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Sticks and smoke

Country cousins and close communities



Illegal drug use is not just an urban pursuit, so how do responses to drug use differ according to locality? Is the same approach applicable in the sticks and in the smoke?

We have become familiar with the notion that 'drugs are everywhere' in the UK. Documentaries, studies and events have become a staple of TV and papers – it's a popular subject of discussion.

Go to the far-flung corners of any county, as I have in recent years, and you'll find people repeating the mantra 'there's easy access to drugs here'. An increasing number of studies tell us that more young people try drugs at an earlier age and there is new heroin use in 'non-traditional' areas.^{1,2}

But it's easy to fall under the spell of 'ubiquity of drugs'. Easy to be lazy about uncovering the exact nature, attitudes to and extent of drug use in any given area – failing to tailor responses according to need. National policy acknowledges this; it emphasises the need for aimed evidence-based initiatives.³

But the inclusion of place or location in service criteria is still in its infancy: place defined using geography, economy, demography, local community structures and values. Place matters when directing services at specific drug cultures, markets and trends.

In 1998 the Advisory Council on the Misuse of Drugs (ACMD) recognised that the majority of research, prevention initiatives and models of good practice are urban, by default. They drew attention to the need to do something about it.⁴

The Home Office Drugs Prevention Initiative (DPI) (before it became the Drugs Prevention Advisory Service (DPAS) in 1999) was already trying to discover more. It commissioned research to take stock of current knowledge of drug use in rural communities – to map the broad social context of drug use and identify

models of good practice by evaluating rural projects it supported.^{5,6} The research provided useful ideas about place in rural/urban terms, and showed how little we still think and know about responding to different communities.

Rural information

The starting point for considering rural/urban differences has to be what we know about drug use.

My review of the literature found an inconclusive picture of rural drug use. The 1995 White Paper on Rural England just noted the need to tackle drug problems in rural communities.⁷

Local studies have found all forms of drug use in rural areas, but there is currently no clear pattern to and few reliable indicators of the extent of rural drug use and misuse.^{8,9,10,11}

Some studies, national ones among them, suggest rural drug prevalence

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is the same as urban with similar patterns of use.^{12,13,14,15,16} Others have found lower levels of drug use.¹⁷

Local studies have found that one in four young people: have been offered drugs by the age of 15;¹⁸ have used an illegal drug or solvents in the past year;¹⁹ or have some experience of illicit drug use.²⁰ Drugs appear to be widely available, and can be cheaper, due to natural occurrence and the proximity to insecure farm stores of veterinary drugs.²¹

Everyone believes that levels of drug use in their area are higher than elsewhere. But rural residents actually underestimate levels of drug use, unlike their urban counterparts. Country people are less likely to consider cannabis (and to a lesser extent other drugs) harmful and more likely to view economic and social problems as causes of drug use, rather than 'fun' seeking.²²

Rural communities

If we know little about rural drug use, the same is true of rural communities in a different but important sense. Although a great deal has been written on the subject, the question of what makes a community 'rural' has been in dispute for years. Some commentators conclude that there is no universally acceptable definition.²³

Easier to grasp is that over 10 million people (one fifth of the population) live and work in what the Rural Development Commission classifies as rural England. This population is growing and changing in character. Almost every aspect of rural life has altered significantly since the Second World War.

Rural areas suffer limited and disappearing job opportunities, outward migration of young adults, shortage of affordable housing and declining provision of local services, including transport.²⁴

Although crime rates in rural areas have remained relatively low over the last decade, compared to the national average, they are rising faster than in most urban areas – along with, perhaps disproportionate, anxiety among rural residents. These major social changes have formed the landscape for moral panics around young people, crime and drugs.

The evaluation of DPI-supported rural projects provided insights of



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features that may be particular to rural communities – despite the ambiguity of definitions of rural areas. It is important to remember that this is in the absence of extensive rural drugs prevention literature.

Just like in towns, young people with 'nothing to do' are viewed as a community problem, but this question takes on specific significance in the country. Moral panics about young people and crime are relatively recent phenomena in rural areas. In consequence, local resignation to perceived 'deviant' behaviour is at a lower level than in city centres.

The globalisation of popular culture may now mean that where you live makes less difference to everyday young life, but some important differences survive. Rural populations are much older, whiter and more lacking in diversity. Young people lack anonymity in small, close-knit communities and consequently there's a higher level of informal policing of their behaviour. Lack of public transport means heavy dependence on parents for access to a social life.^{25,26,27}

Country ways

Despite recent changes, rural communities still have a different way of 'working' – with a few powerful, 'multi-hat-wearing gatekeepers'. To

become an 'insider' is difficult. Just to live in a village long enough to bring up children does not necessarily guarantee inclusion.

Less developed rural infrastructure, absence of local services and lack of sustained national policy input have all translated into low expectations of service provision. The practices and community organisations widely established in urban community development work are far from the norm. Voluntary/community organisations are likely to be of a more traditional nature, as is the patchy Youth Service provision. There is also greater reluctance to acknowledge and address drug issues as a problem.

Such features of rural society have direct implications for policy makers and service providers. Generally speaking, new projects are likely to be seen as 'outside interference', which occurs periodically, but provides few long-term positive contributions to the community.

An important way to overcome this is to provide continuity and consistency by linking projects to local and regional policy structures. These include: Drug Action Teams (DATs), Drug Reference Groups (DRGs) and local Drugs Forum but also, the Rural Development Commission and Rural Community Councils.

