or to discuss suitability with the police. One drug agency and the hospital kept disclosed information separate from the application unless or until an individual was shortlisted. In this way prejudice could not affect the shortlisting process and the circumstances could then be discussed at interview.

The main issues when recruiting staff were how the crime might be offset by the quality of the applicant and how recently the crime occurred. Employers thought that some crimes were more acceptable than others. Non-violent crimes were the most acceptable, though there were several who were also forgiving of crimes committed some time ago. A common view was that people can change over time, but a non-violent disposition was vital for many jobs involving contact with the public. There was more agreement on unacceptable crimes: violent and sexual crimes, for example. Similar observations have been made in other research (Fletcher *et al.*, 2001).

## Drug testing

Only two employers included drug testing in their recruitment procedures. Smaller companies tended to have no specific policies for recruitment, relying on existing policies on alcohol, health and safety, and additionally the discretion of managers. Drug testing of existing employees was conducted by five companies: food production, bus service, home shopping, a hospital and one drug service. This was not generally popular and was a strategy only adopted when there were well-founded suspicions of drug use:

*There's a lot of problems with screening and I think businesses are not aware of the drawbacks. If you speak to management about drugs screening, half the time they don't understand what the screeners are screening for, they don't know the specific drugs, they don't understand the background behind those drugs and they don't try to find out what drugs are being used in their community.*

(Janet, Occupational Health Officer)

Other companies were also considering introducing tests. The employers were asked about the advantages and disadvantages of such tests. There was greater emphasis on the disadvantages: these included hostility from the staff, implications for civil liberties and concerns that unknown numbers of staff might have to leave or be dismissed. In many cases, the issues seemed unresolved:

*There's conflicting views about that. Some of the executives feel that everybody should be tested for drugs and that's it. That means you'll probably*

*end up sacking half the workforce. So what we've tended to do is ... you deal with the issues as and when they arise. We've raised awareness with the management team so that everybody looks for the signs, you know, erratic behaviour, lateness, and then tackle it locally with support from us.*

(Sheila, Personnel)

### Criteria for disciplinary action and dismissal

Drug policies dealing with employees who were discovered using drugs were more numerous. There were no differences between large and small companies in the options they described: dismissal, disciplinary action, or treating it as a medical problem. However, in large companies, the procedures were developed through collaboration between senior management and the personnel department, or senior management alone.

Dismissal was considered for behaviour that threatened safety in the workplace or if substances were found on the premises. Disciplinary procedures would be started if the employee was involved in dealing rather than simple use, or where an employee had been

dishonest. Most employers said that their companies would treat an employee's drug use as a medical problem if the employee co-operated fully, there was no threat to work performance or safety and there were no other offences committed, such as harassment of or theft from colleagues. In practice, however, it was mainly those companies big enough to have an occupational health department who could respond in this way:

*Unless it turns into some other problem, you know, like complete inability to turn up in a working condition that wouldn't cause injury to himself or others, then we'll endeavour to support them. We'd try and be supportive in trying to get him assistance, both in the workplace and out, and monitor it. What goes on outside we can't control too much.*

(Liam, Personnel, large national company)

All employers said that ETE schemes were a good idea, but most of them did not expect drug users to make very good employees. Nearly half believed that the employee should be in low-risk work. Some felt employers should seek to get them off drugs, increase supervision and offer in-house counselling.

# 8 Key issues and their implications for policy

## Evaluating client employability

ETE clients avoided making forecasts about their prospects of getting a job. A common phrase was 'I've got a long way to go', referring to the changes needed in drug dependence and lifestyle. The dominant conditions that made problem drug users unemployable according to the ETE professionals were: poor mental health, lack of motivation and chaotic lifestyles. Others were: lack of work experience, employers' attitudes, inability to adapt to a structured environment and poor social skills. Most are relevant to the concept of 'readiness' that is strongly supported by drug workers and drug users themselves, and regarded as a goal that must be reached by the individual user before being able to work to conventional standards. According to McIntosh and McKeganey (2001), the recovering drug user 'has to perceive an alternative lifestyle that is not only desirable but also feasible'. Feasibility has to be judged in the context of current health, level of education and training, social conditions and attitudes.

In Scotland (Richards and Morrison, 2001), a classification of 'job readiness' that had three levels was used by advisers. The three levels were: those who are or are nearly job ready; those who are not ready at present but have potential; and, for those with multiple problems, the need to address these first. The main problem was in assessing clients in order to make an accurate judgement. Randall and Brown (1999) have suggested a job readiness index that measures improvement on a variety of dimensions that could include basic skills such as literacy and numeracy and social

behaviour such as punctuality and attendance. This is an explicit recognition of the reality of the problems faced by many recovering drug users which are not currently accommodated in 'hard outcomes' required by many funders.

