

**COMMUNITY ENGAGEMENT PROJECT: HOME OFFICE DRUG
INTERVENTIONS PROGRAMME**

**REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSING
ON A GAP ANALYSIS OF TREATMENT SERVICES FOR BLACK AND
MINORITY ETHNIC SUBSTANCE MISUSERS IN THE CRIMINAL JUSTICE
SYSTEM**

**'REACH REPORT' BY THE BAC-IN BLACK AND MINORITY ETHNIC
PROJECT**

COMMUNITY IN NOTTINGHAMSHIRE

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Personal Profiles

Manjit Singh Johal - I am 31yrs of age, born in Derby city. I am an ex-service user who has been in recovery for just over three years. I have been helping the Asian community for two years on raising the awareness of addiction and treatment for Black and minority ethnic users in the East Midlands. I have gained qualifications in Counselling (one year), Mentoring, Teacher training and Drug level 3-substance misuse practitioners award (DANOS) accredited NVQ level 3.

I have worked for Addaction as a DIP worker but then left to work for a 12 step rehab called Jericho House as a project worker. I also helped to promote this new service in Derby city.

For the past eight months I have been working for the Derbyshire DAAT as a Service User Involvement & Advocacy Officer.

I am a co founding member and a sessional Black and minority ethnic drug support worker for the BAC-IN project that provides cultural and therapeutic support to Black and minority ethnic communities in Nottingham.

Sohan Sahota - 39 years of age. I am a qualified Counsellor/Psychotherapist, Reiki Practitioner, Supervisor, Drug Worker, Mentor, Substance Misuse Trainer and an experienced Addictions Therapist. I gained my Certificate and Advanced Certificate in Counselling along with a Diploma in Professional Counselling Practice from the University of Nottingham. I also studied at the Temenos Institute in Sheffield, gaining a Postgraduate Certificate in Person Centred Psychotherapy Supervision. I recently became a Graduate of the BSY group of London in Human Anatomy and Physiology.

I have been providing therapeutic and cultural support to Black and minority ethnic individuals and families for the past 9 years working with issues related to substance misuse, recovery education, mental health, language barriers, personal development and complementary healing.

As an ex-drug user and an ex-offender my life is now committed to helping others from similar backgrounds to my own to achieve sobriety, self-empowerment and more purposeful ways of living.

I am the co-founding member and the team leader of the BAC-IN Black and minority ethnic project based in Nottingham.

Ashveen Sethi - 35 years of age. I studied Business Studies BA (HONS) as well as passing the Chartered Institute of Marketing and Chartered Institute of Personnel Development. I have recently qualified as a NLP Life Coach.

As an ex substance user I have been involved with BAC-IN (a Black and minority ethnic support group for substance misusers) working as a drug

support worker. The work with BAC-IN involved me in a Peer Led piece of research entitled the ASK Report, finding out about the profile of Black and minority ethnic substance misusers within the county of Nottinghamshire.

The ASK report and its findings then led to a role to work as diversity lead within Nottinghamshire County DAAT, where I have been working for the last 6 months. The role consists of implementing the key recommendations from the ASK report and helping to implement the Diversity Agenda.

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Executive Summary

This is a Community Engagement Project report within The Home Office Drug Interventions Programme (DIP).

It has been produced as a result of a community led research project focusing on a needs analysis of treatment services for Black and minority ethnic substance misusers in the criminal justice system. The report is a 'Reach Report' by the BAC-IN Black and minority ethnic project in Nottinghamshire.

The target community for the report is Nottinghamshire.

The target group for the research project was male Black and minority ethnic substance misusers over the age of 18 within the prison service, engaged with the Probation Service or the local CJIT or in the community.

The BAC-IN Black and minority ethnic project was appointed to carry out the project due to their knowledge of drug related issues in the Black and minority ethnic community; the fact that the team are all ex substance misusers; have strong links to the local Black and minority ethnic community and are aware of the increasing problem of drug use within that community.

Aim of the Report

'A Beginning-To-End Support System'

Offenders are unlikely to come into contact with the programme just once, and their support needs will not end when they finish their sentence or treatment. Therefore, DIP interventions form part of a beginning to end support programme that follows and manages offenders as they pass through the criminal justice system, covering the following areas:

- Police custody
- Treatment
- The courts and probation
- Through care and aftercare
- Prison

This is called 'intensive' DIP – the full package.'

***Drug Interventions Programme, Nottinghamshire County Strategy Document
April 2004***

'During the course of this research it became apparent that there are real opportunities to undertake specific work with BME offenders, prisoners and ex-prisoners. A review would look into the treatment being received whilst in prison and the links and relationships between prison based and community

based services. The review would also take into account the current provision of through care and aftercare services for [Black and minority ethnic] substance using offenders across the county.'

The research could concentrate on service providers both in prison and the community; and track substance using offenders in prison and after their release.'

Ask Report: Asking Nottinghamshire's Black and Minority Ethnic people and communities about substance misuse – their needs and experiences.

Sheik-Latif, N. and Smith, Z. November 2005

The report aims to examine how far the aim of the Drug Interventions Programme to provide a beginning to end support programme for offenders with drug problems passing through the criminal justice system is a reality for BME substance misusers.

It aims to build on the work of the ASK report to examine the experience of Black and minority ethnic substance misusers in prison and after their release. It is not the comprehensive review called for by the ASK report, rather it is an attempt to begin a process of research into the needs of Black and minority ethnic substance misusers in the criminal justice system.

The aims of the report are ambitious but seek to build on the earlier work and conclusions of the ASK report.

Overall the report seeks to:

- understand and analyse the experience of Black and minority ethnic substance misusers in the criminal justice system
- analyse how effectively Black and minority ethnic offenders with substance misuse problems are able to access treatment services at different stages in their journey through the criminal justice system
- identify gaps in the treatment pathway for the target group
- examine the obstacles and barriers to effective access to treatment services. make recommendations to ensure that any gaps can be filled and barriers removed
- make recommendations to ensure that those with substance misuse problems from the Black and minority community in the Criminal Justice system can access the kinds of treatment and support they need at all stages – from arrest to prison to community treatment and aftercare.

Methodology

Mixed methodologies were employed to gather and analyse the data for this project. A combination of focus groups, questionnaires and secondary data from existing reports and reviews of local policies and documents, were

employed to provide both the qualitative and statistical information within this report.

The questionnaires were compiled using the researchers own knowledge of substance misuse within the Black and minority ethnic community, along with questions that the researchers felt needed to be answered.

There was a particular focus on ensuring access to research clients by the employment and training of peer interviewers and gaining access to Black and minority ethnic offenders with substance misuse problems within the prison system as well as within the community.

Findings

It is recognised that the research sample is small; with only 25 questionnaires of the final eighty-six target for completion having been completed and returned. Statistically this is not a particularly significant sample. However, particularly within the qualitative data gathered, the research has a great deal of validity. It raises some interesting and challenging questions for treatment services. The views expressed by those who completed questionnaires in terms of the effectiveness of wrap-around treatment appear to point to considerable gaps and failures in treatment services for Black and minority ethnic substance misusers.

The questionnaire findings are backed up by the views expressed by those who took part in the focus group. The focus group findings provide important qualitative data on the experiences of Black and minority ethnic substance misusers who have passed through the criminal justice system.

The findings are set out in both chart and text format to allow for ready access to and interpretation of the data.

Discussion

The discussion section of the report aims to pick out and analyse the most significant findings from the questionnaire and focus group in order to highlight the key themes that emerge from them.

It places a large emphasis on the qualitative responses to the questionnaire and from the focus group as providing the most powerful insights into the experiences of the target group.

This analysis is then used to form the basis for the recommendations contained within the report for improvements to services identified both by the respondents and focus group participants themselves and by the authors of this report

Key Recommendations

The report makes 22 key recommendations to enhance the availability and improve the effectiveness of services to Black and minority ethnic substance misusers in the Criminal Justice system. The recommendations set out below can be summarised as:

Enable access into prisons by ex-offenders involved in treatment initiatives/self-help groups 'Passport to Prison' system

Increased recruitment of culturally competent and trained Black and minority ethnic workers

Increased recruitment of former drug users

Increased recruitment of more staff from all communities:

Provision of Specialist Counselling and Psychotherapy

Faith based and spiritual approaches as part of a range of options for Black and minority ethnic substance misusers

Enhanced Black and minority ethnic Service User Involvement

Inreach Black and minority ethnic support services (for those in custody)

Enhanced Housing services

Better defining of treatment modalities

Enhanced Black and minority ethnic Aftercare Provision

Family Education and Awareness:

Effective assessment procedures:

Enhanced Outreach Support:

Provision of Drugs Awareness Education:

Choice for Abstinence based programs

Black and minority ethnic specific training for all staff involved in treatment and support

Culturally specific 24-hour free phone help line

Dealing with referrals more quickly

Better definition and explanation of specific front line staff roles

Need to challenge those workers that offer quick fixes/incorrect advice, wrong guidance and misinformation

Encourage ex-user involvement at service provision, decision-making, strategic and treatment planning levels

Introduction

The Centre For Ethnicity and Health's Model of Community Engagement

Background

We often hear the following words or phrases:

- Community Consultation
- Community Representation
- Community Involvement/Participation
- Community Empowerment
- Community Development
- Community Engagement

Sometimes they are used inter-changeably to mean the same thing. Sometimes the same word or phrase is used by different people in the same meeting to mean different things. The Centre for Ethnicity and Health has a very specific notion of Community Engagement, and this paper is an attempt to describe it. The Centre's Model of Community Engagement evolved over a number of 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 awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire 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 Department of Health had two key things in mind when it commissioned the work; first, the Department of Health 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 Department of Health had wanted was a needs assessment and a 'glossy report', they could have directly commissioned a number of researchers who could have gone into local Black and minority ethnic communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially do not have any long term impact. This scheme was different however. The Department of Health 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; what they would have is 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 about how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity & 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. 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 or domains of work. These include:

- Substance Misuse
- The Criminal Justice System
- Sexual Health
- Mental Health
- Regeneration
- Higher Education
- Asylum

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

In addition to the Department of Health, 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 and Aimhigher.

Key Ingredients

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 a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target community¹ (whoever this is) such that it is able to recruit a number of people

¹ The target community may be defined in a number of ways – in many of the Community Engagement Projects that we have run we have defined it by ethnicity. We have also worked with projects where it has been defined by some other criteria however, such as age (e.g. young people); gender (e.g.

from the target community 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 provide a co-ordination and infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day to day activities that will be undertaken once the project is underway. One of the first tasks that this host community organisation undertakes will be to recruit a number of people from the target community to work on the project.

A Host Community Organisation	With Good Links To The Target Community	To Provide Basic Infra-structure For The Project (Recruit And Co-ordinate Project Team; Provide Office Space, Phones And Computers; Look After The Finances)	To Recruit A Number Of People From The Target Community To Do The Work
A Task	Time Limited Meaningful Manageable	A Piece Of Research Into Key Needs/Gaps/Issues For The Community	Learning And Development Of Key Individuals; Access Hard To Reach Groups; Raise Awareness and Debate; Community Ownership
Support	Financial (Typically Up To £20,000)	Training And Workshops; On-Going Support And Guidance; Personal Tutor	Statutory Partnerships; Steering Groups; Sustainability

The second key ingredient is the **task** that the community is to be engaged in. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects that we have run have involved communities in undertaking a piece of research or a consultation exercise within their own communities. Sometimes we have been met with an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme that we ran on behalf of the Department of Health, *the process (i.e. of getting ordinary people involved in doing the work) is as important, if not more important, than the report that they produce at the end of the day.* The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be *the first time that these individuals have undertaken a research project.*

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate **support** and guidance. We do not expect community groups to become involved for nothing. Typically we would make in the region of £15-20,000 available to the host organisation. We would expect that the bulk of this money would be used to pay people from the target community as community researchers². We then allocate a named member of staff from our Community Engagement Team as a project support worker. This person will visit the project at for at least half a day once a

women); sexuality (e.g. gay men); service users (e.g. drug users or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with or rally around (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.

fortnight. It is their role to support and guide the host organisation and the researchers through the project. We also provide 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 pull together a steering group for the project³. The steering group is an essential element of the project: without one, it is difficult to see who the community are engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is also their role to help to pick up the key individuals who are developed through the project process to help them to take their ‘next steps’.

The Community Engagement Team

The Community Engagement Team comprises of 25 members of staff. They work across a range of Community Engagement areas of specialism, within a tight regional framework.

National Programme Directors			
Northern Team	Midlands Team	Southern Team	Senior Programme Advisors
Senior Support Worker	Senior Support Worker	Senior Support Worker	
Support Workers X 3	Support Workers X 3	Support Workers X 6	Drug Interventions Programme
			Regeneration
			Mental Health
Teaching And Learning Team			
Administration Team			
Communications Officer			

Programme Outcomes

Each group involved in any of our Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community that it consulted with. The qualitative themes that emerge from

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.

the reports are often very powerful, particularly when taken together with other reports produced by groups involved in the same programme. 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.

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.

In November 2000, the Department of Health awarded a contract to the Ethnicity and Health Unit (now Centre for Ethnicity and Health) at the University of Central Lancashire 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 project was hugely successful. Nearly £1.2 million was invested in the scheme and 49 groups were selected to take part (47 of whom completed) after 500 initial expressions of interest were received. These 47 groups represented more than 30 different ethnic and national groups. 350 people trained in research methods and basic drugs awareness at the University of Central Lancashire, and the 47 groups went on to consult with over 12,000 people (2,000 of whom were drug users) about their needs. The groups produced 51 local reports, which were summarised in two over-arching national reports published in May 2003. The project had a huge impact upon the individuals who took part, the community groups that the groups represented, and the DAAT's within whose areas they were based.

Also in May 2003 the Department of Health indicated its continuing support for the programme by announcing a further round of Community Engagement Funding for up to 120 additional community groups to become involved during the period to March 2006. Although Black and minority ethnic communities remained a focus for the work, the scheme was also extended to include other disadvantaged groups. The project has four main objectives. These are:

- to ensure that Black and minority ethnic and other disadvantaged and marginalised groups gain a better understanding of the drug misuse issues for their communities;
- to establish information networks across participating projects creating linkages both between different groups and across geographies, in order to encourage information to be shared and gaps in services to be identified;
- to provide capacity building for local Black and minority ethnic communities and other disadvantaged and marginalised groups to ensure not only the completion of the work, but also an enhanced ability to articulate identified needs to service planners and providers;
- to ensure local health and social care planners and providers are involved in the process in order to enable the development of services that are sensitive to and meet identified needs.

Each group undertook a piece of research within their local community. The focus of this research was different for each group depending on local priorities. In the main groups focused on one or more of the following issues:

- the characteristics and extent of the drug misuse problem in their chosen setting (e.g. particular group or location);
- new patterns of drug misuse;
- culturally specific explanations of drug misuse and the terminology employed by local misusers;
- the interventions which have taken place or are needed;
- the availability and adequacy of treatment;
- the nature and effectiveness of drug misuse prevention and education programmes;
- the types of community resources that could be mobilised to develop appropriate interventions;
- the relevance of all of the above to their communities.

Home Office Drug Interventions Programme

BAC-In BME Project was one of 11 community groups who took part in the Home Office's Drug Interventions Programme Community Engagement Programme in 2005. The programme shared a number of objectives with the Department of Health's Substance Misuse Community Engagement Programme (2000 – 2005):

- To ensure that Black and minority ethnic groups gain a better understanding of the drug misuse issues for their communities;
- To establish information networks across participating projects creating linkages both between different ethnic groups and across geographies for the same ethnic groups, in order to encourage information to be shared and gaps in services to be identified;
- To provide capacity building for local Black and minority ethnic community groups to ensure not only the completion of the work, but also an enhanced ability to articulate identified needs to service planners and providers;
- To ensure local health and social care planners and providers are involved in the process in order to enable the development of services that are sensitive to and meet identified needs.

