Black and minority ethnic communities in England: a review of the literature on drug use and related service provision
National Treatment Agency

More treatment, better treatment, fairer treatment

The National Treatment Agency (NTA) is a special health authority, created by the Government in April 2001, with a remit to increase the availability, capacity and effectiveness of treatment for drug misuse in England. The overall purpose of the NTA is to: double the number of people in effective, well-managed treatment from 100,000 in 1998 to 200,000 in 2008; and to increase the proportion of people completing or appropriately continuing treatment, year on year. This is in line with the UK drugs strategy targets.

The Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire

Established in the late 1990s, the Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire has developed flagship projects and partnerships pursuing high quality, innovative, community-based research and development initiatives, focusing on the health and social care of Black and minority ethnic communities. The Centre currently consists of a multi-disciplinary team with a range of bilingual skills and extensive understanding of the UK’s multi-cultural and multi-faith communities. The Centre’s main activities lie in the fields of drugs and alcohol, mental health, community engagement, racist victimisation, regeneration and health, equality and diversity strategy development, and mental health law. To compliment the Centre’s research portfolio, teaching and learning activities are in continual development, with the aim of contributing to knowledge, expertise and good practice in the fields of ethnicity and health.

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Audience

This report is aimed at the providers and commissioners of drug treatment services and drug action teams. Further briefings will be developed by the NTA outlining the implications for practice of these findings.

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Definitions

Black and minority ethnic

In the documents we have read for this literature review, we are very conscious that various terms are used to refer to the many diverse communities in England. We prefer the term Black and minority ethnic groups / communities. This reflects that our concern is not only with those for whom ‘Black’ is a political term, denoting those who identify around a basis of skin colour distinction or who may face discrimination because of this or their culture: ‘Black and minority ethnic’ also acknowledges the diversity that exists within these communities, and includes a wider range of those who may not consider their identity to be ‘Black,’ but who nevertheless constitute a distinct ethnic group.

A Black and minority ethnic group is absent from this review only because no information relating to drug use amongst them was discovered. Information about drug use amongst those from other European Union countries living in England and amongst recently-arrived refugees and asylum seekers (from countries including central and eastern Europe) is particularly sparse.
Executive summary

- This literature review makes a significant contribution to understanding the needs of Black and minority ethnic communities in relation to drugs and the processes by which agencies could respond better to the needs of diverse populations.

- Three key themes are evident in the complex relationship between ethnicity and illicit drug use:
  - the lack of knowledge about the nature and extent of drug use amongst the UK’s Black and minority ethnic groups
  - that Black and minority ethnic groups are not homogeneous
  - and the impact of social, economic and psychological factors on drug use.

These issues, coupled with the multi-dimensional nature of drug use, fears of accusations of racism, and a general lack of Black and minority ethnic health and social care workers and researchers, has created an environment where the issue of ethnicity, drug use and related service provision has been neglected.

- It is clear that consideration of the drug service needs of Black and minority ethnic groups is urgently required so that these services can improve delivery, retention, and outcome to all members of the communities they serve.

- A thorough literature search was conducted in order to identify literature relevant to this review. Much of this can be defined as ‘grey literature,’ most of which has used qualitative research methods and has often been conducted by those with unique access to the Black and minority ethnic community under investigation. Whilst individually, some of this research may lack academic rigour, collectively, over the last 14 years, unpublished research reports have produced largely consistent, valuable snapshots of drug use and the related drug service issues amongst Black and minority ethnic groups.

- Drug-related issues are researched amongst some Black and minority ethnic communities far more than amongst others. For instance, there is far more information on drug use amongst South Asian populations (Bangladeshis, Indians and Pakistanis) than amongst other BME groups, especially those more recently-established in the UK, such as refugees and asylum seekers.

- The review is presented in terms of key themes that arise directly from the literature, comprising prevalence and patterns of drug use amongst Black and minority ethnic communities; drug service issues, including barriers to service access; and drug awareness. The concluding chapter looks specifically at service development issues and identifies the key messages for drug service planners, commissioners and providers, taking account of the implications of the Race Relations (Amendment) Act 2000 and Models of care for the treatment of drug misusers (NTA, 2002).

