BRIEFING

Centre for Mental Health

48. Employment support & addiction: what works

Introduction

"Ask me about work and even if I'm not ready, keep asking me."

People who experience problematic substance use, once unemployed, face multiple barriers to returning to work. As a result, their employment rate is well below that of the general population.

The benefits of work to mental and physical health and the harmful effects of unemployment are now both widely recognised. Yet support to get or keep work isn't routinely available for people who are in treatment for addiction or who are using mental health services.

The New Zealand and UK addiction sector have been looking at the employment results that have been achieved for people in contact with mental health services and have been seeking to understand whether a similar approach could be used for people with problematic substance use. We identified an approach which offers individualised employment support as part of a London mental health and addictions service. Central and North West London NHS Foundation Trust (CNWL) is applying research from the mental health sector to the provision of supported employment for people in treatment for addiction.

The research CNWL are using originated in the United States and has been generated over the past twenty years from around the world, including the UK and New Zealand. It is an established and proven approach to supported employment, called Individual Placement and Support (IPS).

The experience of CNWL shows that it is possible to successfully establish intensive employment support as part of an addiction recovery team and that it is valued highly by service users. It shows that providing employment specialists within addiction treatment teams can also raise expectations among clinical staff about the ability of people using addiction services to secure and sustain competitive employment, and increase the recovery focus of the clinical team by incorporating support to gain employment into day-to-day practice.

Individual Placement and Support (IPS)

IPS has proved effective at supporting people who experience a severe mental illness to get jobs and build careers. This includes people with co-occurring mental illness and substance dependence.

The approach works in an integrated way with the person's mental health treatment team such that employment support is offered alongside clinical treatment not afterwards. The supported employment 'intervention' is intensive in its approach; intentionally addressing the barriers to employment faced by people with a mental illness and as a result is able to override individual characteristics and circumstances which place people at a disadvantage in the labour market.

Considering the multiple barriers faced by people with an addiction, and the effectiveness of this approach in supporting people with co-occuring or co-existing problems (including problematic substance use) to get competitive employment, a logical progression is to apply this evidence to supporting people in treatment for an addiction.

Employment rates and addiction

"I might want to work but who would give someone like me a job?"

While many people with problematic substance use continue to hold a job for years, the employment rates for people in treatment for it are very low. The reasons for this are varied and may not relate to the severity of the addiction.

Over the course of a year around 200,000 people in England receive treatment for drug dependency and around 110,000 for alcohol dependency (DWP, 2013). There are an estimated 400,000 'problem drug users' in Great Britain, up to 330,000 are in England, an estimated 56,000 in Scotland, and 20,000 in Wales (*ibid*). Around 80% of these individuals are unemployed and claiming benefits (Home Office, 2007).

In New Zealand, people who use drugs problematically are significantly less likely to be employed compared to other adults of working age (MacDonald & Pudney, 2001, 2002 cited in Bauld *et al.*, 2010b). Analysis of the Dunedin (New Zealand) longitudinal cohort found a significant relationship between cannabis use at ages 14-21 and low educational attainment and unemployment in later life (Fergusson & Boden, 2008). Studies also suggest that the more drugs a person uses the longer they will spend unemployed (Plant & Plant, 1986 cited in Bauld *et al.*, 2010a).

The links between problematic alcohol use and employment appear more complex. There is evidence to suggest that the amount of alcohol a person drinks, alcohol dependency and the physical health problems that may result from drinking, damage employment prospects (Bauld *et al.*, 2010a). However there are also studies that suggest that alcohol use is more likely to become problematic during unemployment (Bauld *et al.*, 2010b) and others that suggest that 'alcohol misuse' has no impact on employment (Schmidt *et al.*, 2007, Feng *et al.*, 2001).

