1. The Merseyside Probation Service created four new posts for Probation Officers working solely with drug abusers in October of 1986. Two of the appointments were made to the Wirral Division and two to the Sefton Division. Julian Buchanan, who had been working as a main grade Probation Officer at the Bootle Office, where he had developed a particular interest in drug abusers due to the high level of such clients upon the Bootle caseload. The expression of that interest was made through representing the Bootle Probation Team at the Divisional Drug Representatives' Meetings and attendance at a number of drug abuse courses. Geoff Wyke had been a main grade Probation Officer at Southport where his particular interest developed along similar lines but having the additional perspective of working at the Southport Drug Dependency Clinic and indeed assisting in its development. Both Officers were committed from the outset to the idea of forming a Sefton Drugs Team. It was initially intended to appoint a Probation Service Assistant, though latterly it was recognised that other areas in the Merseyside Probation Service may have a greater need for a Probation Service Assistant, and thus that appointment will now not be made in Sefton.

2. A Management decision was made prior to appointment that the Drugs Team should be based at the Sefton Day Training Centre in Bootle and thus Miss P. M. Fahey became the Team's Senior Probation Officer. One additional Clerical Assistant was also appointed with joint responsibilities involving both the Day Training Centre and the Sefton Drugs Team.

3. A job specification dated 13th August, 1986 was drawn up as a base guideline for the development of this venture, that document was influenced by a report written by Mr. R. T. Adams, Deputy Chief Probation Officer, dated 29th July, 1986 and the subsequent Management discussion of 31st July, 1986, the recommendations for which are contained in the Management Team memorandum, 6th August, 1986 entitled, DRUGS - NEW GROWTH. From the outset there was an understanding that the aforementioned documents were not to be seen as restrictive but rather to provide some indication of the direction such a project may take. The appointments took place on 1st October, 1986 with an initial period of three months being given for investigation and formulation of a detailed project to commence operationally on the 1st January, 1987. That three-month period was to include an assessment of the drug abuse problem and facilities within Sefton or available to Sefton.

4. The Sefton area is itself somewhat complex, comprising four Probation areas. Southport, Waterloo, Old Roan and Bootle with the additional facility teams of the Sefton Day Training Centre, H. M. Prison, Walton and the Community Service Unit, Old Roan. The same geographical area is covered by the Social Services Department, the Health Service, the Police and Education Department, but all have different boundaries. These differences have implications for the District Teams, for example half of the Old Roan Probation district have its drug abuse clients referred to Southport Clinic, the other half to Hope Street, Liverpool, but for medical matters those same clients would be referred to Ormskirk and Walton Hospitals respectively. The Court Petty Sessional Divisions also have complications, there being three Courts covering four areas. The Northern P.S.D. covers Southport and part of Waterloo Probation Offices whilst the Southern P.S.D. covers part of Waterloo, Bootle and Old Roan. Whilst such differences may appear to be unimportant it is, we believe necessary to understand the complexity of the area in order to begin to come to terms with the reality of the drug abuse scene. Geography is important for it has implications of a cultural nature. Sefton is a 20 mile long coastal strip within Merseyside. Southport Probation Office to the north of the Borough is isolated by farmland and nature reserves. Southport is a predominantly middle-class area. Old Roan Probation office is divided by a motorway and farmland, the northern section being predominently middle-class and the southern section is industrial, made up of council housing with incidence of high unemployment. Waterloo Probation Office includes the isolated villages of Hightown, Little Crosby and Ince, is a mixture of rural farmland, urban middle-class and working-class industrial areas, whilst the Bootle Office is a tightly packed working-class population living in an area of run down industry where poor housing is evident. The main agencies within this Sefton area dealing with drug abuse are the Police, the Probation Service, the South Sefton Drugs Project, the Health Service, the Education Department and the Merseyside Drugs Council. There are S.A.C.O.D.A.S.A. meetings (Sefton Advisory Committee on Drugs and Solvent Abuse). Indeed it is S.A.C.O.D.A.S.A. which has been the meeting point for all agencies both professional and voluntary.

5. Since the recognition of a nationwide heroin problem in the early 1980's the Government and the media have embarked on a strong shock/horror campaign in an attempt to dissuade young people from experimenting with opiates. Sadly this approach has neither been particularly helpful nor successful. To many adolescents prohibition increases their interest and desire to experience and experiment. The Nationwide Campaign has tended

to be extreme both visually and verbally, with media headlines such as "Baby born a junkie!" and the Government response of - "Heroin screws you up". In some ways it has not painted an honest picture of heroin. Addicts have often mentioned the great sense of well-being that they experience, or the routine and structure that a drug-centred lifestyle has given them, or the sense of belonging or identity that they feel. It is true that misuse of heroin is likely to screw you up and can lead to serious withdrawal symptoms in a baby if the drug is taken during pregnancy, but it is also true that the misuse of tranquillers and alcohol can have the same effect and lead to tragic permanent abnormalities for the unborn child.

6. There is therefore a danger in isolating and highlighting the effects of one particular so called "evil" drug such as heroin. Not only because it is dishonest but because it is important that people appreciate the effects and possible consequences of all drugs, both legal and illegal. Certainly there is a danger in emphasising heroin so much that one is distracted from the socially acceptable and legal drug, alcohol. The British Medical Association's figures[1] for 1984 revealed that 235 people had died as a result of drug abuse compared with 6,500 deaths from alcohol and 100,000 deaths from tobacco. Other figures[2] indicate alcohol misuse is responsible for over 50% of homicides, and 40% of road traffic accidents involving pedestrians. Alcohol is also cited as a contributory factor to the breakdown of marriage in over 30% of all divorce petitions. Tranquillisers too are widespread in our society and a particularly difficult drug habit to give up as withdrawal symptoms can last from months to years.[3] Every year 14% of the adult population in this country will at some time take tranquillisers.[4]

7. We live in a drug using society where 'a pill for every ill' is a philosophy that is widely adopted. People want instant pleasure and immediate solutions to problems. When coupled with hard advertising techniques and social and economic deprivation within our cities, frustration and despair develop. This in turn creates a climate which is rife for encouraging widespread drug misuse, not just of heroin, but a whole range of drugs. For this reason it is important that we all identify ourselves as drug users, whether it be caffeine, tobacco, alcohol, distalgesics or tranquillers. We can then see drugs on a spectrum appreciating how they can each be used both positively and negatively. This does not then isolate any one drug or create a false sense of acceptance of potentially damaging legal drugs. Society should no longer regard drug abusers as outcasts or deviant but simply people whose use of drugs has become uncontrolled. Such fundamental attitudinal changes are a pre-requisite

to the progress of understanding drug abuse.

8. The isolation of heroin has led to misinformation. The belief that school children are being preyed upon by pressurising and pursuasive drug pushers does not hold true, neither in our research, nor that carried by Howard Parker[5] or Geoffrey Pearson.[6] Indeed our survey of 154 heroin users who began using during the past four years indicated that not one began taking heroin prior to the age of 15. Only 8% began at 15 years of age. A massive 54% began between the ages of 16 to 18 years old. This clearly shows that heroin is not a particular problem for young people at school but those particularly susceptible are the school leavers who are attempting to make the transition from adolescence to adulthood. Clearly drug education and prevention within schools is therefore a vital component of educational, health and social care matters together with an honest appraisal aimed at abstention with risk reduction advice. Within the schools it would appear that the most predominant drugs taken are tobacco, solvents, alcohol and cannabis. This should not be seen as a lesser problem, particularly as recent research on the Wirral[7] has revealed that the percentage of school children involved in this type of drug abuse has more than doubled in recent years.

9. Prior to the 80's, abuse of drugs like heroin was regarded as something a very small minority of the population engaged in, and they would be regarded as "hippies" or "junkies". It was generally outside the normal everyday adolescent experience. Heroin use today is very much within the range of a normal adolescent experience, similar to getting drunk at a party. This normalisation process has no doubt contributed to its acceptability and has been assisted by the widespread availability of drugs. No longer is there a typical drug user who can readily be identified within certain groups or stereotypes. The drug user today is potentially everybody's child, mother or father. Problems are created by the misuse or abuse of drugs, it is not the coming off drugs which is the greatest difficulty rather staying off drugs. Experience and research[8] does reveal that the person who is staying on drugs is predominately from socially deprived areas with high rates of unemployment. Many clients of the Probation Service have been unemployed for many years and it is difficult to ever envisage them being able to find work. This has far reaching effects upon their lives. One aspect is the difficulty in establishing themselves as adults and making the transition from adolescence. It now seems that many young people nearing their mid-twenties are stuck at an adolescent phase in life trying to find identity, purpose and meaning.