It also had a number of its own specific additional objectives however. These were:

- To enhance the local work force and planning agenda to ensure the delivery and growth to the areas workforce of Black and minority ethnic employees, including the development of mentoring, accredited training, volunteer networks and employment.

- To improve the treatment engagement and sustainability of DIP offenders from Black and minority ethnic communities throughout the end to end process of DIP assessment, treatment and reduction of offending outcomes.
- To ensure local DIP Champion/Boards DAAT, Community Safety Planners and Commissioners are involved in a process in order to enable the development of services that are sensitive to and meet the needs of Black and minority ethnic communities within the DIP localities.
- To undertake a needs assessment of Black and minority ethnic offenders within the CJIT process including users, ex users and family carer voices from Black and minority ethnic communities within your DIP locality.
- To identify gaps and developments required within DIP projects to enhance the delivery of DIP for Black and minority ethnic communities and across the whole population of a DIP locality.

Aims and Objectives

The BAC-IN research project aims to build on a key recommendation from the ASK report, which examined the needs and experiences of Nottinghamshire's Black and minority ethnic Communities relating to substance misuse. The report identifies the need to target research at Black and minority ethnic offenders within the prison system as well as ex offenders within the community.

The overall aims of the BAC-In research project were to:

- Generate a better understanding of substance misuse within the Black and minority ethnic population, including the travelling community. It has been cited within the ASK report, that the Black and minority ethnic population is at greater risk of problematic substance misuse than the population as a whole. This research aims to give us a better understanding of some of the issues behind this.
- Assess the needs of the target community and to understand their perceptions of existing services.
- Understand why the Black and minority ethnic community might not be accessing tier three treatment.
- Identify any barriers to treatment services particular to the target group
- Have a greater understanding of what alternative treatments might exist for the Black and minority ethnic community and what substance misusers might currently be using as an alternative to treatment services.
- Explore the links between crime and substance misuse and examine the types of crime the target group are committing to fund their addictions.
- Make recommendations on future initiatives that could be taken to improve drug services to Black and minority ethnic communities in

Nottinghamshire, in the form of a short and long term strategy taking into consideration local DAAT priorities.

The views expressed in this report are those of the BAC-In project team who were commissioned to undertake the research and complete the report based on the research findings. They are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire.

The aims of the report are ambitious but seek to build on the earlier work and conclusions of the ASK report. Overall the report seeks to analyse how effectively BME offenders with substance misuse problems are able to access treatment services at different stages in their journey through the criminal justice system. It seeks to identify gaps in the treatment pathway for the target group; examine the obstacles and barriers to effective access to treatment services. It seeks to make recommendations to ensure that any gaps can be filled, and barriers removed to ensure that those with substance problems from the BME community in the Criminal Justice system can access the kinds of treatment and support they need at all stages.

The project initially aimed to involve the Nottinghamshire travelling community and a local and experienced young persons drugs worker who has strong contacts within that community was approached to take part – helping to reach travellers. However, unfortunately, due to work constraints he was unable to be involved. This meant that the research project was unable to engage with the travelling community.

The Government's 10 year drug strategy 'Tackling Drugs to Build a Better Britain' (HMSO 1998) was ground breaking in its recognition of the perception by people from BME communities that drug services were designed by white people for white people. The strategy required local Drug Action teams to ensure that BME communities are consulted and involved in the design and delivery of services. This commitment is enhanced in the updated strategy (2002) and the aims of this report are consistent with that commitment.

Background & History of BAC-IN:

BAC-IN started in October 2003 as a self-help support group by four ex-users.

BAC-IN was formed out of a need for Black and minority ethnic people in recovery or seeking recovery from drug and alcohol addiction to have their own forum, which would acknowledge & empower their cultural, traditional, religious, social and spiritual values.

Many Black and minority ethnic people are not accessing resources or completing treatment. The reasons commonly expressed are:

- The absence of cultural empathy
- Lack of cultural identification
- Distrust

- Under representation of culturally appropriate services
- Insufficient understanding of cultural stresses and cultural issues in relation to the treatment of alcohol and drug addiction
- Lack of psychological and cultural counselling for 'deep rooted' problems
- Lack of Black and Minority Ethnic Counsellors/Therapists within the drug and alcohol services
- Lack of psychological/cultural after-care support in the community, e.g. insufficient emotional support, support with overcoming institutionalisation, low self worth, low confidence and lack of help for developing skills for rebuilding broken relationships with family, spouses and children

Therefore, the need to form BAC-IN was driven by a gap within the existing support services.

In September 2004 the BAC-IN Black and minority ethnic project started work in the county of Nottinghamshire for Black and minority ethnic communities as well as offering support for Black and minority ethnic serving prisoners and also offering after-care for prisoners on release.

The aims of the BAC-IN project are:

- To support the cultural needs of the Black and minority ethnic community and service users in relation to their problematic drugs/alcohol use
- To empower members of the Black and minority ethnic communities to seek culturally appropriate help and advice to address their substance dependency issues

The founders of the **BAC-IN Project** are all ex-users and collectively have extensive knowledge and working experience within the drug/alcohol field, with cultural issues, psychological counselling, mental health issues, complementary healing, group work, family support work, mentoring, peer advocacy, drug support work, Black and minority ethnic research, specialist training and consultancy.

Services offered by BAC-IN include:

- One to One counselling
- Group work for Black and minority ethnic serving prisoners
- One to One support for Black and minority ethnic serving prisoners
- After-care support for Black and minority ethnic ex-offenders
- Mentoring
- Peer Advocacy
- Outreach drug/alcohol support
- Black and minority ethnic Training & research
- Two weekly BAC-IN self-help support group

Target Community demographics:

The target community for the research project was offenders in the Black and minority ethnic population with substance misuse problems. The particular geographical focus was Nottinghamshire.

Nottinghamshire is divided into seven districts; Ashfield, Bassetlaw, Broxtowe, Gedling, Mansfield, 'Newark & Sherwood' and Rushcliffe. At November 2005 the total population of Nottinghamshire was 748,510. The main towns range in size from Mansfield, with a population of 80,000 to Newark and Retford with populations of between 20,000 and 25,000. One third of the population of the county lives in towns and villages with populations of less than 10,000.

Of the County's total population 97.5% are classed as white. This is far greater than the national average of 91.3%. This group does, however, include Irish and 'white other' and therefore, taken as a whole including the white minority groups, the County's Black and minority ethnic population accounts for just 4.3% of the total population. It is however a diverse population with over 32 different ethnic groups being recorded. Of the major ethnic groupings, the 2001 Census shows that the White Irish community is the largest, with those classed as Mixed and the Indian community following close behind in terms of size. The smallest ethnic group is classed as Black Other.

The largest concentrations of Black and minority ethnic people are to be found in the districts of Broxtowe, Rushcliffe and Gedling with Ashfield District recording only 1.9%. A local study on behalf of the Children's Fund found that the majority of travellers' (not identified as such on census data) were to be found in Newark, Bassetlaw and Hucknall with an estimated 500-600 travellers' households in Newark & Sherwood District alone.

Statistics for Nottinghamshire as a whole show that the unemployment rates within the County are at 1.7% which is below the national average of 2.4%. There are, however, 39 wards within Nottinghamshire that feature in the top 20% most deprived wards in the UK. (Nottinghamshire DAAT Action Plan 2004/5) In the larger conurbations, for instance Mansfield, there has been severe and rapid economic slow down in the recent past owing to the decline of traditional employment opportunities in the textile and coalmining industries.

Nottinghamshire County Council's Community Safety Strategy for 2004/5 illustrates a marked rise in key crime categories – violent crime, vehicle crime and burglary – in the period 2001/2.

The Common Monitoring Project is a multi-agency initiative designed to improve the response to racist attacks and harassment in Nottinghamshire. In its 9th Annual Report, the project reported 1703 incidents, an increase of 22% on the previous year. There is a high level of repeat victimisation (35%) and in many districts racist incidents appear to have grown in number over the span

of the project, although this is acknowledged to be a possible outcome of improved reporting procedures rather than increased incidents of racism.

The *South Nottinghamshire Black and Minority Ethnic Housing Needs Study* involved the community in the process of its own needs assessment, and found that individuals from the Black and minority ethnic communities had specific concerns on a whole range of health and social care issues including:

- High levels of unemployment and low incomes
- Poor housing conditions impacting on the health of families
- Issues pertaining to community safety and racial harassment played a huge role in choice of relocation
- Inequality to access and opportunity to housing varied according to ethnic group
- Long-term ill health and disabilities were found in 1 in 10 households
- 4 out of 10 women requested additional local facilities for BME women
- Older people needed to be engaged and consulted more about their particular needs

As part of the study, 55 questionnaires were self-completed by users of temporary accommodation. The largest group involved in the survey was African-Caribbean, followed by mix parentage (Caribbean) and white. Individuals who identified themselves as 'Asian' equated to 7.2%. The primary reason for their homelessness was due to a 'dispute with parents' and more than a quarter of the group had experience of rough sleeping.

Methodology

Steering Group:

A multi agency steering group, which was hosted by Nottinghamshire DAAT gave support to the research project which became “mainstreamed” by using the DAAT DIP Parallel Board as the steering group. This included senior membership from the DAAT, the Criminal Justice System such as representatives from Prisons, Probation and the Police. Various other representatives from drug services within the community were also represented. The aim was to provide support and guidance to the Research Team and to look at any issues that arose in order to provide solutions.

Recruitment, Roles and Responsibilities of Individuals:

The local Drug Interventions Programme proposed the Community Engagement Project in Nottinghamshire be carried out by the BAC-IN project as a result of a questionnaire sent out to Black and minority ethnic support groups in Nottinghamshire.

The BAC-IN project team was interviewed by representatives of the Home Office and UCLAN to confirm their ability to carry out the research project.

The key points the interviewers were looking for are listed below:

- Ability to work on own initiative
- Realistic views
- Some knowledge of drugs within their community and local areas
- Good communication skills to influence Black and minority ethnic substance misusers in taking part in the research
- Gaining trust and capacity building
- Ability to analyse and feedback information
- Team working
- Networking

The BAC-IN project was appointed to carry out the project due to their knowledge of drug related issues in the Black and minority ethnic community; the fact that the team are all ex substance misusers; have strong links to the local Black and minority ethnic community and are aware of the increasing problem of drugs within that community.

Training and Support:

The researchers were provided with training on the research methodologies and the analysis of data on the data collated. This training was provided by the University of Central Lancashire’s training programme. The training also revolved around the issues of drugs awareness.

The research group was also allocated a key worker from the University of Lancashire who was there to provide guidance, help and support throughout the project.

Mixed methodologies were employed to gather and analyse the data for this project. A combination of focus groups, questionnaires and secondary data from existing reports and reviews of local policies and documents, were employed to provide both the qualitative and statistical information within this report.

The questionnaires were compiled using the researchers own knowledge of substance misuse within the Black and minority community, along with questions that the researchers felt needed to be answered.

There was a particular focus on ensuring access to research clients by the employment and training of peer interviewers and gaining access to Black and minority ethnic offenders with substance misuse problems within the prison system as well as within the community.

Where possible, the researchers themselves went through questionnaires with the interviewees and recorded the responses.

In total three local prisons, Nottinghamshire Probation Service and the Criminal Justice Integrated Team in Nottinghamshire as well as members of the community were contacted. A final target of 86 questionnaires was set for the research project but in the end only 25 completed and returned.

In addition to the questionnaires a small focus group of 5 participants was involved. The aim of this focus group was to gather information from black and Asian users about their experiences with CJIT, in police custody, of drug use, alcohol use and of treatment. The group aimed to provide participants with the chance to get into dialogue and openly express their experiences of the criminal justice system and treatment services; their views, needs and any recommendations they might want to make about how services could be improved to meet their particular needs.

The researchers clearly informed participants about the project, its purpose, aims and objectives, which were:

- To have a better understanding of substance misuse of offenders within the Black and minority ethnic population, including the travelling community, it has been cited in the ASK Report that the Black and minority ethnic population is more at risk of problematic substance misuse than the larger population as a whole. This research aims to give us a better understanding of some of the issues behind this.
- To target Black and minority ethnic offenders within the Prison system as well as ex offenders within the community.
- To understand why the Black and minority ethnic community are not accessing tier 3 treatment. (Tier 3 is structured treatment predominantly prescribing and including cognitive behavioural therapy)

- To assess their needs and to understand their perceptions of existing services.
- To have a greater understanding of what alternative treatments/ways the Black and minority ethnic community are currently using instead of tier 3 treatment service and the barriers that may exist to accessing these services.
- To explore what crimes are being committed by the target group to fund their addiction.
- To make recommendations on future initiatives that could be taken to improve drug services to Black and minority ethnic communities in Nottinghamshire, in the form of a short and long term strategy taking into consideration DAAT priorities.

Effectively Delegating Tasks:

There were various tasks throughout the project; through effective teamwork tasks were delegated to each member of the team. These were carried out and completed by the relevant member.

Regular steering group meetings were held in order to monitor the researcher's progress and solve any problems which arose. The training provided the researchers with useful information that would be beneficial when carrying out their research, analysing and producing information. The training also looked at how the findings and data would be compiled into the report and how this research would benefit them.

Access to the Community:

Communities were accessed/approached by the researchers through their strong links with their local communities. Members of local Black and minority ethnic communities with substance misuse problems were asked to take part in the research. The researchers informed people about the project, its purpose, aims and objectives.

The Prisons, Probation and CJIT team were also accessed and approached through the strong links with the steering group and with the help of Nottinghamshire DAAT.

The researchers obtained a broad knowledge of the issues of drug use within the local Black and minority ethnic communities and the Black and minority ethnic population within the Criminal Justice System.

Action Planning:

An action plan was drawn up in order to assist the project. This programme included tight deadlines, meetings and targets that had to be reached. This action plan also outlined the aims and objectives to be achieved.

Analysis of Data:

To arrive at the findings the following steps were taken. Quantitative data was put into an Excel data sheet and subsequently analysed and where needed processed into graphs and charts.

Qualitative data was analysed manually by going through each questionnaire and recording comments. The tape recording taken during the focus group was transcribed, noting down remarks and responses given by the interviewees. Particular attention was paid to common themes that arose from both the questionnaires and the focus groups.

Target Groups:

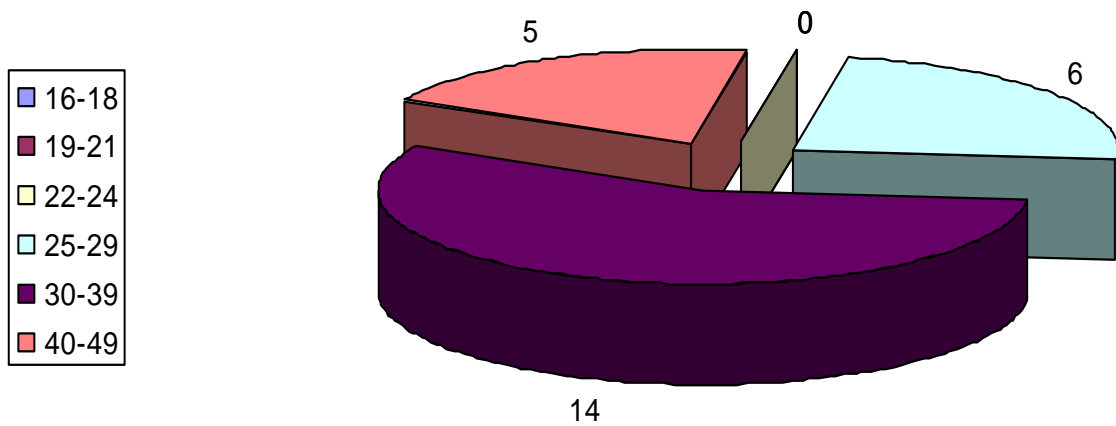
The target group for the research project was male Black and minority ethnic substance misusers over the age of 18 within the prison service, engaged with the Probation Service or the local CJIT or in the community.

