COMMUNITY ENGAGEMENT PROJECT

Home Office Drug Interventions Programme

CARDIFF COMMUNITY LED RESEARCH PROJECT

into

ACCESS AND RETENTION OF DIP BME CLIENTS

Final Report

by

COMMUNITY IN CARDIFF

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Research team

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Born in Gdansk, Poland. Graduate of the Gdansk University. I decided to join the project to improve my research skills and to find out more about the community I have been living in for the last three years.

Yasmine Abdulrahman (Assistant researcher)
Graduated from the University of Wolverhampton with BSc (hons) Criminal Justice and Psychology in 2005, and since then has completed a Masters Degree in Law and has a great deal of experience in criminal law. She was drawn to the project as she has had a lot of dealings with her local community for a number of years through youth work and homework clubs, and had growing concerns about the increase in substance misuse related issues. She hope to use the experience gained in this project as a stepping stone to furthering her career within the Criminal Justice System.

Shane Dickson (community researcher)
Shane has currently taken up a post as a specialist case manager with the drugs intervention programme in Cardiff. He was actively involved with the compilation of the questionnaire and development of the project. The research project has given him some   insight into the need for ongoing support and specialist care for clients entering the programme, as well as the necessity for care plans to be tailored to needs of the individual.

Abdul Ullah (community researcher)
Being an Asian Muslim and a resident of Cardiff for over 30 years, and having extensive knowledge of the drug scene due to being an ex-user, has given Abdul privileged access to key individuals involved in drug misuse. Abdul feels that his capacity to develop has massively improved by his involvement with the programme and is aspiring to be a drug worker sometime in the future.

Mohammed Jannah (community researcher)
Mohammed came to the project at its beginning as a community researcher, and was a great help with designing the main research questionnaire.

Charlotte Holiday (volunteer)
Charlotte came to the project as a volunteer from NewLink. She was an invaluable member of the team providing support during one-to-one interviews, and transcribing to a high standard.

Hanna Miyir (volunteer)
I am a 3rd year student at Cardiff University doing 'Social policy and Criminology' who got involved in the project through volunteering with Newlink Wales. I am also a part-time BME Facilitator for 'Cardiff People First' an organisation that helps people with learning disability to know their rights and speak up about problems and issues that they face in society. I am also an active member of the voluntary sector where by she has gained a lot of experience from working along with a numbers of groups such as young people, elderly citizens, refugees and women from minority groups in various projects and service. This one of the many reasons why I chose to take part in this project and help assist in getting

information on reasons behind the lack of BME groups in utilizing DIP services and facilities.

Jeanne Alice Muroriwabo (volunteer)
Originally from Burundi, I moved around several times within Africa. I came to the UK three years ago and have since managed to complete an English course and an access course in Social Welfare. I started volunteering thereafter with New Link Wales who placed me directly with the DIP. This is how I started getting involved with the project. Due to the fact that I wish to pursue a career within the Criminal Justice System, this has not only been an interesting experience but has also provided me with a wider view of the field that I intend to work in.

Simon Rea (volunteer)
Simon came late to the projects as a volunteer from NewLink, and made a short but important contribution in research support.

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Acknowledgements

The views expressed in the report are those of the group that undertook the work, and are not necessarily those of the Welsh Assembly Government or the Centre for Ethnicity and Health at the University of Central Lancashire.

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Background, methods and research aims

Cardiff BME Community Engagement Research Project started in April 2007 and was funded by the Welsh Assembly Government (WAG). The research was supported and managed by University of Central Lancashire's (Uclan) Centre for Ethnicity and Health. NewLink Wales, as a current provider of BME services in Wales within substance misused field, was invited to host the project.

The project examines the issues around Black and minority ethnic (BME) groups' experience of the Drug Intervention Programme in Cardiff, identifying possible gaps in service provision, and how the service can be improved to meet needs of BME communities.

The Centre for Ethnicity and Health's community engagement model requires that wherever possible those members of the BME community who are being researched should be engaged to form part of the research team and be involved in carrying out the research. This was partially achieved in this project where three of the team were BME ex-offender/users, but their involvement was limited due to personal circumstances. However, all three achieved University Certificates in Community Research as part of the research programme, as well as the lead researchers.

The new Welsh Substance Misuse Strategy 2008-18 (WSMS) sets the policy context for this project on a number of levels. Of the four 'key aims' which underpin the delivery of the strategy, this report particularly speaks to aims 1, 3 and 4. Respectively, these are: reducing harm, supporting evidence-based decision-making and embedding the WAG values of sustainability, equality and diversity and a citizen-focused approach to delivery.

More specifically, but not exclusively, the recommendations set out here address many of the priorities of **Action Area 2** in the strategy.

The research team consisted of two lead researchers and three community researchers. A three-part strategy was devised:

- 33 interviews with BME ex-offenders, both current and past DIP clients
- 4 focus groups (BME offenders and families, and two white groups for comparison)
- 12 questionnaires sent to treatment and support providers

The project was designed to attempt to answer the following questions:

- Are there problems in the design of the system that lead to gaps in provision?
- Are there gaps as a result of the way DIP etc is implemented?
- How does the aftercare system integrate?
- How do the characteristics of BME clients and their communities make these problems better or worse?

Main findings

At the crucial first stage, arrest referral, there are high drop-out rates of up to 75% of potential DIP clients not getting to assessment. One reason might be the very limited window of opportunity at this stage, particularly when many arrestees might be having medical or psychological difficulties. The nature of the police station situation can make the problem worse, with arrestees being unable to distinguish between the CJS and the treatment programs and, for the BME groups, real or perceived prejudice in the CJS.

In prison, treatment was identified as a problem, particularly limited methadone prescribing; nor did courses seem to address users' problems adequately. Final referral was identified as a particular problem area with an apparent lack of co-ordination inside and outside prison. More importantly, users' claims to have come off drugs while in prison appeared to be taken at face value by staff, despite all the evidence presented here to the contrary. As a result, opportunities to refer users to DIP were missed.

When the users eventually end up at DIP, a number of specific problems were recognised:

- Referrals to DIP are frequently not followed up and there is little knowledge in the community about self-referral.
- Treatment is limited and dispensing does not take account of clients' lifestyles. Moreover, the mixing of users and ex-users in the dispensing centres encourages relapses
- Staffing is a problem: there are concerns over lack of experience and confidentiality. There seems insufficient time for effective counselling; and there are worries about the messages having a predominantly white staff is sending out to the BME community
- Finally, families would like to get more involved, but have limited information about where to turn for advice; and the problems that a community aversion to drug use causes to clients is not addressed.

Turning to aftercare, the involvement of GPs in the drug treatment process was widely regarded as unsatisfactory, at best. Particular problems were GP attitudes, the availability of time for appointments, and the expertise of the GPs in specific drug-related areas. For the BME community the problem of GPs and clients from the same community was important. In the Community Addiction Unit (CAU), in contrast to GPs, users were more likely to be happy with the service, but the very long waiting times put off many potential participants.

Discussion

DIP was intended to be part of a single system to cover drug users from arrest to final treatment, with a seamless transition between stages. However, in practice there are some difficult problems and the transitions between components of the system are not seamless. Users can fall through the gaps; and some problems in the way the programme is implemented increase the number of holes.

DIP has some of its own problems, but a major concern is the way the different parts of the CJIT work together. This does require more co-operation across units, and may also require a re-evaluation of working methods to ensure that co-operation between the units is effective.

What this means for the BME community is hard to tell. It would seem that for the more institutional parts of the process (ARW, prison) there is less opportunity for ethnic differences to show up. However, once users are in the community and have to take more responsibility for their actions, then cultural, ethnic and religious differences do seem to make a difference.

It seems then that cultural factors have a bigger effect on whether to enter the system or not, and less on retention, as those in the system have already made the decision to face the community and families. This does not mean that retention is not a problem, but the first bridge has been crossed.

This does increase the importance of the CJS in getting people onto DIP. Prison is a fishing net for users, but as treatment and counselling does not seem to be provided for all, many slip through the net and, as a consequence, do not take up treatment in the community. In contrast, the Drugs Rehabilitation Requirement programme (DRR) is compulsory and is seen as positive by many. Interestingly, some families expressed a wish for relatives to go to jail as this was the best chance to come off drugs, and one of the suggestions made by BME respondents was that DIP should be made a compulsory service. The BME community, then, has recognised that users might need a helping hand to overcome cultural factors.

Recommendations

The following recommendations are made:

1. DIP Service

Dispensing
    1.1. Increase dispensing time to maximum on Friday
    1.2. Longer or multiple dispensing times on other days
    1.3. Develop consistent policy on methadone prescribing for clients who are unable to attend due to absences such as holidays
Accessibility
    1.4. Facilitate transport access (for example bus passes) for clients so engagement can be sustained
Treatment
    1.5. Explore more non-methadone based treatment options for heroin users
    1.6. Long-term support for stimulant misusers
    1.7. Provide wider range of interventions such as psychosocial interventions
    1.8. Provide a wider range of treatment regimes to enable user choice
Care plans
    1.9. Clear structure for support through the whole duration of the care plan
    1.10. Regular one-to-one sessions for support and counselling
    1.11. Set baseline minimum for frequency of meetings

1.12. Safe and private environment for client meetings

1.13. The same case manager for re-entering clients where appropriate

1.14. Actively support clients having difficulties communicating with other agencies

1.15. Regular update for GPs about client's progress in treatment

1.16. Review the feasibility of using an incentive structure for clients

Confidentiality

1.17. Staff undergo (re-) training in confidentiality (legal and practical)

1.18. Ensure clear definition of confidentiality

Family support

1.19. Where the client does not want the family involved, check regularly whether this is still the case

1.20. Ensure that separate independent support for families is available even if client does not wish family to be involved, as long as client confidentiality is not breached (eg cannot discuss client's treatment or confirm client is on programme); this could be done by DIP or by referral to an external agency

1.21. Support for clients to deal with problems with family

1.22. Explore demand for and feasibility of family sessions outside normal DIP hours to provide confidentiality for both families and other clients such as weekend work

Staffing

1.23. Encourage recruitment of staff with first-hand experience in substance misuse, including ex-users

1.24. Encourage recruitment of staff reflecting ethnic breakdown of clients

1.25. Staff speaking languages of the local communities

1.26. Cultural diversity education built in to the continuous professional development of all groups of staff; delivered by appropriate agencies with knowledge of the local BME communities

Outreach work

1.27. Build contacts with different BME communities by cooperation with projects or agencies with good contacts among local BME communities.

1.28. Educate the local BME communities by cooperating with local BME agencies

1.29. Education should cover drug issues; the family/community context; DIP services; and other support available in the local area by co-operating with local BME agencies

1.30. Set outreach targets

1.31. Involve local religion leaders in the education programme

1.32. Educate young people in school; invite ex-users to deliver the message

1.33. All community information about DIP programme should stress confidentiality and the multi-culture profile of the services

Public awareness

1.34. Use community events to publicise the DIP service

1.35. Develop a communication and marketing strategy involving workshops, local radio, local/BME television channels, websites, leaflets, posters etc. to ensure that awareness of DIP is covered across all media and in relevant languages

1.36. Have a section on the DIP website for clients

Targets

1.37. Ethnicity monitoring of BME clients

1.38.BME referral/retention figures reflected in KPI

DIP offices

1.39.Create a more welcoming environment for clients

1.40.Review office layout to see how contact between users and ex-users can be reduced to a minimum

1.41.Re-brand DIP as a separate entity

1.42.Ensure the potential for drug dealing is minimised by adapting the office set up

Referral

1.43.Develop an 'immediate-response' policy for self-referrals

2. Custody suite

Medical support

2.1. Doctor available around the clock in each of the 4 main police stations in Cardiff to provide quick medical assistance/intervention/consultation to all

Language

2.2. Staff speaking languages of local BME groups

2.3. Info about DIP in relevant languages

Cultural awareness

2.4. Culture diversity education built into the continuous professional development of all groups of staff working within the custody setting, delivered by appropriate agencies with knowledge of the local BME communities

Image

2.5. ARW (and leaflets) to clearly identify their roles

2.6. Encourage recruitment of staff reflecting ethnic breakdown of clients

2.7. Encourage recruitment of staff with first-hand experience in substance misuse, including ex-users

3. Prison

Treatment

3.1. One-to-one sessions, and 'talking therapies'.

3.2. Methadone treatment allowed even for those not on pre-existing prescription

3.3. Explore more treatment options for heroin users

3.4. Treatment provision for stimulant users

3.5. Address mental health problems associated with substance misuse with more 'talking therapies'

Courses

3.6. Make all substance misusing inmates eligible to do courses

3.7. Shorten waiting times for courses

3.8. Ensure prisoner attends more courses over a duration of sentence and more evenly spread

3.9. Design educational strategy for a prisoner rather than ad hoc arrangement

3.10.Provide final (pre-release) course on DIP and other services

Referral

3.11.Challenge refused referrals, using evidence about numbers return to drug use

3.12. Use electronic communications where possible between custody and community
3.13. Ensure that information sent between DIP and CARAT has been received and acknowledged
3.14. Referral should be made as soon as possible after release, ideally within one day.
3.15. CARAT formally hands over responsibility to DIP as client leaves prison with an acknowledged appointment
3.16. Ensure adequate over dose awareness information is provided to every client leaving custody
3.17. DIP to meet and greet at the prison gates where possible

Staff

3.18. Culture diversity training as an on-going process for all members of staff to deliver culture sensitive services

4. Aftercare

GP attitude

4.1. GPs/ medical staff trained in drug related issues in respect of lifestyles, psychological problems etc of drug users
4.2. GPs undergo (re-) training in confidentiality and disclosure specifically in respect of addressing confidentiality in ethnic groups, and in communicating this to patients

GP appointments

4.3. 'Long appointment' option for substance misusing clients

GP lack of expertise

4.4. Train more GPs and medical staff in Cardiff in substance misuse
4.5. Surgeries to offer an appointment with a drug worker at the surgery as an option for patients
4.6. Educate GPs about DIP service and other drug treatment and support agencies in the community

GP treatment

4.7. CJS treatment agencies regularly update GPs on client's progress in treatment

Role of GPs

4.8. In the longer term, review whether GPs are an appropriate 'first point of contact' and develop an appropriate strategy for directing substance misuse cases to the appropriate place

CAU

4.9. Significant cut in waiting times
4.10. Alternative structure sought
4.11. Ongoing waiting times should result in a review of service operations and adaptations piloted to measure resource impact

Section 1: Introduction, project background and methodology

1 Introduction

Cardiff BME Community Engagement Research Project started in April 2007 and was funded by the Welsh Assembly Government. The research was supported and managed by University of Central Lancashire's Centre for Ethnicity and Health. NewLink Wales, as a current provider of BME services in Wales within substance misused field, was invited to host the project.

1.1 Project aims and objectives

The aims of the project are to examine the issues around Black and minority ethnic (BME) groups' experiences of Drug Intervention Programme in Cardiff; to identify possible gaps in service provision, particularly access and retention; and to study how the service can be improved to meet needs of BME communities.

The main objectives of the project are as follows:

- To identify problems in the design of the system that lead to gaps in provision
- To identify gaps as a result of the way DIP etc is implemented
- To review how the aftercare system integrates with DIP
- To study whether the characteristics of BME clients and their communities make these problems better or worse

Also, the project aims to develop community involvement via these additional objectives:

- To engage the BME community in the project research and findings
- To develop members of the BME community as 'community researchers' receiving training, qualifications, and experience in community-based research
- To ensure that awareness of the project is maintained at a high level in both relevant agencies and the community

1.2 Community Engagement Projects

1.2.1 Community Engagement models of research

This project followed the Community Engagement model of research developed by UCLAN.

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Background to the community engagement model

We often hear the following words or phrases:

- Community consultation
- Community representation
- Community involvement/participation
- Community empowerment
- Community development

- Community engagement

Sometimes these terms are used inter-changeably; sometimes one term is used by different people to mean different things. The Centre for Ethnicity and Health has a very specific notion of community engagement. The Centre's model of community engagement evolved over several years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health (DH) awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire (UCLan) to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The DH had two key things in mind when it commissioned the work; first, the DH wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done.

If all the DH had wanted was a needs assessment and a 'glossy report', they could have commissioned researchers and produced yet another set of reports that may have had little long term impact. However this scheme was to be different. The DH was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; however they would have proven access to the communities they were working with, the potential to be supported and trained, and the infrastructure to conduct such a piece of work. They would be able to use the nine-month process to learn about drug related issues, and how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity and Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams (DATs). It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of areas of work. These include:

- Substance misuse
- Criminal justice system
- Policing
- Sexual health
- Mental health
- Regeneration
- Higher education
- Asylum seekers and refugees

New communities have also been brought into the programme: although Black and minority ethnic communities remain a focus to the work, the Centre has also worked with:

- Young people
- People with disabilities
- Service user groups

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- Victims of domestic violence
- Gay, lesbian and bi-sexual and trans-gender people
- Women
- White deprived communities
- Rural communities

In addition to the DH, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, the National Institute for Mental Health in England, the Greater London Authority, New Scotland Yard, Aimhigher and the Welsh Assembly.

The key ingredients of the model

There are four essential ingredients or building blocks to the UCLan Community Engagement model.

1. An issue about which communities and other key stakeholders such as commissioners and policy makers share some concern

The issue can be almost anything, but frequently involves a concern about inequitable access to, experience of or outcome from services. The community and other stakeholders may not agree about the causes of inequity or what to do about it – the key however is that they share a concern. Usually the concern will be framed within some kind of local, regional or national policy context (e.g. teenage pregnancy reduction).

2. The Community

According to the Centre for Ethnicity and Health model, a community engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a host community organisation. This may be an existing community group, but it might also be necessary to set up a group for this specific purpose of conducting the community engagement research.

The key thing is that this host community organisation should have good links to the defined target community1, such that it is able to recruit a number of people from the target community to take part in the project and to do the work (see section on task below).

It is important that the host community organisation is able to co-ordinate the work, and provide an infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day-to-day activities of the project. One of the first tasks that this host community organisation undertakes is to recruit a number of people from the target community to work on the project.

3. The Task or Tasks

The third key ingredient is the task or tasks that the community undertakes. According to the Centre for Ethnicity and Health model, this must be action oriented.

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1 The target community may be defined in a number of ways – in many of the community engagement projects it has been defined by ethnicity. We have also worked with projects where it has been defined by some other criteria, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. users of drug services or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with (e.g. victims of domestic violence, sex workers).

2 This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

It should be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects have involved communities in undertaking a piece of research or a consultation exercise within their own communities. In some cases there has been an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme run on behalf of the DH, the process and its outcomes have equal importance. The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn; awareness will be raised; stigma will be reduced; people will opportunities to volunteer and gain qualifications; new partnerships will be formed; and new workers will enter the workforce Besides, it is important not to lose sight of the fact that it will be the fist time that these individuals have undertaken a research project.

4. Support and Guidance

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate support and guidance. It is not expected that community groups offer their time and input for free. Typically a payment in the region of £15-20,000 will be made available to the host organisation. It is expected that the bulk of this money will be used to pay people from the target community as community researchers2. A named member of staff from the community engagement team is allocated as a project support worker. This person will visit the project for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers throughout the project. The University also provides a package of training, typically in the form of a series of accredited workshops.

The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to form an appropriate steering group to support the project3.

The steering group is an essential element of the project: it helps the community researchers to identify the community they are engaging with, and can also facilitate the long term sustainability of the projects recommendations and outcomes. The community researchers undertake a needs assessment or a consultation exercise. However the steering group will ensure that the work that the group undertakes sits with local priorities and strategies; also that there is a mechanism for picking up the findings and recommendations identified by the research. The steering group can also support individuals' career development as they progress through the project

The UCLan community engagement team

The Centre for Ethnicity and Health has a large and experienced community engagement team to support the work. The team comprises of two programme directors, senior support workers, support workers, teaching and learning staff, an administration team and a communications officer. They work across a range of community engagement areas of specialisation, within a tight regional framework.

National Programme Directors			
Northern Team	Midlands Team	Southern Team	Senior Programme Advisors
Senior Support Worker		Senior Support Worker	

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3 Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

Support Workers	Support Workers	Support Workers	Drug Interventions Programme
			Citizen Shaped Policing
Teaching And Learning Team			
Administration Team			
Communications Officer			

Programme outcomes

Each group involved in the Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community. The qualitative themes that emerge from the reports are often very powerful. Such information is key to commissioning and planning services for diverse and 'hard to reach' communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

In 2005/-6 the Substance Misuse Community Engagement Programme was externally evaluated. This concluded that:

- the Community Engagement Programme had made very significant contributions to increasing awareness of substance misuse and understanding of the substance misuse needs of the participating communities. It also raised awareness of the corresponding specialist services available and of the wider policy and strategy context.

- the Community Engagement Programme had enabled many new networks and professional relationships to be formed and that DATs appreciated the links they had made as a result of the programme (and the improvements in existing contacts) and stated their intentions to maintain those links.
- most commissioners reported that they had gained useful information, awareness and evidence about the nature and substance misuse service needs of the participating organisations.
- all DATs reported positive change in their relationship with the community organisations. They stated that the Community Engagement Programme reports would inform their plans for the development of appropriate services in the future.
- A significant number of the links established between DATs and community organisations as part of the Community Engagement Programme were made for the first time.
- The majority of community organisations reported their influence over commissioners had improved.
- Training and access to education was successful and widely appreciated. 379 people went through an accredited University education programme.
- A third of community organisations in the first tranche reported that new services had been developed as a result of the Community Engagement Programme.
- The vast majority of participants and stakeholders expressed high levels of satisfaction with the project.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

1.2.2 The Community Engagement Projects in Wales

In 2006 the Social Justice and Regeneration Committee's review of Substance Misuse asked the Welsh Assembly Government to undertake research to identify barriers to access for services and involve service users.

Each of the recommendations slant the issues slightly differently, but ultimately focus upon the needs of BME groups, gender, sexual orientation issues and engagement with service users.

The Cabinet Written Response acknowledged the importance of understanding what barriers exist and putting measures in place to remove or minimise them.

Three Community Engagement Projects in Cardiff, Swansea and across North Wales were identified that would address the issue of barriers to access.

By using action research through community engagement, it would facilitate the full participation of the local communities in the projects from initial development, planning, through to undertaking surveys, managing the project and producing the final report. This means that the project would be engaging with a broad spectrum of the local communities including BME groups, existing and ex-service users, potential service users, family and friends and carers.

Those who participated in the survey work, analysis and production of the report would have the opportunity to receive accredited training in a range of key skills, including interview and survey techniques, IT skills, report writing, basic mathematics and English skills where appropriate.

The two projects of 9 months duration beginning April 2007, would seek to improve the uptake of services under the Drug Intervention Programme from within the BME communities in the DIP contract areas of Cardiff and Swansea by identifying reasons for the low uptake and barriers/disincentives to accessing services.

The third project of 12 months duration began in April 2007, would complement the Cardiff and Swansea projects and would seek to identify more general barriers that impact on an individual/community's ability or desire to access treatment including BME issues. This project would run across North Wales where there are three well established service user involvement groups who are keen to tackle the issues of barriers to access.

The Welsh Assembly Government made arrangements to run the projects by participating in a Home Office community engagement programme that had been contracted to the University of Central Lancashire (UCLAN), Centre for Ethnicity and Health.

The policy context for this particular project is provided by the Welsh Substance Misuse Strategy 2008-18. Of the four key aims underpinning the delivery of the strategy, this report speaks to aims 1, 3 and 4 in particular: Respectively, these are reducing harm, supporting evidence-based decision-making and embedding sustainability and equality & diversity in a citizen-focused approach.

The recommendations made here are, in the majority, in compliance with Action Area 2 in the strategy. But they also address priorities in Action Area 1, namely: working to reduce stigma and ensuring information and education are available in Welsh and ethnic minority languages.

It is therefore hoped that the Community Safety Partnership will see fit to implement as many of the recommendations as possible.

1.2 Demographics[4]

1.2.1 Demographic make up of the community

Cardiff is Wales' capital and the largest city, with a population of just over 300,000. It is the country's most diverse place with 12 % of its population being from an ethnic background other than White British according to the 2001 census.

The largest group is Asian, nearly 4% or around 12,000 people. The Black population numbers nearly 4,000. Almost two-thirds of these are of Somali origin. Recently, Cardiff has seen a rise in the Bangladeshi population and this trend suggests that they are likely to form the majority within the Asian population in the next few years.

Cardiff also has unusually high numbers of people with a Mixed ethnic background. More than 6,000 (2% of all people) identified themselves in this way in the 2001 census. The largest group within this was the White and Black Caribbean category at nearly 2,500.

The Butetown area of Cardiff is the most deprived area in Wales, as shown by the overall deprivation scores of the Welsh Index of Multiple deprivation (2005) and several other areas of Cardiff fall in the top quarter of deprived areas. The top 10 physical environment deprivation scores were all Cardiff areas. Several areas of Cardiff featured in the top quarter of the education, skills and training deprivation scores as well as in the employment and income deprivation scores.

1.2.2 Ethnicity

Cardiff contains the largest concentration of 'non-white' populations of any local authority in Wales, both in terms of actual numbers and overall

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[4] References for this section are based on information available on the websites of
- Information Centre about Asylum seekers and Refugees www.icar.co.uk
- Wikipedia en.wikipedia.org/wiki/Cardiff
- Commission for Racial Equality (now the Human Rights and Equality Commission www.equalityhumanrights.com

percentages. More than 40% of Wales' 'non-white' population are resident in Cardiff.

The 2001 census found that 5.47% of Cardiff's population were born outside Europe. This compares with the Welsh average of 1.92% and the England and Wales average of 6.6%. The percentage of Cardiff's population born outside the UK but within Europe is 1.47%, while the percentage of those born in the UK but outside of Wales is 18.2%.

According to the 2001 census figures, 66.9% of Cardiff's residents describe themselves as Christian, compared with 71.90% in Wales generally. The next largest group of religiously aligned people are Muslims at 3.70%, compared to the Welsh average of 0.80%. People who describe themselves as Hindus, Buddhists, Jews and Sikhs together represent 1.70% of Cardiff's population, while 18.80% of people resident in Cardiff ascribe to no religion.

The 2001 census figures show that the majority of minority ethnic communities in Cardiff live within Butetown, Riverside, Grangetown, Plasnewydd, Adamsdown and Cathays, with smaller communities in Ely, Canton and Splott.

1.2.3 Unemployment

As the capital city of Wales, Cardiff is the main engine of growth in the Welsh economy and conveys economic, social and cultural benefits across the wider region. The economy of Cardiff and adjacent areas makes up nearly 20% of Welsh GDP and 40% of the city's workforce are daily in-commuters from the surrounding south Wales area.

The total unemployment rate ranges tenfold across the City from 0.6% in Lisvane to 6.3% in Butetown and compares with 2.5% in Cardiff as a whole. The electoral districts in the 'southern arc' of the city show the highest unemployment rates: Butetown [7.2%], Adamstown [7.1%], Ely [6.9%], Riverside [6.8%], Caerau [6.5%], Grangetown [6.2%] and Splott [5.3%].

1.2.4 Housing ownership vs rental

The 2001 census recorded a total of 127,476 households in Cardiff. Over 65% of household dwellings were either semi-detached or terraced houses, while around 20% were flats of various types, the remainder being detached houses.

The tenure position was as follows:

- owner occupied - 69.83% [a combination of owned outright and mortgaged];
- socially rented, local authority - 10.34%;
- housing association rented - 6.60%;
- private rented - 10.12%; and
- other rented - 3.11%.

Minority ethnic groups are significantly under-represented in the 'owner occupied without a mortgage' tenure group, according to research by Cardiff Council and the Welsh Assembly Government.

However, the highest group of owner-occupiers with a mortgage was 'Asian' groups, while 'black' groups were significantly higher in the Cardiff Council tenure category. 'Mixed' groups were the highest in the housing association and the private rented sector tenure categories.

1.3 Crime and drug use

5.3% of total arrests in Cardiff for period from April 2007 to March 2008 were for drug related crime. Of those half are for trafficking. Interestingly, 17% of all drug related crime was committed by BME offenders, which are three times over represented compared to their share in the population of Cardiff (see section 1.2.2; crime figures from South Wales Police)

Figure 1.1 shows the numbers of positive tests for drug use in Cardiff over the period April 2006 to December 2007.

The figure shows that, for the BME population, the numbers of arrestees testing positive for cocaine and opiates is quite variable over the period.

