



Quaker Action on Alcohol and Drugs

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## **RESPONSE TO THE DEPARTMENT OF WORK AND PENSIONS** **CONSULTATION 'NO-ONE WRITTEN OFF'**

Quaker Action on Alcohol and Drugs (QAAD) is a listed group of the Religious Society of Friends (Quakers). QAAD is an independent national charity that has a concern with the use and misuse of all drugs, legal, illegal and prescribed, and with gambling. QAAD offers prevention and information services for Quakers and contributes to public debates and consultations on matters relating to our concern and experience. Trustees give their time to QAAD freely, and bring voluntary and statutory experience from settings that include prevention, treatment, medical services and criminal justice. QAAD does not represent the Religious Society of Friends as a whole, but the views we express are grounded in our Quaker principles. We have focused in our response on the consultation questions that fall particularly within our concern.

**Question 6: Do you agree with the proposed approach for identifying problem drug use? How should it be implemented? Do you think that everyone claiming a working-age benefit should be required to make a declaration of whether or not they use certain specified drugs?**

We find it positive that more help for drug treatment problems would be offered to a greater number of those in need, and welcome several of the ideas outlined. However, we do not agree that a statement of drug dependency/addiction to certain drugs should be required at the time of a benefit claim, particularly if this is linked to conditionality and sanctions. Our reservations are partly 'in principle' concerns, and partly related to practical difficulties of implementation and/or the likelihood of perverse outcomes. We have some differential points regarding JSA and Incapacity Benefits, but will start with common issues.

### **A. General points:**

- I. Benefits are for subsistence: that is, for meeting the basic human needs of food and shelter. We have concerns about the principle of subsistence payments being breached.
- II. This has particular force given that those most severely dependent on the most serious drugs are more likely to suffer from social disadvantage and to have multiple/ complex needs, including dual diagnosis.

- III. The consultation document does not discuss what provision there would be for the families of drug users if they are also claiming for dependents, and particularly children. It is hard to see how suspension would not impact adversely on families – at least emotionally – when they are already under stress.
- IV. On a practical level, suspension of benefits puts people in a position of at least needing to borrow, and some may be tempted to meet their needs through dishonest means, particularly the most chaotic drug users or those who are already involved in criminality. A measure that increases this likelihood seems misguided. The most difficult to engage group are likely to be least responsive to sanctions: conversely, those who are easier to engage would be likely to respond to positive voluntary arrangements.
- V. We know of situations where the suspension of benefits for non-compliance has resulted in the suspension of housing benefit, which has then resulted in eviction. This again increases the risk of a cycle of personal and social costs, including criminality.
- VI. At least some claimants may choose not to declare their drug problem if the fear of potential sanctions outweighs the perceived benefits of treatment. Given that ambivalence is part of a drug problem, this may have the perverse outcome of deterring such users from interventions, rather than encouraging them into them.
- VII. There are likely to be ambiguities around a definition of dependency on specific drugs, particularly since poly-drug use is a common pattern.

## **B. Specific points relating to the drug treatment system**

Our general observation is that the drug treatment system does not currently have the capacity to deal with the numbers that would become eligible – and certainly not to provide the quality of treatment that enhances quality of life and provides good outcomes. Specifically, we draw attention to the following factors:

- I. Evidence cited by the National Treatment Agency (Research into Practice number 4, 'More than just Methadone Dose' May 2004) indicates that methadone maintenance is best supplemented by skilled counselling, with at least weekly provision being available. There are still many areas in which services do not stretch to this, or anything approaching it. Workforce development is also an issue in the field.
- II. Residential provision, needed for the most severely dependent users, is already insufficient for need.
- III. As regards crack cocaine users, services need substantial development. A recent NTA report found that: 'Considerable work is needed to improve the quality of treatment routinely available to stimulant users in the UK.' (Turnbull and Webster, 2007, Supervising crack users on Drug Treatment and Testing Orders NTA research publication 22)
- IV. Patterns of engagement for cocaine users - often shorter than for heroin, and having drop-out rates of two fifths within 30 days, in one recent study (NTA

research briefing 21, April 2007) – would present issues both in terms of access and compliance decisions under the DWP proposals. It is worth also noting in this context that even some of those who dropped out of this treatment did benefit in terms of some indices of progress. Black and Ethnic Minority service users may be particularly affected by this provision or the lack of it.

- V. Mandated treatment via the criminal justice system has increased treatment take up, which has had many benefits. However, the current position is summarised in a recent report, which recommended ‘Following a period of expansion and an emphasis on quantity, attention should now focus on improving quality.’ (Sweeney et al., 2008: The Treatment and Supervision of Drug misusing offenders’ UKPDC Report) This improvement needs to take place before the system imports a large tranche of other needs.