Findings

Findings from the Questionnaires:

Section A: Profile

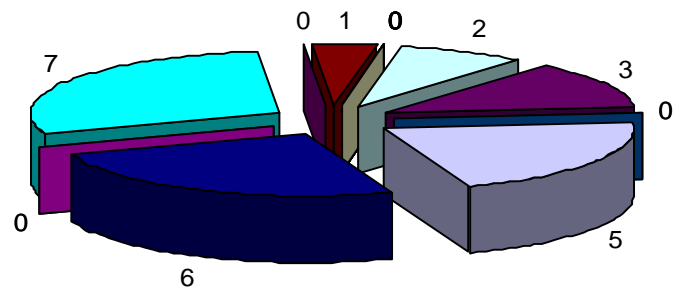
1. Age



2. Gender

The target group was all male; no one described themselves as transgender, 1 person did not respond.

3. Ethnicity

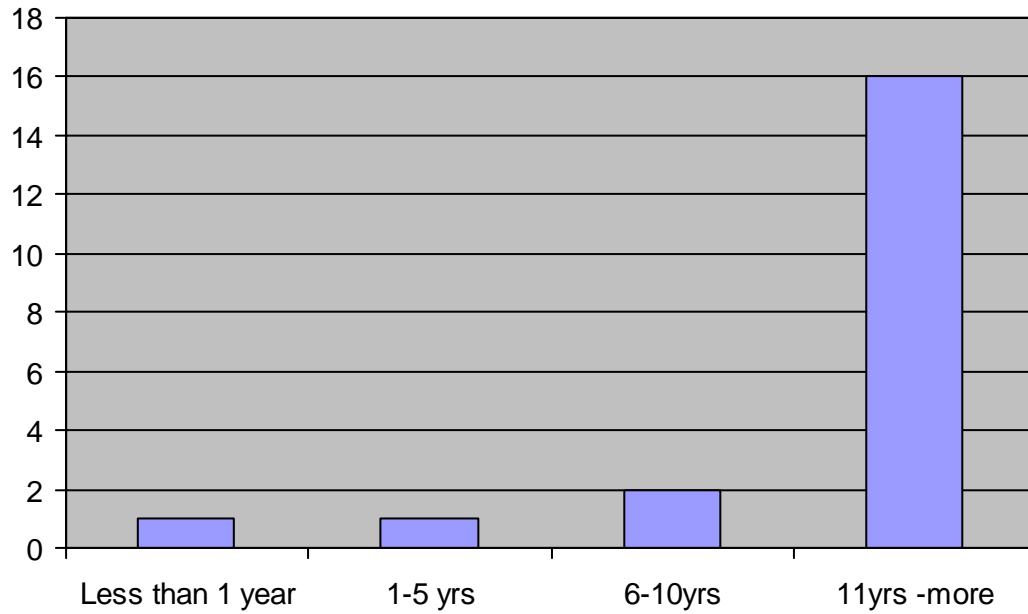


Note that there were only 24 responses to this question

4. Born in the UK

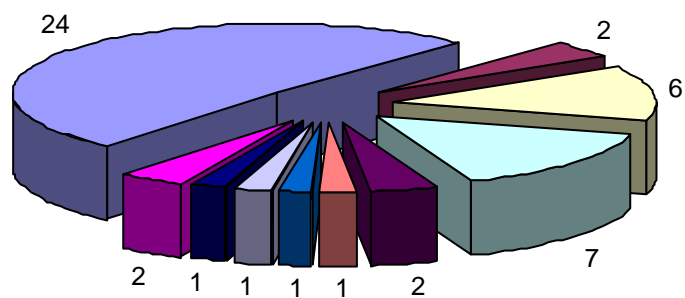
18 responses all stated 'Yes'. 7 did not respond.

4a Lived in UK

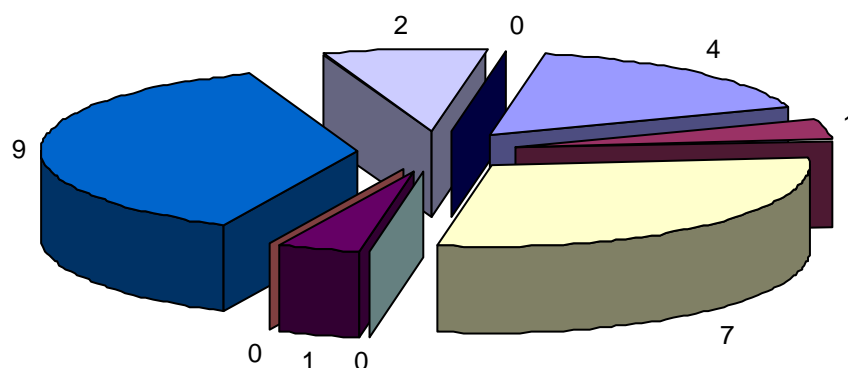


Note that there were 20 responses only to this question.

5. Languages



6. Religion



7. Sexuality

24 of the 25 respondents described themselves as heterosexual. 1 did not answer.

8. Disability

8 out of 25 indicated they have a disability. 17 did not answer.

- 3 with a mental health issue
- 1 with liver damage
- 1 with a stammer
- 1 with leg and head injuries
- 1 with right sided hemiplegia
- 1 did not define their disability

9. Citizenship

22 out of 25 described themselves as British.

Of the remaining 3:

- 1 described themselves as French
- 1 as Dutch
- 1 as an Asylum Seeker

Section B: Experience of Criminal Justice System

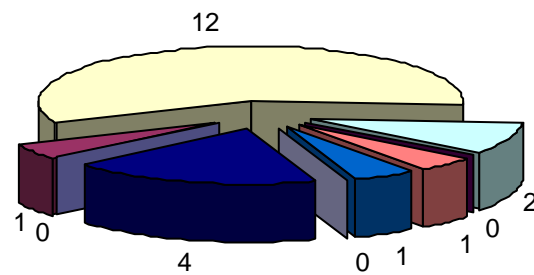
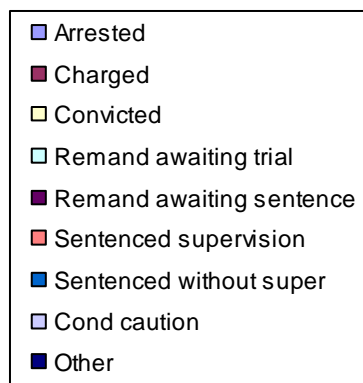
1. Arrested by the Police

All 25 stated 'Yes'.

1a. Arrested in the UK

24 out of 25 stated 'Yes'. 1 did not answer the question.

2. Current Legal Status



56% of the respondents were convicted and drugs were the reason for more than half the respondents being imprisoned. There were 21 responses only to this question.

3. Question 3 did not appear in the final questionnaire format

4. Length of Sentence

14 of the target group were serving a sentence.

Sentences ranged from 30 days to 19.5 years.

Average length of sentence was 125 months.

9 stated they had been put in contact with a support agency; 4 said 'No'. 12 made no response

Of the 9, 1 stated they could not remember which agency; 5 identified their Support Agencies as follows:

- 1 APAS
- 2 Carats Worker
- 1 Carats/DIP
- 1 DIP arrest referral

8. Contact with Arrest Referral Worker

8 stated 'Yes', 4 said 'No' and the remainder did not answer.

9. Did Arrest Referral Worker make an assessment of need?

8 stated 'Yes', 1 said 'No' and the remainder did not answer.

* Additionally, 1 stated they had not seen an Arrest Referral Worker but said an assessment of their needs had been carried out.

10. Did you receive a clear explanation of treatment?

2 stated 'Yes', 3 said 'No'. and the remainder did not answer.

4 responses were as follows:

- 'Suggested' APAS
- 'Said I was with Agency'
- 'Put on Meds'
- 'Drug use/Housing'.

11. Did staff understand the kind of help you wanted?

There were 10 responses only, 15 did not answer, as follows:

- 'Yes'
- 'Not helpful, robotic, dismissive'
- 'Very helpful, info and assessment'
- 'Yes they give you things that can help you'
- 'Not one off so think they are used to helping'
- 'Yes should go in DTTO'
- 'Don't understand accommodation issues'
- 'Yes everything I asked for was answered'
- 'Yes to make sure I don't go back down road'
- 'No'

12. Do you believe culturally appropriate support would have been beneficial?

9 stated that culturally appropriate support would have been beneficial, 4 said not. The remainder did not respond.

13. Was this offered?

12 stated 'No', 2 said 'Yes'. The remainder did not respond.

14. Did you feel this type of support was an option?

9 stated not, 4 said 'Yes'. The remainder did not respond.

15. Did staff care about you and your problems?

2 stated 'No', 1 said 'Yes'. Other responses were as follows:

- 'Didn't feel any connection or empathy'
- 'Seemed to listen and genuinely care'
- 'Becomes boring to them see so many'
- 'No on release will have to live in bail hostel with drug users'
- 'To a degree'
- 'Helpful and listened'
- 'My worker has been very helpful and I'm very grateful'

16. Offered a range of treatment options?

7 stated 'No', 3 'Yes' of which 1 stated 'Methadone/Subutex'. The remainder did not respond.

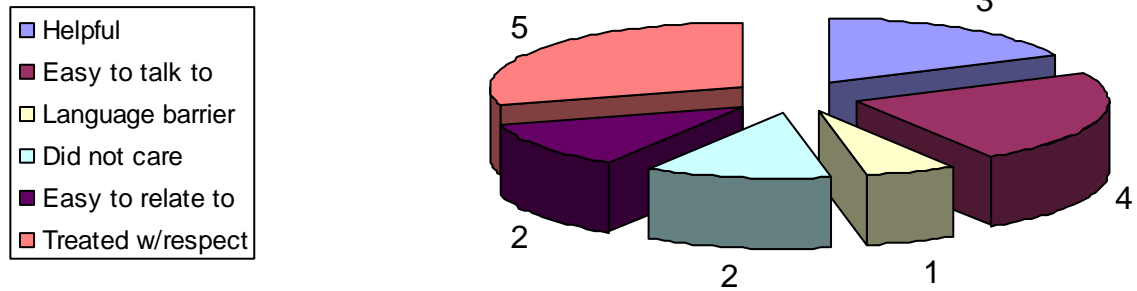
17. What helped or did not help when speaking with the drug worker?

There were 8 responses only as follows:

- 'Didn't speak to anyone'
- 'Felt patronised another statistic'
- 'Wasn't helpful'
- 'Initially judgmental but helpful later when developed relationship'
- 'Able to get off chest, some drug workers ex users so inspired me'
- 'Seem to go through same issues nothing don't about accommodation'
- 'Everything was fine'
- 'Only spoken to drug worker while in prison'.

The remainder (17) did not respond.

18. Encounter with Arrest Referral Worker



19. Did you take any treatment offered?

There were 7 responses only as follows:

- 'No/trust issues'
- 'No I said I could stop on own'
- 'No treatment offered'
- 'Yes methadone/subutex'
- 'Referred to a counsellor'
- 'No'
- 'Yes Carats'

20. How can the arrest referral service be improved?

There were 6 responses only as follows:

- 'More empathy/information/cultural identity'
- 'Follow up appointment, to monitor behaviour in aftermath of offending'
- 'Knowledge of culture, listen, kindness and follow through support'
- 'On arrest Police Doctor couldn't help; needed doctor who could help whilst in custody'
- 'Bit more contact with individual problem'
- 'Better interview rooms'

21. Were you referred to any other support agencies?

12 stated 'No' and 3 said 'Yes'. The remainder did not respond.

22. Did you visit any of these agencies?

9 stated 'No' and 2 said 'Yes'. The remainder did not respond.

23. Please describe what information you were given?

There were 7 responses only as follows:

- 'None/police said do want drug worker yes or no'
- 'No info said would contact key worker but he didn't'
- 'Leaflets/1 to 1 therapy/support info for parents'
- 'No info more advice'
- 'Told about a programme I can attend when get out'
- 'Info on naltrexone/info on relapse'
- 'Only went once not had chance to go properly'

24. Were your immediate needs e.g. Food and Housing, discussed?

5 stated 'No' and 3 said 'Yes'. The remainder did not respond.

4 responses were as follows:

- 'No was statistic, no empathy' (Did not answer the above question)
- 'No consideration taken for drug problem'
- 'Live with parents so not applicable'
- 'Couldn't get accommodation'

25. Please list all the agencies and describe your experience including during arrest, in court, and at sentencing:

5 responses were as follows:

- 'Wells road/probation'
- 'John Storer clinic/Probation/Compass'
- 'Carats'
- 'DIP/arrest referral/Carats'
- 'Arrest referral/DIP/Carats'

8 stated they were contacted by agencies and 3 not.
The remainder did not respond.

26. Do you have any advice or suggestions on how the agencies could improve their service and have better met your needs?

There were 11 responses only as follows:

- 'Info/cultural'
- 'Asian/black drug workers - ex-users'
- 'Therapy when a teenager would have helped me'
- 'Black/Asian drug workers - ex-users'
- 'Knowledge of Asian culture more empathy'
- 'Access to solicitor & drug worker at same time, quicker access to independent GP'
- 'Take into account ethnic identity, ask the questions and offer in-house treatment'
- 'Drug workers in prison overworked, if given full support & more workers could do better job'
- 'Team up with probation supervise on release, flexible on positive drug tests'
- 'Access to accommodation'
- 'No'

Section C: Prison

1. Been in Prison in United Kingdom

There were 16 responses only, of which 13 stated 'Yes' and three said 'No'.

2. Is Drug Use Reason for Imprisonment?

There were 13 responses only, of which 6 stated 'Yes' and 7 said 'No'.

3. Did you see a CARAT/CJIT worker in prison?

There were 16 responses only, of which 7 stated 'Yes' and 9 said 'No'.

4. Did you see a DIP worker?

There were 14 responses only, of which 3 stated 'Yes', 7 said 'No' and 4 'Not Sure'

5. Did you see a Probation officer?

There were 15 responses only, of which 11 stated 'Yes', and 4 said 'No'.

5a. How did you feel while speaking to the [A] CARAT Officer [B] CJIT/DIP worker, and [C] Probation Officer?

[A] CARAT officer – 4 responses as follows:

- 2 stated comfortable
- 1 anxious
- 1 relaxed/anxious

[B] CJIT/DIP Worker – 2 responses as follows:

- 1 stated comfortable
- 1 anxious

[C] Probation Officer – 10 responses as follows:

- 2 stated comfortable
- 1 anxious
- 1 anxious/annoyed/misunderstood
- 3 relaxed
- 1 ashamed
- 1 relaxed/annoyed/misunderstood
- 1 comfortable/annoyed/misunderstood

5b. Best explains your encounter with the [A] CARAT Officer [B] CJIT/DIP worker and [C] Probation Officer.

[A] CARAT officer – 4 responses as follows:

- 'helpful/easy/didn't understand language'
- 'easy/helpful/respect'
- 'helpful/respect'
- 'helpful/easy'

[B] CJIT/DIP Worker – 1 response as follows:

- 'easy/helpful/relate'

[C] Probation Officer – 10 responses as follows:

- 2 'respect'
- 'helpful/easy talk/respect/no empathy culture'
- 'didn't care/didn't empathise/ culture'
- 2 'easy to talk to'
- 'helpful'
- 'easy to talk to/respect'
- 'helpful but not empathise with cultural issues'
- 'easy/respect'

6. Did you have any treatment for your drug use in prison?

There were 13 responses of which 7 stated 'Yes' and 6 'No'. 12 did not respond.