## Policy implications

Assessing client readiness requires a detailed knowledge base. ETE advisers and trainers, particularly those in mainstream services or hired by private companies, admitted to poor levels of knowledge about drugs and the lifestyles of problem users. Recovering or dependent drug users are likely to have multiple disadvantages; the complexity of their problems requires comprehensive general knowledge on the part of advisers about them and the physical, social and sub-cultural environments they inhabit.

An adviser assigned the role of dedicated worker could receive training that would help sensitise them to these clients' needs, inform their assessments and identify ways of guiding them into appropriate ETE channels. Basic training should cover:

- information about all aspects of disadvantage and their consequences
- education in drugs, drug use and the histories and lifestyles of drug-dependent people
- the multiplicity of risk factors associated with drug dependence
- awareness of protective factors and ways of enhancing them: family and partner support, stability and rewarding activities

- the value and limitations of various forms of treatment
- the nature and consequences of relapse.

Collaboration between treatment agencies and ETE services in developing appropriate ‘welfare to work’ plans for adult clients with drug problems seems essential, and yet there was little evidence in this research of serious intent or signs of initiatives in this direction. Since some are likely to need more intensive help with their rehabilitation, mechanisms that facilitate access to specialist information should be sought. Channels of communication with local CDTs should be developed with a view to working together in devising appropriate assessment measures and action plans. The proposed extension of Progress2work (Appendix 1) into other areas of the country anticipates additional responsibilities for drug treatment staff. This has many implications for training and resources, and also for professional priorities and working practices. There will be a need for reconciliation between the very different perspectives on rehabilitation among drug workers and mainstream employment workers.

### Progressive rehabilitation

Consultations between treatment and ETE professionals are needed to arrive at an operational definition of readiness that is satisfactory to practitioners, policy-makers and employers. Many drug-dependent people and drug workers believe that the first step towards rehabilitation should be to get ‘clean’ before seeking employment or pursuing the acquisition of a skill or the qualifications

associated with it. However, certain activities can contribute to rehabilitation and need not wait on becoming drug-free.

A recurring theme across ETE advisers was that currently dependent and recovering drug users need intensive support that avoids high pressure and entails gradual change. Alternatives to this strategy risk initiating a chain of events that result in relapse. Courses that dealt therapeutically with fundamental problems such as confidence, social skills and behaviour control were seen by professionals as a part of the rehabilitation process. Subsequent enrolment on to access courses provided a way into a chosen area of education or training.

The data from a variety of studies of disadvantaged people tend to be pointing in similar directions: an ‘holistic’ approach that can involve several stages (Fletcher *et al.*, 1998), which in other terms is a form of ‘through-care’ (Richards and Morrison, 2001; Randall and Brown, 1999). This is a strategy that grew out of ideas formed in case management and medical models of a ‘continuum of care’ for patients (Carnwath *et al.*, 2000; Gerada *et al.*, 2000). Components of such schemes can be self-contained (see Duckert, 1984) offering a wide range of services and hence require few mechanisms of collaboration between different agencies, which is a source of difficulty for those attempting ‘joined-up’ professional services. It is generally acknowledged that the ‘stage’ approach to rehabilitation and work that involves different agencies can take some time and will need much more co-operation than exists at present.

An approach aimed at drug-using offenders is through links between treatment and prison services. An attempt at through-care for drug-

dependent newly released prisoners (Burrows *et al.*, 2000) was partially successful. Four months after release there were reductions in drug use for 20 per cent of the sample, and their spending on drugs, on average, had halved. The programme started while the offenders were in prison and was managed by other agencies after they left. However, it was reported that the service was marred by disputes 'over professional boundaries, areas of responsibility and fragile funding'.

### Policy implications

The analysis of the needs of problem drug users in finding employment suggests that these would be best served by a range of flexible and multi-faceted models that allow for staged progress. Addressing the potential risk factors for relapse should be an essential feature of them. They should be identified jointly by professionals and their clients in order to develop avoidance strategies. An after-care service would monitor successes and failures to modify the strategies. This service could include help for those who had not been employed before or who had not worked for some time with such problems as finances, accommodation and time management.

The financial implications of getting a job were often the most worrying for the clients. The major deterrents were that the work might bring about a drop in income and that relapse would mean renegotiating Social Security benefits. These deterrents perhaps helped to perpetuate the state of unreadiness in those who could have been more ambitious with sufficient support. A change in the system of benefits, combined with sustained monitoring and support in the first months of employment, or

access to sheltered employment opportunities, could help to avoid such outcomes.

