

# Moving Towards Inclusion

A Picture of Disadvantage in the South West

Drugs and Alcohol Misuse

March 2003



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## 1. INTRODUCTION

In December 2002, the Home Secretary published an updated drug strategy, building on the ten-year drugs strategy published in 1998. This is in response to continued public debate on the potentially harmful effects of drugs on not only an individual user, but on society as a whole, especially in relation to rising levels of crime. The Government announced significant increases in funding levels, which will rise to some £1.5 billion by spring 2005.

Of greatest relevance to this work is the government recognition of the importance of getting drug-using offenders into treatment:

*'Every opportunity from arrest, to court, to sentence, to parole will be used to get offenders into treatment and out of trouble.'*

A 'significant proportion' of the extra funding will be made available specifically for that purpose.

Initially, areas with the highest crime levels and most severe drugs problems will be part of an initiative to identify offenders with drug addiction problems at the point of arrest and charge. A choice can then be offered to them – custody or drugs treatment. This will of course require extra resources for:

- arrest referral;
- drug treatment and testing orders;
- treatment in prison and Young Offenders Institutions;
- post-release treatment and support for those leaving custody.

Clearly, this new initiative will only work if proper resources are available across all stages. Research undertaken for *Moving Towards Inclusion* shows that drug abuse is inextricably linked to the social inclusion debate, most particularly in relation to support for other beneficiary groups such as ex-offenders and young people at risk of exclusion.

One of the greatest difficulties faced in the analysis of drugs and alcohol misuse is the lack of accurate local data. Official statistics only mask the real levels of drugs use, focusing on numbers in treatment. This report will make best use of available data, but will adopt an approach which will look at key issues and the work which is being undertaken at a regional and national level to address them.

## **2. THE ABUSE - A DEFINITION**

Drug abuse can be defined as the regular use of illicit (illegal) drugs or the abuse of legal prescription drugs such as tranquilisers or sleeping pills. For the sake of simplicity, this section of the report will also include the misuse of alcohol as 'drug abuse'. 'Abuse' refers generally to a voluntary use of drugs, at least at an initial stage. As use increases or continues, abuse may become 'dependence'. The element of 'choice' is then lost to the user as the need becomes compulsive.

There is a perception that a person with a 'drug abuse' problem is someone stealing to feed a desperate heroin addiction or an alcoholic shouting abuse in the street. However, drug dependency agencies stress the wide 'spectrum' of dependence – a spectrum which will include those using drugs and alcohol to boost confidence levels or forget personal problems, through those using it to avoid withdrawal symptoms and to those desperate addicts which most readily spring to mind. It is the intensity of the desire for a particular substance that is at the root of the social problems caused by misuse.

### **3. THE POTENTIAL IMPACT OF ABUSE**

#### **3.1 The effects**

Issues relating to impact are not confined to the health of the user. Those misusing drugs and/or alcohol have a serious impact on those within their close circle of friends and family and on society as a whole:

- Risk to personal safety, including dangers of overdose, accident and violent behaviour;
- Damage to health, including possible brain damage, liver failure and mental health problems;
- Contact with the legal system, including risk of imprisonment or fine;
- Destructive behaviour, having an impact on the user, family and friends.

The Centre for Recovery, an agency based in Wales but offering advice via a national web presence ([www.recovery.org.uk](http://www.recovery.org.uk)) draws attention to the denial associated with drug abuse, which can be as destructive as the drug itself, causing the user to lie and cheat and consequently lose the trust of friends and family whose support they need. Financial problems and the impact on work or education have a long term impact on the user's inclusion within the formal boundaries of society, and this combination of factors is often present when examining the background of those who find themselves homeless or in and out of the prison system.

