DRUG STRATEGY DIRECTORATE

DIVERSITY ACTION PLAN
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DIVERSITY ACTION PLAN

1. **AIM**

To ensure that diversity issues are mainstreamed into the drug strategy.

2. **TARGETS**

To increase the number of women (including sex workers) and minority ethnic users entering and retained in drug treatment.

To increase the number of minority ethnic young people, who are disproportionately represented within vulnerable groups, receiving drug prevention education and treatment services.

3. **STRATEGIC CONTEXT**

Women, minority ethnic communities, the disabled and other groups have specific needs in relation to the delivery of drug services. Women and minority ethnic users are under-represented in drug treatment. Some communities are disproportionately represented within vulnerable groups who may be at risk of future drug misuse. The Drug Strategy must be targeted specifically to address these issues.

**Prevalence**

- Men are twice as likely as women to have taken an illicit drug in the last month or year\(^1\). However, this difference narrows as younger age groups are considered. A survey of 11 - 15 year old school children across England suggested only a small difference in drug use between boys and girls\(^2\).

- Irrespective of age, lifetime prevalence of drug use is greatest amongst the white population. With the exception of crack, young white people consistently have higher prevalence rates for all types of lifetime drug use. Low levels of drug use have been found particularly among the South Asian and Black African communities.

- However, primarily due to cannabis use, members of the African-Caribbean community have similar levels of drug use to the white population. Research suggests that African-Caribbean communities use crack at a slightly higher level than that of white and Asian communities. It is not clear what percentage of primary crack users are black compared to white users. However, many of those who report crack use in the white community do so as part of combined habits, such as heroin, whereas African-Caribbean users are much less likely to use heroin.

- Qualitative data indicates that problematic drug misuse exists in the more recently established minority ethnic communities, based largely on refugee migrations.

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\(^1\) Ramsay et al, 2002  
\(^2\) Goddard & Higgins, 1999
Further research needs to be done in this area, particularly in relation to concerns about the effects of Post Traumatic Stress on such communities.

Vulnerable Groups

Some minority ethnic communities are disproportionately represented within groups which research suggests may be vulnerable to drug misuse:

- Men, and particularly women, from minority ethnic communities are disproportionately represented in the prison population. The Home Office Prison Service commissioned research into the substance misuse needs of women and ethnic minorities in prison and identified a number of particular needs in relation to the provision of treatment. This is due to be published in early 2003. There is evidence to suggest that treatment for the crack cocaine addiction of offenders is more effective when begun in prison.

- Members of minority ethnic communities are more likely to be unemployed: an African-Caribbean graduate, for example, is more than twice as likely to be unemployed as a white person with "A" levels.

- They are more likely to be living in low income households. In fact, 70% of Britain's minority ethnic population live in the 88 most deprived local authority areas, where there are twice as many people on means tested benefit, 30% higher mortality rates and three times more child poverty.

- There is a small but significant group of children and young people looked after by local authorities who are at particular risk of future poverty and exclusion. At present up to three-quarters of all care leavers are estimated to leave school with no qualifications and ethnic minority children are disproportionately represented in this group.

- In deprived areas, there are significant numbers of disaffected minority ethnic young people involved with the youth justice system and the latest statistics from DfES show that African-Caribbean boys are around three times more likely to be excluded from school.

- Compared to the white majority population, the rates of diagnosis of certain mental illnesses are high in some minority ethnic groups. The black and minority ethnic population fare worse than the majority population when it comes to mental health. Some of the major areas of inequality are:
  - African-Caribbeans have a higher admission rate to psychiatric hospitals and are diagnosed from schizophrenia 3-6 times more than the white population;
  - Depression in Caribbeans is 60% higher than the white groups;

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3 Sangster et al, 2002
4 Race Equality in Public Services, 2000
6 DTLR Deprivation Indices 2000
7 Race Equality in Public Services, 2000
8 Race Equality in Public Services, 2000
• Women born in India and East Africa have a 40% higher suicide rate than those born in England and Wales. In those aged between 25-34, it is 60% higher.

• There is also a wide variation in the level of inequality in black and minority mental health. The high representation of Africans and African-Caribbeans compulsory detained under the Mental Health act is not shown by other ethnic groups. Similarly, the high rate of suicide in Irish and Indian communities is not reflected in other groups.

• Anecdotal evidence suggests that Chinese women have particularly high rates of mental health problems, particularly amongst the 30-45 year age group.