The drug scene does, without doubt, occupy this void. It provides excitement, extremes of emotion, a sense of belonging, an identify, attention. It involves the person in using all their physical and mental ability to become more cunning and deceptive at obtaining money to enable them to feed their drug habit. But heroin abuse places the drug user in a position where he constantly has to choose between immediate reward to immediate punishment. If he fails to obtain heroin he will suffer unpleasant and painful withdrawal symptoms, whereas if he continues in his cycle of drug abuse he can have the pleasure of a great sense of well-being.

10. Given the physical dependance of heroin and the pain involved in withdrawal, it is easy to understand why so many do not readily consider coming off drugs. To give up drugs also means relinquishing a drug scene which previously kept the person wholly occupied. Therefore if a person becomes drug free he has to cope with a vacuum left in his life and alternatives must be found. We feel that it is not so much the physical dependance upon drugs that makes it difficult to regain control but rather the psychological dependance which is exacerbated by grave socio-economic limitations. Indeed this view is confirmed by many addicts who apparently suffer many physiological effects such as sweating, palpitations and restlessness as a result of a psychological craving for heroin. They feel a great sense of relief and well-being simply having a bag of heroin in their possession. There are also many other psychologically addictive drugs which are not believed to have any physical dependance such as amphetamines, cocaine and cannabis. The difficulty therefore in trying to regain control of ones use of drugs can best be seen in the context of the widespread difficulties faced by nearly every member of society who attempts to regain control of other similar forms of habitual behaviour, such as eating, drinking, smoking, sex, gambling etc. It is widely acknowledged that any form of habitual behaviour can only be broken if the person with the habit is committed to change. Therefore, forceful removal from the drug scene such as imprisonment, does no more than deal with the physical side of addiction, it fails to address the sociological or psychological aspect of drug dependance.

11. When first appointed we discovered no documented evidence within the Probation Service that there was any real problem of drug abuse in the Sefton Borough. Howard Parker's[9] research had centred upon the Wirral and this indicated the belief that 25% of Probation Officers Criminal caseloads were made up of drug abusers. Support for that view was found in the Merseyside Probation Service - Research and Information Unit's document.[10] Neither of these items related specifically to Sefton and

both analysis were of samples rather than a detailed examination of all Probation clients. Despite this lack of hard evidence we found a good deal of subjective feeling within Probation Officers who were expressing frustration and exhaustion when speaking of the demands made by drug abusing clients. Running alongside these experiences was some evidence within other agencies, such as the Drug Dependency Clinics, the South Sefton Drugs Project and the S.A.C.O.D.A.S.A. that many of their clients were also clients of the Probation Service. Thus we decided to initiate a survey of the Sefton area, however, the exercise was designed for two purposes. Firstly to gather factual information and secondly to provide a focussed opportunity for us to meet with every Probation Officer in Sefton and discuss drug related issues. This approach enabled us not only to gather facts but also to listen to opinions and to hear the needs expressed by Officers relating to work with drug abusing clients.

12. At the same time as examining the local "scene" we also sought to establish an awareness of available literature on the subject of drug abuse and related matters. In this context we enlisted the aid of the Merseyside Probation Service's Information Officer, Jill Baines, who has proved to be an invaluable source. We undertook the task of reading all articles and publications which we felt had some relevance using not only the above mentioned source but also the Institute of Drug Dependency (I.S.D.D), the Regional Health Training and Information Office and the Local Education Authority Drug Co-ordinator. Much of that literature has been retained by us to form an information resource available to colleagues. Those same sources also proved useful in providing an opportunity to assess practice material, that is material for use directly with clients. That material includes a variety of video films, interview techniques, questionnaires, programmes of intervention and strategies for coping with habitual and dependent behaviour. It is a matter of some regret that very little of this type of material is directly available from the Service and we have had to develop close working relationships with other agencies in order to use that which we feel to be appropriate and useful. It is our belief that such material should form a part of the Probation Service's own facilities.

13. Appendix (X) is a sample of our Survey Questionnaire which we used with each Probation Officer. The questionnaire was completed by ourselves in discussion with the Officer as we reviewed together their entire caseload. There were six basic questions which we sought to answer in this way:-

1. What percentage of service clients are abusing drugs?
2. What drugs are they abusing?
3. How are clients using those drugs?
4. What are the ages of those clients?
5. How long have they been using drugs?.
6. Is their drug abuse leading to offending?

14. The information gathered provided the following answers:-

1. 37% of the Sefton Probation Service Criminal Caseload are drug abusers.
2. 74% of those abusers use opiates (heroin/methadone).
3. 58% smoke, 15% inject and 15% take by mouth.
4. Ages range from 16 to 65. Average age 24.2.
5. Two and three year users are most common - 47%.
6. 81% of offending by drug abusers is drug related.

15. Gathering sufficient information to answer those six questions has left us with many statistical cross references, and comparisons of district offices reveals many interesting questions. For example, Old Roan identified 26% of criminal caseload whereas Waterloo identified 43%. There were wide variations between individual officers, the most remarkable being in the same office where one officer identified 97% of criminal caseload compared with 0% by a colleague, whilst in another office the extremes were 77% and 18%. In one district no single Probation Officer exceeded the Sefton average for identification of drug abusers, whilst the other three offices reflected high averages of 57%, 55% and 53%. Such figures beg the question, Why should there be such differences? Is it that officers perceptions of what constitutes drug abuse are so different? Or perhaps there is a variation in levels of awareness. Certainly in discussion with officers a wide variance of attitude was demonstrated which is illustrated by the comment that drug abuse is self inflicted and therefore its treatment is no part of the work of the service. There is also the belief in some officers that enforced abstinence, through imprisonment, means that drug abuse for that person is no longer a problem, whereas others believe that this merely compounds the difficulties (the binge effect). Yet another view is the belief that the occasional smoking of cannabis should be seen as a major problem. Such divergent views will obviously give rise to differing perceptions of drug problems and thus the apparent randomness of identification becomes more understandable.

16. The appended tables and graphs are the results of a survey of every Probation Officer in Sefton carrying a caseload taken in October 1986. The aim of the survey was to identify drug users but the context of the survey means that those people referred to are drug users who have also resorted to offending. This is, we feel an important distinction. A person taking drugs will usually start at an experimental level, move on to a recreational stage and may then become habitual before reaching the addictive/chaotic phase. It is likely that as Probation Officers we will only be seeing drug users who have reached the addictive phase and are by that time resorting to crime to finance their drug use. It is therefore likely that the drug users known to the Probation Service will have been taking drugs for some time as opposed to those in the early stages of their drug career. This does then help us to understand Appendix (V) which analyses the length of time that Probation clients have been taking drugs.

17. Our identification of 294 drug users are only the ones who have commited a crime and been placed under the supervision of the Probation Service. There must therefore be a number of drug users who do not commit crimes, either because their drug use is still at a recreational or experimental phase or because they have the capital to finance their drug habit and do not need to resort to crime. The latter is more likely to be true in the more wealthy areas of the Borough. Indeed it could be argued that there are probably even more drug users already under the supervision of the Probation Service in Sefton who have been able to deliberately avoid detection. Given these factors this survey should not be regarded as a complete picture of drug abuse in Sefton, but more realistically as the tip of the iceberg.

18. The tables and graphs in the appendices illustrate differences in drug use between Southport and Bootle. The length of drug abuse, types of drugs and the method of use all suggest the possibility of separate cultures, referred to later in this report as "the two waves of abuse". Variations of the age range are also worthy of note in this context.

19. An interesting trend is the age of those who have more recently begun taking heroin Appendix (VIII). This firmly places the susceptible age group as being the young unemployed, and in particular those making the transition from adolescence to adulthood, while at the same time trying

to find some routine and structure to their life. At the opposite end of the scale the statistics relating to the older and long term drug user population of the first wave illustrate how difficult it is to change a drug habit.

20. What is hard to understand is the extremely small number of people identified who have difficulty with tranquillisers. One would expect the figure to be much higher than the overall total of twenty identified. Despite Southports' high percentage of clients who take tranquillisers the overall ratio between male and female drug users remains constant in all four offices with only a 4% difference between the highest and lowest. Overall in Sefton the ratio of drug abuse is 78% male and 22% female.

21. The figures in Appendix (IX) are based upon regular surveys carried out by that team during the past three years. They clearly show how heroin abuse has escalated rapidly from a very low level of prevalence to its present position. One would expect these figures to reach saturation point at some time as there are probably only so many susceptible people available, but nobody knows at what point this figure will stabilise.