### Funding issues, competition and 'joined-up' working

The nature of the funding of ETE services had profound effects on the type of assistance offered to their clients, and also on the morale and working practices of their employees. Since most professionals worked for services funded by grants that were the focus of competition, there was inevitably a spirit of rivalry that undermined attempts to share information about developments that could improve the service. Reference was made at times to cases in which referrals elsewhere were resisted because of their financial implications. Although there was no way of substantiating these charges, they are indicative of the nature of the relationships that have implications for collaborative working practices.

The targets set by funders were inappropriate for ETE clients with drug problems. Entry to a scheme was not the only or the best index of success. Other measures are needed to record the gains they make. Strain in meeting targets tended to set limits on time spent in contact with clients and increased the pressure on advisers to push clients forward, perhaps prematurely. Also stressful to some professionals was the need to spend valuable time and effort in the search for new or extended funding. The proposed changes to the New Deal may help to remedy this situation by strengthening collaborative mechanisms and reinforcing the goal of working together.

Connexions partnerships aim to overcome this problem more directly since the service is

multi-agency and multi-disciplinary based. It is difficult to predict whether this can remove the more damaging aspects of competition since partnerships delivering the service have to include private profit-making companies as well as statutory, voluntary and community bodies.

### Policy implications

The targets set by funders were often discouraging to staff and were seen to undermine the value of their work. To maintain a highly motivated staff who will be encouraged to maintain high standards and improve on them there should be an early examination of competitive systems of funding since this seems to encourage isolation and poor communication. In particular, the relevance of target outcomes to problem drug users should be reviewed. There is now sufficient evidence that they are inappropriate to the needs of many people in this group who are in the early stages of recovery. Targets that are staged to achieve gains in areas of need such as time management, basic literacy and social skills, anger management and self-confidence could be legitimated and recorded.

To increase job satisfaction among staff, development programmes should be available and participation encouraged, working practices reviewed and improved, staff efforts recognised and acknowledged, and better line management and supervision introduced. In procedural terms this means:

- sufficient numbers of advisers, computer provision and administrative support
- training courses for staff that are relevant to the needs of disadvantaged clients

- improving and formalising systems of communication
- devising contingency arrangements for clients who have to wait to start treatment or courses
- exploring ways to obtain the co-operation of employers
- monitoring and evaluation of procedures and dissemination of results across agencies in the region.

### Support for ETE staff and job satisfaction

The roles of some advisers, particularly in specialist agencies, involved a high degree of mentoring and personal involvement with the client. Several dedicated staff members found their work stressful, albeit rewarding. They believed that communication between agencies was by far the most dysfunctional aspect of their work. More widely, there were complaints about the lack of coherent policies and procedures, and inadequate recognition of the staff by management. A feeling of isolation was evident in some agencies and seemed to be part of an institutional syndrome that also included lack of access to a good line manager, appropriate supervision and training, administrative support and lack of appreciation. These failings were attributed mainly to the need for fast throughput required by the funders.

Even if agencies were willing to share, the value of the information might be low. There were no standardised records of the number of referrals made, the outcomes of referrals, or feedback on standards achieved through

educational and training courses. If adequate monitoring and evaluation is to be developed then comparisons need to be made, which involves standardisation on key items in the assessment and records of referral. However, taking detailed records is time consuming and problems of time management and staff overload were reported. Advisers were engaged in rapid analyses and decision-making in an environment in which information was not always readily available to them. Referrals to treatment agencies were stalled by long waiting lists. Referrals to other agencies could be held up by delays in knowing what opportunities were available, the procedures of the target agencies and finding the course full or not starting for several months.

### Policy implications

ETE advisers were frustrated by the limited range of courses available to their clients which were within easy reach. This seems to be particularly important to many problem drug users and may also apply to other disadvantaged groups. Rapid access to details of the timing of courses, the entry requirements and current enrolment status would enable advisers to avoid raising client expectations. In practice this means:

- keeping track of demand for courses
- a listing of courses starting in the near future
- flexible expansion of popular courses
- offering more courses more widely.

Channels of communication could be improved. Information of relevance to workers with drug-using clients could be an electronic database that includes local employment needs

relevant to disadvantaged groups, details of educational and training courses that are updated to show current recruitment status and advice on available treatment options, NGOs and helplines. The use of IT should be ensured for advisers, and monitoring and evaluation software should be developed that records not only changing patterns in these data but also anonymised data on outcomes in order to build a database on 'what works'.

