Réseau d'Echanges et de Formation

ANNEXES

Convention de subvention
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Toxicomanie Europe – Echanges – Etudes
T3E

Projet substitution 2002-2003

Rapport

Descriptif des résultats…

Novembre 2003

Annexe 1-1.

Sommaire

I. Présentation

1. Cadre d'une problématique :

Autrefois largement décriés, les traitements de substitution occupent aujourd'hui en Europe une place grandissante dans l'éventail des possibilités de soins qui s'offre aux toxicomanes. Une importance qui ne se révèle pas seulement à la lumière du nombre d'usagers dépendants qui profitent de tels traitements mais une évolution qui s'inscrit également au niveau de la controverse scientifique, mais également et peut-être surtout politique, de plus en plus présente autour de ces modalités de prise en charge au sein de l'Union Européenne. Le scénario actuel des pratiques de substitution en Europe est varié et complexe et largement tributaire du contexte à la fois historique et socio-politique de chaque pays. En conséquence, l'objet de ce travail était de tenter de faire un état des lieux des pratiques professionnelles et de leurs évolutions dans le champ de la Réduction des risques et des traitements de substitution en Europe. Un objectif qui sous-tend la nécessité de comparer les pratiques initiales avec les pratiques actuelles dans chaque pays, dans le but de déterminer à terme les points de convergence- divergence des *représentations* et *pratiques* en la matière au sein de l'Union.

2. Le projet d'enquête :

Depuis 1991, le réseau européen d'études et de recherches Toxicomanie Europe Echanges Etudes (T3E) a contribué à impulser un certain nombre d'initiatives et d'actions pour les différents intervenants travaillant dans le champ de la prévention des toxicomanies et de la Réduction des risques. C'est à ce titre que depuis janvier 2002 une recherche-action a été lancée par l'association T3E en lien et avec la collaboration de l'Ecole Nationale de la Santé Publique (E.N.S.P.) et de l'Institut National de la Santé et de la Recherche Médicale (INSERM).

Financé par la Commission Européenne et faisant suite à diverses réunions préparatoires permettant de clarifier les axes de cette recherche, cette enquête s'inscrit dans le cadre d'un projet européen portant sur les dispositifs de substitution mis en place dans six pays de la Communauté (Allemagne, Angleterre, Belgique, Espagne, France, Italie Portugal). Réalisée sous la direction du Docteur Claude Védeilhie (président de l'association T3E), le présent rapport s'inscrit dans la lignée d'un travail qui se veut avant tout être exploratoire.

Ne s'agissant pas d'un recensement quantitatif à grande échelle ni d'un dispositif d'évaluation, cette étude n'a jamais eu l'ambition de dresser une liste exhaustive de ce qui se fait dans chacun des sites étudiés, mais plutôt d'analyser le point de développement et de pratique actuels de cette *troisième voie* que constitue la Réduction des risques. Malheureusement, un certain nombre d'obstacles (voir *Limites et problèmes rencontrés*) nous ont empêché d'y voir un peu plus clair à ce sujet.

3. Présentation de l'enquête :

3.1· Phase de pré-enquête.

Née d'une interrogation générale du regard porté par les professionnels sur la Réduction des Risques et les traitements de substitution en Europe, il nous a fallu déterminer une méthode d'enquête adaptée à ce que nous souhaitions rechercher. Parmi les perspectives d'enquêtes en sciences sociales et compte tenu d'impératifs logistiques et financiers, le choix d'un travail exploratoire s'est imposé à nous. A cet égard, et comme l'a récemment noté la Fédération Européenne des Associations d'Intervenants en Toxicomanie (ERIT) « *au contraire d'une étude évaluative exhaustive des pratiques de substitution, dont toute sa validité dépendrait de l'obtention d'un échantillon représentatif et significatif des pratiques de substitution en vigueur en Europe, l'étude exploratoire exige surtout que les apports d'information puissent, de la façon la plus économique possible, fournir un niveau d'analyse de la réalité qui soit fiable et générateur des bonnes hypothèses, celles dont l'investigation pourra mener les modèles d'analyse à un nouveau type de conclusion*. »[1[1]]. A cette fin, la construction de cette étude s'est réalisée en deux périodes.

La phase de pré-enquête a eu lieu durant l'année 2002 et a consisté en plusieurs réunions de travail. Réunissant le groupe de pilotage, ces réunions ont eu pour objectif de définir et clarifier les axes de cette recherche et d'identifier les points nodaux des divers réseaux nationaux directement confrontés au problème des drogues et dépendances[2[2]]. A l'issue de cette première scène, la recherche documentaire (littérature scientifique et sources secondaires) fut la seconde étape. Une recherche dite de pré-compréhension pour cerner les contours de notre objet mais également du riche et complexe contexte dans lequel nous allions l'inscrire. Une investigation nécessaire qui nous a en outre permis de réfléchir sur les thèmes qu'il nous fallait aborder. C'est également lors de cette phase qu'a été élaboré et validé un questionnaire préliminaire adressé à chacun des participants[3[3]]. Plus fortement pré-construit que les autres méthodes de collectes et comme il est de coutume en sciences sociales, ce questionnaire a posé les mêmes questions formulées dans les mêmes termes et présentées dans le même ordre. L'homogénéité formelle se doit d'être rigoureuse. Principal outil d'investigation, ce dernier a permis de récolter les informations préliminaires nécessaires et s'est organisé selon trois axes :

1° - Le premier axe du questionnaire a cherché à dresser un état des lieux des traitements de substitution utilisés dans diverses structures ainsi que les modalités de leurs utilisations.
2° - Le deuxième axe a consisté à mesurer, par le biais d'indicateurs préalablement construits, l'appréciation des professionnels par rapport à ces traitements et plus globalement par rapport à la Réduction des Risques à la lumière de leurs pratiques quotidiennes.
3° - Le troisième axe a eu pour objectif de saisir les représentations et appréhensions à l'égard de ces « nouvelles pratiques » avant que ces dernières ne s'implantent. Nous avons voulu cerner les éventuelles « a priori » inhérents à toutes pratiques innovantes pour voir dans quelles mesures ils avaient pu influer sur l'acceptation et le développement de ces outils.

[1[1]] L. PATRICIO (dir.) et al., Etude exploratoire sur les pratiques de substitution opiacée en Europe, Abrangrafica : ERIT, 1998, p. 17.
[2[2]] La liste des organismes se trouvent en annexe 1.
[3[3]] Le questionnaire se trouve en annexe 2 et en annexe 3.

3.2· Phase de traitement :

La phase de traitement a débuté au mois de juillet 2003, à la lumière de l'ensemble du matériel informatif recueillie, et s'est concrétisée par la rédaction de cette note de synthèse. Ce travail a consisté à réaliser une codification de chaque question posée et de chaque réponse recensée. Une fois l'ensemble des données codifiées, le travail d'analyse a pu commencer.

4. Limites et problèmes rencontrés :

Malgré de vastes ambitions de départ, il est utile de faire un point sur les difficultés rencontrées lors de l'élaboration de ce rapport. En effet, au fil des mois, il s'est avéré que la méthodologie choisie était particulièrement inadaptée.

En premier lieu, nous avions prévu, sur 6 pays de l'Union, un retour d'environ 78 à 90 questionnaires, chaque pays devant renvoyés entre 13 et 15 questionnaires. Cet échantillon nous permettait de disposer d'une base quantitative minimum de résultats, pour espérer pouvoir tirer un certain nombre de conclusions significatives. L'envoi des questionnaires s'est fait à partir de janvier 2003 et devait se terminer en avril 2003, laissant ensuite un mois pour analyser les résultats et établir un rapport. Nous avons reçu 50 questionnaires au total, soit une différence de 28 à 40 questionnaires. De plus, parmi ces 50 questionnaires, 3 étaient totalement inexploitables.

Cette étude devait se prolonger par des entretiens de type semi-directifs dans 3 – 4 pays pour approfondir et compléter cette première étape. Considérant l'insuffisance du nombre de questionnaires rendus pour finaliser cette étude en respectant, à minima, les critères statistiques requis, il a été décidé de ne pas effectuer cette série d'entretiens semi-directifs. Nous avons néanmoins entrepris d'exploiter les réponses. Pour finir, notons que l'un des objectifs de cette étude était de mettre en évidence les différences entre les différents pays. Nous n'avons pu remplir cet objectif que partiellement eu égard à la représentativité insuffisante des réponses reçues.

A la lumière de ces différents éléments, on comprendra facilement l'extrême difficulté de pouvoir établir un rapport qui se voudrait objectif et enrichissant par rapport à la problématique étudiée.

II. Identification

Envoyés à partir du mois de Janvier 2003 à 6 pays de l'Union Européenne, nous avons reçu à ce jour 50 questionnaires (dont 3 inexploitables) (Juillet 2003). Telle est la distribution de ces derniers :

Tableau n°1 : Distribution géographique des retours

	Nombre de retours de questionnaires
Belgique	9
Danemark	4
France	10
Italie	9
Portugal	10
Royaume-Uni	5
Total	47

La méthode utilisée a tout d'abord consisté à définir un référent dans chaque pays retenu. Ensuite, les questionnaires ont été envoyés à ces référents qui avaient pour charge de les diffuser auprès de leurs partenaires.

Tableau n°2 : Identification et répartition des effectifs globaux par pays et par sexe.

	Hommes	Femmes
Belgique	8	1
Danemark	3	1
France	8	2
Italie	8	1
Portugal	9	1
Royaume-Uni	4	1
Total pays	40	7

Tableau n°3 : Moyenne d'âge des enquêtés par pays.

	Moyenne d'âge des enquêtés
Belgique	42
Danemark	38
France	43
Italie	39
Portugal	41
Royaume-Uni	38
Total pays	40,16

Tableau n°4 : Villes d'exercices des enquêtés

	Villes d'exercices
Belgique	Bruxelles : 5, Malmendy : 1 , Liège : 3
Danemark	Salgelse : 4
France	Bordeaux : 2, Rennes : 4, Creil : 2, Beauvais : 2
Italie	Reggio Emilia : 6, Ravenna : 2, Rimini : 1
Portugal	Lisbonne : 8, Ciombra : 1, Porto : 1
Royaume-Uni	Plymouth : 3, Lancashire : 2

Tableau n°5 : Exercice en région[4[4]] :

	Urbaine	Péri-urbaine	Rurale
Belgique	8	1	1
Danemark	6	1	1
France	9	2	1
Italie	9	2	1
Portugal	8	2	0
Royaume-Uni	3	2	2

Tableau n°6 : Professions :

	Prescripteur	Non prescripteur
Belgique	6 (4 médecins, 2 psychiatres)	3 psychologues
Danemark	2 médecins	1 psychologues, 1 responsable structure sociale
France	4 médecins (dont 2 psychiatres)	3 infirmiers, 2 psychologues et 1 non renseigné
Italie	4 médecins	3 psychologues, 1 travailleur social, 1 non renseigné
Portugal	3 médecins, 4 psychiatres	3 psychologues
Royaume-Uni	3 médecins	1 responsable de centre, 1 travailleurs social

[4[4]] Plusieurs réponses possibles.

Tableau n°7 : Durée d'activité auprès de toxicomanes

	Moins de 5 ans	De 5 à 10 ans	Plus de 10 ans
Belgique	1	4	4
Danemark	1	2	1
France	2	3	5
Italie	3	2	4
Portugal	2	4	4
Royaume-Uni	2	1	2

Tableau n°8 : Durée d'activité dans une institution travaillant dans le cadre de la Réduction des risques et/ ou des traitements de substitution.

	Moins de 5 ans	De 5 à 10 ans	Plus de 10 ans
Belgique	3	3	3
Danemark	2	2	0
France	4	4	2
Italie	3	3	3
Portugal	5	4	1
Royaume-Uni	1	2	2
Total pays	**18**	**18**	**11**

Tableau n°9 : Type de structure d'exercice[5][5]

	Structure spécialisée			Structure non spécialisée		
	Centre ambulatoire	**Centre résidentiel**	**Centre de soin**	**Hôpital**	**Urgence**	**Exercice médical généraliste**
Belgique	7	2	0	0	0	1
Danemark	4	0	0	0	0	0
France	7	2	1	0	0	0
Italie	6	1	2	0	0	0
Portugal	6	2	2	0	0	0
Royaume-Uni	3	0	2	0	0	0

[5][5] Plusieurs réponses possibles.

III Représentations des risques

Au travers cette partie, nous allons tâcher de dresser un bref panorama des représentations et appréhensions à l'égard des traitements de substitution, avant que ces derniers n'aient été implantés dans les différents pays. Autrement dit, ce qu'il s'agit ici d'observer est la manière dont étaient perçue les nouveaux traitements apportés aux toxicomanes avant leur implantation effective. En raison du faible nombre de réponses obtenues, nous nous voyons contraint de procéder à une analyse globale, c'est à dire prenant en compte les résultats des différents pays dont les réponses ont été soumises à la même codification[6[6]].

De manière générale, ce qu'il ressort de l'analyse des différents questionnaires est qu'avant l'apparition de la réduction des risques et des traitements de substitution, les principaux risques perçus pour les toxicomanes étaient par ordre d'importance :

1. risque sanitaire (overdose, épidémie …)
2. risque social (stigmatisation, dévalorisation…)
3. risque psychiatrique (dont T.S…)
4. risque judiciaire (délinquance, emprisonnement …)

Face à ces risques, 100 % des réponses recueillies indiquent que le dispositif sanitaire alors en place était totalement insuffisant pour prévenir ces dangers. La perception des aspects insuffisamment pris en compte par ordre d'importance était :

1. l'aspect thérapeutique du problème,
2. l'aspect réduction des risques insuffisamment développée,
3. l'aspect social,
4. l'aspect préventif insuffisamment présent,
5. l'aspect répressif mal adapté à la situation.

La réduction des risques était globalement considérée :

1. comme une étape préalable à un processus devant conduire à une prise en charge sanitaire : 32 réponses,
2. comme un objectif à bas niveau d'exigence mais néanmoins adapté : 10 réponses,
3. comme une pratique d'incitation à l'usage de produits : 3 réponses,
4. sans opinions : 2 réponses.

Les objectifs perçus de la réduction des risques étaient :

1. la réduction des contaminations infectieuses
2. la diminution du nombre d'overdose
3. l'amélioration de l'accès aux soins et de l'insertion sociale
4. la réduction des comportements délictueux

[6[6]] Pour ce faire, nous avons établi un barème qui a consisté à comptabiliser, dans le cas de plusieurs réponses possibles, l'ordre de priorité donné par les enquêtés. Cet ordre a été converti en points nous offrant ainsi le nombre de réponses affectées à chaque choix.

Concernant les traitements de substitution, ils étaient globalement connus avant leur généralisation. Ainsi, 46 questionnaires sur 47 indiquent que les praticiens avaient une connaissance de leurs existences ainsi que de leurs finalités, contre 1 qui en connaissaient l'existence mais en ignoraient partiellement les buts. Ces traitements étaient perçus majoritairement comme des produits ayant comme objectif la réduction des risques. Les potentialités thérapeutiques de ces traitements sont citées en seconde intention. Une minorité percevaient plutôt des produits susceptibles de favoriser des comportements d'addictions (6 réponses). Beaucoup ont néanmoins pointé une appréhension à l'égard d'éventuelles dérives qu'ils pouvaient y avoir avec la substitution. Les risques identifiés ont été les suivants :

1. risque judiciaire (trafic illégal)
2. risque social (maintenance dans la dépendance)
3. risque sanitaire (injection sauvage) : essentiellement en France en relation avec l'usage du Subutex®.

Par ailleurs, la perception de la prescription de la substitution opiacée aux toxicomanes qui le désiraient était globalement perçue de manière :

1. 36 réponses favorable,
2. 10 réponses très favorables
3. 1 peu favorable.

Concernant les programmes d'échanges de seringues, ceux-ci étaient perçus :

4. 34 réponses très favorable,
5. 9 réponses favorables,
6. 4 peu favorables.

IV- Appréciation du dispositif.

L'objet de ce deuxième thème a été de mesurer l'appréciation des praticiens par rapport à la Réduction des risques et aux traitements de substitution à la lumière de leurs pratiques quotidiennes et des outils utilisés dans leurs institutions.

De manière générale, les traitements de substitutions sont perçus comme des outils importants de la réduction des risques (40 réponses positives) et qui devraient davantage être développés (32 réponses positives). Selon le pays, l'accessibilité à ces traitements diffère. La distribution est la suivante :

En Belgique :

a- Très bonne accessibilité	4
b- Bonne accessibilité	5
c- Accessibilité difficile	0
d- Accessibilité très difficile	0

Au Danemark :

a- Très bonne accessibilité	2
b- Bonne accessibilité	1
c- Accessibilité difficile	1
d- Accessibilité très difficile	0

En France :

a- Très bonne accessibilité	5
b- Bonne accessibilité	4
c- Accessibilité difficile	1
d- Accessibilité très difficile	0

En Italie

a- Très bonne accessibilité	5
b- Bonne accessibilité	3
c- Accessibilité difficile	1
d- Accessibilité très difficile	0

Au Portugal

a- Très bonne accessibilité	5
b- Bonne accessibilité	4
c- Accessibilité difficile	1
d- Accessibilité très difficile	0

Au Royaume-Uni :

a- Très bonne accessibilité	5
b- Bonne accessibilité	0
c- Accessibilité difficile	0
d- Accessibilité très difficile	0

Parmi les avantages attendus d'un traitement de substitution, les réponses des questionnaires s'articulent autour des thèmes suivants, cités par ordre d'importance :

1. accès aux soins, réduction des risques et stabilisation de l'usager : 47 réponses,
2. création d'un contact médico-socio-administratif : 42 réponses,
3. amélioration de l'insertion sociale et de la qualité de vie : 35 réponses.

Parmi les inconvénients perçus d'un traitement de substitution, les réponses des questionnaires s'articulent autour des thèmes suivants, cités par ordre d'importance :

1. durée du traitement : 41 réponses,
2. chronicisation du statut d'usager : 38 réponses,

3. risque de dépendance : 22 réponses,
4. marché noir (revente de produits) : 20 réponses,
5. risque d'accidents : 13 réponses.

Par ailleurs, l'appui psychothérapique et/ou psychosocial dans le cadre d'un traitement à la méthadone et/ou à la Buprénorphine est recommandés par 92 % des réponses obtenues. Pour ce qui est de la substitution par voie injectable, 15 praticiens trouvent qu'il s'agit d'une pratique permettant d'éviter certains échecs et certains risques. Cette solution mériterait à ce titre d'être développée. Cette hypothèse est avancée dans 25 questionnaires et en particulier dans les réponses venant du Royaume-Uni. De même, une proportion équivalente considère favorablement l'utilisation de l'héroïne dans le cadre d'un protocole thérapeutique (seul 6 réponses expriment une hostilité radicale à cette hypothèse).

V Dispositif de prise en charge.

L'objet de ce dernier thème a été de dresser un état des lieux des outils que les praticiens et/ ou leurs institutions ont mis en place dans le champ des dépendances. Il s'agit à cet effet de déterminer les choix qui les ont guidé dans l'utilisation de certains instruments de la réduction des risques ainsi que la manière dont ces instruments sont utilisés.

Tableau n° 10 : Outils de réduction des risques utilisés par les structures[7][7].

	Belgique	Danemark	France	Italie	Portugal	Royaume-Uni
Information pour l'éducation sanitaire	7	4	9	8	9	4
Distribution de produits de substitution	7	4	9	9	6	2
Contrôle de qualité des drogues consommées	1		1			
Existence de groupes d'auto-support et d'aide	2	1	1	1		2
Travail de rue	3		2	3	2	2
Echanges de seringues	2	1	4	4	4	3
Travail de consultation	9	3	6	6	10	3
Accueil bas-seuil	1		2	1	1	1

[7][7] Plusieurs réponses possibles.