#### **3.2 Why people abuse drugs**

There are many and various reasons why people become dependent on drugs, most personal and painful. However, to generalize, there are certain people who are more likely to become involved in the abuse of drugs, all of which are directly relevant to issues of social inclusion:

- People who have deep-rooted insecurities and want to feel 'better' about themselves. The drugs offer feelings of greater self-confidence but can result in aggressive responses;
- People who feel alienated from society in some way. Becoming part of a drugs 'scene' may offer a feeling of belonging;
- Anger and resentment – the use of drugs and alcohol to blot out feelings of anger against family members, or simply life in general;
- Stress and anxiety – scary life situations or just being scared of life, drugs and alcohol seem to relieve the feelings of apprehension;
- Unhappy home or school life and poor immediate environment – drugs may appear to offer life in a fantasy world;
- Loneliness – the drug becomes a 'friend'.

#### **3.3 Alcohol**

There may be some debate as to the necessity to include alcohol in the same section as the abuse of hard drugs such as heroin. However, alcohol depresses the central nervous system, and can produce deceptive feelings of stimulation as it works to reduce anxiety and self-consciousness. In that way it actively changes the emotional state of the user,

potentially making them feel 'better'. In that respect it is no different from other drugs. The only difference is that it is legal.

The Centre for Recovery clearly has its own particular position on drugs use and misuse. However, it does offer clear advice and guidance, and there is a particularly interesting analysis of why alcohol is actually the most dangerous drug available.

- It kills over 50 times as many people in the UK than heroin, ecstasy, cocaine, crack and methadone put together;
- More than 30,000 people die in the UK each year from alcohol-related illnesses;
- More than 4,000 murders have been carried out by people under its influence since 1987;
- Eight out of ten people treated in hospital accident and emergency units are there for alcohol-related problems;
- Ten people die each week in the UK as a result of their own or someone else's drink-driving.

The Centre also highlights the impact of alcohol abuse on illness, family breakdown, homelessness and property crime, and the level of alcohol abuse amongst those perpetrating domestic violence and child abuse.

It is clear that this is a significant issue for all regions, including the South West. Accurate figures relating to the abuse of alcohol are of course even more difficult to obtain. There is still a stigma attached to admitting a problem to anyone else, particularly statutory agencies. It is difficult to identify the true extent of the problem and who the individuals are within this group, making addressing the problem a complex issue. However, it must be noted that alcohol is readily available even in the most isolated areas. Whereas hard drug use might not be a problem in remote parts of Cornwall, for example, it cannot be assumed that there are not significant numbers of people with some sort of dependency problem right across the South West.

## 4. THE PUBLIC PERCEPTION OF DRUGS USE

### 4.1 The British Social Attitudes Survey 2002/2003

This survey, published by the National Centre for Social Research shows that there has been a 'sea change' in the increasingly tolerant attitude of the public towards cannabis use. However, there has been no change in the perception of heroin as a highly dangerous substance, and this does not vary across any perceptible generational 'divide'. In fact, a greater percentage of respondents in the most recent survey (94%) considered heroin to be a cause of crime and violence than in the 1993 poll (85%).

Interestingly, respondents to the survey were asked to mention which drugs they considered to be 'most harmful to regular users'. Although heroin and crack cocaine were predictably at the top of the resultant 'league table', tobacco and alcohol were the next two most frequently mentioned, above cocaine, ecstasy and LSD.

The authors of the survey report point out that this has significant implications for those devising drugs policy and strategy. When 'legal' drugs are considered to be far more harmful than many currently 'illegal' substances, a blanket approach is hardly workable. Only 5% of respondents cited cannabis as most harmful compared with 34% mentioning tobacco. This is further evidence to support the lobby to legalise cannabis.

### 4.2 Drugs uncovered – *The Observer* poll

In April 2002, *The Observer* revealed details of its research into the drugs scene in Britain today. Entitled *Drugs Uncovered*, the special edition featured articles by leading journalists in the field and results of qualitative and quantitative research undertaken on the Sunday paper's behalf. For the survey, 1,075 people aged 16+ were interviewed in February/March 2002.