Figure 1.1 Results of positive drug tests (BME only)
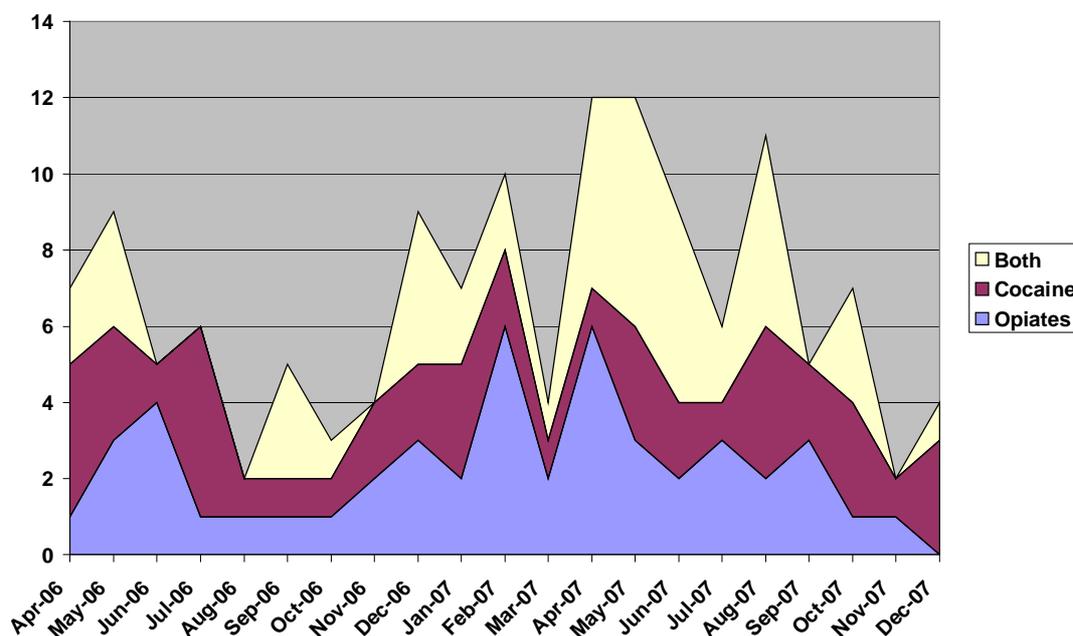
Source: South Wales Police

More importantly, it is often stated that opiate use is much more common than cocaine use. This does not appear to be the case for the BME community. In fact, over this period, there is almost no difference between opiate and cocaine use, or between either of these and poly-drug use. Table 1.1 illustrates this.

Table 1.1 Proportion of drug use in positive tests Apr 06 – Dec 07

	Cocaine	Opiates	Both
Number of positive tests	46	48	45
Presence in all tests	65.5%	67.0%	

2 Methodology

This section describes the recruitment and training of researchers, sample and questionnaire design, the fieldwork, and governance issues.

2.1 The role and involvement of the community researchers

This project followed the standard model for Community Researchers (CRs) identified in section 1.1, and followed UCLAN's training strategy.

2.1.1 Recruitment of researchers

The ideal CRs would reflect the ethnic mix of Cardiff DIP clients, would have substance misuse experience, and ideally some experience of the substance misuse treatment within the criminal justice system.

The time to find CRs was short, especially given that the two lead researchers had no direct experience of or contacts in the drug-using community. To find candidates with a high percentage of ex-users and ex-offenders, the lead researchers engaged early on with local criminal justice and community agencies.

For the criminal justice system, the Cardiff operations of DIP, Arrest Referral, Probation, and DRR were all approached. For community organisations, this required a snowball approach to finding contacts. The researchers initially contacted local community centres and community based projects: MILE, AXIS, SIS, Butetown Pavilion.

The researchers organised meetings with these organisations; or occasionally they attended staff meetings, which gave them a chance to propagate the research project and discuss in detail the criteria for CR candidates. Job description posters were posted on the organisations' notice boards and leaflets were distributed; these were also used to help staff identify and provisionally select candidates from among their clients. The same information was posted on the Newlink website, and the Steering Group and BME Task Group of Cardiff SMAT were also involved in distributing information.

Initially, six community researchers (five male, one female) were recruited, with an ethnic make-up reflecting the clients of Cardiff DIP who were the focus of the research. The CRs were all from different BME communities (Black African, Afro-Caribbean, Arab, Pakistani, White-Indian, and White Mixed), and all had first-hand substance misuse experience. Most had also experienced substance misuse treatments within the criminal justice system (DIP, DRR). The candidates came from Progress2work, Probation, DIP, and Newlink Wales, and were accepted after being interviewed by the lead researchers.

2.1.2 Lead and community researcher training

Training began a week after recruitment had finished, with both lead and community researchers attending thematic training courses provided by UCLAN:

- a one-day training session providing basic information about DIP and the National Drug and Alcohol Strategy
- 5 separate training sessions in Community Based Research

The latter discussed different phases of the planned research, from formulating research problem and literature reviews, to writing the final report and dissemination of the data. The courses were spread over time so that the sessions would correspond to phases of the research project the team was working on.

Weekly meetings attended by all researchers were held at the project office from June to the start of fieldwork in November. The CRs could often only devote limited time to the project, and so sometimes more than one meeting was held during a week to accommodate everyone's time restrictions . The meetings allowed lead researchers give updates on the project's progress, and work with the team on the plan for the following week.

The meetings were held in informal atmosphere to help the CRs relax and to build team spirit. However, a key aim of the meetings was also to develop some regularity in the CRs' involvement with the project before the field work started, and punctuality was stressed. To give them an incentive to attend regularly, the CRs received Tesco vouchers as a token to recompense them for the time that they gave to the project.. Once the field work started, the weekly team meetings were replaced with post-interview one-to-one feedback sessions.

2.1.3 Community researchers in the project

The main contribution of the CRs was to bring their knowledge of the community and environment to the discussion. They were an important source of

- experience on the nature of addiction
- local knowledge of Cardiff BME communities
- practical knowledge, as clients, of the treatment services and methods they experienced and of the local justice system

all of which contributed to both the design of the questionnaire and the nature of some contacts.

Together with the lead researchers, the CRs spent 6 weeks in October/November, jointly designing, piloting and redesigning the main research tool, the questionnaire.

Unfortunately, there was a high attrition rate. Three CRs dropped out after the first training session, and two more by the start of the fieldwork; the reasons for this are examined in Chapter 3, Reflections. The remaining CR couldn't maintain his involvement due to other arrangements; he did, however, continue to participate as a note-taker in interviews. It proved impossible to find other CRs, which meant that the fieldwork was largely carried out by the two lead researchers with support from Newlink volunteers.

2.2 Sample design and data collection

2.2.1 Choosing the sampling frame

The population of interest from which the sample was to be drawn was largely determined by the project's focus on the entrance and retention of Cardiff DIP BME clients. Respondents needed to be from the BME community and at least one of

a) ex-clients of DIP
b) active clients of DIP
c) arrested for a substance-misuse related offence in Cardiff since February 2006 (when DIP came into existence)
d) had finished a substance-misuse related prison sentence or DRR since February 2006

The lead researchers argued at an early stage that a control group from the white community should be included in the interview plans; without this, it would be difficult to separate systematic issues from cultural issues. At the time, UCLAN decided that this should not be pursued. In February 2008 UCLAN suggested reconsidering the idea to increase the numbers of interviewees, but at this late stage the practicalities of such a shift in methods were insurmountable. Hence, no control group was included in this study. However, the team did arrange for two focus groups with non-BME users to provide some insight.

The project target set by UCLAN was for 70+ interviews and three focus groups: one for families and carers of DIP clients, and two for BME ex-/current substance misusing offenders. Information supplied by DIP in July 2007 suggested that the number of BME clients who had actively used the service since its start was around 120 individuals. As the number of BME trigger offenders going through Arrest Referral was thought to be considerably higher, the target seemed feasible.

As all the respondents had to have substance-misuse related criminal past, DIP, Probation, DRR and Prisons were selected as the main sources of interviewees.

2.2.2 Questionnaire and focus group design

The research team designed a questionnaire (see Appendix 5) as the main research tool. The questionnaire was meant to be used in an interview context, to give consistency and structure to the interview; respondents did not directly fill out the questionnaire.

The questions were organised into five main sections highlighting different aspects of the respondents' experience with DIP service, from entering the service on arrest to aftercare in the community:

1. *Entry into DIP*: studies respondents' experience of Arrest Referral at the Police station and its outcome
2. *Take-up of service within DIP*

a. *Pre-sentence experience*: studies the experience of those referred to DIP from the Police station
b. *Post-sentence experience*: studies the experience of those referred to DIP from other sources: DRR, Prison, treatment agencies, self-referral
c. *Prison experience*: focuses on respondents' CARAT experience, and subsequent referral to DIP and/or treatment agencies in the community
3. *Aftercare drop-out points*: studies respondents' experience of different treatment agencies in the community (CAU, GP)
4. *Where are the respondents now*: investigates respondents' personal history of drug/alcohol experience, and the community view on drug use.
5. *How can services be improved for BME clients*: seeks respondents' opinions on how DIP services could be made more accessible for them personally.

The questionnaire was designed to cover all the different possible interactions between respondents and DIP. This led to a long and detailed questionnaire, but the questionnaire was designed so that a respondent would not need to answer all parts; for example, the longest parts are sections 2(a) and 2(b) above; but if an interviewee answered section 2(a) there was no need to complete section 2(b). In fact, despite the length of the questionnaire, all interviews were completed within the target time of one hour.

The questionnaire contained a mixture of closed and open questions. The team used simple, everyday language to avoid confusing or intimidating the respondents. For the same reasons, the questionnaire was checked for any ambiguous or double-barrelled questions.

The questions were developed with and tested on the CRs; the full questionnaire was then piloted in November to check for timing and to iron out any ambiguous or hard-to-answer questions. The pilots led to a small number of changes; for example,

- *When was your most recent related arrest?* became *When was your most recent substance related arrest?*
- A new question *Were you drug tested at the Police Station? Yes/No* was introduced along with a follow-up *(If Yes) Was it positive? Yes/No*

The questionnaire was piloted in further two interviews, and was then put into the field.

The questionnaire was designed to capture the experience of individual substance misusers. This was complemented by the focus groups, which were to be used to uncover the shared perceptions of the wider community. Focus groups were aimed at:

- family and carers of DIP clients, to explore the barriers they encountered in their attempts to help or support substance misusing relatives
- BME ex-/current offenders, to identify problems at a community level

All the focus groups were to use a similar structure, based upon an "inner" and "outer" community model. The facilitators used a simple diagram and an example of a fictional drug user to focus the discussion. Notes and summaries were written on a flip-chart as the sessions progressed, and the discussion was tape-recorded. Characteristics of the focus groups were noted, but no names were recorded. For details, see Chapter 10, Focus Groups.

Towards the end of the project, it became clear that some of the respondents' comments about service needed to be challenged or confirmed by the service providers. Accordingly, a questionnaire (Appendix 6) was designed and circulated to service providers, with the aim of seeing both sides of some of the important issues raised.

2.2.3 Fieldwork

For the safety of the researchers all interviews and focus group were conducted in pairs, an interviewer/facilitator and a notetaker. For the same reason, all respondents were clients of community and criminal justice agencies (DIP, Probation, DRR, Prisons, hostels, community centres) and were approached via those agencies. The agencies were involved in the initial selection of potential respondents among their clients, and facilitated the interviews by providing private rooms.

All interviews were recorded and transcribed for further analysing.

Before the project officially started, the host organisation, NewLink, propagated information about the project via an information meeting with local community members. This was accompanied by letters and leaflets explaining the nature of community engagement projects and the reason for this specific research.

Once the lead researchers had been recruited, these contacts were followed up and extended so that the lead researchers established a personal contact with most of the relevant operations in Cardiff. However, at the first Overarching Steering Group meeting the focus of the project was changed to DIP retention of BME clients, and so these contacts became less directly relevant.

However the project team identified that community centre staff were engaged in outreach work, and asked a representative to join the Steering Group. This later became important for setting up the focus groups, as the community centre contacts helped to find participants.

Early discussions with community groups suggested that male family members from black and ethnic minority groups would be a difficult group to come forward and talk about their substance misusing relatives; this proved to be the case. Female family members were more willing to take part, and so a focus group of 7 women was organised. These were mainly mothers of drug using sons (including 2 ex- DIP clients) from various ethnic backgrounds (Indian, Pakistani, Sikh, and Afro-Caribbean).

Due to the difficulties in organising and executing BME ex-/current offenders focus group, in the late stage of the project, the research team decided to extend the sample group by a non-BME DIP clients (focus group).

2.3 Governance and ethics

2.3.1 Boards and committees

The management and governance of the project had four components:

- An "overarching" Steering Group
- The Project Steering Group
- NewLink management meetings
- UCLAN support worker

The Overarching Steering Group provided general guidance to both the Cardiff DIP BME project and its sister project in Swansea. Both were hosted by NewLink. While not directly involved, this group had a major influence by redirecting the Cardiff project towards retention and away from the community focus.

The Project Steering Group was set up to

- *support and facilitate the work of the [project] and encourage the adoption of its recommendations*

Table 2.1 lists the steering group members. See the full Terms of Reference in the Appendix 1 for detailed objectives.

Table 2.1 Project Steering Group members

Organisation	Name
Cardiff BME CEP	Maria Beata Kreft
Cardiff BME CEP	Yasmine Abdulrahman
UCLAN	Imran Mirza
South Wales DIP	Glyn Davies
Cardiff DIP	Cheryl Chapman
NewLink Wales	Andy Lilley
Progress2work	Jon Jones
Turning Point Cymru	Steve Worobec
South-Wales Police	Graham Bartley
South Riverside Community Development Centre	Mashmooma Din
	Dr. Abdil R Ali
Probation Service, Newport	Kauser Mukhtar

The Steering Group met roughly monthly from June 2007; core members were UCLAN, Regional DIP and NewLink. The Steering Group, and these core members in particular, did provide effective support for the project:

- Sharing contacts
- Obtaining statistical data
- Informing the research team about relevant meetings and workshops
- Circulating materials from workshops etc
- Providing additional financial support for the research team to attend conferences
- Ad hoc support (for example, additional recording devices)

NewLink Wales provided direct line management for the project team and arranged monthly meetings to review progress and needs for support.

Finally, a UCLAN support worker met with the research team every two weeks for a detailed review of work and to give support and direction. Together with NewLink Wales, UCLAN closely supported the team over the whole duration of the project.

2.3.2 Ethical framework

The ethical framework used a standard UCLAN model for assessing research projects. The research team submitted, and received approval for, a detailed Ethical Monitoring Form to the UCLAN Centre for Ethnicity and Health in mid August 2007 (see Annex 2)

The ethics form showed how the researchers addressed three main issues:

- Safety of all parties (researchers and respondents) taking part in the research
- Avoiding bias in information collection, sample design, and analysis
- Confidentiality of individuals and security of data

The form describes what risks may occur, strategies to avoid them, and management responses if they occur. All CRs and volunteers were made familiar with the project ethics form; and they were trained in safety procedures during interviews (UCLAN) and personal risk avoidance (NewLink), including dress code.

For the focus groups and interviews, the team produced two standard Information Sheets. These explained, in simple language, what the interview or focus group was about; how it would be confidential; how participation was voluntary; and project/researcher contact details. The appropriate information sheet was read out before an interview or focus groups. Participants were then asked to confirm they were still willing to take part. These Information Sheets were also reviewed and approved by the UCLAN ethical committee. The Information Sheets are included as Appendix 3 and 4.

3 Reflections on the community research process

This section reflects on the impact of the project on the participants, and the lessons learned.

The project was a crash course on substance misuse issues among local BME communities, treatment agencies both in community and criminal justice system, and the criminal justice system itself. It has given the researchers an insight into the complexity of drug dependency through personal contacts with substance misusing individuals. The main discovery though was how difficult the struggle to get off the drugs can be, and how little help, even from their own families, is available for those individuals who were trying to face their addiction.

3.1 Impact on the researchers

All participants of the project were offered training in community based research, both theoretical and practical. The research team had the opportunity to gain a university qualification with UCLAN university, and five members of our research team achieved this. At the same time, the research part of the project gave the researchers and volunteers a practical experience in community based research at all its stages.

One of our researchers decided to apply for a volunteer training with NewLink Wales once his role in the project was finished.

The lead researchers also took part in the Birmingham Drug Conference, where we had a chance to find about other community engagement projects in England, promote our research, and make contacts.

3.2 Effectiveness of the Community Researchers approach

The contacts researchers were making for the duration of this project have helped to promote the project and its community engagement model among the local BME projects, and treatment and support agencies both in the community and CJS. However, promoting the project into the BME community was limited mainly through the focus group and interview respondents. The main reasons for this was the busy project schedule and limited amount of time in which the researchers had to complete individual tasks.

These same contacts helped with the recruitment of the community researchers, mainly through those in criminal justice setting, due to the specific combination of the criteria set for the candidates (BME ex-users and ex-offenders) and limited time.

Our project had a high drop out rate for the community researchers. First, a number of researchers left immediately after the first training session. Although we suggested ways in which the training could be improved, and these were taken up for the next session, there was a permanent loss of researchers who had required some effort to recruit. Second, researchers dropped out due to the long pause between the end of the first training period

and the beginning of field work, where the researchers had little to do, despite our efforts to keep them occupied. Ultimately, we needed to bring in volunteers, mostly from NewLink Wales, to give us sufficient support (note-taking etc) to carry out the interviews and focus groups.

To avoid this happening in other projects, we would suggest

- starting with a bigger pool of candidates to choose from. There was a very limited number of suitable BME ex -offenders and ex-users the agencies could provide, and so even though all candidates were accepted, this was still a small number. Even if the research is to focus on a particular group, we would suggest that the community research group can be drawn from a wider pool to ensure sufficient researchers are available.
- dividing training into smaller modules and spreading it over a longer period of time. This not only would have improved the ratio of researchers taking on qualifications but also would have kept them active till the designing the main questionnaire gave the researchers something practical to do

This had further impact on the respondents' pool. As the majority of our community researchers dropped out before the field work started, the personal contacts they brought were lost too; without obvious contacts in the BME community, the majority of our respondents had to come from agencies in criminal justice system. The real contact with the community came via the family focus group. Despite the initial prospect of follow-up with the sons and brothers of the community respondents, the next focus group did not happen as the potential participants refused to take part, and we had no alternative source of contacts.

3.3 Project timetable

Throughout the project, there was heavy pressure on timetables; delays in one stage had a knock-on effect on later stages. As a result this final report, for example, has not had enough time for reviewing as it might have done.

The work itself also increased the pressure on the timetable. To give an extra viewpoint on our sample group, and make up for the lack of white interviewees, we decided to include a focus group for non-BME DIP clients. We also created a questionnaire for generic service providers so that some of the ideas of BME interviewees could be challenged. All these changes prolonged the field work and delayed the transcribing, and in consequence the report writing. Adding the fact that due to personal reasons one of the lead researchers had to leave the project prematurely, the delay increased.

The project team did recognise this, by increasing the paid-for hours of the lead researchers from 5 to 20 per week over the course of the project. However, although this was very welcome, the work was increasing at the same time.

Two lessons come out of this:

- First, there is a need for more realistic timetables, and for those timetables to be able to adjust in response to the project
- Second, the amount of work to be done at each stage of the project should be reflected in the number of working hours for the lead researchers

3.4 Communication with agencies

Engaging with the agencies proved to be a long process, and required lots of support from the steering group and the host organisation to materialise some of the help needed. It proved to be a case both in the community and criminal justice system. Moreover, with few positive exceptions, we found the local hostels reluctant to co-operate.

With hindsight, the most important factor in getting co-operation was having the support of the Steering Groups and the Welsh Assembly Government. As the project progressed and specific problems arose, these contacts became increasingly effective. For future project, it might be helpful for WAG (or a similar body with a wide influence over the agencies concerned) to use its influence early on to ensure that doors are opened more easily.

3.5 Personal development

Taking part in this project was a great experience in getting to know the community we live in. It also gave us a chance to see the BME substance misuse problem in Cardiff on many levels by opening the discussion to the various groups in the community and criminal justice system. As our research showed, outreaching some BME communities is not an easy task, but once approached and engaged, the communities are more than happy to take part in the debate over their own issues.

Section 2: Results

22

4 The arrest experience

4.1 Description of the interviewees

We interviewed 33 people. Table 4.1 describes the core characteristics of the interviewees. Because of the small number of subjects, data are aggregated to preserve confidentiality of respondents and it is not possible to provide cross-tabulations.

Table 4.1 Interviewee Characteristics

		Number of interviewees (proportion)
Gender	Male	29 (88%)
	Female	4 (12%)
Born in the UK	Yes	26 (79%)
	No	7 (21%)
Residency	British citizen	29 (88%)
	Other[1]	4 (12%)
First language	English	28 (85%)
	Other[2]	5 (15%)
Disability	Yes[3]	6 (18%)
	No	27 (82%)
Age	25 or younger	10 (30%)
	26-35	14 (42%)
	Over 35	9 (27%)
Ethnic group	British Asian	7 (21%)
	British black	7 (21%)
	Mixed[4]	13 (39%)
	Other	6 (18%)
Religion	Islam	17 (52%)
	Christianity	7 (21%)
	Sikhism/Hinduism	4 (12%)
	None/atheism	5 (15%)
Source for interviews	Prison	13 (39%)
	DIP	7 (21%)
	Probation/DRR	8 (24%)
	Other	5 (15%)

Notes to table:
1. Includes "don't know". All interviewees who were not British citizens had been resident for over 5 years in the UK.
2. Includes Welsh
3. Includes mental and physical disabilities
4. British/non-british not differentiated

This section reviews respondents' most recent arrest referral experience. Although almost all respondents have multi- arrest experience, not always at the same police station, the focus on the most recent arrest was intended to obtain the most reliable accounts of respondents' experience around their encounter. Even so, several interviewees noted that they were too ill, confused or distracted at the time of arrest to recall all details of their experience.

4.2 Sources of information and drop-out points

All the interviewees had been arrested after February 2006, and were mainly taken to either Rhymney, Cardiff or Fairwater police station (see figure 4.1).

Figure 4.1 Destination police stations
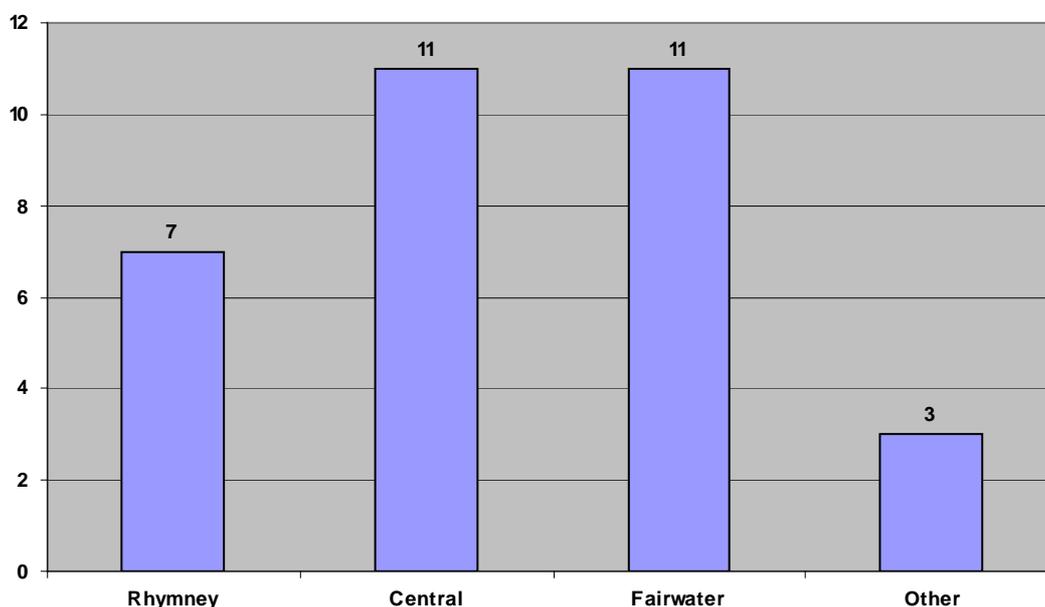
Table 4.2 presents basic descriptive statistics.

Table 4.2 Summary statistics for the arrest experience

		Number of interviewees (proportion)
Arrest date	Feb-Dec 2006	7 (21%)
	2007/2008	26 (79%)
Arrest outcome*	Custody	20 (63%)
	Bail	12 (37%)
Prior knowledge of DIP	Yes	18 (55%)
	No	15 (45%)
Prior experience of DIP*	Yes	8 (25%)
	No	24 (75%)

Was information offered?	Yes	17 (52%)
	No	16 (48%)
If information was offered, by whom?	ARW	13 (78%)
	Police	4 (22%)
Was assessment offered?	ARW	13 (100%)
	Police	0 (0%)
Was assessment accepted?	Yes	8 (62%)
	No	5 (38%)

* One respondent did not answer these questions

Roughly half the respondents had some prior knowledge of DIP, with "friends" identified as the main source; see Figure 4.2.

Figure 4.2 Sources of information on DIP
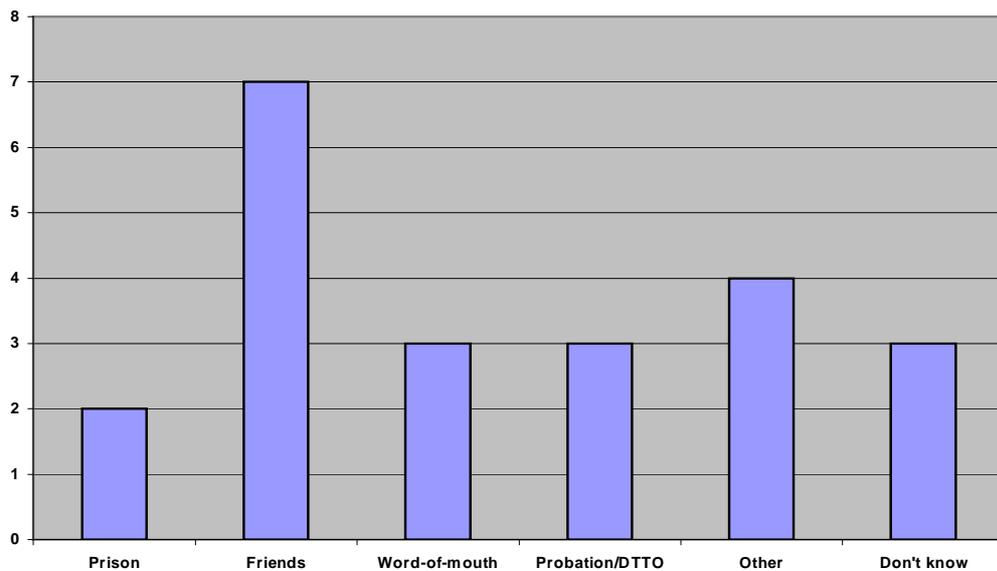
In terms of getting to assessment by the ARW, significant numbers of respondents/arrestees are lost at each stage of the process. Half of those arrested were not offered any help or advice around their substance misuse. Of those who were approached at a police station about their drug related problem, only three-quarters saw the ARW, and of those, one third refused assessment. Those approached by a police officer were not assessed. In summary, only a quarter of those arrested got to the assessment stage; see Figure 4.3

Figure 4.3 Drop-out points at the police station

Arrested	████████████████	100%
Offered drugs advice	██████	52%
Offered assessment	████	39%
Accepted assessment	███	25%
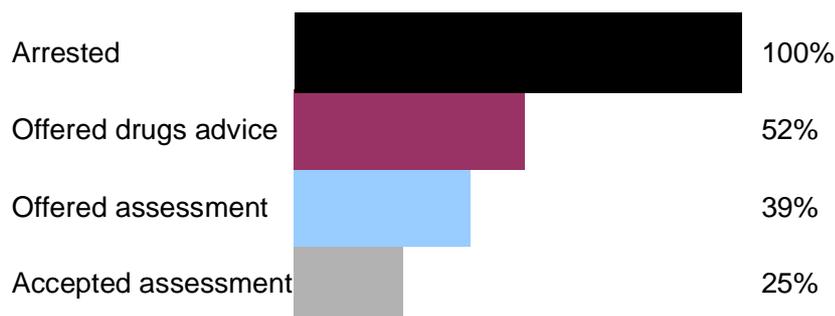
Figure 4.4 shows the numbers approached about drug information at different police stations.

Figure 4.4 Chance of information at different police stations
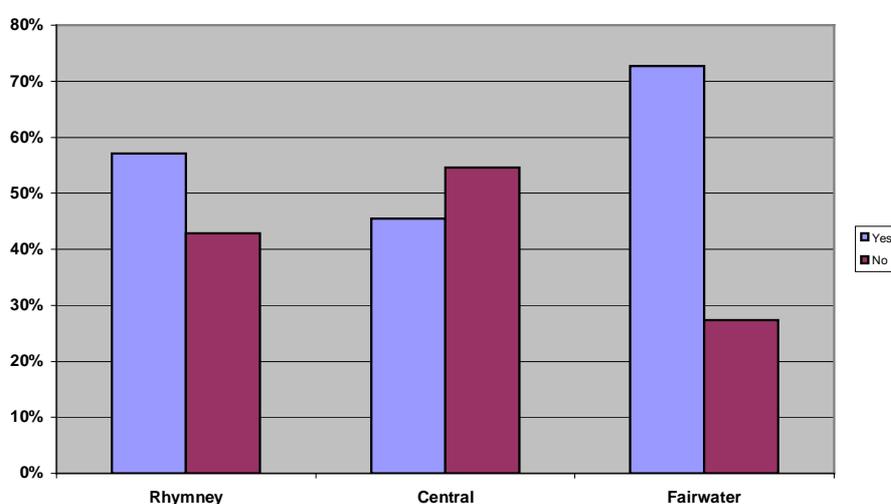
There was little difference between Cardiff and Rhymney police stations – in both cases the likelihood of arrestees being offered help or advice around their substance misuse was roughly 50-50. Fairwater was the only station to show a notable difference, with three quarters of arrestees being offered the help or advice. Fairwater is the only station to have an ARW from the BME community, but this is not necessarily related to the likelihood of being offered information or advice; the proportion of arrestees being seen by police or ARWs at Fairwater is roughly 25%-75%, the same as the overall proportion in the survey.