One regional New Zealand study found that 43% of the alcohol and drug service users they surveyed were unemployed or not working due to health issues (Counties Manukau AOD Sector Collaboration Group, 2013). These figures are substantially higher than for the general New Zealand population where unemployment figures sits at approximately 6.4% (Statistics New Zealand, 2012). This is not surprising given the number of barriers that people who are or have been problematic drug and alcohol users experience. According to a UK study, these barriers include lack of education and skills; health inequalities; social disadvantage; poor provision of support services; low levels of engagement with employers and support professionals and dealing with stigma (Sutton *et al.*, 2004). This study also identified that co-existing mental health problems and an offending history were also significant barriers. Disclosure of addiction issues and criminal offending were also two of the major barriers identified by individuals accessing addiction services in the New Zealand study as a high proportion of the treatment population were people involved with probation services (Counties Manukau AOD Sector Collaboration Group, 2013).

According to Bauld *et al.* (2010a) when people with problematic drug use are employed it is often in low paid and short term jobs, which can be a deterrent to working if people are used to more lucrative illegal activity. There is evidence that people who have a drug dependency move in and out of the labour market more than other benefits claimants. In 2012, data collected from the UK's National Drug Treatment Monitoring System (NDTMS) was used to look at benefits being claimed by people who have undergone treatment for drug dependency. The data showed that the average person claiming Jobseeker's Allowance (JSA) in addiction treatment spent approximately 40% more time on benefits over the next three years than the average person claiming JSA (National Treatment Agency, 2010).

The importance of employment to motivation and recovery

"Work gave me the motivation to begin to address my addiction, without I wouldn't have had a reason to change".

Being in employment can enhance recovery, improve symptoms and adherence to treatment and prevent relapse (Burns *et al.*, 2007; NTA, 2010)

Access to employment support should therefore be made available right from the start of the recovery journey. The UK's National Drug Strategy recognises that in the past a lack of effective employment support has, for many individuals, eroded the benefits that treatment offered them. Recovery is not just about tackling the symptoms and causes of dependence, but about enabling people to successfully reintegrate into their communities (HM Government, 2010).

Employment is therefore often part of recovery. Having a job offers much more than structure to one's day, it also provides meaningful goals, self esteem, money, access to a different social network, and other changes that help many people to develop hope, change their self image, and envisage a different life (Jahoda, 1982). Individuals who currently have problematic substance use often reduce their use or become motivated to try to abstain when they have a job (Mueser *et al.*, 2003). In this way, most studies have found that employment can moderate relapse and assist treatment retention (Walls *et al.*, 2009; Keane, 2007; Magura, 2003; Center for Substance Abuse Treatment, 2000; Godley *et al.*, 2006).

It is also acknowledged that unemployment is a risk factor for the development or exacerbation of problematic substance use and mental health problems (Mueser *et al.*, 2003; Marmot & Bell, 2009).

Policy imperatives

In 2009, the New Zealand government commissioned a review to estimate the social costs of harmful drug use and concluded that the costs had an impact on many government agencies and departments including the police, courts, prisons and health services (BERL, 2009). Arguably implementing evidence-based practices like IPS and focusing on employment for people with problematic substance use could save the government money in the long run.

The UK and New Zealand governments are increasingly concerned about the numbers of people with mental health issues and addiction who are unemployed and claiming welfare benefits. And both regard employment as a key facet of recovery from addiction and mental health conditions.

In New Zealand, increasing employment and education opportunities for those with the highest mental health and addiction related needs is a priority in the current mental health and addiction policy, Rising to the Challenge (Ministry of Health, 2012). Public mental health purchasers and providers, the District Health Boards, are required to: *Increase access to employment specialists delivering evidence informed individual placement and support (IPS) services, with the aim of increasing the percentage of people who are either in employment or advancing their education* (ibid, p28) and *The numbers of people in employment and education should be an accountability measure for DHBs* (ibid, p22).

The UK Government's Drug Strategy states that recovery involves three overarching principles – wellbeing, citizenship and freedom from dependence. Sustained employment is identified as a required key outcome, along with suitable accommodation, improved physical and mental health and improved relationships with family and friends (HM Government, 2010). Furthermore, the UK mental health strategy: *No Health without Mental Health* (HM Government, 2011), gives explicit reference to the importance of increasing the employment rates of people with co-existing problems.