• We need a better understanding of the relationship which exists between mental health and homelessness and drugs misuse and diagnosis, and the implications this has in particular for minority ethnic communities.

• Research also suggests a strong association between sex working and drug use\(^9\). Women engaging in such activity are likely to be at a greater risk of both negative health and social consequences.

**Crack cocaine**

• There is convincing evidence that crack use is disproportionately more damaging and prevalent within centres of African-Caribbean population, even in cities where the majority of crack users are white.

**Treatment**

• Women who are problem users tend to use drug services less frequently than their male counterparts\(^10\) and those from ethnic minority groups are less likely to engage in drug treatment than white opiate users\(^11\).

• The Regional Drugs Misuse database indicates that men are three times as likely to enter treatment compared to women, but only twice as likely to misuse drugs.\(^12\)

• Information from the Arrest Referral Scheme\(^13\) highlights that:
  - where arrest referral workers have engaged with an arrestee and subsequently made a referral to treatment, those from Black and Asian communities were less likely to make a treatment demand than their white counterparts;
  - female crack-using sex workers were significantly less likely to be associated with a referral to specialist drug treatment.

\(^9\) McKeganey and Barnard 1996  
\(^10\) ACMD 1998  
\(^11\) Sangster et al ,2002  
\(^12\) Department of Health, 2000  
\(^13\) October 2000-September 2001
Women who do access services often find that there are significant shortcomings in the provision they receive in terms of childcare and transport facilities, women-only services, specific provision for minority ethnic women and services within the Criminal Justice System.\(^4\)

Services are criticised for failing to meet the needs of minority ethnic communities.\(^5\) In part this failure is due to the historical processes by which services developed. Many emerged out of the heroin epidemics of the mid-1980s and were crucially concerned with the way in which injecting provided a potential route for HIV-transmission. It has been argued that services have developed largely around the needs of white males who tend to dominate this category of drug use.\(^6\)

The focus on opiate injecting has been accompanied by an apparent reluctance to develop cannabis services and an underdevelopment of stimulant services.\(^7\) Ethnic differences in patterns of drug use suggest that the needs of some minority ethnic groups are marginalised by services which are limited and focus on injecting rather than smoking.\(^8\)

4. **KNOWLEDGE BASE/WHAT WORKS**

Research commissioned by the Home Office and published in July identified a number of reasons why women and ethnic minority drug users do not access drug treatment services. They are often reluctant to make initial contact with drug services when they have a problem, for example due to the stigma attached to being identified as a drug user in one's local community, or as a drug-using mother. They are also less likely to be retained in treatment by drug services, either due to practical matters, such as the way drug services address childcare provision and child protection issues, or due to the lack of services aimed at their specific form of drug misuse, for example the smoking of heroin and stimulant misuse.

We recognise that:

- there is a requirement for specialist services specifically targeting minority ethnic communities, women and other groups of drug users. However, it is equally important to ensure that mainstream providers also develop accessible and appropriate services;

- drug services must be more flexible and willing to develop methods for ensuring that women and minority ethnic users are attracted and maintained in treatment. This means widening the range of drug-specific services offered and extending and combining services, where necessary, to provide alternative therapies, such as acupuncture and cognitive behavioural therapies, outreach services, support for mental health problems and culturally sensitive services.

The recruitment of more workers from BME communities is a key issue in ensuring the development of culturally sensitive services. We are supporting the Federation in its work

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\(^6\) Sangster, 1997
\(^7\) Bottomley, 1999; Cripps, 1997
\(^8\) Sangster et al, 2002
to develop four regional fora to support black and Asian drug and alcohol workers and to ensure that their employing agencies are adept at recognising need and delivering appropriate services.

Children who grow up in poverty are less likely to do well at school and are more likely to suffer unemployment, low pay and poor health in adulthood. Poor educational attainment is linked with exclusion and juvenile criminality. A key aim of the drug strategy is to ensure that we identify and engage with children from these groups.

A co-ordinated effort is needed to tackle the deprivation and social exclusion which disproportionately affects our minority ethnic communities and can lead to drug misuse. We must work closely with other government departments - both centrally and at a regional level - to develop a coherent approach to tackling these issues.

There are a number of barriers to engaging vulnerable young people in drug prevention education and treatment services. For example, the stigma attached to drug misuse and/or the close-knit nature or isolation of some Asian communities, (including the Chinese community) and the lack of trust and fear of authority inherent in some communities (eg the African-Caribbean community) means that young people from these groups are reluctant to access services.