Programme de réhabilitation			1	1	1	1

Tableau n°11 : Traitements de substitution prescrits dans les institutions[8][8]

	Belgique	Danemark	France	Italie	Portugal	Royaume-Uni
Méthadone	9	4	9	9	9	5
Buprénorphine haut dosage	2	2	6	2	4	2
Sulfate de morphine	0	0	1	0	0	0
Héroïne	0	0	0	0	0	1
LAAM	0	0	0	0	1 (2001)	0

Tableau n°12 : Parmi les traitements de substitution, lesquels sont ressentis comme ayant la plus grande efficacité[9][9]

	Belgique	Danemark	France	Italie	Portugal	Royaume-Uni
Méthadone	9	4	8	9	8	5
Buprénorphine haut dosage	2	1	5	2	2	1
Sulfate de morphine	0	0	0	0	0	0

[8][8] Plusieurs réponses possibles.
[9][9] Plusieurs réponses possibles.

Héroïne	2	1	1	2	0	2
LAAM	0	0	0	0	0	0

Tableau n°13 : Parmi les traitements de substitution, lesquels sont ressentis comme étant les plus contraignants[10][10]

	Belgique	Danemark	France	Italie	Portugal	Royaume-Uni
Méthadone	3	3	9	8	8	0
Buprénorphine haut dosage	1	1	1	3	6	0
Sulfate de morphine	3	0	3	3	4	1
Héroïne	0	0	0	0	0	3
LAAM	0	0	0	0	0	0

Caractéristique de la prescription de méthadone par pays :

En Belgique[11][11] :

Les neuf questionnaires indiquent (3 non prescripteur) que la prescription de méthadone est systématiquement soumis à un protocole d'admission. Les conditions les plus souvent évoquées sont :

- l'échec d'autres traitements (7 réponses) = échec d'au moins 1 traitement (5 réponses), échec d'au moins 2 traitements (2 réponses),
- l'âge (6 réponses) = avoir plus de 18 ans (5 réponses), avoir plus de 25 ans (1 réponse)
- l'ancienneté dans la dépendance (5 réponses) = au moins une demie année (1 réponse), au moins cinq années (1 réponse)

selon le produit de prédilection (héroïne, cocaïne…) = (8 réponses)

[10][10] Plusieurs réponses possibles.
[11][11] Plusieurs réponses possibles.

Le dosage moyen de prescription est établie entre 40 mg et 80 mg. La prescription se fait le plus souvent à long terme (2 réponses). De plus, la prescription est généralement suivie d'un accompagnement psychosocial (6 réponses pour *oui toujours*). Par ailleurs, la prescription est quasi-systématiquement suivie d'un contrôle pour éviter les mésusages et détournements de produits (6 réponses ont répondu *toujours*, 3 *parfois*) pour éviter les risques suivants :

Surconsommation, surdosage et risque vital (6 réponses)
Stockage, revente et marché noir (3 réponses)

Pour ce faire, le contrôle s'effectue généralement par :

Un contrôle biologique (5 réponses)
Une prise de traitement vérifié en consultation (2 réponses)

Au Danemark[12][12] :

Les quatre questionnaires indiquent que la prescription de méthadone est systématiquement soumise à un protocole d'admission. Les conditions les plus souvent évoquées sont :

l'âge (avoir plus de 18 ans) = 4 réponses
la dépendance aux opiacés (4 réponses).

Le dosage moyen de prescription est établi entre 80 mg et 160 mg. La prescription se fait le plus souvent à long terme (3 réponses). De plus, la prescription est suivie d'un accompagnement psychosocial (4 réponses). Par ailleurs, la prescription n'est pas systématiquement suivie d'un contrôle pour éviter les mésusages et détournements de produits (3 réponse pour *parfois*, 1 réponse pour *jamais*). Les risques identifiés sont les suivants :

Surconsommation (3 réponses)
Revente et marché noir (2 réponse)

Pour ce faire, quand il y a un contrôle il s'effectue par :

Discussion régulière avec l'usager (3 réponses)
Une prise de traitement vérifié en consultation (2 réponses)

En France[13][13] :

Les dix questionnaires indiquent que la prescription de méthadone est systématiquement soumise à un protocole d'admission. Les conditions les plus souvent évoquées sont :

la dépendance aux opiacés (10 réponses).

[12][12] Plusieurs réponses possibles.
[13][13] Plusieurs réponses possibles.

l'âge (avoir plus de 18 ans) = 8 réponses

Le dosage moyen de prescription est établie entre 60 mg et 80 mg . La prescription se fait à long terme (9 réponses) et à moyen terme (1 réponses). De plus, la prescription est généralement suivie d'un accompagnement psychosocial (9 réponses pour *oui toujours*, 1 pour *parfois*) et peut donner lieu à un contrôle pour éviter les mésusages et détournements de produits (8 réponses ont répondu *toujours*, 2 *parfois*) pour éviter les risques suivants :

Détournement et abus (10 réponses)

Pour ce faire, le contrôle s'effectue généralement par :

Un contrôle biologique (6 réponses)
Une prise de traitement vérifié en consultation (6 réponses)

<u>En Italie[14][14] :</u>

Les neufs questionnaires indiquent que la prescription de méthadone est soumise à un protocole d'admission. Les conditions évoquées sont :

la dépendance aux opiacés (9 réponses)
Etre dépendant depuis au moins 3- 4 ans(6 réponses)

Le dosage moyen de prescription est établi 200 mg. La prescription se fait à moyen terme. De plus, la prescription est *parfois* suivie d'un accompagnement psychosocial. Par ailleurs, la prescription donne lieu à un contrôle pour éviter les mésusages et détournements pour éviter le risque suivant :

Détournement et abus (9 réponses)

Pour ce faire, le contrôle s'effectue par :

Une prise de traitement vérifié en consultation (5 réponses)
Un contrôle biologique (5 réponses)

<u>Au Portugal[15][15] :</u>

Les dix questionnaires indiquent que la prescription de méthadone est systématiquement soumise à un protocole d'admission. Les conditions les plus souvent évoquées sont :

- l'échec d'autres traitements (9 réponses) = échec d'au moins 1 traitement (2 réponses), échec d'au moins 3 traitements (9 réponses),

[14][14] Plusieurs réponses possibles.
[15][15] Plusieurs réponses possibles.

- l'âge (8 réponses)= avoir plus de 18 ans (3 réponses), avoir plus de 21 ans (2 réponses)
- l'ancienneté dans la dépendance (9 réponses) = au moins trois années (6 réponses), au moins une année (1 réponse)
- selon le produit de prédilection (héroïne, opiacés …) = (10 réponses)

Le dosage moyen de prescription est établie entre 45 mg et 80 mg . La prescription se fait le plus souvent à long terme (9 réponses) pour 2 à moyen terme. De plus, la prescription est généralement suivie d'un accompagnement psychosocial (10 réponses pour *oui toujours*) et donne lieu à un contrôle pour éviter les mésusages et détournements de produits (9 réponses ont répondu *toujours*) pour éviter les risques suivants :

Surconsommation, surdosage et risque vital (9 réponses)

Pour ce faire, le contrôle s'effectue généralement par :

Un contrôle biologique (9 réponses)
Une prise de traitement vérifié en consultation (6 réponses)
Dialogue avec l'usager (6 réponses)
Contrôle à domicile (1 réponse)

Au Royaume-Uni[16][16] :

Les cinq questionnaires indiquent que la prescription de méthadone est soumise à un protocole d'admission. Les conditions évoquées sont :

la dépendance aux opiacés (5 réponses)
Etre dépendant depuis au moins 1 an (4 réponses)
Etre âgée de plus de 16 ans (5 réponses).

Le dosage moyen de prescription est établi à 50 mg. La prescription se fait à long terme. De plus, la prescription est *parfois* suivie d'un accompagnement psychosocial (3 réponses) et est accompagnée d'un contrôle pour éviter les mésusages et détournements pour éviter les risques suivants :

Surconsommation (5 réponses)
Revente (4 réponses)

Pour ce faire, le contrôle s'effectue par :

Une prise de traitement vérifié en consultation (3 réponses)
Un contrôle biologique (3 réponses)
Dialogue avec l'usager (3 réponses)

Caractéristique de la prescription de Buprénorphine par pays :

[16][16] Plusieurs réponses possibles.

En Belgique[17][17] :

Les questionnaires indiquent que la prescription de buprénorphine est systématiquement soumise à un protocole d'admission. Les conditions les plus souvent évoquées sont :

l'âge (9 réponses) = avoir plus de 18 ans (7 réponses)
l'ancienneté dans la dépendance (7 réponses) = au moins une demie année (1 réponses)

Le dosage moyen de prescription est établie entre 2 mg et 4 mg . La prescription se fait à moyen terme (1 réponse) et à court terme (4 réponse). De plus, la prescription est suivie d'un accompagnement psychosocial (4 réponses pour *oui toujours*) et peut être accompagnée d'un contrôle pour éviter les mésusages et détournements de produits pour 1 réponse.
Les risques identifiés sont :

Mésusage (6 réponses)
Revente du produit (3 réponses)

Pour ce faire, le contrôle s'effectue généralement par :

Une prise de traitement vérifié en consultation (2 réponses)

Au Danemark[18][18] :

Les questionnaires indiquent que la prescription de buprénorphine est systématiquement soumise à un protocole d'admission. Les conditions les plus souvent évoquées sont :

l'âge (4 réponses) = avoir plus de 18 ans (4 réponses)
la dépendance aux opiacées (4 réponses)

Le dosage moyen de prescription est établie entre 4 mg et 8 mg . La prescription se fait à long terme (2 réponses) et à court terme (2 réponses) et est suivie d'un accompagnement psychosocial (3 réponses pour *oui toujours,* 1 réponse *non renseignée*). Elle peut être accompagnée d'un contrôle pour éviter les mésusages et détournements de produits pour 2 réponse.

Les risques identifiés sont :

Mésusage (4 réponses)
Revente (2 réponses)
Injection (3 réponses)

Pour ce faire, le contrôle s'effectue généralement par :

[17][17] Plusieurs réponses possibles.
[18][18] Plusieurs réponses possibles.

Une prise de traitement vérifié en consultation (2 réponses)
Discussion avec l'usager (4 réponses)

En France[19][19] :

Les questionnaires indiquent que la prescription de buprénorphine n'est pas systématiquement soumise à un protocole d'admission puisque ce produit peut être prescrit en première intention par les médecins généralistes. Les conditions les plus souvent évoqués sont :

dépendance aux opiacés (10 réponses)
l'âge avoir plus de 18 ans (9 réponses)

Le dosage moyen de prescription est établi à 8 mg. La prescription se fait à moyen terme (3 réponses) et à long terme (7 réponses). Elle est suivie d'un accompagnement psychosocial (6 réponses pour *oui toujours*). Par ailleurs, la prescription est *parfois* (3 réponses, 1 pour *toujours*) suivie d'un contrôle pour éviter les mésusages et détournements de produits. Les risques identifiés sont :

Injection (8 réponses)
Mésusage (7 réponses)
Revente (4 réponses)

Pour ce faire, le contrôle s'effectue généralement par :

Une prise de traitement vérifié en consultation (3 réponses)

En Italie[20][20] :

Les questionnaires indiquent que la prescription de buprénorphine est systématiquement soumise à un protocole d'admission. Les conditions les plus souvent évoquées sont :

L'ancienneté dans la dépendance (9 réponses) = au moins trois années (2 réponses)
dépendance aux opiacés (9 réponses)
l'âge avoir plus de 18 ans (8 réponses).

Le dosage moyen de prescription est établie entre 8 mg et 12 mg. La prescription se fait à long terme (8 réponses). Elle est suivie d'un accompagnement psychosocial (8 réponses pour *oui toujours*). Par ailleurs, elle est accompagnée d'un contrôle pour éviter les mésusages et détournements de produits (3 réponses pour toujours, 5 réponses pour *parfois)*. Les risques identifiés sont :

Injection (7 réponses)

[19][19] Plusieurs réponses possibles.
[20][20] Plusieurs réponses possibles.

Mésusage (7 réponses)
Revente (4 réponses)

Pour ce faire, le contrôle s'effectue généralement par :

Une prise de traitement vérifié en consultation (4 réponses)
Un contrôle biologique (3 réponses)

Au Portugal[21][21] :

Les questionnaires indiquent que la prescription de buprénorphine est systématiquement soumise à un protocole d'admission. Les conditions les plus souvent évoquées sont :

l'âge avoir plus de 18 ans (8 réponses) avoir plus de 21 ans (2 réponses) dépendance à l'héroïne (10 réponses) dépendance à l'héroïne et à la cocaïne (4 réponses) ancienneté dans la dépendance (6 réponses)

Le dosage moyen de prescription est établi à 8 mg. La prescription se fait à long terme (7 réponses), à moyen terme (2 réponses) et à court terme (1 réponse). De plus, la prescription est suivie d'un accompagnement psychosocial (10 réponses pour *oui toujours*) et est systématiquement suivie d'un contrôle pour éviter les mésusages et détournements de produits. Les risques identifiés sont :

Injection (6 réponses)
Mésusage (6 réponses)
Revente (4 réponses)

Pour ce faire, le contrôle s'effectue généralement par :

Une prise de traitement vérifié en consultation (7 réponses)
Un contrôle biologique (6 réponses)
Un contrôle familiale (2 réponses)

Au Royaume-Uni[22][22] :

Les questionnaires indiquent que la prescription de buprénorphine est soumise à un protocole d'admission. La condition évoquée est :

la dépendance aux opiacés.

Le dosage moyen de prescription est établi 8 mg. La prescription se fait le plus souvent à moyen terme (4 réponses). Elle est *parfois* suivie d'un accompagnement psychosocial (4 réponses) et accompagnée d'un contrôle pour éviter les mésusages et détournements (3 réponses) pour éviter les risques suivants :

[21][21] Plusieurs réponses possibles.
[22][22] Plusieurs réponses possibles.

Injection (2 réponses)
Mésusage (2 réponses)
Revente (2 réponses)

Pour ce faire, le contrôle s'effectue par :

Une prise de traitement vérifié en consultation (1 réponse)
Un contrôle biologique (1 réponse)

Caractéristique de la prescription d'autres produits de substitution par pays :

En Belgique, prescription de Rivotril (3 réponses). Dosage moyen de 4 mg. Prescription toujours suivie d'un accompagnement psychosocial. Prescription également de Méthylphénidiate (2 réponses). Dosage moyen de 40 mg. Prescription toujours suivie d'un accompagnement psychosocial.

En France, prescription de Skénan (2 réponses). Dosage moyen de 600 mg. Prescription toujours suivie d'un accompagnement psychosocial.

Au Portugal, prescription de LAAM de 1994 à 2000 (1 réponse). Programme suspendu depuis. Pas d'autres renseignements.

Au Royaume Uni, prescription d'héroïne (1 réponse). Dosage moyen 300 mg. Prescription suivie occasionnellement d'un accompagnement psychosocial.

Accessibilité aux produits, pratique d'échange de seringue et prescription d'antagoniste :

En Belgique :

Il n'existe pas de liste d'attente pour les produits de substitution (9 réponses) et leurs usages est très majoritairement gratuit (8 oui, 1 non). Par ailleurs deux structures pratiquent l'échange de seringue et la reconnaissent comme une pratique courante. Aucune de ces structures ne prescrit des antagonistes.

Au Danemark :

Il n'existe pas de liste d'attente pour les produits de substitution (4 réponses) et leurs usages est gratuit (4 réponses). Par ailleurs une structure pratique l'échange de seringue bien qu'il ne s'agisse pas d'une pratique courante. Aucune de ces deux structures ne prescrit des antagonistes.

En France :

Sur dix questionnaires (1 non renseignée sur cette partie), l'usage des traitements de substitution est gratuit (9 réponses). En revanche, deux structures sur quatre ont une liste d'attente pour la prescription de méthadone d'un délai inférieur à 3 mois. Par

ailleurs trois structures pratiquent l'échange de seringue et deux d'entre elles la reconnaissent comme une pratique courante. Aucune de ces structures ne prescrit des antagonistes (1 réponse seulement indique une prescription occasionnelle.

En Italie :

Sur neuf questionnaires, l'usage des traitements de substitution est gratuit (9 réponses). En revanche, une structure sur quatre a une liste d'attente pour la prescription de méthadone d'un délai inférieur à 3 mois. Par ailleurs trois structures sur quatre pratiquent l'échange de seringue et la reconnaissent comme une pratique courante (3 réponses). Deux structures prescrivent des antagonistes.

Au Portugal :

Sur dix questionnaires (1 non renseignée), l'usage des traitements de substitution est gratuit (9 réponses). En revanche, trois structures sur six ont une liste d'attente pour la prescription de méthadone d'un délai compris entre 3 mois et 1 an. Par ailleurs aucune structure ne pratique l'échange de seringue. Quatre structures prescrivent des antagonistes (Naltrexone).

Au Royaume-Uni :

Sur 5 questionnaires (dont un non renseigné), l'accès au traitements de substitution est gratuit et comporte un délai de 3 mois à 1 an. Trois structures pratiquent l'échange de seringue, qui est reconnue comme une pratique courante. La prescription d'antagoniste est rare mais existe.

Annexes

Annexe 1

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Annexe 2

Version Française.

Toxicomanie Europe Echanges Etudes
(T3E)
Projet substitution 2002-2003.

Lettre d'accompagnement à la passation du questionnaire.

Vous trouverez ci-joint le questionnaire T3E concernant les pratiques professionnelles (réduction des risques et traitements de substitution) en matière de toxicomanie. Validé par le comité de pilotage de T3E, nous procédons ici à la deuxième étape du travail qui consiste à dispatcher ce questionnaire au sein de 6 pays européens.

Apparaissant comme les référents nationaux, nous vous demandons de bien vouloir le remplir (pour ceux qui ne l'ont pas déjà fait) et de le diffuser à vos réseaux, c'est à dire aux professionnels avec qui vous êtes en contact dans le champ de la toxicomanie. Merci de le diffuser aussi rapidement que possible aux professionnels concernés.

En raison du calendrier qui est le nôtre, nous avons convenu d'une date limite de retour (**22 Avril 2003**) afin de pouvoir rester dans les temps et d'anticiper d'éventuelles rencontres avec certains d'entre vous.

Aussi, nous vous remercions de l'intérêt que vous lui porterez et vous prions de bien vouloir le retourner aussi vite que possible aux adresses suivantes :

Méthodologie :

Pour ce faire, et après la sélection de professionnels européens travaillant dans le cadre de la Réduction des risques et des traitements de substitution, le choix de l'envoi de ce questionnaire fermé s'est imposé. Ce dernier se décompose en trois parties et a pour objectif de rendre compte à la fois : - de vos pratiques quotidiennes en matière de Réduction des risques et des traitements de substitution (thème n°1), - de la perception que vous avez de ces traitements à la lumière de votre expérience et pratique actuelle (thème n°2), - et enfin de vos représentations concernant la Réduction des risques et des traitements de substitution avant que vous vous y soyez engagés (thème n°3) [23][23].

Identification

Portrait enquêté :

Initiales de votre nom-prénom[24][24] :

1. Sexe masculin
féminin

2. Age

3. Coordonnées :

- Ville d'exercice de votre activité :
- Pays d'exercice

4. Profession :

[23][23] Ce travail d'enquête exploratoire sera suivi dans les mois à venir d'une rencontre dans trois pays ayant participé à ce questionnaire, dans le but de rendre compte de manière plus précise et moins directive des pratiques mises en œuvre.

