IAS response to the Department for Work & Pensions' Call for evidence on the impact on employment outcomes of drug or alcohol addiction, and obesity

About the Institute of Alcohol Studies (IAS)

The core aim of the IAS is to serve the public interest on public policy issues linked to alcohol, by advocating for the use of scientific evidence in policy-making to reduce alcohol-related harm. The IAS is a company limited by guarantee, No 05661538 and registered charity, No 1112671. For more information visit www.ias.org.uk.

Response to the Call for Evidence

The IAS welcomes the opportunity to respond to Professor Dame Carol Black's review into the relationship between employment and alcohol addiction. Dependency and unemployment are, in many cases, linked phenomena, and increased efforts to deepen understanding of the relationship between the two are a positive development.

However, the IAS maintains that the most effective way of dealing with harmful drinking is at a population level, addressing the underlying structural causes of alcohol dependency rather than focusing on individual responsibility. There is a wealth of international evidence to indicate that prevention is better than cure: policies that reduce alcohol consumption at the population level also reduce rates of alcohol dependency, and are often the most cost-effective interventions, as outlined below.

Structural, population-based measures are the best response

In the IAS' view, efforts to bring alcohol dependent people back into the workforce should not be isolated from the rest of the government's policy on alcohol, but should be considered as part of a comprehensive alcohol strategy.[1]

Evidence suggests the introduction of a minimum unit price for alcohol would be particularly effective in reducing unemployment. The Sheffield Alcohol Policy Model offers the most rigorous available estimates of the impact of population-level policy measures on unemployment, drawing together the best available evidence from national statistics and academic research.[2] It shows that **a minimum unit price for alcohol would achieve at least a 17% reduction in unemployment** among harmful drinkers if set at a level of 45p per unit (at 2010 prices).[3] A minimum unit price of 50p per unit (at 2010 prices) is forecast to bring 24% of unemployed harmful drinkers into the workforce.[4]

A minimum unit price would be such a successful measure for two reasons, according to the Sheffield model. First, because harmful drinkers are relatively price sensitive: a 10%

[1] Alcohol Health Alliance (2013) Health First: an evidence-based alcohol strategy for the UK. University of Stirling: Stirling provides an indication of what this might look like.
[2] NICE Public Health Collaborating Centre (2010) Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.
[3] op cit., p111.
[4] Ibid.

increase in the price of a drink leads to a 4.5% reduction in alcohol consumption amongst harmful drinkers.[5] Consequently, any substantial increase in the cost of alcohol consumed by harmful drinkers is likely to reduce their drinking, and therefore reduce their risk of alcohol related unemployment. This leads to the second reason: the impact of a minimum unit price would be focused on the drinks consumed primarily by the most harmful drinkers – only the very cheapest drinks – and so would reduce their drinking, with limited effect on the rest of the population.

Misleading claims put forward by the alcohol industry that a minimum unit price would negatively affect responsible drinkers have no basis in fact; research has found that low-risk drinkers spend on average £1.10 per unit of alcohol, well above the suggested minimum unit price level of 45-50p per unit. As such, a minimum unit price at this rate would have almost no impact on them at all. However, dependent drinkers were found to spend 33p per unit on average, meaning that a minimum unit price at around 50p per unit would have a considerable impact on their purchasing power.[6]

Other interventions supported by a strong evidence base include widespread screening for alcohol misuse and dedicated alcohol care teams in general hospitals. **Screening and brief intervention by GPs has been identified as a particularly cost-effective preventative approach** – identifying at-risk individuals before they develop major dependency or health problems and encouraging behavioural change by promoting awareness of the negative effects of drinking.[7,8]

It is worth noting that such policies would go some way to addressing the challenge of social, economic and health inequalities. It is well established that poorer communities suffer greater alcohol harms, and so measures to address harmful drinking at a population level can be expected to have positive spillover effects within these communities (in contrast to the negative effects associated with benefit cuts below).[9]

Finally, the IAS believes that employers should take greater responsibility for the health and wellbeing of their workforce. A 2007 survey found that 43% of workplaces did not have a specific alcohol policy, and just 27% had capability procedures for managing staff with alcohol problems.[10] Engagement with employers should therefore involve encouragement for them to monitor issues with their staff's drinking and support those with problems to reduce the likelihood of alcohol induced unemployment in the first place.