Professionals wanted to communicate with others similarly employed. More informal gatherings or conferences would be one way of sharing information across professional boundaries and could also include user groups. However, the development of a more formal infrastructure to support information sharing between ETE agencies would be contingent on the removal of fears of competition.

### Employer participation

There is much evidence that many employers are not supporting the New Deal. In the 'hard core' of disadvantaged people who are being encouraged to seek work, problem drug users, particularly those with a criminal record, are likely to be those subject to the most discrimination. Special procedures will be needed if they are to overcome this final barrier.

### Policy implications

Better support and perhaps greater incentives for employers are needed if they are to participate more fully in New Deal. Some companies are known for the opportunities they offer to disadvantaged people and extending this to recovering drug users would be helpful. The forthcoming Disclosure Service is likely to

remove uncertainty for employers who are concerned about criminal records among applicants. It would be advisable for ETE services to develop strategies and procedures to reassure employers that the risks are manageable when employing problem drug users and ex-offenders. Monitoring and supporting them at this time should be part of a system of after-care. At present, the opportunities for education and training for people with drug problems are increasing but their hopes may ultimately be dashed at this final stage.

### Conclusions

Despite real efforts by clients with drug problems to start on the process of rehabilitation that ends in employment, and despite the sincere efforts by ETE advisers to help them, it

seems that the legacy of damaging life events is likely still to bar the way to a satisfying and productive life. Sadly, this perpetuates powerlessness, low morale and depression. The remedy familiar to these clients is to consume more drugs and go back to their old lifestyle. It appears that new developments are planned to reorganise ETE provision for recovering drug users in order to ensure the cycle is broken. They will require significant changes in working practice that may be uncomfortable as well as challenging for all professionals involved if a more effective approach to the rehabilitation of drug users is to be achieved. The removal of the final barrier is dependent on a change in attitudes among employers that involves recognition and acceptance of a genuine desire to change, and their willingness to co-operate with ETE services in devising procedures that enable them to do so.

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# Appendix 1: The New Deal, Connexions and Progress2work

## New Deal

At the time of the research study covering the period 1999 to 2001, there were four main New Deal programmes of interest to drug users, none of them wholly satisfactory in meeting their needs:

- New Deal for Young People (NDYP): this was the first and largest programme, compulsory for unemployed 18–24 year olds who have received a Job Seeker's Allowance (JSA) for more than six months. There are four options: subsidised employment, full-time education and training, voluntary work and environmental work. This is the only compulsory programme and non-participation can result in the removal of benefits. Those drug users receiving Sickness or Disability benefits rather than JSA are ineligible for New Deal for Young People (NDYP), hence this programme does not attract the bulk of users.
- New Deal for Long-term Unemployed: this is targeted at the 25+ age group who have been unemployed for between one and two years, depending on area. There is greater support from the personal adviser, and it leads to two main options: subsidised employment or education/training.
- New Deal for Lone Parents: targeted at lone mothers of school-age children who have been on Income Support for over six months. There are no options but individuals are helped in looking for

work. Other forms of support, such as financial assistance with childcare, are available.

- New Deal for Disabled People: similar in support to New Deal for Lone Parents, but it also seeks to improve employers' and service providers' understanding of problems associated with disability (Millar, 2000). This benefit is available to drug users if the mental or physical consequences of their drug use satisfy the programme's definition of disability.

## Connexions: guidance and support for 13–19 year olds

This is aimed specifically at young people and was initiated by the Department for Education and Skills (DfES). Although still in its early stages, this seeks to offer young people access to a 'coherent service' of help, support and advice, not only about education and training but also about drug-related problems and other factors that are likely to need attention before an individual's full potential can be realised. The service is delivered through regional partnerships by a network of personal advisers and will be particularly attentive to the needs of the more socially isolated groups. Some Connexions Partnerships are already operational and there is an ultimate target of 47 by 2003–4. Because of the age range, these will be unavailable to the majority of drug-dependent people, but they offer the potential for preventative interventions at a critical stage in adolescence.

It is particularly noteworthy that, rather than outcomes in terms of increasing percentages staying on at school and achieving more GCSEs or their equivalent, the planned target for substance users revolves around referral to specialist advice systems. This represents a qualitatively different criterion, not shared by other disadvantaged groups; outcomes for those supervised by Youth Offending Teams and for teenage mothers are to be measured by raising the proportions that enter education, training and employment schemes. However, recent research (Britton *et al.*, 2002) on the needs of socially excluded young people in multicultural

areas gave rise to doubt that the service will be able to achieve its aims.

### **Progress2work**

This is a project that is scheduled to be implemented in all Employment Service districts when it completes a two-year pilot period. It is aimed at current and recovering drug users and is meant to work alongside New Deal, bridging the end of their treatment and employment. The first priority is to build liaisons between treatment agencies and the Employment Service.