Prevalence of drug use amongst Black and minority ethnic communities

- The risk factors for problematic drug use centre around social exclusion and deprivation. There is much evidence to show that Black and minority ethnic populations are particularly at risk, despite general population and school surveys reporting that Black and minority ethnic respondents - particularly South Asians - are less likely than white respondents to use illicit substances.

- A number of studies have examined the perceptions of Black and minority ethnic communities on the prevalence of drug use and, in some areas, within some communities, it is perceived to be increasing and as prevalent as it is within the white population.
Results from studies specifically designed to discover the actual drug use of members of Black and minority ethnic groups provide statistics to support the impressions that it both occurs and is increasing.

Patterns of drug use amongst Black and minority ethnic communities

- The literature provides evidence of various forms of drug use within young Black and minority ethnic communities and indicates that this is based on a similar range of substances used by white respondents. However, differing patterns and levels of drug use amongst the different Black and minority ethnic communities have been reported.
- As in the white population, cannabis is the most widely-used illicit drug amongst the younger members of Black and minority ethnic communities.
- The inclusion of heroin and crack cocaine in the drug-using repertoires of some Black and minority ethnic drug users has been reported since 1993.
- Evidence of the widespread use of ‘dance drugs’ (ecstasy, amphetamine and LSD) by young members of Black and minority ethnic communities is contradictory.
- Qat (or kat, khat) use appears to be restricted to certain Black and minority ethnic communities.
- The use of pann, bhang and the excessive use of prescribed tranquillisers appears to be specific to the older generation of some young Black and minority ethnic groups.
- The reasons why younger members of Black and minority ethnic groups use drugs are the same as for the white population - curiosity, boredom, peer influence, and pleasure - with the significant additions that drugs are used to gain acceptance from, or ‘fit in with’ white peers and to cope with the tension of being non-white in a predominantly white community.
- Injecting by Black and minority ethnic drug users is found to be less prevalent than amongst white drug users. Nevertheless, this mode of administration is not unexceptional amongst Black and minority ethnic drug users.

Drug service issues

- The issues raised by the literature on the subject of drug service provision for Black and minority ethnic communities are an acknowledgement of need, ethnic monitoring, anti-discriminatory strategies, publicity, drug services for Black and minority ethnic women, services for the carers of drug users, and barriers to service access.
- Barriers to service access are identified by the literature as the lack of acknowledgement of drug use by Black and minority ethnic communities themselves, ethnicity of staff, a lack of understanding of Black and minority ethnic cultures, language, lack of awareness of services and their functions, and fears about breaches of confidentiality.

Drug awareness amongst Black and minority ethnic communities

- The research conducted on drug awareness implies that younger members of Black and minority ethnic communities are more knowledgeable than the older generations.
● Increasing drug use amongst young people from Black and minority ethnic communities has been attributed to differences between the cultural norms of different generations.

● The relatively poor knowledge about drugs by the older generations of Black and minority ethnic communities, and their unwillingness to discuss the issue both within and outside the family and community, contributes to drug use amongst some Black and minority ethnic communities remaining hidden. Coping strategies include sending the drug user to the family’s country of origin, paying for private treatment, and an enforced ‘home detox.’

● It is demonstrated throughout the review that cultural appropriateness - including community consultation and drug awareness training - is at the centre of policy and planning initiatives to provide drug services to Black and minority ethnic groups.

Developing appropriate drug services for Black and minority ethnic groups: the way forward

● The key methods by which drug services can be made more accessible to Black and minority ethnic communities are identified by the literature as multi-agency working, outreach work and action research, and, particularly, community engagement initiatives. There is a continuing debate amongst commentators over whether specialist or generic drug service provision is the best way forward.

● The Race Relations (Amendment) Act 2000 challenges all public services to eradicate discrimination and disadvantage and it requires public organisations to have clear race equality action plans. This provides the impetus for drug services to address the shortfalls in the provision of appropriate and accessible services for Black and minority ethnic groups.