[24][24] Facultatif. Nous rappelons néanmoins que le traitement de ce questionnaire se fera de manière anonyme.

- prescripteur statut :
- non prescripteur statut :

champ social
champ psychologique
champ para-médical
autres professionnels
veuillez préciser :

5. Depuis combien de temps exercez-vous une activité auprès de toxicomanes ?

Moins de 5 ans
De 5 à 10 ans
Plus de 10 ans

6. Depuis combien de temps exercez-vous une activité dans une institution travaillant dans le cadre de la Réduction des risques et/ ou des traitements de substitution ?

Moins de 5 ans
De 5 à 10 ans
Plus de 10 ans

7. Depuis quand estimez-vous que votre gouvernement s'est engagé dans la Réduction des Risques[25][25] et/ ou des traitements de substitution ?

Moins de 5 ans
De 5 à 10 ans
Plus de 10 ans

8. Dans quels types de structure travaillez-vous ?

- Structure spécialisée
  Centre ambulatoire
  Centre résidentiel
  Autres (veuillez préciser)

- Structure non spécialisée :
  Hôpital
  Urgence
  Centre social généraliste
  Exercice médical généraliste
  Autres (veuillez préciser)

9. Quel est le nom de votre structure ?

Quelles sont les missions de votre structure ? (Lister les tâches en lien avec la toxicomanie).

A-
B-
C-
D-

10. Exercez-vous en :
en région urbaine

[25][25] « *Les stratégies de Réductions des risques peuvent être définies comme toutes les actions individuelles et collectives, médicales, sociales, visant à minimiser les effets négatifs liés à la consommation des drogues dans les conditions juridiques et culturelles actuelles* », A. MINO., « Les nouvelles politiques de la drogue : exemple genevois », Psychiatrie de l'enfant, 1994, 37, (2), 577-600.

en région péri-urbaine
en région rurale

I- Dispositif de prise en charge.

L'objet de ce premier thème est de chercher à dresser un état des lieux des outils que vous et votre institution avez mis en place dans le champ des dépendances. Il s'agit à cet effet de déterminer les choix qui vous ont guidé dans l'utilisation de certains instruments de la Réduction des risques ainsi que la manière dont ces instruments sont utilisés.

11. Parmi les outils de la Réduction des risque, quel(s) outil(s) sont utilisés par votre structure ? (Indiquez les instruments du plus utilisé (choix n°1, n°2…) au moins utilisé (choix n°5…).°

- Information pour l'éducation sanitaire (plaquettes, tracts, etc..) choix n°
- Distribution de produits de substitution choix n°
- Contrôle de la qualité des drogues consommées choix n°
- Existence de groupes d'Autosupport et d'Aide par les pairs choix n°
- Travail de rue choix n°
- Autres (Veuillez préciser) choix n°

12. Parmi les traitements de substitution énoncés ci-dessous, lesquels sont prescrits dans votre institution ? (Indiquez les produits du plus utilisé (choix n°1, n°2…) au moins utilisé (choix n°5…).°

Méthadone choix n°

Buprénorphine haut dosage choix n°

Sulfate de morphine choix n°

Héroïne choix n°

LAAM choix n°

Autres (veuillez préciser) choix n°

12.1 Parmi les traitements de substitution, lesquels ont, selon vous, la plus grande efficacité ?

- Produit n°1 :
- Produit n°2 :
- Produit n°3 :

12.2 Parmi les traitements de substitution, lesquels vous paraissent les plus contraignants pour l'usager ?

- Produit n°1 :
- Produit n°2 :
- Produit n°3 :

13. Si vous prescrivez de la Méthadone :

13.1 *Existe t-il un protocole d'admission ?*

oui non

13.2 *Si oui, quelles en sont les conditions ?*
(cochez les cases correspondants aux critères et précisez en fonction des critères retenus)

- Age Avoir plus de ans.

- Produit de prédilection Quel(s) produit(s) ?

- Ancienneté dans la dépendance Etre dépendant depuis plus de années.

- Echec d'autres traitements Avoir suivi et interrompu au moins traitements.

- Autre (veuillez préciser) :

13.3 Cadre de prescription et de délivrance :

13.3.1 Quel est le dosage moyen ? mg.

13.3.2. La prescription est-elle plus souvent à : long terme
moyen terme
court terme

13.4 La prescription est-elle contrôlée pour éviter les mésusages et le détournement du produit ?

a- oui toujours
b-parfois
c- non jamais

- Si vous avez coché l'item a ou b, quels risques principaux avez-vous identifiés ?

Risque 1 :
Risque 2 :

Si vous avez coché l'item a ou b, de quelle manière s'effectue le contrôle ?

Prise du traitement vérifiée en consultation
Contrôle biologique
Autres (veuillez préciser) :

13.5 La prescription est-elle suivie d'un accompagnement psychosocial ?

a- oui toujours
b-parfois
c- non jamais

14. Si vous prescrivez de la Buprénorphine haut dosage :

14.1 *Existe t-il un protocole d'admission ?*

oui non

14.2 *Si oui, quelles en sont les conditions ?*
(cochez les cases correspondants aux critères et précisez en fonction des critères retenus)

- Age Avoir plus de ans.

- Produit de prédilection Quel(s)produit(s) ?

- Ancienneté dans la dépendance Etre dépendant depuis plus de années.

- Echec d'autres traitements Avoir suivi et interrompu au moins traitements.

- Autre (veuillez préciser)

14.3 Cadre de prescription et de délivrance :

14.3.1 Quel est le dosage moyen ? mg.

14.3.2. La prescription est-elle plus souvent à : long terme
moyen terme
court terme

14.4 La prescription est-elle contrôlée pour éviter les mésusages et le détournement du produit ?

a- oui toujours
b-parfois
c- non jamais

- Si vous avez coché l'item a ou b, quels risques principaux avez-vous identifiés ?

Risque 1 :
Risque 2 :

- Si vous avez coché l'item a ou b, de quelle manière s'effectue le contrôle ?

Prise du traitement vérifiée en consultation
Contrôle biologique
Autres (veuillez préciser)

14.5 La prescription est-elle suivie d'un accompagnement psychosocial ?

a- oui toujours
b-parfois
c- non jamais

15. Si vous prescrivez un autre traitement de substitution :

Lequel :

15.1 Existe t-il un protocole d'admission ?

oui non

15.2 Si oui, quelles en sont les conditions ?
(cochez les cases correspondants aux critères et précisez en fonction des critères retenus)

- Age Avoir plus de ans.

- Produit de prédilection Quel(s) produit(s) ?
- Ancienneté dans la dépendance Etre dépendant depuis plus de années.

- Echec d'autres traitements Avoir suivi et interrompu au moins traitements.

Autre (veuillez préciser) :

15.3 Cadre de prescription et de délivrance :

15.3.1 Quel est le dosage moyen ? mg.

15.3.2. La prescription est-elle plus souvent à : long terme
moyen terme
court terme

15.4 La prescription est-elle contrôlée pour éviter les mésusages et le détournement du produit ?

a- oui toujours
b-parfois
c- non jamais

- Si vous avez coché l'item a ou b, quels risques principaux avez-vous identifiés ?

Risque 1 :
Risque 2 :

Si vous avez coché l'item a ou b, de quelle manière s'effectue le contrôle ?

Prise du traitement vérifiée
Contrôle biologique
Autres (veuillez préciser) :

15.5 La prescription est-elle suivie d'un accompagnement psychosocial ?

a- oui toujours
b-parfois
c- non jamais

16. Dans votre structure, existe t-il une liste d'attente pour l'accessibilité aux produits de substitution ?

oui non

-Si oui, quel(s) produit(s) ce délai concerne :

- Si oui, le délai est-il :

Inférieur à 3 mois
Entre 3 mois et 1 an
Supérieur à 1 an

17. L'accessibilité à ces traitements est-elle gratuite ?

oui non

18. Si la personne est sous substitution, donnez vous des conseils et messages d'informations sur la Réduction des risques ?

oui non

19. Votre structure pratique t-elle l'échange de seringues ?

oui non

Si oui, est-ce une pratique courante ?

oui non

20. Prescrivez-vous des antagonistes ?

oui non

Si oui, dans quel(s) cas ?

II- Appréciation du dispositif.

L'objet de ce deuxième thème est de mesurer votre appréciation par rapport à la Réduction des risques et aux traitements de substitution à la lumière de votre pratique quotidienne et des outils utilisés dans votre institution.

21. Les traitements de substitution vous paraissent-ils des outils primordiaux de la Réduction des Risques ?

oui non

21.1 *Si oui, pensez-vous qu'ils devraient être développés davantage ?*

oui non

21.2 *Que pensez-vous de l'accessibilité à ces traitements ?*

a- Très bonne accessibilité
b- Bonne accessibilité
c- Accessibilité difficile
d- Accessibilité très difficile

21.3 Si vous avez répondu c ou d, quelle est la nature des difficultés rencontrées ?
(Plusieurs réponses possibles à indiquer par ordre d'importance)

- Absence de volonté politique
- Législation nationale en vigueur
- Obstacle idéologique
- Obstacle financier
- Obstacle technique
- Autres (veuillez préciser)

21.4 Quel impact principal voyez-vous à ces traitements ?
(Plusieurs réponses possibles à indiquer par ordre d'importance)

- la réduction des contaminations infectieuses
- la diminution du nombre d'overdoses
- l'amélioration de l'accès aux soins
- l'amélioration de l'insertion sociale
- la réduction des comportements délictueux
- autres(veuillez préciser)

22. Quels sont, selon vous, les deux ou trois avantages les plus significatifs d'un traitement de substitution ?

1.
2.
3.

23. Quels sont, selon vous, les deux ou trois inconvénients les plus significatifs d'un traitement de substitution ?

1.
2.
3.

24. Considérez-vous comme obligatoire l'appui psycho-thérapeutique dans le traitement avec :

-méthadone oui non
-buprénorphine oui non
-autres (veuillez préciser)

25. Considérez-vous comme obligatoire l'appui psychosocial dans le traitement sous :

-méthadone oui non
-buprénorphine oui non
-autres (veuillez préciser)

26. Considérez-vous que seul le système de soins doit contrôler l'administration des substitutifs opiacés ?

oui non

27. A la lumière de votre expérience, êtes-vous d'accord avec la substitution par voie injectable ?

oui non sans opinion

Si oui, pensez-vous qu'il devrait être davantage développé ?

oui non

Quelles en sont les raisons ?

28. Que pensez-vous de l'héroïne utilisé comme traitement thérapeutique dans certains pays européens ? y êtes-vous :

très favorable
favorable
peu favorable
pas du tout favorable

29. Pensez-vous que la finalité des traitements de substitution est l'abstinence ?

oui non sans opinion

III- Représentation des risques

L'objet de ce troisième thème est de chercher à comprendre la manière dont vous perceviez la Réduction des risques et les traitements de substitution avant que vous ayez eu une activité professionnel en ce domaine (pendant vos études, durant l'exercice d'une autre profession…)/ où avant que ces méthodes ne s'implantent dans votre pays. L'objectif est de saisir quelles étaient vos représentations et appréhensions à l'égard de ce nouveau paradigme dans le traitement apporté aux toxicomanes.

30. Selon vous, quels étaient, avant l'apparition de la Réduction des risques et des traitements de substitution, les principaux risques encourus par les toxicomanes ? (veuillez citer 3 risques du plus important au moins important)

Risque 1 :
Risque 2 :
Risque 3 :
Risque 4 :
Risque 5 :
Risque 6 :

31. Face à ces risques, le dispositif qui existait jusqu'alors vous semblait-il suffisamment adapté pour y faire face ?

oui non

Si non, quel(s) aspect(s) prenait-il insuffisamment en compte ? (plusieurs choix possibles par ordre d'importance)

Aspect préventif aspect n°

Aspect thérapeutique aspect n°

Aspect Réduction des Risques aspect n°

Aspect social aspect n°

Aspect familial aspect n°

Aspect répressif aspect n°

Autres (veuillez préciser) : aspect n°

32. Comment perceviez-vous la Réduction des risques ?

- comme une pratique d'incitation à l'usage de produits
- comme un objectif à bas niveau d'exigence mais adapté
- comme l'étape préalable d'un processus devant conduire à une prise en charge sanitaire

- je n'avais pas d'idée sur la question

33. Quels objectifs avaient, selon votre perception, une politique de Réduction des risques ? (veuillez classer par ordre d'importance)

- la réduction des contaminations infectieuses
- la diminution du nombre d'overdoses
- l'amélioration de l'accès aux soins
- l'amélioration de l'insertion sociale
- la réduction des comportements délictueux
- autres(veuillez préciser)

34. Aviez-vous déjà entendu parler des traitements de substitution ?

a- je n'avais aucune connaissance de l'existence des traitements de substitution
b- j'avais connaissance de leur existence sans en percevoir les finalités
c- j'en connaissais l'existence ainsi que les finalités

35. Si vous avez répondu à l'item *b* ou *c*, comment perceviez-vous ces traitements ?

a- comme des produits susceptibles de favoriser les comportements d'addictions
b- comme des produits n'ayant que des objectifs de Réduction des Risques

c- comme des produits ayant des objectifs de Réduction des Risques et d'autres effets thérapeutiques

36. Comment perceviez-vous la prescription de la substitution opiacée aux toxicomanes qui le désiraient ?

- de manière : très favorable
favorable
peu favorable
pas du tout favorable

37. Comment perceviez-vous les programmes d'échange de seringues ?

- de manière : très favorable
favorable
peu favorable
pas du tout favorable

38. Appréhendiez-vous les éventuelles dérives qu'il pouvait y avoir avec la substitution ?

oui non sans opinion

Si oui, quels risques appréhendiez-vous le plus ? (classer par ordre d'importance)

1. 26. risque sanitaire (injections sauvages) risque n°
2. 27. risque social (maintenance dans la dépendance) risque n°
3. 28. risque judiciaire (trafic illégal) risque n°
4. 29. autres (veuillez préciser) risque n°

Annexe 3

Version anglaise.

European Network T3E
Drug Addiction : Europe-Exchange-Training
Substitution Project 2002-2003.

Information letter

Please find enclosed the T3E questionnaire on professional practices (risk reduction and substitution treatments) in the field of addiction. After validation by the steering committee, this second stage of the project consists in sending out this questionnaire within 6 European countries.

As national referents, you are requested to kindly fill it in (for those who have not yet done so) and to circulate it among your networks, ie to the professionals with whom you are in contact in the field of addiction. We would be grateful if you would circulate it as quickly as possible to the relevant professionals.
In view of our schedule, a return date has been fixed (**22 April 2003**) in order to respect the deadline and anticipate any meetings with any of you.

We would therefore like to thank you for your interest and ask you to please return this questionnaire as soon as possible to the following addresses :
….

Method :

European professionals working within the framework of risk reduction and substitution treatments were selected, after which it was decided that a closed questionnaire should be sent. This questionnaire is divided into three parts and aims to give an account of : - your daily practice concerning risk reduction and substitution treatments (theme n° 1), - your perception of these treatments in the light of your experience and current practice (theme n° 2), - and finally your representations of risk reduction and substitution treatments before you became involved (theme n° 3)[26][26].

Identification

Respondent :

Initials of your surname and first name[27][27] :

1. Gender male
female
2. Age
3. Details :

- Town where you practise:
- Country where you practise :

4. Occupation :
- prescriber _ (specify)

- non prescriber (specify)
social field

[26][26] This exploratory study will be followed in the coming months by a meeting in three of the countries that have taken part in this questionnaire, in order to give a more specific and less directive account of the practices set up.

[27][27] Optional; we would nevertheless remind you that this questionnaire will be processed anonymously.

psychological field
paramedical field
other professionals (specify)

5. How long have you been working with addicts ?

Less than 5 years
Between 5 and 10 years
Other ten years

6. How long have you been working in an organisation involved in risk reduction and / or substitution treatments ?

Less than 5 years
Between 5 and 10 years
Over 10 years

7. How long do you consider your government has been committed to risk reduction[28][28] and / or substitution treatments ?

Less than 5 years
Between 5 and 10 years
Over 10 years

8. What type of organisation do you work in ?

- Specialised centre :
  Ambulatory care centre
  Residential centre
  Care centre
  Other (please specify)

- Non specialised centre :
  Hospital
  Emergency service
  General social centre
  General medical practice
  Other (please specify)

---

9. What is the name of your centre ?

What is your centre or organisation commissioned to do ? (List the tasks related to addiction).

A-
B-
C-
D-

10. Do you practise in :

an urban area
a peri-urban area
a rural area

---

[28][28] « Risk reduction strategies may be defined as any individual or collective medical or social action aimed at minimising the adverse effects linked with drug use in the current legal and cultural conditions», A. MINO, «New drug policies : the Geneva example», Psychiatrie de l'enfant, 1994, 37, (2), 577-600.

I- Care provision.

-

The aim of this first theme is to draw up an inventory of the tools that you and your organisation have set up to tackle dependency and thus define the choices behind the use of certain risk reduction tools and the way they are used.

11. Which of the risk reduction tools are used in your centre ? (Rank those most used (1st choice, 2nd choice…) to those least used (5th choice…).°

- Health education information (leaflets, pamphlets, TV commercials...) choice n°
- Distribution of substitute drugs choice n°
- Quality control of drugs used choice n°
- Existence of self-help and peer-support groups choice n°
- Outreach community work choice n°
- Other (Please specify) choice n°

12. Which of the following substitution treatments are prescribed in your centre ? (Rank those most used (1st choice, 2nd choice…) to those least used (5th choice…).°

Methadone choice n°
High-dose buprenorphine choice n°
Morphine sulphate choice n°
Heroin choice n°
LAAM choice n°
Other (please specify) choice n°

12.1 Which of the substitution treatments do you consider to be the most effective ?

- Substance n°1 :
- Substance n°2 :
- Substance n°3 :

12.2 Which of the substitution treatments do you see as most restrictive for the user ?

- Substance n°1 :
- Substance n°2 :
- Substance n°3 :

-

13. If you prescribe Methadone :

13.1 Is there an admission protocol ?

yes no

13.2 If so, what are the terms ?
(tick the boxes corresponding to the criteria and specify according to the criteria chosen)

- Age Over years of age.
- Preferred drug Which drug(s)?
- Duration of dependency Dependent for over years
- Failure of other treatments Having followed and given up at least treatments.
- Other (please specify) :

13.3 Framework for prescription and issue :

13.3.1 What is the average dose ? mg.

13.3.2. Is the prescription usually : long term
medium term
short term

13.4 Is there prescription control to avoid misuse and misapplication of the drug ?

a- yes always
b- occasionally
c- no never

- *If you ticked a or b, which major risks have you identified ?*

Risk 1 :
Risk 2 :

- If you ticked a or b, how is this control carried out ?

Treatment taken during consultation
Biological monitoring
Other (please specify)

13.5 Is the prescription followed by psychosocial counselling ?

a- yes always
b- occasionally
c- no never

14. If you prescribe high-dose Buprenorphine :

14.1 Is there an admission protocol ?

yes no

14.2 If so, what are the terms ?
(tick the boxes corresponding to the criteria and specify according to the criteria chosen)

- Age Over years of age.
- Preferred drug Whichdrug(s) ?
- Duration of dependency Dependent for over years
- Failure of other treatments Having followed and given up at least treatments.
- Other (please specify) :

14.3 Framework for prescription and issue :

14.3.1 What is the average dose ? mg.

14.3.2. Is the prescription usually : long term
medium term
short term

14.4 Is there prescription control to avoid misuse and misapplication of the drug ?

a- yes always
b- occasionally
c- no never

- If you ticked a or b, which major risks have you identified ?