4.3 Contact with police officers

All respondents approached by police officers said the contact was brief; in some cases information provided was limited to posters and leaflets.

- *'He just asked if I needed help with drugs'*
- *'When I was [at the police station] I saw a piece of paper giving out information and advice about do you have a drug problem. I asked the sergeant about it and he gave me a piece of paper to read.'*

- *'It was mentioned in one or two sentences but it wasn't spoken about afterwards. I think the sergeant at the desk said to me ' would you like any help or further information?'*

Others complained about not being helped at all

- *'I never received or got offered any help. I actually asked for it myself and it was never spoken about.'*
- *'Well, all I did was read some information on the wall, some papers they gave me. They didn't tell about any places you can go there and get help.'*

And some were offered information inappropriately

- *'I said I'm on DTTO order and I can't do anything else. I was on DRR as well.'*

There was also some confusion between drugs counselling and the wider criminal proceedings

- *'I chose not to talk to the police because I wanted to limit the cooperation with'm coz I was advised to do so.'*

4.4 ARW contact and assessment

4.4.1 Reasons for agreeing or refusing assessment

While all seemed able to identify whether they were speaking to a civilian or a police officer, there was confusion about what an ARW was. The majority associated a civilian with a 'drug worker' but were not familiar with 'arrest referral worker' term. Respondents were confused about who was helping them:

- *This guy came and says that he will pass my name to some people to help me but never heard from them. Civilian I think it was.'*
- *(Do you know who it was?)Drug Intervention Officer (Do you recognise him as an arrest referral worker?) Sorry?(Have you come across arrest referral worker?)No, I don't think I have. He may have been - I don't know.'*

Those agreeing to assessment all listed it as a positive choice to address their drugs problems and get help. Only one respondent noted later that he also thought it might help his case in court.

- *'I wanted to change and he said he can help me.'*
- *'It might help me come off the class A drug and to lead me to a better life.'*
- *'I was offered a chance and I agreed – seemed like a good idea.'*
- *'I want to get off the drugs or I'll end up back in [prison]'*
- *'So at least maybe things could be better.'*

- *'When you get arrested and you're on drugs you start thinking about getting clean.'*
- *'I had a drug problem and I thought if I took this on it would be better for my future.'*

Refusals were more varied – sometimes it was a specific reason, but just as often the interviewees expressed a simple lack of interest. As with police officers, some arrestees' legal situation prevented them from getting help at police station

- *'I wasn't sure about it. I had to get a bit more information about it… before I proceed like.'*
- *'No reason.'*
- *'Because I was with DTTO, and I felt no need to find out about DIP.'*
- *'I didn't want to. … I had other things on my mind. I just needed a rest.'*
- *Because I'd been involved with them before, and plus I was on licence recall and knew I would be going back to prison, so there wasn't really much they could do for me.'*

4.4.2 Information provided

For those accepting assessment, the information they received varied considerably:

Table 4.3 Help provided to respondents

	Number receiving this help	
Info about help DIP can provide	6	75%
Address/ telephone no of DIP	5	63%
Name/ telephone no of a contact at DIP	5	63%
24-hour help line telephone number	3	38%
Contact details on your mobile	3	38%

Most interviewees were offered help in at least four of the ways mentioned above, but it was not always the same four; and 3 out of eight received only one piece of information or none at all.

Some interviewees also confused DIP with CAU; two respondents mentioned long waiting lists for DIP (up to one year).

Most of those who refused assessment still got some oral or written information about DIP. But in this group more respondents had problems with recalling what information about DIP they had been given, for various reasons:

- *'I can't remember it was so far back'*
- *I just wasn't interested. I was concentrating more on being in the police station.'*
- *'I think they gave me some sort of leaflet. I can't really remember because I was in pretty much of bad way'*

One interviewee was not impressed by the quality of the information given by ARW.

- *'.. like in bits and bobs they explained, like. They didn't actually get down to the gritty bits… they just sort of told, like what they do. Things like you gotta qualify, you gotta be sort of, you gotta be arrested recently or having trouble with the law, or something like that, like you couldn't come off the street and, and they were giving you that information like. It was like that with me anyway… I found about DIP from a friend,*

The same respondent mentioned prior negative experience of DIP with respect to self-referral

- *'… the first time I came to DIP, I asked to join it and I – about the conversation, and I was told the same thing … that I had to be in trouble with the police or I had to get arrested, or I had to be committing crime constantly to qualify, but that wasn't the case. A friend of mine told me about it and I've gone and seen, I dunno if you know him at [agency]. I've gone and seen him and had a chat with the gentleman that was there, and he referred me…'*

4.4.3 Assessment

For those who agreed to assessment, the reaction to assessment was mixed. In all cases the attitude of the ARW was crucial, more than the quality of the information provided. In five out of the eight cases, there were no negatives and they all felt comfortable talking with the ARW about their drug problems. The ARW's positive attitude was strongly highlighted:

- *'[ARW] insisted that I get help. [ARW] explained everything to me clearly. [ARW] was very caring.'*
- *'The [ARW] was very nice: [ARW] gave me all the information, [ARW] reassured me, told me what would happen. [ARW] said [ARW]'ll do everything for me.'*
- *'[ARW] was very kind, told me the main factors of how I'd benefit from methadone. [ARW] was easy to talk to.'*

Equally, where there was criticism, it focused on the ARW handling of the situation, and it sometimes affected the uptake of the information :

- *'I told [ARW] I'm going to jail anyway and [ARW] kept going on about it which was pointless.'*
- *'[ARW] talked more about [themselves]; if [ARW] had learned more about me I think [ARW] could've have personalised it more, gave me more of an idea of what I'd have to do.'*
- *'[ARW] didn't, well, [ARW] didn't know how to approach you.'*
- *'It was confusing for me because [ARW] wasn't straightforward.'*

Some assessments were limited to a short conversation,

- *[ARW] took my details and asked me questions, can't remember. It lasted 5-10 minutes.'*
- *'All [ARW] said was that [ARW] will write down my details and will send it of to someone else and someone else will get in touch with me.'*

And one respondent felt it was a complete waste of time:

- *Well, the impression as I thought, they could help give me help, like magic, that was my impression. The negative thing about it was never come back to my cell [as respondent was promised]. It was just once they saw me. So that was not true….Well, I did feel ok when [ARW] said that [ARW] will pass my information on, and that someone will write to me and arrange an interview. So I felt good about that. But nothing came of it. So every time I go to the police station I know it's a waste of time, they don't get in touch with anybody. It's just a saying, like.'*

This respondent felt let down twice: once when the only contact was the initial assessment, and once when there was no follow-up from DIP. This respondent was also the only one to respond negatively when asked if the ARW understood the kind of help wanted.

4.5 Evaluating the ARW service

Generally the interviewees who agreed to assessment were happy with the ARW service and claimed that at the end of their assessment that they had a good understanding of DIP service and treatment. However, there were some improvements suggested, that included

- Better access to methadone on arrest for those already in treatment
- Better information flows when an ARW is not present: substitutes may give misleading information, or not pass the information to ARW at all:
- *' I think that it could be better the guy could tell you which company is going to see you and what kind of help will they offer you. Not just came up and say that you will see somebody and they will sort you out.'*

And one respondent – who did not agree to assessment – suggested that the ARWs needed more credibility

- *'What would be really helpful like you know if the staff wasn't just from one background but from all walks of life, people who've been through drugs, people who haven't been through drugs…it's culture and communication barrier ain't it, with certain people, not everyone like, with certain people.'*

One person questioned the rules about who qualifies to be offered a referral to DIP on arrest; one must have a multi-arrest drug related criminal record to be qualified, which is too late and negatively effects the legal situation and

health of the substance misusing person –(it may explain why so many arrestees are not approached on arrest)

- *'There has to be a 3rd [arrest] and then only will the police then take you seriously. Otherwise they don't have time. It could take up to 6 months or a year [to be arrested several times]. I can't wait that long! Probably if they helped earlier, things would have got better for me.'*

Interestingly, however, getting treatment was cited by two different interviewees as a reason for getting arrested:

- *'I was already motivated anyway because I wanted to get help…I couldn't go to DIP and say that I want help. I had to get arrested 3 times till they actually get a drug officer and then they refer you to the DIP…I had to go through that road'*
- *'The first time I came to DIP I asked to join it and…I was told the same thing … that I had to be in trouble with the police or I had to get arrested, or I had to be committing crime constantly to qualify, but that wasn't the case. A friend of mine told me about [the real situation]… if it wasn't for him I wouldn't be here.'*

This may be related to the delays in getting into the CAU programme (see Chapter 7 Aftercare, below).

4.6 Ethnicity

No group saw ethnicity or culture as a problem around their experience with ARW. However, one respondent stressed the ethnicity of the BME ARW who approached him/her as a bonus.

- *'..[ARW] was [BME] and that help… It was positive that that [ARW] was [BME], [ARW] knew where I was coming from, being an ethnic minority.'*

There was a single voice who suggested it might have been a problem on a previous experience but couldn't be more definite.

Interestingly, however, there were some voluntary comments on ethnicity issue around general arrest experience (staff attitude)

- *… because of my colour. Most of them think that I am natural criminal…. I noticed from the way they spoke to me and deal with me. It's not right! They don't chat to me like they chat to the next guy. They just bang me into cell and leave there… They took me to court and the judge gave me bail. But the police station never gave me bail'*

4.7 Wider comments on arrest experience

There were various comments on police staff attitude around arrest, mainly about negative experiences, some from previous arrests.

- *'I've gone to other police stations and I've been told 'no, I won't pick up your methadone.' I'd to wait … like from 7am to 10pm… until I got my methadone. They think coz you're on heroine they've got no respect for you because you're junkie.. I wasn't taken seriously.'*
- *'It was hard I had no food or anything. It was awkward, the police was torturing me saying 'Oh, bless him, he can stay in here for another week now.'*

The medical help at a police station was often late and limited ,

- *'I had to ask them about a Doctor…Well, first of al they said the Doctor will be here in two hours and then I had to wait – like I got arrested in the night and I had to wait, I didn't go to court in the morning. I had to wait all morning and then he came the following night… (of whether the medicine given helped) Not really, no because I had a bad fit- one DX(?) and he kept me waiting hours- I was like sick in the cell, I was puking up in the cell, everything. They knew I wasn't putting it on.' '*
- *… in the police station for three days I was, but they didn't even call a doctor – so I had to suffer a fit when I was withdrawing; I suffered epilepsy, and that's when took me to the hospital and gave me methadone.'*

4.8 Summary

Generally, respondents were pleased with the ARW service. However, a relatively small number of those actually arrested get on to the programme. The critical comments referred mainly to an ARW's handling of an assessment or the quality of the information provided. Ethnicity was not an issue with respondents' experience with ARWs, yet some pointed to their negative experiences with police staff on arrest.

There was a number of improvements suggested to arrest referral, mainly referring to medical help and drug service info on arrest, and a need of an ARW with a first-hand experience.

The major drop out points are:

- Respondents not being approached at police station (50%)
- Those approached by an officer are lost as no referral is made (respondents are not aware there is self referral, and none reported being informed about it at police station)
- Of those approached by ARW some are lost due to refusal to participate in assessment
- Of those assessed, some are lost due to lack of arrest referral follow-up

There are several factors that affect referral experience

- Majority of respondents were tested positive for drugs on arrest, and some of them were too ill or aggressive to be approached; or if approached the communication was affected by their condition at the time.

- Some of the meetings were too short for some respondents to get/take up a full sense of what DIP has on offer; many respondents had limited or patchy knowledge of DIP service, some felt misinformed
- Not all were provided with written information re their drug problem/DIP service
- Some were confusing DIP referral with referral to CAU
- A small number had bad previous experiences re entering DIP/treatment in CJS
- Some bad experience around arrest due to unsympathetic police staff;

There is also some suggestion that a small number of users may be using trigger-offences to hurry up their entry into a rehabilitation programme.

5 DIP experience

This section looks at the experience of DIP. 17 respondents had a referral to DIP, and 13 had experience of the DIP service. This section focuses on

- the follow-up to referral
- the initial appointment
- treatment
- case managers
- ethnicity issues

5.1 Follow-up to Referral

Of the 17 respondents with a DIP referral

- 10 were referred by ARW (see Chapter 4, The Arrest Experience)
- 3 were referred by probation/DRR
- 2 were referred by prison (see Chapter 6, Prison)
- 2 were self-referred

6 of the 10 ARW referrals were not able to take up their appointments as they were sent to prison or on DRR; and one person thought the referral was for CAU, not DIP. Of the other three, one had to self-refer, claiming that no appointment or details were given by the ARW:

- *'Only way that I can do that is if I go there myself. I asked [friends] where the place was and I came down [to DIP]… I spoke to someone in reception. I said 'Excuse me, how do I get my name put down for here' and [DIP worker] said that I need to get referred or I put my name down. So, I asked my probation officer if [Probation] can have a word for me but I don't think [Probation] did… I say so because [Probation] did not even know about DIP. I told [Probation] I was in DIP and [Probation] looked shocked.'*

The 3 referrals from probation/DRR were informed about their appointment dates with DIP by their probation officers, and did make their first appointments. During the first appointments the respondents were told what kind of help they would receive. In 2 cases mainly methadone was mentioned, and both respondents reported some confusion over post-appointment letters DIP was to send to them. Both claimed the letters did not happen, and they had to chase their cases themselves; instead of contacting the clients directly, DIP contacted probation/DRR. After finishing their DRR orders, both respondents were waiting over 2 months for methadone with DIP. For this period, DRR put them back on their methadone dispensing list. One could not start a methadone prescription with DIP because the case manager was repeatedly unable to make the appointment with the respondent. Both were critical about DIP's service; lack of communication was the main problem:

- *'they should send you a letter but they haven't sent anything, they are slow like, you know what I mean? I've never seen anything like these [DIP] before…'*
- *'…I thought that maybe they would start my Methadone now, so I went [to DIP]. The person wasn't there so I came back [to DRR]… I told [DRR] I went [to DIP] and the person wasn't there and [DRR]…done something in the computer and [DRR] re-started my Methadone from [DRR].'*

Only 2 respondents with referral to DIP from prison mentioned any follow-up, and both were contacted by DIP by a letter. One came into contact with DIP straight after prison before receiving the letter .

Of the self-referrals, one claimed that he/she had to repeatedly take the initiative in contacting DIP as there was no follow-up to the original referral from an agency.
- *'It took like two-three weeks and I wasn't getting any feedback. In the end I went in and kept harassing them and asking them what's going on…In the end someone contacted me about the fourth occasion.'*

In summary, there were no positive comments on the effectiveness of the follow-up to referral process, and many important negative ones.

5.2 First appointments

The questions in this section asked respondents to focus on their first meeting with DIP, highlighting the good and bad elements. Opinion was almost evenly split.

Good:

- *'They knew I was pretty desperate so they tried to accommodate me and help me along. I saw someone on the very first day.'*
- *'It was good. I had my first appointment with [name] and then with [case manager], they seemed more interested in helping you, when I was telling [person] about the other problems I had, other than drugs, they seemed to listen – DRR didn't want to listen – they just gave out the medication and that was it.'*
- *'No negative points about the first DIP meeting. It's nice that people want to help people like me on drugs. They go out of their way so you have to keep up appointments and not let them down'*
- *'I met the person, and was offered a cup of tea and felt comfortable, had a chat about my issues, they were understanding. I felt relaxed and walked out feeling a bit better. I can use the telephone, nothing is rushed etc.'*
- *'It was o'right'*

Mixed:

- *'The first time, after I got referred [to DIP] the person I had the interview with. I dunno maybe it could be me, but I found [DIP worker] a bit arrogant towards me. So the next time we went I asked to be removed*

from [DIP worker], that's why then I've gone with [name] and [DIP worker] got fine.'

- *'It was just a straightforward meeting. I was only in there about five mins, just a couple of details and that was it.. we'll get in contact with you in six weeks time or something… they offered me methadone*
- *'I put my name down to get help and I turned up once and after that I got into trouble so I didn't go back.'*

And bad:

- *'They said we'll send you a letter… but I haven't heard nothing… I had to go see them to find out for myself. They never sent a letter or anything to say who my case manager is. I had to pop in, they said to me they had a case meeting, and your case manager is [name]'*
- *'To me they look like a bunch of cowboys…because a couple of times I've been over there now and said what's happening and they've not know what's happening, and I'm going to have to go there now again…With DRR everything is straight forward; there's no stalling tactic or any of that business.'*
- *'[No letter sent; 2nd DRR appointment was first visit] The first time I went [to DIP] for an interview and they told me they would send me another appointment, for starting, but I didn't receive anything where I live. So I came [to DRR] and there was a message from [DIP] to say you go to the next appointment with the person whose name is [name]. So I went there and the person wasn't there, [DIP worker] was in Court or somewhere, so I'm still waiting…[Of the interview] It was poor. I had an appointment with the person and the person was not there, so when I went there at the right time and the person wasn't there it's not my fault*
- *'They did not even know who I was! They couldn't find my record. This continued till the very last minute. I had to keep coming back and they said they lost my urine sample. I think they did it on purpose. At the end they did find it after I kept on coming in all the time and asking 'Did you get my urine sample?"*

In summary, while case managers and DIP staff seem helpful and friendly, the organisation itself comes across as very disorganised.

5.3 Treatment

The respondents were asked about their support with methadone, housing, counselling, alcohol and crack interventions, and support from voluntary workers.

Most of the respondents received methadone, which was seen as a mixed blessing:

- *'I didn't want methadone… coz to me it's just another way of… covering up the problem…I wanted these pills…if you know them, … they are another way of substituting but not as addictive… Methadone is more addictive than what you are taking on the streets… they don't*

do that [in DIP], they only do methadone so even though it wasn't my choice…It stopped me taking drugs but what you gonna do when it comes to the end of the road… it's good in a way and it's bad in a way'

- *'[Rating Very Good] Helps I get off heroin!'*
- *'The only good thing about meth is that it's free and it's the only thing that can stop the pain. And it's worst. You can't sleep. You can't walk. You get diarrhoea.'*
- *'I take heroine too, but only a small amount, because the meth quantity that they give me is just not enough and it isn't helping me enough*

For all 3 respondents with referral from probation/DRR there was a delay in the start of DIP methadone treatment:

- *'DRR keeps people on meth till they are taken over by DIP even their DRR order is finished. … So that's good thing coz a fortnight before I was panicking, I thought – what if I can't get to DIP before my order runs out.'*

The prescribing was good, if the measures weren't:

- *'The service is very good, if you want any help they're willing to help you'*
- *'They don't do a pee test when you're on the methadone, they should do one before you start it. I've gone up and up, at first I was on 40ml now I'm on 70.'*
- *'I just come and get my meth and go…They are not giving me the right amount of meth for my need. Like on first day it's 30 mil…2nd day is 40ml and 3rd day was 50ml. I can't take that because I will go and take up heroine to get the same high'*

The timing was mentioned as a problem:

- *'Well, it's hard getting [to DIP] for 10-12. To be honest I think it's stupid when this building is open until 4pm and there are people in here till 4…sometimes I just can't make it and I have to call and ask them to put my methadone away somewhere. Sometimes they do it and sometimes they don't. If you're later you just have to suffer.'*
- *'On a Friday they give you methadone for the weekend, if you're 2 minutes late then you have to go without for three days and this will make you really ill. So if you had an appointment in the morning on Friday and didn't get back on time I'd miss having methadone on a Friday, Saturday and Sunday.'*

Finally, having other drug users visiting DIP was seen as a potential problem:

- *I would prefer to go to the chemist to pick up my prescription, coz coming here, you still see people that are still using, there's a lot of people dealing outside – so you've got to get past that, it's tempting. If you're doing it just to get off a court case then it's not going to help you…They couldn't do that outside DRR – there are cameras outside – if you get caught, you get taken straight off methadone and that's it*

- *'I don't like coming in here at all- the surroundings, the people in here and all like. The people on drugs and all that, I don't like being around it. …I'm saying coz I ain't on drugs anymore. I ain't running them down but I just don't,… like being around them coz I know what it leads to.'*

And the problem seemed not to be addressed

- 'Some people still use drugs when they're on methadone but they don't pressurise you or anything. They pretty lenient in a way.'

Respondents received their methadone at various times after their assessment:

- two in less than a week
- three in 2-4 weeks
- two took over six weeks

although both of the longer cases had problems with documents. During the waiting period, contact with DIP varied from nothing to once a week. Overall contact with DIP in some form (case manager, doctor, nurse) seemed to be about once every two weeks.

Housing advice, where relevant (as half of the group did not need it), was more often viewed as good but there were complaints:

- *'Very good'*
- *'They picked me up from prison the first time I was in prison…then took me where I needed to go'*
- *'Poor – reason for this being that I told them about my situation and they did not come and help me'*

In some cases, the burden was still on the respondent to follow up:

- 'My case manager did mention the YMCA but [case manager] said that I need to go to them and get a letter that [case manager] can follow up and hopefully something can be done. [case manager] said it's better if I show myself first and then they see that I am keen and I want to change my life around. But I do not know of any other reason for this.'

Hostels were mentioned as a less-than-ideal solution for those wanting to stay off drugs:

- I am living in a hostel- all the bad people are living in hostels, most of them do- for selling and smoking, stuff like that. So first thing I want is my own room or my own flat which is the other side of city centre- they know me and I know them. I don't want to stay here. I want to go somewhere else. Stay away from the same people.'

Counselling on harm reduction received one each of 'poor', 'ok' and 'good' ratings. Overdose management counselling got three 'good' ratings out of five and one 'poor'; one respondent commented but couldn't tell whether the advice came from DIP or a doctor from another agency.

Information about alcohol and crack intervention programmes was similarly mixed:

- *'[Alcohol] That's good, coz you never know the person could have been drinking, so I do agree that you should give information about that.'*
- *'[Alcohol] The last few years I've had a problem with drink…Info on alcohol is brilliant coz you have the steer project.'*
- *'[Alcohol] I need help with my alcohol and they have not helped me with it. They say wait, wait but they didn't do anything about it. '*
- *[Crack] It sounded to me like the person who was talking about it didn't know much about cocaine.'*
- *'[Crack: rating Very Good]- that's my main problem and heroine'*
- *'[Crack] All they say is give up and you will have more money in your pocket.'*

There was no awareness of practical support from volunteers.

Although comments on this section are mixed, in general respondents were consistent in their remarks – that is, a good experience in respect of methadone treatment was also associated with helpful information about crack interventions, for example. In other words, the interaction between respondent and case manager usually leads to a good experience across the board, or a poor one.

5.4 Case managers

Four of the five respondents who answered the question said that they received appointments with their case managers (CMs) less than a week after the first assessment; the other had to wait several weeks and repeatedly chase up DIP.

A slim majority of the respondents were positive about contacts with the case manager. Two commented on their contact with CM outside the medical treatment

- *'It's more friendly than the other [person], will phone you and ask you, you know, you need this…or if there's…football or swimming that [case manager]'ll say I'll come pick you up… to me [case manager]'s more professional.'*
- *very good, comes up my house whenever I needs [case manager], [case manager] comes straight away, so that's good*

And one more reported 'very good' support and enough contact. But there were some negative reports; once again, contact on personal level was the issue:

- *'It either 'yes' or 'no' and when do I get my methadone, and that's it. No need to socialize. It was very poor. I had to change my case manager… [case manager] didn't bother with an appointment, it took [case manager some] weeks to actually come and see me! [Re the 1st meeting] there was no structure, no nothing. [case manager] spoke to*

*me the first time and said to me ' what do you want to speak about?!!'
…Frankly, I heard one of them say to another 'so and so would do
without our help'…[case manager] took [case manager] off because
[case manager] said I don't need [case manager's] help. [case
manager] said I can rely on myself. I always do!…(of initial delay in
being put on methadone)I felt that no one was helping me with the
methadone. After the trouble I had with the first one [case manager], no
one helped me. I did not to want cause more trouble so I had to keep
my mouth shut'…In 3-4 months I only saw [case manager] 3 times! We
did not even have time to discuss different organizations that can help
me.'*

- *They don't want to help me. And in most cases [case manager] did not
  know what to say to me. Maybe [case manager] was feeling
  uncomfortable with me. I don't know.'*

- *'They don't care what I'm doing. They just give me the meth… They
  don't ask you how were your day or yesterday? How did you sleep last
  night? Did you have breakfast this morning? They are not interested in
  any things like that. They just give you your meth and goodbye! …*

The latter respondent also complained about having to discuss personal
issues in front of other people, often in the reception area:

- *'People are listening and I don't want them to know about my business.
  But you have no other choice but to chat to them in front of other
  people. It would be better if it was private.*

This situation was often observed by the researchers during visits to DIP. It
was noted by the researchers that case managers, on several occasions,
discussed client information audibly in an open waiting area.

One person was confused about the procedures for contact:

- *'I was thinking that if he thought he wants me to see him, he will make
  an appointment for me so I haven't tried to make an appointment. I see
  it as they try to make an appointment only when they want to and when
  they are ready to see me'*

And one commented that, although the experience was positive, there was a
need for continuity:

- *'I met the person [at first assessment] and was offered a cup of tea and
  felt comfortable, had a chat about my issues, they were
  understanding…I have a case manager now but [case manager] is a
  different one. I think it's better to have one manager all the way
  through. It's more personal. I think the contact we have isn't enough….
  If I had too many professionals I don't like it.'*

Interestingly, most respondents did feel that DIP service worked in the way it
had been explained – even those who complained:

- *[From a complainant:] 'In practice, yeah [it worked as described]. It was good in regards to receiving my methadone. They explain very well. It was all explained adequately'*

When asked about whether managers understood the needs of the respondents, one respondent suggested that case managers 'could do more' while three others were happy with the service. There were two negative comments:

- *'No one will listen to me or anything that I had to say. I tried a lot but I'm always called a trouble maker!'*
- *'No [no help], not with my crack or my alcohol only the heroin problem and that's it.'*

In summary, there were some very unsatisfactory examples, and the general impression of the case managers was mixed.

Some suggestions for improvement in respect of cases managers were mentioned:

- *'I reckon [case manager] could have been more professional. That's how [DIP worker] was coming across to me; instead of staring…the body language was terrible…They should have more interaction with the doctor, you know what I mean, certain people are not reliable. If they [DIP] actually went to see the doctor face to face instead sending a letter saying we are giving so and so methadone…*
- *'Confidentiality with the case manager…Communication in a sense that they only want to know about my drug problem and nothing else.'.*
- *'More privacy. They talk about you in front of others sometimes and I think they should do this in a private place… More one to one consulting, give more overdose awareness…'*
- *Only my heroine addiction [was addressed]. They gave me meth and that was it. But other than that there was no other help…They don't tell you what's going to happen. …What are they going to do. If they meet with me, we can discuss all that. … I don't know what they are going to do about my alcohol. I don't know what they are going to do about my housing..'*
- *'Try and see them on regular basis and stay longer.'*
- *'They should have one to one support. They should try to give more support than what there is now, like counselling..'*

More widely, suggestions for improvements to DIP service included methadone dispensing:

- *Too short dispensing time - 10-12 isn't a good time for handouts (of methadone), there are too many people to serve between 10 and 12. There should be handouts at the chemists at night…If I have support every single day and got tested everyday it would be a lot more helpful and would make me stay off it more…find it hard to talk to people and people look down upon me and judge me. A lot of people feel like that.'*
- *Making the time a bit longer to get your methadone, that's about it.*

- *'I have probation which is all the way in Cardiff. If I have an appointment at 10 am then I can't get back until 12.30pm and then I miss my methadone and then they won't give it to me.'… with CAU you can get your script at the chemist so you can get it up until 6.00 in the evening*
- *'If I wanted to go away on holiday there's no help. I'd have to go without methadone but with the CAU they will help you and give you methadone…if they don't abuse that system I think everyone should be allowed one holiday once a year.'*
- *'I wish I could come in once or twice a week though and pick it [methadone] all up at once because coming in everyday is a hassle and can be difficult. I think they should issue bus passes too. Probation provides it for you when you're with DTTO and you can go anywhere on these passes.'*

Waiting time for treatment:

- *' a doctor should see you the first day and put you on treatment straight away so you don't commit crime. …(of 1-2 week waiting list) - it's just by that time you could commit crime, it's a long time to wait.'*
- *'The negative was the waiting list, the positive is the service that they provide when you're fortunate enough to get into the DIP*
- *' they could have done a lot more. I don't know why they're taking so long. They are dragging their heels whereas CAU were straight forward.'*

Bringing DIP physically into the client's environment:

- *'Another DIP office in another place, down the docks. Ethnics don't come here, do they? They are ashamed, ain't they? An office in the Bay, the Pavilion. Even two days a week. They are just seeing the people they want to see. There's lot of people out there suffering, believe me. … There are a lot of my friends need help and they won't come [to St. Mary St.]*

And the importance of wider help, not just methadone:

- *'DIP service can improve by helping us get good jobs. I always apply for jobs but they always say No, no, no. So I just give up and forget about it…If I had a proper place of my own, I would have something to live for. Work for and keep it tidy and live like the Jones.'*

5.5 Ethnicity

Ethnicity was raised as a negative experience by one respondent:

- *'They are not used to having ethnic minorities as clients. They are used to dealing with their own people. They have patience for their own people only but they quickly get upset with anybody else. English people like helping English people and if we don't like this we are told to leave the country. Their country, their people, their help. So you*

have to shut up and take it or you will make it difficult for yourself… I had problems with my case manager over ethnic issues. [case manager] wanted to discuss arrange marriages for some odd reason. [case manager] was very rude about it actually. I heard [case manager] speak to other English people and they don't think much of ethnic people! So I don't need to speak to any of the case managers. They said they understand different people. I don't think so!…DIP has not had any training in to deal with ethnic people …They would only want to deal with their own people'

One, who had no personal experience, suggested a potential general problem

- *'There are lot of minority people who's got drug problem, you know what I mean. It's not just British people…there's people who can't even speak English, they should have more other people [you mean translators?] Yeah, or, they could improve that or they could have someone who's from other backgrounds or ethnicity, it would help.'*

One suggested that ethnic differences in support did not always work the same way:

- *'A white person get better drug treatment than a black person, but then coming to housing a black person will get better help with housing than a white person.' (from sec5)*

And, as noted in section 5.4, DIP offices are not based where ethnic communities are concentrated, which may have an effect on their uptake of services.