Investment in services is critical to increase treatment rates

The IAS recognises that there is a significant issue with alcohol dependent people seeking treatment. In England, 6% of dependent drinkers receive treatment, far below the levels achieved by Italy (23%) and Spain (18%).[11] However, the treatment system

[5] op. cit, p85.
[6] Sheron. N., Chilcott. F., Matthews. L., Challoner. B., Thomas. M., (2014) Impact of minimum price per unit of alcohol on patients with liver disease in the UK. *Clinical Medicine 14*.
[7] Hutubessy R., Chisholm D. & Edejer T. (2003) *Generalised Cost-Effectiveness Analysis for National-Level Priority Setting in the Health Sector. Cost Effectiveness and Resource Allocation*. World Health Organisation: Geneva.
[8] O'Donnell A., Anderson P., Newbury-Birch D. et al (2014) The Impact of Brief Alcohol Interventions in Primary Healthcare: A systematic Review of Reviews, *Alcohol and Alcoholism, 49(1)*, 66-78.
[9] Smith K. & Foster J. (2014) Alcohol, Health Inequalities and the Harm Paradox: Why some groups face greater problems despite consuming less alcohol. Institute of Alcohol Studies: London.
[10] CIPD (2007) Managing drug and alcohol misuse at work.
[11] Alcohol Concern (2013) 15:15 The case for better access to treatment for alcohol dependence in England, p10.

must have the capacity and resources to absorb more harmful drinkers. Requiring people to seek treatment when the availability of services is restricted is clearly unfair and counterproductive.

All else equal, it is preferable to encourage people to seek treatment voluntarily rather than by threat of sanction. The evidence suggests that there is a segment of dependent drinkers that would be more likely to seek treatment from better resourced services. Consequently, the IAS believes that **any effort to increase the number of people in treatment should involve increased investment in services**.

The National Institute for Health and Care Excellence has acknowledged that "the limited availability of specialist alcohol treatment services in some parts of England" is at least partly responsible for the under-treatment of alcohol dependency.[12] This is supported by the fact that most treatment service providers believe there are significant gaps in provision: 64% believe that specialist alcohol services are under-resourced, 47% believe there is insufficient access to residential rehabilitation in their area and 40% believe that waiting times affect treatment programmes for service users.[13] The quality and availability of treatment is often patchy, with some parts of the country much better resourced than others.[14]

Moreover, the example of Scotland suggests investment in services can be an effective way of attracting service users. Despite a higher proportion of dependent drinkers seeking treatment than England to begin with, increased budgets from the Framework for Action were found to have "facilitated support to greater numbers of service users".[15]

This implies that greater funding and resources are required for alcohol treatment. Increasing investment will ensure greater availability and choice of treatment, with shorter waiting lists. This is likely not only to improve take up of treatment, but also to improve the likelihood of its success. Unfortunately, the recently announced £200 million cuts to this year's public health budget for England, which equates to a 6.2% cut in councils' public health budgets, seems very likely to result in cutbacks to many local alcohol treatment services. This will make it more difficult for dependent drinkers to access treatment, and reduce their chances of successfully taking on work.[16] Given the DWP's interest in dependency and employment, a more joined up approach across government departments would be highly desirable.

Utilising interactions with the welfare system to encourage treatment may have merit, but linking benefit entitlements to treatment is a risky policy, which could be counterproductive

The only measure explicitly considered in the call for evidence is the linking of benefit entitlements to the take up of appropriate treatment or support. While the principle of

[12] National Institute for Health and Care Excellence (2011) Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.
[13] Ward M., Holmes M. & Booker L. (2015) Final Report: The Recovery Partnership Review of Alcohol Treatment Services.
[14] Drummond C., Oyefeso A., Phillips T et al (2004) The 2004 national alcohol needs assessment for England, pp20-22. As part of the Specialist alcohol treatment capacity project, this analysis is in the process of being updated. Researchers from the project have confirmed in private correspondence that inequality between regions remains a significant issue.
[15] Clark I. & Simpson L. (2014) Assessing the availability of and need for specialist alcohol treatment services in Scotland. Edinburgh: NHS Scotland.
[16] Department of Health (2015) Local authority public health allocations 2015/16: in-year savings A consultation.

using interaction with the welfare system as a prompt to encourage treatment may merit some investigation, the IAS has concerns about the ethics, efficacy and unintended consequences of compelling treatment by threat of negative sanctions.

