

Scottishdrugs**Forum**



Drugs and poverty: A literature review

**A report produced by the Scottish Drugs Forum (SDF) on behalf
of the Scottish Association of Alcohol and Drug Action Teams by:**

April Shaw, Research Officer, SDF

James Egan, Head of Policy and Practice, SDF

Morag Gillespie, Research Fellow, Scottish Poverty Information Unit,

Glasgow Caledonian University

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Contents

Acknowledgements	2
Executive Summary	3
Drugs and Poverty - a literature review	6
Introduction	6
Literature Review	10
Deprivation	10
The causes of problem drug use	11
Lines of causation	11
Communities and social capital	16
Crime and Social Exclusion	19
Welfare Reform	25
Employability	26
Women and drug use	33
Black and Minority Ethnic Groups	37
Rural Areas	39
Policy Implications	41
Conclusion	44
References	45

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Further enquires - contact James Egan at Scottish Drugs Forum (james@sdf.org.uk) or Mike McCarron at the Scottish Association of Alcohol and Drug Action Teams (mike.mccarron@saadat.org.uk).

Executive Summary

What are the links?

- There are strong links between poverty, deprivation, widening inequalities and problem drug use but the picture is complex. It may involve fragile family bonds, psychological discomfort, low job opportunities and few community resources.
- Relative poverty, deprivation and widening inequalities, such as income, are important factors that need to be given a more central role within the drug policy debate as they weaken the social fabric, damage health and increase crime rates.
- Not all marginalised people will develop a drug problem, but those at the margins of society, such as the homeless and those in care, are most at risk.

Communities and Crime

- The drugs-crime link is not straightforward and three explanations have been put forward - drug use leads to crime; crime leads to drug use; crime and drugs are related to wider factors.
- Wider factors include the international drug trade impacting on local communities and also the negative effects of globalisation on local job opportunities.
- Changing housing markets and policies have had a clustering effect resulting in a concentration of multiple social problems including drug markets within deprived areas. Drug markets occur in fragmented local areas but also within highly deprived areas with strong networks.
- Drug markets are economically destructive and damaging but may also bring 'benefits' such as trading in illicit goods (otherwise unaffordable), supplement low incomes and offer personal 'protection' from other criminal activity such as burglary. Drug markets may also impair regeneration efforts in areas where there is a lack of job opportunities.
- The move from a producing to a consuming society may have generated a sense of relative deprivation - stimulating criminal activity in deprived areas among those feeling excluded from a consumer society. Those involved in this type of criminal activity may view it as 'work' that provides an income, a sense of structure and an identity in their daily lives.
- Governmental drug policy response has involved a shift from public health towards criminal justice priorities. This has resulted in coercive elements being introduced into the health and social care sectors (e.g. Drug Treatment and Testing Orders) and

care elements introduced into criminal justice sectors (e.g. police custody suites offering needle syringe facilities).

Welfare Reform and Employability

- Scotland's poverty figures are stark. There are 910,000 people experiencing poverty which includes one in four children. Those at risk of poverty change over time - while poverty levels among children and pensioners have dropped recently, the levels among working age adults have increased.
- The main route out of poverty for working-age adults has been a mix of welfare-to-work programmes (e.g. the New Deal) and in-work benefits (tax credits). This response may reduce poverty but it does not eliminate it.
- Drug users face a range of employability barriers including a fear of drug relapse linked to having to renegotiate welfare benefits, restrictive pharmacy dispensing of prescription drugs and various health, social and criminal justice problems.
- Structural employability barriers include employer discrimination and a lack of engagement between drug and employment services. Criticism of employability provision includes simplistic targeting within a free market competitive culture of short-term funding - an approach at odds with the need to fit in with long-term interventions with problematic drug users.
- Large scale detachment from the labour-market among problematic drug users may require more preliminary activities being considered - such as confidence-building or improving literacy and numeracy skills before employability programmes.

Other areas of concern

- Black and Minority Ethnic (BME) groups - there are high levels of poverty, deprivation and unemployment among BME groups but the links with problem drug use are even less clear than that of the wider drug using population. Future research into these links needs to acknowledge within its methods an awareness of BME groups.
- Rural areas - research and policy attention to the links between rural poverty and drug use are sparse and require further attention.
- Women - a seminal study has shown that far from being 'mad, sad or bad', women drug users were rational and pragmatic given their life experiences and situations. Nevertheless many lack access to the socioeconomic resources that would help them 'escape' their situations, with poverty one of the main obstacles.

Policy implications

- Re-visiting how we define certain types of drug use and users and seeking out their views could illuminate current policy priorities and responses. For example, the focus on problem drug-using mothers as a group of concern may have resulted in other important areas of child and family concern being overlooked, such as alcohol misuse.
- To avoiding more clustering of multiple social problems, an increase in public/council housing provision needs to be considered.
- There is a need to move away from means-tested welfare benefits which stigmatise those unable to take up work.
- The drugs-crime relationship requires more attention and needs to take account of the complex relationships involving local drug markets, changes in the housing market, long term unemployment and low benefit levels.
- There is a need to improve upon the limited welfare claimant figures for people with a drug problem. From a 'fit to return to work' perspective the unfolding Hepatitis C epidemic will present a range of challenges that may require improved working links between the Department of Work and Pensions and NHS services.
- With kinship carers emerging as a significant care group (e.g. grandparents looking after their grandchildren), there is a need to remedy the postcode lottery approach to financial support for these carers.
- Reducing inequalities, such as income, may lower high levels of damaging drug use. New policy options are worth considering such as the concept of a Citizen's Basic Income.
- Policies that focus on reducing poverty, exclusion and inequalities, per se, should help clarify realistic boundaries for health, social care and criminal justice responses to individuals.

Drugs and Poverty: A literature review

There were an estimated 51,582 people with opiate and/or benzodiazepine drug problems in Scotland in 2003 (Hay et al 2005) and the overall unemployment rate of new contacts seeking help from drug services has averaged out at an annual rate of 85% - a stark contrast to the national unemployment rate of 5.2%.¹ Furthermore it has been estimated that 80 - 90% of all Scottish prisoners taken into custody have been misusing drugs and/or alcohol (Scottish Consortium on Crime and Criminal Justice (SCCCJ) 2002) and that significantly high rates of prisoners come from the most deprived council ward areas (Houchin 2005).

Aware of these statistics the Scottish Association of Alcohol and Drug Action Teams commissioned this paper to review the literature exploring the links between poverty, social exclusion and problematic drug use. The Scottish Drugs Forum and Scottish Poverty Information Unit, supported by the Association also organised a conference in June 2006 to explore the links between drugs and poverty.

Introduction

“We want now and in the future to see deprivation given its full and proper place in all considerations of drug prevention policy, at both the local and strategic levels, and not let slip from sight.”

(Advisory Council on the Misuse of Drugs ACMD:
Drug Misuse & the Environment 1998)

This recognition of the importance of the links and relationships between drugs and poverty came early in the life of the New Labour government. In Scotland, the Scottish Parliament Social Inclusion, Housing and Voluntary Sector Committee held an inquiry into the links between drug misuse and exclusion for individuals, families and communities. The Committee recognised that deprived communities with poor housing, poor amenities and high levels of unemployment were the areas most seriously affected

¹ The Scottish Drug Misuse Database (SDMD) definition of a new patient/client is any person who is attending the service for (a) the first time ever or (b) it has been at least six months since the last attendance at the service.

by drug misuse and that problem drug use:

'...is inextricably linked with other extreme forms of social exclusion, notably homelessness, persistent offending and street prostitution.'

(Social Inclusion Housing and Voluntary Sector Committee 2000)

However, the statistics on 'problematic' drug use and high unemployment rates in Scotland raise questions about whether this link is being followed through into policy and practice and suggests that the time is right to open up the debate on poverty and deprivation as important factors to be addressed in drugs policy and for drug use to be a more central consideration in work on poverty, particularly in understanding the links and interactions and their implications for policy and practice.

Structural changes in the 1970s and 80s brought de-industrialisation in many labour-intensive industries and as a consequence many communities were destabilised by mass long-term unemployment. For the first time in the post-war period a generation was leaving school with no prospect of a 'job for life' and few opportunities to gain employment. Instead of addressing the impact of de-industrialisation on urban working class communities the 'New Right' chose instead to blame the victim. This strategy portrayed young heroin users as social outcasts who threatened the cohesion of communities and society at large. Drug users were categorised into two groups: one group, largely drawn from the unemployed working class were seen as social deviants heavily involved in drugs and crime and causing havoc in their communities: The second group were viewed as 'respectable' youth who were at 'risk' of being drawn into drug addiction (Buchanan and Young 2000).

Although the tone of the debate has changed since the 1980s, commentators suggest that there are policy shifts taking place that redefine traditional roles in relation to drugs policy. For example, in drugs policy, there is a move from voluntary services towards compulsory services combined with a shift in priorities from helping the 'health needy such as those drug users affected by Hepatitis C' towards the 'criminal needy' with a cultural shift from co-operation between agencies and their clients towards coercion/conflict (Stimson 2000). A term has been coined for this new shift: 'A Social-Public Order Regime'. It involves changing working cultures between health and social care sectors and the police, from antipathy or suspicion towards cooperation and consensus. So we have a situation whereby more coercive elements are introduced

into health and social sectors (for example, Drug Treatment and Testing Orders) and care elements are introduced to police operations (for example, police custody suites offering needle syringe facilities). Although these agencies are addressing health and social problems of drug users they are also extending social control over them (Kubler and Walti 2001).

