

# In-House Research

## Evaluation of the Jobcentre Plus Intensive Activity trial for substance misusing customers

by Cate Fisher

Department for Work and Pensions

In-House Research No 2

# **Evaluation of the Jobcentre Plus Intensive Activity trial for substance misusing customers**

Cate Fisher

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## Abbreviations:

ASM	Advisory Services Manager
BDC	Benefit Delivery Centre
BME	Black and Minority Ethnic
CSOM	Customer Service Operations Manager
D(A)AT	Drug (and Alcohol) Action Team
DDC	District Drug Co-ordinator
DERM	District External Relations Manager
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
IA	Intensive Activity
IB	Incapacity Benefit
JCM	Jobcentre Manager
JCP	Jobcentre Plus
JSA	Jobseeker's Allowance
LMS	Labour Market System
NTA	National Treatment Agency for Substance Misuse
PDU	Problem Drug User
RDSL	Regional Drug Strategic Lead
TU	Trade Union

## Glossary:

**Caseloading** - Managing Jobcentre Plus Personal Adviser time to achieve regular contacts between a customer and a specific Adviser.

**District Drug Co-ordinator** - Introduced in Jobcentre Plus in England from April 2009 along with the RDSLs (see description below). DDCs were the local partnership managers responsible for: developing and strengthening relationships with external agencies in the drugs field; raising awareness amongst them of JCP's programmes and services; and ensuring that JCP staff have the skills and support necessary to identify, refer and work effectively with substance misusing customers. The funding for the DDC role came to an end in March 2011, however the key functions of this role are still being carried out. Jobcentre Plus Districts now have the flexibility to decide how best to deliver them in light of their local priorities and resource.

**Drug (and Alcohol) Action Teams** - Multi-agency partnerships, responsible for the local implementation of the drug (and, where applicable, alcohol) strategy.

**Drug Champion** – Jobcentre Plus local office front-line staff (for example Personal Advisers) who have agreed to take on responsibility for supporting drug strategy activities in their office in addition to their other duties. Activities include raising awareness of the voluntary referral process amongst colleagues, supporting them in identifying and working effectively with substance misusing customers, and supporting the work of their DDC. There should be at least one Drug Champion in each JCP office.

**Labour market system** - The computer system used by Jobcentre Plus to record customer details.

**Personal Advisers** - Members of front-line staff in Jobcentre Plus responsible for holding interviews with customers, deciding on the best way forward for them and working with them to move them into or closer to the labour market.

**Regional Drug Strategic Lead** – Introduced in Jobcentre Plus in England from April 2009 along with the DDCs, RDSLs were responsible for the drug agenda within JCP on a regional level, and oversaw the work of the DDCs. The funding for the RDSL role came to an end in March 2011.

**PDU markers** – Markers contained on individual customer records in the LMS system which Personal Advisers can use to record disclosures by customers of heroin and/or crack cocaine use, and whether or not the customer is in treatment.

**National Treatment Agency for Substance Misuse** – The National Health Service special health authority established to improve the availability, capacity and effectiveness of drug treatment in England.

**Outreach** – Services provided by Jobcentre Plus staff in locations other than the Jobcentre. In this report, JCP outreach refers to sessions conducted by a Personal Adviser in a drug treatment provider's premises.

**Problem Drug User** – An individual who uses heroin (or other opiates) and/or crack cocaine.

**Voluntary referrals** – From April 2009, Jobcentre Plus customers in England who were in receipt of either JSA or ESA and disclosed a problem with heroin and/or crack cocaine but were not in treatment for this problem were eligible for a voluntary referral to a discussion of treatment options with a local treatment provider. Voluntary referrals have now been opened up to JCP customers receiving any benefit who have a problem with any substance, where the use of that substance represents a barrier to work.

## Executive Summary

### Background

The Department for Work and Pensions' (DWP) is committed to helping individuals tackle their substance misuse problems. As part of this commitment Jobcentre Plus (JCP) introduced a system of voluntary referrals for customers to a discussion with a treatment provider in April 2009<sup>1</sup>. It was hoped that these referrals would help to significantly increase the number of people being referred to treatment providers, and subsequently engaging in treatment.

Although this initiative has seen some success, with 2,500 referrals made by August 2010, stakeholders were concerned that only a small proportion of those customers who would benefit from this opportunity had taken it up<sup>2</sup>. The Intensive Activity (IA) trial was developed in response to this, to explore whether a model of closer working between JCP and treatment providers could increase the number of disclosures of substance misuse by customers to JCP and the number of voluntary referrals; and improve the service offered by JCP to substance misusing customers.

Three Jobcentres were selected for the trial on the basis of their having a high estimated number of customers who are substance misusers and not in treatment, but a relatively low number of achieved referrals. The trial, which took place between May and July 2010, lasted 8 weeks in two of the Jobcentres and four weeks in a third. It involved a treatment provider presence in the Jobcentre for multiple sessions per week, as well as a variety of other supporting activities.

This report contains the findings from the evaluation of the IA trial. It explores:

- whether IA can produce an increase in the numbers of disclosures and referrals;
- what the main positive and negative elements of the trial were;
- best practice when implementing IA; and
- best practice when working with substance misusing customers more generally.

The evaluation consists of qualitative evidence derived from focus groups and interviews with key stakeholders in JCP, the treatment providers and the local D(A)ATs, as well as front-line JCP and treatment provider staff involved in the initiative. Fieldwork was conducted between June and September 2010. Management Information on the number of disclosures of substance misuse<sup>3</sup>

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<sup>1</sup> Voluntary referrals were introduced to Jobcentres in England only.

<sup>2</sup> The Department estimates that there are around 30,000 users of heroin and/or crack cocaine in England who are in receipt of Jobseeker's Allowance (JSA) or Employment and Support Allowance (ESA) but are not in treatment. The voluntary referral system was originally only open to users of heroin and/or crack cocaine on JSA or ESA, but during the trial was opened up to users of any substance on any benefit.

<sup>3</sup> This is measured using the proxy of the number of problem drug use (PDU) markers that were set on the Labour Market System (LMS), which is the computer system used by JCP to record customer details.

and the number of voluntary referrals recorded by the three Jobcentres before, during and after the trial was also collected.

## **Qualitative Findings**

### ***What worked well***

- Stakeholders broadly felt that the model of closer working between JCP and treatment providers trialled was successful and central to any increase in referrals that occurred during the trial period. JCP front-line staff said they were more comfortable raising the issue of substance misuse with customers knowing that the provider was on hand to take over any difficult discussions. Stakeholders from both JCP and the treatment provider reported having a better understanding of the support offered by the other party and, as a result, were better placed to deliver more informed advice.
- Outreach by JCP staff in the treatment provider premises was felt to be a good way of engaging with hard-to-reach customers in an environment in which they felt comfortable and unafraid of stigma.
- The trial was successful in raising awareness within Jobcentres of the importance of staff broaching the issue of substance misuse with customers, and in supporting them to do so. The contribution of the District Drug Co-ordinators<sup>4</sup> and Drug Champion/s<sup>5</sup>, training for staff on how to ask customers about substance misuse and deal with disclosure, and enabling JCP staff to 'case conference'<sup>6</sup> within their teams were thought to be particularly valuable.
- Caseloading substance misusing customers to the Drug Champion was seen as positive both for the customers, who benefited from greater continuity and more intensive support, and for those JCP staff who said they were not comfortable discussing substance misuse with customers.

### ***What worked less well / problems encountered***

- Due to concerns around JCP staff safety, JCP Health and Safety risk assessments required before the treatment provider sessions in the

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<sup>4</sup> District Drug Co-ordinators were the local partnership managers in JCP responsible for developing and strengthening relationships with external agencies in the drugs field; raising awareness amongst them of JCP's programmes and services; and ensuring that JCP staff have the skills and support necessary to identify, refer and work effectively with substance misusing customers. The funding for the DDC role came to an end in March 2011, however the key functions of this role are still being carried out. Jobcentre Plus Districts now have the flexibility to decide how best to deliver them in light of their local priorities and resource.

<sup>5</sup> Drug Champions are JCP local office front-line staff (including Advisers) who have agreed to take on responsibility for supporting drug strategy activities in their office in addition to their other duties. Activities include raising awareness of the voluntary referral process amongst colleagues, supporting them in identifying and working effectively with substance misusing customers, and supporting the work of their District Drug Co-ordinator.

<sup>6</sup> Case conferencing involves JCP front-line staff discussing with their team how best to work with individual customers who have disclosed, or who they suspect have, substance misuse issues.

Jobcentres resulted in significant restrictions being placed on the activities treatment providers could carry out whilst in two of the trial Jobcentres<sup>7</sup>. For example, treatment providers were not allowed to approach customers or advertise their presence in the office, and Jobcentre Plus front-line staff were not permitted to visit the treatment provider's premises. Stakeholders in these two offices reported that this was frustrating and damaging to the trial.

- Operational pressures also represented a barrier to the success of the trial. Advisers were concerned about raising the issue of substance misuse with customers in case a disclosure, and lengthy discussion with them around it, prevented them from dealing with the other issues they are required to cover during their time-limited appointments. Additionally many were not released to attend training sessions on working with substance misusing customers due to operational pressures, despite having a skills gap in this area.
- Productivity targets around starts to training and employment were a significant issue for the Drug Champions who were responsible for conducting outreach sessions in the treatment provider premises and caseloading substance misusing customers. They found it difficult to achieve their targets whilst also devoting increased time to working with substance misusing customers, who require more intensive support than most customers to achieve the same outcomes.
- Having effective communications within the Jobcentre was an additional barrier in two of the offices. Due to the lack of all-staff meetings, stakeholders reported difficulty in finding the right platform through which to raise awareness of the trial and the treatment provider's presence amongst staff.

### ***Overall success and sustainability over the longer term***

Views about the overall success of the IA trial were mixed. There was widespread agreement that the trial period was relatively short and any success represented only the start of what could be achieved over the longer term. Stakeholders in two of the trial offices felt that the success of the trial had not been reflected in the limited increase in disclosures and referrals.

However, on the whole stakeholders were positive about the overall impact of the trial, citing improvements in:

- the confidence, motivation and skills of JCP staff in working with substance misusing customers;
- the profile of the substance misuse agenda within JCP;
- working relationships between the JCP office and the treatment sector;
- and

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<sup>7</sup> These restrictions are not reflective of Jobcentre Plus (or DWP) Health and Safety Policy, which allows for such activities to take place provided that suitable risk assessment processes have been followed and any necessary control measures or risk mitigations put in place, but instead were a result of decisions taken at the local Jobcentre Plus office level.

- the standard of service provided by JCP to substance misusing customers.

The exception to this view was held by some stakeholders in one of the offices who felt that the trial had not been successful, largely as a result of the outcome of the Health and Safety risk assessment.

Following the trial period, maintaining IA over the longer term was thought to be realistic from the point of view of the JCP staff resource required, in spite of operational pressures and targets. The treatment providers reported having to reduce the amount of time they spent in the Jobcentre due to resource constraints, and an insufficient increase in the number of referrals during the trial to justify sustaining the activity on that scale. However, all three intended to continue working more closely with JCP, and two intended to maintain one session a week in the Jobcentre.

### Quantitative Findings

Table 1 contains details of the number of customers voluntarily referred to a discussion with a treatment provider achieved by each Jobcentre before, during and after the trial period. They should be understood in the context of the qualitative findings.

**Table 1: Referrals in JCP A, B and C by time period in which they were made**

Time Period	Referrals made by trial JCP office		
	JCP A <sup>1</sup>	JCP B	JCP C
<b>Before trial</b> (6 months prior to trial start)	13	1	12
<b>During trial</b> (JCP A & B - 8 weeks; JCP C – 4 weeks)	6 (+ 2 self-referrals) <sup>2</sup>	3	21
<b>Post trial</b> (3 months after trial)	2	4	55

<sup>1</sup>Only PDUs were referred before the trial, but during and following the trial misusers of any substance (including alcohol) were referred. Also note that closer working was already taking place in JCP A prior to the trial period, although in a less intensive form.

<sup>2</sup>'Self-referrals' are customers who visited the treatment provider to discuss treatment options after finding out about them through the Jobcentre, but who were not officially referred by JCP.

### Conclusion and Recommendations

- The impact of the trial on disclosures and referrals to a treatment provider was variable, but increases were seen in all three Jobcentres. However, even in Jobcentre C which saw the largest increase, the number of referrals was still substantially smaller than the estimate

which JCP hoped could be achieved<sup>8</sup>, indicating that these estimates may need to be revised downwards.

- Given the limited increase in referrals achieved during the trial and its resource intensive nature, it is unlikely that in the current climate many JCP offices will be able to justify adopting intensive activity on this scale with a view to increasing the volumes of such referrals.
- Lessons for best practice for those JCPs who do wish to adopt such a model include: involving the treatment provider early on in the design of the activity; securing buy-in from JCP senior management; developing standard guidance for conducting Health and Safety risk assessments in advance of the activity; and ensuring good communications with JCP staff around the trial.
- Importantly, the evaluation also identified various lessons for best practice within JCP around supporting substance misusing customers more generally. These include: having effective and dedicated Drug Champions within each Jobcentre; the importance of close partnerships between the treatment sector and JCP; ensuring JCP staff receive training on raising the issue of substance misuse and dealing with disclosures; JCP outreach at treatment provider premises; caseloading substance misusing customers to a Drug Champion or other skilled Adviser; and tailoring productivity targets for any dedicated advisers working with this group.

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<sup>8</sup> JCPs estimates were as follows: JCP A – 143 customers who are heroin and/or crack cocaine users, in receipt of JSA or ESA and not in treatment; JCP B – 113 customers who are heroin and/or crack cocaine users, in receipt of JSA or ESA and not in treatment; JCP C – 92 customers who are heroin and/or crack cocaine users, in receipt of JSA or ESA and not in treatment. Estimates of the number of customers addicted to *any* substance (including alcohol) and on *any* benefit (but not in treatment) would be substantially higher. These figures were derived from published DWP estimates (Hay, G., and Bauld, L. (2008) *Population estimates of Problematic Drug Users in England who access DWP benefits*. DWP Working Paper No. 46) and treatment take-up information.

## 1. Background

The Coalition Government has stated that it is committed to tackling drug and alcohol addiction, which it views as one of the most damaging root causes of poverty. The Government believes in an approach to tackling addiction that is firmly rooted in the concept of recovery and reintegration; a process through which an individual is enabled to overcome the symptoms and causes of their dependency, and become an active and contributing member of society. The Department for Work and Pensions (DWP) have joint responsibility for the 'recovery and reintegration' strand of the 2010 Drug Strategy 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'<sup>9</sup>. This strand is concerned with enabling the development of a system whereby treatment, employment, education and skills programmes, family support, probation and wider health services around treatment are delivered in a holistic, person-centred fashion to support sustained recovery for substance misusers.

As part of DWP's commitment to helping individuals tackle their substance misuse problems, a system of voluntary referrals to a discussion of treatment options with a treatment provider was introduced into Jobcentre Plus (JCP) in April 2009. The voluntary referral was initially designed to be offered to JCP customers in England who are in receipt of Jobseekers Allowance (JSA) or Employment and Support Allowance (ESA) and are a Problem Drug User (PDU), meaning that they use heroin and/or crack cocaine. If a customer agrees that they would benefit from a discussion with a treatment provider, an appointment with a local treatment provider to discuss available treatment options is then arranged for them.

District Drug Coordinators (DDCs), who were also introduced into JCP in April 2009, were the local partnership managers responsible for supporting the drug strategy on the ground. This included raising awareness of the voluntary referral process amongst JCP staff, arranging training for staff on substance misuse issues and the process of making a referral, and ensuring that the process is working successfully<sup>10</sup>. From April 2009 to the end of August 2010, in England 10,300 customers were identified as PDUs and had the relevant marker set on their Labour Market System (LMS)<sup>11</sup> records. Nearly 8,000 of these customers were in treatment at the time the marker was set and 2,400 were not in treatment. In the same time period a total of 2,500 referrals were made, which resulted in 861 recorded discussions with a treatment advisor<sup>12</sup>. Given that DWP estimates put the number of PDUs in England accessing JSA

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<sup>9</sup> Home Office (2010)

<sup>10</sup> Funding for the DDC role came to an end in March 2011. The key functions of this role are still being carried out, but Jobcentre Plus Districts have the flexibility to decide how best to deliver them in light of their local priorities and resource. In some Districts these functions are being encompassed into a new role which has a wider remit to consider all excluded and disadvantaged groups.

<sup>11</sup> LMS is the computer system used by JCP to record customer details.

<sup>12</sup> Due to restrictions around data sharing between treatment providers and JCP without the customers' consent, the actual number of discussions that have taken place are not known but are likely to be higher than the recorded number.

or ESA and not in treatment at 30,000<sup>13</sup>, the number of referrals made by August 2010 stood at just over 8% of the total potential number of PDU referrals which we estimate JCP could make<sup>14</sup>.