6a. Type of treatment offered

There were 8 responses only as follows:

- Methadone
- 4 DF118
- DF118 and Paracetamol and Temazepam
- Temazepam
- DF118 and Subutex

6b. Please explain i.e. what type of support, was it beneficial, did it help?

There were 5 responses only as follows:

- 'medication helped pain but couldn't talk to anyone in Prison'
- 'helped me minimally but could have been extended'
- 'given DF's for a couple of days when first in then that was it'
- 'detox from heroin'
- 'carats beneficial helped me see what on offer'

7. Were you offered support services for drug use in Prison?

There were 14 responses only. 7 stated 'Yes' and 7 said 'No'

8. Were you given drugs education in Prison?

There were 14 responses only of which 7 stated 'Yes' and 7 said 'No'.

9. Did treatment continue upon release?

There were 8 responses only of which 7 said 'No' and 1 stated 'Yes'.

10. Were you referred to any support agency upon release?

There were 11 responses only of which 5 stated 'Yes' and 6 said 'No'.

11. Did you go to the agencies referred to?

There were 4 responses only of which 2 stated 'Yes' and 2 said 'No'.

Section D: Drug Use

1. Currently receiving treatment for drug use

There were 17 responses only of which 9 stated 'Yes' and 8 said 'No'.

1a. If yes what type of treatment?

There were 7 responses only, as follows:

- 3 'self help'
- 1 counselling
- 1 'John Storer'
- 1 'subutex'
- 1 'detox'

2. Currently waiting to receive treatment for drug use

There were 15 responses only of which 14 stated 'No' and 1 said 'Yes'.

2a. How long waiting?

There was 1 response only that stated '6 months'.

2b. Agency or treatment programme waiting for

There were 8 responses only as follows

- 3 'John Storer'
- 'Double Impact/Compass'
- 'Health shop/Inpatient in City'
- 'John Storer clinic/Elms clinic/Priory clinic/Phoenix House/Southview Rehab'
- 'Compass'
- 'DIP'

3. Received drug treatment in the past

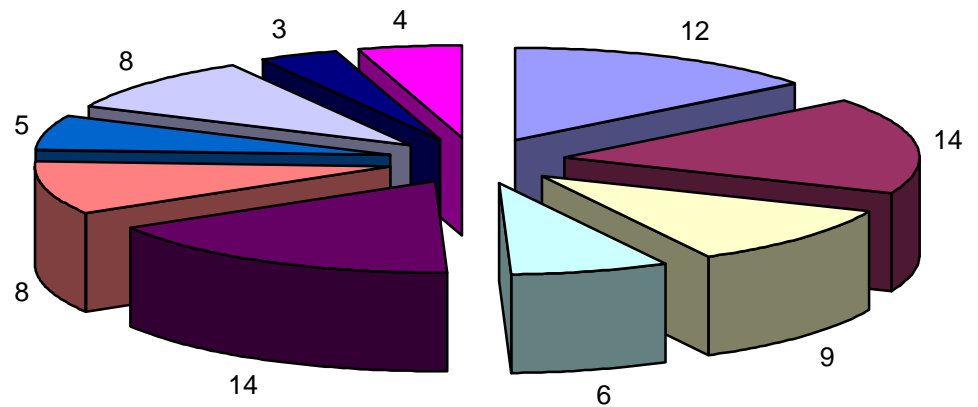
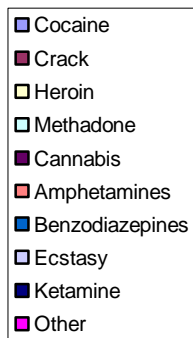
There were 13 responses only of which 7 stated 'Yes' and 6 'No'.

4. Treatment Programme completed

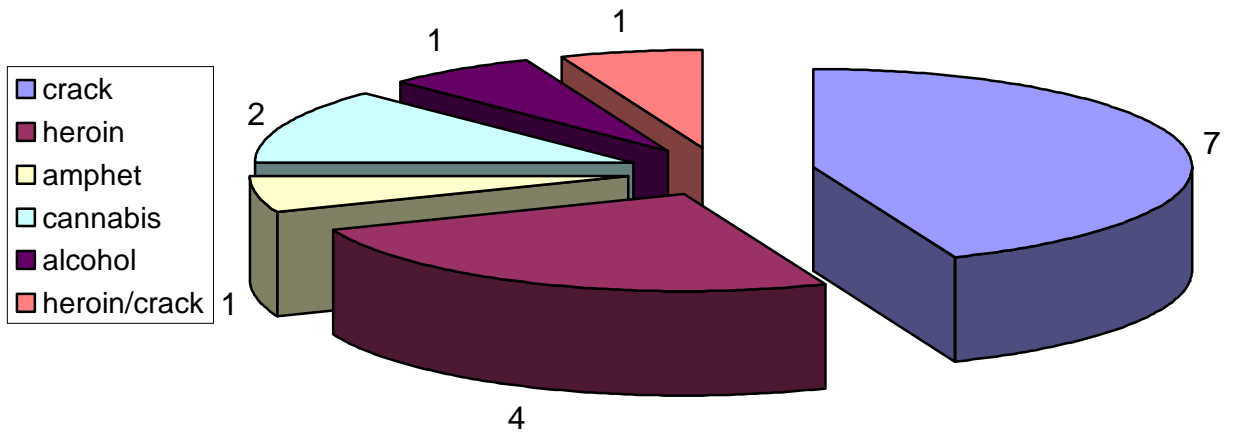
There were 9 responses only as follows:

- 2 'Yes'
- 'Yes psychiatric ward, if not was death or prison'
- 'Sense of achievement and understanding'
- 'No, staff no support for cultural problems & spiritual crisis'
- 'No, managed to get clean myself in the community'
- 'No, lack of cultural identification/empathy & understanding'
- 'Yes 1 to 1 support/new pathways counselling'
- 'No, getting off methadone harder than heroin'

5. Type of drug used



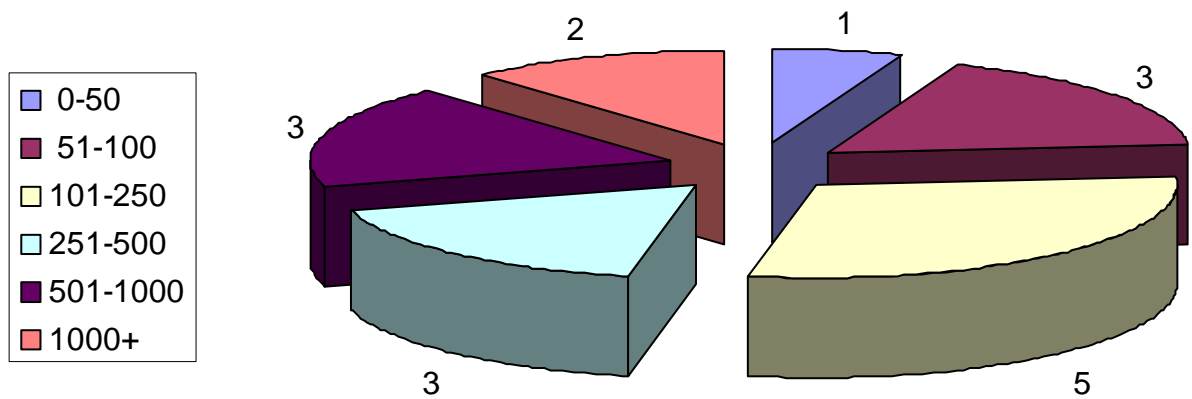
6. Preferred drug



7. Used drugs in the last month?

There were 15 responses only of which 5 stated 'Yes' and 10 'No'.

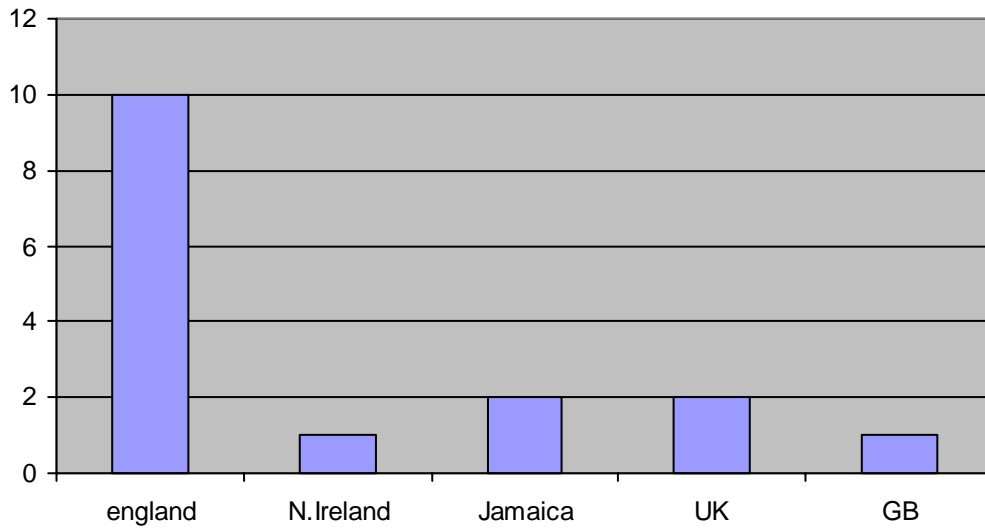
8. Spend on drugs per week



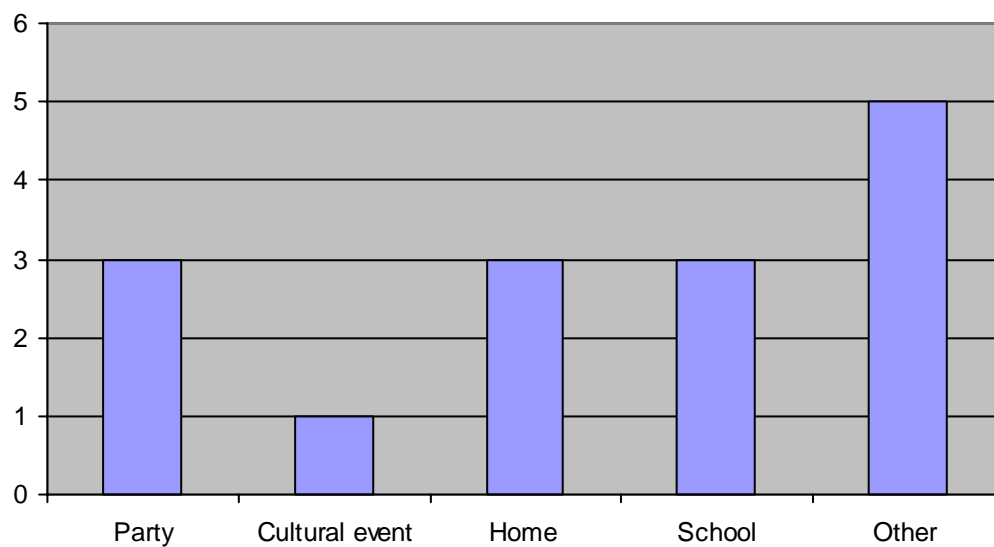
9. Age when drug use started

There were 15 responses only indicating ages when drug use started ranged from 9-27 years averaging at 15.7 years approximately.

10. Country first used drugs



11. Where drug use started



5 respondents who stated other specified as follows:

- 2 - 'Friends house'
- 'After mental hospital released to area drug present'
- 'With friends'
- 'Went to score in car'

12. Have you ever tried to stop using drugs?

There were 17 responses only with 15 stating 'Yes' and 2 said 'No'.

13. For how long did you stop using drugs?

There were 12 responses only as follows:

- 2 days
- 2 weeks
- 3 weeks
- 21 days
- 4 weeks
- 60 days
- 4 months
- 8 months
- 1 year
- 18 months
- 3 years
- numerous [occasions]

14. Why did you resume using drugs?

There were 12 responses only as follows:

- 'Cravings'
- 'Hard to break cycle'
- 'Couldn't on own'
- 'Boredom/depression/anxiety'
- 'Boredom/emotions/environment'
- 'Inner battle/lack of support'
- 'Cravings/life issues/not care about self'
- 'Very weak at the time'
- 'People you meet'
- 'Problems at home'
- 'Boredom and loneliness'
- 'Stress'

15. Have you ever shared equipment for your drug use?

Of the 15 responses 7 stated 'Yes' and 8 said 'No'.

16. Are you aware of the needle exchange system?

Of the 16 responses all stated 'Yes'.

17. Have you received information about Blood Borne diseases such as Hepatitis?

Of the 16 responses 14 stated 'Yes' and 2 said 'No'.

17a. Have you been immunised against Hepatitis?

Of the 16 responses 8 stated 'Yes' and 8 said 'No'.

Section D: Alcohol Use

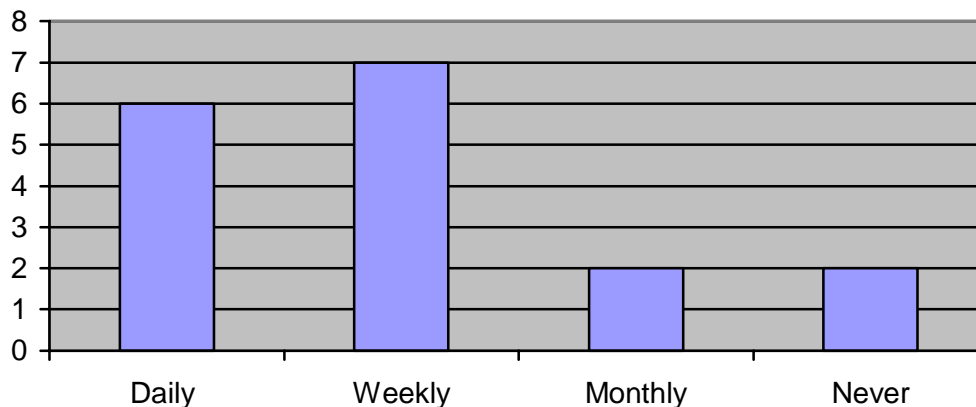
1. Have you had any alcohol in the last month?

Of the 17 responses 3 stated 'Yes' and 14 said 'No'.

2. Do you think you have ever had a problem with alcohol?

Of the 17 responses 6 stated 'Yes' and 11 said 'No'.

3. How often do you or did you drink alcohol



4. How many units of alcohol do you drink each week?

There were 12 responses only as follows:

- 5 – ‘0-25 units’
- 3 – ‘25-50 units’
- 4 – ‘50 or more units’

5. Has your alcohol use contributed to your drug taking?

Of the 14 responses 7 stated ‘Yes’ and 7 said ‘No’.

6. Have you frequently mixed drugs and alcohol?

Of the 13 responses 11 stated ‘Yes’ and 2 said ‘No’.

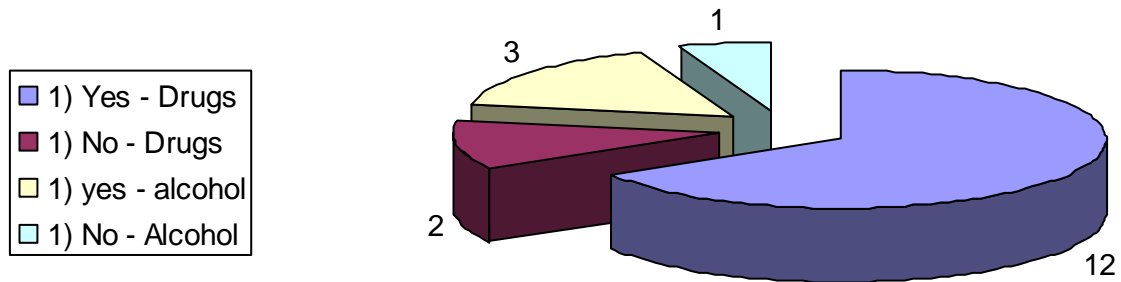
7. Have you ever-substituted drugs with alcohol? - Please explain

There were 7 responses only as follows:

- ‘Yes took back to drug of choice’
- ‘When abroad and couldn’t score drugs’
- ‘Yes to reach oblivion’
- ‘Alcohol drug of choice used drugs to control alcohol’
- ‘Alcohol with drugs and drugs with alcohol’
- ‘Tried to see if substituting would help’
- ‘Used to drink when cannot get gear’

Section D: Treatment

1. Have you ever accessed treatment for your drug/alcohol use?



2. Are you currently receiving treatment for your drug use?

Of the 7 responses all stated 'Yes'.