Supporting people into employment – an evidence-based approach

Over the past 20 years, researchers concerned about the low employment rates of people with mental health conditions have focused on what makes an effective supported employment programme. In 2008, a review of the sixteen randomised controlled trials which had been conducted internationally to test supported employment programmes against standard vocational rehabilitation services found that the supported employment interventions were out-performing the controls on competitive employment outcomes by three times (Bond *et al.*, 2008). Competitive employment is defined as a job in the open labour market that anyone can apply for which is paid at the minimum wage or above. Supported employment focuses on rapid search for competitive employment and provides on-going support once a job is secured. It is often referred to as a 'Place then Train' approach in contrast to traditional vocational rehabilitation which offers lengthy pre-job training with minimal in-work support, a 'Train then Place' approach. Bond *et al.* (2008) identified a particular method of supported employment, Individual Placement and Support (IPS), which they found to be the most effective. This has eight principles (see right), each having its own underlying evidence base, such that IPS is also referred to as evidence-based supported employment (EBSE). Adhering to all the principles is associated with achieving better employment outcomes.

IPS programmes have been found to get more people with mental health conditions into jobs. People secure jobs more quickly, earn more, work longer hours and maintain their jobs for longer (Bond *et al.*, 2012). IPS has been found to be effective regardless of a person's clinical history and has successfully supported people with a co-occurring mental health condition and problematic substance use into employment (Campbell *et al.*, 2009).

Some key distinguishing features of IPS are that it integrates employment support with clinical treatment through the co-location of an employment specialist (ES) as an equal member of the multi-disciplinary team, it provides an intensive, personalised service, with individual ES caseloads of between 20 and 25, and has a strong focus on developing jobs through local employer networks. When employment programmes and clinical services fully integrate, this is much more than active joint working, a new service develops which has employment at the heart of recovery and an integral part of treatment programmes (Shepherd *et al.*, 2012).

(For a more detailed discussion on IPS see the Centre for Mental Health publications *Doing what works* and *Implementing what works available at http://www.centreformentalhealth.org.uk/publications/*.

There are also resources on the following sites:

Te Pou - http://www.tepou.co.nz/ebse and

Dartmouth Psychiatric College - http://sites.dartmouth.edu/ips/)

The eight principles of IPS

1. Competitive employment is the primary goal
2. Everyone who wants it is eligible for employment support
3. Job search is in line with individual preferences and strengths
4. Job search is rapid – it begins within four weeks
5. Employment specialist and clinical teams work and are located together
6. Support is time-unlimited and individualised to both the employee and the employer
7. Welfare benefits advice and information is available
8. Jobs are developed with local employers

Applying the evidence in addiction teams

Central and North West London NHS Foundation Trust (CNWL) has been delivering IPS services in mental health teams since 2004. It started delivering IPS in addiction teams in 2009.

CNWL is one of the largest mental health service providers in the UK. The Trust employs over 7,000 staff providing mental health support in six London boroughs.

CNWL's Addictions Directorate comprises: a network of adult community substance misuse services; a specialist inpatient medically-managed substance misuse unit taking referrals from Greater London and beyond; and a young person's unit.