Concern about the low number of identifications and referrals being recorded led to the development of the Intensive Activity (IA) trial. The purpose of the trial was to explore whether a model of closer working between JCP and substance misuse treatment providers could potentially increase the numbers of disclosures of drug and alcohol misuse by customers to JCP and of voluntary referrals being made to a treatment provider; and improve the service offered by JCP for substance misusing customers<sup>15</sup>. The decision was taken to extend voluntary referral offer in the trial areas to customers on any benefit and misusing any substance, including illegal drugs, prescription drugs, and alcohol. This decision reflected the Coalition Government's focus on helping customers for whom the abuse of any substance is a barrier to employment to overcome their problems and move back into work.

Three Jobcentres were selected for the trial on the basis of their having a high estimated number of customers who are PDUs and not in treatment (and are therefore eligible for referral to a treatment provider), but a relatively low number of achieved referrals. The trial took place between May and July 2010, lasted 8 weeks in two of the Jobcentres and four weeks in the third. It involved a treatment provider presence in the Jobcentre for multiple sessions per week, as well as a variety of other supporting activities. Further information about these three Jobcentres and the activities that took place in them during the IA trial period can be found in Chapter 3.

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<sup>13</sup> This estimate is based on those contained in the following DWP report: Hay, G., and Bauld, L. (2008) *Population estimates of Problematic Drug Users in England who access DWP benefits*. DWP Working Paper No. 46.

<sup>14</sup> This calculation assumes that individuals who are already in treatment would not be referred by JCP staff, although there may be situations in which a referral would still be judged to be valuable.

<sup>15</sup> Independently-conducted research commissioned by DWP highlighted the negative experiences that many substance misusers report in relation to JCP. These included dealing with advisers who they felt were not sufficiently responsive to and understanding of their circumstances and needs, and who they felt were not supportive enough in helping them to resolve problems with their benefits: Bauld, L., Hay, G., McKell, J., and Carroll, C. (2010) *Problem Drug Users' experiences of employment and the benefit system*. DWP Research Report No. 640; Bauld, L., Carroll, C., Hay, G., McKell, J., Novak, C., Silver, K., and Templeton, L. (2010) *Alcohol misusers' experiences of employment and the benefit system*. DWP Research Report No. 718.

## 2. Evaluation Aims and Methodology

### 2.1 Aims

The key aims of the evaluation were:

- To explore the views of JCP staff and treatment sector professionals on the effectiveness, efficiency and sustainability of the key elements of the IA trial;
- To assess whether IA has the potential to increase the numbers of disclosures of drug and alcohol misuse being made by customers to Jobcentre staff and voluntary referrals being made to a treatment provider;
- To explore qualitative measures of success including (but not limited to) improved working relationships between JCP and treatment providers, and increased JCP staff skills in working with substance misusing customers; and
- To produce recommendations for good practice when designing and implementing an IA initiative, and when working with substance misusing customers more generally.

### 2.2 Methodology

The main element of the evaluation consisted of qualitative research with key stakeholders exploring their perceptions of the impact of the trial and its success, or lack of it. Limited quantitative data in the form of Management Information was also collected to enable comparison of the number of referrals and disclosures taking place before, during and after the trial. However, this data should be interpreted with caution due to the very small number of trial sites involved and the relatively brief duration of the trial. These two strands of the evaluation are discussed in more detail below.

The final report was peer reviewed by a DWP Principal Research Officer working in a different policy area.

#### 2.2.1 Qualitative Strand

The main strand of the evaluation utilised qualitative methods to explore in depth stakeholders' perceptions of the impact of the trial, including which elements worked well and were successful, which were less successful, what issues were encountered during the trial and how any problems were overcome, and the feasibility of sustaining IA over the longer term. The fieldwork took place between June and September 2010 following the end of the official IA trial period in each Jobcentre. A mixture of focus groups (lasting between one and a half and two hours) and face-to-face and telephone semi-structured interviews (lasting between 20 minutes and one hour) was employed to elicit views from key stakeholders involved in the trial. These

included staff at various levels from each trial Jobcentre (including those with a specific remit around the drug strategy), as well as the treatment provider staff who took part in the trial, and representatives from the National Treatment Agency for Substance Misuse (NTA), and the local Drug (and Alcohol) Action Teams (D(A)ATs) who commission treatment services.

In addition, two focus groups with JCP front-line staff (predominantly Personal Advisers) were also conducted in each trial site. Care was taken to ensure that a range of Advisers were recruited so that the diversity of opinion was captured. This included advisers from different teams, of different levels of experience, and with different degrees of involvement in the trial.

Semi-structured topic guides were used during the focus groups and interviews to ensure that the key issues were explored with all participants (see Appendices A and B). Detailed notes were taken during the course of all focus groups and interviews as it was not possible to record the interactions. These notes formed the basis of the information which has been analysed and reported on in Chapter 4. The information was analysed using thematic analysis techniques.

### **2.2.2 Quantitative Strand**

This element of the research took the form of a before-and-after comparison of the number of referrals being made to a treatment provider in each of the three Jobcentres, and the number of disclosures of substance misuse being made, before, during and after the trial. This latter outcome was measured using the proxy of the number of Problem Drug Use markers that were set on LMS. This measure is likely to be an undercount of the number of disclosures taking place as it only includes those customers who have admitted to using heroin or crack cocaine, and only those who have agreed to JCP placing this information on their record. However, it is likely to give a broad indication of any increase or decrease in the number of disclosures being made.

The before-and-after evaluation design represents a very simple method of measuring the impact of an intervention. It does not involve the consideration of a counterfactual (in other words, what would have happened if the intervention was not introduced) and therefore is subject to a number of criticisms. These include the fact that outcomes, in this case the numbers of disclosures and referrals recorded, could have increased or decreased during the trial period for a reason unrelated to the trial itself. For example, a change in patterns of drug use or benefit uptake during the period of the trial could have an impact on the numbers of disclosures and referrals taking place. One way of deriving a counterfactual, thereby producing a more robust evaluation, is to identify Jobcentre sites which are very similar to those involved in the trial but are not introducing IA to serve as a comparison. However, as there was no robust way of identifying such comparison sites the before-and-after design was the only feasible option.

As a result of these limitations, and due to the very small scale of the trial, care should be taken not to place too much emphasis on the quantitative evaluation findings. Additionally, for the same reasons, robust cost-benefit

analysis that could be extrapolated to other Jobcentres could not be produced, and hence information of this nature is not provided here.

### 3. Intensive Activity Trial

This section provides a brief description of the Jobcentres selected for the trial, the treatment providers who took part in each area, and the activities that were undertaken as part of the IA. The exact nature and extent of the IA initiative was left to the trial Jobcentres and treatment providers to develop and agree in each area, the only stipulation being that it should involve closer working between JCP and treatment providers with the treatment provider having a greater presence in the Jobcentre. The three sites developed broadly similar models with variations resulting from differing local needs and resource.

As mentioned above, the JCP offices involved in the trial were selected on the basis of their having a high estimated number of customers who are PDUs and not in treatment (and therefore are eligible for referral to a treatment provider), but a relatively low number of achieved referrals.

#### **3.1 JCP A**

##### **3.1.1 Jobcentre description**

Jobcentre A is situated in one of the most deprived areas of a large city, with high levels of unemployment. The office has a large customer base including around 5,000 customers claiming JSA and 12,000 claiming ESA and IB. JCP A has 140 staff including 5 Adviser Team Managers (ATMs) and 1 Jobcentre Manager (JCM).

The area has a large number of residents with English as a second language, a high prevalence of crack cocaine users, and contains a higher than average proportion of people with no qualifications. The main sources of employment are the local authority and the retail sector.

DWP estimates suggest that the office has a total of 143 potential referrals<sup>16</sup>.

##### **3.1.2 Treatment provider description**

The treatment provider who participated in JCP A's IA trial provides a service where crack cocaine and poly-drug users can receive information and advice to help them deal with issues relating to their substance misuse. They run a drop-in centre offering individual and group counselling, one-to-one key working sessions, a needle exchange, complimentary therapies, computer access, and hot meals, amongst other services.

##### **3.1.3 IA Trial description**

The IA trial in JCP A ran for a period of eight weeks, starting on the 24<sup>th</sup> May and ending on the 23<sup>rd</sup> July 2010. A scoping meeting involving Jobcentre Plus

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<sup>16</sup> This figure was derived from published DWP estimates (Hay, G., and Bauld, L. (2008) *Population estimates of Problematic Drug Users in England who access DWP benefits*. DWP Working Paper No. 46) and treatment take-up information, and relates to the number of individuals in England who are dependent on heroin and/or crack cocaine, in receipt of JSA or ESA and not in treatment.

managers and team leaders, the District Drug Co-ordinator (DDC) and Regional Drug Strategic Lead, as well as NTA and DWP representatives, was held prior to the start of the IA to agree the programme of activities that would take place. It is important to note that JCP A already had a close working relationship with their local treatment provider, and that the provider had been providing a presence once a week in the Jobcentre for approximately 8 months prior to the start of the trial – although only when the DDC was present. During these sessions the provider spoke to customers about their services, and had appointments with customers who had been referred to them for a discussion about treatment options. Prior to the trial only PDUs in receipt of JSA or ESA were referred to the treatment provider, and at the initial meeting stakeholders decided to keep the focus on this group during the trial. However, soon after this and before the start of the trial the decision was taken to extend the referrals to include misusers of other drugs and alcohol who were in receipt of other benefits. For this Jobcentre, unlike the two others, the IA represented an extension of a closer working initiative that was already in place. As a result there was no need for a new health and safety risk assessment for this element of the trial, as having the treatment providers attend the office and interact with customers was already covered by the existing risk assessment.

The first week of the trial consisted of a familiarisation phase, during which two Advisers from each of the customer stages (10 Advisers in total) attended the treatment provider premises during an open day. During this day they found out more about the services the provider offered, and about the nature of substance misuse and treatment. The Advisers then fed this back to the rest of their teams. The treatment provider also delivered a workshop along with a local provider of alcohol treatment services to 12 JCP staff to raise awareness of drug and alcohol issues. This workshop covered signs of drug or alcohol abuse to look out for, how to broach the issue of substance misuse with customers in a sensitive way, and how to manage conflict with and emotional breakdown from customers in relation to this issue. The workshop involved presentations, discussions and role plays. Those treatment provider staff who had not already been attending the Jobcentre familiarised themselves with the office during this week.

Two review meetings involving key stakeholders took place during the course of the trial to monitor progress against its key aims and to make revisions or improvements to the operating model if necessary. These took place at the end of the first week (during which an action plan for the rest of the trial was drawn up) and at the end of week 5.

During weeks 2 to 8 two staff from the treatment provider were involved in attending JCP A three times per week, with one member of staff attending during each session. The sessions were held on different days each week to maximise the number of customers who had the opportunity to speak to the treatment provider. During these sessions the treatment provider floor-walked, unaccompanied by a member of JCP staff, and approached customers to raise awareness of the treatment services on offer. They also sat in on and observed customer interviews, provided the agreement of the customer was

secured beforehand, to gain a better understanding of what happens during them. The treatment provider had a desk in a prominent position in the JCP office on which they were able to set up a display of leaflets and literature, however they often lacked a private space in which to have discussions with customers when referrals were made. The treatment provider was allowed to conduct team meetings and take breaks in the staff canteen, and was encouraged to approach and engage with staff in all teams, including the Fortnightly Job Review (FJR) and Crisis Loan teams.

Another key element of the trial involved a JCP Adviser conducting outreach sessions at the treatment provider premises. The Adviser who undertook this role was already familiar with the treatment provider as a result of volunteering with them in her own time for several months prior to the start of the trial. She had also nominated herself for the Drug Champion role within JCP A at a similar time, and was very interested in working with substance misusing customers. During the IA trial she conducted outreach sessions one afternoon a week, for a total of five weeks, on behalf of JCP at the treatment provider. The first of these was a scoping session involving a group of service users to canvass their views on what they wanted to get out of the sessions, and how they would prefer them to be run and structured. Due to confidentiality issues she saw customers on a private, one-to-one basis in the following four sessions. The treatment provider booked appointments on her behalf with customers who wished to see her, then called her to let her know who she was scheduled to see and what they wanted to talk about. This enabled her to prepare for the appointments by looking up the customers' LMS records before the outreach sessions to get a better picture of their history and current situation.

A Health and Safety risk assessment was required before the outreach activity could go ahead to ensure that it would not pose any serious risks to the Drug Champion. An Adviser from the Lone Parents team who was experienced at conducting assessments for outreach at children's centres attended the treatment provider premises, along with the Drug Champion and the manager of the treatment provider, to undertake the risk assessment a week prior to the start of the outreach sessions. She ensured that all appropriate risks relating to the working environment were explored, including the risk of substance misusers who aren't stable in treatment potentially displaying aggressive or violent behaviour. Flexibility on the part of the treatment provider was necessary to find an alternative room to that originally proposed for the outreach sessions which had an easier exit route for the Drug Champion should she feel threatened during her appointments. The treatment provider also agreed to install a panic alarm in this room for the Drug Champion to use if necessary. Following these adjustments the Adviser gave approval for the outreach to go ahead.

Additional supporting actions that were undertaken as part of the IA trial included promoting the use of the locally produced 'Are you missing out' form (see Appendix C) to help staff raise the issue of drug and alcohol use in the context of other barriers to work, and without having to ask this question out loud. Case-conferencing within teams took place, in which Advisers had the

opportunity to discuss with colleagues and their team leader (ASM) how best to handle any cases where they believed or knew a customer to be a substance misuser. Guidance on Adviser flexibility around sanctions for non-compliance with benefit conditionality (eg. in the case of JSA, fortnightly signing and proof of job search activity) when drug or alcohol misuse was involved was re-issued.

Coinciding with the start of the IA trial was a four-week exercise to increase the number of Disadvantage Markers being recorded on LMS. This involved Advisers being encouraged to ask all new Stage 3 New Deal customers whether any of the disadvantages (including ex-offender, homeless, refugee and drug or alcohol misuser) applied to them, and recording them on LMS if they did (provided the customer consented). Advisers were instructed to encourage customers who disclosed drug or alcohol misuse to take up the offer of a referral to a treatment provider. Additionally, the exercise involved a one-off drive to ask all stock Stage 3 New Deal customers about whether any of the disadvantages applied to them, and similarly to encourage those customers who did disclose substance misuse to take up the voluntary referral opportunity.

Following the end of the trial the treatment provider reduced their attendance at the JCP back down to one session a week as a result of resource constraints on their part. The JCP outreach at the treatment provider premises stopped during the summer holiday period as the Drug Champion conducting it only worked during term time, and it wasn't deemed feasible to train up another Adviser to cover this role while she was away. However, it was anticipated that the activity would resume when she returned in the autumn, and discussions were due to take place then about the possibility of the Adviser conducting outreach at another local treatment provider who had expressed an interest in becoming a JCP outreach site.

## **3.2 JCP B**

### **3.2.1 Jobcentre description**

JCP B is a purpose built Jobcentre Plus office and was the pathfinder office for the District. Its current register contains approximately 4,000 customers. The Jobcentre employs around 100 staff, including 4 ATMS and one JCM.

It is situated in an urban area close to an area of high deprivation, with a high rate of teenage pregnancy and substance misuse. There is very little infrastructure in the local area at the moment to provide employment. JCP B was selected for the trial on the recommendation of the DAAT Joint Commissioning Manager due to the high prevalence of injecting heroin users in the area.

DWP estimates suggest that the office has a total of 113 potential referrals<sup>17</sup>.

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<sup>17</sup> This figure was derived from published DWP estimates (Hay, G., and Bauld, L. (2008) *Population estimates of Problematic Drug Users in England who access DWP benefits*. DWP Working Paper No. 46) and treatment take-up information, and relates to the number of

### **3.2.2 Treatment provider description**

The treatment provider who took part in the IA trial at JCP B offers support, advice and treatment for individuals misusing any drugs, including prescription drugs. They do not currently conduct any formal outreach in any other settings, however they are willing to be flexible with regard to visiting service users in their preferred location. Alongside treatment and support they also offer harm reduction services, for example a needle exchange, and vaccinations against Hepatitis B.

### **3.2.3 IA trial description**

The IA trial in JCP B ran for a period of eight weeks, from 10<sup>th</sup> May to 2<sup>nd</sup> July 2010. As with JCP A, a scoping meeting, in this case chaired by the DERM and involving Jobcentre Plus managers and team leaders, the DDC, Drug Champion and a JCP Work Psychologist, as well as the DAAT Joint Commissioning Manager, was held prior to the start of the trial to agree the programme of activities that would take place. It was agreed that during the IA period the treatment provider would attend the Jobcentre for four half-day sessions a week. Four treatment provider staff were involved in these sessions, with one member of staff attending during each session. The DDC spent a significant amount of time in JCP B for the duration of the trial. One review meeting involving key stakeholders took place at the end of week 3 to monitor progress to make revisions or improvements to the IA operating model if necessary.

An initial familiarisation period of around a week saw the treatment provider sitting in on interviews with customers from various stages, including Crisis Loan interviews, and talking to a variety of Advisers and staff at all levels to gain experience of how JCP works and what standard customer interviews are like. They also attended the team meetings of several (though not all) teams, and delivered an up-skilling session for front-line staff. This covered how to raise the question of substance misuse with customers, and how to deal with disclosures when they are made. In addition the treatment provider offered to have one-to-ones or small group sessions with Advisers to discuss any outstanding issues they may have. The Drug Champion also attended an up-skilling session arranged by the DAAT during the trial.