Furthermore, the absence of some groups of children for a variety of reasons, from the education system means they miss out on drug prevention education, eg: school excludees - disproportionately high among the African-Caribbean pupils; poor attendance by the Gypsy and Traveller community; and the exclusion of disabled children from mainstream education.

We know that consultation works when dealing with minority ethnic communities and other hard to reach groups. Some of the most effective drug treatment and prevention programmes have been those where the communities concerned were fully engaged in the development and delivery of the projects, for example the “Not Another Drop” campaign against crack cocaine and gun crime in Harlesden and Brent. Here, local focus groups comprising a diverse range of real local people with real skills in communicating with minority ethnic communities has proved very effective in finding and implementing solutions to local drug problems.

There is a need for more lateral thinking on the best methods for engaging with hard to reach groups. The “Not Another Drop Campaign”, for example, had used pirate radio and had offered a Crime Stoppers PO Box number to which local people could report drug crime (it was found that minority ethnic communities did not trust the phone line). Agencies need to be aware that some communities have a deep mistrust of authority and will not visit services located near mental health institutions or police stations, for example. Such communities are also more willing to identify with local campaigns which are not in any way associated with the police or council (ie via the logo).

**Drugs and Alcohol Research Unit**

Home Office commissioned research was published on 16 July which provides a clear overview of the issues concerning the provision of drug services to women and minority ethnic users, and to identify specific areas that need attention in the future. A summary of the main findings is attached at Annex A.
The Home Office Drug and Alcohol Research Unit has undertaken several studies which will improve our knowledge base. Research due to be published in January 2003 should give us a clearer picture of why certain groups do not participate in arrest referral and what can be done. And several pieces of research due to be published in February 2003 should provide us with a clearer understanding of the nature and prevalence of drug use among vulnerable groups, ie young people in care, young offenders, young homeless people and sex workers.

Work of Other Researchers in and outside Government

The Prison Department has commissioned research into the needs of women, minority ethnic and young offenders in prison which is due to be published in early 2003 and identifies specific needs in terms of treatment.

The Youth Justice Board has commissioned research on the substance misuse service needs of young people in custody. The researchers have been asked to investigate the particular patterns for women and ethnic minorities. The Report is due to be completed by April 2003.

The Department of Health Mental Health Taskforce is developing a national strategy to address issues surrounding black and minority ethnic mental health. Consultation is taking place during 2002.

Communications Research

The COI has a Diversity Unit with access to a large database of information concerning communications, consumer information etc. This includes a number of reports on communicating effectively with people at risk and disadvantaged groups.

The Home Office Communication Strategy and Co-ordination Unit is producing guidance for CDRPs on communicating with people with disabilities and minority ethnic groups.

5. IMPLEMENTATION PLAN

Diversity issues will be incorporated into the Young People, Communities and Treatment delivery plans, the overarching delivery plan and the crack cocaine strategy. This will provide the strategic framework within which diversity action plans for each DAT should be drawn up in consultation with DPAS regional teams. The diversity team will be working closely with the DPAS lead advisers on diversity in each regional team who will play a key role in taking work forward at a regional and local level.

At a national and regional level, we will be working to ensure that a more strategic and co-ordinated approach is taken in tackling issues concerning drugs and diversity. In particular, action needs to be taken within the context of wider Government aims to tackle inequality, discrimination and social exclusion. We hope to secure ministerial approval for the establishment of a cross-Departmental task force to take this work forward.
DPAS lead advisers on diversity will be key to ensuring that action is co-ordinated at a regional level and we see their role developing into one where they have a much closer working relationship with regional representatives from other initiatives, such as neighbourhood renewal and community cohesion. The relocation of DPAS teams to Government Offices for the Regions will support this process. They will also form a vital link with key stakeholders at regional level, such as the Federation and CRE Race Equality Councils. The diversity team will support lead advisers in this role as much as possible. A training course has been arranged in December which aims to increase their knowledge of diversity issues, improve their understanding of the lead adviser role and provide an opportunity for team building.

At a local level, needs analysis surveys covering women, BME communities, people with disabilities and gay and lesbian communities need to be completed by each DAT as a matter of priority and will provide the baseline data from which to assess how best to target action and resources.