There are also significant changes in the direction of policy in relation to poverty and social security. In 1999 the New Labour government committed itself to eradicating child poverty within 20 years.² The government has identified work as the main route out of poverty. A series of reforms have been implemented to take forward the welfare to work agenda in the UK including:

- reform of the tax and benefits system with the aim of making work pay
- the introduction of programmes such as the New Deal to tackle unemployment and obstacles to labour market participation
- changes to the way in which welfare to work is delivered
- specific initiatives that target drug users such as the New Futures Fund projects in Scotland and the UK wide Progress 2 Work.

This review provides an overview of the main literature found during a five day literature search that explores the links and relationships between drugs and poverty.

Methodology

The key academic databases that were accessed and searched included ASSIA, British Humanities Index, Cambridge Scientific Abstracts Illumina, Medline, OVID, Proquest (health and social science plus) and the Cochrane Database of systematic reviews. Other sites accessed and searched for 'grey' literature included DrugScope, Joseph Rowntree Foundation, Scottish Poverty Information Unit, Scottish Centre for Research

² On 18 March 1999, Prime Minister Tony Blair announced: 'And I will set out our historic aim that ours is the first generation to end child poverty forever, and it will take a generation. It is a 20-year mission but I believe it can be done.' Cited at http://www.psi.org.uk/news/pressrelease.asp?news_item_id=134

on Social Justice, Joint Centre for Poverty Research, National Centre for Social Research, Shelter and Communities Scotland.

It was decided to begin the literature search from 1997, the year the Labour Party was elected to government and to review literature from the UK. However due to the limited number of papers that explored the links between poverty and drug use in that period, reference has been made to selected studies prior to 1997 and from other English speaking countries.

Key terms used in the literature search included: poverty, deprivation, social (exclusion/inclusion), socio-economic, drug(s), heroin, addict(ion), cocaine, crack. The key terms were searched within the title and abstract only and not whole texts.

It is acknowledged that the literature search is not extensive and that there are many more papers that workers, academics and other interested parties could cite, nor is it the intention of this review to undertake methodological assessments of the reviewed studies but rather the aim is to give an overview of the connections and hypotheses relating to drugs and poverty.

Literature Review

The review has been grouped into the following sub-sets outlined below concluding with a separate section examining the policy implications:

- Deprivation
- Communities and Social Capital
- Crime and Social Exclusion
- Welfare reform
- Employability
- Women and Drug Use
- Black and Minority Ethnic groups
- Rural areas
- Policy implications.

Deprivation

The individuals who are most at risk of developing problem drug use are those who are at the margins of society. They are individuals who are socially and economically marginalised and disaffected from school, family, work and standard forms of leisure. However the relationship between these factors and drug use is not linear. For example although the majority of problem drug users may have experienced a number of these problems the converse may not hold true; that is, individuals who are economically and politically/socially marginalised will not necessarily become problematic drug users. Neale suggests however that particular sub-groups of the population such as the homeless, those who have been in care and/or excluded from school and those in contact with the criminal justice system or mental health services are more susceptible to the various risk factors and that drug misuse is more prevalent among these particular groups (Neale 2002).

According to Spooner (2005) the social environment is a powerful influence on health and social outcomes. In this context drug use and related problems result from the complex interplay of the individual and the environment whereby social institutions or structures can influence the environment in a manner that can influence drug use and related problems. Societal structures include government policies, taxation systems,

laws and service systems such as welfare, education, health and justice. As such increased attention to the 'social' determinants of drug use is required.

The causes of problem drug use

People from all backgrounds and classes take drugs for many reasons: for pleasure, to treat physical or emotional pain, for stress or anxiety, or because their friends do. But the pattern of who develops a drug problem and encounters other problems shows a close link between drug misuse and social exclusion.

The first signs of the link between problematic drug use and social exclusion became apparent in the US post-war period as some of the big cities encountered the first shocks of de-industrialisation. A series of studies by the Chicago School of Sociology showed clearly that poverty and decay in inner cities were the key causes of the heroin epidemics of the 1950s and 1960s in New York, Chicago and other US cities. In the 1980s those same factors helped to fuel the crack epidemics in the US.

An influential study by Parker et al (1986) undertaken in the Wirral during the 1980s showed the average prevalence of heroin users across the peninsular was 18.2 per 1,000 among 16-24 year-olds. But the spread ranged in different districts from zero to 162 per 1,000. The variation in geographical prevalence was highly correlated with seven indicators of background deprivation levels in each area: unemployment rate, council tenancies, overcrowding, larger families, unskilled employment, single parent families and lack of access to a car. A study by Dr Laurence Gruer of some 3,715 drug-related emergency hospital admissions in Greater Glasgow from 1991 to 1996 plotted them by postcode using a standard index of deprivation (cited ACMD 1998). The admission rate from the most deprived areas exceeded that from the least deprived areas by a factor of 30, so that if the admission rate for the least deprived area had applied across the city, the number of admissions would have been 92 per cent lower. It was noted that the relationship between deprivation and drug misuse is higher than any other health variable they had studied.

Lines of causation

There is a strong statistical correlation between deprivation and problem drug use but the nature of these links is not simple (ACMD 1998). Deprivation does not directly cause addiction, instead it increases the propensity to misuse - it weakens what are sometimes called the protective factors and it strengthens the risk factors. So even

though the causes of deprivation are social, they are experienced individually. Not everyone in a poor neighbourhood will become drug dependent, and those who do have their own set of reasons for responding to their circumstances within a particular manner (Young 2002).

The combined health and crime approach focuses largely on drug dependence and takes little account of the underlying causes of long-term problem drug use and the social context in which this problematic use takes place. Buchanan (2004) argues that problem drug use for a significant number is a 'socially constructed phenomenon that has less to do with individual choice or physical dependence, and much more to do with the structural disadvantages, limited opportunities, alternatives and resources.' He provides evidence for this assertion by looking at a number of British studies whose findings indicated that for a significant proportion of clients, social disadvantage and exclusion were major issues prior to the onset of a drug habit. While Buchanan contends that not all people who suffer deprivation will go on to develop problem drug use he does argue that compared to the wider population, problem drug users are more likely to have suffered difficult childhoods and often experienced being taken into care or excluded from school.

These factors then should be taken into account and form the development of assessment and intervention strategies which recognise that many problem drug users will have had limited options in life, lack personal resources (confidence, social skills and self-esteem) and have limited positive personal life experiences to return to. He argues that what this client group needs is 'social integration not social reintegration, they need habilitation not rehabilitation.'

Tending towards the 'retreatist' theory of drug 'addiction' Buchanan says that for those who experience social exclusion and disadvantage prior to drug use, the onset of excessive drug taking in early adulthood may be a form of escape, a way to deal with the lack of resources available to the rest of society. But this sense of social exclusion lends itself to further exclusion setting in motion a cycle of increasing exclusion that is exacerbated by the discourse of the 'war on drugs' and a strategy that is concerned with 'punishment, control and exclusion of drug users rather than care, rehabilitation and inclusion.' The result is widespread discrimination. The constant experience of marginalisation leads problem drug users to internalise their problems and blame themselves (Buchanan 2004).

Room (2005) has argued that stigma and marginalisation of problematic drug and alcohol use are important factors in adverse outcomes and that this is an area of study that has been relatively neglected in the literature. Although he posits that there is no 'necessary relation' between poverty and stigmatisation and marginalisation he does argue that those who are more affluent have more social and economic 'capital' and are better able to protect themselves from these forces.

Pearson (1987) argues that the relationships between heroin use and deprivation work on a number of levels. First the potential for heroin misuse in areas of high social deprivation is determined by the mechanism of the housing market which 'clusters' together those with the most urgent housing needs, including problem drug users in the most 'hard to let' areas. Through this mechanism heroin becomes available within an area with the potential that the drug becomes available through friendship networks on an experimental basis. However, once established as another commodity in a hidden and irregular local economy, heroin use can become a means by which to confer local status within a community particularly where there is an absence of other effective means to establish meaningful lives and identities. It is more likely that patterns of occasional use will pass over into habitual use more quickly in those areas where there are fewer sustaining life commitments such as work. Finally the life style of the heroin user with its necessary daily routines can 'solve' the 'heavy psychological burden of unemployment caused by the dislocation of habitual time-structures'. However the conditions of unemployment make it more difficult for heroin users to give up these routines and establish alternative patterns of daily activity that are both meaningful and rewarding.

In *Matters of Substance*, Edwards (2004) examines the history, culture and language behind each drug - their physical and psychological effects, medical uses, trade routes and the involvement of 'big business' and control and legislation. Edwards considers key issues such as why do people become addicted, which drugs are most dangerous and what causes a drugs epidemic. The author gives some space to the question of drug use and deprivation and argues that social deprivation 'sometimes' influences drug taking. Edwards chaired the working group that drafted the Advisory Council on the Misuse of Drugs report which for the first time told the government directly that deprivation was a 'strongly relevant item on the drug policy agenda'(ACMD 1998). Edwards describes deprivation as an 'outwardly observable cluster of disadvantages,

deprivation is also an inner state - a chronic not feeling good about one's life position, a sense that other people are doing better and of there being no way out or up.'