Risk 1 :
Risk 2 :

If you ticked a or b, how is this control carried out ?

Treatment taken during consultation
Biological monitoring
Other (please specify)

14.5 Is the prescription followed by psychosocial counselling ?

a- yes always
b- occasionally
c- no never

15. If you prescribe another substitution treatment :

Which :

15.1 Is there an admission protocol ?

yes no

15.2 If so, what are the terms ?
(tick the boxes corresponding to the criteria and specify according to the criteria chosen)

- Age Over years of age.
- Preferred drug Which drug(s) ?
- Duration of dependency Dependent for over years
- Failure of other treatments Having followed and given up at least treatments.
- - Other (please specify) :

15.3 Framework for prescription and issue :

15.3.1 What is the average dose ? mg.

15.3.2. Is the prescription usually : long term
medium term
short term

15.4 Is there prescription control to avoid misuse and misapplication of the drug ?

a- yes always
b- occasionally
c- no never

- If you ticked a or b, which major risks have you identified ?

Risk 1 :
Risk 2 :

If you ticked a or b, how is this control carried out ?

Treatment taken during consultation
Biological monitoring
Other (please specify)

15.5 Is the prescription followed by psychosocial counselling ?

a- yes always
b- occasionally
c- no never

16. In your centre, is there a waiting list to have access to substitute drugs ?

yes no

If so, which drugs are concerned by this waiting time ?

- If so, is the waiting time :

Less than 3 months
Between 3 months and 1 year
Over 1 year

17. Is access to these treatments free ?

yes no

18. If the person is on substitution therapy do you still give advice and information about risk reduction ?

yes no

19. Does your centre exchange needles ?

yes no

If so, is this common practice ?

yes no

20. Do you prescribe antagonists ?

yes no

If so, in which case(s) ?

II-Assessment of provision

The aim of this second theme is to consider your assessment of risk reduction and substitution treatments in the light of your daily practice and the tools used in your centre.

21. Do you consider substitution treatments to be essential tools in risk reduction ?

yes no

21.1 *If so, do you think they should be more widespread ?*

yes no

21.2 *How do you rate the accessibility of such treatments ?*

Very good
Good
Difficult
Very difficult

21.3 *If you answered c or d, what sort of difficulties are encountered ?* (Several answers possible, to be ranked in order of importance)

- absence of political will
- current national legislation
- ideological obstacle
- financial obstacle
- technical obstacle
- other (please specify)

21.4 *In your view, what is the main impact of these treatments?* (Several answers possible, to be ranked in order of importance)

- the reduction in infectious contamination
- the decrease in the number of overdoses
- the improvement in access to care
- the improvement in social integration
- the reduction in criminal behaviour
- other (please specify)

22. In your opinion, what are the two or three main advantages of substitution treatments ?

1.
2.
3.

23. In your opinion, what are the two or three main drawbacks of substitution treatments ?

1.
2.
3.

24. Do you consider psycho-therapeutic counselling to be imperative in treatment with :

-methadone yes no
-buprenorphine yes no
-other (please specify)

25. Do you consider psycho-social counselling to be imperative in treatment with :

-methadone yes no
-buprenorphine yes no
-other (please specify)

26. In your opinion, should the health care system alone monitor the administration of opiate substitutes ?

yes no

27. From your own experience, do you agree with the administration of substitutes by injection ?

yes no don't know

If so, do you think it should be more widespread ?

yes no

If not, what are your reasons ?

28. What are your views on the use of heroin as treatment in some European countries ? Are you :

very much in favour
in favour
somewhat opposed
very much opposed

29. Do you consider that the aim of substitution treatments is abstinence ?

yes no don't know

III- Representation of risks

The purpose of this third theme is to comprehend how you viewed risk reduction and substitution treatments before you worked professionally in this field (while studying or working in another profession) / or before these methods were introduced into your country. The aim is to understand your representations and apprehensions of this "new" paradigm in the care of addicts.

30. In your view, what were the major risks incurred by addicts before the advent of risk reduction and substitution treatments ? (Please give 3 risks ranked from the most to the least important)

Risk 1 :
Risk 2 :
Risk 3 :
Risk 4 :
Risk 5 :
Risk 6 :

31. In view of these risks, did you consider the measures existing at that time to be appropriate ?

yes no

If not, which aspect(s) was / were not sufficiently taken into account ? (several choices possible, ranked in order of importance)

Preventive aspect
Therapeutic aspect
Risk reduction aspect
Social aspect
Family aspect
Repressive aspect
Other (please specify) :

32. How did you regard risk reduction ?

- as an incentive to drug use
- as an undemanding but adapted objective
- as a preliminary stage, prior to health care
- I had no opinion

33. What did you consider to be the aims of a risk reduction policy ? (please rank in order of importance)

- the reduction in infectious contamination
- the decrease in the number of overdoses
- the improvement in access to care

- the improvement in social integration
- the reduction in criminal behaviour
- other (please specify)

34. Had you already heard of drug substitution treatments ?

a- I did not know that substitution treatments existed.
b- I knew of them but did not appreciate their purpose.
c- I knew of them and of their purpose.

35. If you answered b or c, how did you view such treatment?

a- as drugs likely to promote addictive behaviour
b- as drugs aimed solely at risk reduction
c- as drugs aimed at both risk reduction and other therapeutic effects

36. What was your opinion of the prescription of opiate substitution to those addicts who requested it ?

very much in favour
in favour
not really in favour
not at all in favour

37. What was your opinion of needle exchange programmes ?

very much in favour
in favour
not really in favour
not at all in favour

38. Were you apprehensive of the possible deviations that may accompany substitution ?

yes no don't know

If so, which risks did you fear most ? (rank in order of importance)

5. 30. health risk (uncontrolled injection)
6. 31. social risk (maintaining state of dependency)
7. 32. legal risk (illegal trafficking)

- other (please specify)

ANNEXE 2.1.

GUIDELINES FOR MEETING THE NEEDS OF DRUG USERS FROM 'VISIBLE MINORITIES': **WHAT DRUG SERVICES & ALLIED INSTITUTIONS CAN DO BY USING EU's DIRECTIVES ON COUNTERING XENOPHOBIA & RACISM**

Introduction & Background

Towards the closing years of the last century there was a movement at the level of the European Parliament to implement the principle of equal treatment between persons, irrespective of racial or ethnic origin, and for establishing a general framework for equal treatment in employment and services across the then 15 EU Member states, Under Article 13 of the Treaty of Amsterdam the European Commission published proposals to take appropriate action to combat xenophobia and racism (November 1999). This was because of concerns that due to the existence of racism and xenophobia, the various "minorities' " populations in different EU countries, bedeviled by the daily experience of racism and xenophobia, were also experiencing disadvantage and discrimination in other spheres of life, notably in employment and in equitable access to public services.

There are now two directives[29] adopted and incorporated in that Treaty following ratification by the Council of Ministers and with the European Parliament. The first of these is an Employment Directive establishing a general framework for equal treatment in employment and occupation. The second, known as the Race Directive, is a proposal for implementing the principle of equal treatment of people, irrespective of ethnic or racial origin.

Our Project and its work has, over the years and in some significant ways, anticipated the directives by rigorously using conceptual and analytical tools provided by our historical association with the Race & Culture Policy Research Unit (RCPRU). This connection has so regularly been mentioned in our previous reports and writings that it is not worth labouring the

[29] Proposals for CEC Council Directives: **a)** COM (1999) 566 final, Implementing the principle of equal treatment between persons irrespective of racial or ethnic origin; **b**) COM (1999) 567 final, Establishing a Community Action Programme to combat discrimination 2001 - 2006; and, **c)** COM (1999) yyy final, Establishing a general framework for equal treatment in employment and education.

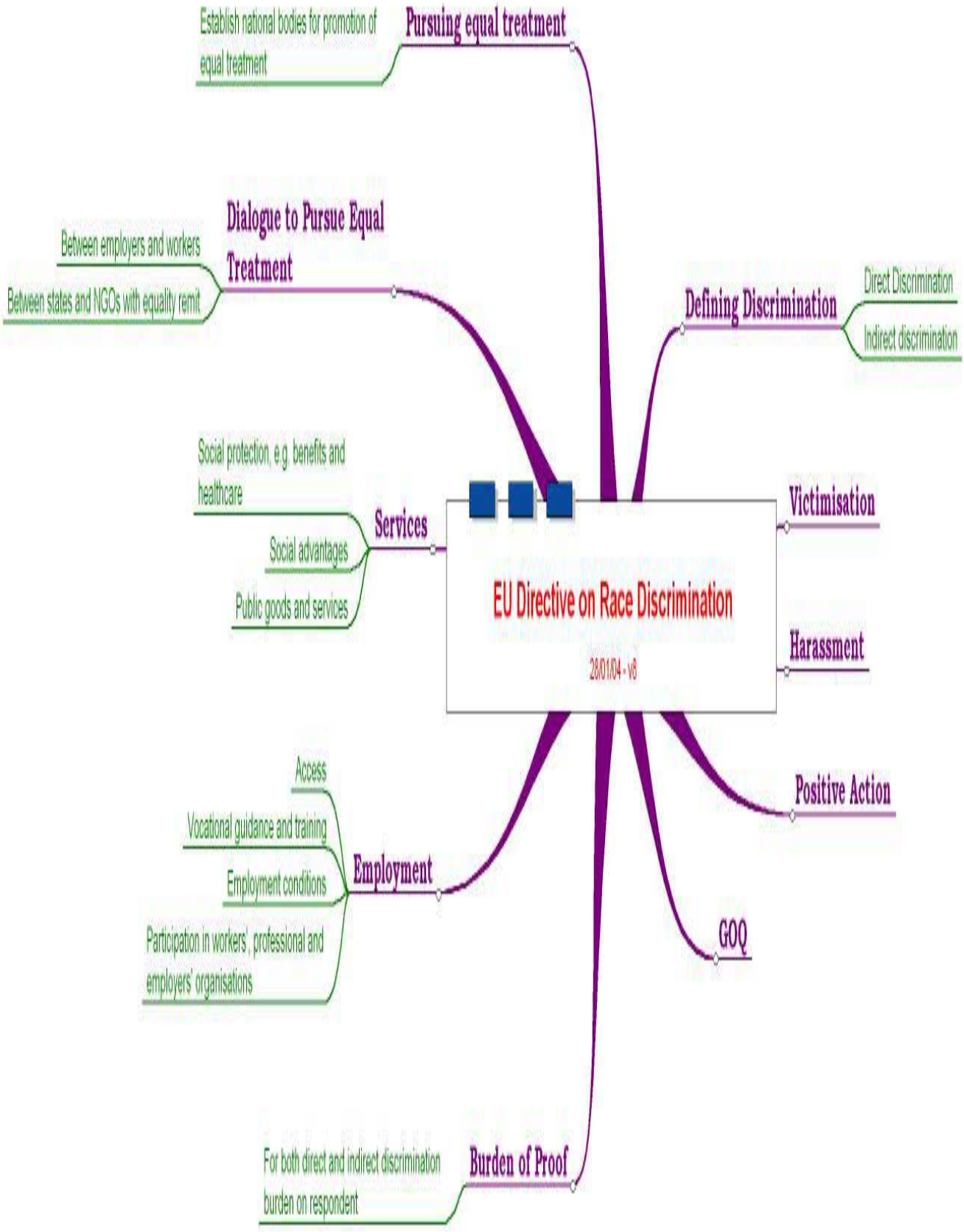
point again. However, suffice it to say, that it has given us the advantage in assisting agencies and organisations by somewhat anticipating the directives and helping drug services to take proactive steps to ensure that the principle of equal treatment (employment and services) in the field of drug abuse has been properly taken on board.

Over a number of years, T3E [UK] has been privileged by the support given to us by the European |Commission, to work with partners from different EU countries, who have been piloting our Action Points for Change document in order to refine them. It was a consensus view, emerging from this partnership, that these tried and tested guidelines be reproduced for the general benefit of drug prevention, care and treatment services across EU.

These guidelines consist of the following:

- A Mind Map of EU's anti-discriminatory legislation for combating racism and xenophobia
- Implications for drug services enabling them to get to grips with the key operational principles arising from this legislation
- The core actions identified by our partners for ensuring that required changes do come about in the agency's policies, procedures and practices
- Highlighting the action points or a series of prompts required once the core implementation and accountability structures are in place

Mind Map of EU Directive on Race Discrimination



2.a. Mind Map Explained

2.1. The EU Directive on Race Discrimination defines discrimination:

- It points out that discrimination can take a direct form by excluding someone because of their 'race', and that this is unlawful
- It also points out that indirect racial discrimination is also unlawful. In other words that actions and practices that register an adverse impact or outcome upon someone because of their 'race', national or ethnic origin, culture, etc., is also unlawful
- Any victimisation or harassment because of the person's 'race', national or ethnic origins, culture, etc. is further made unlawful
- The Directive also allows for Positive Action to be taken. This means that action that is designed to take into account past omissions and neglect in order to redress the situation is allowed by the targetting of policies in the spheres of employment and services, towards those who have previously been neglected or received poor access and services

2.2. Burden of Proof

In cases of direct and of indirect discrimination the EU Directive shifts the burden of proof on to the respondent. In other words, any agency or person accused of such offences has to show innocence. The burden of proof has now, under the Directive, shifted the onus from the accuser to the accused.

2.3. The Pursuit of Equal Treatment:

In order to ensure that the above mentioned aims are met, EU has also promised a Community Action Programme (2001-2006) that requires national governments to establish bodies for the promotion of equal treatment in their country. In UK, for example, this has meant the alignment of existing anti-discriminatory legislation with EU's own legislation. The British Government's consultation exercise on this process has already taken place.

2.4. Dialogue to Pursue Equal Treatment

The requirement to pursue equal treatment for all at the national level means that national bodies, established by the government of a Member State for the purpose, need to encourage dialogue about the EU Directives primarily between:

- Employers and workers,

and between

- States and NGOs with an equality remit

The dialogue thus established and pursued is to focus upon equality issues

2.5. Services

The EU Directive on Race Discrimination has the area of Services in mind as a major area of concern. The area of Services covers the following components:

Social Protection, for example benefits and healthcare
Social advantages, e.g, education
Public goods and services

2.6. The second major area of concern covered by the EU Directive is that of employment.

What this covers and implies are the following:

A. Access: to help ensure that there are equitable arrangements for access to services for all, and that those that are racially disadvantaged from access to employment do not face unreasonable barriers in the access to employment processes themselves.
B. Vocational Guidance and Training: to help ensure that appropriate guidance and training are made available to visible minorities to facilitate their entry into employment.
C. Employment Conditions: this means that equality issues do form an integral part of the conditions of work and ensure that visible minority workers do not suffer disadvantage and discrimination once they are in work, and that they continue to receive the same benefits in terms of wages, holiday leave, maternity leave, professional development, promotion, and pensions as do white workers.
D. Participation: in workers' professional and employment organisations, such as trades unions and employer's organisations

Implications for Drug Services

It is perhaps not necessary for us to spell out in detail just what the EU Directive means in terms of policy, procedure and practice for agencies and organisations providing drug prevention, care and treatment services. The implications are fairly easily drawn from what has been explained above. They are also covered in some detail in Sections 3 and 4 of these guidelines. What we will discuss here are some general implications specific to the drugs field. These are based upon our research and findings, on the initiatives and actions taken by our partners, as well as upon a general survey of available and relevant literature.

3.1. The need for race equality in the drugs field

The same principles as laid down generally by the EU Directives on combating racism and xenophobia, and for the provision of equal treatment apply because:

3.1.1. A mapping survey for EMCDDA that we carried out with partners from all EU countries - except for Sweden, where we were not able to identify a partner - made it clear that very little data was available, and only from some countries, for constructing an epidemiology of drug use amongst EU's "minorities". The term "minorities" was used by EMCDDA to include and cover those of non-European national origin, gypsies and travelers, refugees and asylum seekers, and Jewish people.

3.1.2. This confirmed the findings of in-depth qualitative and quantitative studies we had earlier carried out in seven EU countries, for the EC (1995-96 and 1996-97). In these we tried to assess the extent to which the needs of drug users from visible minorities were being met, and how?

3.1.3. Our analyses revealed that very little was being done in a systematic and structured way; that what was being done depended usually upon the initiatives of individual workers, usually from a visible minority themselves; and, that it was *ad hoc,* and, therefore, likely to prove ephemeral because the individuals members of staff responsible were not guaranteed to stay with one agency or organisation for very long.

3.1.4. We found this situation to be both surprising and not surprising. The former because those working with drug users work with those who are already stigmatised and excluded because of their drug use. Their work is often difficult and unrewarding, but it also involves a strong advocacy role on behalf of drug users, raising issues of rights and social justice. We would, therefore, have

thought that drug services working at the margins of social inclusion and exclusion would have been alert to the fact that visible minority drug users also needed services and provided such services. However, we are also aware that the discourse on drugs is seemingly and inextricably intertwined with that on 'race'. As one notable text poignantly observes about this phenomenon:

"The styles change; so do the issues. The grand themes may, regrettably, be more endurable. Although the undiluted racial venom has been flushed out of the dope discourse, drugs still provide a way to articulate racist themes in code. They act as a discursive alarm bell – halt the debate, declare war, take cover. In such an atmosphere, associations between drugs and a particular ethnic group may become more important than the underlying reasons for those associations. Now that racist themes are largely confined to the subtext of public debate, the payload can be transferred to drugs: the menace implicit in 'black' is shifted to 'crack'.

"In its more general lines, the drug problem today retains much of the earlier xenophobic geometry. The theme of foreign criminal conspiracies is accompanied by a profound anxiety about the violation of national boundaries by smugglers; the discourse is dominated by metaphors of war and disease – the 'war on drugs', the 'drug plague'. Drugs remain the 'other', and arouse the same passions in the Western subconscious, as does the non-European Other. Mrs. Thatcher once spoke, notoriously, about British fears of being 'swamped' by an alien culture; the media speak incessantly of being 'swamped' by a 'flood' or a 'tidal wave' of drugs."[30]

The racialised images of drugs can and do interfere with the work of drug services and can become an obstacle to the provision of equitable services, but it need not do so. THERE IS NOTHING INTRINSIC ABOUT THE 'NATURE' OR 'CULTURES' OF VISIBLE MINORITIES THAT DISPOSES THEM TO USE DRUGS. THE POINT IS SIMPLY THIS: IT IS WIDELY ACKNOWLEDGED THAT THERE IS NO KNOWN SOCIETY THROUGHOUT HUMAN HISTORY WHERE DRUGS HAVE NOT BEEN USED. IN ALL SOCIETIES THERE HAVE ALSO BEEN KNOWN TO EXIST FORMS OF SOCIAL, RELIGIOUS AND CULTURAL SANCTIONS AND CONTROLS FOR USING DRUGS. SOME CORE ACTIONS NEED TO BE TAKEN TO ENSURE THAT THE CIVIL RIGHTS OF VISIBLE MINORITY DRUG USERS ARE NOT OVERLOOKED SIMPLY BECAUSE OF IMAGES CONJURED UP BY STEREOTYPES THAT INTERFERE AND ACT AS OBSTACLES IN THE WORK OF DRUG SERVICES.