Apart from this, no ethnic, cultural or religious issues were raised.

5.6 Summary

The results of the DIP service review are a mixed bag, some very positive responses, but some very negative ones. The impression given by case managers reflects this, varying from very good to very bad. DIP as an organisation comes across very poorly, especially in basic organisation. Most evidence suggest that DIP is perhaps not active enough in effectively picking up the range of referrals. The DIP environment itself is singled out for criticism – methadone issuing times are inconvenient, and mixing with drug users at different stages of their treatment provides an opportunity for backsliding.

There were some specific ethnicity issues raised, but, with one spectacular exception, these were relatively general and were ambivalent about the impact of ethnicity.

6 Prison experience

30 out of 33 BME respondents have prison experience within the last three years. 13 were interviewed in prison, and 17 were interviewed in the community. All interviewed inmates were selected by prison staff or CARAT. 2 out of the 30 claimed that the prison sentence was not drug related. This section discusses the prison experience for these 30 respondents including

- their interactions with CARAT, their medical treatment and rehabilitation courses
- the referral process for post-prison treatment

Many respondents have multi-prison experience, from different prisons, from previous sentences. The opinions given below come from all respondents and reflect both current and past experience. Interestingly, the answers given by respondents was more down to an individual's experience and communication skills rather than how 'fresh' the experience was (in other words, there was little difference between inmates and ex-inmates). Note also that some of the prison experiences referred to are from prisons outside South Wales.

6.1 In-prison experience

In this section we review the contact with CARAT workers, the effectiveness of rehabilitation courses and treatment experience.

6.1.1 Contact with CARAT

75% of respondents saw a CARAT worker (CW) in prison. Of those, many reported a good relationship with the CW:

- *'speaking one on one with the [CW], [CW] was helpful, made you feel comfortable, seemed like [CW] cared, wanted to help and it was descript.'*
- *'[CW] was good as gold'*

Although there were a (slightly smaller) number of negative comments:

- *'You need somebody there who can listen and not treat you bad and knows what they are doing… they should have somebody who is there to help you realize what is good for you and give you moral support but… they weren't interested…If they have somebody who will understand why we use it and what effects of it are and what the consequences are too, than we will all be happy. Always people ask for help but help never comes.'*
- *' I don't get the feeling that they care, it's just a job'*
- *'One CARAT worker basically told me how stupid I was and why I couldn't just give up the heroin, and in the end I said to [CW] 'Have you ever been on it? When you've been on it come back and tell me what it's like.'*
- *'they say they will come and they don't'*

- *'Because they're not doing their job, they are supposed to help but they're not. I don't know why.'*

However, the main concern raised was the length and frequency of CW visits.

- *'The main problem for me was the fact I wasn't given help or methadone straight away or somebody from CARAT coming out to see you. I've committed 2 more offences before I went to court. On the first occasion they should help you, start on 20mil to help and go from there.'*

In seven cases, there was only one meeting with a CW, and this could be anything up the four months after arriving in prison. Four respondents commented that the visits were very short, and two complained that you needed to book if you wanted to see the CW. However, one respondent stated that

- *'any time I need [CW] I can just ask'*

Some respondents did not engage with the CW for personal reasons, as they didn't see how it was relevant:

- *'I felt fine. I only wanted to do a course, which I did…Not drug or health related help'*
- *'I wanted was my script'*
- *'I was ill, I just couldn't be bothered…[Then, after detox programme and in a different prison]…I didn't really need it because I was clean at that time'*

Finally, one respondent reported that the reason for seeing the CW was pragmatic:

- *'[Were you comfortable talking with the CW at all?] Yeah, but that was just to get out of the cell. It was hopeless'*

In terms of improving the service, the key request was for more counsellors and more opportunities to meet with CWs – not necessarily so that inmates must meet CWs, but so that they have the opportunity to do so.

6.1.2 Courses

9 respondents did courses in prison, generally to a positive reception

- *'I was doing a few – one was drug and alcohol awareness [How would you rate the quality of the courses?] Very good…Everybody should have a chance to do these courses that are available in Prison because it all helps you when you get out'*
- *'She offered me courses straight away'*
- *'You go to on classes if you haven't got a job and they just talk about drugs in general within the class'*

Opinions on courses largely related to the respondents' attitudes to coming off drugs.

- *'I've heard it all before…You can have all the drugs talk lin? the world, but if you aren't ready you can just say yeah, yeah, yeah and agree: but then if you aren't ready to come off yourself, then it's no good.'*
- *'You can get only certain help, rest depends how you want to help yourself.'*

Several commented on the waiting times (up to a year) and on the limited choice; in some places, inmates are simply told what courses they will do:

- *'It's hard to get on a course because they can get easily full up…Say you do one course, you are going to have to wait another six weeks to do another course'*
- *'When I went into prison they told me what courses I had to do. I started the courses two months into my sentence'*
- *'I'm going to do a rehab course. I've been waiting for this for three weeks. I don't know when this is going to happen'*
- *'…just dropping them at the end of my sentence is not enough either. There should be courses at the beginning, one in the middle and one at the end.'*
- *'If they had more things made aware to us when we were there [prison]… I had to get off my own back and find it for myself, because no one told me or made me aware…I was quite surprised when I first went to jail, I can't remember the name of the course, but basically all the ethnic minorities are on this course together. It was more for immigrants than anything. …it didn't really benefit us who were born and live here.… giving us the option rather than sitting there [at the course] thinking well I don't really want to be here… is this for us? What are you going to do for us?'*

The last respondent also emphasised that keeping inmates 'busy' is one of the key benefits of the courses:

- *'They should also have something to keep me active and doing these courses so I don't forget what it's like coz I could get out and start doing drugs again'*

When asked to suggest improvements, inmates and ex-prisoners suggested several improvements
- Increase the number and variety of courses
- Spread the courses out over time
- Increase availability for courses (ie not just for heroin addicts)
- Make participation in courses voluntary
- Give free choice of courses
- Try to keep inmates occupied

6.1.3 Treatment

Of the 30 respondents with prison experience, 15 received some treatment, 13 didn't, and two claimed their offence was not drug-related. Of the 15 who

were treated, 13 were using heroin; 7 of the 13 untreated were heroin users. Most of the heroin addicts were using it in combination with other drugs.

Respondents were generally very critical about the quality (or lack of) of medical treatment. These complaints related to:

- Treatment of methadone users
- Appropriateness of drug regime offered
- Appropriateness of drugs
- Quality of medical staff
- Lack of mental health treatments

We will take each of these in turn.

In respect of methadone users, there was concern that only those on a pre-existing methadone script already were likely to receive methadone:

- *[Said one heroin user of the drugs test] It wasn't positive for heroine, it was positive for crack cocaine, so the doctor wasn't helpful and didn't proscribe me anything because I wasn't positive when I was tested. There was no evidence to show I had a problem. I asked for help, medicine, and they said no just because I was negative for heroin.'*
- *They said there's not much we can do about it unless you are on heroin.'*
- *Outside I wasn't on meth or anything like that, so [the doctor] couldn't give me anything. I said when I'm outside I'm on heroin, I can't be on both can I? And [the doctor] still refused me.'*

Even those who did receive methadone felt that often the treatment regime was poorly handled:

- *'Went in on Friday and didn't get in contact with DIP until Monday. It's because I went in on the weekend…Positive was I had my meth everyday, negative was the meth wasn't given out around the clock'*
- *If you're a drug user and you've obtained outside, there's no help whatsoever, you have to have a script. I've seen [people] clawing the walls. But once you're inside taking meth they drop you so quick. If you're a heroin user they give you 30 [drops to 15, 10,5]. If you've obtained outside though they'll keep you on 70…then cut you down to 30. They try and cut you down too quickly by 5 a week. In prison you got no help'*
- *'Reduction is too quick. They don't care about your needs.'*
- *'Normally if you're on a script when you're out, they've got to maintain your script [But the doctor didn't accept as a genuine prescription] and what he did was start me on…a 12-day meth treatment.'*
- *'They start you on about 10mils, take you up to 40 and then they bring you down- it's the worst detox I've ever had in my life. I'd rather lie on my bed and dribble…Suicides everywhere coming off methadone. It's awful, I've seen a few over there'.*
- *I've seen people crawling the walls- what makes it worse on the detox wing, they stick you two in a cell and it's not nice seeing people like that'*

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- *I had 10ml…I feel I could be a lot better…I tell the nurse and they say they may talk to DIP but 99% of the time it gets rejected so I just haven't bothered'*
- *'The prison should've supported me because I was a criminal and criminal offenders should get supported from jail as far as I'm aware.'.*

Two of the respondents suggested that changing methadone dispensing times would be a big improvement.

Although several respondents complained about the lack of methadone, others were more concerned that it was the only solution on offer:

- *'No, I wouldn't take anything from them anyway, I wanted to do it myself… jail got a detox thingy but you know what I mean, it's not for me.'*
- *'Medication is not right, it doesn't do anything.'*
- *'I didn't want it. I've never taken it. From what I've heard … you get withdrawals symptoms from that as well so I thought I'm bad enough as it is.'*

The majority were not happy with their treatment:

- *They just gave me DFs and chlorides that's all they gave me really, it was rubbish, it were, to be honest with you.'*
- *'It did help when there were DFs and stronger medication, so I wasn't in such a pain.'*
- *They didn't give me what I needed to get off drugs. I was put in treatment but it didn't help me…'*
- *'I asked for some kind of meds to come off the cocaine but they never helped me…I saw the doctor three weeks later because the list is so long…[Three weeks later the doctor said] It's okay, it's just phase you were going through, so you'll be all right now'*
- *'Very poor, disgusting.'*

And two respondents highlighted Valium or painkillers as a control strategy:

- *'If you're positive for crack they will probably just give you Valium…All they basically do is dose you up to shut you up.'*
- *'I was on [painkillers] for about two months. I was walking round in a day dream…A inmate knew who I was from past experiences and he told me to stop taking the medication because they were making me drowsy and I didn't realise what was going on [other inmates taking advantage]'*

These views on treatments were reflected in judgements on staff. While nursing staff were generally ignored or praised, doctors came in for more criticism:

- *'They were nice people, doctors, officers. They treated me good…the staff were good, not aggressive or demanding, they were very understanding'*

- *'I seen them but they weren't helpful at all, just gave me DFs for about 2 weeks, that was it, then get on with it.'*
- *'I felt ill for 2 months so I went to the doctor and the doctor said 'you're fine.' I told [the doctor] my drug related problems but [the doctor] never put me on anything.'*
- *'Prison officers, doctors and nurses were not very nice…Went though a lot of pain [with non-drug related illness] coz the doctor wasn't there to help me or make these decisions…Nurses in general were not nice at all, maybe coz they have so much trouble with any prisoners they stereotype us all'*

However, at least two of the respondents had had their treatment restricted because of bad behaviour

- *'They wouldn't let me see the doctor because last time I was here I [attacked the doctor].'*
- *'Afterwards I wasn't happy with my medication, so I kicked off a bit, so they put me on basics, so I lost my TV and wasn't allowed out of my cell…I didn't mind then because I wasn't very well anyway. That jail is completely wrong like.'*

And one respondent was forced to stop his treatment by returning to court.

Some respondents mentioned the lack of support for mental health problems:

- *'I could've been seriously ill with mental health issues and they still wouldn't have given me a mental health worker, someone to talk to, to make you feel a bit better, they send you to a [prison doctor]…They said…leave the drugs alone and your mental health will be all right'*
- *'There was no help related to my drug problem. If I was given help I wouldn't have re-offended. The staff should talk to the inmates and ask them what kind of help they need and stuff like that. They don't do that. My opinion is, If you're in prison, they should have staff to give you on-on-one and ask what your problems are.'*

Finally, there were some comments about the wider environment. Three inmates noted lots of people bringing drugs into prison, even the detox wings, which made coming off drugs much harder:

- *'Lots of people were bringing drugs to prison so I was taking drugs then inside'*
- *'When you've been on [detox] wing for 2 weeks, they move you off onto different wings, but then there's someone coming into prison who's got drugs on them…. It's vicious circle.'*

The respondents did comment that prisons differed in their approach to drugs offenders – some prisons were better or worse than others.

6.2 Referrals to treatment agencies

17 respondents were interviewed in the community; this section looks at how post-prison contact with treatment agencies came about. Of those 17,

- 6 did get a referral
- 7 either did not get a referral, or could not remember if they did
- In 4 cases a referral was inappropriate (either inmate was placed on DRR, or other reasons)

Turning first to the 7 who did not get a referral, 6 of those saw a CW in prison.

4 of the 7 (all heroin users) saw a CW, and did at least one course - and went straight back on to drugs after release:

- *'I got straight back into the same problem with drugs the same day I was released'*

3 out of 7 said they had no treatment at all; those who did get treatment rated it as very poor. One person received methadone despite not wanting it; for the others, anti-depressants were the main medicine.

Two users noted lack of accommodation as an important factor in going back on to drugs:

- *'I got into trouble about three days later because I had nowhere to live. …Prison didn't help me with accommodation or anything, didn't set up somewhere for me to go when I was put out.'*

For those 6 who did get referred, 3 were not interested: two because they thought they were clean, and one because the respondent was already on the waiting list for another agency. The two who claimed to be clean were mistaken:

- *'[CW] told me where they are but I said I'm off the drugs; I don't need it. It was only a five-minute explanation but I felt I knew all I needed to know…[On the first day of release] I went to a place I know to get [drugs]'*
- *'When I left prison I was clean by then…I was fine and I didn't follow it through, but I'll never forget. That prison officer was a very nice guy giving me all that information if I wanted to do anything afterwards; I just thought I didn't need it at the time...Then one thing led to another and I relapsed and started…again'*

One (different) respondent noted that coming off drugs in the enforced prison environment did not necessarily lead to sustained success outside:

- *'The only reason people come out of prison clean is because it's not real. That's why there's such a huge number of relapses'*

Of the other three, two were placed on DRR, and so, ultimately, DIP only got one referral from 17 potential candidates.

Finally, two respondents interviewed in prisons were planning their post-prison contact with DIP – and one of them referred to the DIP process as a useful discipline:

- *'If I have tests done it kinda takes away the opportunity I suppose for me to take drugs'*

6.3 Ethnicity

In general, ethnicity was not a problem with the drug workers.

Only one respondent mentioned ethnicity problems, although he didn't raise it with the CW:

- *'Some staff would make smart remarks, but I would just ignore it. They're small minded, they've got the problem, I don't have the problem…They called me suicide bomber, terrorist, but it didn't bother me coz they're sad lonely old men. As long as they don't put a finger on me, words don't hurt."*

Others commented that, while there might be a problem, they hadn't had direct experience:

- *I thought there was going to be problems and I would have difficulties but I had to be strong coz I knew I was the only [ethnicity group] guy there but I think coz the way I've been brought up I know how to talk to people, I've got a lot of courtesy, I'm very polite and I think that helped me. I do believe in certain areas with different minorities if they have a different attitude or if they haven't got the right attitude people get very offended and they get discriminated… but it didn't happen to me.'*
- *[of CARAT and DIP] It's sometimes difficult to kinda, like, I suppose people that's non-skin-coloured… which you wouldn't have the same religious background to open up to them and kinda you know talk about various things that go on in your life and things like that so it can make things really difficult because at times they don't really understand. Well, they can understand to a point but they don't really you know fully understand where you're coming from so that's the difficulty that we face in here, especially on the out.'*

However in one case a course was withdrawn from a religious group because of a previous dispute:

- *'I was told I couldn't do it because [someone else] had dispute of religion on the course, the CARAT worker told me.'*

Several did comment on wider discrimination in the criminal justice system, not always negatively:

- *'[In prison] They brought me a [co-religionist] and that was the only time, once, and that was basically just to calm me down cos I just freaked out and I was taking it out on everybody'*
- *'[In prison] Coz I was the only [BME] there… they made a point of putting me in a single cell…It was a positive but at the same this is where we clash, if people can't mix they never will mix.'*
- *[after arrest in a police van] The policeman got off his chair and he said that I could sit down, and then the other officer turned around and said to him you sit down, then he said to me, you go and sit on the floor over there…It's little things like that that doesn't help and that's why [BME] people feel offended…[In court for first arrest] When went to court I said to my solicitor I asked for DTTO… he spoke to the judge and the judge didn't look interested one bit and I thought it was because of my colour.'*
- *'It was definitely an issue in the police station'*

In this wider context, religion was more important than ethnicity. Two respondents noted problems with the diet:

- *'Food was an issue. There is a limited choice for muslims. One time I missed out on eating for an afternoon coz there was only pork there and they just said 'tough'. This would happen once a week'*
- *'I can't say I want this food or that food. If you don't eat the food, that's it, you either eat it or you don't…'*

In the latter's case, mixed ethnicity was a problem. The respondent was told regularly praying was required for religious preferences to be taken into account.

Finally, one noted differences between ethnic/religious groups

- *'I found prison helped more Asian people than white people in terms of drugs. People are favoured in prison…an Asian would get a better job than a white person.'*

There were no prison-specific traits identified.

6.4 Summary

In general, CWs get a good report; the main concern is that there is insufficient contact, and that the referral rate is much lower than 100%. There seems to be little follow-up, and users' over-optimistic projections of their likelihood of staying off drugs are not challenged.

Inside prison, treatment is generally seen as very poor (noting that this is, of course, the opinions of the prisoners), and the attitude of medical staff mixed, at best. Rehabilitation courses are popular, if for no other reason than to keep inmates occupied – but this is recognised as a genuine benefit. However, it seems widely accepted that the effect of the courses is strictly limited until the user has made his or her own decision to come off drugs.

Because of small numbers, no prison-specific comments are included, but generally there are no obvious differences between prisons.

Finally, evidence for ethnicity being important was patchy. In the context of medical and CARAT workers, there seemed little evidence of differential treatment. However, there were several comments about wider perceptions of racism and bias in the criminal justice system. Moreover, some respondents were keen to point out that religion, rather than ethnicity, causes difficulties; and that not all minority groups were treated the same.

7 Aftercare

This section looks at aftercare outside the criminal justice system. Much of this falls upon the Community Addiction Unit (CAU) or GPs, although some respondents also describe their experience with other agencies.

17 respondents gave answers in this section: 12 had experience of CAU, 7 commented on GPs, and 5 agencies were referenced. The other 16 respondents had no experience of these services.

Note that it was not possible to obtain an interview with CAU staff, and so our understanding of CAU processes may be wrong in places.

7.1 CAU

Generally respondents got on well with CAU staff, although there were some complaints:

- *'staff were good, it's just the waiting game that hurts'*
- *'I've been at least three times. She said she couldn't put me on no treatment for drugs. She didn't refer me anywhere. It wasn't helpful'*
- *[good parts?] If I had a problem I'd ring phone them up and ask to speak to them [bad parts?] there weren't any'*
- *'they were one of the best out of the lot of them [agencies]…they were very professional'*
- *'there weren't really any bad points, just the time limits [when medication could be collected'*
- *'I didn't really get on with that…Don't think [CAU worker] really wanted to hear what I had to say, [CAU worker] just wanted me to get on with it. They didn't have the time for me'*

However, the problem of waiting lists was mentioned repeatedly. Although one respondent received medication in a week, often respondents would get a meeting arranged soon, and then have no follow-up, or be told to wait:

- *'I had my appointment, about 3 or 4 actually, and everything was good but I got put off coz they said there was an 8-10 month waiting list [for treatment and medication]…I was really upset about that because I wanted and needed the help sooner rather than later, and I was quite stubborn so I stopped going there…It's a massive let-down'*
- *'I had an interview but nothing happened…It's no good for me because they didn't start nothing for me. They don't help with nothing. I went there twice or three times'*
- *'They're shit! I had appointments that were cancelled and I'd go there and the person I was supposed to be meeting wasn't there, and to come beck the next day, and they weren't there again, so I gave up.'*
- *'There was an 18 month waiting list'*
- *Trying to get into CAU? My god!…I've been on the waiting list about two years.*

Although there were some positive reports:

- *'I suppose one of the good things was how quick the referral happened… I got to see someone because I was going through a bad patch and I needed to see someone almost straight away'*
- *'[how long did it take to put you on any medication?] Like, a week'*

As a result, respondents often felt that chances for rehabilitation had been missed, even after a week's waiting:

- *'I was meant to go on a certain day and then by that time after waiting I could still be carrying on with class As'*
- *'I did go to CAU but there was a long waiting list so I was still using heroine at this time.'*
- *'They said I'd have to wait 18 months, I said in 18 months I'll be dead or in jail'*
- *'If I want to stop and I walk into a clinic then I need help straight away…They always say oh we'll talk to you in two weeks or send you a letter so you just continue with other drugs'*

However, for some of the respondents the contact with CAU stopped after them missing their appointments there; the reasons for not attending an appointment varied

- *They gave me a counselling appointment but I didn't go… just forgot really.'*
- *'There was no reason as such, it's just at the time I couldn't get there.'*
- *'I came back to jail.'*

7.2 GPs

There were almost no reports of GPs helping respondents

- *'GPs are useless. [GP] reckoned [GP] couldn't [give me valium/methadone] anyway. But I know they can. I know someone who's on medication with the same doctor'*
- *'[GP] said 'Are you on drugs?' and I said yes, and I said is there anything you can do? The doctor said there's nothing [GP] could do for me, and [GP] didn't point me in the right direction either'*
- *My first experience with the GP- I felt let down and angry'*
- *'Have you been to your GP] (laughs) Dr X? It's impossible even trying to get even a painkiller out of [GP]…[GP's] just having none of it'*

For the last respondent, the GP stopped all the respondents other medicine when the drug addiction came out.

More importantly, respondents felt that GPs did not want to get involved:

- *'He basically said go home and stop taking drugs'*
- *'I got no help from there, [GP] made it clear [GP's] not impressed with drug addicts and didn't even want to talk about it'*
- *'I thought I'd be judged'*

- *'Some of them sort of – stick their nose up at you and all that'*

One respondent reported a change in GP's attitude after DRR involvement

- *' I am know in contact with my GP who at first took no notice of me. He didn't believe what I was saying to him, then he got in contact with DRR, and he knows I'm clean now, and he's more open with me. The help am receiving now is a lot better than at first.'*

The same respondent suggested GPs should be the body dealing with drug problems in the community.

- *The prison should've supported me because I was a criminal and criminal offenders should get supported from jail as far as I'm aware; and people who don't go to jail and take drugs it's down to the GP.*

7.3 Other agencies and DRR

Only one or two other agencies were mentioned, with variable results. These are not discussed here for confidentiality reasons, but some of the comments made will be picked up in the discussion.

One issue that did come out was the differing perceptions of DRR:

- *'they gave me a DRR which I was very pleased about'*
- *'I'd rather not do DRR again…It's a court order hanging over your heads'*

7.4 Ethnicity

There were no real ethnic, cultural or religious problems raised, except in two cases:

- *'I just didn't relate to the person that I was - to the counsellor, and that's mainly because of, you know, like, what I mentioned to do with ethnic minorities thing, the ethnic background. Obviously I found it hard to open up and kind of talk about various things, that was the difficulty there. Even though I did talk about various things but obviously I couldn't go into detail and stuff but that was because they didn't understand at all'*
- *'[GP] was Asian, [GP] just looked down on me.'*

7.5 Summary

The feedback on CAU services was generally good, with positive personal relationships; however, this is for the small number who did receive treatment. Long waiting times for CAU interviews meant many respondents were dissuaded from taking up the programme.

GP services were universally seen as poor – patients disagreed with what was appropriate and what was allowable, and the common view amongst

respondents was very negative: GPs were, at best, badly informed, and at worst, malicious.

Although ethnicity was mentioned twice as a potential problem, in practice there seemed little unfair treatment.

8 The drug user's world

This section looks at the how the drug user relates to his or her family and community, explores how his/her drug usage has developed, and studies how history and circumstance interact to affect outcomes.

8.1 Characteristics of drug use

This subsection gives some basic statistics for drug use from the interviewees. Note that the total number of responses varies because not all candidates answered all questions. Most respondents did not have problems recalling their history of drug use.

Table 8.1 shows the ages at which drug users first started taking drugs and when their drug taking become problematic (usually either an uncontrollable addiction or serious illegal activities).

Table.8.1 Age when drug-taking started

	Under 16	17-20	Over 20
Age when drug-taking started	20 (69%)	6 (21%)	3 (10%)
Age when drug taking become problematic	6 (22%)	11 (41%)	10 (37%)

Over two-thirds of users start at school, often around 11-12 years old. This may be related to the move to secondary school for those schooled in the UK. Most become problem users before 20.

Table 8.2 shows the drugs used by the interviewees. Totals do not add up to 100% as multiple answers are possible. "Other" includes cocaine, methadone, glue, LSD, ecstasy etc. So, for example, four users reported crack as their first drug experience; ten reported it as their main drug currently used; and twelve mentioned it as at least one of the drugs they currently use.

Table 8.2 Drugs of choice

	Crack	Cannabis	Heroin	Alcohol	Other
First drug(s) tried	4 (14%)	18 (62%)	4 (14%)	4 (14%)	4 (14%)
Main drug(s)	10 (32%)	9 (29%)	16 (52%)	3 (10%)	3 (10%)
All drugs used	12 (39%)	11 (35%)	16 (52%)	4 (13%)	10 (32%)

Cannabis is the most popular "starting" drug, sometimes in combination with alcohol. Most of the crack users started at school age. Where heroin is the first drug tried, this is more likely to be one of the users starting at a later age.

Several users mentioned another drug (usually crack) as their "first" drug; when the interviewers tried to verify this, the respondents recalled that they had in fact started on cannabis. This suggests that cannabis is not seen as a "real" drug in the way that crack and heroin are, for instance. We return to this below.

12 of the 31 users are poli-drug users, with heroin and crack being the most common combination. All those taking heroin mentioned it as their "main" drug, suggesting that heroin dominates their lifestyle.

Several users made a point of not taking alcohol. This may be related to their religion, but this was not explicitly asked.

Table 8.3 shows the reasons given for starting to take drugs:

Table 8.3: Reasons for taking drugs initially

As an experiment	5 (17%)
To be sociable	18 (60%)
External pressure (peers, partners, the 'wrong crowd')	6 (20%)
Response to personal problems	2 (7%)

Two thirds of use is "positive" ie sociability and experimenting. A relatively small number suggest that they were pushed into drugs by peers, schoolmates, partners or friends. However, there is likely to be some rationalising after the fact.

Several respondents commented on how the environment affected not just take-up of drugs, but continuing drug use. This seems to be mainly for two reasons; first to avoid loneliness:

- *'It was hard for me to meet friends and I got in with the wrong crowd…I didn't really enjoy it, but unfortunately I carried on doing it.'*
- *'I've got nobody to support me, no. [Does it affect you somehow not having any support here?] The way I see it in this world, everybody needs a friend and a friend is very important, if you can find the right person and the right friend and at the moment with the life that I've got I've only got friends who are into drugs and I can't really rely on them. [Do you have a place on your own at the moment?] Yes I do, I live on my own. [Does it help?] Yes it does, if I don't want to see anybody or any drugs I can go home and stay home, the horrible thing is it does get lonely sometimes. [Could this be the reason why you want to get out of drugs, the feeling there's no support around?] if you've got friends that don't do drugs, it does help because you know you can go and see them and its not drug related, but because of the way things are at the moment the people that I move around with and see, I have got friends that don't do drugs but I don't see them much at the*

moment. The people that come to my house sometimes are the ones that use drugs and the people that I see sometimes are the ones that use drugs. But it is important to have friends that don't use drugs, I just don't have anybody like that that I can rely on.'