22. Whilst conducting the survey, discussion with Probation Officers revealed a divergence of opinion as to how to treat a drug abuser once identified and here again this can be epitomised by extremes. "Abstinence as opposed to maintenance". The abstentionists encourage clients to consider giving up as the only answer to the problem of drug abuse, whereas maintenance followers see the legal substitution of another drug as the answer. Both views seem to us to have credence and limitations. If one approaches all drug abusers from an abstentionist viewpoint then the expectation to give up is pressed from the outset of contact. The client either succumbs to that pressure of expectation and attempts abstinence through "cold turkey", "detoxification programme" or "rehabilitation unit". Unfortunately the degree of success achieved is minimal with by far the majority failing and returning to the drug scene, increasing officer, family and self frustration and feelings of failure. The other alternative open to the client is to ignore the advice and simply continue to abuse drugs either openly or more furtively, thus becoming deeply involved in manipulative and avoidance game playing with similar results on his relationship with the worker as those who have tried and failed. The maintenance approach is more attractive to the client and he is more likely to accept and try it. Unfortunately this is substituting one dependence for another and whilst during the early months of maintenance it can appear to be

progressing in terms of reducing offending and stabilising lifestyle, there is a danger that those self blame feelings of frustration and failure could set in with the realisation that progress has reached a plateau. We have come to believe that a different philosophy should be adopted which incorporates both apparently irreconcilable views onto a scale or ladder of achievable targets. This philosophy begins with the pragmatic statement that "If it is, at a particular moment in time, impossible to cure a drug addict, one can at least try to create an environment for harm reduction". The implications of such a statement are that first one must identify those drug abusers who are dependent and differentiate from those who are experimental or recreational users. One must also seek to ascertain what the clients themselves wish to do, for whilst we might see their drug abuse as problematic, they may see it as the answer to a problem or may not wish to change their abuse for a variety of reasons. If one begins therefore with the philosophy of "Risk Reduction" many more doors are open to engage with the client and discover ways of helping them to come to terms with the difficulties that they may have. Thus whilst drug abuse may be self inflicted, if it is causing problems then the pragmatist would argue that it is better to do something than simply ignore the issue for it will not go away of its own accord.

23. The Probation Service engages with more drug users than any other agency or organisation. Indeed most of its contacts with clients are regular, ongoing and may stretch back a few years. Working with drug users is now a large part of Probation work. In Sefton it now represents 37% of the present criminal caseload. These clients tend to be the most demanding and problematic due to family tensions, reoffending and a chaotic lifestyle which again makes it difficult for the supervising Probation Officer to ensure regular reporting. Our research found that 81% of those known to be using drugs were offending directly as a result of their drug use. Of those clients breached by the Sefton Day Training/Activity Centre 92% were identified as problematic drug users. In relation to Youth Custody, at the Bootle Office 76% of those on Youth Custody Orders were identified as problematic drug users.

24. Given this background one would expect drug use to be given high priority as a practice issue within the Probation Service, such a high priority would be encouraged by the implementation of a training programme which could be organised by the Regional Staff Development Office in the North of England. If the subject of drug abuse was given the credence that is given to topics like Child Abuse and Racial Awareness, then the discussion generated would serve to heighten awareness and understanding.

The circulation of literature remains a poor substitute for such training, the knowledge it would impart and the dialogue that would ensue. Probation Officers within Sefton have identified approximately 300 drug users and this may reflect a good overall awareness and engagement with clients and their problems. However, the number of drug users identified by individual Probation Officers varies considerably, as stated earlier. The types of drugs identified was at times limited, and Probation Officers were not always able to state how the drug was administered. This was particularly worrying in view of the strong correlation between the spread of the AIDS virus and intravenous drug use which suggests that there is a need for further training to be made available to increase our effectiveness in these areas. One would expect that a hightened awareness would lead to identification of yet more drug users.

25. It would appear the Probation Service has, in recent years, been forced to cope with a new phenomenon which has frustrated and debilitated the impact and effectiveness of the Probation Officer, that is, mass long term unemployment. 95% of all Probation clients in one Sefton Office were unemployed, a not uncommon feature. This phenomenon will be with us for the forseeable future, and it may be that drug abuse will become yet another (apparently permanent) social problem which Probation Officers will need to respond to. There may be some debate about its permanence but unquestionably, past experience indicates that the drug problem will be with us for some time to come. We therefore need to be alert to any changes that occur within the drug culture such as a transfer from smoking to injecting drugs, an increase in amphetamines, the introduction of "crack" and an increased identification of H.I.V. (AIDS virus) among drug users. There are really a whole range of possible changes which will require different responses from Probation Officers. However, certain understandings are required before it is possible for changes to be identified, and again this raises the need for a regular drug awareness input to cope with what is a variable drug scene. This can be achieved in part through a regular and structured meeting with the drug representatives from each office where information, dilemmas, resources and current trends could be discussed. Such a meeting must be practical, relevant and concerned with the local drug scene.

26. Despite all our organisation, efficiency, awareness and empathy it appears that most of our drug using clients do not want to give up taking drugs, perhaps because they can see no attractive alternative lifestyle. It should be remembered that their involvement with the Probation Service

began because they commited a crime and not because they have sought help with their drug problem. Initially when first faced with problematic drug users officers seemed to automatically assume that the drug user wanted to immediately rid himself of his drug habit. This was often the worker's goal but seldom the clients. As a result of our expectations of immediate abstinence, and our apparent difficulty in hearing what our clients really wanted, we have made many desperate phone calls to rehabilitation units, who demand clients be drug free, only to discover that three weeks later the placement has broken down and our client is once again back on drugs, except that now he may also feel more of a failure, and his relationship with his Probation Officer has been damaged. This example highlights the need and priority that should be given for a full drug assessment in which it can be ascertained:- i) What drugs is the client taking? ii) How are they being administered? iii) In particular what does the client want to do about his drug habit? iv) What is he able to do? and finally v) What resources are available to help him? Using this approach it may well become apparent that the client is not ready or willing to abstain from drug use but is ready and wanting to control his drug use, which could be assisted by prescribing a legal substitute drug. Many Probation Officers might feel well able and experienced to conduct such an assessment which will, we feel produce a more rational, planned and long term response. Although very few clients show any indication of wanting to become drug free it may also be true that there are not that many clients who are motivated to take control of their drug use.

27. It has been this chronic and chaotic drug state that has frustrated and exhausted many Probation Officers. Despite many offers and attempts to help, there are an increasing number of heroin users whose habit is becoming a way of life. Contrary to popular opinion regular doses of imprisonment have no recognised impact, nor do many drug users grow sufficiently tired of the breakdown in family relationships or the homeless and unstable lifestyle to have the motivation to change. This is not to say drug users do not want to change. It is probably true to say that to some degree many do want to live a different life, but they have become so crushed and defeated that they have no sense of self control or belief. They remain fatalistic, consider themselves dependant upon the drug and the state and see no easy or painless solution. Experience leads us to believe that many become entrenched in negative thought patterns which

shrug off responsibility and admit defeat at the slightest hint of difficulty. Illustrated by comments such as "I had to have some heroin", which perhaps more realistically, and helpfully should have been put "I felt pretty rough so I decided to have some gear". The former comment is really untrue as a user would not die without the drug. It typically emphasises an external loss of control as if the person was in a totally uncompromising position from which there was apparently only one possible outcome. The latter comment recognises the difficulty involved but clearly places responsibility and control internally with the drug user.

28. While it seems many drug users do not want outside help in relation to controlling their drug use there is a serious need to still maintain good ongoing relationships with them so that when they want help it can be given. Therein lies the difficulty in trying to assess a genuine request for help as opposed to a manipulative cry for help in order to achieve a rather different goal. This dilemma is particularly apparent at the pre-sentence stage when a drug user is facing a likely custodial sentence, which will include a period of unaided physical withdrawal. It must be accepted that a drug user in this position may well make all the right responses either to achieve a non-custodial sentence or to be granted bail. It should be recognised that one of the skills of the drug user involves learning to deceive and manipulate, and there are many drug users who flaunt their prowess in this area. At pre-sentence stage this often results in the Probation Officer investing a lot of time and energy to a person whom they think has a desire to become drug free. A recommendation may be made to the court for a Probation Order, in an attempt to try and help this apparently reformed drug user. Sadly the efforts of Probation Officers are not equalled by the drug user who may not have had any real commitment for change but responded in an appropriate way to get himself out of a sticky situation. The obvious dilemma is that occasionally this is a genuine cry for help.