The purpose of the ACMD report was to examine drug misuse from an environmental perspective and to make recommendations that would contribute to prevention efforts at a national and local level. The report concluded that deprivation was related to drug misuse in multiple ways and that there is enough evidence to suggest that social deprivation has some statistically significant causal contribution to problematic drug use. However the direction of causation is not always in terms of deprivation causing drug misuse, drug use itself can lead to deprivation. The connection is strongest for the extremes of problematic drug use and weakest for casual or recreational use. Not only might experiences of deprivation in both the individual and community sense lead to problematic drug use, particularly where there are few opportunities to participate in the mainstream economy, but they will also have an adverse effect on user access to treatment and care. The main mechanisms that are described as credible links between deprivation and problematic drug use are:

- Weak family and social bonds
- Psychological discomfort/personal distress
- Low employment opportunities
- Few community resources

Why though is recreational drug use uniform across the spectrum of social advantage and disadvantage while problematic drug use is significantly associated with deprivation? Edwards suggests this is probably because recreational use is perceived as harmless, however where drug use is dangerous or rated as delinquent the privileged will leave them alone whilst the underprivileged have little to lose and may have something to gain; for example, in terms of the economic advantages of dealing drugs or gaining relief by drug use from the frustration with life's lot.

'The social and psychological soil of poverty thus favours destructive drug use...Deprivation affects the way a person will assess the balance between the short-term rewards from drug use and the possible longer-term harm (2004).'

According to Wilkinson's book *Unhealthy Societies* (2001), there is sufficient evidence to suggest that in developed societies 'absolute' material living standards are less

influential than the effects of 'social relativities'. An individual's health is affected by the scale of social and economic differences among the population and ultimately their social position within the population. Therefore relative poverty is a more important indicator of a developed society's health than absolute poverty.

In countries where income differences are large, inequality weakens the social fabric, damages health and increases crime rates. More egalitarian countries with a strong sense of social cohesion, for example through strong community ties, suffer fewer of the effects of inequality. The individualism and values of the economic market in these countries are constrained by a social morality and so these societies have a stronger sense of 'social capital'.

In terms of increasing problematic drug use Wilkinson notes the rapid growth in widening income differences during the 1980s and the rise in heroin use. Adverse socio-economic circumstances may lead to psychological and emotional damage partly through increasing levels of stress brought on by money worries, unemployment and housing but essentially through a lack of choices. The social and economic environment establishes the context in which domestic life has to cope and cannot be separated from a range of what are normally seen as family problems.

The quality of the social life of a society is one of the most powerful determinants of health and this is closely related to degrees of income equality. However income equality is not the only determinant. Also important are psychosocial relationships for the subjective quality of life that people experience. Sources of social stress, poor social networks, low self esteem, and high rates of depression, anxiety and a lack of control all have a fundamental impact on life experience. In this sense 'unhealthy behaviours' such as 'addiction' may in part be explained by the need to consume psychoactive substances for their psychosocial effects, particularly where they are used to counter stress and reduce anxiety:

'The material environment is merely the indelible mark and constant reminder of the oppressive fact of one's failure, of the atrophy of any sense of having a place in a community, and of one's social exclusion and devaluation as a human being.'

Wilkinson argues that the increased need for relaxants where socioeconomic stress is

greatest has not been properly recognised and this need may play a major part in explaining the social distribution of some forms of health-damaging behaviour such as problematic drug use.

Communities and Social Capital

Pearson's (1987) research in the North of England found that the areas that had the most serious heroin problems were in rapid social and economic decline and the housing was described as having a 'hard-to-let' syndrome. Only those with the most urgent housing needs were prepared to move in to these areas and more often these were families or individuals with their own set of social problems, including people with drug-related problems. Pearson describes this as a 'clustering' of social problems that are in part a consequence of the local housing market and housing policies on poor and disadvantaged people. Not only does this clustering mean that there are 'dense concentrations' of potential client groups within an area but also the presence of problem drug users will increase the availability of drugs. In the case of heroin it will be at the lowest level of the distribution chain, the user-dealer networks. Heroin is a commodity and once it becomes available a local distribution network is established.

How deeply a drug market becomes embedded in a local community will depend on a number of factors. Research by May et al (2005) found at least two preconditions for a drug market to become established in a community. The first is where a community is fragmented and disparate with little social capital; neglect and inertia are characteristics that may provide a suitable setting. On the other hand highly deprived but socially cohesive communities where family and social networks are strong may also provide fertile soil for the development of a market, particularly where this suits some members of the community and brings in benefits such as money and cheap goods. While it may be thought that drug markets are destructive and economically damaging they can also bring benefits to deprived communities, for example in the trade of illicit goods that are otherwise unaffordable, as a supplement to the incomes of family and friends, and/or protection from other criminal activity such as car crime or burglary.

Beyond the influence of individual socio-economic status residents of disadvantaged areas experience more social stressors (i.e. more negative life events and conditions) on average than other persons living outside deprived areas. Residents of highly disadvantaged areas may experience greater exposure to illicit drugs and drug dealers,

and greater contact with drug users (e.g. neighbours, friends and family). In addition residents of such areas may also experience exposure to norms and values that tolerate illicit drug use. Referred to as 'collective socialisation' this generally emphasises the independent effect of role models within particular social contexts. In terms of drug related behaviours, high levels of neighbourhood poverty, unemployment and welfare benefit may indicate a limited number of positive social role models and/or limited social networks to mainstream avenues of socio-economic achievement. In addition it is posited that disadvantaged neighbourhoods may have low levels of community organisation or social capital and as a consequence may have less ability than other more advantaged neighbourhoods to counteract collectively the influx of drugs into a community.

The effects of neighbourhood disadvantage are most obvious among low income individuals compared to individuals with higher incomes. Two reasons may explain this: the first is that the geographic scope of a person's social networks varies significantly according to their socio-economic status. Poorer families may have social networks that are more geographically concentrated compared to more affluent persons. Second, income is an important material resource that individuals can draw upon to ameliorate difficult life situations. Income can provide access to a number of mechanisms other than drugs to moderate feelings of depression, anxiety and despair. This suggests the central importance of immediate material resources in helping decrease the likelihood of drug use among residents of deprived neighbourhoods.

On the other hand it is possible that neighbourhood disadvantage does not lead to drug use but that higher rates of drug use in an area may lead to increased levels of neighbourhood disadvantage. As a consequence, high rates of drug use may be one of the primary causal factors driving the decline in neighbourhood socio-economic status. Residents that can afford to move out of a deprived area will leave behind those with fewer resources (Boardman et al 2001).

Conversely research by Lupton et al (2002) concluded that drug selling did not necessarily have a detrimental effect on neighbourhoods. Indeed the impact of heroin and crack markets was varied. In their study of eight neighbourhoods they found no evidence that drug markets were a sufficient pre-condition for neighbourhood decline or depopulation but rather that a drug market tended to be one of a number of neighbourhood problems. However they did conclude that where drug markets were

sufficiently embedded within a local community they were a barrier to regeneration and added to the poor reputation of an area.

Klingemann (2001) examines the environmental context of substance abuse in relation to natural recovery. Substance abuse and recovery from such is embedded within a larger structure of social relations and networks from which helpful resources might be obtained. So just as drug use is mediated by structured relations within which one is embedded, so too are the opportunities for personal change. Opportunities for self-change among heroin users in an inner-city estate will be more constrained than those of the middle class who will have better access to treatment but will also have more social capital that can facilitate change.

Social capital might influence health behaviour in three distinct ways: First, social capital promotes rapid dissemination of health information thereby increasing the likelihood that healthy norms of behaviour are adopted and increasing the likelihood of community members/neighbours exerting some control over deviant behaviour. Second, neighbourhood social capital may influence health by increasing access to local services and amenities which are directly relevant to health. Third, Kawachi suggests 'social capital may influence the health of individuals through psychosocial processes, by providing affective support and acting as the source of self-esteem and respect' (1999 cited Klingemann 2001).

From this perspective the networks and environments in which people are embedded significantly affect their levels of stress, self efficacy and depression, all of which are related to various types of ill health including problematic drug use.

The quality and quantity of social capital that drug users possess assists them significantly in their levels of motivation and attempts to improve their lives. Individuals who overcome a drug problem do so within a context of improved life circumstances and social relations. Klingemann (2001) suggests that a focus on increasing social support services and non-drug alternatives within the community, as well as enhancing personal networks and relationships may help improve life functioning. It is argued that the effectiveness of interventions aimed at constraining drug use depends critically on what other activities and resources are available. 'If the broader environment is bereft of alternative non-drug reinforcers that can compete with drug use, drug preferences will remain high.' Enriching the broader environment

with appealing non-drug alternatives, including opportunities for employment and social interaction reduces the demand for drugs.

Crime and Social Exclusion

The relationship between drugs and crime is one of the central concerns of British drugs research and policy. Reviewing the drugs-crime literature Seddon (2000) outlines three explanatory models: drug use leads to crime; crime leads to drug use and crime and drugs are related to other factors.