The DDC and Drug Champion facilitated and supported the treatment provider's engagement with JCP staff, and also helped to raise staff awareness of their presence during team and Spotlight meetings, and by emailing the dates of their sessions to staff.

A Health and Safety risk assessment, conducted prior to the start of the IA trial, restricted the treatment provider's activities during the first four weeks of the trial. The treatment provider was not allowed to reveal their identity to customers as a provider of services for substance misusers, unless the

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individuals in England who are dependent on heroin and/or crack cocaine, in receipt of JSA or ESA and not in treatment.

customer had specifically requested to have a referral to them. They were therefore not allowed to wear their usual name badges or to identify themselves to customers whose interviews they were sitting in on. They were also not allowed to approach customers or advertise their presence, but instead sat in a private room during their sessions in the JCP, ready to see customers if they were referred to them during this time. However, due to stakeholders' dissatisfaction at this situation a second risk assessment was proposed at the review meeting and then conducted during week 4 of the trial. JCP senior managers also took the opportunity to meet with the TU representative responsible for carrying out the risk assessment to clarify the aims and objectives of the IA trial. A representative from the DAAT attended the second assessment in order to provide expert guidance and input.

As a result of this second assessment some of the restrictions that were placed on the treatment provider were lifted. For example, after this point they were allowed to have a desk near the front of the Jobcentre on which to display leaflets, posters and a banner to make customers aware of their presence, although they were not allowed to man this desk. They were also allowed to wear their badges from this point, however were not permitted to approach customers. JCP staff were still not allowed to visit the treatment provider's premises to find out more about the services they offer and substance misuse generally, as had been originally planned.

As mentioned above, the treatment provider supplied leaflets containing information on drug misuse and treatment for Advisers to display on their desks and for customers to take away if they wished. These leaflets contained the treatment provider's contact details and information about their services. Their details were also added to a sheet given to Crisis Loan applicants containing information about local support services. Additionally the Drug Champion provided FRANK<sup>18</sup> booklets for the Advisers to display and distribute to customers where appropriate.

In addition to the treatment provider presence in the Jobcentre, the use of a form similar to the locally produced 'Are you missing out?' form (see Appendix C) to identify customers' barriers (including drug and alcohol misuse) was encouraged. These were used primarily by the 18-24 teams (both by Advisers and Signers) but some other teams adopted the use of them as well.

Following the end of the trial, the treatment provider stopped regularly attending JCP B, although they were willing to come into the office for pre-booked referral appointments as and when necessary. They also offered to deliver up-skilling sessions to staff whenever there was felt to be sufficient need. The JCP had decided to move from a model of one Drug Champion for the whole office to one per team, as in JCP C (see below). Additional planned activity, time and resource permitting, included the Disability Employment

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<sup>18</sup> FRANK is the Government's campaign aimed predominantly at young people to provide them with advice and information about drug use and treatment. Launched in 2003, they offer a 24-hour confidential telephone helpline, an online chat facility and a service providing callers/visitors to their website with details of local counselling and treatment services.

Adviser undertaking an exercise to try and identify any PDUs in their caseload.

### **3.3 JCP C**

#### **3.3.1 Jobcentre description**

JCP C is a large office situated in a heavily deprived inner city area. It has a JSA claimant count of 5,000, and the longest average duration of claim as well as the worst performance on-off flows in the region. The Jobcentre employs 100 staff, including 3 ATMs and one JCM.

JCP C serves a very diverse customer group including a large BME population, amongst whom English language skills are a big issue. Evidence suggests that there is a high prevalence of substance misuse in the area.

DWP estimates suggest that the office has a total of 92 potential referrals<sup>19</sup>.

#### **3.3.2 Treatment provider description**

The treatment provider engaged with the IA trial in JCP C offers services and treatment for people who have problems with any drug (including alcohol), although their main remit is to work with users of Class A drugs. They aim to be able to support service users at every stage of their recovery. Their services include engagement on the streets and in communities; harm reduction measures at drop-in centres; structured day programmes; residential rehabilitation; supported resettlement; and services within prisons. They employ a dedicated outreach worker to engage with substance misusers in the community, and it was this member of staff who visited JCP C during the IA trial. This individual was also involved in outreach projects at a hostel and in various other locations at the time of the trial. In addition to treatment services the provider also offers personal development programmes to help service users gain skills, confidence, motivation, and employment.

#### **3.3.3 IA trial description**

The IA trial in JCP C lasted for four weeks, starting on 21<sup>st</sup> June and ending on the 19<sup>th</sup> July 2010, making it half the length of the trial in the other two sites. As with the other sites, a scoping meeting involving key stakeholders was held prior to start of the trial to develop and agree the programme of activities that would be taking place. The key strand of the trial was having a local treatment provider attend the JCP, in this case for 2 sessions or 'surgeries' a week lasting around three and a half hours each time. During these surgeries the dedicated outreach worker from the treatment provider sat in a private room or screened area waiting to see customers as and when they were referred. When the treatment provider was not in the Jobcentre, customers wanting a referral were asked whether they would prefer to have

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<sup>19</sup> This figure was derived from published DWP estimates (Hay, G., and Bauld, L. (2008) *Population estimates of Problematic Drug Users in England who access DWP benefits*. DWP Working Paper No. 46) and treatment take-up information, and relates to the number of individuals who are dependent on heroin and/or crack cocaine, in receipt of JSA or ESA and not in treatment.

an appointment booked with the treatment provider during their next session in the JCP, or have their details passed to the DAAT who would then contact the customer to arrange a meeting with a local treatment provider. The DDC spent most of their time at JCP C during the trial to support the IA, and was always present during the treatment provider surgeries. One review meeting involving key stakeholders took place half-way through the trial at the end of week 2 to monitor progress and to make revisions or improvements to the operating model if necessary.

The treatment provider spent four days during the first week of the trial familiarising themselves with JCP C, and spent time sitting with Advisers observing interviews at different stages in the customer claim, including Crisis Loan interviews. They also spent time with the DDC who talked them through the customer journey, and the services and support JCP offers to customers. In order to increase staff awareness of the IA trial and the treatment provider's presence in the Jobcentre, the provider attended an early morning Spotlight meeting and gave a short presentation about their services and the trial. Following this initial session the treatment provider attended as many Spotlight sessions and team meetings as possible that were taking place during the surgeries. Throughout the course of the trial the treatment provider made time to sit and talk to staff in between their interviews to discuss and raise awareness of substance misuse issues and treatment, setting markers on LMS when customers disclose substance misuse, and to give them advice on how to raise the issue of substance misuse with customers.

A 'whole office' approach to the trial was adopted, which involved a member of front-line staff from each team being appointed a Drug Champion. There were five Drug Champions in total. Their role was to promote the drug and alcohol misuse agenda and raise awareness of the IA trial throughout the office, and within their own team in particular. The DDC conducted a workshop with the Champions prior to the start of the trial to give them more information about the agenda and explain what their role would entail. All five Champions had previously attended drug awareness training arranged by the DAAT. One of these Advisers - who had been the Drug Champion for the office since referrals were introduced in April 2009 and had attended a significant amount of training in working with substance misusing customers - was appointed the Lead Drug Champion, and was given the role of caseloading customers who were known to have, or suspected of having, substance misuse issues. This Adviser had one afternoon a week allocated to focusing on these customers, during which she saw them in booked appointments, or called them to chase up on progress including, where relevant, whether they had attended their referral to the treatment provider. During these afternoons the regular restrictions around the length of customer interviews was lifted and the Adviser was allowed to see the customers for longer periods of time to enable her to have a fuller discussion with them about their current situation and any support needs. She also saw them more regularly to enable her to monitor their progress more closely. The Lead Drug Champion spent her time between appointments sitting with other staff during their interviews and offering advice on raising the issue of substance misuse with customers. Although it had originally been hoped that the Lead

Champion would also be able to conduct outreach sessions at the treatment provider premises, the District felt that they could not support this activity and as a result it didn't go ahead.

As in JCP B, a Health and Safety risk assessment meant that there were restrictions on the activities that could take place as part of the IA trial. A planned trip for the Drug Champions to the treatment provider premises and to a hostel in which the provider conducts outreach work – to give them a greater understanding of substance misuse and treatment – could not go ahead. Concerns were also expressed during the risk assessment about the treatment provider observing interviews; using a desk in the front of the JCP rather than sitting in a private room or screened area; and putting leaflets and posters up in the office to increase awareness of their presence. However, as a result of negotiations prior to the start of the trial the issues were resolved and these activities were allowed to go ahead.

The DDC created a number of other activities and materials to support the IA and raise awareness of the relevant processes. Advisers were provided with a question and answer sheet (Appendix D) to help them respond accurately and effectively to customer queries about substance misuse and JCP services for misusers, and was encouraged to complete a drugs quiz (Appendix E) to increase their knowledge. Additionally, the DDC organised referral marker walk-through sessions to inform Advisers about the referral process and provided the Advisers with a referral process guide to keep on their desks as a memory aid (Appendix F). The DDC also encouraged Advisers to keep copies of the locally produced 'Are you missing out?' form (Appendix C) on their desks for customers to complete. Customers in the Back to Work group sessions were also asked to complete these forms.

The DDC also spent time looking through the LMS records of customers with forthcoming appointments for signs that they may have substance misuse issues, including for example having had a marker set in the past, having made frequent applications for Crisis Loans or having frequently been sanctioned for non-compliance with their benefit regime. When such cases were identified the DDC made the Adviser the customer was due to see aware so that they could discuss the issue of substance misuse and voluntary referrals, if appropriate, during the appointment.

Following the four-week trial, the treatment provider scaled back their presence in the Jobcentre to one morning a week, during which he is able to see up to 6 clients in booked appointments. However, the provider aimed to be as flexible as possible and come straight down to the JCP to see customers as soon as they had been referred, if he was available and in the area. He also offered to deliver this service to two other local Jobcentres. This commitment was being reviewed regularly in light of any changes in the number of referrals being achieved, and in the capacity of the treatment provider, to monitor whether his attendance should be increased or reduced. Since the trial the treatment provider has been recognised for this work by the local DAAT who awarded them a partnership award. The provider also made use of his new contacts and organised workshops for unemployed clients on

their Structured Day Programme through the local Next Step<sup>20</sup> provider. These workshops were held on the provider's premises and included information and advice on career options, CV writing, interview techniques and job search advice.

The Lead Drug Champion has been able to continue caseloading substance misusing (or potentially substance misusing) customers following the end of the trial, and has also continued to give advice and guidance to colleagues on identifying and referring substance misusers when needed, raising awareness of the agenda amongst all staff. She has attended other JCP offices following the end of the IA trial period to share best practice in working with this customer group. The Lead Drug Champion was achieving the most referrals and starts in the District and as a result was nominated and awarded the Regional Employee of the month award.

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<sup>20</sup> Jobcentre Plus contracted out employment provision.

## 4. Qualitative Findings

This section presents the findings from the focus groups and interviews which were conducted with key stakeholders in each JCP following the end of the IA trial. Stakeholders included the RDSLs, DDCs, Drug Champions and senior management as well as front-line staff at the Jobcentres, treatment provider staff, and representatives from the D(A)ATs and NTA. The focus groups and interviews explored stakeholders' perceptions of the trial and its impacts, the degree of success it achieved, and whether or not it would be sustainable over the longer term. Findings are structured according to key themes.

### 4.1 Initial Reactions

Initial reactions on hearing about the IA trial and what it would involve varied across stakeholders and JCP offices. In JCP A treatment provider sessions in the office had already been taking place successfully for a number of months in advance of the trial, so the prospect of increasing this activity during the trial period and raising its profile was largely greeted with enthusiasm and positivity by key stakeholders. Nonetheless some front-line staff expressed concerns about the additional pressures that might be placed on them as a result of the trial. Staff who hadn't made a referral to a treatment provider or who didn't feel comfortable discussing substance misuse with customers said they were particularly worried about what they might be required to do as part of the IA trial.

Reactions were also mixed in JCPs B and C, where closer working of this nature between their respective offices and the treatment provider was newer territory. The RDSL and DDC in JCP B reported feeling very positive about the trial and keen to start implementing it, saying that they felt it represented an excellent opportunity to try and improve the service JCP provides for substance misusing customers. The same stakeholders at JCP C reported reacting in a similar way. However, although some front-line staff in JCPs B and C were equally positive, as in JCP A others felt more uncertain and had concerns about the additional pressure and burden that this project might place on them. In the context of the current high customer count being experienced at most Jobcentres, these staff felt that they were already being asked to do an increasing amount but with limited time and resource, and that the IA trial represented yet another demand on the brief amount time that they have to see each customer.

Although stakeholders commented that most JCP staff in all three offices were on board with the aims of the trial, they also felt that some staff had entrenched negative views about substance misusers which would be difficult to change, and which meant they were less likely to engage positively in the trial. Some front-line staff also voiced the concern that substance misusing customers might become violent at the Jobcentre if they felt they were being targeted or pressurised into entering treatment.

The treatment providers in JCPs B and C reported feeling both positive and enthusiastic about the new challenge presented by working more closely with

Jobcentre Plus, but also apprehensive due to the reputation that JCP has amongst their colleagues for being a very process-driven organisation which is un-sympathetic and inflexible to the needs of vulnerable groups such as substance misusers. The treatment provider in JCP B also reported being slightly concerned about the increase in their workload that the IA trial would entail. However, above all they said they were eager to engage with the Jobcentre as employment is a key goal in many of the recovery plans they produce with clients, and because they would be able to promote and encourage the use of their services to individuals who they might not be able to reach otherwise.

## **4.2 What worked well**

### **4.2.1 Treatment provider presence**

The treatment provider presence in the Jobcentre was viewed in a very positive way by most stakeholders in all three trial sites, and was perceived as being central to any increase in referrals that had occurred during the IA trial period. JCP front-line staff reported feeling reassured by the provider's presence in the office, and more comfortable raising the issue of substance misuse with customers knowing that the provider was on hand to refer to immediately and take over any difficult discussions if necessary. In JCP C it was agreed that Advisers did not have to probe the nature of a customer's substance misuse (ie. which substance they were using and the extent of their problem) if they did not feel comfortable doing so, and that this could be left for the treatment provider to explore with the customer. Stakeholders felt this worked well and took pressure off JCP staff. Jobcentre staff in all sites also reported feeling that it was easier to sell the services of the treatment provider to customers when they knew more about that particular provider, trusted the organisation and were familiar with the staff at that service.

The treatment providers in JCPs A and C were both very positive about their role in the trial and their attendance at the Jobcentre, perceiving it as having been a success. They felt that the Jobcentre was an appropriate and productive location for outreach due to the fact that a significant number of individuals with substance misuse issues are in receipt of benefits<sup>21</sup>, and therefore that their regular visits to the Jobcentre represented a good opportunity to engage such individuals in a discussion about treatment. They also felt that, when referrals were made to them during their sessions in JCP, the ability to speak to customers then and there when they were willing and able to talk reduced the numbers failing to attend such discussions.

The treatment providers in JCPs A and C also mentioned various occurrences of JCP staff approaching them to ask questions about substance misuse and the services they provide, and were pleased that they could help raise awareness in this more informal way (in addition to presentations in meetings and training sessions). The treatment provider in JCP C in particular talked

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<sup>21</sup> Estimates commissioned by the DWP of the number of problem drug users in receipt of benefits suggests that around 80% of PDUs in England are on benefits: Hay, G., and Bauld, L. (2008) *Population estimates of Problematic Drug Users in England who access DWP benefits*. DWP Working Paper No. 46.

about receiving a warm welcome from the majority of staff, and being reassured to see so much commitment to the drug and alcohol agenda and eagerness to improve their skills in working with this customer group.

The treatment provider in JCP A faced no restrictions on the activity they could undertake whilst in the Jobcentre, and were able to independently floor-walk and approach customers to discuss their services, man a desk at the front of the office with their literature and leaflets, and make customers aware of their presence. The provider was very positive about this freedom and recorded engaging with just under 400 customers about their services during the course of the trial. Due to restrictions resulting from the TU risk assessment, the treatment provider at JCP C on the other hand was not allowed to approach customers, identify themselves as a treatment provider to customers (at least at the start of the trial) or display their literature and posters on a desk. Instead they were required to stay in a private room during the majority of their sessions in the Jobcentre. These restrictions were described by the provider as frustrating, however the DDC and front-line staff in JCP C noted that the treatment provider remained very visible by keeping the door of their private room open and maintaining excellent communication with staff. The restrictions didn't prevent the trial from being perceived as highly successful in this JCP and achieving an increase in the number of disclosures and referrals taking place, which was credited by some stakeholders to the proactive attitude of the treatment provider (see Chapter 5).

The treatment provider staff who conducted the sessions in JCP B were less positive about their experience during the trial and about the suitability of a Jobcentre as an outreach location, although their manager and the DAAT representative did feel there was value in their having a presence in the JCP. Their dissatisfaction largely revolved around the restrictions placed on them as a result of the Health and Safety risk assessment (see Section 4.3.1). However, despite this they were still able to talk about positive outcomes resulting from their sessions in the Jobcentre, mentioning in particular an occasion when a substance misusing customer was referred to them during one of their sessions and was identified during that referral discussion as a suicide risk. They acknowledged that, when it happened, being able to see customers as soon as they were referred had significant benefits for those individuals. A member of JCP B staff also commented that those customers who were referred during the trial frequently ask to see the treatment provider again when they were in the Jobcentre so that they could update them on their progress and seek further help.