Apart from the key findings (detailed below), the major themes to come out of the work were as follows:

- Grey areas in the law will always be exploited by those keen to produce the next 'Big High', drugs go in and out of fashion in the same way as other consumer items;
- The price of cocaine has fallen significantly in the past two years, resulting in a significant increase in its use across the social spectrum;
- Research indicates that genetic factors 'substantially influence vulnerability to substance abuse'. There is also an emerging, tentative genetic link between addicts, 'adrenaline junkies' and thrill seekers (such as bungee jumpers)

The most chilling results were obtained from undercover work undertaken by an *Observer* reporter, who obtained drugs in three urban areas and, with relevance to the South West, one rural market town. Predictably, it was easier to obtain drugs in some places than others, but possible everywhere. The point of greatest interest however, is what is actually in the drugs that the reporter was sold. His purchases were sent to a forensic scientist for analysis, with the following results:

- What you get for your money varies from area to area, with the amount of heroin present in a 0.5g deal amounting to less than 0.04g;

- Purity is crucial – there is no way to assess the purity of the heroin, and if a user regularly injects low-grade heroin and then injects a purer form, it can be fatal;
- Heroin is often mixed with brick dust, nutmeg, stone or glass. Ecstasy is mixed with starch and talcum powder. Cocaine, too, is mixed with starch and talcum powder, as well as sugar, flour and starch.

The scientist concluded that, illegality aside, drug users 'are being exploited in a way that no trading standards would allow if this were any other consumer commodity'.

*Key points highlighted by the survey*

- Men are more likely to take drugs habitually than women;
- 28% of those over 16 (some 13 million people) have taken illegal drugs;
- Cannabis is the most popular drug amongst all age groups;
- Only 7% buy drugs from strangers – belying the myth of the seedy encounter in an alley by a club;
- 80% of people are more likely to use drugs at home or at a friend's compared to 20% in a pub or club;
- 75% of respondents first took drugs out of curiosity rather than through peer pressure or a desire to emulate heroes;
- The average age of first drug use is 18. Significantly, of those who stopped taking drugs, the average age to stop was 23, suggesting some form of 'rite of passage' experience, such as university;
- 16% of users who are not currently working feel they have a 'problem' with drugs, compared to 7% in work;
- Respondents, asked to assess what level of street crime or burglary is drug related, produced an average of approximately 66%;
- 94% of respondents stated that they had never committed a criminal act to fund drug taking. This strengthens perceptions of the 'one person crime wave' – that is a small number of users committing a large percentage of drug-related crime;
- 42% of adults believe that those arrested for possession rather than supply should be spared prison;
- Respondents supported new improved treatment for crack and cocaine users, heroin-prescribing for all those who would benefit from it and more harm minimisation, with improved access to GP medical services;
- Tobacco was perceived to be more harmful than ecstasy, cocaine and LSD.

## 5. GOVERNMENT POLICY

### 5.1 The drugs strategy

As mentioned in the introduction to this chapter, the Government has recently published an *Updated Drug Strategy* to build on the major drugs strategy first disseminated in 1998.

The key points to come out of this strategy can be summarised as follows:

- There is a tougher focus on Class A drugs;
- A stronger focus on the 250,000 Class A drug users with the most severe problems. This group accounts for 99% of the costs of drug abuse;
- Better targeting, focusing on the communities with the greatest need. Expansion of treatment services tailored to individual need, including residential treatment where appropriate and reduced waiting times;
- More support for parents, carers and families so they can easily access advice, help, counselling and mutual support, expanded outreach and community treatment for vulnerable young people. This will include 'increased outreach and community treatment ... and expanded testing and referrals into treatment within the youth justice system';
- New aftercare and through care services to improve community access to treatment and ensure that people leaving prison and treatment avoid the revolving door back into addiction and offending;
- Improved services in those communities affected by crack, fast track crack treatment programmes in the worst affected areas and new police initiatives to close crack markets.