29. Assessing the motivation of a drug user is a difficult task at the best of times, but at times of crisis and pressure, such as when facing the likelihood of a custodial sentence before the court it becomes extremely difficult. However, the drug using client is no different to any other client faced with the same possibilites. Indeed given the general lack of motivation there is some reason for abandoning the complexities of assessing mixed motives and responding to the request for help, accepting

it at face value whilst allowing the client to set realistic targets. Offers and attempts to help drug users are made by Probation Officers in Social Enquiry Reports but too often the drug problem is swept aside by comments such as, "drugs are no longer a problem, I understand" or "he has been drug free and adamant to remain in this state". There is room for such comments but underlying the courtwork appears to be a strong optimism that anticipates the immediate cure of the drug user or his abstinence of all drugs; such expectations are generally most unrealistic. It would be far more realistic and more helpful to all concerned if report writers could begin to focus upon a risk reduction philosophy which may involve for some continued use of prescribed drugs. There is the recognised difficulty that such recommendations may not be acceptable to court sentencers, but we would argue that such recommendations would be realistic, reduce harm and set realistic and achievable targets. Compared with an alcoholic the drug user is expected to achieve far more, and in less time, yet there is no evidence of positive results to support such pressure.

30. Coming off drugs has never been a particularly difficult task for the drug user but they will tell you it is staying drug free that is the real difficulty. One of the reasons for this may be too great an emphasis on the physical side of dependancy and not enough understanding of the habitual nature of drug use or the psychological dependancy. The physical effect of the drug is of minor importance when balanced with the social and emotional impact it has upon the persons whole functioning. Once that person comes off drugs there remains a void in his life, a vacuum which had been filled with an all embracing drug centred lifestyle. It is likely that unless the person has found alternative interests or employment then an invitation to return to the drug scene will be difficult to refuse. Here lies a rather sad dilemma, in that many clients have no past occupations or interests to lean upon, and indeed their social, economic and political positions are poor. To some extent this leaves them powerless and dependant upon others for both their present and their future. But if they are to make a transition from coming off drugs to staying off drugs then a structured lifestyle is crucial. In an ideal economy this would involve meaningful employment, but for the unskilled long term unemployed opportunities are scarce, and the best alternatives are job schemes, voluntary work and leisure activities.

31. In an attempt to respond to these integrational difficulties we have met with two organisers of Community Programme Schemes, who have both agreed to look favourably upon any referral from the Sefton Drugs Team in an attempt to give a drug user a chance. We have also met with the Manager of the Employment Rehabilitation Centre in Fazakerley who has assured us that he is quite willing to accept drug users at his Centre. This would appear to be a particularly useful resource in re-training, providing a wide range of work experience and assisting in future occupational planning. We have also met with all the Disablement Resettlement Officers at the Sefton Job centres, and they are willing to see any person with a drug problem and if necessary and advantageous, register them disabled. Besides these efforts to secure employment or training, there is a need to make all existing community resources available to drug users. This could be in the form of a Divisional Directory of Activities so that a person expressing an interest in, say weight-lifting could immediately be given a list of all the organisations providing this facility, the day, the time, the cost etc.

32. During imprisonment clients make the transition from coming off drugs to being drug free but he wrongly perceives himself to no longer have a drug problem. In prison the decision to become drug free has been imposed upon him while the pressures of normal everyday life are kept at bay. Furthermore, if we see the answer as being solely'chemical' i.e. the removal of the drug from the person's system, and if we ignore other factors such as the vital roles played by the mind and the will, then ultimately we seek the same 'chemical' answers that led them to their addiction. In this way it could be argued that 'taking drugs' and 'enforced abstinence' are both ignoring the real issues, for exactly the same reasons. Neither address the real problems nor speak to the 'whole' person. There are numerous stories to be told of how drug users have gone back on drugs, sometimes in a matter of hours after their release from prison. Some may not have had any real desire to remain free from drugs but for those who have some desire they are totally unprepared having only dealt with the physical aspect of drug abuse. While in prison they will have had little or no drug education material. This would appear to be a critical stage in a drug users life, one where he may be helped to reinforce the transition to remain off drugs by recognising and learning to cope with the pressures of everyday life. This can be achieved by the introduction of structured inputs, covering such topics as psychological dependence, habitual behaviour, craving, anxiety management, coping with stress etc. Further possibilities in relation to penal institutions are the establishment of a Youth Custody Pre-Release Scheme and a Parole Release

Scheme which contains a specific package for drug users.

33. Within Sefton there appears to be two separate waves of drug abuse. One which began in the late 1960's hippie scene, which involved a group of people who shared common interests. Besides using drugs to highten experiences, they often had similar styles of dress, similar tastes in music and a common philosophy of life towards greater peace and a better future. These people predominately abused cannabis, amphetamine, L.S.D. and latterly heroin, which they normally injected. This wave of drug abuse tended to be more concentrated in the Southport area of Sefton. It is both ironic and tragic that a large majority of the heroin users who attend the Southport Drug Dependency Clinic are people who first began taking drugs in the optimistic 1960's scene described. This scenario is based on talking to drug users in the Southport Clinic and is also supported by our findings......which clearly show a high percentage of long term drug users, a much older age group, and greater prevalence of injecting in the Northern part of Sefton. The second major wave of drug abuse which occurred during the early 1980's contrasts sharply to the first. It was concentrated in the South end of the Borough, mainly in Bootle, where heroin was widely and easily obtainable from dealers in council tenament blocks. This time the drug was not injected but "chased", (fumes inhaled from burning heroin on silver foil). Predominantly this new wave of drug users shared few cultural similarities; unlike the 1960's wave of drug users. There appeared to be no shared philosophy in life, no shared musical tastes, nor any corporate style or fashion in dress. There are, however, some common factors in that many of the users are long term unemployed, with little or no work experience. They share a common sense of hopelessness and consequentially the reasons for taking heroin are not to heighten existing experiences but to achieve a state of euphoric oblivion by blotting out all pain.

34. Initially there was little response from the statutory agencies to this recent wave of drug abuse. It was the voluntary group, Sefton Advisory Council on Drug and Solvent Abuse (S.A.C.O.D.A.S.A) who highlighted the extent and escalation of the problem within the Borough, and for a number of years they were the main pioneering agency. Now that it is recognised as a national epidemic and accepted that the drug problem will be with us for some years to come many statutory agencies have appointed a number of specialist posts. Working solely in the drug field within Sefton at the moment are Community Psychiatric Nurses, two Psychiatrists with responsibility for the Drug Dependency Units, an Education Drug Co-ordinator, two Probation Officers, two Drug Counsellors with the Social Services Department and one Drug Counsellor with the Merseyside Drugs Council. Appointments yet to be made include, a Health Promotions Officer and

Social Worker. However, some of these workers are only responsible to certain parts of the Borough, due to the geographical interlacing of different agency boundaries. Many of the appointments are new posts leaving those appointed to establish and evolve new contacts and responsibilities. Obviously this poses some difficulty and takes time to create, however, they are all posts which involve the worker at the 'coalface' working directly with drug users, suggesting a need for increased co-operation.

35. There have been a number of statutory agencies represented by managers and policy makers on various committees within Sefton such as The Working Party, The Steering Group, The Advisory Committee, The Liverpool and South Sefton District Drug Dependency problem Team and at S.A.C.O.D.A.S.A. meetings. While there is clearly a need for such, there is at the moment in South Sefton a conspicious absence of a forum or meeting for practitioners who work directly with clients, although North Sefton have for some time now met and worked together as a Drug Team at the Southport Drug Dependency Clinic. We feel there is a great need for the 'coalface' workers to form an organised Drug Problem Team as per D.H.S.S. Circular LAC (86)5. This team could share resources, information and skills; enable much greater co-ordination and co-operation; work together on joint ventures; discuss and develop new strategies to meet local needs and address the drug problem in a united approach.

36. Southport has an established Drug Dependency Clinic covering Southport, Formby, Maghull and Lydiate, but the South of the Borough is served only by the Liverpool Drug Dependency Clinic. This has posed some difficulties, partly due to the history of the communities in that Bootle was once a separate town and still many people from that area are reluctant to travel to, or identify with Liverpool, but also because the Liverpool Drug Dependency Unit has been inundated in the past and overstreched. Following consultation with those involved there is the possibility of establishing a Satelite Clinic at the Drugs Centre shortly to be opended at Great Georges Road, Waterloo. If given management approval this move would, we feel, have great advantages for the local area. Already at the Hope Street Clinic input is made to South Sefton clients, Julian Buchanan, Probation Officer and Andrew Bennett, Counsellor with the South Sefton Drugs Project. The establishment of a team of workers for South Sefton clients at the clinic allows a more wholeistic approach and not just a medical model. It also enables drug users to have contact with the other agencies who are already working within their area. In all we see the creation of a multi-disciplinary drug problem team and a satelite clinic as a clear way of improving the service

offered to drug users in

37. In terms of treatment, the prescribing of methadone within the Drug Dependency Unit is really little more than a 'carrot', a way of attracting and maintaining contact with problematic dependant drug users who would normally have little contact with other Drug Agencies. Methadone also has a number of advantages, it alleviates withdrawal symptoms and has the added benefit of potentially stabilising drug use, removing the need for crime, and enabling pure drugs to be used as opposed to the 'junk' which makes up a greater proportion of any heroin 'bag'. In no way do we see methadone as a treatment in itself but merely as part of a treatment. The other treatment components will often address the social or psychological needs. It may not always be appropriate to prescribe methadone and it is widely accepted that there are a whole range of services and treatments available which can all claim some success. These include counselling programmes, cognitive therapy, groupwork, rehabilitation units, electro-stimulation and Drug Dependency Units. Given that there are so many different types of help available we feel that it is important for all Probation Officers to be fully aware of what agencies there are - exactly what they do, who are they prepared to accept and how to apply. Each drug user is an individual and each will require an individual response, so there is a need for a whole range of treatment models.