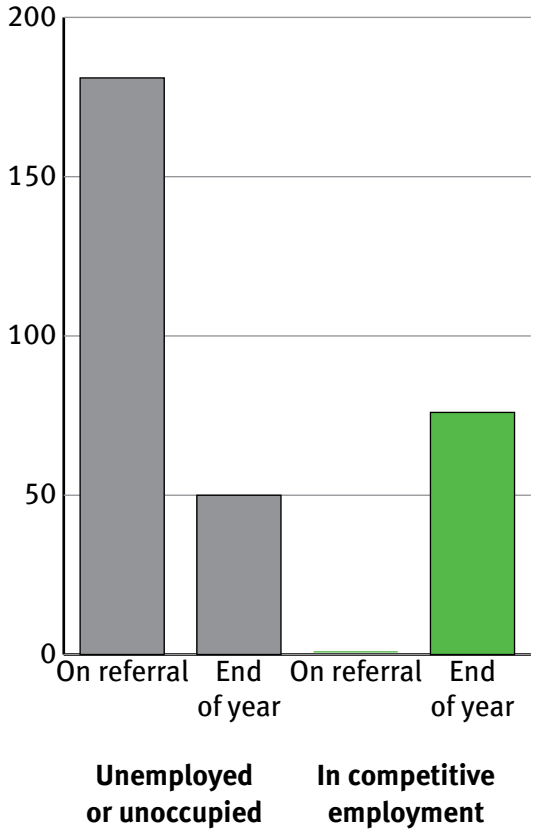
A typical CNWL addiction recovery team would comprise a sector manager, consultant psychiatrist, service coordinator, specialty doctor and key workers made up of nurses, social workers, an occupational therapist, a drug worker, psychologist, psychology assistant, employment specialist, family therapist, peer mentor and administrative staff. Local budgets and team expertise determine the exact composition of health professionals in each team.

The addiction employment service

Accessing mainstream NHS funding for the addiction employment services was problematic, but a bid to the Big Lottery Reaching Communities Fund was successful. This funded the employment project manager and four employment specialists to deliver IPS for three years. A second bid was successful for European funding which funded a fifth post for two years which was then funded by local commissioners for a further year due to its high performance.

In 2012, 212 people in treatment for addiction accessed the IPS service with 84 people getting

Fig 1: The employment status of service users who accessed the service in 2012

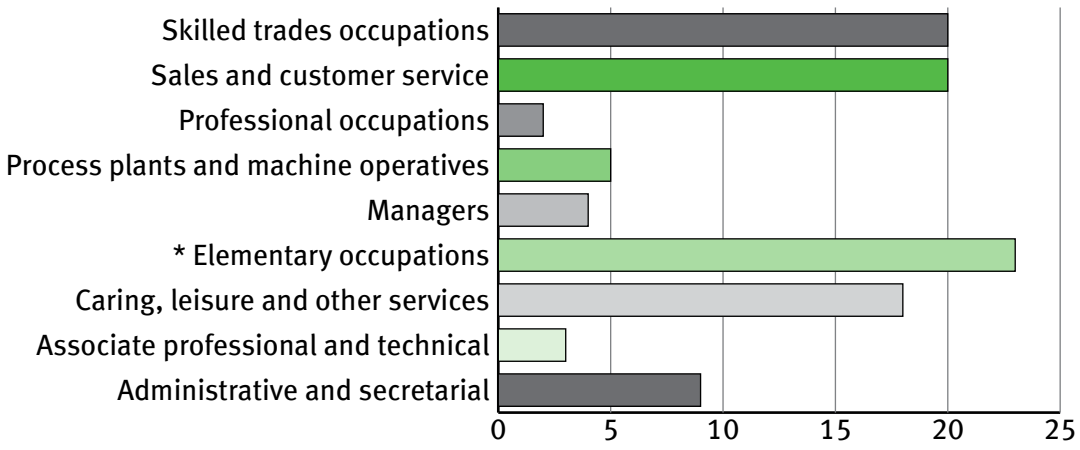


a job. 71 education or training outcomes were also achieved and 31 people accessed volunteering opportunities. 56 of the people accessing the service were people recovering from alcohol related problems; 152 were recovering from problematic drug use and six had a dual diagnosis (co-existing problems). 181 (85%) of the people accessing the IPS service were unemployed and completely unoccupied at the time of referral (see Fig 1); by the end of that year the number of people unoccupied, with no structure to their week, had fallen to 50 (23%). Fig 2 shows the types of jobs the people went on to do. The average length of time people accessing the service had been unemployed was 3 years and 3 months (CNWL, 2012).

CNWL carries out annual service user satisfaction surveys. The latest survey was completed in April 2013 with thirty two users of the addiction services completing it. Thirty one (97%) said they were either 'very happy' or 'happy' with the support they had received to achieve their vocational goal and 28 (90.4%) reported that the service had helped them move closer to finding employment or accessing education or training.