● The National Treatment Agency’s service framework for treatment - Models of care - has a specific section on Black and minority ethnic communities and draws on some of the evidence also presented in this literature review, identifying many of the same issues to be addressed. Models of care provides significant support to the evidence in this review and should result in more services and commissioners addressing the drug-related needs of Black and minority ethnic communities.
1 Introduction

1.1 Background

“The influence of ethnicity on illicit drug use is an under-researched topic. Ethnicity is not a single dimension of experience but a composite of identity, beliefs, expectations, cultural history and language. Many of these components are liable to change over time across successive generations. In addition, there will be a degree to which ethnicity overlaps with other social variables including, for example, unemployment, so that it becomes very difficult to identify the specific influence of ethnicity on drug use. A necessary first step is to establish accurate information on the extent of drug use within different ethnic groups.” (ACMD, 1998:25).

The above succinctly raises three key themes that are evident in the complex relationship between ethnicity and illicit drug use:

- the lack of knowledge about the nature and extent of drug use amongst the UK’s Black and minority ethnic groups
- that Black and minority ethnic groups are not homogeneous
- the impact of social, economic and psychological factors on drug use.

These issues, coupled with the multi-dimensional nature of drug use, fears of accusations of racism, and a general lack of Black and minority ethnic health and social care workers and researchers, has created an environment where the issue of ethnicity, drug use and related service provision has been neglected.

In 2001, the National Treatment Agency for Substance Misuse (NTA) was established by Government with the aim of increasing the capacity, quality and effectiveness of drug treatment in England. The NTA (2001) has identified diversity as one of its key strategic objectives, recognising that significant portions of England’s diverse population are often excluded from drug treatment:

“Action to ensure equal access to relevant and appropriate services for the whole population, regardless of age, gender, sexuality, ethnicity, disability or location, will be a theme across all NTA activity.” NTA website, 2002

The NTA has published this literature review as the first step referred to by the ACMD (above) in order to establish the knowledge base. The available information on the extent and patterns of drug use within different Black and minority ethnic groups has been collated, and the review also explores what can be learned from the literature about the types of service developments that will be needed to meet their needs.

This review shows that drug-related issues are researched amongst some Black and minority ethnic communities far more than amongst others. For instance, there is far more information on drug use amongst South Asian populations (Bangladeshis, Indians and Pakistanis) than amongst other Black and minority ethnic groups, especially those more recently-established in the UK, such as refugees and asylum seekers. However, a recent project funded by the Department of Health (Centre for Ethnicity and Health / Department of Health, forthcoming) will result in the publication of 47 drug needs assessment reports that were undertaken by Black and minority ethnic community groups representing 25 different ethnicities, including some about which no other drug-related information has been discovered in the search for literature to include in this review (this project is further reported in section 6.5.2).

Patel (1997) discusses the rise in research into substance use by Black and minority ethnic communities in the 1990s, but stresses that it was uncoordinated and sporadic, leading to much duplication, and that although this research produced valuable evidence of a problem, little action resulted in terms of service development. Sheikh et al (2001) also report that some young Black and minority ethnic communities feel there is too much research on their drug use and too little action on
the findings. A comment by Hall (1987) in relation to the ‘race riots’ of 1985 is recalled by Solomos (1999) in a critique of *The Stephen Lawrence Inquiry* (Macpherson, 1999), the inquiry into the racist murder of Stephen Lawrence and is significant in this context too:

“...I have a reluctance about entering once again into what seems to me a terribly familiar and recurring cycle. The cycle goes something like this. There is a problem that is followed by a conference; the conference is followed by research; the research reinforces what we already know, but in elegant and scholarly language. Then nothing happens.” Solomos, 1999:45

There is relatively little peer-reviewed, published literature concerning drug use amongst Black and minority ethnic groups and related service issues from England although, as this review demonstrates, many relevant initiatives have been carried out at local level. However, results and recommendations are usually unknown outside the agencies and communities involved. The result is that there is a history of ad hoc and piecemeal projects that rarely translate into sustainable service developments and appear to have had little or no impact on drugs strategy. Several commentators insist that drug service development initiatives for Black and minority ethnic communities should be monitored, evaluated and disseminated, in order that lessons can be learned by all service providers (Gooden, 1999; Hothi and Belton, 1999; Patel, 2000b).

Until recently, national drug policy was notable for its failure to address Black and minority ethnic drug use and service provision. *Tackling drugs together* (1995), the Government drug strategy for 1995-1998, neglected to mention anything at all. The *Task Force to review services for drug misusers* (1996) contained only a small section on ethnicity and drugs, claiming that there was insufficient evidence to judge whether Black and minority ethnic groups find treatment agencies less accessible than the rest of the drug-using population. The Task Force (p89) pointed out the need to work with local community representatives to identify and respond to service needs, adding that “These responses may include ensuring services have people from ethnic minorities on their staff”.