Second, there is the temptation of being in a group where drug use is commonplace:

- *'I come back after three months. Of course, my friend, he used to smoke heroin, and he smoked in front of me in the street…So how can I stop when they smoke in front of me?'*
- *'I was then living in a flat. Every person who was living with me at the time was an addict. Before moving to the flat I was clean.'*

8.2 Family influences

In this section, we review two questions, for both of which the answers were split (NB not all respondents answered the questions):

Table 8.4 Family support and information requirements

	Yes	No
Did you receive sufficient support from your families?	17 (55%)	14 (45%)
Do you think your families need more support/info?	18 (64%)	10 (36%)

For the 28 respondents who answered both questions, it is interesting to compare how they answered both:

Table 8.5 Family support versus information needs

		More support/information for families needed?	
		Yes	No
Sufficient support from families?	Yes	7 (25%)	9 (32%)
	No	11 (39%)	1 (4%)

In other words, most of those who felt they didn't need additional support already received the support they required from their families. For those who felt more information would be useful, these were more likely to feel that their families didn't give them adequate support.

8.2.1 Help from families

For most of those who did get support from their families, all of the immediate family tends to know about their drug problem:

- *'We've been up and down, the support is there. Now I need them. They're main support for me and my partner'*
- *'My family is good as gold'*
- *'[Source of support?] My sister mainly. She comes to court with me, comes to appointments with me, without my sister I wouldn't be here.'*
- *'Their view on drugs is they don't know much, they are pleased I'm on treatment but I still do it coz its early days. We don't talk much about drugs. They don't think DRR is helping.'*
- *'The door is open for me, my mother even said that on the phone to me you can always live with us however long you want to.'*
- *'My mum gives me money, clothes, phones me.'*
- *'I get more than enough support'*
- *'[Support from..?] My mum... [Who would be the person you turn to first?] My [partner is] supportive to help me get off the drugs. [Partner] didn't know I had a problem just before I got in here, [partner] thought I was clean coz I didn't tell [partner] I was using. I just didn't want to tell anyone I wanted to hide it. I feel better now I told [partner] coz we talk about it a lot and I know I won't relapse coz I got a lot of support now…They first found out I had a problem the first time I went to jail. [What was their reaction?] Angry, then upset, then sympathetic…My sisters are cool; they write me letters and that.'*
- *'My mum found out [about respondent's drug use and lifestyle] and said 'I love you. There's nothing you could do I could be ashamed of' so I have the family support now. If that didn't happen I would never have told her. A lot of people know now.'*
- *'[Family support?] From my sister, limited.. [asked about family] –I hid it from them, they found out in the end. I just confessed after a while. [of family's reaction] –disappointed'*

Note that this seems to be moral or material support, but there is little mention of involvement with agencies. In other words, families provide a supportive atmosphere but do not help users go beyond the family circle.

Several users mentioned that was often some conflict to go through:

- *'[Have you had a hard time with them, your family?] Yes, I was selling drugs at 19 and I went through a phase where I was smoking a lot of ganja and stinking of it and I'd go home and my grandma said to what you got in your pockets? It smells like you got a bloody car down you. She said, you have to stop you need to stop! So I stopped but I started needing more money to fund my habit coz I was smoking more and more. So I asked for money from my family and when they wouldn't I'd get angry and cause a scene and they'd get angry at me so I started selling again and ended up in prison again.'*
- *'[Does your mum know about your problem?] Yes. She was a bit disgusted in me and said please leave it alone...So I left it alone for her and my methadone is working for me now. I'm […] now, I think its time to start moving on, I'd rather take my [partner] out to the pictures and buy clothes etc. Mum accepts me for who I am, I'm her [child]. We stopped speaking once for 2 years coz I didn't give back £20 and she knew I was involved in drugs. But everything is much better now. We make each other laugh and we talk.'*

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However, some users also mentioned trying to keep knowledge of their drug use to a minimum, even where this has resulted in a public event like prison:

- *'My family do know. My mum said 'don't smoke' and she doesn't like the people I hang around. She thinks I'm in prison for weed. … Sister and father know.'*
- *'I told [mum] I had stopped.'*
- *'No, my mother helps me out. When I went to prison my mum had the kids. They've never been in care, they've never seen me use drugs, they never seen me on drugs, I kept them away from all that.'*
- *'I had friends but I've lost all of them. They asked me about everything- if you want to stop- but I refuse everything and keep lying to them- 'I'm not smoking, I'm not smoking' - and now we've lost everything.'*

It is noticeable that most of the positive references are to female members of the family. Fathers seem to leave a more negative impression, perhaps due to being absent or to being seen as responsible for discipline:

- *'[What about your father did he support you?] Yeah my father's always been there, like. I had a slap from him - he loves me, that's why, not course of the drugs. He's strict as well, because there are some things they cant take no more, because I have gone out of hand like, and no one could stop me…I used to take a beating, I just used to go and do it. Now I'm realising why they did do it?'*
- *'[And do you receive any support from your father?] My father is always working. He says he may help now.'*
- *'My mother will take me back but my dad isn't. He's the hard one.'*
- *'My aunties, uncles and grandma are most supportive and my sister…Then up the road is my father with his new wife and little son. I get more than enough support.'*
- *'[Father] used to beat me with sticks and belt'*
- *'[Do you have support from your dad?] No. I never see him, they got divorced when I was a baby.'*
- *'My father works all the time and doesn't have an opinion what I do.'*

For those who say they don't get enough support from their families, most respondents say that they want to disassociate themselves from their families:

- *'I never let them know. My kids don't know my situation. My misses knows but she doesn't like it, she tries to help me stop.'*
- *'It does cause problems, drugs affect people around you but, personally, myself I wouldn't get any help from my family, I wouldn't want my family to know… it's just I've got kids and that and I wouldn't want my kids to know I got a drug problem, … see my family don't know anything about it, they don't know that I'm here'*
- *'I'm on my own. My family is in Cardiff though. They don't know about my drug problem. I don't know them to know. I'd would be disowned if they found out; my family is very strict. I think it would be easier if I had more family support. But my sister does support me. I trust her.'*

- *'I live on my own, my mum doesn't know about heroine, my family doesn't know about heroine, I wont tell them [why are you keeping yourself away from them?] Because it will break my mum's heart.'*
- *'I don't talk to my family.'*

One reported that he refused help from agencies because he was concerned they wanted to involve his family:

- *'I tried [agency] and didn't like it at all because they want to get the family involved and I wanted them away.'*

But some reported that the families have refused to help:

- *'I have no family and no friends at the moment. It's to do with my religion because there is a big pride in a sense where people don't want to be associated to people who have drug problem. It's a bad thing…They know everything about it, but they don't accept it. They don't have any patience. When you make a mistake, it's your problem, your mistake. They won't help you out.'*
- *'[No support because they don't know?] Ummm – no, 'coz I live at home with my granny. [Do you think they wanted to help?] No.'*
- *'Family don't understand, my dad tells my siblings not to talk to me. They don't understand how hard it is to get off the drugs.'*
- *'She gave me five or six chances to stop…She helped me a lot but I couldn't stop…She thought I don't want to stop [she subsequently divorced him]'*

And some just did not have any family to help:

- *'[Support from mother?] I don't know. She's an alcoholic and my father is just a dickhead…[In contact with one brother] But he's in jail at the moment.…And then I've got my other younger brother but we don't speak.'*
- *'I phoned my mum every now and then but I know she always prefers my brother to me… I went to see my mom once and they used to say that I brought shame into the family and my so-called cousins who I don't know about… Why would I run away from home if they were treating me well? They obviously were not… I was unwanted child…They love my brother more than me'*

8.2.2 Is more support/information needed?

Many respondents said that getting more information for their families would help the families to understand and support them:

- *'If they knew more information it would be more helpful.'*
- *'The families should get more educated coz in my culture, in my family I don't think they would understand a drug problem.'*
- *'If the family knew more about it, it would help more. My mother went through seeing my father be an addict. He was my role model and it was big negative seeing him go through this. Now my little brother will not touch drugs coz he saw what I've gone through.'*

- *'They just think heroine users are just junkies and that's it. They don't look further.'*
- *'My sister tries to get as much information as she can through the internet and calling people.'*
- *[Family] just say you can do it, you can do it.'*
- *'I dunno - coz I think when people have got a drink problem, drug problem, people don't really know how hard it is to get clean off the drink and drugs. [So if they had more information maybe they could support you better?] Yes.'*
- *'It might but I just don't want to involve them.'*
- *'[Does your mum know much about drugs?] No. She was on it but she's off it now.'*
- *'[Is your brother in danger of trying drugs?] No he's only 10. [Do you think that it would be good for his future to find out more about what drugs can do to your body and health, to prevent him?] Yes. He looks at me and I know he won't be like me. He's a good boy. If there was more info available, that would definitely prevent him.'*
- *'But when you find out about drugs you get curious even though you know it's bad for you. It takes a strong willed person to say 'no'…[How much did you know about drugs before you started?] A little. Not enough about the mental health problems it can cause. [When did you first realise the effect it had on your health?] About 2 years, but it was combined with some major things that happened with my life.'*

One respondent raised a potential problem for his family:

- *'[Would they accept the information if they were all given some?] Yes but they don't speak English well.'*

For those replying 'no' and giving a reason, in most cases the respondent felt his or her family had enough information, sometimes through their own drug use:

- *'My mother is well clued up, knows the score pretty well, my brother is anti-heroin… he's seen me through so much in sixteen years so he's pretty much opened his eyes now. He knows how hard it is, I think.'*
- *'My brother knows everything, my mother never used to know drugs etc, but now they do. I'm the only one out of the family. None of my brothers did anything like that or go jail or anything.' .*
- *'They know enough, they see me at 4am waiting around the house and that. They say do what you have to do but you can't keep living like this all your life, you need to do something while you're still young. When you're older and wiser you will understand why we told you not to do this. I should've listened because look where I've ended up. [Did your family or friends suggest any therapy or drug treatment to help you?] No.'*
- *'Oh, she's been through it all.'*
- *'They know a lot about it anyway, they are supportive. They know a lot, like, you know, through other people and you know what they seen [and from yourself?] and through me, yeah.'*

However, some felt that information was not needed because it didn't have much use:

- *'My mum has enough knowledge but she can only do as much as she can… [Does she talk about how to avoid situations like that?] Yes…It gets on my nerves though.'*
- *'She only knows little about drugs from the 60's. She used drugs back then and her sister raised me. If you're going to do [drugs] you're going to do it no matter what. Once your friends get their claws in you, that's it'* .

This view was echoed by one who wanted to have more information for his family, but still didn't expect it to have much impact:

- *'But the only way you get off is if you want to.'*

8.2.3 Summary on families

In summary, those who do get support from their families often find that getting that family support requires a period of getting the family used to the idea. Several users mention conflict with families before, for example, returning to being on speaking terms.

Whilst mothers and siblings provide support, fathers are often conspicuous by their absence or are mentioned in connection with punishment.

For those who do not receive any support from their families, most of the time this is due to the respondents themselves trying to keep families out of it, but there are some cases where respondents are shunned by their families.

Generally, respondents are in favour of more information to improve support for and understanding of drug users. Where this is not necessary, it's because families have enough information already, sometimes through experience. Note, however that this is the respondents perception that families know enough – very few mention that the families are actively seeking out information, as opposed to learning how to cope with a drug user in the family. For example, no-one mentioned getting help with agencies etc.

Finally, a small number suggest that family support doesn't make much difference to the decision to come off drugs.

8.3 The role of the community

8.3.1 Community attitudes and the effect on drug users

Unsurprisingly, most people said that their 'community' had a very negative view on drugs:

- *'Very close community. If they knew about me they would treat me different. I'm scared of rejection. Nobody wants to be considered in society as the lowest and that's what a druggie is viewed as.'*
- *'Terrible, bad news, especially Cardiff, disgusted'*

- *'Very negative'*
- *'My community all know me, friends, neighbours, and people in the area. I don't really hang around the Asian people as I don't associate with them coz they hate what I'm doing. They wanted to sell drugs too and they asked me if they could do it and I said no and I always argue with them, the Asian boys don't like me. I hang around with mixed race people, white people, black people etc. [View on cannabis?] All the kids are doing it but I'm probably the only one who is open about it. When I started cocaine no one knew, they only found out when I got to prison and that's it.'*
- *(Do you think you'd have more contact with the Asian community if they were more positive about your situation?) Yes.*
- *'It's very bad. In my community now, there are 4- youths that I know that are doing heroin. That's not a lot of people. But I know that maybe around 50% of my community are doing cannabis though!'*
- *'They're against it.'*
- *'It's bad. They don't like heroin smoking people. ….No, they keep asking me to stop, to stop. …They just help me with advice. If I asked anyone I've got no place to live, they can't help me, they just give me advice.'*
- *I haven't had a chance to think about community, I've only been in Cardiff for 5 years…I don't know what my communities view on drugs is but my neighbours are my friends, I do knock on their doors I do have drinks with them and things like that, they're family people that don't do drugs and just by knowing them and talking to them I'm sure they don't like drugs, they don't know about me. I won't tell them. [Can you tell me why you wouldn't tell them?] Because people stereotype drug users. If you tell somebody I use drugs the first thing they think is, you're dirty, you're scum, you're not trustworthy and you're just horrible people and I've already proved to a lot of people that's not the case. It's not always like that. Yes there are drug users out there who are horrible people, they've robbed people, they've robbed houses, they've hurt people, but not every drug user is the same. (What are you afraid of if you were to tell people about your drug problem?) I'm afraid I would lose their friendship.*
- *'They don't agree with it.'*
- *'The community have a Negative attitude towards drugs – I was always told to stay away from drugs. Some elders would do drugs but Muslims and Asians etc wouldn't do drugs. Some of us did but not everyone. We didn't tell anyone we did drugs because we were scared they would isolate us and pick on us. [When you were 16 were you a practising Muslim?] No.'*
- *'Obviously they don't want it in their community which is understandable. I feel there is not enough information out there about drugs, especially not enough deterrent for young people so they truly understand what it is like and where you're likely to end up.'*

But two young users took a different approach:

- *'Everyone's taking drugs nowadays, you know young people like us. [And what does the community think about it?] Good. [They agree with*

it?] Yeah. Obviously like the old people don't. [What about your parents, do they like it when you take drugs?] My parents don't like me taking drugs at all. My mother don't want me taking no drugs at all, my father don't mind me just smoking weed or smoking you know. [Have you actually got drugs from your father?] Umm, no.'

- *'[If the community knew, would you have been rejected?] yeah, maybe, told off (laughing) or maybe they won't speak to me etc.'*

Most users saw the community as family and friends, and sometimes neighbours. But other users they saw their "community" as quite different:

- *'I classify my community as my family and friends. … they all take heroine too.'*
- *'Everyone is trying to get off the drugs. My community is drug users. I got 2 separate friends, one lot do drugs, the other lot wouldn't touch drugs, and they all come from different backgrounds and cultures. It's hard to explain but when you're on drugs you spend the whole time trying to get off it, it's just that you never do.'*

Three respondents described themselves as 'loners' and denied they were part of the community at all:

- *'Everybody is better than me. I have nothing to offer…I am a loner.'*

Some immigrants distinguished the community's attitude in the UK from that of their home country:

- *'It's not acceptable at all at my community back home. My community here is full of mixed ethnic backgrounds here, some do drugs some don't. Here they don't judge other people, more relaxed.'*
- *'I've got a lot of good friends in Cardiff…They ask me to go back to [country] but there's no point to go back to [country] because there might be more cheap heroin, lots of heroin and more cheap.'*

But some thought that drugs issues were largely ignored by the non-drug using community:

- *'They don't know much about it'*

And two commented that what had become acceptable, or just normal, had changed over the years:

- *'20 years ago there was a lot of elders and they didn't like us using heroine at all, now it's openly spoken about and more people are doing it now. Down the docks in the 80s it was everywhere. Now there's about 80-90% people using. If I could live my life again I would live it the way I have. The drugs of choice in society change as time goes on. A lot of people do it for fashion then it becomes a culture.'*
- *'It's getting worse down there now; when we was kids you could leave your door open with the rent money on the side and no one would come and take it. If anything happened to anyone, everyone would chip in. Not no more. My son, he's always down there constantly. My*

mother, she still lives down there and I want to go back down there but it's not like it used to be, drugs have gotten worse down there, not like when we were kids, you never saw it happening like you do now.'

10 out of 18 respondents said that the community's opinion didn't really affect them. Of the other 8, there was a difference in opinion. Whilst most felt the community's attitude had made things harder:

- *'I have experienced hostility from the community because I'm on drugs.'*
- *'They look down on me and walk away from me it's so painful. Most my family would walk away from me too…It's just the way they are.'*
- *'In the community and with normal people in general, they automatically think drug users are bad people that don't have morals, that's just how people think, and me, myself, I've got morals… but the problem is, in this world everybody thinks a drug user is a selfish, horrible person and I'm not like that.'*
- *'[In prison] You see, they got their own opinions, when I go to prison they don't want to know. When I come out everyone's gonna be like "how are you? How you been?" I've put on enough weight; they're going to be shocked to see me. When you're in a place like this there's a lot rumours…and I try not to listen to it but it does affect me.'*
- *'[Does it affect you?] No, it doesn't but I do care about what they think.'*
- *'[Does it affect you?] No, I think it's gonna have an affect on my kids. My son, he's 18 now and I think he's started smoking weed.'*

Some thought it encouraged users to come off drugs:

- *'It's good. Because they keep you off it. I don't see the views of my community as bad!'*
- *'[Does the community's opinion affect you?] Now it do, now it do; at the time, no it didn't, but now it do, you know what I mean, yeah. [Why is there a difference now?] Because I've turned my life around now, so the people who I'm with, like, are strictly muslim, and I've started reading the Quran.'*

8.3.2 Can the community contribute to the solution?

Respondents were asked whether greater community involvement would help users with their drug problems. This elicited many detailed responses, of which only a sample are included here.

Fourteen thought that community involvement would be a good thing, for two reasons. First, there was the view that greater awareness would lead to more understanding and more support:

- *'Because if no one understands about drugs they won't understand why he's taking it. They don't know how to help or how hard it is.'*
- *'If the community had more involvement in helping people with drugs, understanding their needs I think it would help.'*
- *'Yes, especially if police could see where we're coming from. They don't want to listen to us when we explain why we're doing what we do,*

- *they just want to pin stuff on us and lock us up. They just think we're a bunch of thieving low lives. If we had a nice meeting somewhere get everyone together, police, neighbours, council and gave us some help crime would go down, drug use would go down, but no one wants to help or listen. So that's why everyone's going out smoking drugs. We need something to do and places to go.'*
- *'Because if no one understands about drugs they won't understand why he's taking it, they don't know how to help or how hard it is.'*
- *'Community just expect you to just stop straight away and it's hard. When you're addicted you just can't stop like that. It would help if they were more understanding. (do you think if you had a chance to talk to them and talk about the problem, would it be helpful for you?) Yes.*
- *(Would you like a chance to talk to them?) Yes. '*
- *'Yes, this is taking something as a whole rather than just an individual person. It's like with the community involvement at least your whole community is working towards something rather than just one individual person. So, yeah, I suppose if that were to happen it would make it a better world. [How do you think the community could get more involved?] I suppose that realisation that drugs are a major problem in the community . Yes they know it's there but I don't think they understand that's a major problem. [What could they do about it?] I suppose get more involved, try get more info, try and get more into local schools and youth clubs to talk about drugs and their effects- probably get people like myself who have had problems with drugs and prison and stuff to talk about their experiences and be honest and truthful about how things really are, and so reach out to kids so they don't see it as 'oh well it's a good thing to do let's get involved' coz everyone else is doing it before it's too late you know coz there's young kid at the age of 12 smoking heroin stuff like that. It's not a good thing. If we took more care what we show kids, they wouldn't be doing that.'*

Second, it was recognised that the community's involvement could act as a restraint on individual behaviour:

- *'If I was practicing religion, in my muslim community, I would not be taking drugs as much.'*
- *'I feel embarrassed to tell you the truth when I think about facing my community, When I get out know, no on can say anything to me because I have done my sentence. Obviously I'm still going to have my shame there, because of my immediate family. In our culture it's different: if I did something bad, one of the members of my community will find out just like that, that's what happens. I am going to put up my head up and walk, and go to the [religious building]. I am going to be proud. Most of them understand me like, I aren't that bad person, they know me, the good side of me, they've never seen the bad side of me, because they've never been there to see that.'*

For those who didn't think the community involvement made much difference, it was mostly because they felt that it was something the user needed to sort out on his or her own:

- *'It's down to the individual person who is doing the heroin,'*

- *'I don't think so, at the end of the day it's up to you. If you're going to stop, then you're going to stop.'*
- *'Yeah it would help me. [how would it help you?] they don't do the things what I was doing [so if you're community got involved more would it have stopped you going down the road you did?] no, because I chose it you know what I mean? It was my choice.'*
- *'The only people who can help are if they can take bits of in[?]. It's not going to change how I feel or what I've done in the past. I don't intend to take drugs when I get out. I'm looking to work and not mess around. The only opinions that matter are my families…I'm not going to be hanging out with the friends I use to mess around with; I'm going the other way. [Did prison courses help?] Yes, 2 of the courses helped a lot, because yeah, I could go out and go back to the life I was living, or I could turn it around and show my back, and go the other way. I don't want to go down that road, I've wasted most my life and my teenage years and it's not good. [Did your school discuss drugs with you?] Yes, that's when I started smoking drugs and the teachers knew. There wasn't actually a lesson about drugs. It's just we use to ask the teachers about different ones and they would tell us. Like we asked about smoking ganja and they said you get the munchies and that. You can smell it. It wasn't much information. I didn't go to college or anything I ended up in prison.'*
- *'They could've helped but instead they shunned users because you know if kids were playing on the street and came across a dirty needle it's dangerous so no one wants users around, it was looked down upon. [Now think about yourself a minute, what else could help you get off the drugs?] My [partner], we both had drug problems and since I met [partner] I don't use, [partner] gives me…something to live for. I have to keep clean.'*
- *'I take drugs coz I want to and I drink coz I like to get drunk.'*

But two were concerned about the community involvement being inappropriate or badly handled:

- *'Not really, because if they knew more they wouldn't help, I don't know them well, I don't talk with them. They know something's up because they can see it on you. They mention it to me sometimes, but they say it the wrong way or they're on something themselves so it's hypocritical. No one's ever just mentioned it by coming up to me normally.'*
- *'In certain cases it would and certain cases it would cause problems… that's why I'd rather just avoid it.'*

8.3.3 Summary on the community contribution

On the whole, the community view on drug use was seen as very negative.

Most said the community attitude didn't affect them, but some did find it made life harder. However this was not seen as a universally bad thing: a small number would welcome the discipline an unforgiving community would bring to their lifestyles. For those who felt the community's attitude didn't make much difference, it was because choice of treatment, when to start or stop

drugs etc was driven by the user's own craving, and so the community didn't come into it much.

Most did feel that more community involvement would be a good thing, increasing understanding and support. However, one or two users suggested that the community should not be involved because they were more liable to make mistakes or act inappropriately.

Finally, it is not clear what the 'community' is – it could be neighbours, family and friends, other drug users, or a migrant's home country. Moreover, there are suggestions that community perceptions are not fixed – they do change over time.

8.4 Ethnic, cultural and religious issues

As for other parts of this project, it was difficult to identify specific ethnicity or cultural issues. One reported culture was important

- *'Cultural issues? I'm [over 30] and I still don't answer my father back. Very strict they are.'*

But this did not seem to have an effect on the respondent's lifestyle – partly because heroin use seemed endemic in that community.

One respondent was quite vociferous on the subject of race:

- *'[Do you think there is a difference between the way a white person is treated at drug treatment agencies and how an ethnic minority person is treated?] It's easy for me because I speak good English…I know how things run, what happens and what doesn't happen, so life I a bit easy for me. But I've got African friends, black, white, green, orange friends, but the ones that come from abroad to stay in this country that can't talk English and are on drugs and need help - the British people think that they should get the help first, and these ethnic minorities are taking their places in clinics or at the doctors. If you're an ethnic minority member, they feel that they're second. The British white person they can be selfish sometimes.'*

And one commented

- *'[Do you think there is a difference between cultural backgrounds and their difficulty of experiences with drugs?] Yes. It can be more difficult for more people.'*

Although it's not clear whether the drug use or rehabilitation gave more 'difficulty'.

In general, however, ethnicity or religious issues did not seem to be important factors:

- *[Is the pain caused to your family somehow related to your religion or culture?] No it isn't. It's just personal. [When it comes to your father, is this the same reason you keep him away from you?] I don't see my*

dad much, my mum is married again, she's married to [other ethnic group] man so religion and culture is out of the window.'

- *'[Does it matter what ethnic background you come from when you have a problem with drugs?] No.'*
- *'In my community there's more white people with drug problems; most black people I know only smoke weed because it's our culture. It comes down to personality…My community are people I've grown up with. All types of people with different cultural backgrounds and religions. We all looked after each other.'*
- *'[Do you think there's a difference between someone from an ethnic minority back ground and someone from a white background having a drug problem?] No I don't not really, we're all equal.'*

8.5 Summary

First, there is no great lack of knowledge within families where they want to help – the problem is where families don't want to help. However this view may be coloured by two reflections. First, the questionnaire checked the respondents' perceptions of what the families knew, not what families actually do know. Second, families' knowledge seemed to be passively gathered in response to the situation of drugs users. In other words, families wanted to know how what drug users were up to, but were not seeking out ways to help them.

Within families, there are noticeably more females than male members mentioned, and there does seem to be a sense that fathers are often absent from the drug-takers' lives – or are there to administer punishment.

Community involvement may be a mixed blessing: while most thought this would be a good thing, some were concerned that making the users' "shame" more widely known might be counter-productive. In any case, there was the feeling that community and family involvement had relatively little influence on drug taking: while it might help to keep users clean, a user's decision to come off drugs was very much a personal decision.

In terms of the community influence, ethnicity issues seemed to play a small part; however, there were some suggestions that religion, in particular, gives rise to actual or expected shunning by the community.

Most users start in school and with cannabis (or, to a lesser extent, alcohol); the reason for starting was most likely to be "being sociable". Most young starters were also in trouble by their late teens. There is a noticeable difference between the younger and older users – younger users are more relaxed about hard drug use.

Finally, there were several comments that being amongst other users increases use or encourages relapses, because of peer-pressure, ubiquity, socialising, threats etc. This may be rationalisation on the part of the users, seeking out 'friends' who use drugs and then blaming them. However, it does indicate how difficult it might be for users to find a 'safe' environment, even within a supportive family or community.

9 Service improvements

In this section of the questionnaire, respondents suggested ways to improve DIP and other services. Where these relate to specific parts of the service, comments have been included in those sections. This section deals with the more general comments, which covered the accessibility of the service, staff skills, and ethnicity.

9.1 Service availability and awareness

A key general comment relates to awareness of the service and who is eligible for it.

- *'The service shouldn't have to rely on whether you are having trouble with the law… when I first came [to DIP] they tried to say I had to be in trouble with the law and have to be constantly being arrested, which was a lie anyway. You didn't have to have them things, so they shouldn't mislead people, they shouldn't give people fake information.*
- *'The only time you hear about them is when you come to prison or see a probation officer.'*
- *'… letting more of them know that they're there and can help… I didn't know about these people until I came to a jail… and a lot of people when you tell them about it they say 'who are they' [when do you think is the best time for people to be told?] At police stations when you're arrested or probation or something like that?'*

Although slightly outside the scope of current DIP remit, some respondents commented on a need for better general involvement in the community:

- *'Information for Muslim community as well so they can get involved and try to get to understand the drug problem and that. You should do it anyway but the Muslim community is quite bad - getting that information across.'*
- *'Go to parks - people there use drugs. Go up to them, inform them and show pictures of what happens if you keep smoking ganja. If someone had done that to me I wouldn't be here today. …I have spent most of my life in prison. When you're in a park smoking away, you don't think, oh, I'm going to a drug rehab and sort out my life. You just think I'm going to smoke this spliff and then smoke another one after. No one's going to mention it to you in the park, no one thinks of that.'*
- *'There used to be more white heroine users, now it's more mixed. Drug are much more available so users are getting younger, they should address it in schools more…There is help for users but the problem is much bigger than the amount of help that is available. … If they spent more money helping people instead of locking them up.'*

9.2 Staff skills

For both prison, DIP and other agencies, respondents stressed how important it was that support officers could relate to the experiences of respondents:

- *'Personally, I would say, get more people with experience…people with more understanding, or people who actually been there and done it themselves..'*
- *'You also need some one who can help, someone who has been in the situation you're in and can understand where you are coming from.'*

Some highlighted cultural differences as a specific area of knowledge that was lacking:

- *'[What could be done to improve the service for BME?] Religious and culture awareness'*
- *'Having more information on BME people would help people develop and good service would be provided.'*

Along with appropriate language skills being available, even if not offered at first:

- *'I think if staff had someone who spoke different languages then this could help people who didn't speak English. This happened in [agency], another dispensing programme: I didn't have any problems but a few refugees people couldn't speak English and they would have to bring a family with them.'*

One person also noted that language difficulties could, deliberately or accidentally, be used to the respondents disadvantage:

- *'Ethnic minorities coming from countries that struggle with the language, their confidence is very low, and they are the ones that need the help, and your typical white person will take advantage of their little knowledge and try to overpower them.'*

9.3 Ethnicity issues

Generally, respondents liked the idea of having support workers from the same ethnic group

- *'He's a minority himself, the guy who dealt with me…he's from [ethnicity] or something, so he had more understanding with him…personally myself people from the same ethnic as you are probably more easy to deal with then other people.'*
- *'I would prefer having more BME ethnic workers. They would be more helpful because they are more comfortable for people like themselves!'*
- *'More ethnic workers would help ethnic minority groups.'*
- *'It's true that our needs are different to those of white, but this doesn't mean that we should be marginalized and discriminated against. If you*

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don't know what to do, employ people who do! We need for BME staff working at DIP and then maybe things can be changed!'