Quoted targets include:

- to provide support to 40-50,000 vulnerable young people by the year 2006;
- double the number of Drug Treatment and Testing Orders by March 2005;
- all drug action teams to have a co-ordinated system of aftercare in place by April 2005;
- to improve access to GP medical services and have the capacity to treat 200,000 problematic drug users by 2008.

The Government has announced that funding for treatment services, including those undertaken through the prison service, will increase by £45 million in 2003/4, £54 million in 2004/5 and £115million per annum from April 2005. Including funding associated with Drug Treatment and Testing Orders, the total direct annual spend on treatment will be £589 million by 2005.

Other initiatives that have a less well-evidenced chance of success are:

- New cross-regional Police 'hit squads' to break up middle drug markets, the link in the chain between traffickers and local dealers;
- An 'innovative' advertising campaign, to educate young people about the dangers of drugs and prevent them from falling into drug misuse.

There is currently much 'tough talk' coming out of Whitehall. David Blunkett, announcing

the latest strategy, is quoted as saying:

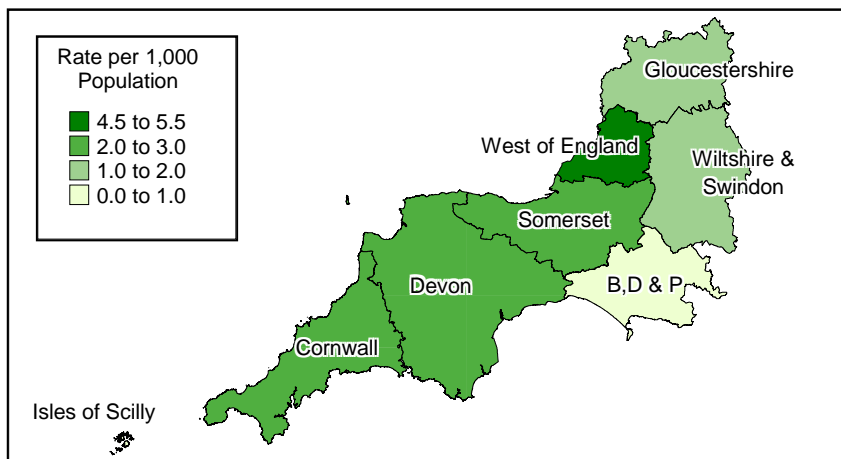
*'All controlled drugs are harmful and will remain illegal.... We will maintain our focus on Class A drugs as they cause the most harm. We must achieve real reductions in the level of problematic use if we are to turn around the lives of individuals and their communities... Education, prevention, minimising harm, treatment and effective policing are our most powerful tools in dealing with drugs... The best place for drug-using offenders is in treatment and out of trouble.'*

## 6. DRUGS MISUSE IN THE SOUTH WEST REGION

### 6.1 Background

Figures available from the Regional Drug Misuse Database maintained by the Department of Health show that 2.4 people per 1,000 head of population in the region were part of a drugs misuse treatment programme. This equates to an approximate total of 11,000 people. There are, of course, 'hotspots' where there are greater concentrations of those in treatment. Nearly 50% of the total for the region are within the West of England (including Bristol) where the rate per 1,000 population rises to 5.1. More than 2,500 people are in treatment in Devon.

#### ***Rate of Drug Misuse per 1,000 Population***



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Source: Regional Drugs Misuse Databases - DOH 2001

Interestingly, analysis undertaken by SLIM in *Reaching Out Across the Region* (2002) shows that the spread of ESF projects supporting those with drugs misuse problems does not follow the pattern of the population in treatment. The report highlights that although the West of England has a 'significantly higher rate of drug misuse' the area delivers far fewer projects than Devon, for example, and has a relatively low concentration of drug misuse beneficiaries.

This disparity highlights the undesirability of making assumptions based on available statistics. There is little doubt that those working 'on the ground' with those with drugs misuse problems have the best appreciation of the level of use and abuse within the region.