3. What was the length of your waiting time for treatment?

There were 7 responses only as follows:

- '6 months'
- '4½ months'
- '1 month'
- '1 week'
- 2 – 'varied'

4. How did you get into treatment – were you referred?

Of the 6 responses all stated 'Yes'.

5. Are you currently on medication?

Of the 10 responses 1 stated 'Yes' and 9 said 'No'.

6. How effective were these medication options? Please explain

1 respondent only stated 'Very'

7. Have you ever relapsed after treatment - If yes why do you think that is?

There were 7 responses only as follows:

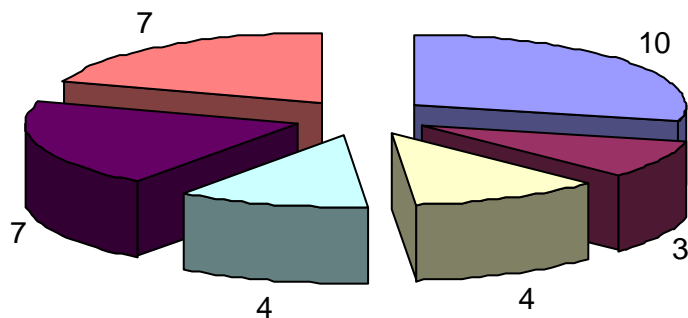
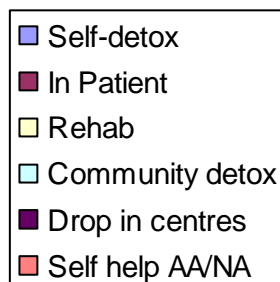
- 'Yes - let out too early too little support'
- 'Yes - no cultural support/action plan/development'
- 'Yes - not dealing with cravings/lifestyle/issues'
- 'Yes - felt very run down at the time'
- 'Yes - not ready to stop was family that wanted me to'
- 'Yes'
- 'No'

8. If you have received treatment in the past how satisfied have you been with the support from the staff? (Scoring from 1 – 10 with 1 'not very satisfied' and 10 'very satisfied'.) Please explain.

There were 10 responses only as follows:

- 10 – 'Drop in'
- 10 – 'Self help'
- 10 – 'Clean 5 wks BAC-IN self help helpful'
- 8 – 'Aftercare'
- 8 – 'Got off heroin'
- 7 – 'Staff kind/caring but not understand me'
- 7 – 'Well it usually comes down to me if I miss appointment its my fault/staff are helpful'
- 6 – 'In-house treatment would have been helpful but I worked so felt discriminated against'
- 1 – 'No aftercare support/action plan/relapse prevention'
- 1 – 'What is being called treatment is punishment as I am to relapse whilst on licence will put me back inside'

9. Types of treatment received



10. Have you been abroad for treatment?

Of the 12 responses 3 stated 'Yes' and 9 said 'No'.

11. Was this treatment successful?

Of the 3 responses 1 stated 'Yes' and 2 said 'No'.

12. Do you feel or think that there may have been an underlying cause or causes for your addiction and if so can you please try to explain?

There were 14 responses only as follows:

- 'Poor life skills, poor identity as black man'
- 'Broken home, lack of guidance poor education'
- 'Unable to understand mental illness used drugs block pain'
- 'Low self esteem from racism alcohol=confidence=drugs=escape'
- 'Loss bereavement in childhood/neglect & spiritual deprivation'
- 'Family pressures, depression psychosis from weed=heroin'
- 'Esteem issues/depressions, lack of guidance childhood issues'
- 'Loneliness/alienation/risk taking/wrong idols/stomach pain/escape'
- 'Was having problems heroin took them away'
- 'Environment and people/lack of perceived support in community/lack of accommodation'
- 'Myself, my motivation to stay clean its my decision'
- 'Started taking drugs when brother died, always a loner, isolated, drugs my friend'
- 'When under stress, being around wrong people'
- 'No'

13. How do you feel that these cause or causes could be addressed?

There were 13 responses only as follows:

- 'Cultural, spiritual counselling, self awareness/development'
- 'Positive role models, mentors cultural support, info on treatment'
- 'Better access to support, Asian needs service complimentary therapy'
- 'Give rebellious child a voice as could be underlying problem/justice system need to notice out of character behaviours'
- 'Through psychotherapy & spiritual counselling'
- 'Cultural, religious, ghetto identification not text book, someone understanding to talk to'
- 'Need cultural support specialist, complimentary healing one to one psychotherapy'
- 'Religion/self awareness/understanding drugs short term fix for long term problem/psychiatric evaluation'
- 'I have addressed these by using tools learned on R & R also finding solutions to my problems'
- 'Accommodation is the key'
- 'By myself wanting to'
- 'More support on release'
- 'By stop hanging around with those people and move out of Nottingham'

14. What type of additional support do you think you may need or you may have needed to help address these causes?

There were 12 responses only as follows:

- 'Black/Asian counsellors, role models etc, more involved in hierarchy of decision making'
- 'Support network, mentor, programme, self help groups and aftercare support.'
- 'Cultural, empathic identification with service providers, Asian project drug workers, education'
- 'Will continue self help group, additional therapy welcomed but cost is a factor'
- 'Cultural, empathy about mental health, talking to someone who has been there'
- 'Mediation between me and family, educational support for family to understand'
- 'Asian drug workers, ex users, cultural counselling'
- 'In-patient support/direction to accessing religion/quicker referral/cultural supportive drug workers'
- 'I needed someone to advise me on how I can deal with the problems'
- 'Project worker available 24/7'
- 'Motivation to turn up for appointments'
- 'Make sure no crack around me when I'm under stress'

Findings

Findings from the Focus Group:

Profile:

There were 5 participants in the focus group.

Those who took part were all male.

Their ethnicity is described as

- 2 Black Caribbean (age 39 and 41)
- 2 Pakistani (age 25 and 31)
- 1 Indian (age 31)

Ages ranged from 25 to 41 with 4 from the 5 in the age range 31 to 39 (consistent with the questionnaire respondents sample.)

Themes:

The themes that the group explored were as follows:

- Participants experience of services offered by CJIT
- Participants experiences in Police custody
- The nature, extent and causes of participants previous drug use
- The nature of participants alcohol use -
- Participants experience and views of drug treatment services
- What participants feel are their real needs relating to substance misuse, treatment and support
- The response of participants' families to their addictions and support needs
- Views on their experiences of treatment and other support services
- Changes that may need to be implemented

Questions and Responses:

1. Have you ever been arrested by the police?

Indian male aged 31: "I informed the custody officer that I was withdrawing from drugs he replied you'll see the doctor in the morning-nothing we can do till then. They didn't seem to show any concern. I didn't see an arrest referral officer, neither was I informed of the DIP."

This is the experience of a service user prior to the DIP programme, before drug testing became compulsory within the police cells for drug related crimes/behaviour; the staff attitude was nevertheless uncaring to this Black and minority ethnic drug offender.

Pakistani male aged 25: "... first time I was in custody I wasn't offered any help for my drug use even though I was drug tested. "

This service user expected to see a drug worker, access to medication and moral support. In this instance there appears to be neglect and indifference shown towards this particular individual.

"Custody officer said support is available...it will be a lot quicker to process you if you leave the support being offered."

This response highlights inappropriate advice given by custody officers giving the option of quick release to offenders who are vulnerable, and in desperate need for release. Is it a quick fix attitude or perhaps neglect?

"They were indifferent towards me, wasn't helpful, robotic towards offering me help."

Is this attitude being demonstrated to BME drug users only or is a general staff attitude towards all offending drug users in general?

"If you want to get out of here faster don't bother with the drug support."

Again highlighting inappropriate advice given to a vulnerable individual by staff. He could have been signposted to a drug service. There is also a lack of empathy shown here.

'My recent arrest I was offered a CJIT worker who wasn't helpful at all, he didn't make any contact with other services and offered no support after release.'

Black Caribbean male aged 39: "I was offered no support or help, I was depressed and suicidal."

This service user's experience was prior to the DIP program (1999) In this instance care, compassion, support and human empathy were lacking in the staff attitudes.

Black Caribbean male aged 41 sensed a 'them and us' attitude: "I was offered an arrest referral worker once, his attitude towards me was patronising. Left me feeling discriminated against."

This comment raises the issue of staff attitudes; is there a need to conduct staff surveys to explore why they display such attitudes?

2. Do you believe culturally appropriate support would have been beneficial?

"I felt isolated I felt lonely, seeing workers from similar backgrounds would have helped, to be culturally identified with would have been good."

“Talking to someone from your own culture gives you peace of mind, they understand, they know where you are coming from, can relate to them.”

“They are not culturally empathic, there’s no fairness of treatment, a lot of distrust with them, cultural identification is important, and experience of empathy is too.”

“I saw a qualified BME drug worker in a service who was delegated by the service to help me. I seen him on the town - drunk and staggering about – it’s total abstinence for me, if he’s not practicing what he is preaching himself I am not going to take him seriously. I refused to see him.”

“I told an arrest referral worker that I was a Muslim and that intoxicants, drugs and alcohol is not allowed. He’s reply to this was that must be a boring life. He was so arrogant. “

In this instance the staff member who was white Caucasian was disrespectful to the religious beliefs of this particular service user. Most BME service users are strong faith based and God centred individuals.

3. Do you have any suggestions on how the agencies could improve their service and have better met your needs or the needs of the black and Asian communities?

“Recruit more workers from the BME communities, so service users can approach someone representing their communities.”

This highlights a need for identification, connection, understanding and cultural empathy.

“Make education and drug services more widely available.”

Highlighting a need for Outreach programmes to engage with these individuals and signposting drug users to appropriate agencies.

“Spread information of treatment via solicitors (they could be carrying information packs or service phone numbers with them to give to their clients).”

Wider outreach channels need to be made available.

“Improve services by providing and encouraging early contact with support agencies whilst in custody, arrange assessment or appointments of detainees.”

Efficient early intervention services need to be provided.

“Encourage users to refrain from drug and alcohol misuse/abuse.”

“Follow up client support and shared care progress.”

“Outreach work.”

Again highlighting the need for outreach and aftercare services. This is backed up by the ‘Drugs Intervention Programme in Nottinghamshire’ strategy document, which calls for the setting up of a specific Black and minority ethnic Outreach service.

“Education and awareness starting from school days, prevention work.”

“In depth translated drugs, addiction and recovery material for non-English speaking families.”

Highlighting a need for services to be able to work with clients whose first language is not English – including the availability of translation services.

Free phone 24-hour help line for Black and minority ethnic communities (multi cultural faceted support service) something like the FRANK phone line.

Calling for a Black and minority ethnic specific support service to be made available.

4. Are you currently receiving after care support for your substance addictions?

The focus group participants highlighted the following agencies providing them with after care support:

Self help groups such as:

- Narcotics Anonymous,
- Alcohol Anonymous
- BAC-IN Self Help
- BAC-IN Black and minority ethnic Support Project

Other support agencies were identified as:

- Compass
- Double Impact
- New Pathwaves (specialist counselling services.)

5. How much did you spend on average each week on alcohol and or drugs?

Responses to this question ranged from £150.00 to £550.00 per week between all participants.

6. Have you frequently mixed drugs and alcohol?

Participants indicated that

- All had frequently mixed drugs and alcohol

- All had substituted one for another (alcohol to drugs and vice versa)

7. How did you get into treatment?

Responses to this question were as follows:

- Through work - employer
- Family
- BAC-IN and New Path-waves
- Other Black and minority ethnic ex users

8. Have you ever relapsed after treatment?

Four out of 5 of the focus group participants are still clean today.

One person had relapsed after leaving a detoxification centre. He commented "The staff gave me the feeling that I was cured...no aftercare or community support was offered or suggested by the staff. A member of staff told me that if I stayed any longer than 9 days I might become institutionalised."

Highlighting the issue of service staff giving incorrect and invalid information, which could potentially damage service users.

9. Have you been abroad for treatment?

One participant went abroad to India, after returning to England he relapsed because there was no support available to him.

10. Do you feel that there may have been an underlying cause or causes for your drug and alcohol addiction?

The following are responses from the group members as to what they believed were the causes or contributors that lead them to misusing/abusing substances:

- Genetic predisposition
- Racial abuse
- Low self esteem
- Lack of self worth
- Poor upbringing (single parent, dysfunctional, uneducated and broken families)
- Issues with loss and bereavement
- Lack understanding of emotional experiencing (take drugs to numb the pain)
- Inability to deal with failures in life
- Not meeting family expectations
- Depression
- Anxiety
- Abuse (mental, bullying, physical, sexual)

- Peer pressure

11. How do you feel that the cause or causes could be addressed?

Participants gave the following responses to this question:

- ‘Having ongoing support – counselling, self help groups, 12 step program’
- ‘Recovery program to get and stay clean’
- ‘Specialist help to explore deeper/sensitive problems’
- ‘Recovery and addiction education support for families’
- ‘Develop family support groups’

12. Have your family been supportive with your recovery?

Pakistani male age 25: “No support from my family, didn’t believe me when I was clean, they turned their back on me – they didn’t understand, I went out and started using again.”

Black Caribbean male age 39: “My family still don’t trust me even though I am over 9 months clean, my words don’t seem to get through to them, support provided by another respected ex drug user explaining to them on my behalf really helps.”

Both these comments suggest that families have an important role to play in the recovery process and that family outreach support work is needed.

13. What types of additional support do you think you may need and what else may help address these causes?

Participants gave a range of responses to this question as follows:

- ‘Employ more ethnic minority workers and specialists in the drug and alcohol field’
- ‘Recruit ex users from the BME communities as staff’
- ‘More services like BAC-IN’
- ‘Diversity/cultural/empathy building etc training for non-BME workers and ‘organisations’
- ‘Specific aftercare BME support provisions’
- ‘Support for families’
- ‘Education and awareness’
- ‘More follow-ups’

“Black and Asian don’t come forward for help, but if there was specific Black and Asian services there, maybe I would have got help a lot quicker.”

Indicating a trust amongst Black and minority ethnic substance misusers for service staff from a similar background or culture and thereby highlighting the need for services to recruit Black and minority ethnic staff including former drug users.

The value of this is highlighted in the ASK report, quoted above which recommends:

- 'Having a more diverse workforce with Asian and Black drug workers'

- as a way to make services more appropriate for Black and minority ethnic users.

Focus group recommendations:

The group made the following recommendations for changes to services and new services.

1. Make available psychological support for mental health problems such as those identified by participants as:
 - Depression
 - Anxiety
 - Bereavement
 - Low self-esteem
 - Abuse
 - Boredom
2. Make available culturally specific counselling and support including appropriate counselling/psychotherapy to address underlying psychological, emotional, cultural and spiritual issues/problems.
3. Make services available in the community to provide culturally appropriate education and awareness for families and communities.
4. Focus on the delivery of more abstinence based treatment programmes and encourage the goal of abstinence more widely.
5. Educate non-Black and minority ethnic workers with basic cultural and religious awareness training to make Black and minority ethnic service users more welcome, better acknowledged and respected.
6. Recruit and train more Black and minority ethnic workers in treatment services including in prisons.
7. Increase opportunities for employment of ex-drug users as staff in treatment services, including prisons.
8. Encourage ex-user involvement at service provision, decision-making, strategic and treatment planning levels to include ex-user involvement in all aspects of commissioning and service delivery.