Training, support materials and guidance will be provided/commissioned for DPAS and DATs by the Diversity Team in accordance with the needs identified throughout this process. A key resource for ensuring delivery at regional and local level will be the diversity toolkit we intend to develop as a source of information and step by step guide for DPAS regional teams and DATs in the implementation of diversity strategies and action plans. This is due to be completed by March 2003. The toolkit will be supported by the establishment of a good practice database in July 2003.

A table detailing actions and milestones etc is attached at Annex B.

6. RESOURCES

Money

Estimates for the costs of various activities under the Diversity Plan are attached at Annex B.

Key Players

Central Government

Home office - DSD Prevention, Communities and Treatment teams; Youth Justice Board; Prison Service; Correctional Policy Unit; Community Cohesion Unit; Race Equality Unit

Department of Health - National Treatment Agency; Substance Misuse and Sexual Health (diversity) Team; Community Engagement Agency

DfES - Raising the Attainment of Minority Ethnic Pupils; School Exclusions Unit; Connexions

ODPM – Social Exclusion Unit; Gender and Equalities Unit

Disability Unit

The Federation

Regional and Local Delivery
Regional Government Office

DPAS lead advisers on diversity will work with other Government contacts based at the Regional Government Offices, ie Connexions; New Deal Co-ordinators; and CCU Race Advisers.

VFM of Planned Activities

Research suggests that investment in treatment and drug prevention education has the potential to achieve massive reductions in the social cost of drug use. Action to tackle the under-representation of minority ethnic and women users in treatment and the disproportionate representation of some communities among those group vulnerable to drug misuse could significantly enhance the impact of such savings.

7. STAKEHOLDERS

We are in contact with a number of organisations with a particular interest in diversity issues around drug misuse, including the Federation, the 1990 Trust, Drugscope and the Community Engagement Project. A key aim of the Diversity Action Plan is to develop further links with other interested parties. A series of meetings will take place in early 2003 with organisations representing black and minority ethnic communities, women, the mentally and physically disabled and gay and lesbian communities, to explore ways of working more effectively together to meet the drug service needs of these groups.

We need to liaise more effectively with other Government Departments to develop a more coherent national diversity strategy. We are working to establish links with key Government Departments and agencies with an interest in this area, in particular: the Commission for Racial Equality; the National Treatment Agency; DoH; DfES; ODPM; Disability Unit; Youth Justice Board; Prison Service; Correctional Policy Unit; Community Cohesion Unit and the Race Equality Unit.

It is vital that the strategy links with key stakeholders at a regional and local level. We will be working closely with DPAS lead advisers on diversity through regular meetings and they will have close contact with other Government initiatives based at the Regional Government Offices, ie DTLR New Deal Co-ordinators, Connexions advisers and CCU Race Advisers. This should assist them in developing links with other key players such as DTLR Neighbourhood Advisers and Connexions partnerships. We will encourage and support closer working partnerships with ACU BME contacts, Crime Reduction Partnerships and NTA regional advisers. We will also provide all DPAS regional teams with links to minority ethnic communities, the CRE Race Equality Councils, women's groups and other relevant organisations at regional level.

8. COMMUNICATIONS

Our aim is to be more targeted in our information campaigns towards minority ethnic communities and women and more culturally and gender sensitive in our communications. We will be looking closely at this during the development of the national campaign which is due to be launched in January.
A series of training seminars will take place early next year to assist DPAS teams and DATs to develop communication skills which take account of diversity. We will also be coordinating and supporting DPAS teams and DATs in the development and delivery of local public information strategies aimed at women, minority ethnic communities and other groups.

9. INTERDEPENDENCIES/OVERLAPS

Within the drug strategy
The Treatment, Communities and Young People’s aims, in particular, the DSD communication strategy and the crack strategy.

Within the Home Office
The work to tackle inequality undertaken by the Youth Justice Board (eg minority ethnic mentoring), the Prison Service (re treatment), the Correctional Policy Unit (in terms of Women Offending Reduction Programme), the Community Cohesion Unit and the Race Equality Unit.

Within wider Government
DoH/NTA: work to tackle inequality in health and treatment
DfES: work to tackle school exclusions, promote drug prevention education in schools and raise attainment levels of minority ethnic pupils;
ODPM: work of the Social Exclusion Unit and the Women and Equalities Unit Disability Unit

At a national level
The Federation and other organisations representing the interests of black and minority ethnic communities; women; the mentally and physically disabled; and gay and lesbian communities.