3.1.5. Our partner's voice:

During the final session of the final meeting with our partners in Bologna, during October 2002, a major concern was registered about the situation facing EU's visible minorities in the wake of the calamitous events of 2 September 2001. It was pointed out by Jan Lawalata, our partner from the Netherlands, that the feelings of insecurity and anxiety amongst all visible minorities had increased considerably, but particularly amongst those who were Muslims or bore Muslim names. He pointed out that

[2] Kohn M. Dope Girls: The Birth of the British Drug Underground, Lawrence & Wishart (1992)

attacks were on the increase and that settled minorities were being made to feel unwelcome. This concern was unanimously echoed by all the partners and given as a primary reason for the continuation of the kind of work we were all engaged in, its wider dissemination within countries and across other EU countries with identified new partners.

Core Actions for ensuring race equality within the drugs field

Our work with partners and its evaluation over a number of years has identified a number of actions that have helped to ensure that equality issues are embedded in and integral to the working of an organisation. However, our partnership work has also identified some preparatory work that needs to be taken beforehand.

4.1. Preparing the ground for change:

- A recognition within the management and leadership of an agency from the outset that change needs to come about in a structured and systematic way and not simply on the basis of *ad hoc* action

- A knowledge and understanding of the Member State's anti-discriminatory legislation and of EU anti-discriminatory legislation; what it means in practice to transpose the legislation and incorporate and develop an anti-discriminatory policy covering race (and gender, disability, etc.), which is commensurate with their employment, services and user involvement responsibilities.

4.2. Core actions:

Based on the work of our partners, developing such an approach needs to involve the following:

- THE MANAGEMENT COMMITTEE OR BOARD OF TRUSTEES to secure commitment to and ownership of the policy. In other words to understand equal opportunities policies and to feel comfortable in progressing and directing change

- MANAGERS who would take responsibility for it

- THE STAFF who have the front-line knowledge and experience and who largely will be implementing it

- USERS, in particular users from visible minority groups

- COMMUNITY BASED SELF-HELP ORGANISATIONS, in particular visible minority ones who are in a position to say what is needed and act as a resource

4.3. Supplementary Actions:

There are a number of policies that are helpful for ensuring that issues of anti-discrimination are properly addressed in agencies, including:

- Equal opportunities policy
- Human Resources policy
- Service Development programme
- Communications Strategy (for internal and for external purposes)

Whichever policy or policies are to be taken forward, an implementation process needs to be worked through which will contain a number of different elements including:

- A separate budget allocation in place for race equality policy development and its operation
- Possibly a special staff/management sub-group specifically to work on the implementation process for change
- Specifics about which objectives are being established in each area and what the expected timetable for the accomplishment of each of the objectives
- Detailed responsibilities of the policy built into the agency's decision-making fora, e.g., staff meetings
- Annual evaluation involving the agency personnel, users and community networks. (The monitoring process should be part of somebody's specific job description)

Action Points for Race Equality Change

5.1. Pointers to Change

During the course of our original work we published some pointers to change. These were later published in a document: Action Points for Change. These have since been tested by our partners across EU and refined and revised also during the work of our Associate, Dr Neville Adams in his training and consultancy work with service providers (drug care and treatment agencies) and with drug services' commissioners, usually government health and social services authorities.

As stated in the documents referred to above, we do not intend to be over prescriptive about the minutiae of changes agencies and allied institutions should be pursuing. Our purpose is to sketch out a framework within which baseline action points covering key areas will be highlighted so as to enable agencies to focus properly on the core issue according to the needs of their respective organisation.

We have no wish to re-invent the wheel. There are many resources, which can be accessed or bought off the shelf. What is needed, however, is some effort to collate and co-ordinate these resources so that potential users can focus on their own needs.

The recommendations below lock into broader areas of organisational change, the possible absence of which does not prohibit the development of race initiatives as pathfinders to wider change. For example the establishment of employee development programmes in some organisations which tie in with government initiated schemes, provides a framework within which strategies around equalities, change and managers can be considered concretely. On the other hand the absence of the former in an agency does not prevent the latter being looked at.

The baseline strategy is not about, and does not address directly, the apparent preferred option of some government bodies for "working with and/or valuing cultural diversity". There in lies a recipe for confirming stereotypes. Instead, this project and recommendations attempts to address those oppressive and discriminatory processes and barriers which prevent Black peoples from making their claims, and having these acted upon justly and equitably, for recognition, respect, and within those, needs.

The recommendations are therefore aimed at a number of levels:

- the agency level
- the purchasing/funding level
- the "quango" level
- the national level
- and, ultimately the EC level

5.2. Framework For Action: Bringing about change in the workplace culture

5.2.1. The framework attempts to address what agencies and allied organisations can do. It is not pretended that these are either exhaustive or that they have not been attempted elsewhere before. If the latter is true, then they bear repeating, given the findings of the project.

5.2.2. These action points are set out in the form of key questions within a strategic management framework, which can be given the workaday definition of *"the process of managing the goals of the organisation while managing the relationship of the organisation to its environment."* Given the fast changing environment to service agencies, including that of being more needs sensitive, it is a skill that all of the agency staff need to be imbued with. This approach does not mean, therefore, simply the production of glossy documents with "standards" and "targets" which do no more than circulate the upper echelons of the agency/organisation, for the ultimate benefit of the funders. It does mean having an implementation process, which locks into other organisational strategies. This approach also allows for the participation of relevant employees and service users in the planning and evaluation elements, and can be tailored to the size of the organisation.

5.2.3. The highlighted action is set out across four core areas:

- implementation
- employment
- services
- community/user participation

5.2.4. For agencies and other bodies these can be configured across an ideal type journey of a drug user who moves from prevention, to day services to residential to aftercare. As an example of this, action points surrounding prevention are outlined at the end.

5.2.5. We also indicate in italics those complementary strategies, especially those that seek to address the organisation under investment, which we think are necessary to the successful achievement of the identified race equality action.

5.2.7. Implementation Structure

- ⇨Has the agency reviewed its equal opportunities policy or anti-discriminatory statement?
- ⇨Has this review process involved all employees, especially visible minorities' employees, relevant community representatives, users and/or their surrogates?
- ⇨Has a specific race equality strategy been derived covering employment, services and community/user participation?
- ⇨Has this been set within a framework of objectives, action points, time scales, responsibility, and resources?
- ⇨For large organisations with several geographically dispersed service units: has the corporate core developed the overall race equality strategy covering human resourcing, service standards and community participation, with service units having to develop individual service and user interface initiatives within that framework?
- ⇨Has the management committee or equivalent endorsed this strategy?
- ⇨Has this been communicated to all staff?
- ⇨Has it been communicated to service users?
  - ⇨ *What is the communications strategy for the organisation, and does it have both internal and external action areas?*
- ⇨Have the employee development tasks arising out of this strategy been identified?
- ⇨See the section below on employment.
- ⇨Is there a comprehensive equality monitoring process covering employment and services in the first instance?
- ⇨Has responsibility for collating and analysing this information been allocated?
- ⇨Are the results from this fed into relevant decision making for a regularly?
- ⇨Are they standing items on management team meetings and supervision sessions?
  - ⇨ *Is there an information strategy in the organisation, and does it include a component on computer resources?*
- ⇨Is there a need for a change catalyst resource? Specialist post? Buying in specialist consultancy/advisory resources?
- ⇨Are the equality responsibilities built into the job descriptions?

⇨ Are the race equality considerations built into the budgeting process?

⇨ Is there a need for a ring-fenced equality development part of the budget?

⇨ Is there proper organisational support for Visible Minorities' for a if these are established?

5.2.7. Employment

⇨ *How has the human resourcing function in the agency/organisation been structured? Is it centralised? Is it devolved? Who is responsible?*

⇨ *Is there a human resource strategy covering, at the minimum, recruitment and selection, employee development and employee relations?*

⇨ *Does employee development have action points on an employee skills deficit audit that flows from identified objectives and allied action?*

⇨ *Does it therefore have action points on appraisal and/or a supervision policy?*

⇨ *Does the employee development programme lock into other government initiatives, on employment training, schemes?*

⇨ *Why not a training scheme specifically for those working in drug services?*

⇨ *Why not an employment training scheme covering equality management?*

⇨ *Has the employee development programme given rise to a career and employee development profile for each employee?*

⇨ Is there a targeting policy aimed at recruiting more visible minorities' staff?

⇨ Is there an equality based recruitment and selection process covering all aspects?

⇨ *Check your Human Resources (HR) strategy*

⇨ Is there an employment monitoring process, and is the information analysed?

⇨ Is there an action plan covering the achievement of the targets?

⇨ Is this an explicit but integral part of the employee development programme?

- ⇨Is the training budget targeted on priorities?
  - ⇨*Check the skill deficit audit? Don't distribute the training budget out equally amongst all employees.*
- ⇨Is access to the training budget on the basis of clear objective criteria?
- ⇨What about equality based HR training for managers covering Recruitment and Selection, employee relations etc.?
  - ⇨*Check your employee development programme.*
- ⇨Is there a need for a positive action element?
- ⇨How does this lock into the employee development programme?
- ⇨On employee relations, do, at the minimum, your grievance and disciplinary processes have explicit references to the race and gender dimensions?
- ⇨*Does your HR strategy include the development of a charter for employees setting out acceptable and unacceptable standards of behaviour?*
- ⇨Are there exit interviews for staff leaving the employ of the agency?

5.2.8. Services

- ⇨*Is there a service development programme in the agency/organisation involving managers, front-line staff, users and community representatives in its design, implementation and evaluation?*
  - ⇨*Does this involve setting priorities for action, targets and timetables, monitoring and evaluation?*
- ⇨Does the agency know what needs exist in relation to drug us in the different communities in the catchment area, especially visible minorities communities?
- ⇨Can this be accessed through research, secondary sources, or networking directly with groups or activists in those communities?
- ⇨How accessible is the agency?
- ⇨Is your publicity reaching the target communities?
- ⇨How does it reach women in the different communities
- ⇨Which media are being used, and does it include media visible minorities communities are likely to use more?

- ⇨Does it find its way to relevant community organisations and groups?
- ⇨Does it stress confidentiality, especially with regard to police and immigration matters?
- ⇨Is it translated into appropriate languages?

⇨Is the translation properly done, i.e. has it been piloted with relevant language groups

⇨Does the translated text take into consideration issues of gender and culture

- ⇨Is it possible to, and does it then offer access to a woman and/or visible minorities' worker on first contact if so desired?
- ⇨Are there partnership groups and/or volunteers from the different communities, which can be used as surrogate contact points?
- ⇨If not is there a need for an outreach function in those communities?
    - ⇨Does your outreach function cover taking services out, identification of need and/or preventative work?
- ⇨Can your agency provide the necessary training for such partnership groups?
    - ⇨If not local community groups, are there are other drug agencies in the vicinity with which you can work in partnership? What about shared funding?
- ⇨Is the first contact with your agency welcoming and non-threatening?
- ⇨Is your reception staff properly trained?
- ⇨What image is portrayed when a visible minorities drug user walks through the door?

⇨Is it still predominantly that of a white agency?

- ⇨If you use an appointment system, is this necessary? e.g. one of the visible minorities' users interviewed was adamant that the initial reception, including the use of an appointment system, discouraged him
- ⇨Can you offer a woman and/or visible minorities' worker if the user requests it? (Check your employment action points)
- ⇨If not, are there volunteer or partnership community groups you can work with?
- ⇨What employment/training links exist between black volunteers and the agency? (Check your equality employment plan)
- ⇨Does the agency need an interpreting service?

- ⇨Does the assessment process pick up on issues of race, culture, gender or religion as appropriate?
- ⇨Is the assessment process comprehensive enough to cover aspects of need more likely to be experienced by the different visible minority communities?
- ⇨How geared up is your agency for working with clients who use differing drugs?
- ⇨Does staff need training?
- ⇨ *Check your employee development plan*
- ⇨Are their extra resources involved?
  - ⇨If appropriate and relevant can and does the agency work with families as part of the treatment?
  - ⇨Is staff trained to do so?

⇨ *Check your employee development programme*

- ⇨Or do you have visible minority staff with the appropriate skills?
- ⇨What's their role in the organisation? Surely not as dumping grounds for all visible minority clients?
- ⇨Can they be mentors for white staff working with visible minority users?

- ⇨How attuned are your information giving, counseling and /or psychotherapeutic services to dealing with issues of race, culture and gender?
- ⇨Is there training your staff can undertake?

⇨ *Check your employee development plan*

- ⇨How rigorous is your agency's follow-up on clients who break their counseling or other appointments?
  - ⇨Are there specialist services provided by visible minority agencies or self-help organisations, which can be bought in or brokered?
  - ⇨If a visible minority service agency has been merged with your agency what guidelines exist on supporting that agency's service autonomy?
- ⇨If a residential agency, how geared up are you to receiving clients from different racial and cultural backgrounds?
- ⇨For example, how many visible minority staff do you have? Are your internal service processes attuned to working with a multi-racial clientele? Do you have an explicit policy and practice covering racism by other clients and staff? Do you take into consideration such factors in your therapeutic services? Your dietary considerations? Your leisure initiatives? Do you encourage family contact? Can you provide help for families wanting to maintain contact? Or, do you

need help in that area? E.g., using partnership community agencies etc. If visible minority users are dropping out at a faster rate, do you bother to find out why? What work do you undertake with your referral source agencies to ensure that Black clients are referred on? Do you advertise your services in ways that can generate demand from potential visible minority users?

- ⇨What guaranteed minimum services can be provided to users without proper immigration papers?
- ⇨Are there appropriate agencies, groups or individuals, which can be brought in at short notice to help sort out immigration matters?
- ⇨If clients have to be referred on to other agencies, what race equality checks are conducted with those agencies?
- ⇨Before the user leaves the agency, is there a formal process of eliciting his/her views about the services provided?

⇨ *Check your service development plan.*

- ⇨Is the agency geared up, to advocacy work around discrimination issues? E.g. helping a user to pursue, or pursuing on his/her behalf, an issue around racist housing allocation practices?
- ⇨Can the agency's aftercare exploit the positive action potential of the legislation?
- ⇨Is there a possibility of joint positive action schemes with other drug agencies, or with funding local authorities?
- ⇨Are there commercial fora, which can be canvassed to encourage private employers to do the same?
- ⇨Is the aftercare linked to networks in the relevant communities?
- ⇨Are your quality processes locked into your equality action points/plans?
- ⇨Are all relevant service processes monitored?
- ⇨Is the information from this fed into the relevant implementation processes covering the agency's race equality strategy?

5.2.9. Community participation

- ⇨What's the agency going to do about increasing the level of relevant visible minority members of the management committee/board of trustees?
  - ⇨Will it canvass relevant networks for visible minority people with relevant expertise?
  - ⇨Will it advertise relevantly, as is done for school governors?

- ⇨What links exist between the agency and community or other relevant groups/organisations with constituencies from the different visible minority communities?
- ⇨Do these links feed into relevant needs and service planning processes?
- ⇨How are visible minority users or their surrogates involved in the evaluation and planning of services?
    - ⇨When will there be a formal user structure?
    - ⇨Check your service development plan.

5.2.10. Putting the Action Points into Practice

We can sketch out a brief action point outline for preventative services, by way of example, to illustrate what should be possible. Apart from the considerations of good practice which stems from meeting need in a multi-racial society, it can also be rooted in the responsibilities that flow from the EU Directive which prohibits indirect discrimination. In other words if your preventative services in effect meet only or mainly the needs of white people, then there is the likelihood that they are discriminating indirectly. There are two parts to the outline - those that relate to primary services, and by this is meant those that directly address drugs' preventative issues, and secondary services which relate to the key conditions that underpin drug use and misuse. Part of the considerations underpinning this outline is that agencies might want to undertake initiatives jointly as a means of ensuring efficient and effective resource use.

On the primary side then:

- ⇨How targeted is your printed material and publicity? E.g., Is it translated into appropriate community languages? Do you know which languages are appropriate? Is it aimed at the young? [By the year 2,000 about one third of young people in the EC will be of so-called "migrant" descent i.e. 'visible minorities'.] Does it pick up on issues of gender appropriate to different communities? Has it been translated properly? [One London health authority translated its HIV preventative and awareness literature into Turkish. Unfortunately whoever translated it used the Turkish colloquial, offensive term for gay men!]

- ⇨Which media are used? What about community radio and/or television if necessary? Is the literature available in community outlets?

- ⇨Are you in touch with appropriate community organisations and activists? Can they be a conduit for access to people? Can you train them in partnership to undertake preventative tasks? Do you have sufficient staff from those communities who can act as bridgeheads? Do you know which are the appropriate community sites, apart from schools, where

people, in particular women, can be contacted? If not, are there community resources that can act as your partners in this? Can this be a basis for developing community preventative schemes? Is there a need for an outreach function? Will this be a post or posts in your agency? How is this to be funded? Or, is there a need for a specific catalytic project or agency?

⇨How do you assess and evaluate the impact of your preventative initiatives? Research? Consultation? [Check your community participation action plan]

⇨*On the secondary side,* it is clear that because a much larger proportion of visible minorities live in urban areas and under conditions generally of socio-economic disadvantage when compared with white communities, the very context which facilitates drug misuse, the need for action in this area is that much greater. It is not expected that drug agencies should take on responsibilities that fall to other organisations, nevertheless, there is a more structured role for drug services in the secondary field other than that of simply responding to individual users' needs. There are three areas, which very often overlap with individual clients' needs and associated service interventions of drug agencies. These are those of employment and training, education, and housing and other associated welfare services.

⇨For example, therefore, how can drug agencies lock into those other agencies and community organisations identified in the primary section, in pursuit of employment action targeted at visible minorities? Are you aware of relevant training provisions? Of the equality and positive action potential available to employers? Of action that can be taken in the educational sector? Is there scope for creating or being involved in local joint agencies' fora which concentrates on employment action for visible minorities? What about a loop back link to after care services?

6. Supplementary and useful information

6.1. National, regional and local levels

- The EU Directives have implications for the national government of different EU Member States. In UK for example, the government has been consulting with all relevant interest groups on the alignment of UK's anti-discriminatory with EU legislation. There are probably similar adjustments and alignments that are being made in other countries. *Try and find out about it from the relevant ministry in your country.*
- As a consequence of this alignment there are likely to be new national structures in place, for example a national body on race/immigrant relations. *Do you know what these are?*
- The EU Directives also have implications for your country's different governmental ministries, including the health, employment and social welfare services. *Do you know what these may be?*
- There are implications for, amongst others, regional health authorities and for social services. *Try and find out what these might be, with special reference to substance misuse services, their planning, funding and commissioning? For example;*
    - *Does the health authority have a race equality strategy covering employment?*
    - *In terms of its planning and commissioning processes does its overview of need include specific measures to pick up on the needs of the different visible minorities?*
    - *Does it therefore commission relevant research? Or convene focus groups involving relevant visible minority groups and individuals? Has it established user for a, which involve visible minorities? Etc.*
- *Are there government led local and regional and national structures in place for overseeing drug demand and drug harm reduction? Are such structures doing anything on drug services for visible minorities? If so, what is it? How can you lock into these structures and initiatives?*

6.2. Useful contacts at EU level

You can contact the European Monitoring Centre on Racism and Xenophobia. They may be able to provide you with information and links within your own country. Their website address is: http://eumc.eu.int.