The box overleaf provides an example of one of the personal stories given by a person accessing the addiction service at CNWL. It illustrates how the person was referred to the employment specialist (ES) when they expressed an interest in having support to look for employment even though they were not well motivated or confident at that time. It shows how the ES worked with the individual and their clinical team to cut down on methadone in order to secure a job which involved driving. They coordinated this support with the problems he was having with his housing. His experience shows the use of work trials, particularly where people haven't got a recent work history or where an employer may have concerns about a person's ability to take on the job.

Fig 2: New employment starts by job type



* Elementary occupations usually require a minimum general level of education, i.e. that acquired through completion of compulsory education.

Case study: a service user of Hammersmith & Fulham Community Drug and Alcohol Service

"I came to my drug and alcohol service because I was addicted to heroin. The nurses there were really good and got me the medicine and support I needed to stop taking it. Once I was comfortable on methadone, I started thinking about what other changes I wanted to make in my life. I spoke to my key worker about support with finding work, and she referred me to the employment specialist.

I had been out of work for over four years and was not feeling very confident. At the start of working with my employment specialist I was not even happy to speak to employers over the telephone, but with his support I soon felt comfortable doing it. He was very positive and made me feel a lot better about myself. We prepared a CV, wrote cover letters, and set up an email address – all things I had known I had to do but hadn't had the motivation to sit down and work on.

I wanted to find a delivery driver job, so I cut down my methadone until I was completely free of the drug (it's illegal to drive while taking methadone unless you have permission from the DVLA). We contacted employers and made lots of applications together, and I had several interviews. Unfortunately, these were not successful.

Around this time, I was given an eviction notice, as they were developing the building where I lived into luxury flats. I was really worried that I would have nowhere to stay. My employment specialist helped a lot, giving me a letter of support, helping me access legal advice, and putting me in touch with agencies that could help me find a new property.

Even though I was worried about my housing, my employment specialist also made sure we kept focused on the job search. As well as us making applications, he also advised me to drop in and talk to people. A lot of small businesses don't recruit online or through the newspapers. I spoke to a tool hire company in the borough I live in, who gave me a day's trial. That turned into a full-time paid job! And I have now saved enough money from that to pay for the deposit on a new room when I need to move out of my current place.

I'm enjoying work and am feeling a lot more confident and happy than I have for years."

Source: Central and North West London NHS Foundation Trust, Addictions Service Vocational Project Annual Report, 2011/2012.

Assessing programme quality - the IPS fidelity scale

The IPS supported employment fidelity scale (Dartmouth IPS Supported Employment Center, 2013) has been used extensively in research studies and is a reliable means of finding out how well services are implementing the eight principles of IPS and making recommendations for service improvement (Shepherd *et al.*, 2012).

In 2013, CNWL secured European funding to conduct fidelity reviews across all of its clinical services delivering IPS.

The fidelity reviews resulted in three IPS programmes in the mental health service achieving 'exemplary fidelity', and three others achieving 'good'. In the addiction services, two achieved 'good' and three 'fair' fidelity. The greater length of time that the mental health services have been implementing IPS could explain the difference. Further fidelity reviews would, however, be needed to understand whether this was the case or whether it was due to wider systemic issues specific to the addiction services.

The fidelity reviews enabled the teams to understand common issues, where more training and support may be needed as well as development issues which are specific to a team.

The most common practice issue to come up was around working to the zero exclusion principle - that everyone who is part of the addiction treatment team who would like to work is offered a referral to the employment specialist. This is known from research to be crucial to the effectiveness of IPS. Some addiction teams, however, saw their role as referring only people they considered "closer to the labour market" i.e. towards the end of their treatment, no longer using drugs or alcohol. This meant that referrals to the ES were being made at the point when the team were ready to discharge the person, rather than as part of their treatment programme. In one of the reviews, a clinician stated that they would not refer a client to the employment programme if they had a psychotic illness; another said they wouldn't refer if the person was very unwell, with another citing homelessness as a reason not to refer.