- *'At the moment with these drug organisations there is predominant white British people who are well spoken people and you need some ethnic members to join them to help the ethnic minority community, that's what you need.'*

- *'I suppose the information side, making it aware that you actually have ethnic minority workers here if you want to speak to them…I have had a black information officer, he understood my situation, it was easier to relate to BME officer than with a white person.'*

But there was one dissenting voice – that it must not be assumed that a BME client would welcome a BME support officer particularly from the same community:

- *'[Would you feel comfortable to talk a member of staff with the same ethnic background?] No, because most of them know each other and it may get back to my family.'*

Finally, one respondent noted that the client's own approach to ethnic differences could be problematic:

- *'Grown-up BME person can have a chip on their shoulder. They can feel they are being talked down to, patronised.'*

10 Focus groups

10.1 Description of the focus groups

Table 10.1 describes the core characteristics of the focus group samples. One group was composed of the families of offenders; the other focus groups were composed of offenders from the white and BME communities. Only the family and the first white focus groups are reported here. Two other groups were run but due to technical problems and the different structure used for these sessions, these were of limited value and so are not used here.

Table 10.1 Focus groups characteristics

		Family	White
Gender	Male	0 (0%)	4 (80%)
	Female	8 (100%)	1 (20%)
Born in the UK	Yes	3 (38%)	5 (100%)
	No	5 (63%)	0 (0%)
Residency	British citizen	7 (87%)	5 (100%)
	Other[1]	1 (13%)	0 (0%)
First language	English	1 (13%)	3 (60%)
	Other[2]	7 (88%)	2 (40%)
Disability	Yes[3]	8 (100%)	2 (40%)
	No	0 (0%)	3 (60%)
Age	25 or younger	1 (13%)	2 (40%)
	26-35	1 (13%)	1 (20%)
	Over 35	6 (75%)	2 (40%)
Ethnic group	British Asian	5 (63%)	0 (0%)
	British black	0 (0%)	0 (0%)
	Mixed[4]	2 (25%)	0 (0%)
	Other	1 (13%)	5 (100%)
Religion	Islam	4 (50%)	0 (0%)
	Christianity	1 (13%)	1 (20%)
	Sikhism/Hinduism	3 (38%)	0 (0%)
	None/atheism	0 (0%)	4 (80%)

Notes to table:
1. Includes "don't know". All interviewees, bar one, who were not British citizens had been resident for over 5 years in the UK.
2. Includes Welsh
3. Includes mental and physical disabilities
4. British/non-british not differentiated

10.2 Focus group exercises

All discussion groups used Figure 10.1, drawn on a flip-chart, to focus the discussion:

Figure 10.1 Image used to focus discussion groups
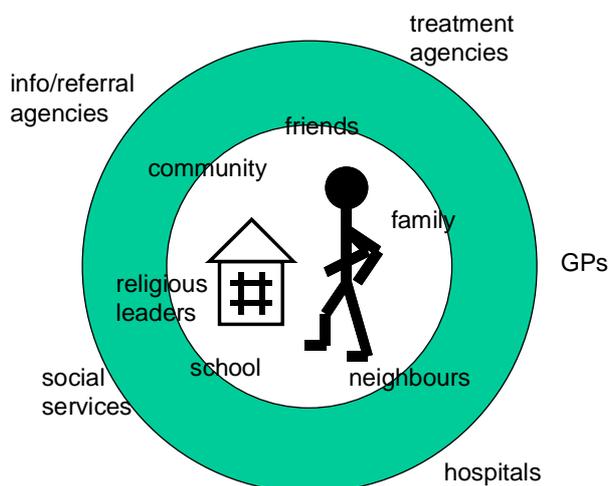
Figure 10.1 represents a drug-user's environment. To make it less personal, the facilitator introduced a fictional figure, Abdul (Ben in the white group), who represented a theoretical problematic drug user from an unspecified ethnic minority background. It was explained to the groups that the inner and outer circles represent the two different communities Abdul lived in:

- The small circle represented the 'inner' community (Abdul's ethnic community, religious leaders, friends, and family)
- The big circle represented the 'outer' community; (GPs, hospitals, treatment and referral agencies etc.)

The focus groups was presented with two exercises:

Exercise 1: The group was asked
- to identify barriers that prevent individual bodies from 'outer' and 'inner' communities effectively helping Abdul with his drug problem

Exercise 2: The facilitator added DIP to the 'outer' community in Figure 10.1, and explained the service it provides. The service description was also written on the flip-chart for clarification. The group was given four scenarios (five for the white group), to focus the discussion. The group was asked
- to identify reasons Abdul did not engage with DIP

In both exercises the group was asked to suggest solutions to the problems they raised.

Note that, when discussing the 'inner' community, the group had problems to keep the family and the community issues separately; the barriers for both

categories were often discussed at the same time. Some solutions referring to family were used by the group in both exercises.

10.3 Focus group 1: BME females with drug misusing relatives

This consisted of 7 BME female relatives of drug-users (including 2 ex-DIP BME clients). Summaries of discussion are given in Tables 10.2 and 10.3.

10.3.1 Results from focus group 1

Table 10.2 Summary of discussion from Exercise 1 (family focus group)

Outer Commu-nity	Barriers	Solutions
GP	• Short consultation appointments, not enough time to sit and talk through the patients problems • GP often coming from the same (ethnic) community as the patient; confidentiality problem – patients worried about their privacy and reputation within the community • GPs expect you to tell them what the problem is, sometimes people do not know what their problem is, and that is why they are seeing the GP in the first place • GPs don't have the knowledge to be able to deal with the (drug) issue • Drug abuse not GPs specialist area • (drug users) lack of self-esteem to go to GP and share their problem, afraid of the outcome • It may take long before users happy to discuss confidential problem with GP	• Ability to make appointments for special circumstances, make sure there is enough time put aside for these appointments so there is no waiting list and there is enough time for thorough discussion between patient and GP • GP needs to act fast when faced with these issues, get the ball rolling the same day the patient visits. • Specific training in the fields relating to these issues. • Extra support for the GP from specialist agencies. • Allow family members to act first if need be, on behalf of the patient. • No referrals because these patients are ill, they can't wait, if they've built up enough courage to come and see the GP they shouldn't be knocked back. • Reduce waiting lists to one or two days instead of 4weeks+. Three weeks can change an addict's life; they could go back to prison in this time. • GPs open on Saturdays • Support for GPs from

		community
Hospital	• Very short interventions, emergencies only; • No treatment • Not really relevant	No solutions suggested
Treatment Agencies	*Respondents struggled with names of treatment agencies* • Not enough information or advertising within communities. • Drug abusers/addicts usually only find out there are agencies when they get in trouble with the law and go to prison or parole. • Too expensive, • Too many waiting lists • Lack of understanding, training, sympathy. • Some agencies don't treat the problem	• Contact local community centres • Advertise the services • Approach local religious leaders to give information on services, location etc
Info/ Referral Agencies	*Respondents could not name any agency* • Don't know where or who they are • Advertising methods are ineffective • Lack of information about these agencies	• Increase advertising in communities on TV i.e.; on popular channels and all the community channels in different languages so people of all nationalities can understand. • Prevent the problem by efficiently educating influential people in communities • Educate teenagers; agency representatives should go to schools and colleges. • Educate teachers so they can recognise the signs of drug use and abuse. • Educate parents; provide a short parenting course covering information on drugs and drug addiction. • Make it compulsory for parents to complete this course because some parents do not even go to parenting evenings because of their

		educational background, some don't know the system and don't know how to get involved, then you get others that don't care and others that are always involved • Go to communities instead of waiting for them to come- outreach work via e.g. religious leaders
Inner Commu-nity	**Barriers**	**Solutions**
Community	• They don't take talking about drugs as a positive thing. People don't share information as they don't want to be judged. • They'll talk about you, but won't help you. • They isolate families with the problematic child. • They tend to judge the parents if there's a problem. • Current or past problems are hidden within communities and families. • Diversion Tactics – parents will focus on other peoples' problems rather than their own. This could be a form of protection. • Glamorising drugs as a way of getting 'quick money'	• *'educate the community...'* • *'If everyone is educated the same everyone will have a good understanding.'* • Involve religious leaders
Family	• Parents will be judged • Parents will be ashamed, embarrassed, dishonour. • Child doesn't want to tell the parents – scared of rejection, trouble • Parents aren't always aware of child's problem; sometimes they will find about them from outside • Family tend to hide the problem within a family, and from the community • A drug addict in the family can have a big effect on the	• Outside people may also have a role to play in educating family/parents- '*Get religious figures involved to help families and give them information on how to support Abdul and each other.'*

marriage prospects for sisters/daughters

- Double Isolation
  - Family with a problem tend to isolate themselves from the community
  - Families disown problematic person because it's a big shame to the family and community.

How are the mothers viewed in the community?

- Mothers are the first to be blamed for any problems with children because in BME families mothers are the main home-keepers who deal with the children more than the fathers
- BME families tend to spoil their boys more and give them more freedom.
- Boys are bored and have too much free time. They enjoy having all this freedom because the family has no control over what they do in their free time. It comes down to rules within families as well.
- BME girls have less freedom and tend to stay at home because they are learning the role of home-keeper for when they are older, so the girls rarely get involved in drugs.

Why do young boys turn to drugs in their free time?

- Peer pressure, social status and material possessions influences them to find ways to earn money so they can obtain all these things.
- Asian boys tend not to have girlfriends before marriage; and social contact with

- Police should provide effective help to boys when they are young and in trouble with the law because that is when their problems are easier to overcome. It's easier to catch a small fish than it is

	women who are not close relatives is frowned upon • Drug dealers glamorise drugs and show this is a way to make a lot of quick money. They come across as role models because they look successful and have social status, so they can be very influential on younger people. • The police only go after the easy targets, the young ones- '*We know of a man in our community who deals drugs and all the money he makes he puts into property development, therefore the police will never be able to catch him, and he is an example of a big fish. This can be intimidating to the community.*' • No support for families from police, doctors etc. –'*We've called police for help and they haven't come and said they cant do anything about it. Even with domestic violence they don't do anything.*' **Are fathers supportive of the mothers?** • No, they are just busy shouting and arguing. • They don't have the capacity to help because they have no knowledge of drugs or drug abuse and they wouldn't know where to get help anyway. • They ignore the situation. • Men are less emotional and deal with problems differently so they would rather cut off problematic children because they don't know how to deal with it. • They turn to violence, such as hitting, to deal with problems. but this doesn't	to catch a big fish • '*Leaders within the community need to be given money so they can help do something about it to prevent and intervene.*' • Involve schools- *[boys] spend the majority of their teenage lives there, its compulsory, take them on tours, let them meets affected families, make them aware and let them see what can happen and how it effects society not just the one person. Show them gross pictures like they do with smoking etc. These things make a person think, you need to reach out to them emotionally.*' • Educate fathers – '*My brother blames my dad because the father is the figure. If you look at all these people committing crimes, most of them don't have a good father figure or one at all. Fathers a huge role model in their son's life. Some don't have any good role models as parents.*' • '*Even if the father is out of the house you still need to have a good parent relationship and still be involved.*'. • Religious leaders should support/help fathers deal with their drug using

	help. - *Kick him out or kill him instead of dealing with it, … They're negative, negative, negative and there the ones that influence that person..'* • They make decisions but don't know how to make the right ones. Some women don't have a say. Sometimes they don't agree but they need to have the same approach for the sake of the child.- *'I blame my husband for where my son is today, he should've had counselling, there should be more awareness. He has no knowledge or understanding.*' • '*Men have the power in the family and because of community issues and values the man will not go as far to stop his son but he will go far to stop his daughter.'*	children -*'I need someone like an influential religious leader to explain one on one to my father what he needs to do to help, because if my brother wont get out of bed he hits him,'* • Fathers need external support re how to help their children

Table 10.3 Summary of discussion from Exercise 2 (family focus group)

Scenario	Reasons	Solutions
1. If Abdul knew about DIP, why wouldn't he go there?	- Lack of confidence & self-esteem - DIP voluntary - he didn't have to - Selfishness- it's easier option, they are happy with this lifestyle, easy money - Doesn't have a proper understanding of the programme *'We are ethnic minority and [DIP] don't know enough about the culture they're dealing with or how to help.'* - Methadone not always works – *'Some drugs would make him sick. By giving methadone you are creating more drug use.'*	- DIP should be made compulsory - Better understanding of the programme; *'..or a video to show other people with drug problems and what happens to you if you go down that road.'* - Counselling first before going on programme *'He needs to realise the effects of his actions on him, his family and his community. Until he realises he will not be involved.'* - More background information about Abdul – '*How many times do these agencies see the family to tell them how the child was at 15 or 19. They only get one side of the story, they don't want any background information from the family.'* - Involve Abdul's family- '*With BME they don't know how to deal with these issues so they should get the family and the person together, make a quick intervention, not just talk about the drugs but the family as a whole. Meetings to discuss how it's happened, what's the best treatment?'* - Bigger choice of treatment – '*Why can't they prescribe something else besides methadone? It's not cost or health effective.'* - Education in Prison- '*You need to think how to prevent this problem when*

		they come out of prison. You need this person to change his brain, heart, mind and attitude in prison'.
2. If Abdul knew about DIP, why wouldn't his family know?	• He didn't tell them and the family weren't involved • The family was part of the problem • Family was not contacted • Confidentiality sometimes used as a cover for officials • Not addressed language difficulties on family's part – '*They need to support BME families especially ones that cant talk English, they need to know what's going on.*	• Agencies involve families directly – *'In the BME community we were saying families feel shame but once they get help the families expect to be involved, its not just one person.'* • Need to bring in community/ religion- even if you don't believe personally, use it as a weapon • Prevention better than intervention • Show by examples e.g. '*this is what happens to this family when one member started taking drugs'*
3. If his family knew about DIP, why wouldn't Abdul go there to get help?	• No pressure from family- they don't understand the system • Not addressed language difficulties on family's part • Info not sufficient- confidentiality restrictions - *I know one lady whose son was going into DIP and she couldn't speak English and I went to the family support worker and she didn't want to speak to me. She said 'no, you are not part of that family'. I said 'well she can't speak English, can I speak to his case worker then?' you can't speak to the case worker because of confidentiality and I can't speak to his mum either because of confidentiality'* • '*This confidentiality thing has gone too far. It's easy for someone to sit in an office and not look at the*	• Involve family more – '*Get a person who can speak their language to sit down with them and give them all the information they need to know to help their child.'* • Educate family • Allow family to take matters into their own hands • DIP need to use different tactics – key aim is to take them off drugs-e.g. get Abdul into job • Involve other agencies/services • Keep Abdul occupied/busy – '.. *if they cant cope with work physically and mentally there should still be something to keep them busy like full time education to keep them away from drugs, send them somewhere for free*

	bigger picture of the family and the community.'	*or let them shadow someone.'* • keep Abdul away from the wrong crowd – '*My brother got clean and was doing nothing then I got him a full time job to give him something to do but then he met up with the wrong crowd again and got back on it. So there's so much you need to do after to keep them off it.'* • give him something to look forward to
4. If Abdul went on DIP, would his family want to be involved in his recovery process?	• Not every family • Also not every member of family- different members react differently, have different levels of understanding • Family don't know how to help • Fathers don't have knowledge or understanding of their children • Fathers not good at listening to family members re bringing up children/managing family • Father doesn't take responsibility- doesn't care that his son ruined his life because it's not his fault	• Educate family • Outside people may also have a role to play in educating family/parents • Fathers need external support re how to help their children –Involve religious leaders • Involve different area of help; Police, Education, religion • Have someone from outside come into their home and help parents, explain things to them • Parents need to work in partnership

10.3.2 Summary for family focus group

Barriers identified around making more use of GPs were that GPs don't inspire confidence or confidentiality; don't encourage drug users; don't understand the importance of a fast response; and don't seem to have the time or skills to deal with them. Several solutions were suggested:

- More training for GPs
- More support from outside for GPs
- Longer opening times
- Appointments granted immediately (or at least very soon).

There was no discussion as to whether GPs were the right place to be taking these problems (instead of, for example, specialised treatment agencies).

Few of the focus group participants knew about any of the agencies, treatment or information; as this group all had a family relationship with drug users, this was surprising. Suggested solutions reflected this: put more effort into advertising, at all levels of the community, and possibly make family attendance at meetings compulsory. There was some mention of long waiting times as a barrier, but this was not followed up.

On the "inner community", the group had a large amount to say about attitudes to drug use. They commented in detail on why drug use is so much higher for BME males than females. They also suggested various factors which might make it harder for convicted drug users to re-integrate and get support from their inner communities; specifically:

- The user may be ostracised by his or her family – particularly by fathers
- The family is very likely to be ostracised by the community

Hence there is a high chance the BME drug users will not be able to call on the support of friends and family. No solutions are offered for this, apart from long-term education programmes.

Turning to the specific DIP service, it was suggested that individuals might have concerns about going to DIP, might just not understand the service or the benefit. Solutions included making all or part of the DIP process compulsory, and more counselling. It was also noted that DIP might not be solving the right problem eg by focusing on reducing drug use through prescription, it might be ignoring the underlying reasons for that drug use (no job, nothing to do).

In respect of family involvement, this is more difficult because not all families and relatives take the same view. Families might be kept out of the loop for several reasons – users wants to keep them out, DIP won't accept family involvement – which may be good or bad. The families did not see confidentiality as protecting the rights of the drug user, but as a barrier which DIP could/did exploit.

On the wider community, it was suggested that the community be involved more actively: as a force for good, showing by examples, helping with language problems

10.4 Whites focus group

This consisted of 5 white ex-offenders. Summaries of discussion are given in Tables 10.4 and 10.5.

10.4.1 Results from white focus group

Table 10.4 Summary of discussion from Exercise 1 (non-BME focus group)

Outer Community	Barriers	Solutions
GP	• Lack of communication re GPs-drug misusing patient • GPs do not want to talk to you about drug issues • *'if you want to talk they say they will not discuss it, then they call CAU and you have to wait 3 months to receive a letter just to solve a problem you had 3 months ago.'* • Only 3 GPs in Cardiff trained to deal with drug issues • Prejudices, judgemental attitude of GP/ med staff • Discrimination • Waiting list – forcing individuals to private treatment • Neglect from GP • All-covering diagnosis of 'depression' • Different depressions gone unrecognized by GPs • GPs do not recognise that drug problem and depression *'go hand in hand'* • *'They seem to help one or the other.'*	• GPs- first instance drug help • GP more educated in drug related issues • Adequate drug training for all health/medical staff • Non-judgemental GPs • Posters, information leaflets • Needle exchange/ syringe handouts in GP surgeries • Drug worker to consult in a surgery once a week • Or, trained nurses to discuss drug issues with • Drug workers hold regular workshops in surgeries • Psychologists to recognise different mental health problems before decision on medication is made • *Syringe vending machines – you get a token from CAU or DIP then you put your token in the machine and out comes a little kit with everything you need.'*

Hospital	Not mentioned	
Treatment Agencies: CAU	• Too long waiting list (6-18months) • Certain staff with bad attitude towards users • Pregnant clients discrimination • *If you have a pregnancy test at CAU it is not confidential. … I wasn't allowed to breast feed my child and basically I wasn't allow to lower in child protection to 29ml and do you know what the child protection worker said 'it is abuse to the baby due to prescribed medication.'* • Lack of specialist midwives • Different areas have different policy • Bad attitude of staff met outside CAU • Bad experience – patients do not want to go back	• Assess individuals on individual basis, especially pregnant clients- no set rule policy for everybody who is pregnant and on drugs • More funding into the service to make the waiting time shorter • Better education for staff • More ex-users among members of staff
Info/Referral Agencies INROADS	• good service	• Put in more funding into service • Encourage ex- users to go for work there
DIP	• Too short dispensing time, not convenient for people who want to work or do courses	• Longer dispensing hours • Meth script from different place for those who want to work or do courses • Confidentiality re potential employer will give a client more chance for employment
Inner Commu- nity	**Barriers**	**Solutions**
Community	Not mentioned	
Family	• Lack of support from family (for some individuals) • Get ostracised from family group (if you steal from them) • Stigmatised • Broken relationships • Some move away from their	• Give up drugs • More support for families • Educate, let families know facts about addiction, rationalise it • Get family together

	families	with a drug user
	• No family at all	• offer counselling to families esp. for teenagers
	• Change of attitude when family found out about one's drug problem	

Table 10.5 Summary of discussion from Exercise 2 (non-BME focus group)

Scenario	Reasons	Solutions
1. If Ben knew about DIP, why wouldn't he go there?	• He is not ready to enter or stop using drugs • He might not have been referred • Mental illness • Does not recognise his addiction as problem • Lack of faith in service	• Needs more reassurance • CARAT worker should inform him of DIP • *'A week before his release they should drum into him go to the DIP and they'll help you.'* • Provide contact numbers for outer services
2. If Ben knew about DIP, why wouldn't his family know?	• Up to him if he wishes to disclose • Ashamed/ embarrassed; does not want to be judged • Stigma attached to heroin • Afraid of consequences	• Sometimes it helps to have family members with you • *'The family shouldn't be told by an agency, it could mess things right up.'*
3. If Ben's family knew about DIP, would they encourage him to go there?	• Do they love him enough ? • They have their own issues • *'Some are sick and tired of the situation.'* • Lack of an awareness • They leave him/her to make his/her own choices	• Educate the family more. • Have different opening times for families • *'…open on Saturdays for families to get together or evening times would encourage them to be involved.'*
4. If Ben went on DIP, would his family want to be involved in his recovery process?	• Up to Ben if he wants to involve them • Do they care about him? • *'…a lot of people can't talk to their families.'* • Family feel ashamed • Does not matter, recovery down to drug user	• Talk to them
5. Ben has dropped out of	• *'He wasn't ready to get clean.'*	• DIP should pay for your travel expenses

DIP. Why do you think this is the case?	• Lack of trust • *'If the people you live with can't trust you, how will agency or jobs trust you…?..It's lack of trust with people on prescriptions.'* • *'Different systems for different agencies can be confusing and maybe he can't cope with it.'* • Frustrated in the daily travelling to pick methadone • Cost of travelling • *With people on the dole, I get £80 a fortnight, and most of it goes on bus fare then I have £30 for everything else.'* • Financial difficulties • Being homeless • Health problem • Overdosed • Mixed with same crowd • Go back to prison	• Take DTTO's methods of working on board – buss passes • Create incentives • quicker referral to CAU as a reward for staying off drugs (urine tests) • More complementary therapies • Move area • Help with housing • More counselling • Family help

10.4.2 Summary for whites focus group

Looking first at the drug user in his environment, GPs are poorly seen by the users:

- knowledge is limited, especially on how to treat drug users' mental problems
- they don't seem to show enough willingness to engage with the patient
- the need to act quickly isn't recognised

Users are however still happy to see GPs involved, perhaps recognising that they play a central role in the community's help. So, the users see the GP as a barrier, but also as a potential solution, and put forward several specific proposals.

Treatment agencies (mainly CAU) come out badly, as having staff with a 'bad attitude'; information agencies in contrast are generally seen as providing a good service. In both cases, users suggested more funds (to reduce waiting times) and more ex-users working there (to improve the service).

For DIP itself, the only barrier mentioned was the inconvenience of dispensing times, particularly for those who would like to work or do courses. It was suggested that this might make it more difficult for employees to hide their treatment from employers.

Finally the users observed that they are likely to be ostracised by family members, and suggested that counselling and information for families might mitigate this; for example, 'family hours' on a Saturday at DIP.

Nevertheless, this group felt that much of the problems of the fictional drug user were of a personal nature: as such, many of the solutions proposed were general ones, such as incentives to stay on the programme, or more complementary treatment. However there was a recognition that such practical help could make a difference to the user's life: bus passes, help with housing etc. While this might not make much direct difference to the user's response to treatment, by making life easier it could provide a more supportive atmosphere.

11 Service providers

The service providers' questionnaire focused on four areas: the legal/procedural background, perceptions of BME clients, the relationships between organisations, and improvements in the service. 12 questionnaires were received from several different organisations. To maintain confidentiality, we limit our comments to the general perceptions of the CJS (including DIP) and the community organisations.

11.1 The legal and operational background

In general, service providers could only share information on clients with consent or where as required by law. However, CJS respondents generally thought they could share information with colleagues (but not other parts of the CJS). No-one believed information could be shared with families. While half of respondents say they were under pressure to share information with clients' families, there was no real difference between the BME and white clients – although different members of the same organisation report different pressures.

Service providers generally work to known targets; for the CJS these are set externally.

11.2 Perceptions of the BME community

All community service providers thought that BME clients did engage differently, and about half of the CJS. Mostly this was due "cultural" factors (including keeping problems in one's family), but two (one each from CJS and community) mentioned BME concerns about confidentiality.

Of those who did not think the BME community engaged differently, one noted it was a performance target to ensure equality of service; and one suggested that BME clients were over-represented in the CJS.

On the more specific question of whether BME clients entered the system differently, social and cultural barriers were mentioned. Some service providers also noted that the different ethnic communities acted differently – some groups (eg Indian) were more aware of the services than others (eg Bangladeshi).

Two service providers, both from CJS, mentioned that BME suffered from prejudice in the CJS; for example, that they were more likely to receive a custodial rather than a community sentence.

Most (including almost all of the CJS) did not think that BME, once on the system, had a different level of involvement. Again, the potential for stereotyping and prejudice in the CJS was commented on.

Most felt that there was no difference in the drop out rates between BME and other clients. Where there was a difference service providers cited a range of

factors – including prejudice, but also family issues, and the lack of BME role models in the CJS.

On the question of whether there should be more BME support staff, opinion was divided: community support staff all felt there would be a benefit, whereas the CJS was more relaxed.

One member of the CJS felt that the attitude of the case manager was the most important thing in making a relationship work, rather than ethnicity. One respondent viewed having more BME staff as 'essential'; others said it would be important in specific areas (eg language skills); and some mainly thought the effect would be to change positively perceptions of the system.

The question of whether BME clients feel comfortable talking with members of the same community came up again here, but with two completely different opinions. One respondent noted that taking on more BME support officers would make this more likely, and so was against the proposal. On the other hand, one respondents saw that having more BME support staff to hand would give agencies more flexibility in avoiding this sort of situation, while still being able to provide support from an ethnic community.

Finally, in terms of getting relevant information out to the community, most thought they were doing "ok" or "fine", with one exception from the CJS who felt that there was a lack of resources to do a good job.

An inconsistency did come to light: some DIP staff believed that clients' families were always contacted when someone enters DIP (which seems to contradict the responses on confidentiality in section 11.1). Moreover, others thought a problem was that families did not know about clients being in DIP. This may be an area were DIP policies need some clarification.

11.3 Co-operative working

CJS respondents said that they did not have any contact with GPs (but note that GPs are automatically informed when users are put onto methadone). Community agencies did try to involve GPs, but only with the client's consent and often as a joint approach.

There was no consistency about whether getting GPs involved as the first point of contact would be a good thing. Positive aspects were that:

- The GP service is more 'anonymous' than a specialist agency
- Widening options is always a good idea
- GPs are an obvious place to turn when you have no other idea and need help

Downsides identified were:

- Users prefer services where you can walk away
- Talking to the GP about drugs might affect other treatments
- Doctors treat illness, and aren't counsellors; so they might be useful as a referral point, but shouldn't be the first contact

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Some service providers also commented on GP attitudes (GPs are 'judgmental' and 'reluctant'), echoing the comments of some users.

In terms of inter-agency work, all said they co-operated with other bodies, and on the whole get the co-operation they require, although some commented that this can be bit much of a one-way street.

11.4 Gaps and improvements

Three main gaps were identified. First, there was the focus on methadone:

- *'It seems that services in the area are predominantly centred around opiate injectors; there is very little available for stimulant users.'*
- *'Some opiate users from the BME community are uncomfortable with the concept of the harm reduction policy model. There should be more support for those wishing to detox rather than be maintained on opiate substitutes.'*
- *'Abstinence based treatment should be a readily available alternative.'*
- *'There are more problem stimulant users than opiate users in the local area within the BME population.'*
- *Too much focus on drug problem to the detriment of alcohol problem, which affects far more people directly and indirectly.'*

Second, there were the problems of entry:

- *'Unless substance misusers commit offences they are unlikely to access service within the CJS, BME members are more likely go for custodial sentences than members of the rest of the society'.*
- *'There is no quick self-referral prescribing service in Cardiff – all realistic routs into treatment are via Criminal Justice.'*
- *'The main gap in provision in Cardiff are the outrageous waiting lists to access substitute medication'*
- *'There are big waiting lists for service users who have not committed crime'*
- *'DIP is a self referral service, but again only open to offenders. No all ethnic groups might found drug use by criminal means which might mean they miss out on the opportunity of DIP as well.'*
- *'Lack of confidence to go outside community to seek help'*

Finally, there was the problem of mental illness:

- *'Instead of treatment BME members are likely to be sectioned under the Mental Health Act.'*
- *'Clients with mental health problem find it difficult to find a suitable service as many services will not accept clients with mental health problem'*

While many of these problems are systematic, there is some evidence that BME clients are differently affected by these problems, particularly with respect to entry.