The government drugs strategy, *Tackling drugs to build a better Britain* (1998) recognised the evidence that has consistently shown that Black and minority ethnic drug users regard much of the existing drug treatment services as run by, and for, white people; that drugs workers require training on not only race, but also wider equality issues; and the need for better targeting and design of services to attract clients from Black and minority ethnic communities. The guidance notes to *Tackling drugs to build a better Britain* accepted that Black and minority ethnic drug users under-use the range of treatment services available and those involved in the purchasing and provision of services are encouraged to give consideration to race equality, accessibility and practice. In addition, the strategy encouraged drug action teams to undertake needs assessments by taking a detailed look at patterns of drug use amongst Black and minority ethnic communities in their areas and to consider cultural diversity in the delivery of services. The Updated drug strategy (2002) reiterates that “opiate users from minority ethnic groups are less likely to engage in drug treatment than their white counterparts” adding that there are “significant shortcomings in......specific provision for minority ethnic women” (p51).

The updated strategy also echoes an observation by ACMD (1998) by noting that “Ethnic differences in patterns of drug misuse suggest that the needs of some minority ethnic groups are marginalised by existing services, which tend to focus on injecting rather than smoking”. (p52).

However, few comprehensive needs assessments have taken place, and there have been little or no attempts to review the effectiveness of mainstream drug treatment interventions for Black and minority ethnic drug users. A progress report on the drugs strategy (Home Office, 2001) contains just five tangible achievements in relation to BME communities:

- the Community Drugs Misuse Needs Assessment Project in which 47 Black and minority ethnic community groups throughout England were supported to conduct drugs needs assessments (Centre for Ethnicity and Health/Department of Health, forthcoming)
- a drug education project aimed at Turkish-speaking people in Haringey
- £1 million to be shared between research on drug services for Black and minority ethnic communities and for women
• a small grant for drugs-awareness-raising initiatives amongst the African Swahili-speaking community of London
• a brief ‘success story’ detailing the help received by a Chinese drug user from a Chinese community worker.

Further action and targets in relation to Black and minority ethnic groups are couched in vague terms such as “substance misuse education for all young people and their families” (p10).

1.2 Methods

In order to identify publications for this review, the four most extensive relevant databases were searched:

• Web of Science
• PsycInfo
• English Nursing Board (ENB)
• Addiction abstracts.

The review contains many references to ‘grey’ literature, generally defined as publications that have not been peer-reviewed. Fountain (2002) points out that there are various shades of grey however: for example, an article in a ‘trade’ magazine (such as Druglink for those in the drugs field) has been accepted by the editor(s), and reports on research funded by government departments are peer reviewed before being accepted and again if they become government publications. As noted earlier, drug-related initiatives dealing with the drug use of young Black and minority ethnic groups have been undertaken at local level, and reports on these comprise the ‘greyest’ literature. They often have an extremely limited circulation and locating them can be problematic. Therefore, as the literature sources listed above do not include grey literature, the following strategies were also employed to identify relevant publications:

• www.QED.emcdda.org (which contains an annotated bibliography of qualitative research on aspects of drug use in the UK)
• DrugScope library database
• documents and research reports collected over the years by the Centre for Ethnicity and Health, including its own research projects and those from elsewhere in England
• documents resulting from a mailshot to every drug action team in England requesting any relevant reports of research undertaken in their areas.