In the first model, 'Drugs leads to Crime', Seddon argues that at best this offers only a partial explanation. Unsupported by research this stance fails to acknowledge wider complexities and views drug user-offenders as passive actors. The second model, 'Crime leads to Drugs' has also been criticised for a mechanist causal approach and for being value laden. Value judgements may be at play here as some user-offenders may not be involved in crime prior to drug use and not everyone involved in irregular economies uses heroin or commits property crimes. Within the Crime-Drugs-related to Other factors model, the user-offender nexus needs to be viewed within a wider socioeconomic context that is influenced by subcultures, lifestyles, individual factors such as drug preference and the effects of long term drug use.

A paper by Bresnihan (1999) estimated that 80% of crime in Ireland was drug related and came from five exceptionally deprived areas in Dublin. The paper which focused on young people engaged in criminal activity, identified socio-economic contributory factors such as poverty and lack of educational and employment opportunities. These broadly defined socio-economic disadvantages were compounded by family-based and individualised problems, for instance 'alcoholism in the home, juvenile alcohol and drug abuse, poor parenting including child abuse and neglect, lack of self-esteem, boredom and truancy'. Irish research has been unequivocal in identifying poverty, low social status, school failure, family disruption and large family size as characteristics of young offenders and suggests that persistent serious offending may be associated with quite small, circumscribed communities of especially disadvantaged families to an even greater extent than in Britain (O'Mahoney 1999). However Pudney's (2003) study of data from the 1998 Youth Lifestyles Survey also states a clear indication that social and family disadvantage are the dominant influences on drug use.

A simplified but plausible summary of the motives for much juvenile crime is that it is committed for reasons of material gain, self-esteem, prestige amongst peers or for pure excitement. All of these motives have an important social dimension and are strongly influenced by social contingencies. While it is theoretically possible for parents, who live in very deprived areas, to insulate their children entirely from the surrounding culture, it is very difficult for them to do so. Most children growing up in a deprived city area will be exposed to, and powerfully influenced by, a strong and vibrant local youth culture.

Poverty and the harsh conditions of deprivation place families under significant stress and can undermine the ability and capacity of parents to provide the kind of environment which fosters pro-social behaviour. However, even children who have been well socialized in a conventional way within the family are open to being influenced and persuaded by peer-groups and the powerful subculture surrounding them. This is especially the case if the subculture involves hard drug-taking. O'Mahoney argues that opiate drug use has proven to be very seductive to all sorts of young people from deprived backgrounds due to the fact that the experience of harsh conditions and of a stigmatised inferior social role leads directly to disaffection, anger, boredom and lack of self-esteem, and psychologically prepares the ground for both crime and drug addiction. Drug use, once established, imposes its own exacting and often criminal imperatives on the addicted. While individual and family factors such as an impulsive temperament, low intelligence, poor parental discipline and the inculcation of anti-social attitudes by criminal fathers or siblings greatly increase the risk of serious, persistent delinquent behaviour and drug use, it is necessary to acknowledge that they are not necessary preconditions for delinquency in deprived areas, where delinquency and drug abuse exists. Opiate addiction, amongst lower social class youths, clearly entails a high risk of serious criminal involvement independent of other individual and interpersonal risk factors for delinquency. Furthermore, in marginalised communities, which see themselves as unfairly excluded, the genesis of juvenile delinquency and crime is sometimes less in the failure of socialisation or in a 'criminal personality' than in the fact that the normative moral values of mainstream society are actively rejected by the local peer group and replaced by a different code that tolerates or encourages certain types of criminal activity. In short, deprivation and disadvantage operate in various and complex ways to foster juvenile delinquency and youth crime.

Roberts (2003) argues that the problem use of hard drugs is a social problem, and not merely a pharmacological one. Roberts begins his paper by describing research from the Vietnam war that showed nearly three-quarters of US troops had used heroin to cope with the war experience but as few as between 1% and 3% continued to use heroin after returning to civilian life. The implication is that these soldiers stopped using heroin because their situations changed and that drug use is an 'escape from reality' which will appeal to those 'with the most to escape from' while the risks associated with hard drug misuse will weigh less with people who have the least to lose. His point is that what applies to the Vietnam War will apply to other situations. Roberts argues that a credible drug strategy has to address the social causes and contexts of problematic use which prominent among its causes are 'poverty and deprivation'. One consequence of problematic drug use is 'high levels' of acquisitive crime. Therefore at the centre of any credible crime strategy must be the political will to tackle problem drug use.

Furthermore in terms of the broader social policy contexts it has been shown that increasing numbers of affluent young people are using hard drugs but there appear to be fewer problems among this group as they remain in jobs and have somewhere stable to live. Apart from the fact that their drug use is 'more controlled' there is another point - the current focus of drug policy is on users who are a source of problems for the wider community. Warburton et al suggest that drug dependence is in part, socially constructed - whereby the expectation and belief that heroin use is uncontrollable leads users to abdicate responsibility for their use and they become locked into patterns of destructive drug use (Warburton et al 2005).

Shewan and Dalgarno's (2005) recent paper interviewed a sample of 'unobtrusive' heroin users; that is where patterns of heroin use are relatively non-intrusive to the user and society at large. The sample had higher levels of educational achievement and occupational status than 'typical samples of heroin users' and the authors found that the frequency of heroin use was largely predicted by psychological factors as opposed to pharmacological. They conclude that cognition is as important as drug pharmacology in understanding drug dependency and that the pharmacological properties of particular substances 'should not be assumed to inevitably lead to dependent and destructive patterns of drug use.'

Roberts (2003) states that a credible drug strategy must address the social causes and

contexts of problem use. This means, for example, that tackling homelessness and providing services for sex workers can do a great deal to reduce the damage done by hard drugs, both to users and the community. It means that cutting child poverty and continuing to improve provision for looked-after children is likely to do much more to prevent problem use in the future than putting up posters or doing a talk down at the local school. It means that we should not be surprised if released prisoners who have received treatment on the inside drift back into drug dependency and offending if they are released with nowhere to go, nothing to do and nobody to turn to.

Quoting from key studies undertaken during the 1980s, Seddon's (2005) recent paper makes a case for linking crime with heroin use and explains the direction of causation. First he puts forward Jarvis and Parker's 'economic necessity model' whereby the basic reason for heroin users either starting or accelerating their acquisitive offending is in order to pay for their expensive heroin habit. Auld and colleagues (1984 cited in Seddon 2005) take this model in a different direction and argue that because social security benefits were too low to satisfy basic needs people get involved in the irregular semi-criminal economy in which heroin is another commodity for consumption and exchange. The argument though that 'crime causes heroin use' or 'heroin causes crime' are too simplistic and in this respect Seddon notes three key points: First, there are distinctive local variations in patterns of drug-related crime; second is the importance of availability through the supply and distribution systems and the introduction of cheap smokeable heroin; and third the studies showed that the new phenomenon of heroin-related crime could not be understood without setting it in the context of the irregular economy in a period of economic recession and high unemployment.

In the second part of his paper Seddon links the drugs-crime research with criminological theory with the aim of showing how social and criminological theory can be used to enhance and further our understanding of the issues involved. He looks at three key areas: the theory of action, globalisation and historical perspective.

Employing the concept of social capital Seddon reminds us that individuals are social actors and that they operate (and therefore need to be understood) in the context of their relations with family, friends, neighbours and so on. In a 'deprived' neighbourhood, the central structural mechanism is the irregular economy and it is here that drugs and crime often come together as responses to a lack of opportunities

in the legitimate labour market. Involvement in drugs and crime is described in these studies very much in terms of active engagements with the irregular economy, hence the idea of involvement in heroin representing in part an 'active solution to the problem of unemployment'. However not all people faced with the same socio-economic disadvantages will make the same choices about drugs. Some will abstain altogether, some will use recreationally and a sub-group will become involved in problematic use. In other words, the stresses imposed by structural difficulties are experienced by individuals in a subjective and personal way and as a consequence individuals will respond differently to the structural difficulties they face. For some, the experience of social exclusion will be experienced as a form of 'psychological burden', for others, their response may be more directly emotional—anger, resentment, desperation or humiliation. The nature and strength of these feelings may relate in part to personal biography, life stage and specific life event. The next step in the argument is critical. These differential responses are not explained simply as individual psychological or emotional reactions, they are also mediated by culture. Pearson observes, for example, that the 'psychological burden' of unemployment is partly related to the removal of the culturally created time routines of factory and office work. Involvement in the irregular economy—and in drugs and crime—is not therefore solely an economic response to limited legitimate opportunities; it is also a cultural response that seeks to create a meaningful daily structure and identity.

Drug consumption is dependant upon drug supply hence Seddon argues for the importance of considering globalisation to further our understanding of the drugs/crime nexus. The smuggling and trafficking of drugs across borders and the connections between large-scale drug trafficking and money-laundering operations will have a 'significant impact' on drug production which further down the supply chain will affect patterns of consumption. Furthermore the impact of global capitalism is powerfully felt at a local level, shaping the uneven distribution of life chances and economic opportunities. It is this differential impact on social and economic relations between and within different localities that is strongly linked with the clustering together of problems of drugs and crime in neighbourhoods suffering from multiple social problems.