One service user said that he felt his referral to the ES was delayed due to him having poor attendance in his psychological therapy sessions and others said they felt their referral was based on whether their key worker let them know about the service and at what point of their treatment they felt it was appropriate.

The other common development issue that was identified was in supporting clients to manage their personal information. The fidelity reviews found that many clients were reluctant to reveal their addiction history to employers. While disclosure is an individual choice, not letting an employer know about an addiction limits the ability of the employment specialist to provide ongoing support to the person and their employer. However, people's reluctance to disclose could also be indicative of the fact that addiction is not included in the definition of a disability under the UK's Equality Act 2010, and therefore there is no obligation for the employer to provide any reasonable adjustments to accommodate an individual employee. (The only exception being when a person has become addicted to a drug that was prescribed to them.)

Following each fidelity review the vocational and clinical teams write a service action plan aimed at addressing the key issues arising from the review.

Lessons from implementation

During the implementation of the IPS programme in addiction teams, the employment specialists and the project manager kept a written open log of points learned as a way of capturing experiences, common issues and sharing best practice when developing the programme across all sites.

The reflection logs identified a number of lessons learnt from this implementation (see box on the next page), many of which are similar to those encountered when implementing employment programmes into mental health teams (Rinaldi *et al.*, 2010). Keys to success were perceived to be the appointment of a vocational champion within each addiction team. The vocational champion also is a clinician who can assist the team to think about their role in relation to the ES and support clients to return to employment, such as regularly asking about employment aspirations at intake and in ongoing care reviews. Addiction key workers also play an important role in working with the ES to manage addiction-related issues as part of the job seeking and return to work process. Examples included addressing cognitive issues and medication e.g. changing time and location that methadone is given out, advising on levels of risk and medication levels in relation to a specific job, ensuring that people are legally able to drive, and aiming to reduce medication over time to make this feasible. Clinicians, including occupational therapists, also offered further support in areas including managing stress, debt management, managing daily routines when going back to work, managing triggers and preventing relapse.

The majority of people in contact with the addiction team were not engaged in any work-related activities in the early stages of recovery and had little faith or trust in external services. Assertive outreach seemed to be particularly important for people using drugs and the ES used a variety of strategies to encourage uptake of the support service, including holding joint referral meetings with key workers and seeing people in community settings such as libraries rather than at the addiction service. (Unlike mental health services, addiction service staff at this service do not meet clients in their own homes so the use of 'neutral' venues was an important innovation in this service.) ES would also make several attempts to engage clients and found that liaising with the clinical team helped with this too. They employed simple tools such as texting clients before meetings and providing them with a diary or appointment card. The ES referred to this as 'the engagement stage' and viewed it as very important.

Job development was also identified as key to success, as many people using either mental health or addiction services are not able to compete with the general public, particularly when applying for advertised vacancies. So the ES must tap into the hidden job market using great canvassing skills. They should be targeted with an individual client, in a specific role, in mind and where employers are ambivalent to suggest work trials. Linking with local business forums was also felt to be particularly useful.

Some other themes that emerged from the learning logs appear to be quite distinct to supporting people with addiction to return to employment. Two main areas of occupational interest predominated – construction and working within drug rehabilitation (see Fig 2 on page 7). Although this isn't necessarily a bad thing, it reinforced the importance of the ES making sure they give as wide a choice as possible and not take for granted that people's decisions were based on good knowledge of the local labour market. The ES also found they needed to spend time helping people to consider the benefits and risks of occupations that can have a high incidence of substance use associated with the industry, particularly where they had experience working in these industries already.

Once in employment, picking up prescriptions caused some conflict, when appointments clashed with working hours. The ES spent time resolving these, changing to pharmacies nearer the person's workplace and re-arranging meetings with key workers for times out of their working hours.

The people accessing the addiction services also had a higher rate of criminal records than those accessing the mental health services.

It was therefore identified as good practice to organise criminal records checks for people unsure of spent or unspent convictions as a way of supporting the job search process. This helped when identifying barriers to accessing certain job types or industries and helped when looking at managing disclosure.