Initial concerns that customers might react negatively to the treatment provider presence proved to be largely unfounded. Staff in JCP C reported that, although some customers were slightly wary of the treatment provider at first, after getting used to them they were generally unfazed by their presence in the Jobcentre and had no negative feedback about it. Front-line staff in JCP B only recalled one situation where a customer had objected to the drug treatment leaflets on their desks, but said this was a relatively minor incident. Even in JCP A where the treatment provider approached customers to

discuss their services, only one negative customer reaction was recorded and again this was perceived as being minor. The provider said that their approach – discussing their service, and explaining that the customer in question may benefit from knowing about it as they may have friends or family with substance misuse issues – worked well and didn't seem to cause any offence in the vast majority of cases. In fact, staff in JCP A reported that the treatment provider presence, in conjunction with the outreach sessions by a member of Jobcentre Plus staff covered later in this section, actually helped to markedly improve the behaviour of a couple of substance misusing customers who had previously acted aggressively towards JCP staff.

However, all three treatment providers raised concerns about resource and the time they could commit to the Jobcentre sessions in the longer term. This issue is addressed in Section 4.5.2.

#### **4.2.2 Closer working / familiarisation period**

Over and above the regular treatment provider presence in the JCP, stakeholders felt that closer working between the two organisations was proving beneficial for the customers involved with both services. In JCP B the familiarisation period – during which the treatment provider spent time with JCP staff, exchanged information about their roles and organisations, joined team meetings and observed Adviser interviews with customers – was described as a 'two way learning-process'. As a result of this activity the treatment provider reported having a far better and more informed understanding of the way in which Jobcentre Plus operates and the pressures that staff are under, and consequently more sympathy for the aims and motivations of the organisation and its staff. The treatment provider at JCP C was also very positive about the familiarisation period which he felt enabled him to adapt to working in a more formal environment than those in which he was used to conducting outreach. He also felt it provided him with the opportunity to speak to staff and 'get his face known'. As discussed in the previous section, JCP staff across the three trial sites felt that their greater familiarity with the treatment provider and understanding of the services they offer made them more likely to recommend a referral to their customers.

The treatment provider in JCP C reported having a greater knowledge of the services that the Jobcentre can offer its clients following the IA trial, and therefore being better able to make clients aware of the support that is available to them. They also said that their greater knowledge of benefit issues, for example in relation to the conditionality which Jobcentre Plus places on the receipt of certain benefits (eg. job hunting and fortnightly signing in the case of JSA), had enabled them to provide advice and encouragement to their clients around complying with these conditions, and therefore helped their clients to avoid facing benefit sanctions. Although they were keen to emphasise that they by no means saw themselves as experts in the area of benefits and still felt they lacked the knowledge to properly advise clients about such issues, they did say that their increased knowledge of applying for benefits and the appeals process meant that they were better placed to provide them with some general guidance on these issues, and where appropriate to provide advocacy on their behalf when dealing with the

Jobcentre. They believed this had helped to resolve or prevent benefit-related problems for a number of their clients.

The treatment providers felt that client feedback on the closer working involved in the trial had been positive. As a result of the trial, the treatment provider at JCP C said that he now encouraged those clients of his service who are JCP customers to disclose their substance misuse to JCP, so that they can access the additional support on offer. He also delivered a briefing session to colleagues at the treatment provider on Jobcentre Plus, the benefit system and the support that JCP offers to customers with substance misuse issues, to ensure that other staff at the treatment provider (and their clients) could benefit from the knowledge he had gained. It's worth noting though that, despite their involvement in the trial, the treatment provider at JCP B said they did not think it was their place to advise customers to disclose to the Jobcentre.

Some Advisers in all 3 sites expressed an interest in finding out about the progress of customers who they had referred to the treatment provider, including whether or not they turned up for the referral appointment and decided to take up treatment. They felt that being made aware of occasions when customers made a real change in their lives as a result of their referral would help motivate them and other Advisers to raise the issue of substance misuse with customers more frequently. This closer working helped to facilitate the sharing of such information between the Jobcentres and the treatment providers (where data protection regulations would allow)<sup>22</sup>.

#### **4.2.3 DDC and Drug Champion contribution**

The DDCs invested a significant amount of concentrated time and energy in the IA during the trial period, and stakeholders in all three trial sites recognised the contribution they had made to any success the trial achieved. Their input included, amongst other activities, raising awareness of the trial amongst staff, organising and facilitating the treatment provider sessions in the JCP, and (in JCPs B and C) supporting senior management in negotiations about the Health and Safety risk assessment. The Drug Champions in all sites were also credited with providing the DDC and the IA trial with crucial support, as well as recognised for the important roles (in JCP A and C) they played in conducting caseloading and outreach activities. The Drug Champion at JCP B relayed her experience of a Jobcentre manager who initially felt he couldn't spare staff time to engage with the activity, but who, after discussing the aims and need for the IA with the Champion, said that her passion had persuaded him of the value and necessity of the initiative. As a result of his support stakeholders reported that the teams he managed ended up engaging well with the trial and making a valuable contribution to it.

All three DDCs spent the majority of their time in their trial JCP office during the IA period, and this level of commitment was perceived as integral to the

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<sup>22</sup> Please note that the JCP Joint Working Protocol makes this sharing of information from the treatment provider to Jobcentre Plus possible only where a TPR2 form has been signed by the customer.

increases in the number of referrals that were seen over this time. However, stakeholders recognised that this had implications for the sustainability of the IA as DDCs were responsible for promoting the drug and alcohol agenda in multiple offices and therefore would not be able to spend the majority their time in only one over the longer term.

#### **4.2.4 Outreach in the treatment provider premises**

The Drug Champion in JCP A conducted outreach in the treatment provider premises during the IA trial, and received positive feedback from all staff and stakeholders (and, according to the treatment provider, service users) involved. She was already volunteering at the treatment provider in her own time and had to push for the outreach herself, but was supported in this both by the DDC and by her manager. According to her manager, an ASM, the need for such an initiative was demonstrated by the number of customers who knew the Drug Champion from her voluntary work at the treatment provider and who approached her at the Jobcentre to ask for her help with their benefits and employment issues. The Drug Champion reported feeling frustrated prior to the IA trial about not being able to caseload these customers or spend as much time with them as she felt they required.

Around a week before the start of the outreach a member of JCP A staff (an Adviser in the Lone Parents team) conducted a Health and Safety risk assessment at the treatment provider to ensure that the activity would not pose any serious risks to the Drug Champion. Adjustments – including changing the room the outreach was going to take place in to ensure that its set-up provided the Drug Champion with a clear exit route should she need to leave during an appointment, and adding a panic alarm to the room for her to use if necessary – were requested following the assessment. However, following these changes, which were viewed by stakeholders as relatively minor, the outreach activity was given approval to go ahead.

After an initial scoping session in which the Drug Champion consulted clients about what they wanted to get from the service and what form they wanted it to take, which she felt was useful for getting clients on board with the outreach service, she saw customers in individual private appointments. This was for confidentiality reasons, and to enable them to feel free to discuss anything they wanted with her. The Drug Champion reported that she received a significant amount of interest in the sessions from substance misusers and that she was booked up in advance for every one she held. She found that, although they always turned up at some point during her sessions, the customers found it difficult to stick to pre-booked appointment times because of the often chaotic nature of their lives, so a degree of flexibility on her part was needed when conducting these sessions.

The Drug Champion reported that almost every appointment she had with customers covered a different issue, ranging from training opportunities and CV writing skills to signposting to other services. Although some of the appointments were benefit-related, she found that the majority were training and employment focused, which was viewed as a positive by stakeholders. Customers were allowed to set the agenda during these sessions. She felt

that most appointments led to a positive outcome and progress being made for the client, and reported that she even managed to support one customer back into employment during the outreach sessions. Both the Drug Champion and the treatment provider expressed the view that service users were more willing to engage openly with JCP staff when in the more familiar and comfortable environment of the treatment provider premises than when in the Jobcentre itself, as customers were not afraid of potential stigma or discrimination there. Also, because all the appointments were held in a private room, the concerns about a lack of privacy in relation to the open plan Jobcentre office were removed.

There was consensus between the Drug Champion and treatment provider about the qualities that an individual needs to possess if they are to be successful in conducting outreach at a treatment provider on behalf of JCP. Empathy with and sympathy for substance misusers; an interest in the issues surrounding substance misuse; excellent inter-personal skills to enable them to develop constructive relationships with individuals who can sometimes display difficult behaviour; a passion for helping people; good listening skills and a non-judgemental attitude were all considered to be very important. Adaptability was also seen to be an important quality to enable Advisers conducting outreach to tailor their working style to the less structured and target-oriented environment (in comparison to JCP) in which treatment providers operate. The Drug Champion also acknowledged that already volunteering with the treatment provider, and hence being a known and trusted face to the clients, made a significant contribution to the success of the sessions. She recognised that gaining the trust of this customer group can take time, and mentioned having seen professionals from other organisations coming into the treatment provider premises and having a more challenging time trying to engage with clients due to the fact that they had no prior relationship with them.

The Drug Champion acknowledged that productivity targets, in terms of the requirement on Personal Advisers to achieve a certain number of interviews and employment or training-related outcomes per week, was a potential issue when conducting outreach with substance misusing customers. She did not record any details of the outcomes of her outreach appointments on the productivity-management system, but felt this was likely to be the next step if the outreach was continued. The Drug Champion felt that her role as an under 18s Adviser, which meant that she had a target of 6 rather than 9 interviews per day, made it easier for her to make time to conduct outreach, but that it would be more difficult for 'normal Advisers' with the higher target to undertake such activity.

#### **4.2.5 Training**

During the IA trial the DDCs and treatment providers in all three offices organised training of some kind for JCP staff, whether in the form of up-skilling sessions, interactive workshops, informal one-to-one and group chats with Advisers between appointments, or a combination of these. All training was delivered by the treatment provider in conjunction with the DDC, and in some cases the Drug Champion as well.

Despite previous staff training sessions having been held prior to the IA trial, DDCs and treatment providers identified a skills gap amongst many JCP staff in relation to knowing how to raise the issue of substance misuse with customers for the first time and sensitively ask the question about whether this is a barrier to employment for them. They therefore aimed to address this in their training. Other issues covered ranged from general awareness of drugs and treatment, identifying possible signs of substance misuse, what to say when a customer discloses substance misuse and the 'can of worms' has been opened, and how to diffuse tension with difficult customers, to selling the benefits of a referral to a treatment provider to customers, correctly referring a customer, and knowing what impact (if any) a particular treatment regime will have on a customer's ability to undertake work, generally and in relation to specific jobs.

Stakeholders reported that the training helped to break down Advisers' concerns about addressing substance misuse with customers – as well as any negative preconceptions around the kind of person who becomes a substance misuser – and had given them the confidence and tools to broach the issue with customers where necessary. Front-line staff reported that the training had made them more aware of what to ask and when, and how to make a referral to the treatment provider. However, despite the positive impact that training had in all JCP trial sites, several members of front-line staff still reported having concerns about addressing substance misuse with customers even after attending training. Additionally, due to the heavy workload of many Advisers and the emphasis on productivity, not all staff were released to attend the formal training sessions. It is due to these limitations around training and Adviser confidence that stakeholders in JCP C felt caseloading to a dedicated Adviser has an important role in working with this customer group (see section below).

#### **4.2.6 Caseloading to a dedicated Adviser**

In JCP C, the practice of caseloading customers with known or suspected substance misuse issues to one Adviser was felt by stakeholders to have worked very well from the customer relationship perspective. The Adviser who volunteered for the role of Lead Drug Champion and was responsible for caseloading these customers was very enthusiastic about working with them, had an easy rapport with them and said she felt very comfortable raising issues around substance misuse. As a result she was able to have productive discussions about the situation and support needs of these customers during her appointments. The customers themselves were said to be developing greater trust in JCP as a result of the strong relationship they were building up with the Drug Champion, and in turn she said that she found helping these customers to make progress very fulfilling. Her practice of following up customers who had been referred to the treatment adviser to check whether they had attended and how they got on was also reported to be working well.

The treatment provider and DDC at JCP C were very positive about the practice of caseloading customers to a specific Adviser who has the motivation and people skills to work effectively with this group, as well as the

additional flexibility to see these customers for the longer and more regular appointments they often require, free from the standard productivity targets. Both felt that developing the role of a Specialist Adviser within JCP who could caseload substance misusing clients would elicit the best results for this group in the longer term. Other JCP front-line staff, some of whom said they weren't comfortable discussing the issue of substance misuse with customers despite the training and upskilling they had participated in, said they thought such a model would be a better way of working with this customer group than expecting all front-line staff to have the skills to work effectively them.

The Lead Drug Champion in JCP A, although unable to caseload substance misusing clients in the Jobcentre in addition to conducting outreach at the treatment provider premises, said she felt such a system would be a very good idea. She believed that there would be significant demand for it, based on the number of substance misusers she knew from the treatment provider who came into the Jobcentre and asked to see her about their employment or benefit-related issues.

However, the Lead Drug Champion in JCP C did raise issues around the conflict between productivity measures and caseloading substance misusing customers, which has implications for the longer-term sustainability of such activity (see Section 4.3.2 below).

#### **4.2.7 'Are you missing out?' form**

The use of the locally produced 'Are you missing out?' form (see Appendix C) was, in the main, viewed positively across all three sites as way of helping Advisers to elicit information about whether drug or alcohol abuse is a barrier for customers. This was a locally produced form, and its format varied between the three sites although its content was the same. It was considered particularly useful as it did not deal with substance misuse in isolation, but as one of a number of possible barriers (including disability and low qualifications). It was also perceived as helping to overcome to some extent the issue of lack of privacy in JCP, which can lead to customers feeling inhibited about disclosing their substance misuse problems due to the concern that other customers might overhear, because customers could just tick a box on the form rather than talking about their issues out loud.

However, not all JCP staff felt that the form was useful. In JCP A views were mixed: those front-line staff in Stage 1 teams working with new customers and those using it in group sessions found it useful, but those Advisers using it with Stage 3 customers reported finding it awkward. They felt that by that point in the customer journey the Jobcentre should know what barriers a customer has, and thought that customers found it strange and untimely that they were being asked about barriers at that point. As such they felt that the use of this form could damage the trust and confidence they had built up with the customer. JCP A and C staff agreed that using the form with new customers, for example in Back to Work group sessions, was more appropriate than using it with longer-term customers. In JCP C around one hundred and fifty forms were completed during the course of the trial, but drug and alcohol issues were only identified as a barrier in ten of these. This was

surprising given that a substantially higher number identified a criminal record as a barrier and the prevalence of substance abuse is high amongst offenders and ex-offenders. Stakeholders felt it could indicate that, despite the form, customers were still not declaring their substance misuse problems in many cases. JCP C front-line staff also reported that many customers did not complete the forms as they weren't mandatory. This led to the conclusion, as expressed by the treatment provider at JCP C, that the form is useful as a springboard into a discussion about substance misuse issues with customers in the early stages of their claim, but is not a substitute for Advisers actually asking customers the question.

#### **4.2.8 Other positive processes and activities**

Across all the trial sites, the leaflets about substance misuse and treatment – including the FRANK and JCP leaflets, as well as those produced by the treatment providers involved in the trial – were seen as a positive addition to the information that JCP already provide. They were seen to allow customers to take away and mull over the information, and also, in JCP A, were reported to have aided self-referrals to the treatment provider for customers who did not want to disclose drug use to JCP staff. Front-line staff in JCP B commented on the number of FRANK leaflets that were being taken from their desks even when the issue of substance misuse had not come up during the appointment. In fact, demand for them was so high that additional supplies of the booklets had to be found mid-way through the trial.

It was agreed across JCPs B and C that it was better to be able to display the leaflets (and other material) on Adviser's desks and in a dedicated area rather than in a stand along with other materials where they aren't as prominent. The DDCs and RDSLs expressed disappointment that the JCP leaflets about referrals and other services for substance misusing customers, including the progress2work employment programme, were no longer being produced due to financial restrictions. In JCP A their solution to this was to photocopy the leaflet and distribute the copies.

Another common view across the trial sites was that having a private room in the JCP in which to engage with customers who have disclosed substance misuse is essential in order to ensure they are comfortable discussing personal and sensitive information without fear of being overheard by other customers. Where such a space was available for the provider most of the time during the trial, for example in JCPs B and C, this worked very well, however this was more problematic in JCP A where there was a shortage of private rooms. It should be pointed out that the providers also valued being able to sit at a desk in the main office space while not seeing customers rather than just a private space or back room, so that they could make staff and customers aware of their presence.

In JCP C, the practice of the DDC previewing customers' LMS records for signs of possible substance abuse issues and flagging these up to the Adviser was deemed to work well, although it was acknowledged to be very resource intensive for the DDC and probably not sustainable in the longer term. The Adviser question and answer sheet (Appendix D), drug quiz (Appendix E),

and referral walk-through sessions and memory aid (Appendix F) also received positive feedback in terms of helping to increase awareness and confidence amongst staff, and were viewed to be more feasible as part of a longer-term activity.