# Appendix 2: The nature of ETE service provision

## Job Centres

Job Centres are run by the Employment Service which is part of the Department of Work and Pensions. They offer a standard service nationwide. Clients are allocated a personal adviser who carries out assessments, advises on available opportunities and facilitates access to other agencies or appropriate jobs. There are specialists within the system, for example disabled employment advisers. Although advisers may correctly identify clients with drug problems, this is not assured. Such clients could be referred by these agencies to CDTs or NGOs with facilities for their rehabilitation or, for those already in treatment, to educational and training centres.

## Community Drug Teams

The six Community Drug Teams that participated in the research were primarily concerned with drug treatment. They varied in their involvement with ETE services; those in towns outside the Manchester area mostly referred clients on to a private company that had extensive links across the whole of the North West region (described below). Those within the Greater Manchester area made referrals to NGOs within their local area. Referrals were made to them from a variety of sources in their areas, including probation, specialist NGOs and local government ETE services.

## Local authority agencies

These were agencies run by the local authority though supported by funding from several

other sources. One was part of a large CDT in Manchester with a reputation for innovative methods backed up by research. It employed four workers that gave ETE advice and information, made assessments and offered support. The ETE worker gave weekly advice sessions in the local drop-in centre. The agency received referrals from other CDTs in nearby areas. Another agency offered a more comprehensive service that included: information, advice and guidance in constructing a CV, filling in application forms and interviewing skills. It ran 'taster' courses for clients who were undecided and workshops on various themes associated with progress towards employment. There were also agencies combining alcohol and drug-dependent clients that offered rehabilitation and referrals to educational and training facilities.

## Non-governmental agencies (NGOs)

The NGOs used in the research were agencies that included, or specialised in, ETE services for substance users. They varied widely in the range of ETE options on offer and how they were delivered. At one end of the spectrum was a private company that was run very much like a business with multiple referral and education and training links. The agency not only received referrals from several CDTs and local government Alcohol and Drug Services, it was also employed by Greater Manchester Probation to deliver New Deal services to their clients. Assessments and advice were mostly made at local sites on certain days of the week. On a smaller scale were agencies that were also run

on commercial lines but had a narrower focus, for example, ex-offenders or clients with mental health problems. One that dealt specifically with drug-dependent clients ran a drop-in centre and a needle exchange. For ETE advice they were referred to another local NGO. A residential rehabilitation centre offered no on-site ETE service, but had links with local colleges and also used another NGO that specialised in education and resettlement for ex-offenders. One agency focused on drug and alcohol treatment in a system of through-care that aimed for total abstinence. Clients needed to be drug-free at the time of admission and could be subjected to urine testing while on the course. The primary course programme comprised a wide range of therapeutic techniques and basic careers training, access to educational courses and help in negotiating with employers. After completing the primary programme there was an option to continue with after-care for approximately a year.

Another range of specialist services was more community oriented. These were 'client-centred' and characterised by 'user-friendly' services with special attention paid to specific client needs. These could include 'women only' times with crèches provided, workshops addressing racial issues, proactive follow-up of clients and a very wide range of therapies including 'alternative' medicine. They had multiple links with access to courses on literacy, numeracy, basic skills and also college courses and ETE advice. In some, the centre was an 'open house' and clients were encouraged to feel part of a community. Unlike mainstream ETE New Deal services, the assessment was extensive, thorough and asked for clients' drug

and offending history as well as current needs such as help with accommodation and finances. One agency encouraged clients to apply for volunteer work there, supervised by a member of staff. A manager described another agency as 'mid-way in a system of through-care' with an eight-week programme that comprised structured day care involving not only therapy sessions but also work-oriented courses that, if possible, led to some kind of qualification, for example in computing.

### Summary

Each of the 18 agencies participating in this research was to some extent unique but also overlapped in aspects of its services. The needs of the clients were complex and what was not available at one agency could theoretically be accessed through referral to another if there were places available. The mainstream New Deal service operating out of Job Centres was the most ill-equipped to deal with problem drug users. Some NGOs had a rich array of opportunities and were able to respond to client needs that ranged from treatment and practical help through to rehabilitation, skill-learning, education, vocational training and ultimately job-seeking. These were the agencies most in touch with strategies and forms of support acceptable to these clients. However, not all recovering drug users would wish to use them. There were many ex-users who wanted to avoid contact with a past lifestyle. They preferred mainstream services that could, if their needs were made known to the staff, provide appropriate referrals to courses and help in job-seeking.



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