From the historical perspective Seddon reiterates the view that the relationship between drugs and crime varies over time. A critical concept within this strand is the concept of 'consumption.' It has been argued that the post-war emergence of consumer capitalism is closely linked with an increase in recorded crime from the 1950s

to the mid 1990s. He further evidences the work of Young who suggests that the shift away from production and towards consumption has 'generated an increased sense of relative deprivation amongst some of those at the bottom end of the class structure which has fuelled crime.'

A second issue is the association between certain drugs and criminality which are seen as 'natural' rather than historical. One argument is that this is part of a wider process of social constructions of drug problems which has tended to focus primarily on socially disadvantaged groups which fits with the broader ideas about the 'criminalisation of the poor' and the ways in which the criminal law and penal responses tend to focus most on the activities of the socially and economically disadvantaged.

Seddon argues in his conclusion that locating the issues of drugs and crime in its social context and by connecting it with social theory can lead towards a more incisive analysis of the problem leading in turn to a more effective, progressive and informed response.

Predating the work of Seddon and Roberts, Foster (2000) draws upon the experiences of a run-down housing estate in the North-east of England to explore the relationship between social exclusion, drugs and crime. Using evidence from the Audit Commission (1996 cited in Foster 2000) Foster states that 40% of offences occur in just 10% of areas with the worst rates found in the most deprived communities. Acknowledging that the links between drug use and crime is not a linear process Foster nevertheless argues that among the minority of problem drug users, drug and crime careers often develop along parallel lines that are 'mutually sustaining'.

While it is difficult to establish a causal link between crime and poverty, research suggests there is a relationship between youth unemployment and crime. In areas with widespread youth unemployment mirrored with high rates of crime, young men are unable to make the status transition into adulthood as they lack the key social structures of employment, marriage and fatherhood however a large body of the research into offending among young men leads to an 'inevitable link between youth, crime and an underclass.'

Returning to a previous geographical area of research Foster found that social exclusion and deprivation were still very much in evidence. Situated in one of the 44 most

deprived local authority districts and in a ward ranked in the worst 5% on work poverty, the housing situation in this area was bleak indeed. High levels of crime and drug abuse combined with high levels of truancy, poor health and unemployment were endemic. Housing turnover within the estate was very high and no housing points were required to be accommodated in the most notorious tower blocks which were dominated by drug dealing, petty crime and nuisance behaviour. Added to this some workers suggested the residents' problems were intrinsically linked with 'generational welfare dependency' whereby familial experiences of poverty and deprivation shaped attitudes and expectations.

Written in 2000 the article is optimistic regarding the work of the Social Exclusion Unit and government investments in addressing the drug problem at that time but does little to add to our knowledge of the links between drugs, crime and exclusion. Citing the 'individual' versus 'structural' approaches to explain the position of the poorest and most marginalised in society Foster states there are no value-neutral positions in the debates concerning the cause of exclusion.

Welfare Reform

Close to a million people in Scotland experience poverty. One in four of them are children. The groups who are at risk of poverty change over time and we have seen pensioner poverty fall in the last 10-15 years, while poverty amongst working age adults has increased. The risk of poverty amongst children is highest in lone parent households, families with no adults in employment and households with young children. However a quarter of working age adults living in poverty are in childless households where at least one adult works. People with disability face a higher risk of poverty and poverty can contribute to mental distress and less favourable health outcomes (McKendrick et al 2007).

The government's approach to poverty has been to see it primarily as a result of exclusion from paid employment so that work is viewed as the key route out of poverty. However, although work may reduce the risk of poverty, it does not eliminate it. It also does not do enough to address the position of individuals who cannot work or cannot gain employment. Current policy often presents poverty in a way that focuses on individual failures, for example "failure to engage in paid work or to fulfil parental or familial responsibilities". The stigmatisation and even demonising of poor people or groups of poor people can have the effect of making poverty a residual or marginal

issue to more significant 'social problems' facing society. In such an approach, instead of identifying and addressing critical underlying causes of poverty and deprivation, the focus is on the individual behaviours of a recalcitrant minority.

Current policy continues to view work as the key route out of poverty and the government has introduced a range of reforms to taxation and benefits to make work pay, including the introduction of Tax Credits that can help parents with the cost of childcare in prescribed circumstances. Plans have been announced recently to increase the groups of people who are drawn into compulsory activation measures. In the Welfare Reform Bill, the government's plans to reduce the numbers of people out of work and receiving incapacity benefits have raised concerns for people with health and impairment issues. The government also intends to move further along the road of compulsory work activation measures for lone parents who are claiming benefits. There is greater recognition now than in the past of the range of personal, financial and social barriers that individuals have to overcome in moving towards work, yet

“The difficulty when looking at poverty and employability in relation to problematic drug use is that we still view drug dependency as either a disease which needs curing or a deviant criminal activity from which society requires to be protected.”(Liddell 2007)

Drug dependency can easily place people within the 'recalcitrant minority' that are the increasing focus of welfare policy, yet they are amongst the groups of people who face the most significant social barriers to achieving employment. The issues of employability and drug use are discussed in more depth in the next section.

Employability

Welfare-to-work programmes such as the New Deal are considered key government responses to addressing poverty with specialist programmes, such as Progress-2-Work, developed to encourage people with a drug problem to move towards the labour market. Some studies have examined these new training, education and employment responses, aimed at moving people with a drug problem into the labour market.

A British wide study by Cebulla et al (2004) looked at the support needs of substance users (drugs and alcohol) and sought to estimate the number and describe the demographic and socio-economic characteristics of substance users claiming social

security benefits and living in private households. Their study covered three areas: a review of the international literature covering barriers to work and initiatives to assist into work; secondary analyses of the British Crime Survey (BCS) and the General Household Survey (GHS); interviews with 10 treatment organisations and 30 drug or alcohol users.

It was estimated that, in 1998, approximately 120,000 claimants of Jobseekers Allowance or Income Support and about 150,000 claimants of sickness or disability benefits living in private households engaged in heavy or problematic drinking (men consuming over 50 units of alcohol and women over 35 units per week). Using BCS data covering private households in England and Wales (but not Scotland), approximately 39,500 individuals potentially claiming benefits had been using Class A drugs in the month before the study with 27,500 using one or more Class A drugs. Approximately 51,000 potential benefit claimants were estimated to have been heavy drinkers while at the same time consuming Class A or Class B drugs.

Although the GHS and BCS surveys are not specifically designed to study benefit claimants, two estimates, based upon and extrapolating data about substance treatment contacts, suggest that the number of drug users in receipt of benefit in England and Wales was closer to 270,000. Cebulla et al (2004) point out that this estimate captured individuals living in communal establishments as well as in private households and being based on treatment registrations, it did not face the problem of non-reporting to the same extent that household surveys, such as the BCS, do. Therefore, all estimates outlined by Cebulla et al (2004) should be seen as complementary and partially overlapping.

Substance users actually or potentially in receipt of benefits and living in private households tended to be largely young men between 18 and 24 years (18-34 years, in the case of drug and alcohol users). Other noted characteristics were that alcohol users in receipt of benefit and in private households were disproportionately likely to live in the North of England or in Scotland, while Class A core drug users were disproportionately likely to live in the North or the South of England. Most drug users potentially claiming benefits were single and never married (Class A core drug users) or living in one-person households (drug and alcohol users). The latter group often lived in areas described as places 'where people go their own way' rather than where people 'do things together and try to help each other'. Alcohol users on sickness or disability

benefits often lived in households with multiple, but unrelated members and tended to smoke cigarettes. Although substance users tended to be poorer or have lower educational qualifications (compared to the total working-age population) these characteristics did not significantly set them apart from other actual or potential benefit claimants - most differences were explained by their younger age. Drug users and users of drugs and alcohol were, however, more likely than other potential benefit claimants to have been arrested, called before a criminal court or to have been in contact with the Probation Service (Cebulla et al 2004).

Psychological and physical health problems, whether acting as a trigger to substance use or as a consequence of it, continued to be present during recovery and health problems were the most immediate barrier to (former) substance users' ability to work and to sustain work. Psychological problems were particularly prevalent among alcohol users. Eroding social networks, homelessness, living in adverse social environments, low confidence or fluctuating motivation to resist 'addiction' and to take steps to change one's lifestyle, were other key barriers to searching for and obtaining a job, according to Cebulla et al (2004). Educational and occupational qualifications among substance users claiming/potentially claiming benefits were low with literacy and numeracy problems prevalent. Although substance users expressed modest employment goals, including advocating education, training or re-training, they also viewed interrupted work histories, CV gaps, and the need to disclose health problems/criminal records to employers, as the greatest barriers to work.

Mistrust of government offices, including Jobcentres, was frequently mentioned by substance users interviewed by Cebulla et al (2004) and drug treatment service providers were viewed as a means to build trust between substance users and employment service providers. Substance users and treatment service providers both emphasised the need for employment service providers to understand the multiplicity and diversity of problems faced by (former) substance users, and the benefits of case management. They also argued for a stepped (re)integration of substance users into the primary labour market, involving the private, public and voluntary sectors, thus allowing them to progressively adapt to work. Substance users and treatment organisations also agreed that, before entering employment, substance users needed to have stopped using drugs or alcohol completely but there was disagreement among substance users as to whether they should, also, first stop using substitute drugs (Cebulla et al 2004).