Discussion

Significance:

It needs to be acknowledged before entering into discussion of the research findings that the research sample is small; with only 25 questionnaires of the final eighty six target for completion having been completed and returned; this is not a statistically significant sample. However, particularly within the qualitative data gathered, the research has a great deal of validity. This raises some interesting and challenging questions for treatment services. The views expressed by those who completed questionnaires in terms of the effectiveness of wrap-around treatment appear to point to considerable gaps and failures in treatment services for Black and minority ethnic substance misusers. Similar views were expressed by the 5 participants in the focus group.

Responses:

The first issue to highlight is the overall response to the research project on behalf of the institutions and agencies that were asked to take part. An analysis of the responses by different bodies to requests to undertake and return questionnaires to the BAC-IN project might raise some questions concerning potential systematic obstacles and barriers to effective services for BME offenders with substance misuse problems.

As indicated above the institutions and agencies that were asked to take part in the research project were:

- Lowdham Grange Prison, Nottinghamshire
- Nottingham Prison
- Ranby Prison, Nottinghamshire
- Nottinghamshire Probation Service
- Nottinghamshire Criminal Justice Integrated Team

76 questionnaires were sent out and only 25 returned as follows:

Agency	Questionnaires received	Questionnaires returned
Lowdham Grange	30	12
Nottingham Prison	30	5
Notts Probation Service	10	0
CJIT	6	0
Totals	76	17

An additional 8 questionnaires out of an initial target of 20 (at a later stage 10 of these were cancelled) were completed with young Black and minority ethnic men with substance misuse problems who have experienced prison and are now living in the community. This gave a total of **25** questionnaires completed in all.

The initial response from the prisons approached was encouraging but eventually decisions were taken by them not to allow the BAC-IN researchers into the prisons to carry out the research. Instead the questionnaires were carried out in the prisons by CARATs and other workers who potentially did not have the same commitment to the research and might not have had the same approach and skills in interviewing Black and minority ethnic clients as those of the BAC-IN researchers. It is reasonable to ask why the response of the prisons changed.

The problem was largely one of security clearance. The BAC-IN project team being ex-offenders were unable to access the prisons themselves despite representations made on their behalf. This is an ongoing problem for inreach peer-led community engagement projects work which needs to be addressed where necessary.

It appears that when prisons became aware of the histories of BAC-IN staff their responses to requests by them to 'go in' changed significantly. This is unhelpful, particularly in the light of recommendations contained in this report and elsewhere that ex-users are recruited to provide help, support and treatment services to substance misusers including those in prison. Clearly, many ex-users will also be ex-offenders and obstacles to their access to potential clients in prison need to be removed. It appears that there are schemes operating elsewhere in the country that provide a 'passport to prison' for staff and volunteers of treatment service and self-help groups who are ex-offenders and who need to gain access to prison. This is likely to be a particular issue for staff and volunteers in self-help groups such as the BAC-In project.

The response by the Probation Service and from the CJIT is disappointing but there are explanations for this. The CJIT identified six Black and minority ethnic clients to take part who eventually decided they did not wish to be involved. The length of the questionnaire might well have been a factor. It was identified that it may have been helpful for a member of the BAC-IN team rather than the CJIT to request completion of the questionnaire; however, time constraints and staffing issues prevented this from happening. With regards to the response by the Probation Service, the demographic profile in North Nottinghamshire in particular means there are few Black and minority ethnic clients on the service caseload. In addition it may also reflect sentencing patterns with respect to members of Black and minority ethnic communities – leading to an over-representation of individuals from these communities receiving custodial sentences. Additionally members of Black and minority ethnic communities do not tend to have confidence in community alternatives to custody.

In retrospect, and representing a learning point, it appears that the length of the questionnaire at 25 pages with 79 questions might well have been an obstacle to completion and return rates. This is likely to have been a particular issue for Black and minority ethnic offenders in custody; the majority of whom will be likely to have literacy problems in English and for many English will not be their first language. 23 out of 25 respondents spoke languages other than

English which suggests for at least some of them English was not their first language.

Key Issues:

The key issues arising from the research findings themselves are set out below.

Profile:

The target group for the research project was male Black and minority ethnic substance misusers over the age of 18 within the prison service, engaged with the Probation Service or the local CJIT or in the community.

The findings confirm that the target group was reached. All participants in the research were male and from Black and minority ethnic communities. The majority were in the age range 30-39. The largest ethnic groups represented were Black British Caribbean, Asian British Pakistani and Asian British Indian.

Most were born in the UK and have lived here for 11 years or more.

The predominant religion was Muslim (38%) for those who completed questionnaires.

These findings raise questions concerning the sensitivity of treatment services and the prison system to the religious and cultural needs of those from Black and minority ethnic communities and of different faiths that are explored further below.

8 of the 25 questionnaire respondents described themselves as having a disability. Three of these defined their disability as a mental health issue. This raises the questions:

- Are prison and treatment services able to meet the needs of those with mental health problems?
- Are the services able to provide treatment for mental health problems/psychological issues alongside drug treatment?

When considering the underlying causes of their drug or alcohol addiction, those who took part in the focus group identified the following problems relating to their mental health:

- Issue's with loss and bereavement
- Lack of understanding of emotional experiencing ('take drugs to numb the pain')
- Inability to deal with failures in life
- Not meeting family expectations
- Depression
- Anxiety
- Abuse (mental, bullying, physical, sexual)

Many of the target group struggle to deal with painful feelings such as guilt, isolation, shame, despair and fear as well as dealing with mental health problems. Clearly these are difficult psychological and mental health issues underlying their drug addictions which services need to be able to respond to sensitively and effectively.

Experience of the Criminal Justice System:

All 25 of the questionnaire respondents had experienced arrest. 14 were serving a prison sentence with sentences ranging from 30 days to 19.5 years.

From the findings, at the first stage when wrap-around treatment services should come into effect there appears to be a significant problem. Crucially, 16 of the 25 respondents stated that their arrest did not lead to a drugs test.

There is some inconsistency in responses to questions concerning contact with arrest referral workers and other support agencies but overall the research presents a worrying picture. For example, only 7 respondents stated they had been put into contact with a support agency and only 5 could identify which agency.

It is worth repeating here the point concerning BAC-IN staff ideally helping respondents complete the questionnaires. This might have helped overcome some of the confusion respondents experienced. This might also apply below.

Amongst respondents there appears to be some confusion, which is underlined again later, concerning which agency they might be in contact with. There appears to be confusion about whether a worker is an arrest referral worker or not? It appears that the different roles of workers and the agencies they represent need to be made clear to service users.

When asked whether respondents felt that treatment service staff understood their needs, whilst the majority of responses were positive there were a significant number of negative responses as follows:

- 'Not helpful, robotic, dismissive'
- 'Don't understand accommodation issues'
- 'No'

Positive responses included:

- 'Very helpful, info and assessment'
- 'Yes they give you things that can help you'
- 'Yes should go in DTTO'
- 'Yes everything I asked for was answered'
- 'Yes to make sure I don't go back down road'

These findings suggest that while the majority experience of staff at this stage was positive, a significant minority did not receive a service they felt was helpful. They are confirmed by experiences related by the focus group participants, for example:

Indian male aged 31: "I informed the custody officer that I was withdrawing from drugs he replied you'll see the doctor in the morning-nothing we can do till then. They didn't seem to show any concern. I didn't see an arrest referral officer"

This is the experience of a service user prior to the DIP programme, before drug testing became compulsory within the police cells for drug related crimes/behaviour. The staff attitude was nevertheless uncaring to this Black and minority ethnic offender.

Pakistani male aged 25: "... first time I was in custody I wasn't offered any help for my drug use even though I was drug tested."

Black Caribbean male aged 41 sensed a 'them and us' attitude: "I was offered an arrest referral worker once, his attitude towards me was patronising. Left me feeling discriminated against."

Similarly, it appears that a significant number of those who took part in the research did not feel that the staff they encountered even cared about their problem. For example, of the 7 responses to this question in the questionnaire 2 stated 'No' and others:

- 'Didn't feel any connection or empathy'
- 'Becomes boring to them see so many'
- 'No [staff did not care] on release will have to live in bail hostel with drug users'

The picture is not entirely negative with 2 of seven respondents answering 'Yes' and one commenting:

- 'Seemed to listen and genuinely care'

Comments on this issue by participants in the focus group include:

"They were indifferent towards me, wasn't helpful, robotic towards offering me help."

Furthermore, when asked to explain what helped or did not help when speaking with a drug worker, 2 respondents to the questionnaire commented

- "Felt patronised another statistic"
- "Wasn't helpful"

Overall the picture is a worrying one. If Black and minority ethnic substance misusers in the criminal justice system feel that staff do not even care about them there would appear to be little prospect of actively and successfully engaging them in treatment programmes and aftercare services. Even if this is not always the case the findings are problematic and call for action.

The findings concerning the availability and usefulness of culturally appropriate support appear to reinforce those above.

Of the 13 responses from the questionnaire sample, 9 stated that culturally appropriate support would have been beneficial to them and only 4 said not. This is backed up by the focus group, with participants stating for example:

“Talking to someone from your own culture gives you peace of mind, they understand, they know where you are coming from, can relate to them.”

“They are not culturally empathic, there’s no fairness of treatment, a lot of distrust with them, cultural identification is important, and experience of empathy is too.”

Whilst both groups identified this kind of support as important few were in fact offered it. Of the questionnaire sample 12 of 14 who responded said it was not offered and nine of 13 said they did not think it was there even as an option.

The findings in questions 12-14 of this section of the questionnaire, backed up by the focus group responses, highlight significantly the need for culturally appropriate support and culturally sensitive treatment options

There is clearly a need for services to make available culturally appropriate support to those clients from Black and minority ethnic communities with substance misuse problems. The best way to understand what shape these services might need to take will be to consult with Black and minority ethnic clients and organisations.

When questioned about what if any treatment was offered at this stage, there were again a number of negative responses. 7 from 10 respondents to the questionnaire stated they had not been offered any treatment. 7 respondents stated they did not take the treatment offered to them. Reasons given for this included:

- “No/trust issues”
- “No I said I could stop on own”

There appears to be some inconsistency in the research findings here, perhaps raising questions concerning understanding of the question or how the questions were put to respondents or more significantly perhaps, respondents perceptions and understanding of treatment and when and how it might have been offered to them.

However, again the findings are not positive. They appear to underline gaps in treatment services available and offered to the target group.

Significantly, some respondents had very useful contributions to make when asked how services might be improved. Respondents to the questionnaire commented:

- ‘More empathy/information/cultural identity’
- ‘Follow up appointment, to monitor behaviour in aftermath of offending’
- ‘Knowledge of culture, listen, kindness and follow through support’

- 'On arrest Police Doctor couldn't help; needed doctor who could help whilst in custody'
- 'Bit more contact with individual problem'

Overall these responses highlight the need for caring services that meet individual needs and are sensitive to cultural issues for the Black and minority ethnic community.

There is an interesting comment here about the effectiveness of the Police Doctor services suggesting the need for improved sensitivity when working with Black and minority ethnic substance misusers.

12 of 13 respondents who answered the question said they were not referred to support agencies and of the 7 who responded to a question on whether they were given information about treatment services the majority said not. These findings raise serious questions about the wrap-around service goal.

Experiences of Prison:

Respondents were asked about the attitudes of prison and treatment service staff and their experiences of the services offered to them in prison.

An analysis of responses to the questionnaire in particular, focusing on respondents experiences of prison, highlights gaps and failings in services to Black and minority ethnic substance misusers.

17 of the twenty-five respondents who completed questionnaires were in prison. Of these 6 stated that drug use was the reason they were there.

Responses to questions asking whether those in prison had seen a treatment service or probation worker whilst in prison present a very mixed view. Again there is a lack of clarity about workers, services and their titles or names but this does not undermine the validity of the overall picture presented, rather it adds to the validity of the suggestion above concerning a single generic service.

For example, 16 respondents replied to the question 'have you seen a CARAT/CJIT worker?' Of these only 7 stated 'yes' and 9 said 'no'. Similarly in response to the question 'have you seen a DIP worker?' of 14 responses only 3 stated yes and 7 said 'no'. Interestingly, 4 respondents stated 'not sure' highlighting the confusion referred to above. Responses concerning the Probation service were more positive with 11 of 15 respondents who answered stating that they had seen a probation worker whilst in prison.

Again this suggests that the wrap-around service goal is not being delivered as effectively as it should be. At least this was the experience of the Black and minority ethnic respondents in the target group.

The findings concerning respondents' experiences of drug treatment whilst in prison paint a similarly unsatisfactory picture. Only 7 respondents stated that

they were offered any treatment for their drug problem, although 8 respondents went on to identify the treatment they were offered. For most of them, treatment was of a short-term and unsatisfactory nature with respondents stating:

- “medication helped pain but couldn’t talk to anyone in Prison”
- “helped me minimally but could have been extended”
- “given DF's for a couple of days when first in then that was it”

The types of treatment offered in prison were predominantly medical and not psychotherapeutic or culturally sensitive.

Questions relating to ‘support services’ offered whilst in prison elicited similar responses. For example only 7 of 14 respondents who answered the question stated that they had been offered any kind of support service for their drug use and only 7 of 14 again said they had received any ‘drug education’.

It is reasonable to ask how far the lack of services available in prison to respondents was related to the fact that they are from Black and minority ethnic communities or whether the same applies to all substance misusers in prison, but the experiences of these offenders was clearly poor.

These are some of the responses from the inmates in terms of their experiences, perceptions and needs regarding their support needs and the support they actually received in the prisons:

- “Not helpful, robotic, dismissive”
- “Didn’t feel any connection or empathy”
- “Felt patronised another statistic”
- “No/trust issues’ no empathy”
- “no support for cultural problems & spiritual crisis”
- “No, lack of cultural identification/empathy & understanding misunderstood”

Again, the lack of support to help deal with cultural and psychological problems, and the unavailability of culturally specific and sensitive support are significant theme.

A particularly worrying finding is that when asked whether treatment had continued after prison, of the 8 responses 7 stated ‘No’. Again, such a finding might raise questions about the actual availability and effectiveness of wrap-around services. However, it needs to be made clear that this refers to respondents’ experience of their last release from prison – prior to the Drug Interventions Programme commencing.

Effective aftercare is vital to address the re-integration process in the community for those leaving prison, as well as the need for emotional, psychological and cultural support; support with overcoming institutionalisation, low self worth, low confidence and help for developing skills for rebuilding broken relationships with family, spouses and children after lengthy spells in prison.

Drug Use:

Findings concerning drug use show that respondents to the questionnaire used a wide variety of drugs with crack and heroin being the drugs of choice for the majority. Respondents to the questionnaire and those who took part in the focus group stated that they were spending between less than £50 to over £1000 per week on drugs with the majority between £150 and £550 per week. It is probably reasonable to assume that this would have been funded through crime.

Questionnaire respondents stated that they started using drugs between the ages of 9 years at the lowest end to 27 years at the highest. Most had started using in the UK and most in some sort of social setting, for example at a party or at a friends house. Further highlighting the link between mental health problems and drug use referred to above, one respondent stated they had started using drugs 'After mental hospital released to area drug present'.

15 of the 17 respondents who answered that the question stated they had tried to stop using drugs, with one respondent managing to stop for three years. When asked: 'Why did you resume?', 12 respondents gave a range of responses with some highlighting mental health issues, some referring to a lack of support and not being able to stop on their own and one respondent highlighting problems at home. Overall responses point to a perceived lack of the right kind of support services available to the target group in the communities in which they live.