In JCP A case-conferencing within teams – ie. the opportunity to discuss individual customer cases where substance misuse is suspected as being a problem with the ASM and other team members – was viewed as having a positive effect on advisers' confidence around raising the issue with customers.

### **4.3 What worked less well / problems encountered**

#### **4.3.1 Health and safety risk assessments**

As discussed in Chapter 3, the Health and Safety risk assessments which were required prior to start of the treatment provider sessions in JCPs B and C were identified as one of the main obstacles encountered during the trial in these areas. Stakeholders in both areas reported that the Trade Union representatives who were responsible for conducting the assessments had not been supportive of the plan to introduce a treatment provider presence into the Jobcentre. They had raised concerns about the activity being likely to attract large numbers of substance misusers to the office, and to potentially compromise the safety of JCP staff if they became a target for drug dealers who felt they were helping to take away their business<sup>23</sup>. Both the treatment providers and DDCs felt that that these fears were unfounded, and that they were a result of limited knowledge and experience in the area of substance misuse. The treatment providers expressed frustration that neither they, the local D(A)AT or a different, impartial treatment provider in the area were approached by the TU representatives for advice and guidance around this issue before the risk assessment was completed, and that the TU representatives seemed unwilling to engage in dialogue with them about strategies for minimising the risks they had raised. However, the DDCs and other stakeholders acknowledged that they had not had as much time as they would have liked during the development of the trial to properly engage the TU representatives in discussion, due to the tight timescales they were working to.

The result of the assessments in JCPs B and C was that significant restrictions were placed on the range of activities that the treatment providers could undertake whilst in the office<sup>24</sup>. In JCP B the treatment provider staff were not allowed to approach customers or identify themselves as treatment workers even when asked, and were similarly not allowed to wear their ID badges. This led to difficult situations in which they (and JCP front-line staff) felt they were deceiving customers about their real role and the reason for

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<sup>23</sup> Please note that these views represent the perceptions of key stakeholders involved in the trial rather than those of the TU representatives themselves.

<sup>24</sup> These restrictions are not reflective of Jobcentre Plus (or DWP) Health and Safety Policy, which allows for such activities to take place provided that suitable risk assessment processes have been followed and any necessary control measures or risk mitigations put in place, but instead were a result of decisions taken at the local Jobcentre Plus office level.

their presence in the JCP. They were initially prevented from making customers aware of their presence - for example by setting out leaflets, posters or banners, or manning a desk on the office floor - and spent their time during their sessions sitting in a private room. They reported that as a result customers often did not realise they were there, but also that staff were frequently unaware of their presence as well. This also highlighted a problem with communication, which is explored in Section 4.3.3. The treatment provider in JCP B felt that their lack of visibility had a negative impact on the number of customers who disclosed their substance misuse and were referred to them during the trial period.

Additionally, the treatment provider staff in JCP B were asked to comply with JCP office dress codes as their usual dress was seen to be inappropriately informal for the Jobcentre. This caused problems for the treatment provider staff who wear more casual clothes in their role so as to create an approachable and comfortable atmosphere for their clients, and they reported feeling undermined and belittled by this request.

During the first week of the trial in JCP B, it was reported that an email was sent to staff from the TU representative informing them that they weren't allowed to ask customers about substance misuse issues. Although asking about such issues in the context of barriers to work is allowed, this email was said to have caused a lot of confusion and uncertainty and made some staff reluctant to engage with the trial.

The treatment provider similarly reported that, as a result of receiving what they perceived to be a hostile reception from the Health and Safety risk assessment, they felt very cautious about 'overstepping the mark' during their sessions in the Jobcentre. They said that the initial enthusiasm they had felt about the trial started to wane as a result of the obstacles they faced posed by the risk assessment, and the feeling that their presence was not welcome in the JCP office. They felt that their resource and skills were being wasted while they sat in a private office, only seeing a very small number of customers despite the extensive time they were spending in the JCP. The treatment provider felt that four sessions a week was excessive given the number of referrals they were getting. These experiences led to some of the treatment provider staff in JCP B concluding that a Jobcentre is not a suitable location for outreach with substance misusers. Front-line staff in JCP B also reported feeling frustrated and disappointed that the treatment provider resource was not made better use of during the trial.

As a result of negotiations by Senior Managers, the DDC and Drug Champion in JCP B half-way through the trial, the TU representatives agreed to conduct another risk assessment with someone from the DAAT present. This resulted in some of the original restrictions being lifted. However, stakeholders generally felt that the relationship between JCP and the treatment provider had already been damaged by that point and that, although things had started to improve slightly as a result, the negative impact it had had on the success of the trial could not be reversed in the remaining four weeks.

The situation in terms of restrictions was similar in JCP C. The treatment provider expressed frustration that he was not allowed to approach customers and discuss his work with them as he felt that this was where his skills as a specialist outreach worker really lay. However, as an outreach worker experienced at working in structured environments (such as prisons) he was very proactive in his role, and managed to ensure that he made customers and staff aware of his presence, despite being in a private room, by always leaving the door open when he wasn't seeing customers, and taking every possible opportunity during these times to talk to and sit with staff. Despite consensus that this was not an ideal situation, stakeholders in JCP C confirmed that the TU restrictions did not seem to have had a significant detrimental effect on the success of the trial.

In both JCPs B and C, the risk assessment also prevented the Drug Champions from visiting the treatment provider premises and an outreach project in a hostel as part of their training. JCP staff and the treatment provider in both sites reported frustration about this as they valued the importance of such activity in helping staff to better understand the situation that substance misusers face.

Conversely, in JCP A the treatment provider was allowed to approach customers, make them aware of their role and promote their presence. It was not necessary to conduct an additional risk assessment at the start of the trial relating to the treatment provider presence as this represented the continuation of pre-existing activity. However, before the sessions began (around 8 months prior to the IA trial) the existing office risk assessment was reviewed to ascertain whether any additional safety measures would have to be put in place. The existing risk assessment already covered third party staff attending the JCP and interacting with customers, and the decision was taken by the TU representative that having treatment providers on site did not pose any additional risks over and above those already covered in the assessment. A risk assessment was, however, conducted prior to the start of the JCP outreach sessions at the treatment provider premises. The assessment was reported to work well and had a positive outcome which supported the activity (see Section 4.2.4 for more details).

#### **4.3.2 Adviser productivity**

In all three JCP sites, conflict between Advisers' productivity targets (in relation to interviews per day and customer starts to employment and training) and their involvement in the trial was raised as a potential barrier to the success of the IA. It was generally agreed by senior managers as well as front-line staff that the trial did not place significant burdens on the majority of Advisers. However, front-line staff reported that they were concerned about raising the issue of substance misuse with customers in case it led to a disclosure and a lengthy discussion which dominated the rest of the appointment and prevented them from addressing other necessary issues, or made the Advisers late for their subsequent appointments. Those Advisers who were concerned about this said that the knowledge that they would be able to make an instant referral to the treatment provider during their sessions in the office who would be able to take over the conversation helped to allay

these concerns, and again confirmed the value of the treatment provider presence in JCP.

Productivity targets were a more significant issue for the Drug Champions in JCPs A and C who were respectively responsible for conducting outreach sessions in the treatment provider premises and caseloading substance misusing customers. They both discussed the challenges of achieving their standard targets when also devoting a set amount of time to working with substance misusing customers who, they agreed, require significantly more intensive and extended support than the majority of customers to achieve the same outcomes. The Drug Champion in JCP A had a lower target number of interviews due to being an under 18s Adviser, and for this reason felt it would be realistic for her to continue with the outreach sessions after the end of the trial. The Lead Drug Champion conducting caseloading in JCP C similarly found it difficult to achieve her targets whilst devoting one afternoon a week to this activity. At the time of the fieldwork she wasn't sure whether, as a result of this, she wouldn't be able to continue with the caseloading activity following the end of the trial period, although it later transpired that she was allowed to do so.

As mentioned in Section 4.2.5, operational pressures affecting Advisers' workloads had an impact on whether they were released to attend substance misuse training sessions. Across all three JCP sites it was acknowledged that they often meant staff were not able to attend such training even when they felt that they didn't have the necessary skills to work effectively with this customer group.

### **4.3.3 Communications**

Having effective communications around the trial within the JCP was something that proved to be a problem in JCPs B and C. Due to the lack of all-staff meetings in both JCPs, the DDCs in both sites said that they found it problematic finding the right platform or channel through which to raise awareness of the trial and the treatment provider's presence amongst all staff. Although the DDCs and treatment providers gave presentations about the trial at early morning spotlight sessions, not all staff attended these. Additionally, the DDCs felt that emails they sent out to all staff to notify them of the days and times of the treatment provider sessions were overlooked because the volume of emails that JCP staff received and the pressures on their time meant that they weren't able to properly engage with them. Smaller team meetings were seen as an effective (if more time consuming) forum for awareness raising around the trial, but where the team leaders weren't on-board with the aims of the IA and didn't view it as a high priority (see Section 4.3.4) they were not prepared to devote time in their meetings to a discussion of it. In JCP B the treatment provider said that, six weeks into the trial, they were still coming into contact with staff who didn't know who they were or what they were doing in the JCP office. The DDC in JCP C felt that the activity lacked the high profile launch that would have maximised the trial's chances of success.

Communication appeared to be less of a problem in JCP A due to the fact that the provider had been attending the Jobcentre for about 8 months prior to the start of the trial and was therefore already well known to most staff, and because they were allowed to have a far more visible presence on the office floor than the provider in the other two trial sites.

#### **4.3.4 JCP management buy-in**

Stakeholders in JCP B felt that they faced difficulty in securing buy-in from all JCP managers to the aims and objectives of the trial. They felt that this was in part due to the short lead-in time for the trial and hence the lack of time to discuss the activity with these individuals and convince them of its importance, and also due to the crowded nature of the agenda and the operational pressures currently being experienced in JCP. The stakeholders felt that, where they were not able to secure the support of a manager, the teams for which they were responsible ended up not engaging with the trial as they did not have the support or encouragement to do so from their senior colleagues. As a result the stakeholders believed that it was significantly harder to make those customers dealt with by the teams in question aware of the trial and the treatment provider presence in the JCP than it was those customers dealt with by teams whose ASMs were supportive of the trial.

#### **4.3.5 Other elements that worked less well**

Two other areas which were highlighted as being problematic concerned the setting of disadvantage and pilot markers following customer disclosures about substance misuse, and the lack of privacy within the JCP for sensitive discussions with customers. In relation to disadvantage markers, stakeholders in JCP C voiced the concern that undermarking was happening, in other words that although customers were disclosing their substance misuse to Advisers the LMS markers recording these disclosures were frequently not being set. This was despite the DDC in JCP C producing a referral process memory aide for Advisers for use during the trial, and talking them through the process in one-to-one sessions. The DDC and RDSL in particular felt that this was happening because the process for making a voluntary referral to a treatment provider is too complex and time consuming, requiring staff to complete a data protection form, set a disadvantage marker on the system and also an additional marker indicating treatment status if the customer is a PDU. These stakeholders were strongly of the view that the process needs to be simplified if a decrease undermarking is to be achieved.

The lack of privacy in JCP for sensitive conversations with customers, such as those about substance misuse, has been previously found by research to be one of the elements of JCP that drug misusers are uncomfortable with<sup>25</sup>. The issue emerged again during the IA trial, with the treatment provider in JCP A citing this as one of the reasons why they felt some substance misusing customers did not want to take up the opportunity of a referral to them in the JCP office. In JCP A, although the treatment provider was given a lot of freedom to approach customers, they were not allocated a private room (as

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<sup>25</sup> Bauld, L., Hay, G., McKell, J., and Carroll, C. (2010) *Problem Drug Users' experiences of employment and the benefit system*. DWP Research Report No. 640

the treatment providers in JCPs B and C were) due to the lack of availability of such rooms in the office. They expressed the opinion that the trial would have been more successful had they been able to speak to people about their substance misuse in an area away from other customers where their discussion could not be overheard.

#### **4.4 Overall success**

Stakeholders were asked about their perceptions of the success of the IA trial as a whole in their JCP. Views were mixed, and there was acknowledgement that the trial periods were relatively short and therefore that any success seen during that time represented only the start of what could be achieved over the longer term, were the activity to continue. However, on the whole stakeholders – especially those in JCP A and C – were very positive about the overall impact of the trial, identifying several key areas which they believed had improved significantly as a result of it. They did acknowledge though that the issues around the Health and Safety risk assessment had affected their perceptions of the success of the trial, and that the success had not always been reflected by the number of referrals and disclosures achieved.

##### **4.4.1 Confidence, motivation and skills of JCP staff**

Stakeholders across all sites felt that, through a combination of training, awareness raising and additional support for staff, many Advisers and other front-line staff had become more actively involved in the substance misuse agenda and more comfortable with discussing such issues with customers. Stakeholders in JCP A cited the fact that referrals had been made during the trial period by four members of staff who had never previously made one as evidence that greater numbers of staff were engaging than was previously the case. Stakeholders in JCP B said that the process of breaking down Advisers' concerns and building their confidence in this area would necessarily be a gradual one, but that the various activities involved in the trial had gone a significant way to achieving this aim. They did acknowledge that some staff (including some ASMs) were still not on-board with the aims of this agenda, and indeed some front-line staff interviewed said they still weren't comfortable discussing these issues with customers and wanted to leave this task to the Drug Champion and DDC. However, most stakeholders nonetheless felt that the IA had resulted in significant progress being made in this area.

##### **4.4.2 Improvement in service and relationships with substance misusing customers**

Stakeholders in JCP A in particular, although also in JCP C, felt that there had been a noticeable shift in the attitudes of substance misusing customers towards JCP since the start of the trial, from quite a hostile and negative – and sometimes aggressive – position to a more positive one. They felt that as a result of staff becoming more aware of and sympathetic to the support needs of this customer group, and as a result of the visible presence of the treatment provider at the Jobcentre and vice versa (during the JCP outreach sessions), the behaviour of substance misusing customers had improved and they were starting to engage with JCP in a more open and productive way.

The treatment providers in JCPs A and C were very positive about having a presence in the Jobcentre, and felt that as a result of it they were able to access individuals who they hadn't come into contact with before. They acknowledged that a significant proportion of substance misusers are in receipt of benefits and that the Jobcentre is often the only organisation that they will visit on a regular basis, making it an ideal place to offer information and advice about treatment. Both treatment providers were keen to continue with their sessions in the JCP (albeit in a reduced frequency – see Section 4.5.2) and the treatment provider in JCP C was also in discussions about extending the service to other JCP offices in the area, demonstrating their belief that this model of closer working with JCP has definite benefits for them and for substance misusers. The treatment provider staff in JCP B, however, were less certain that the Jobcentre represents a good place in which to try and engage substance misusers, citing the problems they experienced in relation to the risk assessment as evidence that key JCP staff do not want to get involved in the substance misuse agenda, making it very difficult for the two organisations to work together in a productive way.

#### **4.4.3 Risk assessment issues**

Although both JCPs B and C had restrictions placed on the trial as a result of the Health and Safety risk assessment, when considering overall success only stakeholders in JCP B felt that it had a significant and lasting negative impact on the trial. The treatment provider and JCP front-line staff in particular felt that, although the trial had represented an excellent opportunity for the two organisations to work together more closely to support substance misusers, it ended up being a missed opportunity as the treatment provider was very limited in the activities they could undertake, and due to the small number of referrals achieved ended up not being able to spend the majority of their time in the JCP in a productive way. Stakeholders felt that if the issues around the risk assessment had been resolved earlier then the trial in JCP B would have been more successful.

#### **4.4.4 (Limited) increases in disclosures and referrals**

Across the three trial sites, very different outcomes were achieved in terms of the numbers of disclosures and referrals which took place during the trial compared to those which had been recorded prior to it. Stakeholders in JCP C were very positive about the increase in numbers that they had seen during the trial and felt that the IA had been key to driving these up. However many in JCP B (and to a lesser extent JCP A) acknowledged that they didn't feel the increases seen in these hard outcomes reflected how successful they believed the trial to be. There was widespread agreement that capturing success in terms of hard outcomes was difficult, but that the success of the IA trial should not be measured in terms of these figures alone, but also according to other 'softer' measures including, for example, staff motivation and confidence.

As touched on at the beginning of this section, stakeholders were also keen to point out that they felt that 4-8 weeks was a very short amount of time in which to see the sort of culture change (both within the JCP and in substance misusers attitudes towards the JCP) which the IA would have to achieve

before it started to see significant increases in disclosures and referrals. Many expressed confidence that if the IA were to be continued they would see a steady increase in the numbers of customers opening up about their substance misuse and accepting the offer of a referral to the treatment provider as the message spreads within the substance misusing community about the support that JCP can offer them.

#### **4.5 Sustainability over the longer term**

Stakeholders were asked about how sustainable the IA would be in the longer term, and whether they were planning to continue with the activity after the end of the trial period.