6.3. Our partners

Do you want more specific information from our partners concerning what they have done and what they are planning? Here are some contact details:

UK	Jerry Sutton Inward House Trust Lancaster E-mail: jerry.sutton@inwardhouse.co.uk
Italy	Professor Umberto Nizzoli SERT Reggio Emilia Via Amendola 2 42100 REGGIO EMILIA

	E-mail: nizzoliu@ausl.re.it
Netherlands	1. Jan Lawalata Stichting Tjandu Postbus 725 3500 AS UTRECHT E-mail: jlawalata@hetnet.nl 2. Piet de Groot Stichting Hard Drugs Flierbodreef 19 1102 BV Amsterdam E-mail: circumlocution-office@xs4all.nl
Portugal	Adelaide Gomes REAPN Rua de Costa Cabral, 2368 4200 PORTO E-mail: adelaidegomes@hotmail.com
France	Jacques Fonzy SATO Picardie rue des Malades Saint-Martin-le-Noeud 60000 France E-mail: sato.t3e@wanadoo.fr

6.4. Do you want to contact us

We can be contacted for information and advice by E-MAIL:
k.khan@mdx.ac.uk

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ANNEXE 2.2.

DRUGS: ADDRESSING 'DIVERSITY' & TACKLING DISCRIMINATION

LEARNING MODULE ON DRUGS & 'DIVERSITY' ('Race')

CREDITS MIGHT COUNT TOWARDS A POST-GRADUATE QUALIFICATION

T3E [UK] / Middlesex University

2003 - 2004

Background

1. In 2001-2, a new distance-learning programme on "*Drugs in Society: Policy and Intervention*", was offered by the School of Health & Social Sciences. At the

time, Dr. Betsy Thom, the programme Coordinator expressed an interest in offering an option on Drugs: 'Race' & 'Diversity'. Because of my pan-EU research

and other work at the interface between 'race' and drugs she approached me to develop a sample unit. This now exists as unit 2 of our module, "Drugs: 'Race' & 'Diversity' – An

Introduction to 'Race', 'Culture' & Substance Use".

2. While developing a sample unit for her, I was also approached by Home Office DPAS with a request to develop a training module on the same theme. This has since been accepted by DPAS and payment made for the development. DPAS, because of financial restraints, have no immediate plans for its delivery, but may have some later. (Copy attached).

3. Dr Betsy Thom has expressed an interest in offering the module as an option on her Distance Learning Programme, and the module is now in the process of revision and revamping.

4. What has been developed so far also offers a timely, unique and innovative opportunity for the development of a more versatile and flexible generic training module, with potentially both specialist and generic spin-offs.

Module on "Drugs: 'Race' & 'Diversity' "

1. This essentially represents the work carried out for Home Office DPAS. They have asked for its unrestricted use, which has been agreed. However, we still hold the intellectual copyrights.
2. Dr Betsy Thom has already expressed an interest in offering a revised module as an option on her distance-learning course. Revision of some units would largely be editorial while for others, such as those on legislation and monitoring, it would mean considerable development since the original DPAS module is a mixture of study units and shorter units designed for 2 days training, using overheads.
3. Dr Thom has made a number of helpful comments, which need to be incorporated.
4. The module, as it now stands, consists of seven units. It anticipates the development of the existing units and the addition of one more, which would be locked into the priority strands of the government's 10-year drug strategy.
5. The target group for the optional module on 'Race', Drugs & 'Diversity' would come initially from the same pool as indicated by Dr Thom in her recent successful bid to the Enterprise Initiative Fund, though with take-up from others in university new groups, i.e., student nurse would be added, that is to say:-

a) The largest proportion, so far, is already working in specialist alcohol/drugs agencies or in jobs (e.g. prison, social work) with a specialist element. These groups often have very definite ideas about their needs (to suit work situations and 'gaps' in their knowledge base). Sometimes individuals in this group are interested in work based learning – but not always.

b) A second target group consists of people in work which is not connected to drugs/alcohol and who are interested in changing jobs or simply interested in the subject and want an MSc. Some of the options, especially WBL), are rejected by this group. They want taught (materials led) options.

c) The third target group are new graduates and mature students completing another degree who are interested in specialising in drugs/alcohol. WBL is not suitable for this group. (Internship is a possibility but has not proved popular).

d) At present, most students are part-time. However, there are a few full time students and some Applied Prior Learning (APL) students. This means that a reasonable range of options must be available within the same academic year.

e) Students recruited so far are all UK and EU (2 students). There is potential to recruit outside the UK/EU and some modules e.g. psychopharmacology, are likely to appeal more than others which may be more culture specific.

The importance and relevance of a generic module on 'Race' and 'Diversity': Changing Work Place Culture….

a) Timeliness:

In the wake of the Race Relations Amendment Act (2000), (RRAA), there is now a statutory duty on public services to provide systematically planned, inclusive, anti-discriminatory access to employment and services. If the field of drug demand and drug harm reduction is anything to go by, there is an urgent need for policy makers, and practitioners to address issues of 'race' and 'diversity'. However, based on personal experience as well as upon in-depth knowledge of the field of race and racism, it is evident that professionals - at the highest level, as well as across the board - are often unable to make considered and balanced judgements on these issues in the same way that they might on other issues. For example, in the drugs field, on issues such as, e.g., outreach work, prescribing, residential care, treatment approaches, etc. This was, indeed, the rationale behind the work carried out for the development of a training module for Home Office DPAS personnel mentioned earlier. It would be reasonable to assume that understanding the RRAA (2000) legislation in terms of organisational policies, procedures and practices would be:

- Highly relevant and important to professionals from health and social care fields, as well as to the probation service.
- Highly relevant also to service commissioners, policy makers and managers
- Of appeal to those without prior knowledge as it provides an entree into a subject matter, which is recognised as important but rarely covered in other certificate/diploma/ MSc courses and which are often seen as 'difficult'.
- Provide a basis of 'transferable' knowledge, useful beyond the particular field the professionals concerned are working in.

- Of assistance to professionals by facilitating the dovetailing of the dimension of equality to quality

b) Uniqueness:

Having carried out a quick survey, it is clear that no comprehensive learning module of this kind is listed in the Universities' Handbook - one which, though it offers a pragmatic approach to bringing about change to the work place culture, is also underpinned by a distinct philosophical rationale. This approach focuses on what it means for a public organisation *"to think"* about and *"do"* on matters of race equality as an explicit mainstream activity. It catalyses this through examining in detail the outcomes of meeting statutory duty under RRAA (2000), and the impending European ant-discriminatory legislation. That is to say:

- Community satisfaction and equal opportunities
- Staff satisfaction and equal opportunities
- Confidence and respect

Meeting the new duty requires of public organisations that they examine their employment, service, and community accountability responsibilities through the development of an appropriate race equality infrastructure. The latter covers policy, procedure and practice planning and implementation processes which should be embedded in transparent accountability systems. In other words, not only monitoring, reviewing and evaluating the planning and implementation processes, but also ensuring that these involve the target beneficiaries by facilitating the provision of evidence of meeting the duty around:

- Leadership issues
- Services and policies
- Employment
- Anti-discriminatory monitoring and evaluation

c) Flexibility:

A generic module of the kind envisaged could be made available, as an option, to relevant courses on offer at the University. For example, apart from it already being welcomed by Dr Betsy Thom, for her course "Drugs & Society", Professor Carol Baxter has also responded positively to its relevance for student nurses. Similarly, curriculum leaders for social work courses, criminology, racial equality studies, education and others are also being approached.

The contents of the generic module would, therefore, consist of the following units:

Generic module contents:

1. Introductory unit
2. Unit one: 'Race' & 'Diversity': Concepts &Terminology
3. Unit two: 'Race' & 'Diversity' - An Introduction to 'Race', 'Culture' & Practice based issues
4. Unit three: Addressing Diversity & Tackling Discrimination
5. Unit four: Racial 'Diversity and Social Exclusion
6. Unit five: Anti-Discriminatory Legislation
7. Unit six: Anti-Discriminatory Accountablity
8. Unit seven: Practice relevant implementation of 'Race' and 'Diversity' Dimension: employment, service delivery and monitoring
9. Unit eight: 'Race', law and criminality
10. Concluding unit

Assessment would be by written essay and the 10 units would be worth 20 credits.

Potential market for a 'Race' & 'Diversity module

To reiterate what Dr. Betsy Thom has said: the extent to which any particular module (as opposed to the programme as a whole) will have a market, depends on a wide range of factors including,

- ***The quality of the content and teaching materials developed***. This is essential as word of mouth (often via Internet exchanges) can gain or lose reputations. Dr. Peter Fraser is a recognised expert in race relations and a historian in the field of Caribbean and Caribbean Diaspora Studies of long standing. Dr. Neville Adams has recently completed his Ph.D. on 'race' and local government and combines this with lengthy experience in local government race relations, research training and consultancy. And, I also have an in-depth understanding of 'race' and racism as a researcher, consultant and trainer.

- ***The potential for the module to be included as an option in other programmes***. Discussions have already indicated that a 'race' and 'diversity' module might be useful for the following MSc programmes: Drugs: 'Race' and 'Diversity'. Professor Carol Baxter has also expressed a positive interest in the module with regard to nursing studies. Other Middlesex colleagues have also been approached with reference to Health Studies and Social Work courses

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Module on "Drugs: 'Race' & 'Diversity' "

CONTENTS

UNIT 1: Introduction to Addressing Diversity & Tackling Discrimination

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I. Introduction

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Official Government documents link the addressing of diversity to ensuring equality and tackling discrimination. But what does 'diversity' mean? In recent years, the term has come to be widely used in UK to convey a variety of meanings. At times it is used to refer specifically to issues of 'race', at others it appears as a more generic term, and refers to issues of gender, disability, race and sexual orientation collectively; at times it is used as a synonym for equality of opportunity, at others it appears as a replacement for it. The question is what does 'diversity' occlude? This Unit is designed to assist students in understanding the term 'diversity' in public discourse by critically unravelling its meaning, and examining its relationship with tackling discrimination and progressing equality.

In the first section we will look at its multi-faceted and evolving meanings. In section two we will examine the general trends in disadvantage and discrimination with reference to the population categories to which 'diversity' and 'equality' apply – gender, race, disability and sexual orientation. Here we will look at long term social trends in society that show up the disadvantages faced by different population groups. In the last section, we will examine, more closely, the more problematic nature of the term 'diversity' when applied to 'race'. Placing 'race' in its historical setting will be the way of doing this. In the main the Unit will draw upon official policy documents and reports.

In this Unit students will be required to demonstrate the following learning outcomes:

1. **A critical understanding of the different meanings attached to 'diversity';**
2. **That they can compare and contrast 'diversity' to 'equality of opportunity', with particular reference to different/changing vocabularies and language**
3. **That they can show a basic knowledge of the trends in disadvantage, discrimination and inequality amongst the different population categories: women, the disabled, racial, ethnic or cultural groups**
4. **That they can demonstrate a detailed understanding of racial disadvantage and its adverse impact in different fields, such as education, employment, housing, health and social welfare and policing**

5. That they have acquired, in outline, a general historical understanding of race relations in UK; and, of the outcomes of different approaches and policies.

- Section 1: 'Diversity': Meaning(s)

Diversity: American Usage

- The term 'diversity' has been in vogue in USA for a number of years. There, it has come to replace affirmative action and the language of equal opportunity, which had come to be seen as being too politically charged during the rise of American right wing ideology over the last two decades. Even during the Clinton years, progress on affirmative action was seen as being hamstrung because of Republican control of Congress. The emergence of the term 'diversity' as an alternative approach to addressing racial and other inequalities seeks to address the same issues as equality of opportunity and affirmative action but in a more diluted form and with different outcomes. However, it has done so at the expense of moving away from terms like fairness, equality and justice, and towards terms such as ethnic diversity, political correctness, and cultural consciousness.[31]
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    - **Problem** with US meaning of diversity: *since it is about attitudinal change, it cannot be mandated into a system, integrated into a corporate culture, or prompted by financial incentives in the ways that affirmative action can. Racism, sexism, homophobia, etc., cannot be managed away because it is neither possible nor desirable to legislate how people should think. That is why structures, using anti-discriminatory legislation as a base, are required to ensure that personal beliefs and prejudices do not come into play when managing diversity and tackling discrimination.*
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Diversity: UK Usage

- In UK, the decline in the pursuit and application of equal opportunities policies in the mid-1980s, and their dormancy through most of the 1990s was due to a similar shift in political ideology here during the Thatcher/Major years. Equality of opportunity for the different categories discriminated against also began to be seen as being politically too charged. In the first instance, this led to the dismantling of the different units in various town halls and their being subsumed into one 'equalities' unit. This led to the dilution of specifically aimed policies. For example, 1976 race equality legislation came to be dominated by a multicultaralist approach. In subsequent years even the few remaining equalities units were themselves done away with.[32] The main catalyst for the reawakening of government and public interest in tackling discrimination and disadvantage, in particular in tackling racial discrimination, was provided by the MacPherson Report into the murder of Stephen Lawrence and the subsequent handling, or rather mishandling, of the matter by the police. This was followed up by the Race Relations Amendment Act (2000), laying a statutory responsibility on public bodies to tackle institutional racism. A consultation process on implementing EU directives on employment and access to public services is also nearing its end, and may lead to the integration of EU legislation into existing UK legislation. The following statement from the consultative document, issued by the Cabinet Office shows, that in UK the language of diversity has thankfully not jettisoned notions of addressing discrimination in order to tackle inequality, as has happened in USA.. However, the risk remains that tackling institutional racism will once again be displaced by the tried and failed policies of multiculturalism.
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[31] See, for example, Becker, B, Erviti, M., Shelley, A., Managing Workplace Diversity, Alexia UIUC, (USA), 1997.

[32] For arguments for and against the US model of diversity: the proponent elements can be found in the literature produced by the Institute of Personnel Development; for arguments against Kenan Malik sketches these out in his article (see section four of this unit).

- ***Equality***
- *"Equality is an integral part of a civilised society – and of a strong and successful Britain. We want to make our society one in which people are given the best possible opportunity to make a success of their lives, whatever their background. Everybody has a valuable contribution to make. Our challenge is to unlock the talents and potential of all our citizens…*
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- ***Changing culture at work***
- *"…The reality is that fairness at work and productivity go hand in hand. Equality is about recognising and getting the right people for the job. It is about effective working relationships and good delegation. In addition, where things begin to go wrong, it is about resolving issues quickly and fairly for both parties. The best employers already know that they need to use the qualifications and skills of their workforce. Moreover, they recognise – indeed, they can demonstrate – that a diverse workforce can give them a competitive edge in meeting the demands of a broad customer base…*
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- ***Tackling discrimination***
- *"We also need to have a clear, shared understanding of basic minimum standards. Put simply, unfair discrimination – whether at the point of recruitment, in conditions of employment or through harassment – is wrong. It can have a devastating impact on the lives of individuals. It also imposes huge costs on business and the economy more generally every year. These costs may not be highly visible – but discrimination inevitably undermines companies' efficiency, productivity and ability to compete. In that situation, everybody loses."..*
- Towards Equality and Diversity: Implementing the Employment and Race Directives, URN 01/1466 (Consultation Document)
- Foreword by **Barbara Roche,** Minister of State, Cabinet Office
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III. Unpacking the meaning

- So what is 'diversity'? Shouldn't we be, rather, speaking of 'diversities? And, can it, whatever it is, really be managed?
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- The above statement yields a number of meanings to the term 'diversity':

(a) In the broadest sense, the management of diversity is a business reaction - including the business, if you like, of managing a government - to rapid cultural and sociological changes in society, as well as globally;

(b) Internally to the business, diversity management means providing a climate where all employees feel they are valued by and contributing to an organisation;

(c) Externally, it means that organisations need to remain flexible and attuned to the changes occurring in the market; but

(d) This is against a backdrop of inequalities that exist for some categories of employees within organisations, due to stereotyping and preconceived ideas about an individual person based on race, gender, national, religious or ethnic origins, age, physical or mental limitations, etc.; however,

(e) Racism, sexism, disability, homophobia, etc., cannot simply be managed away: the conditions that give rise to them need to be tackled,

(f) Therefore, there need to be certain acceptable minimum standards about effective working relationships and good delegation so that preconceived ideas and stereotypical notions are kept, effectively, out of the equation.

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- Now carry out the following activity:
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  - **ACTIVITY / EXERCISE one**
- Using recent documents giving the government approach, apply them to your studies, workplace and general knowledge or experience in terms of employment and service issues. Do this by:
  - i. Defining the term 'diversity' in your own words. Take some notes from the documents and texts indicated in the references given at the end of this unit. Make particular note of the terms and concepts used in the language of equal opportunities and those used in the language of diversity. Discuss your ideas with your colleagues or friends to compare and contrast the differences in terminology, as well as the overlaps.
  - ii. Make a list of the different categories of disadvantaged or excluded groups nationally, and in the locality or region, you work in.
  - iii. Within some categories, such as 'race', make a list of sub-groups living in your area.
  - iv. Make a list of the main types of disability.

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- Take notes and work with one or two other students.
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- **FEEDBACK**
- Are there any categories or groups you have missed out? Have you included gay people and lesbians? What about social class, or age? Are there any categories of disadvantage that you feel have been missed out and that should be included? With reference to 'race', have you remembered to include Jewish people? Gypsies and Travellers? Asylum Seekers and Refugees? Irish people? With reference to disability, you may have listed speech, sight or hearing impairment. Remember to include mental illness, epilepsy, and learning difficulties.

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- Section 2: Trends within 'Diversity': The Need for Addressing 'Diversity' & Tackling Discrimination

A. Trends Impacting Upon the Different Disadvantaged Categories

There can said to be general historical trends in society that continue to show that certain categories of the population - be they defined in terms of gender, race, disability, etc., - are disproportionately disadvantaged from, or denied access to resources such as jobs or services. These trends are simply an exaggeration or intensification of poor treatment meted out generally. *"What makes the needs of, for example, disabled people, women or visible minorities special is the greater probability of any individual member of such groups suffering disadvantages. This principle should be firmly grasped since it enables policies to avoid divisiveness and argues for a coordinated set of policies. Sexism, racism and discrimination against the disabled cannot be treated in exactly the same way because oppression is not by the same thing.* ***Yet, the underlying principle is the same: individual persons belonging to these groups, or a combination of these groups, are treated as if they possess no individual characteristics which are not outweighed by group characteristics based largely, but not only, on physical signs (gender, colour, handicap) regarded as productive of these characteristics****.*

"These trends are, of course, probabilities so that a few disabled people, or women or visible minorities in senior posts do not prove the argument invalid. All three groups suffer from active discrimination. That is to say, explicitly stated or implicitly understood rules hinder them. There are also practices that may not themselves be racist or sexist but which may register racist or sexist effects: conventions or requirements established for an all male, all white workforce, producing a monocultural workplace culture, and which effectively combine to exclude women, visible minorities and disabled people. To eliminate these practices group by group throws away the common interest among these groups for eliminating both the direct and indirect forms of discrimination.

"A further set of interests needs to be coordinated: since these groups often find themselves in jobs with poorest pay, prospects and conditions there is a considerable area of overlap between their interests and those of other poorly paid workers. ***Equal opportunities should never be conceived of merely as a set of narrow group interest based policies without wider relevance."***

Fraser, P. D., (1984)

ACTIVITY / EXERCISE two

Consider the specific barriers, disadvantages and kinds of discrimination faced by particular categories such as women, black and minority ethnic communities, the disabled. Do this by examining the key features, described below, of discrimination or disadvantage faced by each category. Ignoring, for the moment, the overlapping features of discrimination describe the specifics of disadvantage faced by the different categories. Do this exercise by taking notes and discussions with a friend or colleague.

I. Gender:

The general trend in UK for women over the last century shows a weakening in the strict demarcation of gender roles:

- Women have greater control over their fertility
- Family structures have changed
- There is a more racially diverse female population
- In 1900, only a small minority of women worked; large areas of work were a male preserve; women were largely excluded from higher level jobs; they didn't have the vote. In 2000, women made up almost half the work force and work is now a much more central feature of their adult lives; discrimination is outlawed by the Equal Pay and Sex Discrimination Acts. According to the EOC (Equal Opportunities Commission), women in recent years have moved into higher level jobs in greater numbers.