The 'Consultation with Black and Minority Ethnic Families in Nottinghamshire' report published in 2003 highlights a lack of BME led groups that might provide the kind of support the target group need. It states:

'There are few Black and Minority Ethnic organisations in the County [of Nottinghamshire]. They remain small and issues of capacity building need to be addressed'.

Consultation with Black and Minority Ethnic Families in Nottinghamshire. Davis, M E. 2003

When questioned about their alcohol use, 6 of 17 respondents stated that they had a problem with alcohol. 7 of 14 respondents stated that their alcohol use had contributed to their drug taking and 11 of 13 stated they had frequently mixed drugs and alcohol. 7 respondents stated that they had substituted drugs with alcohol. For example:

- "used to drink when I couldn't get gear"
- "tried to see if substituting would help"
- "to reach oblivion".

All those who took part in the focus group stated that they had frequently mixed drugs and alcohol.

Overall these findings paint a picture of the target group mixing drugs and alcohol and moving between the two when necessary or when it helped. This highlights the well-established link between drugs and alcohol and points to the need to provide strategies and services that will enable drug users to tackle their drug and alcohol problems at the same time.

Treatment:

There is some inconsistency in response to the questionnaire in terms of treatment services. At Section D where respondents were asked questions relating to drug use, 9 of 17 respondents stated they were currently receiving treatment for their drug use; whereas further into section D where questions related specifically to treatment, 7 respondents who answered the question all stated they were receiving treatment.

However, there are nevertheless some interesting findings. For example, highlighting a positive situation, only of 15 respondents who answered the question stated that they were waiting for treatment. On the other hand, responding to the question concerning length of waiting times one respondent had waited 6 months and another 4½ months for treatment.

It is now the case, since the advent of the DIP that maximum waiting time is two weeks and for those leaving custody they will be seen immediately – within days of release.

Of the 9 respondents who answered the question whether they had completed their treatment programme, 5 gave positive responses but 4 respondents said they had not completed, with responses as follows:

- 'No, staff no support for cultural problems & spiritual crisis'
- 'No, managed to get clean myself in the community'
- 'No, lack of cultural identification/empathy & understanding'
- 'No, getting off methadone harder than heroin'

Again, these responses highlight the issue of a failure by treatment service staff to respond effectively to the particular needs of the target group.

However, at question 8 of the 'Treatment' section, responses rating the support the respondents had received from treatment staff were overall very positive. 8 of 10 respondents rated their satisfaction with staff as 6 and above on a scale of 1 to 10 (with 1 as 'not very satisfied' and 10 as 'very satisfied').

Some of the most interesting and revealing findings from the questionnaire appear in responses to questions at the end of the 'Treatment' section.

Respondents were asked to identify the underlying causes of their addictions and some of the responses were as follows:

- 'Poor life skills, poor identity as black man'
- 'Broken home, lack of guidance poor education'
- 'Unable to understand mental illness used drugs block pain'
- 'Low self esteem from racism alcohol=confidence=drugs=escape'
- 'Loss bereavement in childhood/neglect & spiritual deprivation'
- 'Family pressures, depression psychosis from weed=heroin'
- 'Esteem issues/depressions, lack of guidance childhood issues'
- 'Loneliness/alienation/risk taking/wrong idols/stomach pain/escape'
- 'Environment and people/lack of perceived support in community/lack of accommodation'
- 'Myself, my motivation to stay clean its my decision'
- 'Started taking drugs when brother died, always a loner, isolated, drugs my friend'
- 'When under stress, being around wrong people'

These responses highlight a considerable number of issues for Black and minority ethnic substance misusers that treatment and support services will need to both be aware of, and make effective responses to. They include:

- Psychological issues
- Cultural issues
- Mental health problems
- Family concerns
- Environmental factors

As indicated, treatment and support services will need to ensure that they can adequately respond to these issues specifically in terms of Black and minority ethnic clients. Respondents themselves went on to identify how the causes of their addictions might be addressed. The responses highlighted below point to the changes and improvements needed to services to provide a comprehensive and effective service for Black and minority ethnic substance misusers. They form the basis of many of the recommendations within this report.:

- 'Cultural, spiritual counselling, self awareness/development'
- 'Positive role models, mentors cultural support, info on treatment'
- 'Better access to support, Asian needs service complimentary therapy'
- 'Give rebellious child a voice as could be underlying problem/justice system need to notice out of character behaviours'
- 'Through psychotherapy & spiritual counselling'
- 'Cultural, religious, ghetto identification not text book, someone understanding to talk to'
- 'Need cultural support specialist, complimentary healing one to one psychotherapy'
- 'Religion/self awareness/understanding drugs short term fix for long term problem/psychiatric evaluation'
- 'I have addressed these by using tools learned on R & R also finding solutions to my problems'
- 'Accommodation is the key'

- 'By myself wanting to'
- 'More support on release'

Interestingly, both here and above some respondents highlight their need or ability to help themselves. It is interesting to wonder if this is a particular issue for Black and minority ethnic drug users and whether it is related to their perceptions of the services available to them.

The questionnaire goes on to ask what additional support Black and minority ethnic substance misusers think they might need and might be helpful. Again the responses are very significant and relevant to services providing treatment and support. Some of the key responses were:

- 'Black/Asian counsellors, role models etc, more involved in hierarchy of decision making'
- 'Support network, mentor, programme, self help groups and aftercare support.'
- 'Cultural, empathic identification with service providers, Asian project drug workers, education'
- 'Will continue self help group, additional therapy welcomed but cost is a factor'
- 'Cultural, empathy about mental health, talking to someone who has been there'
- 'Mediation between me and family, educational support for family to understand'
- 'Asian drug workers, ex users, cultural counselling'
- 'In-patient support/direction to accessing religion/quicker referral/cultural supportive drug workers'
- 'I needed someone to advise me on how I can deal with the problems'
- 'Project worker available 24/7'

The respondent who identifies the need for a 'project worker available 24/7' might not have this need met but the 24 Hour Black and minority ethnic specific help-line recommended in this report might go some way to meeting this need. Again, many of these suggestions are contained within the recommendations made by this report.

Overall, the findings from both the questionnaire and focus group highlight:

- significant gaps in services
- a regular failure by services to respond to the particular cultural, spiritual, psychological and emotional needs of the research group
- often unhelpful attitudes and approached on behalf of staff and institutions

The research findings point to the need to significantly improve services at all stages – from arrest to custody to aftercare – and both the questionnaire respondents and those who took part in the focus group make many useful recommendations as to how services to Black and minority ethnic substance misusers in the Criminal Justice system can be changed and improved.

The authors have used their analysis of the findings, and built on suggestions by those who took part in the research to make their own recommendations.

Key Recommendations

Adopt a 'passport to prisons' or similar system in Nottinghamshire prisons to enable easy access by ex-offenders involved in treatment initiatives/self-help groups.

Recruitment of culturally competent and trained Black and minority ethnic workers:

Recruit black & Asian counsellors, drug workers and mentors to provide a culturally sensitive, empathic and appropriate support service.

Recruitment of ex users:

Recruit ex users from the Black and minority ethnic communities as staff as well as employing more ethnic minority workers and specialists in the drug and alcohol field.

Recruitment of more staff from all communities:

To provide quality care and support and address the issues of overwork for some of the existing staff.

Specialist Counselling and Psychotherapy:

Specialist help to address the causes that underpin substance misuse such as such as: poor life skills, poor identity, self-esteem issues, racism, confidence, depression, loss, bereavement, abuse, boredom, childhood issues, mental illness, family pressures, alienation, loneliness, motivation problems, isolation, support for cultural/spiritual issues, character behaviours, cultural identity, cultural displacement issues, stress and anxiety problems.

Respondents also made references to specific cultural and spiritual counselling as well as psychotherapeutic interventions to explore 'unresolved' issues.

More investment in addressing and treating the causes of substance abuse/addiction for long term effectiveness, quality of recovery and service user success outcomes.

Faith based and spiritual approaches as part of a range of options for Black and minority ethnic substance misusers

Black and minority ethnic Service User involvement:

Encourage ex user involvement at decision-making, provision, strategic and treatment planning levels including involvement at local, regional and national levels.

Inreach Black and minority ethnic service:

Culturally appropriate, sensitive and specific one to one help and group work support for Black and minority ethnic inmates with substance misuse problems.

Housing:

Better & effective relocation and resettlement services including careful assessment on relocations to ensure they meet the recovery needs and safety of those leaving prison. Link these services to housing and support providers.

Better defining of treatment modalities:

Medicinal, outpatient, inpatient, residential, rehabilitation, secondary care, day care, structured programs, educative, psychotherapeutic, psychiatric, cultural, after-care reintegration, DTTO etc

Black and minority ethnic Aftercare Provision:

Specific reintegration support provisions upon release to address psychological/cultural aftercare in the community; help to overcome institutionalisation, low self worth, low confidence, help with developing skills for rebuilding broken relationships with family, spouses and children after lengthy spells in prison. Also support for long-term Black and minority ethnic prisoners with transitional phases from long-term prison life, to life in the community.

Family Education and Awareness:

Education and awareness for families and communities on specific addiction and recovery related areas as well as developing family support groups.

Effective assessment procedures:

Identifying the exact, individual and idiosyncratic needs of Black and minority ethnic substance misusers rather than using a generalised 'one size fits all formula.

Outreach Support:

Engaging with Black and minority ethnic communities and individuals, providing support and education about substance misuse, treatment, recovery process and awareness of existing services.

Education:

In depth translated drugs, addiction and recovery material for non-English speaking families.

Choice for Abstinence based programs:

Full abstinence based programs should be made available and this option provided or those who wish to access it. Abstinence based programs that are culturally sensitive and effective need to be considered/developed by commissioners, ex users and treatment planners. Abstinence needs to be encouraged more widely.

Black and minority ethnic Training:

Educative support for all service workers with basic cultural and religious awareness training to make Black and minority ethnic service users more welcome and better acknowledged

Diversity/cultural/empathy building and cultural competence training for all service workers and organisations.

Culturally specific 24-hour free phone help line:

Free phone 24-hour help line for Black and minority ethnic communities (multi cultural faceted support service) similar to the FRANK phone line.

Quicker referrals:

Waiting times need to be decreased as far as possible to provide quicker access to medication, psychological/cultural support or secondary care.

Better defining of specific front line staff roles:

There seems to be a lack of understanding of the specific roles of different front line staff - highlighting a need for staff to be explicit about who they are and where they fit in the treatment and support process.

Challenge those workers that offer quick fixes/incorrect advice, wrong guidance, and misinformation - addressing staff attitudes towards vulnerable service users.

Encourage ex-user involvement at service provision, decision-making, strategic and treatment planning levels to include ex-user involvement in all aspects of commissioning and service delivery.

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Davis, M E. (2003). Consultation with Black and Minority Ethnic Families in Nottinghamshire. Ajamu (African Joint Achievement and Mentor Unit)

Steele, A. (2004). The South Nottinghamshire Black and Minority Ethnic Housing Needs Study. Salford Housing and Urban Studies Unit, University of Salford

Appendices

- Appendix 1 BAC-IN Needs Assessment Questionnaire
- Appendix 2 Example letter to local prisons
- Appendix 3 BAC-IN Project Information Leaflet

Appendix 1

BAC- IN Needs Assessment

SECTION A: These questions are used simply to help with the classification and interpretation of data. No name and addresses are passed on.

1 **Age**
16-18 19-21 22-24 25-29 30-39 40-49
50+

2 **Gender**
Male Female Transgender

3 **Ethnicity (Please Circle or Tick)**

White	British Irish Other (give details)
Mixed	White and Black Caribbean White and Black African White and Asian Other (please specify)
Asian or British	Indian Pakistani Bangladeshi Other (please specify)
Black or British	Caribbean African Other (please specify)_____
Chinese or other ethnic group	Chinese Other
Travelling Community	Irish Romany Other (please specify)_____

4. **Were you born in the UK?**

Yes No

4a **How long have you lived here?**

Less than 1 year 1-5 years 6-10 years
11 years or more

5 **Which languages do you speak?** _____

6 **What is your religion?**

None Catholic Christian Buddhist
Hindu Jewish Muslim Sikh
Other

Please State

7 **Sexuality**

Gay woman
Homosexual
Heterosexual
Bisexual
Transsexual

8 **Do you have a disability?**

Yes No

If yes, please state

9 Citizenship?

British Citizen Refugee Asylum Seeker

Other _____

SECTION B: Experiences of the Criminal Justice System

1 Have you ever been arrested by the police?

Yes No

1A Was this in the UK?

Yes No

2 What is your current legal status?

Arrested Sentenced with supervision/licence

Charged Sentenced without supervision/licence

Convicted Conditional caution

Remand – awaiting trial other – please give details

Remand – awaiting sentence

4 How long is your sentence? _____

5 What type of offence(s) have you committed?

Theft – shoplifting Supply

Theft – of a vehicle Attempted theft

Theft – from a vehicle Attempted burglary

Theft – other Attempted robbery

Robbery Attempted fraud

Burglary – domestic Attempted handling

Burglary – other Begging

TWOC Soliciting

(Taken without Consent)
Fraud Domestic violence

Handling Wounding or assault

Going Equipped

Possession

Driving Offences
Please List

Other – give details please: _____

6 Did the arrest lead you to be tested for drug use?

Yes No **If NO then please go to Question 21**

If yes was the test positive?

Yes No

7 Were you placed in contact with any support agencies (any organisation that would help you address your drug use?)

Yes No

If yes please list the support agency

8 Did you meet an arrest referral officer whilst in custody?

Yes No

If No please explain why

9 Did they make any assessment of your needs?

Yes No

Please explain

10 Did you receive a clear explanation of treatment?

Yes No

If yes, what was explained to you?

11 Do you think that the staff understood the kind of help you wanted?

Yes No

Please explain?

12 Do you believe culturally appropriate support would have been beneficial?

Yes No

13 Was this type of support offered? Yes No

14 Do you feel or think you had an option for culturally appropriate support?

Yes No

15 Did you feel that the staff cared about you and your problems?

Yes No

Please explain?

16 Were you offered a range of treatment options?

Yes No

If yes, what treatment options were offered?

Were you offered any support to access treatment and other services

Yes No

17 What positively helped or did not help when speaking with the drug worker?

Please Explain

18 Which of the following best explains your encounter with the arrest referral worker?

They were very helpful They were easy to talk to

They couldn't understand my language They didn't care about my problems

They were easy to relate to

They treated me with respect

19 Did you take any treatment offered? Please explain

20 In your opinion, how can the arrest referral service be improved?

21 Were you referred to any other support agencies?

Yes No

Please list the support agencies.

22 Did you visit any of these agencies?

Yes No

If YES please explain the experience

23 Please describe any information you were given?

24 Were your immediate needs such as food and housing discussed?

Yes No

How satisfied were you with the outcome?

Not very satisfied

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

 Very Satisfied

Please explain

25 Please list all the agencies and describe your experience including during arrest, in court, and at sentencing:

Did any agencies or support workers contact you?

Yes No

26 Do you have any advice or suggestions on how the agencies could improve their service and have better met your needs?

SECTION C: Prison

1 Have you been in Prison in the United Kingdom?

Yes No If NO please go to SECTION D

2 Is your use of drugs the reason for your imprisonment?

Yes No

3 Did you see a CARAT/CJIT worker in prison?

Yes No Not Sure

4 Did you see a DIP worker?

Yes No Not Sure

5 Did you see a Probation officer?

Yes No

5A How did you feel while speaking to the [A] CARRAT Officer [B] CJIT/DIP worker, and [C] Probation Officer?

	[A] CARAT Officer	[B] CJIT/DIP worker	[C] Probation Officer
Ashamed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comfortable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relaxed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Annoyed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Misunderstood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5B Which of the following best explains your encounter with the [A] CARAT Officer [B] CJIT/DIP worker, and [C] Probation Officer.