##### **4.5.1 JCP perspective**

In terms of JCP staff resource, the main individuals whose workload saw an increase as a result of the trial were the DDCs and the Drug Champions, in particular those Champions who took on the responsibility of conducting outreach sessions in the treatment provider premises and caseloaded substance misusing customers. The DDCs in all areas spent the majority of their time in the trial site JCP during the trial, and they acknowledged that this wouldn't be sustainable in the longer term as they are responsible for the substance misuse agenda in more than one JCP office. However, they felt it would be valuable and realistic (from their perspective) for the IA to continue but with less intensive support from them now that it was more established and the initial bedding in phase was coming to an end.

The Drug Champion in JCP A was keen to continue with the treatment provider outreach and, following agreement from her ASM, was planning to do so. However, she said that a solution to the issue of how to incorporate this activity into her productivity targets would have to be considered if the sessions were to become a more permanent aspect of her job. The Lead Drug Champion in JCP C similarly continued to caseloaded substance misusing customers following the trial, although she acknowledged that the struggle to achieve her targets whilst also undertaking this activity would be ongoing.

##### **4.5.2 Treatment provider perspective**

The sustainability of the IA for the treatment providers varied, but each was downscaling the amount of time that they spent in the Jobcentre following the end of the trial. For the treatment provider in JCP A, this meant reducing their attendance from three to one session a week, back down to what they were committing to the activity prior to the start of the trial. They reported that, although they felt IA was a productive use of their time, resource constraints meant that they could not spare staff for three sessions a week on an ongoing basis. In JCP B the treatment provider stopped regularly attending the Jobcentre following the end of the trial but said they were prepared when possible to offer a more responsive service and come into the office to meet with customers when any voluntary referral appointments were scheduled in. From their perspective four sessions in the JCP per week had not represented a good use of their time when combined with the limitations imposed on their

activity whilst in the office, and what they felt were the low number of referrals achieved during the trial. They pointed out that, although the softer measures of success, such as improved working relationships, are important, without a significant increase in the number of referrals taking place they would find it very difficult to justify spending a substantial amount of time in the JCP to their commissioners.

In JCP C, the treatment provider was very positive about maintaining a presence in the Jobcentre, but was also having to reduce his time in the office, in this case halving it to one session a week. This was due to his commitments to other outreach projects which meant he had less time to spend at the Jobcentre. However, he also planned to try and offer a more responsive service and come down to the office to see a customer as soon as they had been referred if at all possible. He had additionally expressed an interest in the possibility of extending the service to other JCP offices in the area (time and resources permitting), and the feasibility of this was being discussed by the provider and commissioning D(A)AT at the time of the fieldwork.

#### **4.6 Key lessons and advice**

Stakeholders were asked for the top pieces of advice, or the most important lessons they had learnt during the trial, which they would want to pass on to other JCP offices and treatment providers who are about to adopt a similar model of closer working. While the pieces of advice covered a broad range of issues, some key themes emerged.

##### **4.6.1 Preparation and planning**

The first theme was the importance of conducting full and proper planning in advance of the introduction of IA, and getting various key parties on board with the objectives of the activity early on in its development. Stakeholders in JCP B particular felt they had been required to introduce the trial very quickly and without a reasonable lead-in time, and as a result had not had the opportunity to engage with some of the key stakeholders, including TU representatives, as early and in as structured a way as they would have liked. They felt that this then led to problems during the trial which could have been resolved prior to its start had they had the proper discussions with stakeholders and secured their buy-in early on.

It was also seen as important to engage with the treatment provider at the earliest possible opportunity so that the IA can be co-designed in conjunction with them, and so that the roles of both JCP and treatment provider staff in the trial can be agreed and clarified at the start to prevent any misunderstandings or false expectations.

##### **4.6.2 JCP senior management buy-in**

Linked to the theme above, stakeholders in all three sites also felt strongly that it is important to get buy-in from an early stage from the JCP office senior managers and team leaders. They felt that it is necessary to get these individuals, along with any other 'key influencers' that have been identified in

the JCP, on-board with the aims of the IA in order to maximise the chances of all teams within the office participating fully in the activity, and to ensure that the IA doesn't lose momentum following the initial, more intensive phase.

#### **4.6.3 Intensive start and good communications**

Some of the key stakeholders in JCPs B and C, including the DDCs, felt that having an intensive start to the IA, or what the DDC in JCP C described as a 'big bang' start, was very important to maximise its chances of success. Both the DDCs acknowledged that the trials in their JCPs had not had the easiest of starts due to the issues around the risk assessment and with communications, and felt that this had negatively impacted on the subsequent success of the trial (although more so in JCP B than C). The treatment provider in JCP C said he would stress the importance of spending the initial few weeks of the trial really getting to know JCP staff and developing strong working relationships and trust with them. He said that he did this by taking every opportunity he could to speak to and engage with staff members, including attending team meetings and having conversations with them when they were between appointments, as well as spending his breaks in the staff room every day and talking to them on a more informal basis. The DDCs for their part emphasised the importance of having the DDC (or the member of Jobcentre Plus staff who has responsibility for the main functions of this role) spend the majority of their time in the JCP office in which IA is being introduced during the first few weeks of the activity if possible.

Linked to this advice about an intensive start is that which stakeholders gave around the importance of good communications within JCP, especially during the early stages of any IA initiative. They stressed the importance of promoting and raising awareness of the trial to all staff so that everyone is aware of what is taking place, of the importance of substance misuse issues within the broader JCP agenda, and of the opportunity they can offer to customers of an immediate referral to the treatment provider during the provider's sessions. The treatment provider in JCP B had the experience that, as a result of difficulties around communication within the office, some staff were not aware of the times and days they were going to be present in the office, and indeed reported that there was occasionally uncertainty amongst JCP staff about whether or not they were in the office at the present time. They therefore suggested having a chart on the wall of the staff room listing the dates and times of the provider sessions for the upcoming week, along with their location if the provider is going to be situated in a private room rather than floor walking or sitting at a desk on the office floor.

#### **4.6.4 Training**

There was agreement that training for JCP staff is a key element of IA and crucial in helping to tackle any negative perceptions and stereotypes staff may have in relation to substance misusers, give staff the skills they need to confidently raise and deal with the issue of substance misuse with customers, and understand any limitations that treatment places on an individual's capacity to undertake employment. They felt it was particularly important that all staff attend such training if a 'whole office' approach is to be taken with regards to this agenda, ie. if all staff are going to be expected to work with

substance misusing customers take an active role in the agenda, rather than just specialist advisers (or Drug Champions). Initial awareness training followed by more in-depth sessions involving role plays and guidance in how to ask about substance misuse and deal with disclosures was the approach advocated by the treatment provider in JCP B. Front-line staff in JCP A also recommended visiting the treatment provider premises to gain a better idea of what they do and how to best promote their services to customers.

#### **4.6.5 Being open-minded and non-judgemental**

Stakeholders acknowledged that changing attitudes within the Jobcentre in relation to substance misuse represents a significant culture change which will take time to achieve and will not happen overnight. However the treatment providers, DDCs and Drug Champions were keen to stress the importance of staff keeping an open mind about substance misusing customers, not making assumptions about or stereotyping them and instead learning to simply listen to them and advise without judging. Front-line staff in JCP A echoed the importance of listening carefully and responding to customers' experiences and situations on a case by case basis because 'one size doesn't fit all' with this group. Stakeholders were also keen to emphasise the importance of staff proactively challenging any negative attitudes that they hear being expressed by their colleagues to help speed up the rate of attitudinal change, and spread the message that this customer group needs support rather than negative judgement from JCP staff in order to successfully move towards employment.

#### **4.6.6 Other advice**

Other advice that stakeholders would give centred around the importance of having a committed and motivated Drug Champion (or Champions) in the office; being as flexible as possible during the trial to ensure any problems can be successfully overcome and the IA adapted and improved if it (or elements of it) are not working; having a clear referral pathway to the treatment provider and ensuring that all staff know how to make a referral; and developing close links with the staff dealing with rapid reclaims in JCP to target customers who display chaotic behaviour (suggesting potential substance misuse) and are therefore frequently sanctioned or lose their benefits. The treatment provider in JCP B suggested that it would be helpful if the NTA issued guidance on working closely with JCP. They also suggested that JCP outreach sessions in treatment provider premises would be more useful, in their view, than treatment provider sessions in the JCP. Lastly, some front-line staff said they would advise other staff not to feel pressured into asking customers about substance misuse, but instead only to broach the issue if and when they feel comfortable doing so.

## 5. Quantitative Findings: Referrals and PDU markers

This section contains details of the two main outcome measures focused on during the IA trial: the number of customer referrals to a discussion with a treatment provider that took place; and the number of PDU markers that were set on the LMS system. The latter is a proxy for the number of disclosures of substance misuse that were made by customers.

The tables in this section containing the referral figures also contain information on the number of starts to a discussion with a treatment provider (ie. the number of customers who attended the discussion to which they were referred) and the number of starts to a treatment programme that resulted from those discussions. Please note that these figures may be undercounts of the actual numbers attending discussions and starting treatment, due to the fact that, for data protection reasons, the customer's consent is required before the treatment provider can notify JCP that a customer has attended a discussion or started treatment. Where customers did not give their consent this information will not have been relayed to JCP and therefore won't appear in the tables.

As noted earlier in Section 2.2.2, the figures produced in relation to the number of disclosures taking place are similarly likely to be an undercount as they only includes those customers who admitted to using heroin or crack cocaine *and* agreed to JCP placing this information on their LMS record<sup>26</sup>. However, it is likely to give a broad indication of any increase or decrease in the number of disclosures being made.

For comparison, figures are presented relating to the 6 months prior to the IA Trial, the eight weeks (or four weeks in the case of JCP C) during the trial, and the three months directly after the trial. In the case of JCP A, figures are also given for the period from the introduction of the referral process (April 2009) to November 2009, as the treatment provider did not have a presence in the Jobcentre during this period but did so from that point onwards.

All three Jobcentres saw an increase in the rate of referrals being made and PDU markers set during the trial, albeit to differing degrees. The reasons behind this disparity in success are explored in detail in the previous chapter.

### **5.1 Jobcentre A**

Please note that JCP A did not record the type of substance that referred customers were misusing (ie. whether it was heroin and/or crack cocaine, another drug, or alcohol) and hence these figures cannot be broken down by these sub-groups in Table 2.

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<sup>26</sup> Due to data protection, customers have to consent to having information about substance misuse added to their electronic record. If they do not give their consent then this information is not recorded.

**Table 2: Referrals, starts to a discussion and starts to treatment in JCP A by time period in which they were made**

<b>Time period<sup>1</sup></b>	<b>Referrals to a discussion with a treatment adviser</b>	<b>Starts to a discussion with a treatment adviser (where known)</b>	<b>Starts to treatment (where known)</b>
Before trial (April 09 – end Nov 09)	0	0	0
Before trial (6 months prior to trial start)	13	6	10
During trial (8 weeks)	6 (+2 self referrals) <sup>2</sup>	4	3
Post trial (3 months after trial)	2	1	1

<sup>1</sup>Please note that only PDUs were referred before the trial, but during and following the trial misusers of any substance (including alcohol) were referred.

<sup>2</sup>'Self-referrals' refers to customers who visited the treatment provider to discuss treatment options after finding out about them through the Jobcentre, but who were not officially referred by JCP.

**Table 3: PDU markers in JCP A by time period in which they were set**

<b>Time period</b>	<b>In treatment markers set</b>	<b>Not in treatment markers set</b>	<b>Total markers set</b>
Before trial (6 months prior to trial start)	3	8	11
At the end of the trial (8 weeks)	4	5	9
Post trial (3 months after trial)	0	0	0

## 5.2 Jobcentre B

**Table 4: Referrals, starts to a discussion and starts to treatment in JCP B by time period in which they were made and type of referral**

Time period and type of referral	Referrals to a discussion with a treatment adviser	Starts to a discussion with a treatment adviser (where known)	Starts to treatment (where known)
<b>Before trial (6 months prior to trial start)</b>	<b>1</b>	<b>0</b>	<b>0</b>
Heroin and crack	1	0	-
Other drugs	0	0	-
Alcohol	0	0	-
<b>During trial (8 weeks)</b>	<b>3</b>	<b>0</b>	<b>0</b>
Heroin and crack	0	0	0
Other drugs	1	0	0
Alcohol	2	0	0
<b>Post trial (3 months after trial)</b>	<b>4</b>	<b>2</b>	<b>0</b>
Heroin and crack	4	2	0
Other drugs	0	0	0
Alcohol	0	0	0

**Table 5: PDU markers in JCP B by time period in which they were set**

Time period	In treatment markers set	Not in treatment markers set	Total markers set
Before trial (6 months prior to trial start)	5	2	7
At the end of the trial (8 weeks)	11	4	15
Post trial (3 months after trial)	13	4	17

### 5.3 Jobcentre C

**Table 6: Referrals, starts to a discussion and starts to treatment in JCP C by time period in which they were made and type of referral**

<b>Time period and type of referral</b>	<b>Referrals to a discussion with a treatment adviser</b>	<b>Starts to a discussion with a treatment adviser (where known)</b>	<b>Starts to treatment (where known)</b>
<b>Before trial (6 months prior to trial start)</b>	<b>12</b>	<b>3</b>	<b>2</b>
Heroin and crack	4	0	0
Other drugs	2	1	1
Alcohol	6	2	1
<b>During trial (4 weeks)</b>	<b>21</b>	<b>12</b>	<b>8</b>
Heroin and crack	8	3	2
Other drugs	4	3	1
Alcohol	9	6	5
<b>Post trial (3 months after trial)</b>	<b>55</b>	<b>32</b>	<b>1</b>
Heroin and crack	31	18	1
Other drugs	13	5	0
Alcohol	11	9	0

**Table 7: PDU markers in JCP C by time period in which they were set**

<b>Time period</b>	<b>In treatment markers set</b>	<b>Not in treatment markers set</b>	<b>Total markers set</b>
Before trial (6 months prior to trial start)	20	9	29
At the end of the trial (4 weeks)	12	5	17
Post trial (3 months after trial)	4	3	7

## 6. Conclusions and Recommendations

This final chapter considers the main conclusions emerging from the evaluation, and recommendations for best practice arising from those conclusions for Jobcentres who wish to adopt a model of working with treatment providers similar to that tested in the IA trial. Additionally, it also includes broader best practice recommendations for implementing the substance misuse strategy, applicable across all Jobcentre Plus offices.

### 6.1 Conclusions

As the findings in Section 4 illustrate, stakeholder views about the trial were broadly positive, with general perceptions (with a few exceptions) being that it had been a success. The model of closer working trialled was perceived as having a particularly positive impact in relation to:

- changing JCP staff attitudes towards substance misusers, increasing their understanding of the needs of this customer group, and improving their skills in supporting them;
- forging good working relationships between Jobcentre Plus and the treatment providers, increasing understanding between the two organisations and knowledge of the services that the other offers;
- raising the profile of the substance misuse agenda amongst JCP staff, including senior management and customer facing staff, and helping to embed it in everyday working practices; and
- improving the experience of and service provided by Jobcentre Plus for substance misusing customers.

Where the IA worked well, this model of closer working was viewed as being beneficial for all parties involved. For the treatment providers it was seen to offer an opportunity to work in a new environment and engage with individuals who they might not otherwise come into contact with, as well as to increase their knowledge of JCP services and thereby become better placed to support their clients in resolving any issues they may have around their benefits or accessing employment support. For JCP the IA was perceived as increasing staff skills and confidence, improving staff knowledge of the services available to customers with substance misuse issues, and increasing the likelihood of staff making a referral to a treatment provider. For the substance misusing customers themselves, stakeholders felt that the IA helped to remove the barriers that often prevent individuals from making initial contact with treatment providers, and also started to improve their trust in and attitudes towards JCP. All the treatment providers involved could cite cases where substance misusing customers had, as a result of the trial, been helped to

access support which they needed but had not previously managed to access. This included benefit and employment advice from JCP, as well as treatment advice and support in relation to their dependency from the treatment provider. This sort of holistic, joined-up provision of services is a key element of the recovery and reintegration strand of the 2010 Drug Strategy<sup>27</sup>.

The exception to this positive view was held by the treatment provider and some front-line staff in JCP B who felt that the trial had not been successful. This was perceived as being largely a result of the difficulties it faced in getting off the ground due to the negative outcome of the Health and Safety risk assessment, the mixed messages that JCP staff received about the trial from TU representatives, and the lack of buy-in from some managers. Although there was recognition that, following the second risk assessment half-way through the trial which lifted some of the restrictions on the treatment provider activities, the situation had improved, it was felt that the 'damage had been done' and that it was hard for the trial to recover, bed in and start seeing significant success after such a problematic start.

There was recognition in JCPs A and B by those who deemed the trial to have been a success that this success was not reflected by the increase in numbers of referrals achieved during the trial period, which was only moderate in these trial sites. However, even in Jobcentre C which saw the largest increase, the number of referrals was still substantially smaller than the estimate which JCP hoped could be achieved, indicating that these estimates may need to be revised downwards. Stakeholders in all sites were keen to point out that cultural and attitudinal change within JCP and amongst substance misusing customers is a gradual process that takes time. They felt that the 4-8 weeks of the trials represented only the start of that process, and were hopeful that a further increase in the rate of disclosures and referrals would follow were the IA activities to be continued.