In a study into employability and problem drug users in Scotland, Kemp and Neale (2005) argue that many people seeking help from drug treatment services suffer from serious health and social problems that need to be addressed before employability programmes can be considered. Drawing from a sample of 559 drug users seeking help from treatment services in Scotland, Kemp and Neale (2005) note that drug users may not easily fit into the concept of 'work for those who can, security for those who cannot'. Although this sample was mostly of working age and almost universally eligible for one or more of the New Deal programmes, the overwhelming majority were largely detached from the formal labour market - 95% had received some type of welfare benefit in the last 6 months and only 4% were in paid employment at the time of interview. There was no reference in the study as to whether any of the samples worked in the informal economies.

Besides distance from the labour market, Kemp and Neale echo the study by Cebulla et al by citing poor physical and mental health as a barrier to securing paid employment. Using a questionnaire covering eight dimensions of well being, drug users scored significantly lower in all dimensions compared to the UK norms from a working population study. This has lead Kemp and Neale (2005) to argue that "It is clear from these figures that the health of problem drug users is very poor indeed and thus extremely likely to have a negative impact on their ability to work." Other employability barriers referred to include:

- The impact of drug intoxication and withdrawal symptoms on employability work
- Restriction placed by daily visits to pick up methadone from a pharmacy
- Discriminating employer attitudes towards drug users
- Past convictions or present criminal justice involvement such as a pending court case, outstanding warrants or unpaid fines
- Homelessness including 'hidden homeless' such as living with friends or relatives.

Kemp and Neale (2005) believe these barriers illustrate why programmes such as the New Deal, Progress 2 Work and the New Futures Fund are unsuitable and that "most [drug users] also seem a long way from even being 'education and training ready'" They argue that strategic priorities should focus on tackling and addressing their

dependency and related problems through more drug treatment services, such as substitute prescribing and residential services and ensuring that criminal justice interventions do not further criminalise drug-using offenders. They suggest restorative justice initiatives as an alternative to custody. Preliminary activities may have a stabilising role to play before other employability routes are considered such as employment 'taster' days, literacy and numeracy skills, voluntary work or sheltered employment in addition to the need to also educate employers.

Employers' attitudes to hard-to-employ groups, such as ex-drug users, the homeless, those with mental health problems, ex-offenders, lone parents, and those with disabilities have been explored in a study by Scott and Sillars (2003). Their survey of 33 employers, covering two Social Inclusion Partnerships in west Glasgow, examined their experiences and attitudes to employing the above hard-to-employ groups.

A high proportion of employers surveyed (28 out of 33) reported employing one or more from the hard-to-employ groups. However, only one employer had staff known to have a history of substance abuse and no employers had anyone known to be on a methadone programme. Moreover, Scott and Sillars (2003) uncovered significantly negative attitudes towards drug users. Although one third of employers would happily employ someone recovering from substance abuse (same figure for a mental health problem), less than one third would employ an ex-offender or someone on a methadone programme and 70% were "absolutely certain they would not employ someone on a methadone programme."

Over half the employers surveyed by Scott and Sillars (2003) saw no benefits to employing hard-to-employ groups. However, a list of support for employers included financial support to ease the extra risks employing hard-to-employ groups, provision of job readiness and skills training, resources for staff training and a 'get out clause' if employers did become involved. To address the employers' fears, Scott and Sillars (2003) specifically recommend that job seekers are supported to develop soft skills sought after by employers such as application forms, job interview skills and piloting mentoring schemes. To reduce employer resistance, Scott and Sillars (2003) conclude by suggesting a range of initiatives such as networking with employers to start the cultural shift required, providing them with more Human Resource support and training, assist small companies during recruitment interviews and piloting partnerships that offer job retention services such as intense support in the form of childcare,

transport, housing and counselling to help employees retain their employment once recruited.

In a wider study in the north west of England, Klee et al (2002) examined individual and systemic barriers faced by recovering drug users and ex-users looking for work. Their study revealed that the preferred option of drug users when joining an employability scheme was not to get a job but non-vocational activity aimed at self improvement and that drug relapse was viewed as a serious risk if welfare benefits were stopped and had to be renegotiated during a period of facing failure and experiencing low confidence. Although most drug users reported positive feedback of Education, Training and Employment (ETE) services, they were also frustrated by a lack or delay in accessing ETE spaces, travelling long distances and fear of failure because of a criminal record.

Barriers reported by ETE staff included a lack of client commitment, chaotic lifestyles, a lack of qualifications and a criminal record (Klee et al 2002). Other identified ETE staff barriers were not being able to identify clients who had a drug history, a lack of coordination linked to referral systems and waiting lists for ETE and drug treatment services. Confidentiality and agency competition within a free market to attract clients were considered major barriers and with ETE services required to meet funders' target outcomes, which in some cases was no more than the number of referrals each month, there was pressure for a fast throughput to achieve targets as time-limited grants might not be renewed. Klee et al (2002) point out that most ETE advisers disliked this pressure and preferred 'softer' targets such as improving clients' quality of life, self-discipline, time management and bringing about a more positive sense of self worth and confidence.

Employers tended to view drug users as being more likely to be unreliable, untrustworthy and unsafe but, according to Klee et al (2002), employers also viewed soft drug use separately - largely to be expected from young employees. This view has led some employers to deem those with a history of drug problems requiring placement in low risk work.

Although the North American practice of drug testing was rare among surveyed employers and not popular with management it was still under consideration by several larger companies and company size appeared to influence policy - the larger companies with occupational health departments were more likely to have standard recruitment

and disciplinary procedures that dealt with employment of drug users and ex-offenders. With employer prejudice unanimously acknowledged by ETE staff as a difficult barrier to overcome, few staff directly approached employers but instead supported their clients with tasks such as job applications, writing curriculum vitae and interviewing skills.

The main barriers highlighted by Klee et al (2002) were defining exactly what employability and rehabilitation mean, funding issues and competition, support for ETE staff and employer participation. Key policy implications were:

- The need for confidentiality issues to be addressed and a debate on the meaning of 'readiness for work'
- Understanding the role of drug treatment among ETE services would help to establish a working relationship and relapse prevention/identifying relapse risk factors should be an important element in a system of aftercare
- Simplistic targets within a free market, competitive culture of short-term funding is at odds with the need to incorporate lengthy, therapeutic interventions for problem drug users
- Some modification to the rules governing benefits should encourage users to engage fully in ETE schemes
- There was a high ETE staff turnover and poor staff support in undertaking this demanding and stressful work which involved responding to delays within complex referral systems. Therefore, faster access to information is required and monitoring outcomes focussing on completion rates and client satisfaction may yield information that could contribute to a view of 'what works'.
- Access to treatment options and waiting lists for Community Drug services should be available and interagency communication could be initiated through informal gatherings/conferences that would support staff morale and lead to the sharing of experiences. This has led to Klee et al (2002) suggesting that a neutral coordinator was needed to develop links across services.
- With little employer enthusiasm for the New Deal, problem drug users with a criminal record were likely to be unwelcome applicants. However, in contrast to the significant employer prejudice towards drug users in the

Glasgow study by Scott & Sillars (2003), employer prejudice in northwest England was, according to Klee et al “not extreme” and special measures aimed at reassuring them should be developed that allow for supervision and monitoring of progress.

Women and Drug Use

In the main, research has concentrated upon drug users in general and it is in a minority of papers that research has explored the impact of drug use solely on female drug users.

One of the first ethnographic studies of female drug users was undertaken by Avril Taylor (1998) in the late 1990s. Using participant observation and interviews Taylor examined the lifestyles of female drug users in Glasgow. Refuting the stereotypical image of female drug users as ‘inadequate individuals’, the findings showed that these women were in fact capable of making pragmatic, rational decisions based on the contingencies of their life experiences and far from being chaotic and disorganised, the participants lives required careful planning, structure and decision making. The community in which the women lived was characterised by high rates of unemployment and poverty; although none of the participants were employed in the formal economy many of the women had held down jobs that were low paid, low skilled and in the service or manufacturing sectors.

Echoing the findings of Pearson (1987), Taylor’s findings showed that women could glean many benefits in the initial phase of their drug use that afforded them improved economic independence and social status within their community. The women were involved in a number of money-raising activities that included drug-dealing and the selling on of shoplifted household goods. As with May’s (2001) findings the distribution of stolen goods within an impoverished community was an important source for cheaper consumer goods. A career in drug use provided them with “conditions not ordinarily encountered in traditional working class female occupations...In the social environment in which these women lived, the chance of their finding a legitimate occupation with similar benefits was scarce.” Nevertheless while drug use had a number of benefits at the beginning of their drug using careers as their use progressed the drawbacks began to outweigh the benefits. Taylor (1998) argues however that while the disadvantages of drug use were increasingly evident they were not of sufficient strength to ‘lure’ the women away from their established ‘careers’. The lack of alternative options and

means to restructure their days was a disincentive to establishing a drug-free lifestyle.

In 'Doing Gender- Doing Drugs', Measham (2002) argues that gender is no longer the protective factor in relation to drug use that it once was. Citing quantitative research Measham states that the gender gap in terms of UK drug prevalence is narrowing with increasing numbers of young women experimenting with illicit drugs throughout the 1990s. Despite this apparent decrease in the gender gap in terms of self-reported drug use, Measham (2002) suggests that gender remains important to our understanding of drug use in the 21st century.