When asked to suggest improvements, there was strong support for more BME staff and/or cultural awareness training:

- *'The staff should reflect the community they serve – recruitment of staff from more diverse background'*
- *'Recruit more BME staff to act as role models who understand BME issues'*
- *'All staff should undertake training in cultural diversity, and delivering culturally sensitive services'*
- *'Information to be made available in community language'*
- *'Working partnership with agencies such as the Axis Project in order to engage with communities'*
- *'Acknowledgement of how difficult it is for BME to go walking through to treatment Agencies without initial welcome.'*
- *'For treatment agencies to take part in Cultural Diversity Training at NLW'*
- *'Language barrier so more people from BME communities to be employed at agencies or treatment agencies to work much closer to BME organisation…'*
- *'Increase the number of therapists/counsellors from BME backgrounds'*
- *'Educate CJS members about the needs of BME and the inequality of sentencing'*

Another major area was improving the waiting times:

- *'Rapid self-referral community prescribing'*
- *'No waiting times to access services'*
- *'No waiting times between assessment and caseload'*
- *'More funding to reduce waiting times, and more services for clients who have not committed crime'*
- *'BME service users could access treatment themselves without relying on the court to sentence them to treatment…This is quite important given the court unwillingness to sentence some ethnic groups to DRR treatment.'*

There was support for developing community outreach programmes:

- *'Community outreach to inform people of what services are out there and to identify any gaps in service provision'*
- *'Outreach services'*
- *'Educate BME communities regarding treatment services available'*
- *'Create more outreach provisions to inform BME communities'*
- *'Tier two services doing effective outreach work and preparation'*

Finally, there were comments on the specific services:

- *'There is a lack of services for homeless men who have young children.'*
- *'More activities/therapies available to clients'*
- *'Better housing options'*

- *'The availability of more 'talking therapies'. Family therapies, complimentary therapies etc.'*
- *'Longer time on programme'*

As for the gaps identified above, some of these comments are general and some relate specifically to the BME community. It is interesting to note that none of the suggestions relating to the BME community came from the DIP respondents.

11.5 Summary

The service providers' questionnaire was designed to test some of the claims made by respondents about the various services. Overall, the results here tend to support the views of interviewees:

- Long waiting times are a problem
- Entry is difficult except through the CJS
- There is not much direct discrimination in the drugs programme, but there does seem to be a wider prejudice in the CJS against the BME community which affects take-up.
- having more BME staff is beneficial; but can be a problem in itself
- There is limited support for non-heroin users

There was a difference between CJS and other respondents. Most importantly, DIP respondents throughout were less likely to identify BME-related problems. This does not suggest that DIP is turning a blind eye to problems in its service; there is no evidence of direct discrimination. However, it may be that DIP staff are less aware of the wider BME issues which are affecting take-up of the service.

Section 3 Conclusions

12 Discussion

This section brings together various themes that have arisen from the interviews, focus groups and service provider questionnaires, and ties them into the original project objectives. Rather than re-iterating the summaries from each section, we will look at the DIP system overall, in the context of the wider CJS, and in the way it interacts with the BME community and individuals.

We look at four elements:

- Are there problems in the design of the system that lead to gaps in provision?
- Are there gaps as a result of the way DIP etc is implemented?
- How does the aftercare system integrate?
- How do the characteristics of BME clients and their communities make these problems better or worse?

12.1 Potential gaps in the system

12.1.1 Entering the system: referrals from the ARW and Prison process

Prisons and police stations both offer several opportunities for potential clients to drop out:

- A client may not be approached
- A client may not be assessed
- The referral may not be passed on to DIP
- The client may not turn up for their meetings

At police stations there is an additional drop-out point. If the potential client is approached by a police officer, then he/she will only receive information about drug treatment, and will be expected to follow up for him/herself.

For prisons, information was not collected on whether clients were approached and assessed, only if they were referred. So, a direct comparison of drop out rates is not possible. However some conclusions can be drawn.

For ARW, the most important drop-out point is simply that half of arrestees don't get approached. This may be for several reasons

- Arrestees spend a relatively short time in the station and ARWs do not work at night
- Arrestees might be confused, aggressive or incoherent at the time of arrest
- If arrestees require medical attention before meeting the ARW, the doctor might not be available until the next day, which delays the meeting with the ARW
- Arrestees might be stressed or uncooperative
- In the absence of an ARW, a police officer might not give out adequate information or advice

These also affect the chance of an arrestee agreeing to assessment and being assessed. Finally, ARWs do try to organise immediate appointments, but only those release on bail are able to keep those appointments. As around two-thirds of those arrested are remanded in custody (overall; we don't know how many of those assessed get bail), this is another potential drop-out point.

In contrast, in prison inmates are kept in a stable environment for some time and may also undergo treatment for their addictions. There is plenty of opportunity to approach prisoners about a post-prison referral, and there is not the immediacy in referrals that the ARW process offers. This may lead to better referring, as there is more time to check that interviews and arrangements are in place; but it also could lead to worse referring if there is a gap between appointments with DIP being made and the prisoner being released. Our research supports the second outcome.

Moreover, our research suggests that a significant number of prisoners believe that they do not need further help when leaving prisons in continuing to address addictive behaviours. These prisoners (in our sample) are almost always mistaken regarding their ability to remain abstinent but it is not clear if the prison has an obligation to do anything about this. Once prisoners leave prison they are the responsibility of another part of the CJS, and if they have refused post-prison support, is this the responsibility of the prison service?

12.1.2 Entering the system: self-referral

Self-referral is possible, but not widely understood by potential clients. It appears that the DIP system is geared to referrals from other agencies, not self-referrals. Self-referrals then face several problems:

- They are often asked to wait to make an appointment
- They may be asked to give confidential information out at the reception
- They may need to chase up DIP more because there is no agency checking on the outcome of its referrals

Self-referrals are likely to be the most motivated clients, because they have made the decision to take up treatment without any prodding from an agency. Many interviewees noted that the most important factor in coming off drugs was the user's own state of mind, and willingness to work on the addiction. But several also noted that this might not be a long-lasting state: users "psych" themselves up to come looking for treatment, but may be easily disheartened if they don't get positive help.

All this suggests that making self-referrals welcome and giving them priority could improve the success rate of the programme.

12.1.3 Retention within DIP: maintaining engagement with customers

Methadone is the only visible treatment for heroine users available through DIP. This means that help for all other drug users is limited to giving out information. Hence DIP has come to be known as largely a methadone shop, for heroin users. This may not in fact be the case, but this is clearly the impression the users stated.

The main problems with methadone treatment are the practical ones of dispensing through DIP. First, the very limited distribution times don't take account of users' often chaotic lifestyles. There were also suggestions that other agencies (eg probation) did not seem to coordinate with DIP dispensing and arranged meetings at those times. This is a particular problem on Fridays, when a user missing his or her dose could then be left without methadone for three days. It results in the user experiencing withdrawal symptoms and increases the likelihood of using illegal drugs and having to fund these through necessary means such as drug driven crime. Another issue raised was that there was no provision for clients having to be away (eg for a family engagement).

Related to dispensing times is the location. Some interviewees couldn't understand why methadone couldn't be dispensed through a local chemist, and why they had to spend a relatively large amount of money travelling to get their prescription. DRR, in contrast, provides bus passes, and the difference in systems means that DIP is singled out for criticism.

The dispensing environment is also a problem: it's not private or welcoming, and many users at different stages of treatment come. Several times it was mentioned that mixing with drug users encouraged users to stay on drugs, whereas being in a drug-free environment helped recovery.

12.2 Gaps in practice

12.2.1 Staffing

Across all aspects of the systems (ARW, CARAT, DIP), it is clear that a good relationship between the client and the support worker makes a big difference. This is important because the system relies upon effective contact staff to make it work, and they also create the impression that people form of the system.

Unfortunately, the quality of support varies tremendously, with some getting very good reviews and some terrible ones. The only thing that seems to be consistent is that, in general, female users are more likely to have a better experience of support officers.

Across the system, there are concerns that:

- Support officers do not have enough contact with clients (especially one-to-one sessions and counselling); there is not much evidence that support officers engage on a personal level with clients
- There is no evidence that the help has any obvious structure, apart from ARWs
- Whilst some support officers do provide accurate and appropriate information, in many cases the information supplied, even about the way DIP works, is misleading or irrelevant
- Support officers do not have enough personal or in-depth experience of BME culture or of drugs use – particularly the latter – to relate to drugs users

For DIP, an additional problem is that it has a reputation for missing appointments etc and sometimes a lax approach to confidentiality. The relaxed impression this gives can compare well to, for example, DRR with their strict rules, but it also sometimes is taken to mean that DIP are not very professional.

12.2.2 Information

There is not much evidence for the idea that giving out information by itself helps users fight their addictions. This includes the courses in prison and the leaflets given out at police stations. If the user is motivated, information can have an effect, but our users didn't get much out of leaflets or posters. Groups of users regularly commented that you had to be in the right frame of mind to come off drugs. Families of drug users did want to have more information, and had an idea what was needed, but didn't know where to find it because their knowledge of support services was limited. They also recognised how difficult a job it would be to bring this information to the attention of families and communities.

Two roles for information were identified. First, although families appear to have little direct influence on drug users decision to come off drugs, more information might enable a more supportive atmosphere to be created.

Second, a majority of DIP clients said they found out about the service from friends, and there is a lot of confusion about self-referral and the general DIP process. This is one area where better information circulating might have made a difference. This includes not just posters and leaflets, but the information given out by DIP staff, agencies, and other parts of the CJS. Several respondents were of the opinion that information about DIP etc should be "hammered" into inmates before leaving prison.

The alcohol support leaflets were singled out as useful.

Interestingly, the white focus group showed a much better understanding of treatment agencies and the processes involved. It's not clear why they seem to be so much better informed.

12.2.3 Management of clients

There seems to be general problems with the administration of the DIP service, with clients having to do much of the chasing to get assessments or appointments. Clients mentioned that they turned up at DIP before their documents did. Clients often had to chase up appointments and were supplied with inaccurate information about the process. The impression given is that the way DIP works internally and with other organisations is not very well organised, and DIP itself largely reacts to events.

It may be unfair to put the blame for this on DIP, but this is how users see the service. For example, one criticism is that repeat DIP customers have different case managers each time. This may be because of staff turnover, for example, or it may be a deliberate policy, but users perceive this as a lack of planning.

12.2.4 Treatment

While some clients receive methadone treatment very quickly, others can wait up to a month or more, particularly in prison. Users are either left without methadone or (for those in the community) have to rely upon other agencies to fill the gap. Users also complain vociferously about the level of treatment at DIP and in prison – again, the treatment may be appropriate but users do not see it that way and blame DIP or prison staff for being incompetent. Particularly in prison, where a long-term relationship can be built up, this seems like a missed opportunity to get users on side.

It also seems that there is no real choice in treatment – heroin users get methadone, and others get nothing; in prison, even this seems only feasible if there is a pre-existing prescription. In our study, only half listed heroin as their main drug of choice. Much of the criticism, particularly of prison, is that other drug needs are not being effectively addressed: users expect "treatment" to cater for a wider range of substance misuse, and are not happy at the limited options.

12.3 Aftercare

12.3.1 GPs

GPs receive a bad review from all groups. Major problems identified by respondents include

- Too short appointments
- GPs are judgemental, often condemn clients, don't take time to gain confidence of clients, and in some cases refuse or withdraw help
- Limited knowledge of drug-related issues
- GPs don't pick up on the need to react quickly to requests for help
- Mainly a point of referral rather than treatment

There was a difference between BME drug users and all the other groups. Most were constructive in identifying particular problems with GPs – waiting times, confidentiality etc. In contrast, the BME clients tended to react emotionally to difficulties with their GPs.

All groups mentioned that GPs did not recognise the mental problems associated with drug use, but only the white focus group specifically talked about GPs using "depression" as a catch-all category.

Both service providers and clients noted that GPs finding a patient on drugs might well stop other medication. While this may be medically necessary, this is seen by drug users as a 'punishment' and so can dissuade users from visiting GPs.

Finally, service providers and BME clients and families recognised the particular problems associated with GPs from the same ethnic group as the patient – BME patients see a real possibility that the drug user's problems will be leaked to the community.

One question not addressed by any group except service providers is whether GPs should be involved in treating drug users; the service providers were asked explicitly about this and were split. This indicates that the position of GPs in the community is too central to be ignored. Unlike DIP, people do think of the GP service as one of the first places to go with a drug problem.

In this it is interesting to compare the way people view GPs and DIP. DIP is a specialist agencies with the knowledge to treat users, but few willing clients; GPs, on the other hand, would have many willing visitors but the facility to treat them is not there.

12.3.2 CAU

CAU is the main treatment provider in the community, recognised by almost all of the clients, and the final referral point from all agencies and the CJS. All groups commented on the extremely long waiting lists for CAU ranging from 6 to 12 months (or longer), and saw them as a problem, particularly as the initial impression from CAU assessment was often good and clients then felt let down.

In addition, the perceived likelihood of being dropped from CAU if appointments were missed was widely noted by clients and service providers. Given the long initial assessment phase, and the chaotic lifestyles of many of the client, the chance of this is high. For many, the initial contact was also the final one; a majority of the BME respondents interviewed had dropped out.

12.4 The role of BME community characteristics

Whilst in custody, there are some ethnicity issues which come up, but mostly the problems arise once clients return to the community. Note however that the only source of information on non-BME users is the whites-only focus group, and so we sometimes are speculating on differences in the communities.

12.4.1 Prisons and ARW

In prisons and at police stations, there is not much support for the idea that the treatment and counselling services show any strong ethnicity problems (although without having a control group of in-depth interviews with whites, this is impossible to say for certain).

However, there is some evidence from both users and service providers that there is an element of unfair treatment in the wider CJS. This is outside the remit of this report, but we can identify two specific areas where it can have an impact

- if BME offenders are more likely to be remanded in custody, then this will increase their chance of dropping out at the ARW stage
- because the ARW process takes place in the police station, and the police service does not have a good reputation amongst the BME community (at least in the groups interviewed), BME users may be wary of cooperating with the ARW

12.4.2 Users in the community and their culture

The life-pattern suggested for male BME drug users, particularly by the focus groups, is clear:

- Much more freedom than females
- Mixing with other males only
- Long times spent away from the house
- Drug use starts young, generally while at secondary school, and normally with cannabis
- In several cases, cannabis is a socially acceptable drug
- Limited male role models – fathers often absent, often just seen as the disciplinarians
- Little tolerance for drug users from fathers
- Young Asian males typically live with the parents until married

Obviously this is a generalisation – it should not be forgotten that this picture is painted by a group of people who were chosen particularly because of drug problems in their families, and we are including all ethnic groups in this description when there are differences between groups.

Nevertheless, we think this is a useful starting point, and this does suggest some reasons why BME take-up and retention rates are lower: Young BME users returning to the community are likely to return to their previous social groups, which for these ex-offenders is likely to be a drug-using community. This might be of benefit: for example, sharing information about agencies and help. On the other hand, all the respondent groups identified getting away from other drug users as a key factor in trying to take up treatment.

Does this explain why BME retention rates are lower than non-BME? The feeling of the respondents was that there were significant differences in cultures which encourage young men, in particular, to create isolated communities. In some BME communities, mixing with females who were not relations was heavily frowned upon, and so there was no opportunity for girlfriends to exercise a moderating influence and the young men had more time on their hands. Similarly, young Asian males who are rejected by their families may have very limited options in where to go. In general, maternal influence was not felt to be very strong. In addition, there was the strong possibility that fathers would disown their sons once the addiction comes to the surface, forcing them out of the family.

In short, the families of drug users had no doubt that culture played a large part in both drug-taking and the response to treatment; and the interviews with users provided some support for their characterisation of this life style.

Because only a small number of females were interviewed, no consistent picture was built up.

12.4.3 Family and community attitudes to users

All the interviewees and the family and BME focus groups agreed that community attitudes exercised a big influence. The community was generally

unforgiving, and whole families were liable to be ostracised as a result of the actions of one member. Interestingly, the white focus group did not discuss community at all. They were only concerned with the impact of their action at a family level – if they stole from or upset other family members.

Both positive and negative effects of these strong community views on drug use were raised by the respondents.

Taking the negative first:

- Hiding drug use from the community becomes important – and in many cases, hiding it from the family too.
- This makes taking up treatment more difficult, and harder to get the family involved.
- To protect the rest of the family (particularly if there are unmarried daughters), the family is more likely to reject a drug user and deny any problem exists.
- Rejection by the community and family means that ex-offenders might only feel accepted in their old drug-using groups, increasing the chance that they will return to taking drugs
- Some ethnic groups would avoid participating if they thought they would get (for example) a DIP case manager or GP from the same ethnic group.
- Because there are relatively small numbers of BME clients, any that do attend treatment agencies are going to be more 'visible', bringing their 'shame' into the open, which may again put some people off.
- Chasing up is also more difficult, as users may not want to receive letters or phone calls from treatment agencies which their families might see.
- Awareness of DIP and other services might be poor if no-one wants to talk about it openly.
- Finally, drug awareness campaigns (or just better information) may be rejected as families don't want to be seen to be friendly to drug users.

On the other hand, the strong community spirit described by BME respondents could also be used as a force for good:

- The opportunity to use religion as a weapon against drug use was only mentioned by the BME community, both users and families. The white focus group made no reference to religious issues.
- The community spirit could be channelled into providing a more supportive atmosphere
- Strong community links could be used to disseminate information more effectively
- Some families (usually female members) actively do want to be involved but at the personal and at the community level

In other words, at the moment community attitudes are seen as a barrier to helping drug users, but there is scope for this same community spirit to be used positively, perhaps starting with the families who want to be involved.

12.4 Overall comments

DIP was intended to be part of a single system to cover drug users from arrest to final treatment, with a seamless transition between stages. However, in practice there are some difficult problems and the transitions between components of the system are not seamless. Users can fall through the gaps; and some problems in the way the programme is implemented increase the number of holes.

DIP has some of its own problems, but a major concern is the way the different parts of the CJIT work together. This does require more co-operation across units, and may also require a re-evaluation of working methods to ensure that co-operation between the units is effective.

What this means for the BME community is hard to tell. It would seem that for the more institutional parts of the process (ARW, prison) there is less opportunity for ethnic differences to show up. However, once users are in the community and have to take more responsibility for their actions, then cultural, ethnic and religious differences do seem to make a difference.

It seems then that cultural factors have a bigger effect on whether to enter the system or not, and less on retention, as those in the system have already made the decision to face the community and families. This does not mean that retention is not a problem, but the first bridge has been crossed.

This does increase the importance of the CJS in getting people onto DIP. Prison is a fishing net for users, but as treatment and counselling does not seem to be provided for all, many slip through the net and, as a consequence, do not take up treatment in the community. In contrast, DRR dealing with drug using offenders in the community where they face the problems that perpetuate their drug use, unlike the artificial environment presented within the prison setting. Interestingly, some families expressed a wish for relatives to go to jail as this was the best chance to come off drugs, and one of the suggestions made by BME respondents was that DIP should be made a compulsory service. The BME community, then, has recognised that users might need a helping hand to overcome cultural factors.

13 Recommendations

Recommendations are based on the issues that emerged from the BME research, and aim at BME clients; however, many recommendations are equally applicable to the wider community, and are not limited to non-BME clients. For wider context please refer to the results and discussion sections

We propose that all the recommendations here are reviewed for progress 6 and/or 12 months after being implemented.

Note: it was not possible to evaluate the financial implications or benefits of the recommendations in the time available. Therefore, recommendations are made without reference to resources including cost, and no specific references to sources of funding are made. However, as stated in the Welsh Substance Misuse Strategy (WSMS) 2008-18, it is the responsibility of the established Community Safety Partnership (CSP), as local delivery agents, to support commissioning of local services. We would like support from the CSP to form an 'implementation board', including substance misusers, set up to maximise the uptake of our recommendations.

- *"An expansion of harm reduction services to drug-misusers and an improvement in the range of programmes that can reduce the harms associated with injecting illicit drugs.' (WSMS Action Area 2)*
- *'It is important to ensure that any positive steps an individual makes towards reducing their substance misuse whilst in prison are maintained and built on when they are released'"(WSMS Action Area 2)*
- *'Reducing harm to individuals, families and communities.' (WSMS Delivery aim 1)*
- *'More integration of services, removing the need for multiple assessments reducing risk of drop-out from service.' (WSMS Action Area 2)*

DIP service

	Issue	**Recommendations**
Dispensing	• Users find dispensing times difficult to accommodate	• Increase dispensing time to maximum on Friday to avoid weekend missed pick ups • Longer or multiple dispensing times on other days for ease of service access • Develop consistent policy on methadone prescribing for clients who are unable to attend Cardiff prescribing for a minimum period (suggest one week) to overcome circumstances of absences such as holidays.
Accessibility	• Inconsistent	• Introduce bus passes in common

	treatment of users between DIP and DRR • High costs of travelling to collect prescriptions	system/approach with DRR or equivalent transport access for clients engagement to be sustained.
Treatment	• Treatment limited to methadone • Significant number of stimulant users among local BME population	• Explore more non-methadone based treatment options for heroin users • Provide long-term support for stimulant misusers • Provide a wider range of interventions such as psychosocial interventions • Provide a wider range of treatment regimes to enable user choice
Care plans	• Current care plans confusing to users • not followed consistently • limited one-to-one key working • discussing clients' private issues in the reception area	• Provide users with clear structure for support through the whole duration of the care plan • Ensure one-to-one sessions for support and counselling are frequent, regular, and agreed in partnership with the client • Set baseline minimum for frequency of meetings • Provide safe and private environment for client meetings • Ensure that those re-entering DIP are assigned the same case manager, where appropriate and in agreement with the client • Actively support (not necessarily by case manager) clients having difficulties communicating with GPs and other agencies by, for example, accompanying them to meetings • Regular update for GPs about client's progress in treatment (methadone level, any changes) • Review the feasibility of using an incentive structure to help clients engage, remain retained and progress in treatment
Confidentiality	• Some staff have insufficient knowledge of confidentiality protection	• Staff undergo (re-) training in confidentiality (legal and practical) • Ensure a clear definition of confidentiality is understood by all stakeholders
Family support	• Many families would like to get	• Where the client does not want the family involved, check regularly

	more support and be more involved, but the client may refuse consent	whether this is still the case • Ensure that separate independent support for families is available even if client does not wish family to be involved, as long as client confidentiality is not breached (eg cannot discuss client's treatment or confirm client is on programme); this could be done by DIP or by referral to an external agency • Provide support for clients to deal with problems with family • Explore demand for and feasibility of family sessions outside normal DIP hours to provide confidentiality for both families and other clients such as weekend work
Staffing	• Predominantly white staff means DIP is perceived that it does not cater for multi-cultural community • Question of whether staff have sufficient relevant experience to relate to clients • Need to bring the communication with BME clients on the same level as with the non-BME clients/ those from non-BME groups	• Encourage recruitment of staff with first-hand experience in substance misuse, including ex-users • Encourage recruitment of staff reflecting ethnic breakdown of clients • Staff speaking languages of the local communities • Culture diversity education built in to the continuous professional development of all groups of staff; delivered by appropriate agencies with knowledge of the local BME communities
Outreach work	• Community (including families of clients) have little knowledge of substance misuse issues, DIP services, and other agencies • Communities dislike and avoid involvement with drug-related issues	• Build contacts with different BME communities by cooperation with projects or agencies with good contacts among local BME communities, such as South Riverside Development Community Centre, Bute Pavilion, Inroads, SIS etc • Educate the local BME communities by co-operating with local BME agencies such as NewLink Wales, Axis Project to provide information and training in target communities. • Education should cover drug issues; the family/community context; DIP services; and other support available

		in the local area
		• Set outreach targets to ensure that all groups (including hard-to-reach ones) have some contact with education programme
		• Involve local religion leaders in the education programme
		• Educate young people in school-invite ex-users to deliver the message
		• All community information about DIP programme should stress confidentiality and the multi-culture profile of the services
Public awareness	•Need to raise general public awareness of drug support issues and treatment options	• Use community events to publicise the DIP service
		• Develop a communications and marketing strategy involving workshops, local radio, local/BME television channels, websites, leaflets, posters etc. to ensure that awareness of DIP is covered across all media and in relevant languages
		• Have a section on the DIP website for clients; stress confidentiality and the multi-culture profile of the services
Targets	•No BME performance targets or data	• Ethnicity monitoring of BME clients regarding different drug patterns; engagement and drop out rate
		• BME referral/retention figures reflected in KPI
DIP offices	•DIP not welcoming and users mixing with ex-users	• Provide welcoming environment for clients
	•DIP associated with other parts of the CJS, mainly Police	• Review office layout to see how contact between users and ex-users can be reduced to a minimum
		• Re-brand DIP as a separate entity
		• Ensure the potential for drug dealing is minimised by adapting the office set up
Referral	•Not effective follow up to self-referrals	• Develop immediate-response policy for self-referrals

Custody suite

	Issue	Recommendations
Medical support	• If no medical support on	• Doctor available/based around the clock in each of the 4 main police stations in

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	arrest, opportunities to see ARW may be missed due to limited window of opportunity • Medical support is in theory always available but in practice is not • Medical conditions of arrestees affects ARW's chances to approach client	Cardiff to provide quick medical assistance/intervention/consultation to all
Language	• Language problems mean ARW meetings may not happen	• Staff speaking languages of local BME groups • Info about DIP in relevant languages
Cultural awareness	• Perceived or real prejudice in CJS	• Culture diversity education built into the continuous professional development of all groups of staff working within the custody setting, delivered by appropriate agencies with knowledge of the local BME communities
Image	• ARW confused with CAU • ARW seen as part of CJS and viewed with suspicion	• ARW (and leaflets) to clearly identify their roles • Encourage recruitment of staff reflecting ethnic breakdown of clients • Encourage recruitment of staff with first-hand experience in substance misuse, including ex-users

Prison

	Issue	Recommendations
Treatment	• Limited treatments available, none for stimulants • Methadone support only for those on prescription • Many BME users see methadone maintenance as substitute dependency • Limited treatment for mental health	• More, and regular counselling, one-to-one sessions, and 'talking therapies'. • Methadone treatment allowed even for those not on pre-existing prescription • Explore more treatment options for heroin users • Treatment provision for stimulant users • Address mental health

		problems associated with substance misuse with more 'talking therapies'
Courses	• Course choice limited; long waiting times; and not tied to prisoner's sentence	• Make all substance misusing inmates eligible to do courses • Shorten waiting times for courses • Ensure prisoner attends more courses over a duration of sentence and more evenly spread • Design educational strategy for a prisoner rather than ad hoc arrangement • Provide final (pre-release) course on DIP and other services
Referral	• Users' over-optimistic projections of their likelihood of staying off drugs once back in the community • No co-ordination between courses, end of sentence, and referring • BME client may not want to receive DIP correspondence at home where it can be seen by members of their family • Clients liable to restart drugs use almost immediately on release	• Challenge refused referrals, using evidence about numbers return to drug use • Use electronic communications where possible between custody and community • Ensure that information sent between DIP and CARAT has been received and acknowledged • Referral should be made as soon as possible after release, ideally within one day. • CARAT formally hands over responsibility to DIP as client leaves prison with an acknowledged appointment • Ensure adequate over dose awareness information is provided to every client leaving custody • DIP to meet and greet at the prison gates where possible
Staff	• Lack of cultural sensitivity amongst wider CJS	• Culture diversity training as an on-going process for all members of staff to deliver culture sensitive services

Aftercare

	Issue	Recommendations
GP attitude	• Negative/ judgmental attitude • Many GPs do not want to be involved • GPs from same BME community as client may cause confidentiality concerns	• GPs/ medical staff trained in drug related issues in respect of lifestyles, psychological problems etc of drug users • GPs undergo (re-) training in confidentiality and disclosure specifically in respect of addressing confidentiality in ethnic groups, and in communicating this to patients
GP appointments	• Not enough time during appointment to build confidence and talk through issues	• 'Long appointment' option for substance misusing clients
GP lack of expertise	• Only 3-4 GPs in Cardiff recognised as being trained to deal with drug issues	• Train more GPs and medical staff in Cardiff in substance misuse • Surgeries to offer an appointment with a drug worker at the surgery as an option for patients • Educate GPs about DIP service and other drug treatment and support agencies in the community
GP treatment	• Lack of co-ordination around total level of treatment for patients	• CJS treatment agencies regularly update GPs on client's progress in treatment (methadone level, any changes)
Role of GPs	• GPs may be seen as first point of contact, but may not have time or training to deal with users	• In the longer term, review whether GPs are an appropriate 'first point of contact' and develop an appropriate strategy for directing substance misuse cases to the appropriate place
CAU	• Long waiting times	• Significant cut in waiting times (NB no opportunity given to discuss with CAU staff) • Alternative structure sought • Ongoing waiting times should result in a review of service operations and adaptations piloted to measure resource impact

Appendices

Appendix 1 BME DIP Project Terms of Reference

1. Aims:

The steering group is set up to support and facilitate the work of the BME DIP Research Project (Cardiff) and encourage the adoption of its recommendations.