	[A] CARRAT Officer	[B] DIP worker	[C] Probation Officer
They were very helpful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They were easy to talk to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They couldn't understand my language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They didn't care about my problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They were easy to relate to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They treated me with respect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They didn't empathise with my cultural issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
They were culturally discriminating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6 Did you have any treatment for your drug use in prison?

Yes No **If NO go to Question 7**

6a **Methadone** **Hospital Wing** **DF118**

Other **Please State** _____

6b Please explain i.e. what type of support, was it beneficial, did it help?

7 Were you offered any support services for your drug use in Prison?

Yes No

8 Were you given any drug education in Prison?

Yes No

If YES please explain i.e. how useful was it

9 Did this treatment continue upon release?

Yes No

Please explain why?

10 Were you referred to any support agency upon release?

Yes No **IF NO got to Question 12**

Please list the agencies

11 Did you go to these agencies you were referred to?

Yes No

If No why not? Please explain

Section D: DRUG USE

1 Are you currently receiving treatment for your drug use?

Yes

No

If **YES** what type of treatment?

2 Are you currently waiting to receive treatment for your drug use?

Yes

No

How long have you been waiting?

Which agency or programme are you waiting for?

3 Have you received treatment in the past for your drug use?

Yes

No

If NO go to Question 5

From which agency and what type of treatment did you receive?

4 Did you complete that programme?

Yes

No

Please explain reasons for completing or not completing the programme?

5 What drugs did you use?

- Cocaine
- Crack
- Heroin
- Methadone
- Cannabis
- Amphetamines
- Benzodiazepines
- Ecstasy
- Ketamine
- Other – give details _____

6 What would be your preferred drug? _____

7 Have you used drugs in the last month? YES NO

8 About how much did you spend on drugs each week?

- | | | | | | |
|-------------|--------------------------|--------------|--------------------------|-------------|--------------------------|
| £0 - £50 | <input type="checkbox"/> | £51 - £100 | <input type="checkbox"/> | £101 - £250 | <input type="checkbox"/> |
| £251 - £500 | <input type="checkbox"/> | £501 - £1000 | <input type="checkbox"/> | £1000 + | <input type="checkbox"/> |

9 How old were you when you first used drugs?

10 Which country did you first use drugs?

11 What was the situation where you first consumed the drugs?

Party School

Cultural event

At home

Other, please state

12 Have you ever tried to stop using drugs?

Yes No

Please describe

13 For how long did you stop using drugs?

14 Why did you resume using drugs?

15 Have you ever shared equipment for your drug use?

Yes No

16 Are you aware of the needle exchange system?

Yes No

17 Have you received information about Blood Borne diseases such as Hepatitis?

Yes No

Have you been immunised for Hepatitis?

Yes No

ALCOHOL USE

1 Have you had any alcohol in the last month?

Yes No

Do you think you have ever had a problem with alcohol?

Yes No

3 How often do you or did you drink alcohol?

Daily Weekly Monthly Never

4 How many units of alcohol do you drink each week?

0-25 units 25-50 units More than 50 units

5 Has your alcohol use contributed to your drug taking?

Yes No

6 Have you frequently mixed drugs and alcohol?

Yes No

7 Have you ever-substituted drugs with alcohol?

Please explain

TREATMENT

1 Have you ever-accessed treatment for your drug/alcohol use?

Yes – Drugs No-Drugs Yes – Alcohol No - Alcohol

2 Are you currently receiving treatment for your drug use?

Yes No **If NO please go to Question 8**

3 What was the length of your waiting time for treatment?

4 How did you get into treatment, were you referred? Yes No

If Yes by whom

If No what reasons can you think of?

5 Are you currently on medication? Yes No

If yes what type?

6 How effective were these medication options? Please explain

7 Have you ever relapsed after treatment? Yes No

If yes why do you think that is?

8 If you have received treatment in the past how satisfied have you been with the support from the staff? Please circle:

Not very satisfied

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Very Satisfied

Please explain

9 What types of treatment have you received?

Self-detox

In-Patient Clinics

Rehab

Community Detox

Drop in centres

Self help groups i.e. NA/AA

10 Have you been abroad for treatment?

Yes

No

If NO go to Question 12

Please explain the reasons?

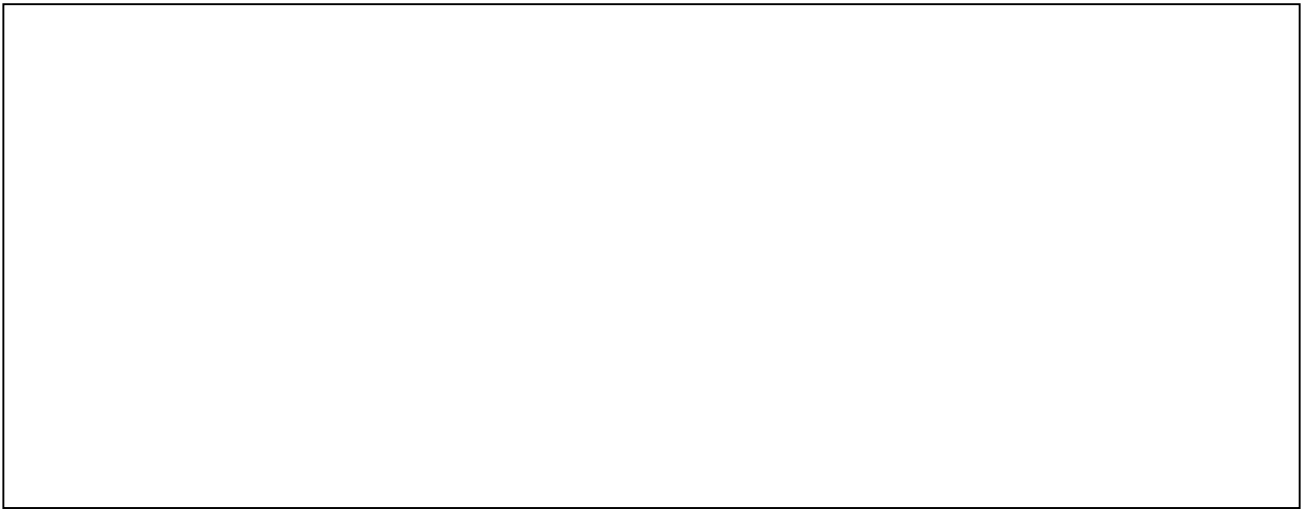
11 Was this successful?

Yes No

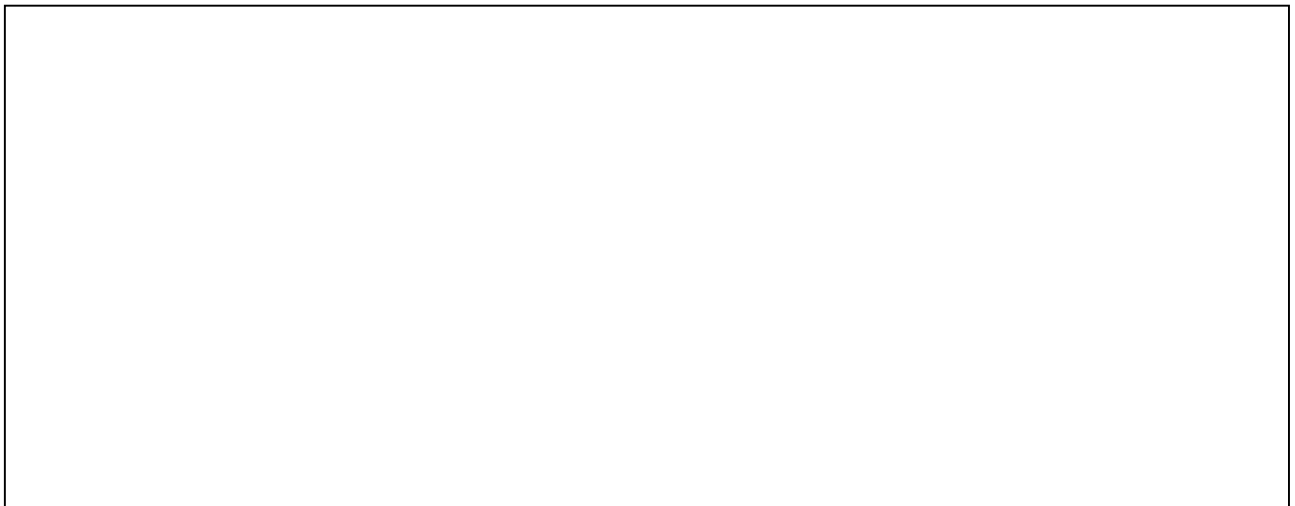
Reasons why it was successful or not successful?

12 Do you feel or think that there may have been an underlying cause or causes for your addiction and if so can you please try to explain?

13 How do you feel that these cause or causes could be addressed?



14 What type of additional support do you think you may need, or you may have needed to help address these causes?



Appendix 2

BAC-IN BME Project

3a Vine Terrace
Hucknall
Nottinghamshire
NG15 7HN

2nd November 2005

HMP Lowdom
Old Epperstone Road
Lowdom
Nottingham
NG14 7DA

Dear Mr Baulf

My name is Mr Sohan Sahota and I am the services leader and co-founder of the BAC-IN project. My colleague Mr Mani Singh spoke with you on Friday 28th October 2005 about carrying out research with the Black & Asian as well as serving prisoners from the travelling community from Nottinghamshire. It is in relation to that call that I am writing to you and sending the following information as requested.

BAC-IN is a support service that operates in Nottinghamshire and helps members of the Black & minority ethnic communities (BME) who have problems with substance misuse issues and related issue's.

In 2004 BAC-IN was commissioned to carry out a needs consultation within the county on behalf of the Home Office, University of Lancashire and Nottinghamshire Drug and Alcohol Action Team (DAAT) through the DIP programme. The consultation is to focus on a local assessment of the needs of Black and minority ethnic communities for drug and alcohol interventions in regards to offenders and ex offenders. This report of the findings, serves to inform decision-making about service development and commissioning priorities.

Aims and Objectives of the research:

- To have a better understanding of substance misuse within the BME population, including the travelling community, it has been cited in the ASK report that Black and Minority population is more at risk of problematic substance misuse than the larger population as a whole. This research aims to give us a better understanding of some of the issues behind this.
- To target BME offenders within the prison system as well as ex offenders within the community.
- To understand why the BME community are not accessing tier three treatment.
- To assess their needs and to understand their perceptions of existing services.
- To have a greater understanding of what alternative treatments/ways the BME community are currently using instead of tier three treatment services and the barriers that may exist to accessing this services.
- To explore the crime element regarding substance misuse, in terms of what types of crime are being committed to fund their addiction.

I would kindly welcome your assistance and guidance of the best procedure to arrange this research that would best suit you Mr Baulf and your prison staff.

I look forward to your response either by phone, letter or by email as soon as possible.

Yours sincerely

Mr Sohan Sahota
Mr Manni Singh

Sohan: 07980149076 e: sohan_newpathwaves@yahoo.co.uk

Mani: 07782349375 e: manikhalsa2000@yahoo.co.uk

The BAC-IN self-help group meeting.

Every Tuesdays

7.30 - 9.00pm

Friends Meeting House,
25 Clarendon Street,
City Centre,
NOTTINGHAM.

Self-help Group for Black and Asian men and women who are seeking recovery and culturally sensitive support from substance misuse (drugs/ alcohol) and related psychological issues.

BACKGROUND & HISTORY

BAC-IN started in October 2003 as a self-help support group by 4 ex-users.

BAC-IN was formed out of a need for BME people in recovery or seeking recovery from drug and alcohol addiction to have their own forum, which would acknowledge & empower their cultural, traditional, religious and spiritual values.

Many BME people are not accessing resources or completing treatment the reasons commonly expressed are the absence of cultural empathy, under representation and the minority status.

Therefore, the need to form 'BAC-IN' was driven from a gap within the existing support services.

In September 2004 the BAC-IN/BME project started work in the counties of Nottinghamshire for the BME communities as well as providing support for BME serving prisoners and also offering after-care for BME prisoners on release from these communities.

FOR ENQUIRIES PLEASE CONTACT

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BME Addictions Therapist
BME Drug Support Worker
Addictions Consultant

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BAC-IN BME PROJECT
3a VINE TERRACE, RUCKNALL
NOTTINGHAMSHIRE, NG15 7JN

Black & Asian Cultural Identification of Narcotics



The BAC-IN project aims to support the cultural needs of the Black & Asian (BME) service users in relation to their problematic drugs / alcohol use.

We aim to empower members of the BME communities to seek culturally appropriate help and advice to address their substance dependency issues.

Services offered

- One to One counselling
- Group work for BME serving prisoners
- One to One support for BME serving prisoners
- After-care support for BME ex-offenders
- Mentoring
- Peer Advocacy
- Outreach BME drug/alcohol support
- BME Training & BME research
- Weekly BAC-IN self help support group

INDIVIDUAL COUNSELLING

The goal of individual and group counselling is to help and improve the everyday functioning of the client. A major focus of counselling involves helping the client to identify, understand and reflect on his or her difficulties and find effective coping strategies so he or she may begin to fulfil their potential, achieve more satisfaction, and restore a sense of well-being into their lives. This can be achieved by helping the client to develop skills, find solutions, make decisions, and to develop effective coping strategies to deal with the stresses of everyday life. Counselling is also used to explore the 'deep rooted problems' that can often suppress or stunt the client's autonomy, passion and personal power. An emphasis is placed on a holistic approach to counselling. BAC-IN believes in providing care and services that includes the unique physical, social, psychological, emotional, spiritual and cultural needs of each client.

A Holistic approach is used that reaches a broader range of healing possibilities for the whole person by involving these dimensions collectively for effective & lasting healing from substance dependency.

ADDICTION THERAPY

BAC-IN provides a therapeutic counselling service for BME communities that addresses their cultural concerns, acknowledges their cultural experiences and also explores the underlying psychological/emotional/spiritual causes that can underpin the drug and alcohol addiction. The illness of addiction wounds many aspects of the unique person, the counselling is purposefully designed to treat those dimensions of the person to bring him or her to a new life and a new way of being. The treatment plan begins by identifying all the underlying issues of distress that move a person to chemicals and or other destructive behaviours, issues such as internalised racism, ostracism, oppression, discrimination, exploitation, prejudice, trauma, anxiety, abuse, depression, feelings of not fitting in, not belonging, issues with cultural/racial identity, spirituality, shame, cultural displacement, family pressures or other personal disadvantages. The treatment plan then combines life-changing experiences that can revive and awaken the person's sense of integrity, sense of self-worth, sense of purpose, also enhance his or capacity for self-empowerment and self autonomy.

MENTORING

Mentoring is about one person helping another to achieve something in a respectful, non-judgemental and non-exploitive manner. Mentoring is not about telling the person what to do but rather 'how to' do something. The aims of mentoring are: to empower, to build confidence, to help attain goals and to encourage informed choice.

ADVOCACY

An advocate is a person who acts on behalf of and alongside the person being represented to support their case with influential others. The benefits of this is to increase the person's sense of power, increase their capacity of choices and help the person to become more confident, assertive and independent.

VALUES

Integrity, Trust, Respect, Sincerity, Compassion, Empathy, Confidentiality and Education are values of the BAC-IN Project.

BAC-IN MISSION STATEMENT

To empower and to support BME individuals and families to seek culturally appropriate and effective treatment relevant to their needs from substance dependency.

EXPERIENCE AND KNOWLEDGE

The founders of the BAC-IN Project are all ex-users and collectively have extensive knowledge and working experience within the drug/alcohol field, with cultural issues, psychological counselling, mental health issues, complementary healing, group work, family support work, mentoring, peer advocacy, drug support work, BME research, BME training and consultancy.