38. Earlier in this report we referred to the unrealistic expectations of abstinance and how such expectations led to a sometimes frantic search for a rehabilitation unit which would provide all the answers to all the problems. There is a similar danger inherent in our dealings with Drug Dependency Clinics and we must be constantly aware that drug abusing clients have a multiplicity of problems, many of which are beyond the facilities of such units. Clinics can provide a measure of medical care and a substitute drug. They can provide openings to other facilities such as detoxification units and rehabilitation units, but so long as they deal with our clients, we must not lose sight of our responsibilities to provide care and support. There will always be areas of work which we, as Probation Officers, are capable of undertaking, perhaps separately but more probably in a shared framework wherein specific tasks and goals are alloted to appropriate workers. The way forward is not to find someone else to take over our responsibilities, but to recognise them and seek a multi-disciplinary approach which is capable of responding to the complexities of our clients and their needs in a positive manner.

39. One of the drug related issues which we believe to be of particular importance is the risk of spreading infections and general health matters. Drug users run very high health risks connected with the substances that they use and their methods of use. All drugs can have harmful damaging effects if taken in sufficient quantity and many "street" drugs add to this risk by incorporating in the illegal substance, other cheap chemicals to make up the weights. Such risks as this involves, are at least confined to the individual who uses them. Of far greater concern however are the infections and diseases which can be spread through the sharing of needles. That sharing is however only one method of spread for the drug cultures include amongst them the partners of users and families, thus infections can and do spread beyond the actual needle users. Many drug abusers also have extreme difficulty maintaining steady relationships, and casual sexual contacts are extremely common, both within the culture and between drug abusers and drug free people. Prostitution, both male and female, is not an uncommon way to pay for or obtain money for the purchase of drugs. General hygiene standards tend to be low and nutritional diets are almost non-existent, added to the fact that the chaotic lifestyle of addicts lends itself to lack of appetite, lack of sleep and lack of self esteem. All of these factors make injecting drug abusers one of the highest risk categories for the transmission of infections and contagious diseases. Hepatitis 'A', 'B' and Herpes have, on occasions reached epidemic proportions within these cultures but appropriate action by epidemiologists and health authorities have always managed to contain, control and eventually stem such epidemics as effective treatment is available. The most recent threat to this group of people is AIDS. This threat is however different from the aforementioned in that it cannot be controlled by the actions which have previously proved successful. There is no cure. There is no immunisation. There are no available figures relating specifically to the Sefton Borough, indeed on Merseyside as a whole the official statistics indicate only ten AIDS patients this far. It can therefore be said on the basis of the limited information available that AIDS has not yet become a problem on Merseyside. Unfortunately there is a danger of complacency in this view. The Scottish Home and Health Departments report[11] on HIV Infection and Intravenous Drug Use indicates the very real dangers that are involved. That report states clearly that "no patient appeared to have had detectable HIV antibody before mid 1983 and that the number of positive patients detected rose very rapidly during 1984 and 1985". Thus from zero rate pre 1983 the rate of infection in Edinburgh rose to 54% in 1986. Similar increases are noted in other European cities, Milan less than one percent in 1981 to 60% in 1985. Bari, Italy 4% in 1981 to 76% in 1985. Geneva 7% in 1981 to 52% in 1985. In Italy by late 1985 50% of all new AIDS cases were found in drug abusers. In Scotland by 1986, 63% of all HIV antibody

positive identifications were drug abusers. The World Health Organisation[12] reports that in Europe overall a rising proportion of AIDS cases is occurring in drug abusers, 3% in 1985, 10% in 1986. It is now accepted that there is strong evidence of an emerging epidemic of AIDS among drug abusers in Europe which is certain to involve the U.K. Based upon the currently available statistics it would appear that we in Merseyside are in a position similar to that of other European cities prior to 1983 with the additional factor that we know what to expect.

40. The U.S. Centre for Disease Control[13] indicates that for each case of full-blown AIDS there are at least 100 symptomless but infectious carriers. This means that the figure of ten AIDS cases identified locally translates to one thousand symptomless but infectious carriers on Merseyside. We suggest therefore that there is no room for complacency if we are not to follow the patters already established throughout Europe. The Scottish Committee[14] made a number of urgent recommendations which we believe have implications for the work of the Probation Service, at the very least for those working with drug abusers.

1. Injecting drug misusers who cannot or will not abstain from misuse must be educated in safer drug taking practices. It is of the utmost importance that those who continue to inject are persuaded to use clean equipment and never share it. Clean equipment should therefore not be denied to those who cannot be dissuaded from injection. In this connection authorities should be reminded that threat to life of the spread of HIV infection is greater than that of drug misuse. On balance, the prevention of spread should take priority over any perceived risk of increased drug mususe.
2. ........testing for HIV antibodies, with appropriate pre-counselling should be offered to those who are given this equipment, (needles and syringes exchanged on a one-for-one basis).
3. Substitution prescribing should be considered.......it should also be considered as a means of establishing and maintaining effective contact with injecting drug misuers.
4. All drug misusers must be given advice on "safer sex" with particular emphasis on the use of condoms....... Counselling about the grave risk to an infant born to infected parents.

41. One particular aspect of the above report is the concern felt over the need to identify injecting drug users and in this field the Probation Service has more contact than any other agency and this is further confirmed by Howard Parker,[15] by the Health Education Council[16] and by the Drug Indicators Project.[17] It is also our own impression that the

Probation Service in Sefton identifies and has ongoing contact with many more drug abusers than any other agency. Thus the Service has the opportunity to engage with clients on a regular basis in what could be an extremely effective campaign of helping stem the remorseless spread of this disease. There are those who may argue that this is not the job of the Probation Service, that such matters should be left to the Health Service and there is some validity in such an argument. However, the situation may be likened to that of unemployment where clearly the treatment or cure agency is the Jobcentre, whilst we recognise the allied needs of the unemployed and readily work with them tackling the related social issues and indeed sometimes seeking to influence the "cure" by finding employment. We would argue that the AIDS issue may be similarly viewed with treatment being clearly the remit of the Health Services but the prevention of spread, which is only buying time until a cure and immunisation is found, is a social issue. Indeed it is about encouraging and enabling a social change in behaviour within individual groups. It is also about coping with a vast range of social and emotional traumas emanating from the disease. In this respect the Probation Service, it may be argued, is the best placed agency. We have established ongoing contact with the highest risk group of people. We have counselling skills, we have inter-agency links and a vast wealth of experience in helping people cope with and change social behaviour.

42. For the Service to effectively face such a challenge will require increasing Officer awareness of drug abuse, particularly in terms of identifying injecting users. We will also need to heighten our counselling skills by increasing the knowledge of the social difficulties related to AIDS and ways of coping with them. Put more broadly there will be a need for in-service training. It is a source of some regret to us to discover that in pre-service training there is no drug abuse input and further that the opportunities for in-service training courses do not reflect the high levels of drug abusers on our caseloads. Even if the Service does not feel able to meet this particular challenge we foresee an increasing involvement by Officers in counselling situations with clients who are concerned at the possibility of having contracted the virus, clients who have contracted the virus and clients who are dying of AIDS. This suggests a need for that same training input in order for Officers to feel themselves capable of tackling such issues. The foregoing is about the practice of dealing with clients who have special needs which are brought about by the disease of AIDS. There are, however, other issues which must be tackled regardless of any decision which the Service may make about that practice. Those areas are about clarity of understanding and policy.

43. In relation to the formulation of Service policy, the following issues should be addressed:-

   a) Confidentiality is of primary importance. Should decisions about who is advised of the situation be left to individual Probation Officers?

   b) Should the presence of the virus be disclosed in Social Enquiry Reports?

   c) Are certain sentences of the Court to be avoided?

   d) Does a client who is attending a Day Training Centre or Probation Hostel have any restrictions imposed if he reveals that he has contracted the virus?

   e) Should Hostels and/or prisons be advised if clients are antibody positive?

   f) What consideration should be given in civil work if one of the parties has contracted the virus?

   g) What, if anything, should be recorded in the case files?

   h) Is there any obligation to discuss with a Senior Probation Officer or the Health and Safety Officer?