In the case of JCPs A and C, the activity (albeit in a modified form) was extended past the end of the trial period, and in JCP C in particular significant numbers of referrals continued to be achieved during this time. The willingness of the treatment providers and JCP staff involved to extend the IA past the end of the trial despite the significant resource involved provides evidence of their belief in its efficacy.

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<sup>27</sup> Home Office (2010) *Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life*

### **6.1.1 Evidence gaps**

To fully understand the effects of closer working between treatment providers and JCP in the model adopted by the IA trial, additional research would be valuable to explore the experiences and perceptions of substance misusing customers and treatment provider clients around IA. Anecdotal evidence from treatment providers and JCP staff working closely with substance misusers during the trial suggests they were positive about this closer working, that it had been easier for them to access the advice and support they need as a result of it, and that it had started to improve their views of and attitudes towards JCP. However, these assertions need to be validated by robust research with customers and treatment provider clients themselves. This work should explore which elements of the IA trial the customers found particularly positive from their perspective, and which had less of a beneficial effect.

A small-scale survey of 46 treatment service users, conducted as part of this research in collaboration with the D(A)AT working in the area of JCP A, explored the issue of barriers and facilitators to the disclosure of substance misuse. The findings indicated that never having been asked about substance misuse by JCP staff, being worried about stigma, worried about how their benefits would be affected, and a lack of privacy in the JCP office were among the key reasons for not having disclosed to JCP. Conversely, they suggested that having greater privacy in JCP, being given assurances that the information about their substance misuse won't be passed on to other agencies such as the police or Social Services, having greater awareness of the support that JCP could provide them with, and having greater flexibility in their benefit conditionality (for example, not having to sign on every fortnight if they are on Jobseekers' Allowance) would all encourage substance misusers to disclose to JCP. The last suggestion, around appropriate relaxation of benefit conditionality, is being proposed for substance misusers in treatment as part of the new Drug Strategy. Further, more robust research is needed to verify the findings from this survey.

Additional evidence would also be useful to understand which individuals are benefiting most from the IA. In other words, to find out whether, as a result of the trial, those hardest-to-reach substance misusing customers (for example, those experiencing the greatest number of co-occurring problems including mental health issues and homelessness, and those unlikely to have sought or accessed treatment providers otherwise) decided to take up the opportunity to attend a discussion with a treatment provider, or whether the customers who agreed to a referral would have accessed treatment provider services in the near future anyway, albeit possibly not as quickly or with as much ease had the IA trial not been in place. Such information would help us understand whether more needs to be done to engage with and support those hardest-to-reach individuals.

A larger scale IA trial and evaluation would be needed for a robust assessment of cost-benefit to be made.

## **6.2 Recommendations**

### **6.2.1 Extending IA to other Jobcentres**

The IA trial has demonstrated that such a model of working can be successful, add value for JCP, the treatment provider and substance misusers, and have a positive impact on the number of disclosures and referrals being achieved. However, given the limited increase in referrals achieved during the trial and its resource intensive nature, it is unlikely that in the current climate many JCP offices will be able to justify adopting intensive activity on this scale with a view to increasing the volumes of such referrals.

Any decision to adopt a form of Intensive Activity within a Jobcentre office must be made at the local and district level, in collaboration with the D(A)AT and the treatment provider(s) who would be involved. When making this decision consideration should be given to:

- the current capacity of the DDC (or the individual who has responsibility for the main functions of this role post-March 2011), any Drug Champions who might be required to undertake caseloading or outreach activities, and the treatment provider(s) who would be involved;
- the current level of disclosures and referrals being achieved by the Jobcentre in comparison to the estimated scale of the substance misuse problem (and level of treatment penetration) in the office catchment area; and
- the expert knowledge of the local treatment provider(s) in relation to whether the substance misusers in the area would benefit from such activity.

For those Jobcentres who take the decision to introduce the IA model in their office, the trial has provided various lessons for best practice which are discussed in Section 6.2.2 below. The trial has also highlighted broader lessons for best practice when supporting substance misusing customers which are of relevance to all Jobcentres, regardless of whether or not they decide to introduce a treatment provider presence into their office. These recommendations are detailed in Section 6.2.3.

The lessons for best practice contained within this report do not constitute an exhaustive list of the most effective ways for JCP to work with treatment providers to provide a more holistic service for substance misusing customers, and to increase the number of disclosures and referrals being made. Other innovative ways of working which have been adopted within JCP districts and have seen successful outcomes include the introduction of office-level targets around referrals to a treatment provider, the use of office and region-level performance league tables, close working with the police, prisons and DIPs (Drug Intervention Programmes), and intensive previewing of customers' LMS records to identify those who have a previous history of substance misuse recorded on the system to enable targeted offers of support to be made. Unfortunately, activity such as this which did not occur in the three IA trial sites is outside the scope of this evaluation. Further research would be required to compare the effectiveness and value for money of these approaches with the IA model.

### **6.2.2 Lessons for best practice when developing an IA initiative**

For those regions or Jobcentres where it is agreed that there is sufficient need and capacity to support the adoption of Intensive Activity, various best practice lessons can be learnt from the trial to help maximise the chances of the activity having a significant positive effect.

#### ***Treatment Provider Role***

As discussed above, any decision to introduce IA into a JCP office should be made in conjunction with the local D(A)AT and treatment provider to ensure they have the capacity to take on such a project, and if so to establish how much resource they could offer. The treatment provider should be involved in the design of the activity to ensure that their expertise in engaging with the substance using population in the area is fully utilised. Additionally, as with Jobcentre Plus, treatment providers frequently have targets set on their activity by the commissioning D(A)AT (for example – in the case of the treatment provider in JCP C – to work predominantly with users of Class A drugs). Where this is the case a consideration at the development phase of how these might be impacted by and accommodated within the IA is essential if it is going to be sustainable in the longer term.

The commitment of the treatment provider appears integral to the success of IA, so it is important that they are on-board with the goals of the initiative and willing to work flexibly with JCP if faced with any barriers or obstacles during the course of the activity. It appears beneficial if the provider has prior experience of conducting outreach and adapting to working in different (and more formal and structured) environments to that of treatment services, as Jobcentres represent a very different environment to those in which most

treatment providers usually operate. A proactive approach on the part of the treatment provider – as far as possible within any restrictions imposed on their activity – in relation to familiarising themselves with JCP practice and processes, raising awareness of their presence and services and forging good relationships with JCP staff and customers, is likely to increase the chances of success of the IA.

This evaluation cannot provide evidence on the optimum amount of time per week that treatment providers should spend in the Jobcentre as part of the IA. This should be agreed based on provider and JCP staff capacity and on perceived need. The trial has demonstrated the importance of the activity having a positive start and being well promoted to both staff and customers, and based on this we would recommend that the treatment provider commit a greater amount of time to the activity during the first 3-4 weeks of the trial and attend the office for several pre-agreed sessions per week. Following this more intensive period it would be sensible for the key stakeholders in the IA to review the situation and take a decision on whether to continue with the same level of attendance, increase the number of sessions, or scale back the amount of time they spend there.

If the latter, the treatment provider might want to only attend if they have booked appointments with customers, or specific meetings or training sessions with JCP staff, if this is deemed to be the best use of their time. If the treatment provider has the flexibility (and is within a sufficient proximity) to consider attending the Jobcentre to see customers as soon as they've been referred then the evidence from JCP C suggests that this can work very well. The treatment provider should also consider attending the JCP on different days of the week if possible so as to maximise their availability to JSA customers on different signing cycles. Whilst it would be ideal and the best use of their time if treatment providers are able to approach customers to discuss their services, evidence from JCP C has shown that this is not a necessary condition for successful IA, and that even if risk assessments prevent this being done IA can still work well provided the treatment provider is sufficiently proactive in making their presence known. Having use of a private room, however, is essential so that customers can talk confidentially to providers about sensitive matters without fear of being overheard.

During the first few weeks of any treatment provider presence, the evidence suggests an initial familiarisation period of a week or so during which the treatment provider focuses on better understanding the work of, and the procedures and processes that operate in, JCP is beneficial. This could be done by enabling the treatment provider to join team meetings and spotlight sessions, sit in on customer interviews and generally gain as much exposure to JCP staff and their work as is possible and appropriate. The treatment

provider should also take this time to explain the work that they do and services they offer, and to answer any questions that JCP staff may have.

### ***Jobcentre Plus Role***

The trial suggests that Intensive Activity is most successful in Jobcentres where there is buy-in and commitment to the activity from management, and where those managers are consequently willing to give their teams the support and encouragement necessary to ensure that they fully engage with the initiative. Evidence from JCP B suggests that some team leaders did not adopt the activity within their teams and were not challenged on this by their managers. Management support is especially important to the success of IA as the findings from this evaluation, as well as those from a survey of advisers conducted by JCP Work Psychologists (unpublished internal report), have demonstrated that not all front-line JCP staff are confident about working with substance misusers, or motivated to do so. A visible show of commitment and encouragement from senior staff is therefore crucial in helping to change their attitudes to working with this customer group, and also in reinforcing the importance of the substance misuse strategy on what is a very crowded and process-driven agenda for front-line JCP staff.

The evidence suggests that a significant amount of commitment is required from the DDC if the chances of success of an IA initiative are to be maximised. As a result it is recommended that, during the initial bedding-in phase of around 2-3 weeks, the DDC spend the majority of their time at that office if at all possible to promote and raise awareness of the activity amongst staff, ensure that the treatment provider's time is being utilised as effectively as possible, and identify and help to resolve any problems early on. This will necessarily mean that, if the decision is taken to introduce IA into more than one Jobcentre falling within any one DDC's remit, it will have to be rolled out gradually in one office at a time. It is also likely that, even after the initial bedding-in period, additional DDC attention and resource will be required by those offices in which the IA initiative is taking place if any early success is to be maintained and built upon. For example, the DDC is likely to need to help maintain the activity's momentum and profile within the office, regularly review whether any changes need to be made, and help implement them when they are required. Careful consideration should therefore be given to the feasibility of any proposals to bring IA in to more than one office within any one DDC's remit. Such consideration is particularly important due to the fact that the DDC role came to an end in March 2011 and Jobcentre Plus Districts now have the flexibility to decide how best to deliver the key functions of this role in light of their local priorities and resource. It therefore may not be possible for the member of Jobcentre Plus staff taking over these functions to devote a significant amount of time to such an IA initiative.

The role of the Drug Champion has also been shown to be very important in supporting IA and maximising its success. Therefore, in offices which don't currently have a Drug Champion one (or more) should be appointed prior to the start of the initiative. Their resource is especially important if caseloading or outreach by a dedicated adviser is being considered as part of the IA. These two elements, along with the personal qualities required by the Drug Champion role, are discussed further in Section 6.2.3 below.

### ***Trade Union Engagement***

As discussed earlier, the outcome of the Health and Safety risk assessment in JCPs B and C resulted in proposed elements of the trial not going ahead. These included staff visits to the treatment provider, and aspects of treatment provider activity during their sessions in the JCP. According to some of the key stakeholders, including the treatment provider, this had a significant impact on the success of the trial in JCP B. Before any other Jobcentres adopt IA it is recommended that DWP and JCP discuss the activity with the TU at a national level and secure agreement in principle from them to support and facilitate the initiative. Having the TU issue guidance for local representatives on completing risks assessments in relation to this activity would be beneficial, as would engaging local TU representatives early on in the development of the activity to allow sufficient time for any concerns to be fully discussed and solutions or compromises found.

### ***Communication***

The evaluation has highlighted the importance of good communication to all JCP staff about the IA and treatment provider presence, especially at the start of any activity. However, it has also highlighted that this is a challenge given the current lack of all staff meetings that appears to be a common theme across JCP offices. Spotlight sessions, along with any other larger staff meetings, as well as smaller team ones, therefore present an important platform for DDCs, Drug Champions and treatment providers to raise awareness of the provider presence and introduce them to staff. Less formal contact between staff and providers during the day is also important for building close working relationships, for example ad hoc conversations taking place in between Adviser appointments and in the staff area during breaks. The times and days that the provider will be attending the JCP, as well as their location whilst in the office, should be clearly communicated to staff so that they can refer customers immediately when they are present and successfully book an advance appointment when they are not.

Good communication between JCP and the treatment provider is also important so that any problems or issues can be identified and rectified as soon as they arise, before they have a chance to cause any damage to working relationships. Following the more intensive bedding in period, a

weekly or fortnightly meeting between the DDC and treatment provider would be one way to ensure that effective lines of communication around the IA are maintained.

### ***Flexibility***

As touched on earlier, flexibility on the part of both JCP and the treatment provider is important when implementing IA. The activity should be monitored closely for any emerging problems and to identify any elements that aren't working well or contributing much to the success of the programme, and stakeholders should be prepared to formulate and implement a quick response, whether it be adapting these elements so that they are more effective, or stopping them altogether.

Ultimately there are no guarantees that IA will be successful in a particular JCP. Therefore if, despite following the best practice recommendations and giving the activity sufficient time to bed in, it is not deemed to be delivering sufficiently positive outcomes, DDCs and treatment providers should be prepared to take the decision to end this model of closer working in that particular office and focus on developing a different approach to the substance misuse agenda in that office. It is crucial that stretched treatment provider and JCP staff resource should not be wasted if the initiative isn't achieving the desired outcomes. Key stakeholders may want to consider setting a target around the increase in disclosures and referrals that would need to be achieved (following a sufficient bedding in period) for the activity to be considered worthwhile, based on a locally produced cost-benefit calculation. However, if this approach is taken it should be remembered that many of the benefits of closer working with treatment providers aren't as easily quantifiable as disclosures and referrals, and that some 'softer' measures of success, such as whether a more holistic service is delivered to substance misusing customers, may be just as important in the longer term.

### **6.2.3 General lessons for best practice in JCP**

Even in JCP offices where the decision is taken not to adopt Intensive Activity, various best practice lessons emerging from the IA trial can be implemented which should help to improve the service for substance misusing customers.

#### ***Drug Champion role***

Drug champions have been shown to add significant value by assisting the DDC in embedding the drug strategy on the JCP agenda; providing support and advice to colleagues on how to ask customers about substance misuse, deal with disclosures and make referrals; and working with the DDC to identify and develop solutions to any problems in relation to the strategy in the office. Additionally, the trial in JCPs A and C demonstrated that Drug Champions can

successfully undertake outreach in treatment provider premises and caseloading of substance misusing customers (both of which are considered in more detail below).

JCPs A and B both had one Drug Champion, but JCP C had five: one Champion per team. Whilst there is some evidence to suggest this latter model worked well to ensure that the profile of the substance misuse strategy was raised in each team and that each had a resource on hand when help and advice was needed, the evaluation suggests that the most important factor is that the Drug Champion(s) have the necessary excellent interpersonal skills, passion and enthusiasm to work with what can be a challenging customer group. Anecdotal evidence from DDCs suggests that if the Champion is not committed to the agenda or is not comfortable working with substance misusing customers it can be difficult to keep them engaged in the role, and it is therefore likely that their impact will be limited.

The capacity of any staff members who want to become Drug Champions needs to be considered carefully before they are given the role. Consideration should also be given to tailoring their productivity targets to take into account of any work they will be doing with substance misusing customers as part of this role, this being a customer group amongst whom outcomes such as training and employment starts are far more difficult to achieve when compared to the 'average' JCP customer. Evidence from the trial evaluation suggests that if Drug Champions are expected to work more intensively with substance misusing customers but still achieve the standard productivity targets then their role may not be sustainable in the longer term.

### **Outreach**

The experience in JCP A demonstrated that outreach conducted by an Adviser (possibly the office's Drug Champion) experienced in working with substance misusers can be successful in helping to engage such customers in conversations about benefits and work who might not be engaging with these issues in a meaningful way when they visit JCP, and starting to move them towards their employment goals. Such an approach could become even more important once tailored conditionality is implemented, and customers in treatment are no longer required to visit the Jobcentre on a regular basis due to the relaxation of conditionality around their benefits. The Drug Strategy contains a commitment that JCP will 'work in close partnership with drug and alcohol services, and will offer face-to-face support, advice and guidance on benefits and employment, through outreach where appropriate, to service users and the drug and alcohol professionals who support them'<sup>28</sup>.

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<sup>28</sup> Home Office (2010) *Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life*, page 21.

As with the Drug Champion role, empathy and compassion are very important personal qualities for an Adviser conducting outreach with substance misusers, as are being non-judgemental and a good listener. Again, consideration would need to be given as to how to overcome the conflict between this work and Adviser productivity targets, as such outreach sessions are likely to be more time consuming but result in less training and employment outcomes due to the nature of this customer group and their likelihood of being a greater distance from the labour market. In terms of necessary equipment, providing the Adviser with a 3G card and laptop so that they can access and update LMS records during the outreach sessions would help to maximise the value that can be gained from them.

In relation to Health and Safety risk assessments for outreach in treatment provider premises, evidence from JCP A suggests that it is beneficial if the treatment provider manager, along with the member of JCP staff who will be conducting the outreach, is present at the time of the assessment. The evaluation also suggests it is beneficial if the provider is able to be flexible in response to any problems or obstacles raised by the assessment and find solutions or compromises to them.