While these may be general trends, nevertheless, according to EOC, much remains to be done if women are to achieve equality with men: there is still a gulf between 'women's work' and 'men's work', restricting opportunities for both sexes. Therefore, EOC sees *challenging gender stereotyping* as a key priority in the next century. Secondly, while the difference in women's and men's earnings has narrowed over the century, it has hardly changed in recent years. Therefore, measures to tackle inequalities in pay continue to be needed. Finally, although women gained the right to

vote during the earlier part of the last century, their political representation still needs to be boosted.

Data from: Women and Men in Great Britain, 2001, EOC web site

EOC would also like legislation extended to make it a duty for public bodies to implement anti-sex discrimination in ways similar to the Race Relations Amendment Act (2000).

Please note that in 'Facts about Women and Men in Britain', that is also available on EOC's web site, there is a useful ethnic cross-referencing of black and ethnic minority women in employment. Also, the issue of social class significantly intersects with gender issues. Since, in contrast with the other discriminated against categories, women are not a minority group but, if anything, constitute a majority, it is social class, disability, race, and sexual orientation that will, on the whole act as determinants of gender, drugs and social exclusion.

II. Disability:

For the disabled the key facts and figures are as follows:

- There are 6.7 million disabled people of working age in Britain, making up almost 20% of the working age population
- Level of disability increases with age: 10% of those aged 16-24 have a current long-term disability compared to 33% of those aged 50-65
- Asian and Asian British aged 35-50+ as well as other ethnic groups have higher disability rates than the white population
- There are regional variations due partially to age profile of the local population. Higher than average are found in the North East and Wales and lower ones in London, the South East and East of England

- Disabled people are almost eight times more likely as non-disabled to be out of work and claiming benefits (2.6 millions). Of these 1 million want to work, even though many of these are not able to start work straightaway.
- Disabled people are twice as likely as non-disabled to have no qualifications
- Disabled people are half as likely as non-disabled to be in employment.
- Employment rates vary greatly between types of disability: these are lowest for people with mental illness and learning difficulties
- Rates for long-termed disabled are 9% compared with 5% for non-disabled people.

Data from the Disability Rights Commission, DRC Briefing: December 2001

Please note that the full text of the briefing also contains an important ethnic breakdown on disability. You may consider some of these indicators highly relevant to your work on tackling racial diversity. The relevance of drugs, disability and social exclusion has not been addressed by research and policy and largely remains a fallow field.

III. Race:

Key Factors

According to the CRE:

Poverty, deprivation, poor education, and poor housing, high unemployment: these are the key indicators to racial inequality and effective racism in Britain today. While it is true that in the poorest, most deprived, most neglected parts of Britain all races and all cultures suffer, ethnic minorities are often the most deprived in our society. They are proportionately more likely to live in the most deprived areas, in unpopular, overcrowded housing. They are more likely to be poor and unemployed, regardless of age, sex, qualifications and place of residence.

'Non-white' ethnic minorities make up 7.1% of the British population, of which Indians are the largest ethnic group (24%), followed by Pakistanis (17%) and Black Caribbeans (13%). The remaining 46% of the ethnic minorities are significantly made up of Bangladeshis, Black Africans, Black Other, Asian Other, Chinese, Black Mixed, Asian Mixed.

1. Public Services

- Public services have a crucial role to helping these communities. Good healthcare, education, housing and regeneration is the only way to ensure everyone gets the opportunity to climb out of the poverty trap – whatever their race or colour.
- Ethnic minorities have poor expectations of public services, and expect worse treatment than other groups. Services most poorly rated for recognising ethnic minorities' needs include the police, immigration services, the courts and local councils, especially council housing. One in eight ethnic minority individuals reported discrimination at a job interview.
- As employees, 38% of black people expect worse treatment than other colleagues in the police service, and 28% expect poorer treatment in the prison service. Amongst Asian employees the respective figures are 28% for the police and the same for the prison service

2. Education

- Approximately 11.5% of school pupils in England are from ethnic minority groups with significant differentials in the level of attainment
- 2,000 asylum-seeking children do not receive formal education
- Gypsy traveler children have been identified as the most at risk in the education system
- Bangladeshi, Black and Pakistani origin children achieve less than other pupils at all stages of the education system, even though black children have equal, if not higher ability on entrance to school; but black boys do least well at school
- In 1999 the attainment of GCSEs at grades A*-C by ethnic background was as follows: 62% Indians; 50% whites; 37% black; and, 30% each Bangladeshis and Pakistanis.
- African Caribbean pupils are 4 – 6 times more likely to be excluded than white pupils are, although their truancy rate is not much different to others. Many of them are of higher or average ability but are perceived to be underachieving.
- An African Caribbean graduate is more than twice as likely to be unemployed as a white person with A levels. African men with degrees are seven times more likely to be unemployed than white graduates.
- The retention and career development of ethnic minority teachers and education staff is a major concern across all education sectors.

- **Health**
- People from ethnic minority groups are more likely to suffer ill health.
- Infant mortality is 100% higher for the children of African Caribbean or Pakistani mothers than white mothers.
- Pakistani and Bangladeshi people are five times more likely to be diagnosed with diabetes and 50% more likely to have coronary heart disease than white people.
- African Caribbean women have 80% higher rates for diagnosed hypertension than whites.
- Irish-born men are the only group whose mortality rate is higher in Britain than in their country of origin.
- 2,000 fully qualified asylum seeking and refugee doctors either are prohibited from working or are forced into unskilled work.

i. Housing

- 70% of all people from ethnic minorities live in the 88 most deprived local authority districts, compared with 40% of the general populations.

- Almost half of all people from ethnic minority groups live in London, where they make up 28% of all residents.
- Some ethnic groups are more likely to live in poor housing. 40% of Bangladeshi and Pakistani households live in overcrowded housing, reflecting a lack of larger housing and lower incomes. Rates for overcrowding for the Irish are twice those of the population as a whole.
- A fifth of the housing occupied by asylum seekers is unfit for human habitation.

ii. The legal system

- Racial harassment incidents are widespread and under-reported – it is estimated that only 5% of incidents are reported to the police.
- Ethnic minorities are over-represented throughout the criminal justice system from 'stop and search' to prison.
- In 1998/99 black people were six times more likely to be stopped and searched than white people.
- 89% of young black prisoners were sentenced for over 12 months compared to 75% of young white and 77% of Asian prisoners.
- People from ethnic minorities made up 18% of the male prison population and 24% of the female population, with black people alone accounting for 12% of the male and 18% of the female prison population.

iii. Work

- Ethnic minorities accounted for 7.2% of the working population in 2,000. Ethnic minority and mixed groups will account for half the growth in the working age population over the next ten years
- Unemployment is considerable higher among ethnic minority communities. In 1998, 5.8% of white people of working age were unemployed on average, but among people from ethnic minorities, it was more than double that at 13%. It was 20% for Pakistani people and 23% for Bangladeshi people.

CRE, Disadvantage & Discrimination in Britain Today – the Facts

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- **EXERCISE three**

- Using the same data make some comparisons and contrasts about the kinds of disadvantages or exclusions faced by the different categories. Do this by taking notes and discussing your ideas with your colleagues or friends. For example, you have probably already noted that, in the view of EOC, women as a category are not a minority within the general population, whereas disabled people and black and other visible minorities are. Overall women, as a category are not so much unemployed as under-employed compared to their male counterparts. The reverse trend is observable for disability and race: overall, they face unemployment rather than under-employment. Have you remembered to use social class in your analysis? It is a category that intersects with and, to some extent, determines the other categories.

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- **FEEDBACK**

- **MODULE ON DRUGS: 'RACE' & 'DIVERSITY'**
- In considering the different kinds of trends for the various disadvantaged categories try also to describe the kind of disadvantage/oppression/exploitation faced by these categories. You will probably note, for example, that women as a category suffer from gender oppression or 'patriarchy', racial minorities by 'racism', etc. Try and say, whether in your view there is any natural point of unity between the different categories while taking into account that for each category oppression is not by the same thing.
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- **MODULE ON DRUGS: 'RACE' & 'DIVERSITY'**

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- Section three: 'Race' & Diversity – A Critical Historical Overview

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- In this section, we will dwell at some length on the problematics of 'racial diversity'. This is because, according to recent surveys of social attitudes in UK (as well as across EU), the issue of race and immigration remains the fourth highest area of concern, after education, health and crime. Moreover, there is now a duty under RRAA (2000) for public bodies and, therefore, also those receiving public funds to deliver public services to address diversity and to tackle racial discrimination institutionally. Hence, for this reason alone, it merits attention.

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- **The field of 'race' and racism has historically remained contentious and seemingly intractable for a number of reasons that will be expanded upon during the course of this module. Terminological issues are addressed in another Unit (Unit 3), as are monitoring and evaluation (Unit 5), legislation (Unit 6), implementation (Unit 7). Here, we examine the problematics of race and immigration in UK in a historical setting.**

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- **EXPLANATORY NOTE**

- *Following a sociological convention, the term 'race' is used throughout as a social construct and not as a natural (biological) given. In general, this means that the term 'race' is given currency by attempts to meaningfully classify human populations into types, wherein each type thus classified is accorded certain (selective) attributes, which each individual belonging to these types is presumed to bear as an essence. This is known as racial classification. A belief that such classification can and does yield meaning is called racialism, which itself provides one of the bases or conditions for the existence of racism. The politics of government (in particular, on immigration control) and a knowledge of the human sciences provide for the other conditions[33].*

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1. Diversity: Historical Context

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RECOMMENDED READING: Malik, K. (2001) The Real Value of Diversity, Connections, Winter 2001/2, CRE

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- In an ongoing debate on the efficacy or otherwise of multiculturalism that recently took place on CRE's web-site there has been a thought provoking article by Kenan Malik [34]. (The article has also previously been published in the CRE journal Connections). While these views are not new because a similar debate on the efficacy of multiculturalism took place in the field of education, for example, between the proponents of anti-racism and those of multiculturalism, Malik's views are a timely reminder of there being two distinct approaches.

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- **Summary of Malik's argument**

- According to Kenan Malik, in the ongoing debate in the wake of last summer's events in Bradford, Burnley and Oldham two broad kinds of responses to the value and meaning of racial diversity may be identified:

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(a) <u>The dangers of multiculturalism</u>:

- For those historically opposed to the immigration and settlement of non-white people in UK, the violence between whites and Asians is proof - if further proof were needed - of the failure of the liberal dream of a cohesive, tolerant, multicultural society are clearly revealed in the apparent rejection by some British Muslims of the core values of a diverse and multicultural society, envisaged in a strategy enunciated as long ago as the 1960s. A strategy that, in the words of the then Labour Home Secretary, Roy Jenkins, set out to create 'cultural diversity, **coupled** with equal opportunity in an atmosphere of mutual tolerance.'

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(b) <u>The proponents of multiculturalism:</u>

- A diametrically opposite and dominant view is that the events of the past year reveal more urgently the need for a tolerant multiculturalism, wherein people can continue with their own customs and traditions, while, simultaneously, respecting those of others.

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[33] For a full theoretical argument see, for example: Feuchtwang, S., "Racism: territoriality and ethnocentricity", in Cambridge, A. X., & Feuchtwang, S., (eds.), Anti-Racist Strategies, Avebury (1990).

[34] Malik, K., The Real Value of Diversity, Connections, Winter 2001/2, CRE

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- Malik sees both these responses as being flawed. For him the former response is "a vision of British (or, more usually, English) identity pickled in aspic". At the same time, he sees the latter response as having "abandoned the very notion of a common identity or of shared values except at the most minimal level."

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- Malik argues that *"The castigation of minorities misses the point. The problem is not that ethnic minorities are alienated from a concept of Britishness but that there is today no source of Britishness from which anyone – black or white – can draw an inspiration."*

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- He calls instead for a process of 'dialogue' whereby *"different values are put to the test, and a collective language of citizenship emerges."* In other words, that multiculturalism should not be treated as a given but as an outcome of a process of constructing a multicultural society, through exchange and education.

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- **In support of this hoped for outcome, Malik advances a number of theses or propositions:**

➢ **The question of difference**: the problem of race in Britain revolves around the issue of how 'different' ethnic minorities are to the rest of the population. This view is projected as emanating from the minorities themselves, in the form of a demand that their cultural differences be recognised and respected. However, multiculturalism, far from being a response to demands from such groups, was imposed from the top: *"the product of government policies aimed at diffusing the anger created by racism."*

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➢ **Legislating race:** the development of a twin-track strategy in response to immigration. On the one hand, increasingly restrictive and racist immigration controls. On the other, a framework for legislation aimed at outlawing racial discrimination. The linkage between the two undermines anti-discrimination legislation and policies by locating the social problem in the very presence of 'culturally distinct immigrants' and their inability to be sufficiently 'British'. Ironically, on their part, the black and brown settlers were less concerned about preserving cultural differences than about fighting for equal rights.

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➢ **Redefining racism:** the emancipatory struggle of black and brown folk in the 60s and 70s and their struggle for political equality focused on opposition to racist immigration control policies, racist attacks and police brutality. The official response to this led to a redefinition of racism. Racism no longer simply meant the denial of equal rights, but the denial of the right to be different. This apparently sensitive approach is underpinned by that same long held assumption: that black people are in some fundamental way different from the 'British' and that the problem of race relations is about how to accommodate these so called differences. In effect, this redefinition of racism meant the displacement of the struggle against racism on to a cultural plane. *"As state funding became linked to cultural identity, so different groups began asserting their particular identities."*

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➢ **Competing cultures:** presentation of a case study of Bradford (1976-). Shift from political issues (policing and immigration, housing, etc.,) to religious and cultural issues (faith schools, separate education for girls, protests over Satanic verses, etc.,). New relationship between local council and mosques – the channelling

of resources through the mosques strengthened the position of conservative minded religious leaders. The continuation of this multiculturalist brief to allow Sikhs and Hindus to express their 'distinct' identities and the enhancing of divisions and tensions between different communities in the struggle for a greater allocation of council funding.

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➢ **Failure of multiculturalism:** multiculturalism is not a demand from black communities for cultural recognition but an effect of official policy in response to earlier militancy over inequality, social deprivation and political disaffection. Encouragement of pursuit of 'parallel lives'. Entrenchment of divisions between communities.

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- **Conclusion of Malik's argument**
- Malik concludes that:
- *"The real failure of multiculturalism is its failure to understand what is valuable about cultural diversity. There is nothing good in itself about diversity. It is important because it allows us to compare and contrast different values, beliefs and lifestyles, and decide which are better and which worse. It is important, in other words, because it allows us to engage in political dialogue and debate that can help create more universal values and beliefs."*

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- According to him, multiculturalism attempts to suppress the making of such choices and judgements. Under the guise of teaching 'tolerance' and 'respect' it breeds indifference to other people's lives.

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- **EXERCISE**
- Using what you have so far learnt, try and draw a difference between multicultural and race-equality policies. Do this by discussing workplace policies or those at the college or university where you are based. Take notes and discuss with friends or colleagues. Then, in the light of Malik's argument, write in no more than 1,500 words whether and to what extent, in your view and experience, multiculturalism hinders or helps to address 'diversity' and tackle discrimination? Use a case study of an organisation or service to illustrate your point.

References

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- Commission for Racial Equality, Disadvantage & discrimination in Britain today – the facts, www.cre.gov.uk/duty/duty_facts
- Malik, K., The real value of diversity, Connections, Winter 2001/02, CRE, www.cre.gov.uk/publs/connections/com_02wi_diversity
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- Feuchtwang, S., Racism: territoriality and ethnocentricity, in Cambridge, A. X., & Feuchtwang, S., (eds.), Antiracist Strategies, Avebury 1990
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- Bissoondath, N., Breaking the Mosaic, Connections, CRE, Winter 2001-2, www.cre.gov.uk/publs/connections/com_02wi_diversity
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ANNEXE 2.3

Does « Crack » Cocaine Discriminate ?
Deconstructing the Stéréotypes

Does 'Crack' Cocaine Discriminate? Deconstructing the Stereotypes

Robert Stutman from the US DEA, as people might remember, visited these shores 13-14 years ago, during 1989, prophesying a 'crack' fuelled doom for UK, similar to the one then being visited on New York City as well as on other US cities. He talked to politicians, the police and some lead care and treatment bodies. According to one of the commentators, the benighted vista projected by Stutman, was one of crazed 'crack' addicts, crime, and guns. The 'yardies', or gangs of violent Jamaican gangsters, were portrayed as the plague-carrying spearhead of this particular epidemic. The substance itself became so demonised as to lead various public agencies to believe Stutman's suggestion of its immediate and lethal addictive properties. This concocted imagery of race (black) and drugs (crack) - so much closer to horror comic-strip portrayals, and so much more distant from every day reality - had the overall effect of titillating some minds with further racist representations and caricatures of black people and drugs through media hype, but left no lasting other effects. It rightly deserved to be ignored. However, there was an unfortunate side of things to all this: the overall neglect of the real public health and public order issues associated with crack-cocaine abuse. These should have been examined thoroughly and pragmatically because, crack had indeed "arrived" though it did not make its appearance in the lurid forms described by Stutman. The rejection of Stutman's "war on drugs" message ought neither to have blinded us to taking a serious look nationally at the use and abuse of crack-cocaine in terms of health (prevention and treatment), nor to ignore its impact on UK drug markets, availability and crime.

Several years on it is once again being claimed that crack has "arrived in" Britain. Its second arrival is once again in danger of being signalled in Stutman-esque terms and suffering a similar fate. Only, this time the message will have been delivered not by the US DEA but by our own experts. The signs look ominous. Much of the imagery and hyperbole of the late 1980s are being regurgitated. Only this time around the association of crack with black is being claimed, in no small measure, on behalf of black communities and individuals rather than simply being foisted from the outside. It is open to question, but only just, whether the second "arrival" of the crack phenomenon, and its announcement, are quite the doom-laden scenario presented by Stutman those many years ago, or whether we are prepared to reserve judgement in our own supposedly pragmatic fashion until we can take a critical look at all the relevant information.

What has always made the latter possibility more problematic is the historical intertwining of race and drugs, and in particular of 'crack' with black to an extent as to make the one almost inextricable from the other. Both race and drugs are emotive subjects for reasoned discussion. Discourse on either is often confused and confusing, impinging as they both do on issues of territoriality, otherness and the crossing of frontiers, rendering open-minded, reasoned discourse well nigh impossible. However, reasoned discourse is what we need if we are to be guided by reality and not by emotions conjured by moral panic. This paper is intended as a contribution to examining things relating to crack-cocaine as they are and not as the 'war against drugs' rhetoric would have us imagine them to be.