44. We have found that some Probation Officers are expressing uncertainty and confusion in relation to these issues. Clerly there is a need to formulate policies quickly but carefully, taking into account good social work practice as well as the implications for the wider community and the Service as a caring agency. In view of the World Health Organisation's statement that "there is an emerging epidemic of AIDS among drug abusers in Europe which is certain to involve the United Kingdom", we believe that the Probation Service must accept its responsibility to equip Probation Officers with an understanding and appreciation of the counselling issues involved. Clearly the whole AIDS issue is complex, fraught with dilemmas and difficulties. Officers will require a high degree of sensitivity and compassion in order to work effectively with clients who become infected. Given the strong correlation between drug abuse and AIDS, and, that as a service we deal with more drug users than any other agency, it will not be long before we shall be working with a number of virus infected clients. We have therefore obtained various articles and leaflets and attended a number of workshops and seminars relating to the subject. Arising from these enquiries we have put together a document on counselling and techniques related to AIDS which we feel would be a useful starting point for examining this dilemma.

45. The issues we have addressed in this report are complicated and inter-related, reflecting the complexity of the individual person and the society

within which they live. Attempting to deal with such issues separately is rather like trying to separate the facets of an individual personality without allowing for the symbiotic nature of that personality. Such an approach seems to us to be impractical. Indeed throughout the process of preparing this report we have come more and more to believe that in dealing with drug abusers we need to adopt a wholeistic approach. To examine the needs of the person as a whole person, not as a drug addict, requires an eclectic attitude, a willingness to draw on many sources.

# DRUG USE AND ITS IMPLICATIONS

A STUDY OF THE SEFTON PROBATION AREA

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Tel: 051 922-6032

Julian Buchanan,
Geoff Wyke.

April, 1987.

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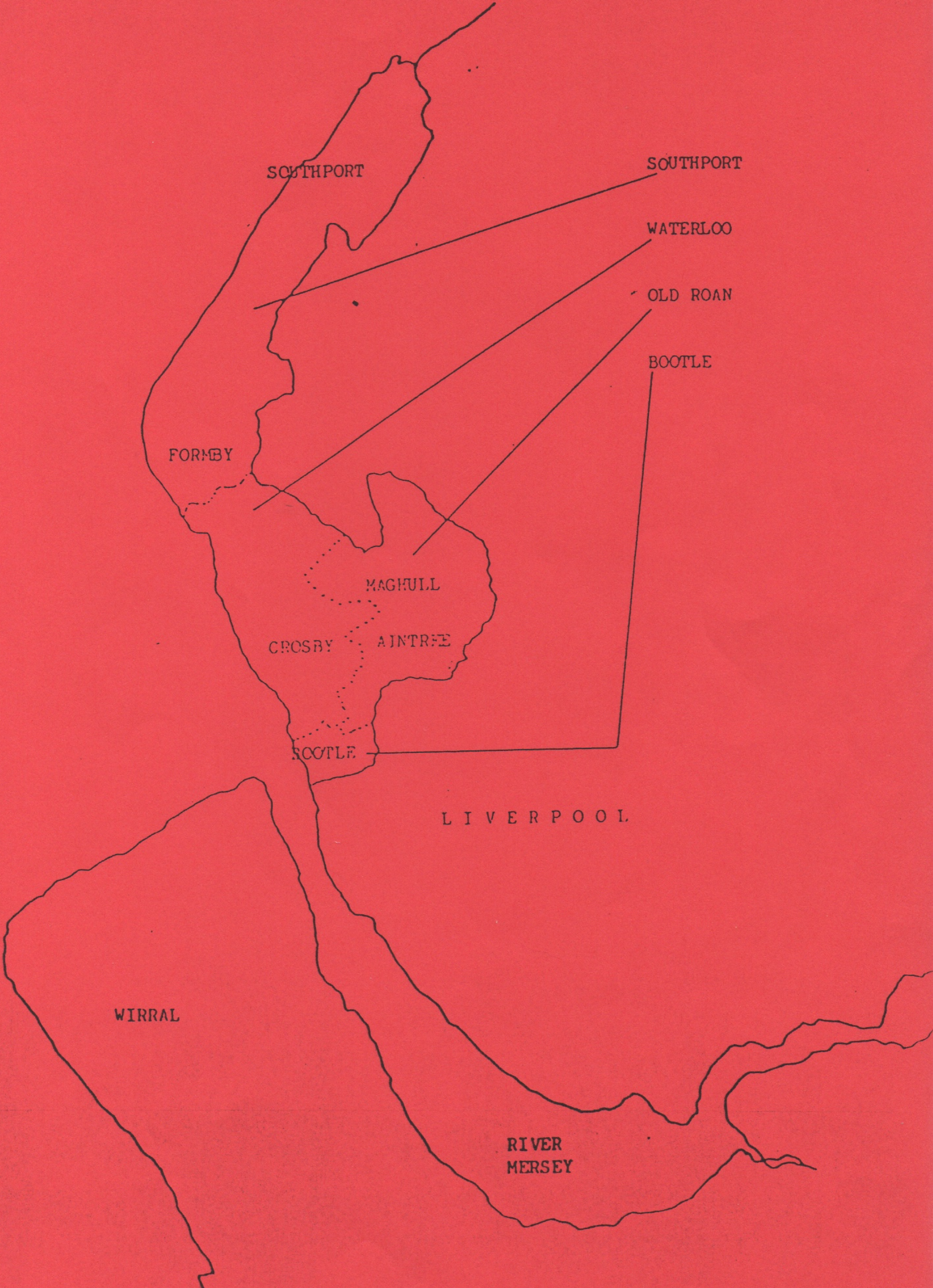
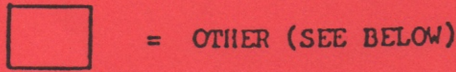
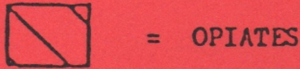
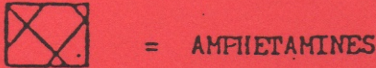
# PROBATION BOUNDARIES WITHIN SEFTON



# DRUG ABUSE AS A PERCENTAGE OF CRIMINAL CASELOAD IN SEFTON

 = OTHER (SEE BELOW)

 = OPIATES

 = AMPHETAMINES

(40 CLIENTS)

(62 CLIENTS)

(95 CLIENTS)

(97 CLIENTS)

| OLD ROAN 26% | SOUTHPORT 33% | BOOTLE 41% | WATERLOO 43% |
|---|---|---|---|
| CANNABIS | CANNABIS | CANNABIS | CANNABIS |
| ALCOHOL | TRANQUILLISERS | TRANQUILLISERS | ALCOHOL |
| LSD | ALCOHOL | ALCOHOL | TRANQUILLISER |
| | MAGIC MUSHROOMS | COCAINE | SOLVENT |
| | SOLVENT | MAGIC MUSHROOMS | LSD |