## 6.2 A demographic profile

### *Age of users starting agency episodes Oct 2000 to March 2001*

RO area/HA of treatment	Under 20	20-24	25-29	30 & over	Total
England	4,223	8,404	8,108	12,499	33,234
South West	442	968	928	1,414	3,752
Avon	201	420	401	573	1,595
Cornwall & Isles Of Scilly	82	78	59	126	345
Dorset	6	43	44	79	172
Gloucestershire	61	143	103	123	430
North & East Devon	15	39	30	38	122
Somerset	26	75	100	145	346
South & West Devon	30	117	135	249	531
Wiltshire	21	53	56	81	211

Source: DoH 2000/01, by regional office and health authority area

As previously discussed, there is a paucity of reliable data on drugs use at a local level. Available data can only offer a profile of the drugs users entering treatment within the region, which must reflect the number of places available at treatment centres.

When looking at the age profile of those entering treatment, it is clear that it is the older age group that is in the majority. In South and West Devon and Dorset, almost 50% of those entering treatment are over the age of 30. The overall proportion for the South West is the same as the national average, with 38% aged 30+. These figures would of course be affected by the demographic profile of the general population of the area.

When figures for the youngest age group are examined, the greatest proportion of under 20-year-olds entering treatment is found in Cornwall and the Isles of Scilly.

### *Gender of users starting agency episodes Oct 2000 to March 2001*

RO area/HA of treatment	Persons	Males	Females	Males	Females
				%	%
England	33,234	24,777	8,457	75	25
South West	3,752	2,790	962	74	26
Avon	1,595	1,216	379	76	24
Cornwall & Isles Of Scilly	345	240	105	70	30
Dorset	172	122	50	71	29
Gloucestershire	430	307	123	71	29
North & East Devon	122	95	27	78	22
Somerset	346	253	93	73	27
South & West Devon	531	390	141	73	27
Wiltshire	211	167	44	79	21

Source: DoH 2000/01, by regional office and health authority

Three quarters of drug users entering treatment in the South West are male. Figures are generally similar to the national average of 75%. The most significant differences can be found in Cornwall where 30% are female and Wiltshire where almost 80% are male.

## 7. DRUGS AND HOMELESSNESS IN THE SOUTH WEST REGION

In May 2002, *The Big Issue South West* (the regional arm of the national magazine sold directly by homeless people) published a report entitled *Real Lives, Real Change: What Big Issue vendors need to escape homelessness*. The report was based on two pieces of research conducted at the beginning of 2002 by the University of Bristol and Vision 21, a social research company. Questionnaires were distributed to *Big Issue* vendors in Bristol, Bath and Bournemouth.

A questionnaire distributed in Bristol, Bath and Bournemouth specifically asked *Big Issue* vendors about their use of illegal drugs and alcohol. The results are disturbing, and highlight how difficult it is to look at ESF beneficiary groups in isolation from each other.

- 92% of the sample had tried illegal drugs, and 83% of them remain regular users (this is in contrast to figures from the British Crime Survey 2000 which indicated that less than 35% of the general population had taken illegal drugs);
- Almost 90% of the drug users take heroin, and 76% of them use it every day (the Drug Monitoring Service has reported that the price of heroin on the streets has fallen drastically over the past few years);
- Crack cocaine is also used by one third of the drug users.

Although the majority of those responding to the questionnaire want to stop taking the drugs they use, a similar figure feels that their use of drugs was none of the *Big Issue's* business.

Levels of satisfaction with drug treatment services were split down the middle. Many of the respondents were happy with the treatment they had received, but of those that were not, the main complaints related to difficulties of access and the 'unbridgeable gulf' between the user and the drug worker – the suggestion being that some workers see only the 'junkie', not the person.

Hearteningly, some 75% of vendors said they used drugs less since they *joined Big Issue South West*, but it remains a serious problem. More than 50% of all vendors cited drugs use as affecting their health in a 'bad way', and nearly 50% said that they worry about their drug use 'often'.