As mentioned above, the IAS supports wider implementation of evidence based screening for alcohol dependency and wider delivery of brief advice to those at risk of harmful drinking. In some ways, engaging welfare officers as part of this process appears a logical extension of the programme of 'making every contact count', as endorsed by NHS England.[17] **There is limited evidence on the effectiveness of briefing from jobcentre staff, but this is certainly a promising avenue for further research and evaluation**.

The threat of financial penalties, as proposed in the call for evidence, is not, however, supported by the evidence base. The IAS believes this is a risky policy which could be counterproductive, as outlined below.

Much scepticism exists about whether a person who feels compelled to seek treatment because of the threat of sanctions is likely to be sufficiently engaged and motivated as to be successful in overcoming their dependency. A review of the evidence on the use of legal coercion in the treatment of substance misusers concluded that "three decades of research into the effectiveness of compulsory treatment have yielded a **mixed, inconsistent, and inconclusive pattern of results, calling into question the evidence-based claims made by numerous researchers that compulsory treatment is effective in the rehabilitation of substance users**".[18]

Moreover, the introduction of financial penalties could threaten the relationship between patients and those treating them. The President of the Royal College of Psychiatrists has expressed concern that "The vital trust that exists between the patient and the health professional will surely diminish if the public starts to perceive the latter as the agents of state employment/welfare policy".[19]

Even if treatment is effective for those who comply, a predictable consequence of such a policy is that some of the most vulnerable alcohol dependent people will see cuts to their income. Any assessment of the policy must, therefore, account for the costs to non-compliers and, equally importantly, their families. Research has shown that **benefit sanctions are associated with greater hardship for a household** – in other words, greater difficulty in paying for essentials, such as food and rent.[20]

Moreover, benefits sanctions have been found to have undesirable spillover effects, For example, Machin and Marie have found an **association between benefit cuts and higher crime rates**.[21] Parts of the UK with more sanctioned individuals faced more incidents of violent and property crime. Similarly, in the US, Paxson and Waldfogel have

[17] NHS England (2012) An Implementation Guide and Toolkit for Making Every Contact Count: Using every opportunity to achieve health and wellbeing.
[18] Klag S., O'Callaghan F. & Creed P. (2005) The Use of Legal Coercion in the Treatment of Substance Abusers: An Overview and Critical Analysis of Thirty Years of Research, *Substance Use & Misuse 40,* p1777.
[19] Wessely S. & Smith G. (2015) Linking benefits to treatment is unethical, and probably illegal, *The Guardian* 29 July 2015. Available from: http://tinyurl.com/nbu8a78 [Last accessed: 26 August 2015].
[20] Lee, B. J., Slack, K. S. and Lewis, D. A. (2004) Are welfare sanctions working as intended? Welfare receipt, work activity and material hardship amongst TANF recipients, *Social Service Review78:3* 370–403.
[21] Machin S. & Marie O. (2004) Crime and Benefit Sanctions, *CEP Discussion Paper No 645.*

found indicative evidence that rates of child maltreatment, physical abuse and neglect rise with benefit sanctions.[22]

In sum, linking benefits to treatment attendance is a highly risky strategy, particularly in comparison to preventative interventions that have a stronger evidence base of effectiveness, such as those outlined above. This policy entails the near certainty of hardship for some of the nation's most vulnerable households and raises the risk of unwanted side effects, such as higher crime, for the mere possibility of effective treatment under circumstances that many experts consider likely to fail.

Linking benefit entitlements to treatment is a risky policy, which could be counterproductive

To reiterate, compelled individualised treatment is far from the most effective response to the problem of worklessness through alcohol dependency. A better step would be to increase investment in alcohol treatment services so that more people voluntarily come forward for treatment, and that these people can be treated more effectively. But, in the IAS' view, none of this is an adequate substitute for a comprehensive alcohol strategy, including policies to manage pricing and screening, leading to greater prevention of alcohol dependency, and so lower unemployment.

[22] Paxson C. & Waldfogel (2003) Welfare reforms, family resources, and child maltreatment, *Journal of Policy Analysis and Management 22(1)*, 85-113.