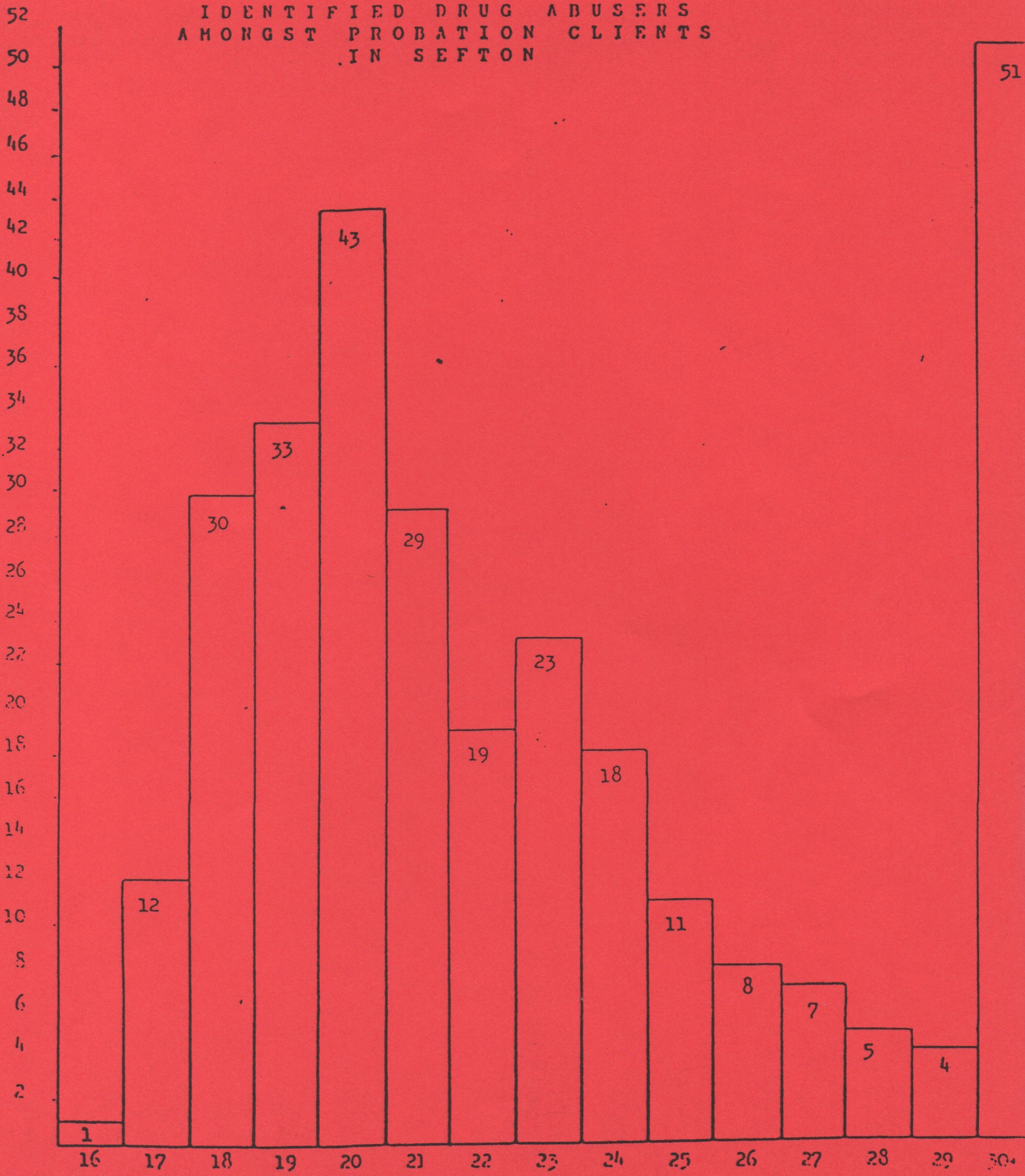
APPENDIX 11

## IDENTIFIED DRUGS ABUSED IN SEFTON

| TYPE OF DRUG | BOOTLE | | OLD ROAN | | WATERLOO | | SOUTHPORT | | SEFTON TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % | No. | % |
| OPIATES | 81 | (85) | 33 | (82½) | 65 | (67) | 40 | (64½) | 219 | (74) |
| CANNABIS | 26 | (27) | 10 | (25) | 50 | (51) | 13 | (21) | 99 | (34) |
| AMPHETAMINES | 4 | (4) | 0 | (0) | 11 | (11) | 15 | (24) | 30 | (10) |
| SOLVENT | 0 | (0) | 0 | (0) | 3 | (3) | 5 | (8) | 8 | (3) |
| COCAINE | 3 | (3) | 0 | (0) | 0 | (0) | 0 | (0) | 3 | (1) |
| TRANQ-ILLISERS | 4 | (4) | 0 | (0) | 3 | (3) | 13 | (21) | 20 | (7) |
| ALCOHOL | 4 | (4) | 4 | (10) | 10 | (10) | 12 | (19) | 30 | (10) |
| LSD | 3 | (3) | 2 | (5) | 1 | (1) | 0 | (0) | 6 | (2) |
| MUSHROOMS | 0 | (0) | 0 | (0) | 0 | (0) | 1 | (1½) | 1 | (0) |
| NO. OF CLIENTS | 95 | | 40 | | 97 | | 62 | | 294 | |

APPENDIX 111

# AGE RANGE OF IDENTIFIED DRUG ABUSERS AMONGST PROBATION CLIENTS IN SEFTON




1. TOTAL No. OF USERS IDENTIFIED = 294
2. AGE AS OF 31. 12. 86.
3. AVERAGE AGE = 24.2 YEARS.

# AGE RANGE OF IDENTIFIED DRUG USERS IN SEFTON ON 31ST DECEMBER 1986

| AGE | BOOTLE No % | OLD ROAN No % | WATERLOO No % | SOUTHPORT No % | SEFTON TOTAL No % |
|---|---|---|---|---|---|
| 15 | 0 (·0) | 0 ( 0) | 0 ( 0) | 0 ( 0) | 0 ( 0) |
| 16 | 0 ( 0) | 0 ( 0) | 1 ( 1) | 0 ( 0) | 1 ( 0) |
| 17 | 3 ( 3) | 3 (7½) | 4 ( 4) | 2 ( 3) | 12 ( 4) |
| 18 | 11 (12) | 3 (7½) | 13 (13) | 3 ( 5) | 30 (10) |
| 19 | 13 (14) | 6 (15) | 9 ( 9) | 5 ( 8) | 33 (11) |
| 20 | 13 (14) | 6 (15) | 20 (21) | 4 ( 6) | 43 (15) |
| 21 | 11 (12) | 7 (17½ | 7 ( 7) | 4 ( 6) | 29 (10) |
| 22 | 7 ( 7) | 4 (10) | 7 ( 7) | 1 ( 2) | 19 ( 6) |
| 23 | 11 (12) | 4 (10) | 2 ( 2) | 6 (10) | 23 ( 8) |
| 24 | 4 ( 4) | 1 (2½) | 11 (11) | 2 ( 3) | 18 ( 6) |
| 25 | 3 ( 3) | 2 ( 5) | 5 ( 5) | 1 ( 2) | 11 ( 4) |
| 26 | 3 ( 3) | 0 ( 0) | 3 ( 3) | 2 ( 3) | 8 ( 3) |
| 27 | 2 ( 2) | 0 ( 0) | 0 ( 0) | 5 ( 8) | 7 ( 2) |
| 28 | 3 ( 3) | 0 ( 0) | 1 ( 1) | 1 ( 2) | 5 ( 2) |
| 29 | 0 ( 0) | 0 ( 0) | 2 ( 2) | 2 ( 3) | 4 ( 1) |
| 30 | 2 ( 2) | 0 ( 0) | 3 ( 3) | 1 ( 2) | 6 ( 2) |
| 31 | 2 ( 2) | 0 ( 0) | 1 ( 1) | 2 ( 3) | 5 ( 2) |
| 32 | 0 ( 0) | 0 ( 0) | 1 ( 1) | 1 ( 2) | 2 ( 1) |
| 33 | 2 ( 2) | 1 (2½) | 0 ( 0) | 3 ( 5) | 6 ( 2) |
| 34 | 1 ( 1) | 1 (2½) | 0 ( 0) | 0 ( 0) | 2 ( 1) |
| 35 | 1 ( 1) | 0 ( 0) | 0 ( 0) | 3 ( 5) | 4 ( 1) |
| 36 | 0 ( 0) | 0 ( 0) | 1 ( 1) | 4 ( 6) | 5 ( 2) |
| 37 | 0 ( 0) | 1 (2½) | 0 ( 0) | 0 ( 0) | 1 ( 0) |
| 38 | 0 ( 0) | 0 ( 0) | 1 ( 1) | 0 ( 0) | 1 ( 0) |
| 39 | 1 ( 1) | 0 ( 0) | 1 ( 1) | 0 ( 0) | 2 ( 1) |
| 40+ | 2 ( 2) | 1 (2½) | 4 ( 4) | 10 (16) | 17 ( 6) |
| TOTAL | 95 | 40 | 97 | 62 | 294 |
| AVERAGE AGE | 22.7 | 22.2 | 23 | 29 | 24.2 |

APPENDIX V

## LENGTH OF DRUG ABUSE

## IN SEFTON

| No OF YEARS | BOOTLE No | % | OLD ROAN No | % | WATERLOO No | % | SOUTHPORT No | % | TOTAL SEFTON No | % |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 10 | (11) | 6 | (15) | 10 | (10) | 8 | (13) | 34 | (12) |
| 2 | 32 | (34) | 7 | (17½) | 29 | (30) | 7 | (11) | 75 | (26) |
| 3 | 22 | (23) | 12 | (30) | 20 | (21) | 8 | (13) | 62 | (21) |
| 4-6 | 8 | ( 8) | 9 | (22½) | 24 | (25) | 13 | (21) | 54 | (18) |
| 7-10 | 1 | ( 1) | 1 | (2½) | 5 | ( 5) | 5 | ( 8) | 12 | ( 4) |
| 10+ | 2 | ( 2) | 0 | ( 0) | 2 | ( 2) | 14 | (23) | 18 | ( 6) |
| NOT KNOWN | 20 | (21) | 5 | (12½) | 7 | ( 7) | 7 | (11) | 39 | (13) |
| TOTAL | 95 | | 40 | | 97 | | 62 | | 294 | |