The report concludes that current government policy fails homeless people with drugs problems, partly because there has been no strategy to challenge the black market for drugs that has an 'effective stranglehold' over homeless people, and that drugs agencies in the South West (and nationally) need to adopt a more 'pragmatic and practical' approach to drugs misuse.

These findings are supported by those published in the Drugscope report, *Vulnerable Young People and Drugs Opportunities to tackle inequalities* (2001). That report found that a wide range of illegal substances were being used by 'the young residents of homeless projects', at a level above those found in the general population. In this case, the drug used most frequently was cannabis. Again, this report reinforces the impact of a multiplicity of problems on social exclusion, as the subjects of the research were young vulnerable, homeless, drug users.

In 2002, the Office of the Deputy Prime Minister and the Home Office jointly commissioned the *Drug Services for Homeless People Handbook*. It aims to help Drugs Action Teams (DATs) and other agencies to plan more effective services for drug users who are homeless or at risk of becoming so. This comes as a response to expressed concerns about the need to have better co-ordination of action on drugs, homelessness and other related problems crucial to the inclusion of those within this beneficiary group. The *Handbook* highlights the need for prompt action, particularly in the light of recent studies that indicate an alarming increase in the use of Class A drugs amongst homeless people. This reaffirms the findings of the *Big Issue South West* survey that showed high rates of heroin use and the increased use of crack cocaine.

## 8. THE COST OF CLASS A DRUGS USE

To look at this from a policy-making perspective, there is much to be said for focusing regional attention on the use of Class A drugs. The report, *The economic and social costs of Class A drug use in England and Wales, 2000* (Home Office Research Report 249), estimates the economic and social costs of such drugs use. The figures are only available for England and Wales as a whole, but the findings are relevant to the South West region nonetheless.

The work analysed drug user groups in three categories: young recreational, older regular and problem drug users. Those in themselves make an interesting distinction, with a suggestion that young recreation users for example do not have a 'problem'.

Consequences were identified for the following:

- GPs
- A&E departments
- Hospital days
- Mental health services
- State benefits
- Police arrests/acquisitive crime
- Police custody
- Court appearances
- Prison.

Costs for each of the groups were estimated as follows:

- Young recreational - £28.8 million per annum – a cost per user of between £36 and £72;
- Older regular users - £6.2 million per annum – a cost per user between £3 and £6;
- Problem drug users – a median estimate of £3.5 billion – approximately £10,000 per user per annum.

It is clear, therefore, that efforts must be concentrated on ensuring that resources are targeted at those whose drugs use has the greatest economic and social cost. Effort also needs to be made to ensure that young people who see drugs as some form of 'leisure' activity do not become users with a 'problem'. Education and diversion have a role here of course, but this is a very difficult area within which to work, and local responses to local problems are likely to be most effective.

## 9. NATIONAL PROGRAMMES IN THE REGION

### 9.1 Drug Action Teams

Drug Action Teams (DATs) are multi-agency co-ordinating groups at a local level set up to implement the Government's strategy 'Tackling Drugs Together'.

The DAT is responsible for the co-ordination and monitoring of all substance misuse, prevention, education and treatment services. DATs work closely with Community Safety Partnerships, 'sharing the common aim of reducing harm to individuals and the community caused by substance misuse' (Bath & North East Somerset DAT). The DAT would normally include representatives of the local authority, the police and prison and probation services.

As an example of the stated aims of DATs in the South West, South Gloucestershire Drug Action Team is committed to:

- Assess the nature and scale of local drug problems and the effectiveness of current responses to them;
- Ensure that the strategies, policies and operations for tackling drug misuse of the organisations represented on the team are in accord with each other;
- Ensure that relevant sub-groups are established and operate effectively;
- Ensure that appropriate action is identified and implemented to make progress in line with the Government white papers 'Tackling Drugs Together' and 'To Build a Better Britain' in the light of local circumstances and needs.