Implementation lessons: comparing addiction implementation with IPS in mental health teams

Similarities to implementation in mental health services

» Achieving zero exclusion takes time. Identifying a vocational champion from within the clinical team is important, as is directly sharing success stories and outcomes with the team as the programme develops.

» Employment is part of recovery not an activity after recovery.

» Negotiating clinical treatment around job hours.

Differences to implementation in mental health services

» Assertive outreach is as important, but the ES needs to work creatively to achieve this.

» Job development is also crucial, a criminal history adds an additional barrier and therefore meeting employers directly, using job trials becomes very important for many.

» That the ES initiates a discussion on the full range of local job opportunities and the benefits and risks of different industries in relation to substance use .

» Managing personal information and the pros and cons of disclosing a history of addiction needs to be discussed in relation to national and international equalities and human rights acts.

» Exploring relapse prevention in relation to return to work and receiving an income again which can be a trigger.

The effects of the employment programme on clinical teams

Having an employment programme integrated with clinical teams can serve to raise expectations among clinical staff about the ability of people with a mental illness or addiction to secure and sustain competitive employment (Sommer *et al.*, 2012). To help to understand this in CNWL a survey was conducted among staff before and after the addiction IPS service was introduced, in 2010 and in 2012, about their expectations that clients could gain employment. The results showed increases in the expectations of staff in what their clients could achieve from an average of 4/10 to 8/10.

The survey also included space for open ended comments. The box below illustrates how clinicians report the effects of the employment programme on the recovery focus in the treatment service.

The effects of the employment programme on the recovery focus in the treatment service

"Since our employment specialist joined the service, the team has been able to focus and incorporate employment into their day to day work with clients. This has been reflected in team meetings, supervision... The team is much more recovery-focused and is aware of the referral pathway for our clients into education and employment."

Service Coordinator Community Drug and Alcohol Service

"One cannot under-estimate the value of employment advice and support to our patients, many of whom have never engaged in employment or training as a result of their addiction. The employment specialist worker has therefore become an integral part of our specialist addictions service. They contribute immensely in helping the patient move forward from their dependence to taking steps to establish a career for themselves far removed from a life which revolved around their addiction. Their role has integrated seamlessly within the multidisciplinary team."

Consultant Psychiatrist, Drug & Alcohol Service

"The employment specialist post has helped focus the team on recovery and social inclusion as part of care planning process."

Service Coordinator Community Drug and Alcohol Service

Conclusions

It is clear from the experiences of Central and North West London NHS Foundation Trust's addiction services that IPS can be applied successfully to people with drug and alcohol problems as well as people with a mental health condition. While there have been challenges in the implementation of IPS among people with an addiction, there is evidence that it is achieving good outcomes for this group and that employment specialists can enhance the recovery focus of the clinical teams in which they work.

This strongly implies that the principles of IPS could be applied to the funding and delivery of employment support initiatives within addiction services in New Zealand, achieving effective and efficient results and in line with current policy imperatives.

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This is a joint project of Centre for Mental Health in the UK and the Wise Group in New Zealand in partnership with Central and North West London NHS Foundation Trust.

The Wise Group and the Centre for Mental Health have a shared objective – to bring about change at practice and policy levels which will improve the lives of people experiencing mental health conditions and/or addiction. Led by the Wise Group's strategic policy advisor, also an international consultant for the Centre for Mental Health, Helen Lockett, the organisations have been discussing areas of shared interest.

The low employment rates of people in treatment for addiction and the lack of evidence-based services is of huge concern. The organisations thus came together to research the issues and to work with Central and North West London NHS Foundation Trust to capture their experiences of running employment support services within their addiction teams along with Matua Raki, the NZ addiction workforce development centre, to compose this briefing paper.

Matua Raki is a leader in the development of the addiction workforce in New Zealand, both at organisational and individual levels. It supports innovation and works towards evidence-based workforce development solutions through a broad range of activities such as policy development, training programmes, boosting sector relationships and networking, resource development, research and competency development. Matua Raki is part of the Wise Group.

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