APPENDIX V1

## HOW DRUGS ARE ADMINISTERED

| METHOD | BOOTLE No | % | OLD ROAN No | % | WATERLOO No | % | SOUTHPORT No | % | TOTAL SEFTON No | % |
|---|---|---|---|---|---|---|---|---|---|---|
| INJECTING | 8 | ( 8) | 3 | (7½) | 14 | (14½) | 20 | (32) | 45 | (15) |
| SMOKING | 67 | (71) | 22 | (55) | 69 | (71) | 13 | (21) | 171 | (58) |
| ORAL | 5 | ( 5) | 4 | (10) | 13 | (13½) | 21 | (34) | 43 | (15) |
| NOT KNOWN | 15 | (16) | 11 | (27½) | 1 | ( 1) | 8 | (13) | 35 | (12) |
| TOTAL | 95 | | 40 | | 97 | | 62 | | 294 | |

## OFFENDING AND DRUGS

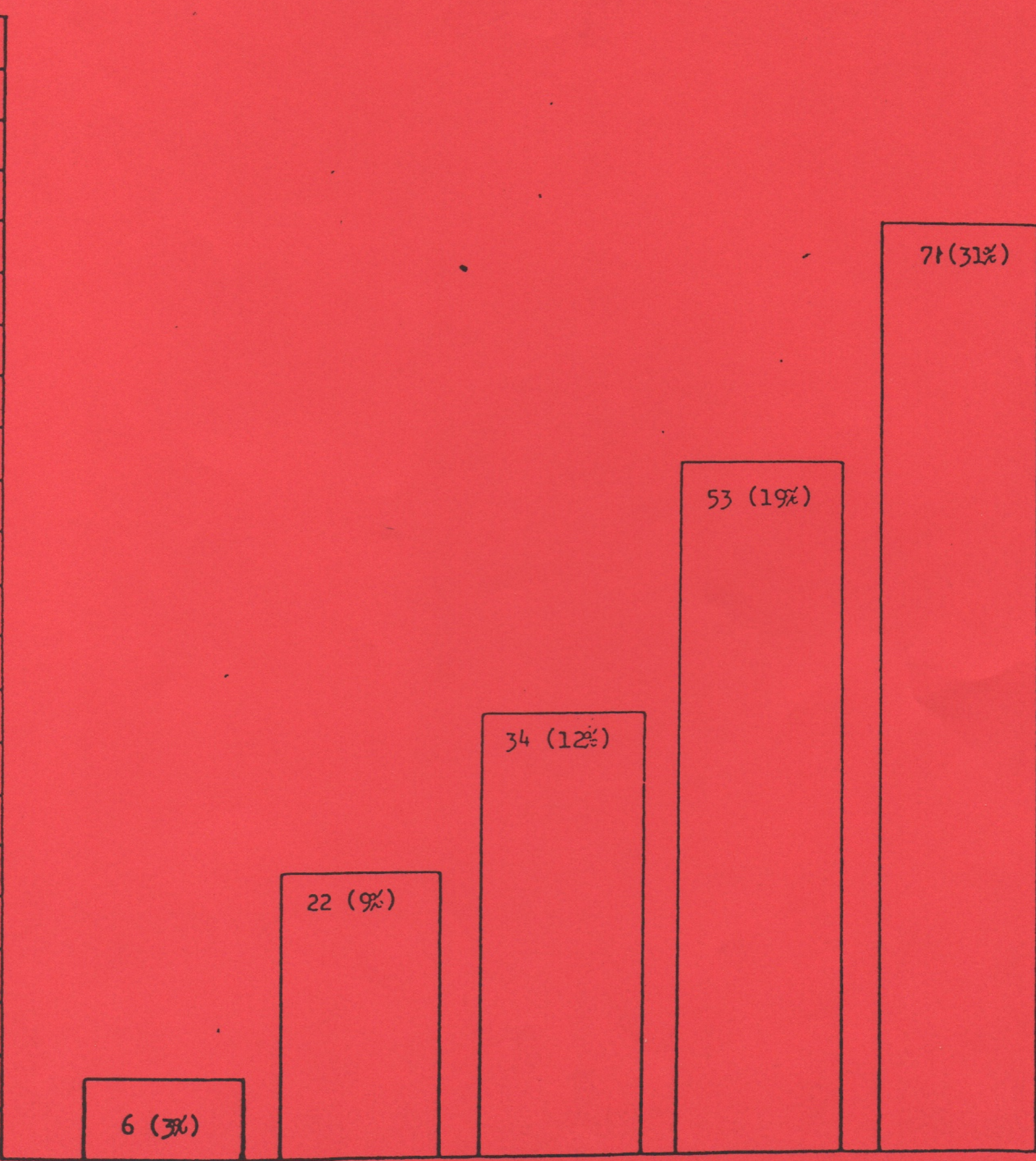
| IS OFFENDING DRUG RELATED? | BOOTLE No. | % | OLD ROAN No. | % | WATERLOO No. | % | SOUTHPORT No. | % | TOTAL SEFTON No. | % |
|---|---|---|---|---|---|---|---|---|---|---|
| YES | 78 | (82) | 37 | (92½) | 80 | (82) | 43 | (69) | 238 | (81) |
| NO | 13 | (14) | 1 | (2½) | 17 | (18) | 16 | (26) | 47 | (16) |
| DON'T KNOW | 4 | (4) | 2 | (5) | 0 | (0) | 3 | (5) | 9 | (3) |
| TOTAL | 95 | | 40 | | 97 | | 62 | | 294 | |

| DID ABUSE PRECEDE OFFENDING? | BOOTLE No. | % | OLD ROAN No. | % | WATERLOO No. | % | SOUTHPORT No. | % | TOTAL SEFTON No. | % |
|---|---|---|---|---|---|---|---|---|---|---|
| YES | 40 | (42) | 21 | (52½) | 43 | (44) | 21 | (34) | 125 | (43) |
| NO | 44 | (46) | 12 | (30) | 53 | (55) | 27 | (44) | 136 | (46) |
| DON'T KNOW | 11 | (12) | 7 | (17½) | 1 | (1) | 14 | (22) | 33 | (11) |
| TOTAL | 95 | | 40 | | 97 | | 62 | | 294 | |

PREVALENCE OF HEROIN ABUSE AMONGST

THE BOOTLE PROBATION OFFICE

CRIMINAL CASELOAD 1983-1986.




| DATE | OCTOBER 1983 (Estimated) | NOVEMBER 1984 | MARCH 1985 | AUGUST 1985 | OCTOBER 1986 |
|---|---|---|---|---|---|
| TOTAL CRIMINAL CASELOAD | 179 | 254 | 278 | 281 | 230 |

APPENDIX X

DATE:- PROBATION OFFICER:- OFFICE:-

| CLIENT | D.O.B. | KNOWN TO USE | SUSPECTED TO USE | METHOD OF USE | LENGTH OF USE | IS OFFENDING DRUG RELATED | DID ABUSE PRECEED OFFENDING | TYPE OF ORDER |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

## OUR ENQUIRIES INVOLVED MEETINGS WITH THE FOLLOWING:-

1. Liverpool Drug Dependancy Clinic.
2. Southport Drug Dependancy Clinic.
3. Every Probation Officer in Sefton.
4. Probation Drug Specialists, Wirral.
5. Drug Abuse Probation Officer, Merseyside.
6. Research and Information Team, Merseyside Probation Service.
7. Community Police Officer, Copy Lane Police Station.
8. Education Drugs Co-ordinator, Sefton.
9. Regional Drug Training and Information Centre.
10. Community Liaison Probation Officer, Sefton.
11. Researcher and Evaluator, Regional Health Authority.
12. Lifeline Drugs Project, Manchester.
13. Rework Employment Project, Rochdale.
14. Drugs Team, Rochdale.
15. Leigh Community Drugs Team.
16. South Sefton Drugs Project.
17. South Sefton Against Drugs.
18. S.A.C.O.D.A.S.A.
19. Waterloo Support Group.
20. Formby Support Group.
21. Merseyside AIDS Co-ordinator.
22. Liverpool AIDS Advisory Group.
23. N.A.C.R.O.
24. Liverpool Diocesan Care and Repair Association.
25. Manpower Services Commission.
26. Employment Rehabilitation Centre.
27. Disablement Resettlement Officers for Sefton.
28. Merseyside Drugs Council, Argyle Street.
29. Merton Road Hostel, Roman Catholic Church.
30. Clwyd Drug Prevention Team.

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