### ***Caseloading***

As with outreach, evidence from JCP C suggests that the caseloading of substance misusing customers to an Adviser experienced in working with this group this can be a successful way of facilitating the development of more positive working relationships between JCP and these customers. Customers with such issues often require more intensive and time-consuming support from their Adviser in order to start to progress towards the labour market, and someone with a dedicated remit to work with this group (if only for a portion of their time) may be best placed to provide this. The personal qualities and skills mentioned in the previous section (empathy, compassion, having a non-judgemental attitude and being a good listener) are all just as relevant here, as is the necessity of overcoming the conflict between this work and productivity targets if such activity is to be sustainable over the longer term.

### ***Close working relationships between treatment providers and JCP***

The IA trial has demonstrated that close working relationships between treatment providers and JCP can improve the service that substance misusers receive from both organisations. The IA trialled a particular model of closer working, however the relationship between JCP and local treatment provider(s) can be developed and strengthened in less resource intensive ways. For example, having the treatment provider attend the JCP for a 'familiarisation week' similar to that recommended at the beginning of an IA trial during which they can attend team meetings, observe customer

interviews and speak to JCP staff about their roles could help the provider to gain greater insight into the work of JCP and the support on offer to substance misusing customers. It could also provide them with the opportunity to suggest improvements that could be made to JCP's service that would benefit substance misusers. In exchange, a visit to the treatment provider for key JCP staff and a presentation for the rest of the office on the services they provide would help to inform and raise awareness amongst JCP about their work, and hopefully increase the likelihood of staff recommending a referral to them to appropriate customers.

### ***Training***

The evaluation has demonstrated the importance of JCP staff attending training to increase their motivation and confidence in working with substance misusing customers. The evidence suggests that awareness sessions are not sufficient to achieve this, and instead that Advisers and other staff benefit most from training that gives them the tools to raise the question of substance misuse with customers and respond sensitively and effectively to customer disclosures, as well as an understanding of the limitations that different forms of treatment (such as substitute prescribing) place on customers' capability for work. The IA evaluation suggests that having treatment providers delivering the training is a good way of making use of their expertise in working with substance misusers, but in other offices not included in the trial JCP Work Psychologists have also delivered successful training. The use of role plays and techniques such as Neuro-Linguistic Programming (NLP)<sup>29</sup> have anecdotally achieved good results. Although getting JCP staff released to undertake such training is difficult at the current time, it is important that all front-line staff receive it given JCP's commitment under the Advisory Services of the Future (ASoftF) initiative to ensure that all Advisers have the necessary skills to work with customers with any barriers, including substance misuse.

### ***Other positive processes and activities***

The evaluation suggests that case conferencing, previewing LMS records for signs of prior drug misuse, referral process 'walk-throughs', and having a private room available in which to discuss substance misuse with customers are all helpful for this group. Further details about these activities can be found in Section 4.2.8.

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<sup>29</sup> NLP has been defined as an approach to psychotherapy and organisational change based on 'a model of interpersonal communication chiefly concerned with the relationship between successful patterns of behaviour and the subjective experiences (especially patterns of thought) underlying them' (Bandler and Grinder, 1979). Originally developed as a form of psychological therapy, it was later promoted as a means by which people can improve their effectiveness by 'modelling' themselves on successful individuals in their field.

Whether or not IA is adopted in a particular JCP office, the sharing of experiences, developments and best practice between offices and between treatment providers is crucial for ensuring that stakeholders learn from each other and build on each other's knowledge. Alongside utilising current platforms for the sharing of best practice it might be valuable to set up some new ones involving treatment providers and D(A)ATs as well as JCP staff.

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## Appendix A – Stakeholder & front-line JCP staff discussion topic guide

### Topic Guide – stakeholders and front-line JCP staff

1. Could you go around the table and tell me briefly what your role was in the trial, and what impact it had (if any) on your daily work routine?
2. Could you give me a brief description from someone of all the activities that were carried out or changes that were made as part of the trial here? And the number of referrals, starts and PDU/other drug or alcohol markers that were made or set during this period?
3. What were your initial thoughts and feelings when you heard about this trial and what it was going to involve?

- Probe:
- Worried about extra workload/responsibility
  - Worried about customer reaction
  - Pleased that it would involve extra training and development of your role
  - Positive about the opportunities it would bring to develop the service you offer customers
  - Scepticism about the aims of the trial

4. Did they change over the course of the trial?

5. Overall, do you think the trial has been a success? Why or why not? What do you think its impact has been?

- Probe:
- On you in particular (more or less work)
  - On (other) staff and customers (reactions)
  - Do you have more insight into the customers/drug users
  - Has it helped you better able to identify substance misusers/raise this issue with customers
  - Has it been more successful with PDUs than with other drug or alcohol misusers, or vice versa

6. What elements of the trial did you feel worked particularly well? Why do you think they worked so well, and what were their effects?

7. What elements did you feel worked less well and why? Could these elements have been improved by making some changes to how they were implemented or what they involved? If so what changes?

Probe any elements not mentioned at the last two questions:

- Marker trial (**JCP A only**)
- Treatment provider presence in JCP
- Training for staff/visits to treatment providers
- 'Do you need help'/ 'Are you missing out?' forms

- JCP outreach sessions in treatment provider premises (**JCP A only**)

8. What problems did you encounter during the trial? Could these have been overcome by doing things slightly differently, and if so how?

- Probe:
- TU resistance
  - Resistance from personal advisers or other JCP staff
  - Hostility or negative feedback from customers
  - Procedural or logistical problems (eg. lack of desks for treatment providers, lack of privacy when talking to customers etc)
  - Workload pressures

9. What would you have done differently during the trial if you had known what you know now?

10. Are there any additional changes/interventions you think would have been effective as part of the trial but weren't included?

- Probe:
- JCP outreach sessions at treatment providers (**JCP B and C only**) or other locations where substance misusers are likely to be
  - Having a specialist adviser for substance misuse issues (as with disability issues)

11. Are you planning on carrying on with the Intensive Activity after the trial period? If not at all/if not any particular elements, why not? For all substance misusers or focusing on PDUs?

12. Do you see the Activity as sustainable over the long term? If not why not? Did it place an undue burden on you/colleagues/staff in terms of time, paperwork or responsibility?

13. Do you think it's realistic to roll this Activity out nationally? Why/why not? Are there any particular circumstances that mean the outcome of the trial is quite specific to your area?

14. What are the three key tips or pieces of advice you would give to other JCP areas who are just about to introduce Intensive Activity?

## Appendix B – Treatment provider discussion topic guide

### Topic Guide – treatment providers

1. Please could you start by telling me your name, role in [treatment provider] and what your day-to-day job involves?
2. Could you also tell me about what you and your colleagues did as part of the Intensive Activity trial?

Probe:

- Presence at the JCP office
- Familiarisation days
- Training for JCP staff

3. What were your initial thoughts and feelings when you heard about this trial and what it was going to involve?

Probe:

- Worried about extra workload/responsibility
- Scepticism about the aims of the trial/working with JCP
- Positive about the new opportunities it would bring to develop the service you offer substance misusers

4. Did these views change over the course of the trial?

5. Overall, do you think the trial has been a success? Why or why not? What do you think its impact has been?

Probe:

- On you in particular (more or less work)
- On colleagues, JCP staff and substance misusing customers/clients
- Do you have more insight into the customers/drug users
- Has it helped you better able to identify substance misusers/raise this issue with customers
- Has it been more successful with PDUs than with other drug or alcohol misusers, or vice versa

6. Did taking part in the trial have any positive or negative impacts on your everyday work at [treatment provider]?

7. What elements of the trial did you feel worked particularly well? Why do you think they worked so well, and what were their effects?

8. What elements did you feel worked less well and why? Could these elements have been improved by making some changes to how they were implemented or what they involved? If so what changes?

Probe any elements not mentioned at the last two questions:

- Marker trial (**JCP A only**)
- Treatment provider presence in JCP

- Training for staff/visits to treatment providers
- 'Do you need help'/ 'Are you missing out?' forms
- JCP outreach sessions in treatment provider premises (**JCP A only**)

9. What problems did you encounter during the trial? Could these have been overcome by doing things slightly differently, and if so how?

- Probe:
- TU resistance
  - Resistance from personal advisers or other JCP staff
  - Hostility or negative feedback from customers
  - Procedural or logistical problems (eg. lack of desks for treatment providers, lack of privacy when talking to customers etc)
  - Workload pressures

9. What would you have done differently during the trial if you had known what you know now?

10. Are there any additional changes/interventions you think would have been effective as part of the trial but weren't included?

- Probe:
- JCP outreach sessions at treatment providers (**JCP B and C only**) or other locations where substance misusers are likely to be
  - Having a specialist adviser for substance misuse issues in the JCP office

11. Are you planning on carrying on with the Intensive Activity after the trial period? If not at all/if not any particular elements, why not? For all substance misusers or focusing on PDUs?

12. Do you see the Activity as sustainable over the long term? If not why not? Did it place an undue burden on you/colleagues/staff in terms of time, paperwork or responsibility?

13. Do you think it would be feasible for other treatment providers to adopt a similar way or working with JCP as you have been doing as part of the trial? Is there anything unique about your organisation that made you particularly well placed (or not well placed) to do it?

14. What are the three key tips or pieces of advice you would give to other treatment providers who are about to take part in an Intensive Activity initiative?

# Are You Missing Out?

**Customers have told us that they don't always know about all the help currently available.**

**Please take some time to look through this list. If any of the following applies to you, please tick the appropriate box**

<b>ARE YOU MISSING OUT?</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>
1. Do you have a disability/health condition that is affecting you looking for work?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is your first language anything other than English?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Do you have difficulty reading, writing or maths?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Do you hold qualifications below NVQ Level 2 (5 GCSE's)?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Do you have any Children/Dependants?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Are you bringing up children on your own?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Are you homeless?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Have you at any time completed a custodial sentence?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Are you concerned about your own drugs /alcohol use?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Are you getting any structured support for your drug /alcohol use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you now abstinent from drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you looking for training opportunities?	<input type="checkbox"/>	<input type="checkbox"/>	

### **Possible Questions asked by Service Users**

**This is a log of questions that may be asked by Service Users. It will help key workers in eliminating some of their concerns whilst encouraging them to declare their drug use to Jobcentre Plus.**

If users disclose their drug use Jobcentre Staff will be able to direct them to specific programmes and additional support.

1. **Q** - If I declare to Jobcentre Plus that I am a Problem Drug User, will my benefit be affected?

**A** – No, your benefit will not be affected. It is in your interest to declare because Jobcentre Plus advisers will be able to support you and arrange an appointment for a discussion with your local treatment provider.

2. **Q** – Will Jobcentre Plus staff tell the Police and Social Services that I am a Problem Drug User?

**A** – No, Jobcentre Plus takes security matters very seriously. All information is treated in strict confidence in accordance with the data protection act. Information will not be disclosed unless JCP are ordered by a court or have lawful authority.

3. **Q** – If I am already in treatment with a drug service, will Jobcentre Plus staff force me to take part in Jobcentre Plus programmes?

**A** – There are certain programmes within Jobcentre Plus that are mandatory and therefore you will have to take part in. However, Jobcentre Plus staff will endeavour to be flexible to ensure that the steps you are taking to get you back into work do not affect your recovery plan. This is why it's important that you tell Jobcentre Plus that you are in Treatment.

4. **Q** – I am worried that other people can hear my conversation during my interview; can I talk to my adviser in private?

**A** – Yes, a private interview room can be requested

5. **Q** - What if there is not enough time during my interviews to discuss my drug issues?

**A** – You can request another interview with your adviser to discuss specific areas of concern.

6. **Q** - Will Jobcentre Plus pay my travel costs to attend an initial discussion with a Treatment Provider?

**A** – Yes, you will need to bring your bus ticket/s. For those travelling by car can claim mileage expenses.

## Appendix E – JCP C drugs quiz

### **Drugs Quiz**

1. Are you aware of the JCP drugs Strategy?
2. What is the telephone number to refer a customer for a discussion with a treatment provider? (SPOC)
3. Which form needs to be completed to gain customer consent?
4. Why is it important to set disadvantaged markers?
5. For Which customers would you set the In Treatment/Not In Treatment Pilot marker?
6. Which form is required when referring a Problem Drug User for a voluntary discussion with a Treatment Provider?
7. Name the 5 Drug Champions at this JCP
8. Which Treatment Provider has a presence in this Jobcentre?
9. What sort of help is available from Drug Treatment Providers (list as many as possible)
10. Who is the ASM Drugs Lead in this JCP?
11. Name the Drugs Co-ordinator linked to this JCP?
12. Have you heard of the Adviser Drug Box?

Name:

(There will be a small prize for the person/s with the most correct answers).

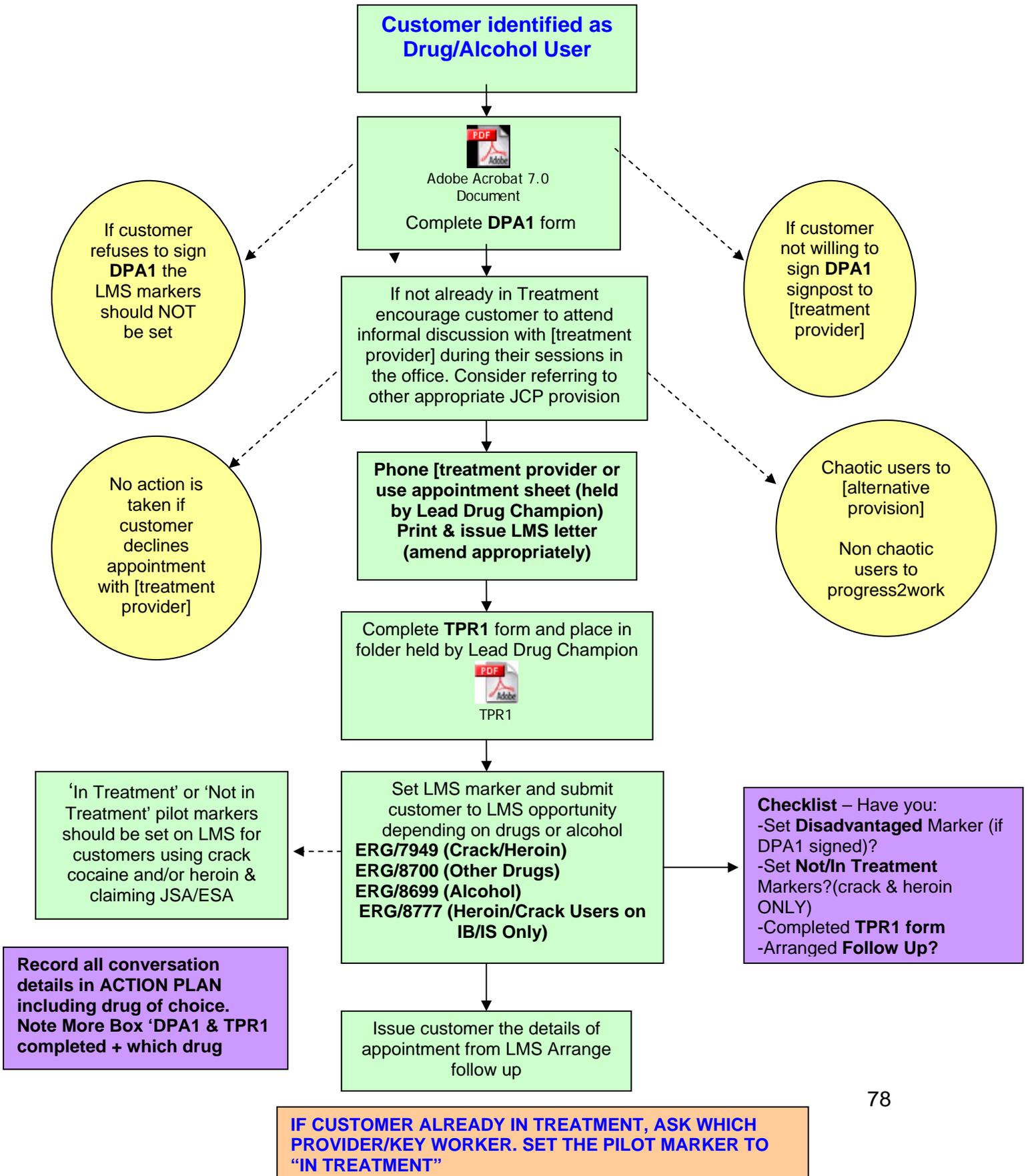
Please pass the completed forms to your team drug champion, DDC or treatment provider.

Many thanks

Appendix F – JCP C referral process memory aide

**Voluntary Referral to [treatment provider]: tel xxxxxx**

**If customer wishes to be seen by different provider or not in office, follow SPOC process and phone xxxxxx for an appointment.**



This report presents the findings of an evaluation of a small-scale Jobcentre Plus trial aimed at customers with drug and alcohol addiction.

The Intensive Activity trial took place in three Jobcentres between May and July 2010 and offered an enhanced service to claimants with dependency issues, including the regular presence of a treatment provider in the Jobcentres. The trial was designed to help improve the service delivered to substance misusing customers, to further develop partnership working between treatment providers and Jobcentres, and to increase the level of voluntarily referrals made by Jobcentre Plus to a treatment provider.

The evaluation, carried out by social researchers at the Department for Work and Pensions, involved qualitative research with key stakeholders and the monitoring of Management Information.

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