#### **Case Study**

##### **The Somerset DAT approach to the Communities against Drugs programme**

The Somerset DAT covers a wide area – from Porlock in the west of the county up to (but not including) Weston-Super-Mare in the East. It includes representatives from five Crime & Disorder Partnerships (local authority areas) – Taunton Deane, Sedgmoor, Mendip, South Somerset and West Somerset. It encompasses two police constabularies – East (covering Mendip and South Somerset) and West Somerset.

The first year's allocation of Communities Against Drugs (CAD) funding amounted to £500,000. The same amount has been allowed for 2002/03. A number of projects are being funded over the three years of CAD, and other projects are shorter term or have used capital allocations to support sustainable projects like the Healthy Living Centre in Chard, or skate parks.

As with other areas more used to finding budgets slashed rather than increased, the funding created issues around how best to allocate and spend the budget. The five districts joined together to fund 1.6 new posts to look at the offenders on probation caseload. That focus might offer the opportunity for early intervention, looking not just at cases relating directly to drugs offences, but also those indirectly related, - where drugs were an issue for the offender in a burglary, for example. Additionally, the two police districts came together to fund two additional police posts to bring together the myriad of statistics and data relating to drugs and drug-related offences.

## The Projects

The comment was made that the CAD guidance documents were not specific in terms of how the funding should be best utilised. This has been both a help and a hindrance. Interpretation of phrases such as 'strengthening communities' is wide and gives no real hint of the type of projects that might be appropriate. However this has also given Somerset a degree of freedom appreciated when the timetable for spending allocations of funding was tight.

There has been a positive effort to work together across Crime & Disorder Partnerships. Audits of the views of local community groups were undertaken to assess local priorities.

In **Taunton Deane**, for example, the Crime & Disorder Reduction Partnership has invested its CAD funding in a variety of ways.

A joint project between Probation and the Taunton Deane Borough Council Physical Activity Referral Co-ordinator aims to establish a sports/leisure activity scheme for drug-using offenders. This looks to ensure that all aspects of an individual's life are explored, not just their drug use and offending behaviour. Through work with Drug Treatment & Testing Order clients, leisure activities have been identified as an important element to individual treatment plans.

Three projects have also been funded to provide diversionary activities for young people, including one in North Taunton where Somerset County Youth Service has set up a project to run for 3 years. A project worker and part-time youth staff will run activities including residential learning experiences, with international opportunities for 15 to 19 year-olds. There will also be one-to-one work with individuals, targeted school outreach and street art activities.

In **South Somerset** the Crime & Disorder Partnership has used £35,500 of its CAD money to support Chard Healthy Living Partnership to refurbish part of the Chard Healthy Living Centre to provide a local venue where a range of support services, for drug users, families and carers and those vulnerable to substance misuse, can be delivered. They have also used this funding to employ a part-time community link worker specialising in drugs use. The link worker is liaising with drug-users, parents, vulnerable young people, local businesses and other agencies. The aim is to develop and strengthen links with all sectors of the community so they have the capacity to work together in response to drug-related issues at a community level.

In the **Sedgemoor** district, the Safer Sedgemoor Partnership has recognised that young people who are excluded from school have an increased risk of involvement with drugs. It has therefore funded a project to provide constructive activities for young people excluded from school and to help prepare them for a return to mainstream education.

## Monitoring the Success of the CAD programme

The main issue for the Somerset DAT in relation to CAD has been the necessity for comprehensive monitoring of the outcomes of the project work. There has been a need to change 'project mindsets' to ensure that they become more systematic in their record-keeping to substantiate the number of people actually attending and the effect attendance has on their lives (and the potential reduction in likely and actual drug use.) This is

obviously not an easy area of work to quantify. The DAT has also identified the need to put support structures in place to help the projects spend the allocation of funding most effectively through the examination and dissemination of good practice.