**C. As regards specific proposals, we have the following observations:**

- I. The sharing of information between Police, Probation and Job Centre staff gives rise to concern in terms of the currency, recording, time-scales for retention, and confidentiality of such data, even within the broader standards that are cited.
- II. We have specific reservations about those who are arrested and agree to a treatment intervention having their details passed to Job Centres. Benefit sanctions would again risk deterring voluntary disclosure/co-operation, and the testing process would not be sufficient to differentiate occasional from problem users. As regards those subject to Drug Treatment Requirements, effective sanctions for non-compliance already exist through criminal justice procedures. We believe this is the proper conduit for them.
- III. As regards the idea of contracted out drug testing as part of this regime, we would point to the systemic review in the study of Holloway et al., (2005). This found no evidence to support the effectiveness of drug testing either by itself or in conjunction with other methods. (The general evidence is considered more broadly in the study of McSweeney et al., 2008). We would not recommend this approach, therefore, since its principle benefits seem to be to encourage those already motivated, who will be finding other positive reinforcements of their progress.
- IV. We strongly agree with the proposal that those leaving prison should be able to access fast track drug treatment/support. Needs on release are high and problems/delays related to claiming benefits all too often add to stress and can be part of relapse. Those subject to short-term sentences have particularly poor access to drug treatment on release (Niven and Stewart, 2005) and can revolve round a door of short sentences, poor accommodation and unemployment, and relatively low level crime. We hope these proposals will allow this group to be given specific attention and support.
- V. We also agree that a Treatment Allowance is a positive proposal, since it would remove the conflicts that can occur between Job Centre procedures and drug treatment requirements. It would give a helpful structure for progress, but would

need flexibility to allow for changes in pace/ relapses that can occur as part of the recovery process.

#### **D. Summary/Proposals**

- I. We support the approach of increased access to treatment for those claiming JSA through a Treatment Allowance. For the reasons outlined above, we believe this should be optional and voluntary rather than compulsory and contingent. If those claiming see benefits rather than risks in co-operating, they are likely to want to do so. If a question were to be included, we would suggest something along the lines of 'Is there any issue in your life which might prevent you taking a job, and which other services could help you to overcome e.g. drug dependence?'
- II. If the Treatment Allowance were to be set at a higher level than JSA, this might provide a positive incentive that would encourage both take-up and compliance. However, we think that an enhanced payment of this nature would be best started when the individual has stabilised in treatment, to reduce the risk of misuse of funds. Similarly, as regards Incapacity/ESA Benefits, we think it is reasonable that co-operation with treatment plans should accompany an entitlement to the higher level of payment this gives. If breaches occur, a return to JSA would seem the most obvious sanction, and one that would minimise the risks of the perverse outcomes outlined above.
- III. The capacity of the treatment sector needs to be increased to meet demand, and we would agree with this being done via local pilots, as the consultation document suggests, since commissioning needs to be responsive to local needs.
- IV. We welcome the fact that alcohol abuse is mentioned in the document, particularly since alcohol treatment is severely under-resourced. We note also the result of recent CARATS research, which showed that alcohol was main drug named by 14% of those in custody in the study, compared with 10% naming crack cocaine. (May, C. Home Office Research Findings 262, 2005). We hope that local pilots would be encouraged to meet this need.

#### **Question 7: What elements should an integrated system of drug treatment and employment support include? Do you agree that a rehabilitation plan would help recovering drug users to manage their condition and move towards employment?**

- I. We find the general proposals in the discussion document to be positive ones. We welcome particularly the emphasis on a broad approach to the accommodation and the other barriers that so often inhibit progress out of a drug problem. Joint and integrating commissioning packages are already developing in the substances field, and a synergy with employment packages would add impetus to this. We welcome the initiatives with employers that are envisaged which build on Ministry of Justice initiatives.

- II. We think a Rehabilitation Plan would be a useful mechanism, as long as it had some flexibility and did not envisage 'recovery' as linear process. This is a particularly important caveat if the thrust of these proposals remains targeted on those who are most dependent on the more reinforcing addictive drugs, who may have periods of lesser progress or relapse. It would also be important for progress to be expected and measured only after a Comprehensive Treatment Plan, rather than a triage appointment. These can sometimes mask internal waiting lists and delays in accessing effective treatment.
- III. We would support the incentivising of employers and feel that there is also a case for putting discrimination against former alcohol and drug misusers in the same legal framework as other forms of discrimination. However, we recognise that work would need to be done on considering appropriate time-frames and sensitive occupations.

We appreciate the opportunity that has been given to contribute to this review.