Although there is some convergence between male and females in adolescent experimentation and use this is superseded in young adulthood by the gendering of their lives in terms of paid and unpaid work, family, relationships, leisure, lifestyles and identities. Furthermore there is evidence that an 'understanding and accommodation' of illicit drug use is spreading across a range of social groups, including those who were previously considered less likely to be involved in drug 'subcultures' such as people from the middle classes and minority ethnic populations, thus leading to the "normalisation" thesis. In terms of drug use the normalisation thesis describes recreational drug use as moving away from a marginal, sub cultural status toward the mainstream of youth culture; and suggests a cultural shift in terms of drug-related behaviours and attitudes for both users and non-users.

Quoting from three UK studies undertaken in the 1990s, these appear to show that while more young women than men are offered and experiment with illicit drugs in their early teens, by mid-teens young men 'catch up' and by adulthood start to 'overtake' women in terms of experimenting with illicit drugs.

Measham (2002) is critical of the focus on quantitative data and argues that this has been to the 'detriment' of a deeper understanding of the socio-cultural changes in terms of drug use and the gendering of drugs cultures. Prior to the 1980s there was very little research on women and drugs and that which existed mostly focussed on dependency and problematic use with female drug users fitted into the wider criminal discourse and portrayed as 'mad, sad or bad.'

By the 1990's, research such as Taylor's (1998) had moved from this stereotypical image of women and attempted to explain women's drug use in terms of notions of

'agency'. Thus women drug users moved from the marginal label of the addict 'out of control' to being mainstream consumers in society. This notion however needs to be viewed within the context of increasing illicit drug use characterised as 'recreational' rather than 'problematic' and secondly in the move from drug use characterised as a marginal activity to one that has become mainstream and part of everyday life. This move can be considered 'part of the repertoire of leisure "lifestyle" and consumer choice available in the legal and illicit economy to both women and men.' Measham (2002) argues this change in drug-related attitudes and behaviour of the 1990s and into the millennium is clearly linked to the socio-economic changes for women. But while there have been increasing educational and employment opportunities for some women there still remains intransigent horizontal and vertical occupational gender segregation and the differential impact of socio-economic changes on different sections of society means that choice, including choice in relation to drug use is 'not equally shared' by all those within and on the margins of society. Within the illicit drug economy women's roles mirror those of wider society; they are invariably employed at the bottom of the drugs supply hierarchies (e.g. as low-level dealers, mules or sex workers). Therefore it can be argued that the illegal drugs economy is a 'gender-stratified labour market with constraints, norms and cultures similar to those of the formal economy.' And women remain in large part at the bottom of the structure.

Powis et al (2000) undertook a study of 66 female opiate users with children with the aim of examining their patterns of drug and alcohol use, their social and economic circumstances, criminal involvement and health problems. The authors reported that almost all the women were living in a state of poverty with only six per cent in paid employment, whilst one third reported criminal activity as their main financial support during the month prior to interview; 91% had had at some time contact with the criminal justice system. Consistent with other studies, one third of the women reported a violent partner. And nearly half the women had received treatment for psychiatric problems.

The women in the study reported a wide range of problematic drug and alcohol use and other problems. The majority of the study sample were poly drug users and between them they had a mean number of two children per household. Although only two of the women reported injecting in front of their children 55% reported that their children were aware of their drug use.

A great deal of concern has been raised over the last few years of the welfare and safety of children of drug using parents and the rhetoric employed by commentators and academics has important implications with regard to the welfare of the children. In this study and elsewhere it has been reported that many drug using mothers indicate a state of conflict regarding both their dependence on drugs and their fears that their children may be taken into care. On the one hand the women in this study thought that seeking treatment would help them avoid having their children taken into care but on the other hand they were afraid that by seeking treatment they would increase the risk of their children being removed from their custody. There is a 'fear'; among women drug users that professionals working with them will view drug use as an 'automatic indicator of their unfitness as a mother.' This is a catch 22 situation that is one of the most important barriers to drug-using mothers seeking help and this barrier to treatment must be reduced.

Many women drug users lack access to social and economic resources which would help get them out of abusive and chaotic situations and as such Powis et al (2000) argue that the poverty of the women in this study and elsewhere should be seen as a 'very real obstacle' to an improvement in their and their children's situation.

While this section is limited in its scope the papers reviewed highlight the need for alternative options for women involved in problematic drug use. While the link between poverty and drug use is not straightforward and lines of causation can be debated it is clear that for those women who live in poverty and are also problematic drug users the opportunities to remove themselves from their lifestyles are few. Where children are involved the problems are compounded by the fear of losing their children through their removal by social services. The rhetoric of some has been to highlight the welfare of children with drug-using parents in the most extreme terms in the popular press which does no favours to services attempting to meet the needs of parents and mothers specifically. Over recent years there has been an increase in parenting skills programmes and women who are pregnant or have children have quite rightly been prioritised for access to community treatment; however while some continue to publicly call for the removal of children from drug-using parents the reluctance of some of these parents to come forward for treatments through fear of losing their children will only serve to worsen the situation for the children, parents and wider family.

Black and Minority Ethnic (BME) groups

Black and minority ethnic groups (BME) are under-represented among the population of known problem drug users despite BME experiencing high levels of social exclusion in terms of poverty, housing deprivation, educational disadvantage and unemployment. Pearson and Patel (1998) conducted a study in 1998 of an outreach project in Bradford which found that despite a sharp increase in Asian heroin users during the early 1990s, they remained under-represented among drug service clientele. Staff at the outreach service found that heroin use among the Asian community was highly stigmatised and as a consequence users tended to be secretive about their use. However in line with earlier work, Pearson and Patel conclude that drugs and deprivation were ‘becoming defining issues’ for Britain’s Asian communities.

A report by the European Monitoring Centre for Drugs Drug Addiction (EMCDDA 2000) attempted to map the available information in the EU member states on the relationship between drugs and deprivation focussing on minorities. The report concluded that there was very little research being carried out in this area and that in some countries (with the exception of the UK and the Netherlands) there was no available data concerning drugs and minority groups. The authors recommended that future work should include data collection and analysis, the development of tools for evaluating the needs of minority groups in respect of drugs and social exclusion, and work around demand reduction and policies that integrate within them aspects of minorities and drug use.

Reid et al’s (2001) review of published literature argues that BME vulnerability to illicit drug use was not due to characteristics of ethnic identity but to social and economic disadvantage brought about by language difficulties, high unemployment, inadequate education and cultural pressures. A combination of these factors rendered BME individuals less able and sometimes less willing to utilise drug services. Utilising the results from their own research in Victoria (Australia) the authors contend that the risk factors of any cultural group’s vulnerability to illicit drug use is young age, strong peer influence, high youth unemployment and poor literacy. Add to this the ‘socio-economic handicaps of an ethnic minority and the tendency are exacerbated.’ Similar to the EMCDDA report (2000) the authors acknowledge there remains a significant gap in our understanding of the relationship between BME and illicit drug use.

A UK research review (Barn 2001) of black youth suggested that drug services which were proving successful in attracting black clients had considered issues of black

community perceptions of problem drug use for individuals, families and the community. In addition appropriate prevention strategies supported locally, awareness raising, and the identification of appropriate methods of delivering services and support were recommended approaches. Barn goes further however and states the importance of further research into the nature and extent of problematic drug use among BME 'to combat misplaced complacency that may exist in this area.'

More recently the Centre for Ethnicity and Health (Bashford et al 2003) presented the findings from 51 needs assessment reports carried out by 47 BME community groups on drug education, prevention and treatment issues. The findings from the needs assessments highlighted a number of important issues which included:

- Low levels of awareness and knowledge about drugs
- The impact of drug use on families (lack of knowledge about services confounds the problems)
- Deprivation, disadvantage and discrimination increasing the risk of developing drug problems
- Community fears regarding crime and drug dealing
- Low levels of awareness and knowledge about available drug services are a fundamental barrier to accessing help and support.

This report is important for two reasons: firstly it provides a substantial understanding of the issues relating to drug use within BME communities and secondly, it offers a model of community engagement and community led approaches to needs assessments that acknowledges the voices of the communities.

Clearly the links between BME, drugs and deprivation are even less clear than that of the wider drug using population, it is therefore important that any future research that attempts to explain the links between poverty, exclusion and problematic drug use should acknowledge within its methods an awareness of BME communities.

Rural areas

Forsyth and Barnard (1999) conducted a comparative study of 2558 schoolchildren, age 14 - 15, attending urban and rural comprehensive schools in two areas of Scotland. The hypothesis that urban deprived areas should have higher drug use prevalence than affluent rural areas was not borne out by the results of their research. The results found that children in rural areas were as likely to have tried drugs as their counterparts in urban areas. Conversely Harrop et al (2002) conducted a comparison of indicators between 'remote rural', 'accessible rural' and urban areas and established that drug 'misuse' was worse in urban areas.