### **2002/2003**

For the current financial year, the Somerset DAT has placed the emphasis on projects aimed to assist offenders on their release from prison. The 'local' prisons for Somerset are actually situated outside the county, in Devon and Dorset in particular, but it is recognised that local people spending time in those prisons need support to re-settle in Somerset from the moment they leave the prison gates. It has been the case that prisoners have taken part in drugs programmes within prison, come out clean and then are left to fend for themselves – resulting in further drug use and potential criminal activity. Projects will aim to address this.

### **Conclusion**

There is a generally positive view of the CAD programme in Somerset. It is of huge benefit to an area such as Somerset which tends not to benefit from other funding streams which are awarded on the basis of indices of deprivation. The rural nature of the South West and the very few urban areas large enough to offer a full range of services make the provision of support more expensive – a fact which has not yet been fully recognised by central government.

The key to success is seen to be the need to ensure that community development continues apace so that local people can be mobilised to respond to the dangers of drug-taking in the community.

## **9.2 Progress2work**

In March 2001, the Chancellor announced a £40 million investment over three years to support those with drugs misuse problems into work. Progress2work is run via the New Deal to help those with a history of illegal drug misuse to engage with the world of work find good, sustainable work via training, support and other types of intervention, including counselling and advocacy. The Government aims to reduce the percentage of people coming out of drugs treatment programmes who relapse (currently the failure rate is around 50%) by finding ways to get them off benefits and into work. In the South West, focus has been placed on three 'Pathfinder' areas – Bristol & South Gloucestershire, North Devon and Plymouth. The Government aims to have the scheme up and running across all Employment Service areas by the end of 2003.

Jobcentre Plus staff are trained to identify clients whom they feel will benefit from such support, and can refer them to appropriate organisations. Those who are currently undertaking drugs treatment programmes will be referred to Jobcentres shortly before their treatment period comes to an end. Progress2work co-ordinators will be responsible for ensuring the identification of the best ways to ensure ex-users can join and remain on New Deal programmes.

Contracted treatment agencies have to support ex-users with housing advice and assistance, assertiveness training and an awareness of relapse and how to prevent it.

There will also be a requirement to offer advice and support in matters such as health and hygiene, debt management and benefit rights. These are areas within which ESF has a significant role to play.

Some of those people involved in managing pilot schemes feel that this scheme is 'not sufficiently intensive to turn around lives scarred by crime, illness and debt'. The main concern is that it is too much of an 'add-on' at the end of a treatment programme, and that any intervention should start much earlier on in the rehabilitation process. Those involved in this work could look to ESF to support the programme.

John Hollis-Davis, chief executive of The Social Partnership in Liverpool, which ran a pilot scheme in Liverpool, was concerned about the timescale within which the ex-user is expected to work

*'We can't expect them to change in a six-month period - even if they're clean... They can't organise chaotic lives and we're expecting them to be part of a system that's based on that.'*

There is also concern expressed at the way in which essentially 'anti-authoritarian' drugs agencies work with bureaucratic, benefit agencies. This is a key concern, and challenge, to local partnerships in the South West who must work to break down barriers in fundamental working practices before there is any hope of success.

Work undertaken by the Centre for Economic and Social Inclusion (CESI) showed that the number of people referred to projects fell well short of the number expected. Further, the percentage of people on the scheme progressing to 'proper' jobs was just 13% - much lower than the target figure of 33%. However, many people who remained on the scheme did well.

The Government has expressed a willingness to adopt a flexible approach to benefit regulations for those on the scheme, who can hardly place a time limit on the months or years it may take to be able to fully engage with the world of work. However, it does appear that the Government set up this scheme without full knowledge of the expertise available to ensure that it runs efficiently.

Those who experience exclusion frequently have feelings of low self-esteem and lack of confidence. It is beholden upon those running schemes such as Progress2work that they are operated in such a way that the possibilities of further perceived 'failure' are minimized.