At a regional and local level
Government initiatives at regional level which aim to tackle inequality and social exclusion, for example ACU BME contacts, DTLR Neighbourhood Advisers and New Deal Co-ordinators, Crime Reduction Partnerships, Connexions advisers and CCU race advisers. The Federation and other organisations representing the interests of black and minority ethnic communities; women; the mentally and physically disabled; and gay and lesbian communities.

10. OUTCOMES AND TRAJECTORIES

Key deliverables and milestones are included in the Implementation Plan at Annex B.

11. PERFORMANCE ASSESSMENT

Impact of Delivery Plans on Diverse Groups

Within the drugs field, statistical data broken down by women and BME categories is patchy and virtually non-existent for other minority groups. There is currently a lack of baseline data from which to measure the impact of policies and practices on diverse
groups. One of the aims of the strategy is to establish such data so that we have a more substantial platform of information from which to work.

We will be monitoring the impact of the drugs strategy on diverse groups as far as possible on a quarterly basis through the DAT returns and through bi-monthly meetings with the DPAS lead advisers. The results of the 2002/3 DAT template will also provide us with some information and will be updated to take account of diversity issues more appropriately in 2003/4. It is therefore unlikely that we will be in a position to make a substantial assessment of the impact of the diversity action plan until April 2004.

To increase the number of women (including sex workers) and minority ethnic users entering and retained in drug treatment.

Progress on this can be measured through statistics provided by the NTA and the arrest referral scheme.

To increase the number of minority ethnic young people, who are disproportionately represented within vulnerable groups, receiving drug prevention education and treatment services

Although we are aware that minority ethnic young people are disproportionately represented within vulnerable groups, there is a lack of firm statistical evidence and baseline data in some areas. Research undertaken by the YJB and statistical data recently collated by the DWP in respect of children in care should improve this.

The British Crime Survey provides information about prevalence amongst minority ethnic groups and the schools survey enables comparisons by minority ethnic categories. A new survey called the Crime and Criminal Justice Survey is about to start this autumn. There are plans for this to include an extra set of interviews with Black and Minority Ethnic people. I understand that this may allow a number of things we cannot obtain from other existing surveys of the general population, including:
- drug use among 10-15 year olds by ethnic group
- more accurate information on drug use across ethnic groups
- the ability to examine links between drug use and offending for ethnic minority groups

Baseline data is also lacking at a regional and local level. A priority for the Diversity Action Plan is to ensure that all DATs complete a needs analysis as soon as possible covering women, BMF communities, people with disabilities and gay and lesbian communities. From this, DATs will be supported in the development of diversity action plans with built-in monitoring and evaluation systems.

Once information from the needs analysis has been established, we should be able to monitor progress through:

- the DAT returns on the implementation of diversity strategies and information;
- Section 5 (Diversity) and other relevant sections of the DAT template.

A variety of sources of data on vulnerable young people will be available through the Young People’s delivery programme, ie:

DPAS annual assessment of the quality of young people’s substance misuse plans
Evaluation of the pooled budget
Positive Futures monitoring and evaluation
Monitoring and evaluation by DoH of drugs prevention education to school excludees, young people in contact with YOTs, children looked after by social services and other groups of young people identified locally as being at particular risk of becoming problem users

The Diversity team will pull together all available information from the above and provide a coherent report on the impact of drug strategies in relation to women, BME communities and other groups.

12. RISK MANAGEMENT

The main risks are:

- inability to reach target audience
- failure to understand the needs of target audience
- failure to achieve joined-up working at a central, regional or local level
- failure to engage with key stakeholders
- failure of treatment and prevention services to meet the needs of target audience
- inability to measure progress against targets
- shortage of skills and understanding of diversity to deliver the diversity strategy locally

13. MANAGEMENT AND INFORMATION

Section 11 sets out plans for establishing baseline information and monitoring our performance against the aims of the Diversity Action Plan.

The Diversity Team will engage with stakeholders representing black and minority ethnic communities; women; the mentally and physically disabled; and gay and lesbian communities, to establish the needs of these groups and to explore ways of working more effectively together to meet those needs.

The Team will also be working closely with key Government Departments to ensure that a more strategic approach is taken to addressing the needs of these groups at a national level.

Local Delivery will be monitored on an ongoing basis through regular, two-monthly meetings with the DPAS lead advisers on diversity.