Pavis et al (2000) looked in-depth at the experiences of a sample of 18 - 25 year olds in two rural areas in Scotland. The authors found that social networks were a key way of accessing employment and housing however these networks were restrictive should individuals gain a 'bad' reputation through personal difficulties such as illicit drug use, criminal activity or mental health issues. Simply getting a job was not enough to avoid social exclusion and lack of diversity within local labour markets was a major issue for the young people interviewed. Young people who had not accessed higher education found themselves in poorly paid, low-skilled work which in turn excluded them from owner-occupation. Added to this many were not deemed 'high priority' on the housing allocation lists and so access to public housing, which in itself was limited, was difficult.

Two further reports recently published on rural poverty made reference to drug use within the context of community concerns. The authors of a report exploring deprivation and social exclusion in Argyll and Bute reported concerns among residents of Campbeltown at the high levels of alcohol and drug misuse among young people. This was seen to be 'directly linked' to lack of amenities and poor job prospects within the area and also residents within a Social Inclusion Partnership area of the town believed the local housing department were using empty properties to house vulnerable and problematic residents, such as drug users (Bailey et al 2004). In Wales, a report identified similar issues. Parents strongly expressed fears about the impact of drug use within their communities. It was reported that even in the smaller communities drugs were a problem and lack of facilities was a priority for every community group visited by the report's authors (Sharpe 2003).

The Effective Interventions Unit (EIU) in Scotland published a report in 2004 with the

aim of providing evidence and information to support the development of services for drug users in rural and remote areas (EIU 2004). The review was informed by a qualitative study that included the views of service users, providers and commissioners on the provision of services in four rural or remote areas in Scotland. The study suggested that while there was a level of under-reporting in these areas the levels of problematic drug use was less prevalent than in urban areas. However alcohol use and its attendant problems far outweighed problems relating to illegal drug use although the experiences of staff working with problem alcohol users and illegal drug users were similar.

Service providers interviewed for the study felt that there was an inclination to deny the 'existence of drugs problems' in rural and remote areas and this was more likely in more affluent areas. Moreover they felt that it was difficult for service users to maintain anonymity and confidentiality in tight-knit rural communities although these fears did not act as a disincentive for drug users to access services. Public transport was infrequent, costly and presented logistical problems which made it hard for service users to keep appointments which could lead to problems with the service providers. Therefore support from family members with transport was crucial to minimise transport problems.

The links between rural poverty and problematic drug use have clearly not been explored in any depth within the literature identified in this review. While an understanding of the links between urban poverty and drug use is elusive a similar understanding of the issues in rural communities is practically invisible.

Policy Implications

A key aim of this literature review was to look beyond traditional health, social care and criminal justice responses to drugs by exploring the wider relationships involving poverty, social and economic inequalities and their implications for current drug policy. A central message emerging from this literature review is that although there appears to be no direct causal link between drug-related problems and poverty per se, the current evidence demonstrates strong associations. Despite these strong associations, over the last 10 years the UK 'drug problem' has been increasingly reframed as a 'crime problem' - part of a growing trend towards the 'criminalization' of a range of policy areas such as youth work and urban regeneration (Duke 2006). By prioritising these policy areas in relation to their crime control potential, a range of inequalities are being exacerbated.

Scotland has one of the highest rates of population experiencing drug-related problems in the European Union. Because of the significant association of drug problems with poverty, addressing wider inequalities in areas such as housing, income, education and wellbeing can play an important preventative role in reducing the prevalence of future drug problems.

Problem drug use and the individual: some policy implications

- It has been suggested that medical, social work and criminal justice professionals have a "dependence on a steady supply of addict-victims" (Pryor 2006). Yet, Taylor's (1998) study of female injecting drug users in Glasgow did not find the "inadequate" and chaotic stereotype but discovered women capable of making pragmatic and rational decisions based on their life contingencies. Revisiting contested definitions such as 'addiction', 'problematic drug use', 'chaotic/stable' may help shed further light on our current assumptions, values and responses to individuals.
- The views of people using or affected by drugs are not a single voice and may be as contestable or illuminating as existing definitions and explanations of drug use. Further ways of encouraging expression of the many voices - rural, minority ethnic, fathers, those not in treatment and also non-drug using partners - are needed as

the concepts of personalised services and choice climb up the policy agenda. For example, what does ‘choice’ mean to people on a day-to-day basis?

- Media and policy debates have focused on drug-using parents as a major risk group, yet a widely unreported study examining calls to Childline Scotland, between 2000 and 2003 concluded that there should be a re-focusing on alcohol misuse issues for families in Scotland as these represent three times as many calls from concerned children as those about drugs (Ogilvie et al 2005).
- With children’s needs being paramount there is scope for debate around two emerging welfare themes: the rising poverty among working-age adults without children (i.e. potential future parents) and resourcing kinship care (e.g. grandparents looking after grandchildren). Redressing the balance from managing risk among families towards wider welfare reform may reduce future harm and strengthen family resilience.

Problem drug use and wider factors: some policy implications

- A recent social housing report predicts that the number of council and housing association homes in Scotland may drop by almost 70% by 2020, which may lead to a further increase in highly concentrated ‘poverty clustering’.³ This changing housing market may lead to those with urgent housing needs, such as problem drug users, being clustered in fragmented, hard to let areas thus fuelling local ‘drug’ economies. To reverse this clustering may require an increase in public/council housing provision in Scotland.
- A policy response to drug-related crime has involved coercive elements being introduced to health and social care sectors, such as Drug Treatment and Testing Orders, and care elements being introduced to police operations, for example, police custody suites offering needle syringe facilities. Yet, the drugs-crime relationship is complex as highlighted by the three competing models of explanation in the literature review. Therefore, the interplay between local ‘drug economies’ and other factors such as housing markets, long-term unemployment, and low benefit levels should be considered.

³ The Future for Social Renting in Scotland - Discussion Paper: A report for the CIH in Scotland (2006) <http://www.cih.org/scotland/policy/future-social-renting.pdf>

- With around 300,000 people claiming Incapacity Benefit (IB), the caseload in Scotland is changing. It is becoming younger with reported health problems shifting from “bad backs” towards mental health problems including alcohol and drug dependency (Fothergill 2005). Therefore, there is a need to improve upon the limited welfare data on drug users in Scotland.

- Over the next ten years, a key welfare-to-work aim is to get one million people in Britain off Incapacity Benefits. From a “fit to return to work” perspective, Hepatitis C figures may shed some light on this challenge which will require crossover public health work. For instance, in Scotland it has been estimated that up to 50,000 people have Hepatitis C and a possible 33,000 with a drug history may have mild to severe liver cirrhosis (Health Protection Agency et al 2005). Furthermore, a recent study revealed that people with Hepatitis C experienced a range of general health problems with physical tiredness and irritability the most commonly reported symptoms (Lang et al 2006). Just over 20,000 have been diagnosed with Hepatitis C, with potentially a large number of them experiencing health problems that could be inadvertently assessed by employment advisers as “a lack of motivation”. Therefore, this unfolding Hepatitis C epidemic will present a range of ‘fit to return to work’ challenges requiring improved working links between the Department of Work and Pensions and NHS services.

- The total costs of mental health problems in Scotland in 2005 were estimated at £8.6 billion.⁴ There is a need for a similar analysis by drug policymakers to recognise the “real” social and economic costs of problem drug use in Scotland, such as wasted individual potential and opportunity, ill-health and death.

- With kinship care (a child being fostered or cared for by a relative or friend) an emerging policy area in Scotland, a study published after this literature review was completed noted that carers experienced difficulties in the transfer of child benefit books, social work staff resented having to temporarily adopt a benefits agency role and carers received uneven payments compared to others receiving foster carer allowance. According to the report’s authors (Aldgate and McIntosh 2006) it may be worth exploring the payment of an allowance to kinship carers through the tax and benefits system.

⁴ What’s it worth? The Social and Economic Costs of Mental Health Problems in Scotland (2006). Report produced by the Sainsbury Centre for Mental Health on behalf of the Scottish Association for Mental Health. www.samh.org.uk

- A recent poverty monitoring report for Scotland argues that part of the welfare contract ('security for those who cannot work') has never been clear in explaining who 'cannot' work or what constitutes 'security' (Palmer et al 2006). Overemphasising welfare-to-work may be creating a clustering of poverty among those on out-of-work benefits thus creating a situation similar to the risk of a "ghettoised" future housing scenario.
- Standing (2002) suggests an alternative to outdated welfare responses based on the idea of the family man, as the sole wage earner, working in an industrialised job. This alternative policy proposal, a Citizen's Basic Income (CBI),⁵ could act as a foundation to address income inequalities, develop basic social protection and promote economic efficiency.

Conclusion

Although relative poverty by itself is not the cause of Scotland's drug problem, this literature review supports the view that there is a strong association between the extent of drug problems and a range of social and economic inequalities. Therefore, narrowing these inequality gaps should contribute significantly to a reduction in high levels of damaging drug use. Furthermore, policies that focus on reducing poverty, exclusion and inequalities, per se, should help clarify more realistic boundaries for health, social care and criminal justice responses to individuals.

⁵ Citizen's Basic Income has been defined as an income granted to all on an individual basis. It is a form of minimum income guarantee that differs from those that now exist in various European countries in three important ways: it is paid to individuals rather than households; it is paid irrespective of any income from other sources; it is paid without requiring the performance of any work or the willingness to accept a job if offered. Definition from the Basic Income Earth Network (<http://www.etes.ucl.ac.be/BIEN/Index.html>)

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