2. Objectives

1. To support the operation of the project by:
    a. providing an opportunity for members to share current resources, knowledge and skills
    b. ensuring the co-operation of the relevant agencies
    c. enabling access to relevant research sites, providing advice and assistance on overcoming difficulties in access where relevant
    d. identifying possible training and capacity building opportunities for the research teams
2. To provide strategic guidance by
    a. advising on all aspects of the strategic direction of the research as well as matters of questionnaire content, design, sampling etc.
    b. undertaking considerations relating to research ethics that are beyond the remit of the University of Central Lancashire. E.g. prisons etc
3. To support the implementation of the project recommendations by
    a. publicising the development of the project within agencies
    b. promoting the use of the research to ensure its impact on DIP service provision for BME populations is maximised
    c. ensuring that the recommendations reflect resource considerations
    d. obtaining commitment from the relevant parties

3. Operation

The steering group will meet monthly. Members of the steering group should delegate if they are not able to attend.

4. Proposed membership

Membership will consist of representatives from;
- University of Central Lancaster (chair)
- Cardiff CJIT Consortium
- Cardiff DIP (Arrest Referral)
- Cardiff DIP (Custody)
- BME Community Representatives
- BME DIP Project (Cardiff) Team Leaders

Secretariat will be provided by the BME DIP Project (Cardiff) team.

Appendix 2: Ethical approval monitoring application

Centre for Ethnicity and Health – Application for Ethical Approval	
Name of Group	*Cardiff DIP-BME Community Engagement Project*
Address	*8 Coopers Yard, Trade Street, Cardiff CF10 5DF*
Name of Support Worker	*Imran Mirza*
Date:	*16th August 2007*

Section 2:

What kind of work does the group intend to do as part of this project?	*Research into the participation and retention of BME clients in the Drugs Intervention Programme (DIP). The research focus is broken down into **5** key areas:*
	*• **1. Entry into DIP*** *-To look at offence committed, experience of entry /referral* *• **2. Take-up of services within DIP*** *-What and why?/experience of the service* *• **3. Drop-out points*** *-Where in the process are these points? Why? (according to respondents)* *• **4. Where are they [the respondents] now?*** *-Are they in treatment? Using again? Receiving support from elsewhere?* *• **5. How can services be improved for BME clients?*** *-What can make them more accessible? What will keep them in treatment? What support required?*
How do they intend to do this?	*70+ one-to-one interviews and 3 focus groups: 1 focus group for family/carers of DIP clients, and 2 focus groups for BME ex-/current offenders.*
Who will the respondents be?	*BME clients and ex-clients of DIP plus family members/carers in the community. BME clients and ex-clients of DIP within prisons.*
Who will they get to do the work?	*Five18+ male/ female community researchers from the BME communities (1male is an ex-offender and 1 female is an ex- drug user), supported by two (paid) lead researchers* We note that you will be using ex-offenders and ex-drug users as researchers. You need to think about how you manage the risks associated with this. Eg. Are there certain kinds of offences (e.g

	violence) that would prevent you from taking someone on? Are their certain situations that it might not be suitable to put someone with a history of offending into (either because they might re-offend, or because they might be accused of a crime [regardless of whether or not they did it] were one to be committed while they were around? Is there a risk that ex-users or offenders may relapse? We think it is important that you develop an appropriate system to manage this – eg suitably close supervision - checking out how people are feeling about going into any particular situation – anticipating possibly risky or difficult situations - debriefing people afterwards. It would not be acceptable for if an outcome of taking part in this research as a researcher was to put back your own rehabilitation.
Where they will undertake the work?	*In preference, at the offices of the project (8 Coopers Yard, Trade Street, Cardiff CF10 5DF) and partnership agencies (CJIT/ DIP offices); but, depending upon the preferences of clients, interviews may take place in cafes, community halls and other public places. The 2 lead researchers who have been CRB cleared may interview in Cardiff prisons. Access to prisons have been agreed and approved with stakeholder partner on steering group (Turning point).*
How will those who are doing the work be supported and supervised?	*The researchers have attended research workshops and are visited fortnightly by UCLAn support worker. The lead researchers will support the community researchers through weekly team meetings and also accompany the community researchers initially to ensure consistency and appropriateness in conducting the interviews, and will provide feedback and general support to the community researchers. Researchers deemed able to work under their own supervision will conduct interviews in pairs, with occasional supervision by the lead researchers to ensure standards are maintained. All the interviews will be tape-recorded and these will also be used for monitoring. Weekly meetings with researchers for general support, already established, will continue. The lead researchers are supported by Newlink project co-ordinator.*

How they will ensure that participants in the project have given consent? You should have an information sheet about the project which is read out and given to potential participants which explains to them (a) what the project is about.(b) that participation is voluntary (c) what will happen to the information that they provide (d) that they can stop the interview at any time and (e) that they do not have to answer any questions that they do not want to.	*An information sheet has been completed* explaining (a) what the project is about.(b) that participation is voluntary (c) what will happen to the information that they provide (d) that they can stop the interview at any time and (e) that they do not have to answer any questions that they do not want to. *This explicitly asks interviewees/focus group members for their consent. The answer will be recorded.*
Please enclose the information sheet and confirm that it addresses issues (a), (b), (c), (d) and (e) above	Information sheet enclosed (√) tick to confirm Issue (a) covered　　　　　　(√) tick to confirm Issue (b) covered　　　　　　(√) tick to confirm Issue (c) covered　　　　　　(√) tick to confirm Issue (d) covered　　　　　　(√) tick to confirm Issue (e) covered　　　　　　(√) tick to confirm
How they will the project ensure confidentiality? Note: you will not usually need to know (or collect) the names or addresses of respondents. If you know them already, or if you are going to ask people their names as a matter of courtesy, these should not be recorded on the questionnaires or the notes that relate to the interview. Note: you cannot guarantee confidentiality to anyone taking part in a focus group. You can request that people	*Reponses are stored without name or address information. Responses will not be available to anyone outside the research team. The responses will be destroyed once the project is completed.* *For focus groups, the information sheet includes a note explicitly addressing the confidentiality of group sessions highlighting that the researchers can request that people keep things within the group, but cannot guarantee that people will.* *The results will be reviewed for confidentiality before being presented to the general public (ie those outside the project team and steering group). Subject to the approval of the steering group, the results may be submitted to an external expert in disclosure control, if this is deemed necessary.*

keep things within the group, but you cannot guarantee that the will. This must be made clear to people who agree to participate in focus groups.		
How will data generated by the project be handled and stored?	*Completed questionnaires and tapes will be stored in a locked filing cabinet at the project offices. Completed questionnaires will be passed onto the lead researcher on the day of the interview for safe storage. Only the lead researchers will have access to the files. All the data will be analysed (and the raw data and analysis stored) on the project laptop, which is shared between the two researchers. Backups of the data will be kept on a memory stick, stored in the locked filing cabinet. All devices will be password protected where possible.*	

	Risk	*Avoidance strategy*	*Management strategy*
What risks are there? How will risks be identified and managed? Note you need to think about risks to researcher and volunteers and risks to participants. For some people, simply taking part in the research may be a risk (e.g. if the parent of a young Muslim woman finds out that she has been talking to someone about drugs). For others, particular situations may be risky (e.g. if you are using ex-drug users to work on the project, are you putting them at risk of relapse by asking them to go back into situations where drugs are being sold or used? If something gets stolen from an office, will they get blamed for it [regardless of whether or not they did it] because everyone knows they are a drug	*1. Physical risks*		
	Personal safety of researchers	*Working in pairs; all meetings in public venues or project offices; office*	
	Inappropriate choice of researchers	*Researchers chosen and vetted by agencies (government and NGO)*	*Meetings held in public places; researchers work in pairs; lead researchers*

		interviews carried out under direct supervision of lead researchers	person from project
	Relapsing of researchers	*Researchers chosen and vetted by agencies; first interviews carried out under direct supervision of lead researchers; assertiveness training to resist peer pressure; interview preparation sessions with lead researchers*	*Meetings held in public places; researchers work in pairs; lead researchers debrief and monitor researchers after interviews; removal of person from project; re-assessment of individual's needs*
	False accusation based upon researcher's reputations	*Preparation sessions with lead researchers describing how researchers might be viewed, and how to react in problematic situations*	*Meetings held in public places – wherever possible, in those agencies which deal with offenders/users; researchers work in pairs; lead researchers provide support in case of accusations*
	Failure of recording equipment at interview	*Check device before start and have a note-taker as backup at all interviews.*	*Use questionnaire and other notes as available*
	Failure of recording equipment at focus groups	*Check device before start; researchers take notes as far as possible*	

user?). Are the interviewees particularly vulnerable or frail? Are interviewers likely to be vulnerable to allegations of misconduct?

Are the risks of carrying out or participating in individual interviews different form those of taking part or running a focus group? They probably are, and you need to show that you have thought about and addressed this.

THIS IS ONE OF THE MOST IMPORTANT SECTIONS OF THE FORM. YOU MUST THINK CAREFULLY ABOUT WHAT THE POSSIBLE RISKS ARE AND ABOUT WHAT STEPS CAN BE TAKEN TO REDUCE AND MANAGE THEM. THE ETHICS COMMITTEE UNDERSTANDS THAT IT IS USUALLY IMPOSSIBLE TO ERADICATE EVERY RISK, BUT THE ETHICS COMMITTEE MUST BE SATISFIED THAT ANY RISKS ARE REASONABLE, AND THAT STEPS HAVE BEEN TAKEN TO MINIMISE THEM

	2. Confidentiality risks		
	Breach of confidentiality of raw data	*Physical security of data; confidentiality awareness training*	*Recovery of data, if possible; notification of individual concerned; notification to Steering Group; review of data security procedures*
	Breach of confidentiality in published results	*Review of results specifically for disclosure*	*Withdraw published results, if possible; notification of individual concerned; notification to Steering Group; review disclosure control procedures*
	Breach of confidentiality of interviewees (questionnaire)	*Confidentiality awareness training; no directly identifying information stored*	*Notification of individual concerned; notification to Steering Group; review of researcher confidentiality awareness*
	Breach of confidentiality of interviewees (focus group)	*Remind focus groups of need to maintain confidentiality*	*Notification of individual concerned; notification to Steering Group; review use of focus groups*
	3. Statistical risks		
	Focus groups dominated by individuals, or poorly balanced (eg information withheld due	*Researcher training in running focus groups*	*Review composition of future focus groups*

	to presence of others)		
	Non-response by target groups	*Early identification of barriers to participation; adjustment of information sheet as necessary (eg describing how confidentiality will be maintained)*	*Increase range of sources; explore use of third-party organisations as go-betweens*
Please confirm the make up of the steering group	*Membership is:* *NewLink* *UCLAN* *DIP: Custody manager* *CJIT: Consortium Manager* *Turning Point: Arrest Referral Manager* *Project lead researchers x 2* *BME community representatives x2*		
How often does the Steering Group meet. It needs to meet often enough to both guide the research and keep it on track, and to pick up on any ethical issues that may arise.	*The Steering group meets once a month. The steering group chair and lead researchers meet at least twice between each steering group meeting to discuss the project.*		
Is the Steering Group clear that is has a responsibility for helping to manage the ethical issues that may arise as a result of running this project?	*The first steering group meeting identified the group's role in providing ethical insight. The specific oversight of ethical issues will be raised again at the third meeting (September 2007) to ensure that the group is fully aware of its responsibilities.*		

Appendix 3 Information sheet for one-to-one interviews

BME Community Engagement Project

One to one interview - Information Sheet

This research project is funded by the Welsh Assembly Government and supported by the University of Central Lancashire. The focus of the research is explore the participation and retention of BME clients in the Drugs Intervention Programme (DIP) in Cardiff, so DIP services can be improved for BME clients.

If you agree to participate in this interview, your identity will remain anonymous. We will not disclose the detail of what you say to anyone unless you tell us that either you or someone else is at risk of serious harm, including child abuse/ child protection issues.

You do not need give you name/ address or prison number so you will be anonymous. When the interview is completed, the information will be analysed to produce a report, which will then be presented to local/ regional and national commissioners and service providers to improve services for BME DIP clients.

The interview could take up to 1 hour to complete. Taking part in this interview is voluntary. If you do not wish to take part, you do not have to. You can stop the interview at any time and you do not have to answer any questions that you do not want to.

Are you happy to proceed with this interview? Yes/ No

Are you happy for the interview to be taped? Yes/No

Thank you for your time.

If you have any queries or complaints about this interview, please contact Maria Kreft or Yasmine Abdulrahman, 02920529002 or write to Cardiff DIP-BME Community Engagement Project 8 Coopers Yard, Trade Street, Cardiff CF10 5DF

Appendix 4 Information sheet for focus groups

BME Community Engagement Project

Focus Group - Information Sheet

This research project is funded by the Welsh Assembly Government and supported by the University of Central Lancashire. The focus of the research is explore the participation and retention of BME clients in the Drugs Intervention Programme (DIP) in Cardiff, so DIP services can be improved for BME clients.

If you agree to participate in this focus group , your identity will remain anonymous. We will not disclose the detail of what you say to anyone unless you tell us that either you or someone else is at risk of serious harm, including child abuse/ child protection issues.

We will request that all participants in the focus group (including yourself) keep everything that is said within the group and that people do not disucss what is said within the group anywhere else. We cannot guarantee that everyone will keep to this rule however, so please be aware of this and the information you want to share with us.

You do not need give you name/ address or prison number so you will be anonymous. When the focus group interview is completed, the information will be analysed to produce a report, which will then be presented to local/ regional and national commissioners and service providers to improve services for BME DIP clients.

The focus group could take between 1-2 hours to complete. Taking part in this focus group is voluntary. If you do not wish to take part, you do not have to. You can leave the focus group at any time and you do not have to answer any questions that you do not want to.

Are you happy to proceed with this focus group? Yes/ No

Are you happy for the focus group to be taped? Yes/No

Thank you for your time.

If you have any queries or complaints about this interview, please contact Maria Kreft or Yasmine Abdulrahman, 02920529002 or write to Cardiff DIP-BME Community Engagement Project 8 Coopers Yard, Trade Street, Cardiff CF10 5DF

Appendix 5 BME questionnaire

First, we will look at entry into DIP and your experience when you were arrested. I'd like to know about your most recent conviction.

1.   When was your most recent substance misuse related arrest?
                                                        MONTH   YEAR

2.   Which Police Station were you taken to? ……………………………..

3.   Did you know/hear about DIP before your arrest?   YES   NO

- *(If Yes)* Where from?
    - Leaflet at the Police Station   []
    - Word of month   []
    - Previous arrest   []
    - Other   []

At the Police Station:

4.   Did someone come to offer help with your drug problem?   YES NO

- *(If Yes)* Who was it?

    - Police officer   []
    - Civilian/ARW   []

- *(If No)* skip to **Q 12, page 3**
………………………………………………………………………………………

5.   Did you agree to assessment by ARW?   YES   NO

- What was the reason you agreed/disagreed?

[ ]

6.   I'd like to know what kind of help you got from ARW – please tell me if you received any of the following

	Yes	No	Don't know
Information about the help DIP can provide	[]	[]	[]
Address/telephone number of DIP (at St. Mary St)	[]	[]	[]
Name/telephone number of a contact at DIP	[]	[]	[]
24-hour helpline telephone number	[]	[]	[]
Contact details on your mobile	[]	[]	[]

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I'd now like to get your general views on the experience.

7. **How would you describe your experience with ARW?**
- Were you comfortable talking with ARW about your drug problem?
- Were there any culture/ethnicity issues that affected your experience?
- What were the positive/good elements of the experience?
- What were the negative/bad elements?

```




```

8. **At the end of your assessment did you feel you had good understanding of DIP service and treatment?**
YES   NO

- *(If No)* What was not clear?

```



```

9. **Do you think that ARW understood the kind of help you wanted?**
YES NO*

- *(If No)* Why?

```



```

10. **Did you feel motivated to take up treatment after meeting ARW?**
YES   NO

- *(If No)* Why not?

```



```

11. **In your opinion, how can arrest referral service be improved?**

```



```

Pause, affirmation and thank you for the info so far!

Now I need some information on what happened after your arrest

12. **Were you remanded in CUSTODY or released on BAIL?**

- Custody   []
- Bail   []

13. **Was this your first offence?**   **YES NO**

(If Yes) skip the next question

14. **Have you had a previous experience with DIP?**   **YES NO**

- *(If Yes)* Has your previous experience with DIP affected your participation in the programme this time?   **YES NO**

- *(If Yes)* How?

!!(If remanded in custody) go to   *B. Post-Sentence Experience, page 8*
………………………………………………………………………

SECTION 2. TAKE-UP OF SERVICES WITHIN DIP

We are now going to look at the services provided by DIP

A. Pre-Sentence Experience (Post-ARW)

1.   **After the referral from the Police Station, did you try to contact the DIP at St. Mary St. yourself?**   **YES   NO**

- *(If Yes)* **How** and **When**?
- *(If No)* Why did you choose not to contact them?

```




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2.   **Did the DIP try to contact you?**   **YES   NO**

- *(If Yes)* How?

```




```

*(If the answer to **both** questions is No) go to **B. Post- Sentence Experience**, page 8*

_____

1.   **Can you describe the experience AROUND your first meeting/assessment with DIP at St Mary St?**
- What were the positive/good elements of the experience?
- What were the negative/bad elements?

```




```

2.   **For each of the items below, could you tell me whether you received this help, and what you thought of it?**

	Help	How appropriate					Comments
	Y/N	1	2	3	4	5	
Methadone							
Housing advice/referral							

Counselling-harm reduction							
Counselling-overdose management							
Brief alcohol intervention							
Crack intervention							
Practical support from volunteers							
Other, please specify							

3. **Did you have needs that weren't addressed?**   **YES   NO**

- *(If Yes)* What were they?

4. *(If on methadone)* **How long did you wait for being put on methadone after the assessment?**

- What contact did you have with DIP in this period?

5. How long did you wait for being given a case manager after the assessment?

| |
| |

- What contact did you have with DIP in this period?

| |
| |
| |

6. How long did you stay with the case manager on your care plan?

| |
| |

7. Was the contact with your case manager sufficient?   YES   NO

- (If **No**)
  - Was it often enough?   **YES   NO**/Why?

| |
| |
| |

  - Was it long enough?   **YES   NO**/Why?

| |
| |
| |

8. How would you rate the quality of support from your case manager?

1	2	3	4	5	Comments/Why?

9. **Are you still on the care plan?**   **YES   NO**

- *(If No)*
  - **Why** not?

  - **When** did you withdraw from the programme?

10. **Did you find DIP service/treatment worked in practice the way it had been explained to you by DIP staff?**   **YES NO**

- *(If No)* Why?

11. **Where there any aspects of your culture or religion which affected the treatment or take-up? YES NO**   *

- *(If Yes)* What was relevant, and was it addressed by DIP?

12. **Do you think that the staff understood the kind of help you needed?**   *
                                           YES NO

- *(If No)* Why?

Pause, affirmation and thank you for the info so far!

Now I'm going to ask you about your experience with DIP when you'd finished your sentence.

B. Post-Sentence Experience – DRR/Prison

1.   After completing your sentence, were you referred to DIP?   YES   NO

(If Yes) skip to Q 3below

2.   Did you have any contact with DIP after finishing your sentence?   YES   NO

(If No) go to C. Prison Experience, page 13
(If Yes) go to the Q4 below
…………………………………………………………………………………………

3.   Who referred you to DIP? Was it:

- DRR   []
- Prison   []
- Self-referral   []
- Some other agency (specify)   [] ………………………

4.   **Were you contacted by DIP before your Prison sentence/DRR finished?**
                                                                YES   NO

- *(If Yes)* How?

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│                                             │
│                                             │
│                                             │
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```

5.   Were you contacted by DIP person after release from prison/finishing DRR?
                                                                YES   NO

- *(If Yes)*

```
┌─────────────────────────────────────────────┐
│  • When?                                    │
│  • By whom?                                 │
│  • How?                                     │
└─────────────────────────────────────────────┘
```

6.   Did you try to contact the DIP programme yourself?   YES   NO

- *(If Yes)* How and when?
- *(If No)* Why not?

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│                                             │
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Pause, affirmation and thank you for the info so far!

1. Was there anything different AROUND your DIP experience after Prison/DRR comparing to what you've already said about DIP?

- Would you say it was roughly similar?
- (If **Not**)Why not?

<table>
<tr><td></td></tr>
</table>

……………………………………………………………………………

1. Can you describe the experience AROUND your first meeting/assessment with DIP at St Mary St.?
- What were positive/good elements?
- What were negative/bad elements?

<table>
<tr><td></td></tr>
</table>

2. For each of the items below, could you tell me whether you received this help

	Help	How appropriate					Comments
	Y/N	1	2	3	4	5	
Methadone							
Housing advice/referral							
Counselling-							

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harm reduction							
Counselling-overdose management						135	
Brief alcohol intervention							
Crack intervention							
Practical support from volunteers							
Other, please specify							

3.   Did you have any needs that weren't addressed?   YES   NO

- *(If Yes)* What were they?

4.   *(If on methadone)* How long did you wait for being put on methadone after the assessment?

- What contact did you have with DIP in this period?

5. **How long did you wait for being given a case manager after the assessment?**

- What contact did you have with DIP in this period?

6. **How long did you stay with the case manager on your care plan?**

7. **Was the contact with your case manager sufficient?** **YES NO**

- (If **No**)
  a. Was it often enough? **YES** **NO**/Why?

  b. Was it long enough? **YES** **NO**/Why?

8. **How would your rate the quality of support from your case manager?**

1	2	3	4	5	Comments/Why?

9. **Are you still on the care plan?** YES NO

- *(If No)*
  - **Why** not?

  - **When** did you withdraw from the programme?

10. **Did you find DIP service/treatment worked in practice the way it had been explained to you by DIP staff?** YES NO

- *(If No)* Why?

11. **Did DIP service/treatment meet your cultural/religious needs as a BME individual?** YES NO *

- *(If No)* Why?

12. **Do you think that the staff understood the kind of help you needed?** YES NO *

- *(If No)* Why?

Pause, affirmation and thank you for the info so far!

C. Prison Experience

1. **Did you see a CARATS worker in prison?** **YES   NO**

2. **What drug treatment/support, IF ANY, were you offered by CARATS/in Prison?**

| |
| |
| |

3. **Did you receive the treatment/support you were offered** **YES   NO**

- *(If No)* Why not?

| |
| |
| |

(If No) go to Q11, page15
………………………………………………………………………………………

4. **What made you decide to take up the treatment?**

| |
| |
| |

5. **How long did you wait for your treatment?**

| |
| |

6. **Are you satisfied with the treatment you *received/are receiving*?**

- *(If No)* Why not?

| |
| |
| |
| |

7. *(If after prison)* **Did you complete the treatment while in prison?   YES   NO**

- *(If No)* Why not?

8.   How would you rate the quality of support you got from CARATS worker?

- What were positive/good elements?
- What were negative/bad elements?
- Were there any culture/ethnicity issues that affected your experience?

1	2	3	4	5	Comments/Why?

9.   How would you rate your experience AROUND the TREATMENT in prison?

- What were positive/good elements?
- What were negative/bad elements?
- Suggested changes?

1	2	3	4	5	Comments/Why?

10. Were there any aspects of your culture or religion which affected the treatment or take-up?   YES   NO *

- *(If Yes)*

  - What was relevant?

- Was it addressed by CARATS ?

```



```

11. (After prison only) Where you referred to any treatment/support agency upon your release?   **YES   NO**

- (If **Yes**) What was it?

```




```

12. Are you still in treatment?   **YES   NO**

13. *(Prison only)* **Do you have any drug needs that won't be met in the within the existing service framework?**   **YES   NO**

- Please explain

```




```

14. *(Prison only)* **Do you want to continue to receive support from the drug services upon your release?**   **YES   NO**

- Please explain

```




```

Pause, affirmation and thank you for the info so far!

Section 3: AFTERCARE DROP-OUT POINTS

We are now going to look at agencies the DIP referred you to (during and after your care plan).

1. **Which agencies were you put in contact with by DIP? (CAU, CADT,**

Agency	What was your experience with these agencies?				Did your ethnic background affect the experience?		Suggestions/comments for improvement
	Good elements	Bad elements	Reason for withdrawal		How?	How was it addressed?	

Section 4. *WHERE ARE THE RESPONDENTS NOW?*

Now I'd like to find out where your treatment has got to

1. **Would you mind telling us the history of your personal drug/alcohol experience?**
- When did you try drugs/alcohol first time?
- Why/under what circumstances?
- What drugs have you experimented with/tried?
- When did you first time get into trouble because of drugs/alcohol?

2. **What was your main drug/s of choice?**

3. **Are you receiving any treatment now?**   YES   NO
- *(If Yes)* What treatment are you in?
- *(If No)* Why was your treatment ended?

4. **Are you receiving any support from your family/carers?**   YES   NO

5. **Do you think your family need education/support to better support you with your drug problem?** **YES NO**

- Please explain

6. **What is your community's view on drug use?**
*

7. **Does this affect you?** **YES NO**
*

- Please explain

8. **Would involvement from your community help you with your drug problem?** **YES NO**
*

- Please explain

Pause, affirmation and thank you for the info so far!

Finally, I'd like to get your opinions on what things could be changed to improve the service.

1.   Could anything have made DIP services more accessible for :

- you

```



```

- BME clients generally

```



```

2.   *(If they have used another org)* How does your experience with other drug service providers compare to DIP?

```



```

Affirmation, and thank you for the INTERVIEW and YOUR TIME

Appendix 6 Service provider's questionnaire

Confidentiality

Do you have a duty of confidentiality to your clients? **Yes/No**

Can you share information about clients <u>without their consent</u> with

	Yes	No
Colleagues	[ ]	[ ]
Medical services	[ ]	[ ]
Other agencies	[ ]	[ ]
CJS	[ ]	[ ]
Clients' families	[ ]	[ ]

Additional comments

Do you face pressure to share information about clients from families/friends of clients

	Yes	No
In the BME community	[ ]	[ ]
In the white community	[ ]	[ ]

Targets

Do you feel under pressure from external targets? **Yes/No**

If yes, please explain

Ethnicity

(optional) What is your ethnic background?
………………………………………….

In your opinion, do clients from different ethnic backgrounds engage with the service differently? **Yes/No**

```
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│  If yes, please explain                                     │
│                                                             │
│                                                             │
│                                                             │
│                                                             │
│                                                             │
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Is the likelihood of particular ethnic groups joining the service different? **Yes/No**

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│  If yes, please explain                                     │
│                                                             │
│                                                             │
│                                                             │
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Is the level of involvement different? **Yes/No**

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│  If yes, please explain                                     │
│                                                             │
│                                                             │
│                                                             │
│                                                             │
│                                                             │
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```

Do the drop-out rates from ethnic groups differ? **Yes/No**

```
┌────────────────────────────────────────────────────────────┐
│  Additional comments                                        │
│                                                             │
│                                                             │
│                                                             │
│                                                             │
│                                                             │
└────────────────────────────────────────────────────────────┘
```

Do the reasons for dropping out differ? **Yes/No**

```
┌────────────────────────────────────────────────────────────┐
│  If yes, please explain                                     │
│                                                             │
│                                                             │
│                                                             │
│                                                             │
│                                                             │
└────────────────────────────────────────────────────────────┘
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Given the above, do you think there is a need for more BME members of staff?
Yes/No

```
┌────────────────────────────────────────────────────────────┐
│  Additional comments                                       │
│                                                            │
│                                                            │
│                                                            │
│                                                            │
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```

Service information

How well do you think your organisation is known in your target community?

Poorly   Ok, but could be better   Fine

For *Poorly* or *Ok*, why is this the case (tick all that apply)

Lack of resources to advertise   [ ]
Adverts not noticed/effective   [ ]
Not advertising in right places   [ ]

```
┌────────────────────────────────────────────────────────────┐
│  Additional comments                                       │
│                                                            │
│                                                            │
│                                                            │
│                                                            │
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```

How do clients' families find out information about you? (circle appropriate please)

Website   leaflets   posters   other agencies   outreach worker   CJS

```
┌────────────────────────────────────────────────────────────┐
│  Additional comments                                       │
│                                                            │
│                                                            │
│                                                            │
│                                                            │
└────────────────────────────────────────────────────────────┘
```

How do clients find out information about you? (circle appropriate please)

Website   leaflets   posters   other agencies   outreach worker   CJS

> Additional comments
>
>
>
>

Relationship with GPs

Do you regularly discuss clients' cases with GPs? **Yes/No**

> Additional comments
>
>
>
>

Do you think that GPs should be the first contact for drug users seeking help? **Yes/No**

> Please explain
>
>
>
>

Other services

Do you need to co-operate with other agencies/services to support your clients? **Yes/No**

If yes: Do you generally get the co-operation you require? **Yes/No**

> Additional comments
>
>
>
>

Do you think there are any gaps in service provision in Cardiff for substance misuse clients? **Yes/No**

If yes, are there any specific issues for BME clients? **Yes/No**

Please explain

Service improvements

Please suggest briefly improvements that could be made to support services that would improve both the <u>engagement</u> and <u>retention</u> of clients:

Are there specific improvements that need to be made relating to BME clients?

Do you have any other comments/suggestions?

Thank you for your time.