Race & Drugs: Historical Context

Marek Kohn's classic *'Dope Girls'*[35], can be regarded as a major corrective to today's anti-historical debate on race & drugs in UK. Karim Murji's various and ongoing interventions, in particular "*White Lines: Culture, 'Race' and Drugs"*[36], and Kohn's book are a serious attempt at unravelling and, therefore understanding the race and drugs discourse in UK. Both refer inevitably to crack. Here is how Kohn sums up the pre-occupations of the day. The underlining has been added:

[35] Kohn M. **(1992)** ***Dope Girls: The Birth of the British Drug Underground*** **Lawrence & Wishart Ltd., London.**

[36] Murji, K. **White Lines: Culture, Race and Drugs, in South N. (Ed),** ***Drugs: Cultures Controls and Everyday Life*****, Sage (1999)**

> ***"The styles change; so do the issues. The grand themes may, regrettably, be more endurable. Although the undiluted racial venom has been flushed out of the dope discourse, drugs still provide a way to articulate racist themes in code. They act as a discursive alarm bell – halt the debate, declare war, take cover. In such an atmosphere, associations between drugs and a particular ethnic group may become more important than the underlying reasons for those associations. Now that racist themes are largely confined to the subtext of public debate, the payload can be transferred to drugs: the menace implicit in 'black' is shifted to 'crack'.***
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> ***"In its more general lines, the drug problem today retains much of the earlier xenophobic geometry. The theme of foreign criminal conspiracies is accompanied by a profound anxiety about the violation of national boundaries by smugglers; the discourse is dominated by metaphors of war and disease – the 'war on drugs', the 'drug plague'. Drugs remain the 'other', and arouse the same passions in the Western subconscious as does the non-European 'Other'. Mrs. Thatcher once spoke, notoriously, about British fears of being 'swamped' by an alien culture; the media speak incessantly of being 'swamped' by a 'flood' or a 'tidal wave' of drugs.*** **(Kohn, 1992, p10).**

In the event that in today's world the citing of such texts could be regarded as contributing to a blind anti-Americanism, two powerful contemporary American texts elaborate a similar logic.

1. Terry Williams, the internationally known author of 'Crack House'[37] and 'Cocaine Kids' tells us that:

"Cocaine has been used, abused, bought and sold by people in just about every strata of society over the last hundred years. The shifting public responses to that use have made it clear that social attitudes are key to our assessment of the drug."

Williams, moreover, is quite precise about the early 1980s being the time during which crack-cocaine came to be seen as a problem drug in New York City (as well as elsewhere in America). He states that, from an upper class drug in the 50s and 60s, one used by artists, poets, writers, musicians, and members of the medical profession - and apparently without the attendant panic, instant addictiveness, and harm attached to it in discourses similar to those of Stutman – free-base cocaine in the form of crack came to be portrayed as a demon drug in the early 1980s.

[37] Williams T. **(1992), *Crack House*, Addison Wesley**

2. The more recently published book *'Crack in America: Demon Drugs and Social Justice'*[38], confirms Williams' view that a shift in social attitudes towards the use of crack in the early 80s is a key to our assessment of the drug. In a series of chapters written by acknowledged sociologists, ethnographers, psychiatrists and clinicians the book sets out to deconstruct all the attendant mythology and media hyperbole surrounding crack-cocaine, and to separate fact from fiction. It, together with Kohn, Williams and Murji, deserves to be read, as a pre-condition to any intelligent discussion by all relevant strategists and policy makers in Britain today.

Both US texts explore the reasons why American and subsequently our attitudes changed so radically around crack-cocaine:

- The early 1980s, as stated previously, are a landmark period, for it is then that crack-cocaine makes its appearance as a street drug, ready made. From being an upper class drug, free-basing cocaine, or smoking 'crack' as it then became known, became available as a street drug, and at very affordable prices.

- The rapid downward mobility of crack-cocaine, already packaged for free-basing, turned it into an attractive product for the illicit ghetto markets. Instant highs and instant profits go together in such situations. As does territoriality and the wherewithal to defend, and when possible, to expand one's territory through encroachment and the search for new openings. Since ghetto life consists predominantly of those who live on the social and economic margins of society, and since many of them are characterised as minorities, their presence itself marks them off as highly visible members of the ghetto. The identification of crack with black thus becomes easy to make, particularly as far as the media is concerned. In presenting us with selective pictures and headline stories of violence, it is the media that makes a killing. Stories and picture of this kind sell. Add the missing ingredients of glitzy jewellery and fast cars and the demonisation of crack by association, is complete.[39]

- As for the substance itself, the authors argue that it has low (3.5 – 7.5 %) addictive liability. This confirms what Professor Patricia Ericson, then based at the Addiction Research Foundation (Toronto), wrote in an article soon after Stutman's visit to UK.[40] Most research since appears to

[38] **Reinarman C. & Levine, H G Eds.** (1997) *Crack in America: Demon Drugs and Social Justice,* Berkeley. University of California Press, London

[39] Of particular note is the portrait of Dave Francis, drawn by Nick Davies in his article "Heart of Darkness", Guardian, June 4, 1997. An illuminating analysis of this article, with its imagery of night and ill lit streets, its selective intertwining of images of race and drugs, is to be found in **Feuchtwang S.** (1999) in Cahiers T3E, No. 5: *"The threat to care: working at the margins of fear and uncertainty."*

[40] **Erickson P.** (1990), Cocaine and addictive liability.

confirm that, compared to heroin and tobacco, cocaine does not lead to anything near the same degree of physical or psychological dependency.

- The use of the paradigm *drug (or substance) – set (the user) – setting (the environment)* is often used by clinicians to understand the range of effects that can potentially be induced by different substances amongst different individuals in different settings. At a more commonsense level it is analogous to the advice often given during the 1960s about the optimum conditions for using LSD. It was said that one would need to be at peace with oneself and physically rested; that it was best to take it with a partner or friend (also at peace with themselves) and, that it was best to take out in the open countryside. The set (user) and the setting may change but the substance remains the same. Cocaine is often described as a "more-ish" drug. Free-basing is said to have the effect of intensifying the "rush". Since the high does not last for very long it leads to a quest for more and more highs, carrying ever-diminishing returns. The settings for such binges, crack-houses and such, are far from the salubrious surroundings of upper class free-basing sessions. The attendant risks to personal health are also higher: poorer people do not have the same economic, emotional and social resources to deal with their crack-cocaine use if it gets out of hand.

History and memory

One of the major problems today is the rush to find instant solutions to things that are, in fact, quite complex and cannot be instantly fixed. Ironically, this instant search for solutions mirrors the user's equally instant search for another gratifying high and it is just as ephemeral and doomed. It can and does lead to an uncritical acceptance of diverse kinds of selective data that are not compatible with each other; to a lack of clarity between what is being presented as anecdote and what is systematically collected qualitative data; to an unquestioning acceptance of things that rest on the dignity of the person saying them rather than on the logic and coherence of facts and ideas that are presented; to an absence of peer-review of epidemiological and clinical (in the broadest sense of the term) research. It is a simplistic quest for what eventually turn out to be self-serving solutions, allowing no time, for example, for examining those very underlying associations between black and crack that Kohn talks about. Conversely, this search for the new also ignores the lessons to be learnt from history. I am reminded of an eminent and respected historian of substance use who visited the then offices of the drugs tsar and deputy tsar in order to try and put historical research and writing on the agenda, only to be told that UKADCU was not about looking into history but into the future (sic).

The French philosopher, Alain eloquently reminds us in his essay on Mnemosyne[41] (goddess of memory and mother of the seven muses) that knowledge is as old as the hills and that one has arrived too late. An architectural column will always recall other columns, be they classical, medieval or modern; baroque or gothic; etc. The problem, he adds, is not that everything has been said but that

[41] Alain (1957), "Mnemosyne" in "Essais sur l'Esthétique", Éditions Gallimard, Paris

nothing has been understood: *"Le paradoxe humain, c'est que tous est dit mais que rien n'est compris".* That is why, he argues it is necessary to write again and again on passions, on wars, on everything. Thus the new picks up on the past and repeats the lessons of the past albeit for changed and changing circumstances.

One of the more important aspects of my apprenticeship in the drugs field was in attending the South West Regional Drug Workers' Forum (SWRDWF), on a regular basis over a period of five years. It provided a unique space for open-minded and structured discussion. It was there that I came to learn of the risks inherent in demonising a particular substance, from some of the most committed advocates on behalf of a much stigmatised group: drug users. Because by demonising a substance you not only demonise the user but also diminish the chances for effective and appropriate public health and public order responses. A person using crack-cocaine on a regular and prolonged basis has effectively tortured his/her body by depriving it of sleep and nourishment. That person will require treatment which, let us say, is diametrically opposed to what is required by someone in a similar situation with heroin use.

SWRDWF also provided the template for the first four or five years of the Black Drug Workers' Forum (1989-94). That was also a space for open-minded and democratic discussion. I remember us grappling with an issue placed on the agenda by one of our members about Khat use amongst the Somalis. The consensus arrived at was that before taking any action we needed to find out something more about why a substance of traditional use around the Horn of Africa and the Arabian Peninsula had now come to appear as a problem. We certainly wanted to have no part in criminalising yet another substance.

Today

History adds another twist: in the process of developing some thoughts for the mapping of all available information on crack-cocaine I conceived of the idea of a comparative three city mapping, including London, New York and Amsterdam. Consequently, I approached Terry Williams in New York as a possible partner, with an outline of my ideas. While agreeing to the project, he did alert me to the fact that in New York City the problem today was no longer so much crack-cocaine abuse as metamphetamines. It would seem that in the drugs field things also follow historical cycles. This should come as no great surprise to those many professionals, like those encountered in SWRDWF, who continue to do committed work at the frontlines of social exclusion with often difficult clients, including crack users, and in demanding circumstances.

This work needs to be supported by policy makers. In doing so, our policy makers need also to appreciate that such work can be undermined easily and front-line workers can become de-skilled by the claims now being made that crack is a black thing, or more of a black thing than a white one.

Finally, there is no natural affinity between crack-cocaine, guns and violence. I am reminded of Spike Lee's seemingly detached but unflinching look at ghetto life. If I read it correctly, his take on the advent of crack as a high profit, high risk, illicit commodity in ghetto life represents an attempt by some to better their life in the ghetto, often at the expense of others occupying the same space, and with disastrous results. People, in particular visible minorities, who are forced to inhabit such ghettos are usually referred to as 'the underclass'. However, Feuchtwang[42] alerts us that *"Underclass is a convenient term, which can be used as sympathy or as condemnation. The analysis of extreme poverty as a trap out of which there is little social mobility, is bedevilled by the sociology which names it a class apart.. 'Underclass' is a description where there should be an indictment of the processes which produce extreme poverty and trap people in it. 'Underclass' is a passive term. But it is difficult to take a more active stand, which in the end must be political, .."*.

References:

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Williams T. **(1992), *Crack House,* Addison Wesley**

[42] **Feuchtwang S.** (1999), op. Cit., p.14

I am thankful to David Tomlinson for reminding me of Spike Lee; to Mike Ashton for his editorial comments; and, above all to Maggie Telfer who invited me to the BDP conference to give a talk, of which this paper is a revised and edited version.

Culture before client – the wrong way for drug services

Many approaches to black and ethnic minority drug services are unwittingly flawed and racialist. In a strong criticism of service planning, Mike Ashton and Kazim Khan argue for a radical approach to providing 'visible minority' drug services[i].

There is a perceived wisdom that runs through most strategies of drug services to 'visible minorities'. It says it is arrogant and patronising to imagine that white policymakers, commissioners and managers can possibly know what services are best for minority groups. This implies that the reason minority groups do not take up treatment is because nobody from 'their' race greets them as they come through the door.

What's wrong with that? Surely we live in a multi-cultural society and those running public services must be culturally sensitive to the needs of us all? Absolutely right. But this emphasis on multiculturalism to determine policy is both wrong and dangerous. The notion that race determines an individual's abilities and characteristics is racialist[43] in the most basic meaning of the word.

More black workers?

Increasing the number and status of black and 'minority ethnic' workers in drug services is central to many of the strategies put forward. But it would only be an appropriate way to improve the race equality performance of drug services if:

1 the problem is the racism of the white and/or 'ethnic majority' people working in and managing these services;

2 the 'ethnic majority' are influenced and/or replaced by people who by virtue of skin colour or family/national/geographical origins do not share the problem of racism and are capable of equitably servicing the entire catchment population.

Neither of these assumptions is correct. Far more important than the views of individuals are organisational practices and structures. Many structures and practices are derived from outdated and narrow views of a population's characteristics and therefore effectively discriminate against individuals and groups who do not conform to that vision. Simply bringing in and promoting black workers is not enough to change these practices for the better.

[43] Racialism refers to a belief that human populations can be meaningfully divided and typologised into racial groups, wherein each such group is ascribed selective human physical and/or social attributes, which each individual belonging to such groups must bear as a sign or an essence. Such categorisation provides one of the conditions of existence of racism.

One face doesn't fit all

The second assumption presents us with two major problems. The first is the idea that matching clients and staff on race and culture dimensions is possible and desirable. It is not necessarily either. Given the shifting and diverse nature of race and culture and the impossibility of pinning down what 'race' and 'culture' people belong to means meaningful matching is not feasible.[44]

Young people born in Britain to immigrant parents or grand parents forge their own cultural identity. These identities are filtered through the experiences of racism. It is false to assume that all people whose parents or grandparents were born in a particular country and share a particular shade of skin colour also share a cultural and racial identity and have similar needs – which is itself a racist assumption.

Unless we assume that race/ethnicity overrides all other individual characteristics (again, racist) matching by racial/ethnic identity would also imply the desirability of matching by class, religion, age, gender, education and so on. Each service's staff would have to be as large as its caseload. More to the point, there is no evidence to show that matching by race improves counselling outcomes in drug or alcohol services.

Alternatively, the implication is that being a member of an ethnic minority makes one more able to understand and respond to anyone else who is a member of *any* other ethnic minority. Underneath yet another piece of racist logic is the assumption that all ethnic minorities are the same.

Clients before culture

Our alternative view at T3E is based on the simple observation that treatment services deal with *individuals*. The prime virtue in face-to-face work is to treat each individual without making assumptions based on skin colour or heritage – including the assumption that you will be *'on their wavelength'* because you share that skin colour or heritage. The task is not to deliver a *culturally* appropriate service but an individually appropriate service that takes account of the full humanity of the client, including culture and heritage.

Access to employment for all

[44] One example of these shifting margins is the racialisation of Islam and Muslims in the post 9/11 world.

Policies that exploit and develop the talents of the entire labour pool will benefit the *full range* of clients at the service, not just those from visible minorities. We do not believe that by improving employment access to minority groups necessarily leads to more of the same people seeking help. The drive to tackle institutional racism to improve service delivery will instead lead to improvements in employment practice.

The new buzz phrase these days is ‘cultural competence’. This is not, however, the key skill that needs to be developed. But if it were, it is not necessarily found in greater quantities in people of a particular skin colour. Neither has research found such an approach noticeably beneficial.

As a therapist, being aware of the *general* cultural background of people who share a client’s heritage may help, but it may also hinder if it leads to unwarranted assumptions about the individual before you.

Individuals not groups

At a management level, it is important to know the social structure of a catchment population and how to tap into it to promote high access. But calling this ‘cultural competence’ does not help. It diverts attention to a single dimension – that of cultural heritage and how it is manifest in the area. Heritage can also vary in terms of affiliation to that culture, wealth, employment, class, education and so on. It makes no more sense to talk of ‘cultural competence’ than of ‘class competence’.

There is also much talk of ‘cultural ownership and leadership’. But how are planners and managers to decide which cultures to own? Moreover, heavy users of illegal drugs often reject the values of their parents, authorities and local cultural and religious leaders.

A service owned and led by cultural spokespersons would not necessarily attract the clients it purports to neither target nor deliver an appropriate service to them.

Who speaks for whom?

Service managers and commissioners are often asked to identify key players who represent minority groups to help improve service planning. But what if we used the term ‘white’ instead of ‘black’? The flaws in this policy approach become obvious.

How would planners go about implementing such a policy? Probably by looking for groups who make their whiteness into a key defining feature like branches of the British National Party or the Royal Legion. This would give such people the power to shape services for white drug users born in the UK who would not consider joining any political party and would be considered unsuitable for the military. Do we believe that services would be any the better as a result? Yet this is the implication for planners seeking to find an ‘authentic’ black voice.

This is not to belittle the importance of engaging with the local community. A much more sophisticated approach can be seen in the document from the Scottish Effective Interventions Unit, *Effective Engagement: A Guide to Principles and Practice*.

Who is an ethnic minority?

Like so much of the terminology we are dealing with, the term ‘black and minority ethnic’ is flawed because it accepts the preconditions of racism: that people can be meaningfully categorised into racial groups. This is not a good starting point in tackling racism. It inexorably leads to an emphasis on how *different* ethnic minorities are from the rest of the population and a search for someone or some body capable of representing and interpreting these differences. This emphasis is fine for the careers of people who claim to be experts on these differences. It also underpins the claims for funding on the grounds that a service can articulate distinct cultures to managers and planners who cannot understand them because of cultural differences. Quite simply, there is a career to be made by claiming cultural competence, reinforcing what amounts to a serious distraction from good service delivery.

The term ‘visible minorities’ is better because it captures the essential fact that being ‘black’ or ‘minority ethnic’ is to do with *how you are seen by others*, not something inherent in you. The rest is a matter of encounter and discovery.

Cultural competence is just another version of the failed policies of multiculturalism that emerged during the Thatcher years as a diversion from the real issue. This was, and remains, social justice. It is the tackling of institutional racism that opens the doors for a more meaningful diversity or multiculturalism to emerge and not the other way around.

As the McPherson report on the Stephen Lawrence inquiry reminds us, it is institutional racism that must be dealt with. Until that is tackled head-on, the only diversity will be the ways in which government, commissioners and service managers do nothing. As a timely warning of the kinds of approaches we are criticising, and of the wider economic, social and political context within which drug services operate, we refer people to the chilling findings that have emerged as an outcome of the Climbié affair as well as from the reports on last year's riots in Bradford, Burnley and Oldham.

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AGENDA FOR MEETING IN REGGIO EMILIA
Friday 25 - Saturday 26 October 2002
The meeting will take place in the room of the Director General, SERT/AUSL Reggio Emilia, Via Amendola

Friday 09.00 - 13.00

1. **Introductions & Matters Arising from Amsterdam meeting**
2. **Discussion of proposed organisational review guidelines as a basis for writing guidelines for EU** (previously disseminated but further copy attached)**:**
   a) **Why? Treaty of Amsterdam and other relevant national legislation**
   b) **Interrogative audit and evaluation: what should this consist of? How should this be carried out? And, by whom?**
   c) **What follows (drawing upon experiences of partners to reflect on guidelines)**

Lunch (13.00-14.00)

3. **Bringing about a change in the work-place culture** (embedding the necessary equalities infrastructure)**:**

a) **The policy, procedure and practice development infrastructure and processes in the organisation**
b) **Implementation infrastructure and processes**

Close for the day (17.30)

Saturday (09.00-14.00)

c) **Accountability infrastructure and processes**
d) **Monitoring, review, evaluation and re-programming infrastructure**
4. **Reflections on follow up programme**
5. **Any Other Business**

Second Forum Meeting with Partners for Progressing Guidelines on Addressing Racial Diversity in Drug Prevention & Treatment Services

Amsterdam 19 –20 April 2002

AGENDA

Friday a.m.

1. Attendance and apologies

2. Stock taking – where matters stand
(a) Kazim
(b) Umberto
(c) Jan Lawalata
(d) Piet
(e) Jan
(f) Jerry

Friday p.m.

3. Moving forward
(a) Implementing EU racial equality directive into national legislation

(b) Can the T3E [UK] Action Points document help?

Saturday

(c) Agreeing areas for guidelines based on partners' experiences:

i. responsibility for implementation and structure
ii. employment issues
iii. services
iv. dialogue involving community based representatives

4. Preparations for final meeting in Bologna

5. Other matters arising

[i] Academics are frequently accused, and not without some justification, of having a penchant for acronyms. But so do others. Thus the fashionable shorthand term for 'black and minority ethnic' today is BME. May I please enter a plea here to avoid using this particular acronym? It demonstrates laziness and it is insulting. It may force some of us to start using the old-fashioned argot 'WASP' to restore some balance to an insulting equation.