'Our village has a reputation for drugs locally. Most people are totally unaware still but drugs first came into the village 10-12 years ago . . . it's out of control now. It only takes one dealer in a small place like this, one rotten apple.' Parent

'For young people in the countryside, it's a case of "We're not hip and trendy living in a cottage in the middle of nowhere". They want to be in Manchester where it's all happening. Unlike their city counterparts, they aren't clued-up, streetwise. Some of our villages are also more affluent. This makes for a fatal mix when it comes to drugs: curiosity, a little bit of money and a lack of information. It can put them at greater risk.' Police Inspector



Close-knit communities where everyone knows everyone else, increase the stigma attached to involvement in drug initiatives. Taking a broader approach capitalises on concerns that are more likely to be publicly acknowledged such as: family problems, community safety, young people's alcohol consumption and disruptive public behaviour.

The extensive networking necessary to achieve this, to involve a wide range of local agencies and community organisations, is also likely to minimise perceptions of the initiative being 'brought in.' It may also co-opt local gatekeepers.

Although 'rural areas are like goldfish bowls', that they are close-knit may provide greater support for individuals and families than is frequently available in towns.^{28,29} Local reticence to acknowledge drug issues and lack of community organisations eager to respond can mean starting from scratch and very slow progress.

Rural drugworkers (who often work alone) can feel isolated and a lack of achievement. This is linked to the lack of immediate line management and other support structures. One person may be responsible for all aspects of a project, which involves: long drives between appointments; being the local 'face' of the agency; a catchall image of 'the drugs person' so anything connected with drugs is seen as their responsibility.

There is even greater need for a

balance between a worker with the flexibility to develop their job, and clear guidance and support.

Rural? Shmural!

It looks like rural peculiarities mean responses different from towns are needed. End of story.

But, it is not that simple. The value of considering rural questions does not stop as you cross a green belt. Differences in community characteristics and attitudes, and the approaches required to respond to them are not confined to villages and small towns in largely agricultural parts of England.

Evaluation of DPI projects in non-agricultural areas has come up with similar findings.^{30,31} Even more interesting, so have people working in visible minority communities in inner city areas.³²

Similar inward-looking and localised attitudes, lack of anonymity in the community and cautious responses to 'outsiders' have been found in communities as diverse as large, urban satellite towns in the North of England, remote rural communities (both with 98 per cent white populations) and Scottish inner-city visible minority communities. Similar distrust of 'one-off' initiatives, feeling 'left out' by administrative structures, low expectations of service provision and of the rate of achieving change presented obstacles to workers in these different communities.

Limited access to both local and

central services is not a feature unique to rural communities. Neither are powerful individual gatekeepers, nor the absence of 'new' community organisations and practices, in particular those responsive to drugs issues. Under-age drinking, litter and vandalism are universal local concerns, while leisure facilities for young people are poor.

People not places

This begs the question whether considerations of place and location matter at all in the business of determining effective responses to drug issues. Clearly there are important differences between the communities mentioned, differences which require more attention and which are key to effective work.

These differences are identified through *descriptive* criteria: basic demographics (population size, class, age, gender, ethnicity, employment, housing and so on), and physical characteristics (distance from large towns and main cities, transport quality, economic activity and so on).

Pursuing their surprising similarities helps to illustrate the importance of additionally taking account of people's sense of place, and of community dynamics.

These similarities arise when we consider more subjective, social and cultural aspects of communities. We can begin to distinguish between socially and culturally rural, and



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descriptively rural communities. For example, Young and Wilmott found supposedly 'rural' societies in the East End of London in 1957.³³

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These are the kind of features my own and other studies have identified in seemingly diverse communities. The local cultures these studies describe are 'rural' in the sense that

they represent more traditional, mono-cultural, collective communities than tends to be the norm in late modern, individualised society.

Place matters

If we work to the modern policy agenda of evidence-based initiatives aimed at groups and communities prioritised according to need, where exactly does thinking about rural/urban differences and similarities get us?

Clearly, it is important to track differences in local drug markets and

cultures and respond accordingly. But, where people live and spend their time play a part in shaping their attitudes, values and behaviours, including in relation to drugs. Attitudes are influenced by: demographic profile, local organisational structures, dominant attitudes values and lifestyles, and the level of collectivity experienced in everyday public life (the degree of 'close-knitted-ness').³⁴

Initial attitudes determine the effectiveness of initiatives to change them. This despite an increasingly globalised culture, in which you can go (almost) anywhere and you can eat, shop and sleep in identical environments and access the same communications media.

It goes even further. One's sense of place, it would seem, is also important. The degree to which people within a location identify with it and other places seems to be key to the development of effective prevention initiatives. Close knit, inward-looking communities where 'everyone knows everyone else' or can link you with your family, are less likely to acknowledge drug issues to 'outsiders' or seek help than more disparate, individualised ones.

Geographical proximity to or location in a city does not necessarily mean taking on its predominant values, beliefs and lifestyles. Strong community links and an inward-looking, 'local' perspective are key to maintaining local values, beliefs and lifestyles – even if these originated in and remain linked to other places (as visible minority communities).

So place does matter, just not in any simple way. The economic and social structures of a place and the (different) values, beliefs and lifestyles they support can make a big impact on the shape and success of community based prevention initiatives.

In these days of gathering research evidence for models of good practice, we need to fine-tune our sensitivities to cultural differences and similarities. Considering local realities rather than making universal assumptions. To define and order the needs of specific social groups is all well and good but the processes of social exclusion and inclusion, now so central to the concerns of social policy and drug policy, vary. Places need to be part of understanding that variation ■

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