Most of the research reported in the grey literature from the sources above has used qualitative research methods and has often been conducted by those with unique access to the Black and minority ethnic community under investigation. Whilst individually, some of this research may be lacking academic rigour, collectively, over the last 14 years, unpublished research reports have produced largely consistent, valuable snapshots of drug use and the related drug service issues amongst Black and minority ethnic groups. Therefore, in order that this review is as comprehensive as possible, all the relevant literature that was identified was included and deviations from the norm were not ignored. The result of this all-inclusive strategy can only be beneficial to building up a knowledge base in the dearth of relevant peer-reviewed publications. The focus of the review is illicit drugs: alcohol and tobacco are therefore not included. However, where appropriate, the use of legal substances such as prescription drugs, qat and solvents are included. A Black and minority ethnic group is absent from this review only because no information relating to drug use amongst them was discovered by the search methods described above. Information about drug use amongst those from other European Union countries living in England and amongst recently-arrived refugees and asylum seekers (from countries including central and eastern Europe) is particularly sparse (see also Sangster et al, 2002:1).
Almost 150 academic journal papers, articles in relevant trade magazines, research and conference reports, and book chapters have been reviewed. Although this review is concerned with England, some of the literature refers to the UK as a whole. For a review of the literature on drug use amongst Black and minority ethnic communities in Scotland, see Hay et al (2001).

The review is presented in terms of key themes that arise directly from the literature, comprising prevalence and patterns of drug use amongst Black and minority ethnic communities; drug service issues, including barriers to service access; and drug awareness. The concluding chapter looks specifically at service development issues and identifies the key messages for drug service planners, commissioners and providers, taking account of the implications of the Race Relations (Amendment) Act 2000 and *Models of care* (NTA 2002). It is clear that consideration of the drug service needs of Black and minority ethnic groups is urgently required so that these services can improve delivery, retention, and outcome to all members of the communities they serve. This literature review makes a significant contribution to understanding the needs of Black and minority ethnic communities in relation to drugs and the processes by which agencies could respond better to the needs of diverse populations.

Finally, it should be noted that this review reports on the issues raised by the literature available at the time of writing. It does not necessarily reflect the opinions of the authors nor of the NTA.
2 Prevalence of drug use amongst Black and minority ethnic communities

This chapter presents information about the prevalence of drug use amongst Black and minority ethnic groups in England. It begins by placing this in the context of social exclusion and deprivation that are so often features of drug use amongst the white population. The chapter continues by collating the information from studies on the perceptions of drug use amongst Black and minority ethnic populations, followed by results from research on actual prevalence.

Since the early 1980s, there has been clear evidence that a concentration of the most serious drug-related problems are in areas of high unemployment and social deprivation (Haw, 1985; Peck and Plant, 1986; Pearson, 1987a, b), where the majority of young Black and minority ethnic groups live. Much has been written about the high levels of poverty, deprivation, educational disadvantage and discrimination in the labour force amongst the UK’s Black and minority ethnic communities. For example, a study by the Policy Studies Institute (Jones, 1996) highlights serious levels of poverty and low economic activity, especially amongst the Pakistani and Bangladeshi communities. There is also recognition that certain people - particularly young people - with a range of predisposing psychological and/or social factors are more at risk of developing drug problems. These factors include a history of offending, mental ill health, school exclusion, being in local authority care and homelessness (Lloyd, 1998). These categories are not mutually exclusive and young people are likely to fall into several of them. A range of economic factors such as neighbourhood deprivation and disintegration and high levels of unemployment underpin these psychological, social and family factors.

The vast majority of England’s Black and minority ethnic groups are concentrated in some of the most deprived inner city areas (SEU, 1998a), where, in some cases they are the majority, not the minority, population. Many of these communities are young and growing, with nearly half under the age of 25 (ONS, 1997). Black and minority ethnic people figure disproportionately in statistics of those:

- unemployed (CRE, 1995; Jones, 1996)
- living in poverty (Jones, 1996)
- in the criminal justice arena (Home Office, 1998)
- detained under the Mental Health Act 1983, especially some BME groups in high and medium secure services (Clarke et al, 1993; Department of Health, 1999a; HSPCB, 1997; MHAC, 2001)
- in ill health (Arora et al, 2000; Erens et al, 2001)
- vulnerable to homelessness (RAPP, 1996; Chahal, 2000).

Thus, the position of many young people from Black and minority ethnic groups is that their social and economic circumstances mean that they are at risk of problematic drug use (Patel and Wibberley, 2002). However, despite the clear relationships between harmful drug use and the range of pre-disposing factors experienced by Black and minority ethnic communities, both general population surveys (Leitner et al, 1993; Ramsey and Spiller, 1997) and school-based surveys (Parker et al, 1995) have suggested that BME respondents - particularly South Asians - are less likely than white respondents to use illicit substances. These results have often been interpreted to mean that drug use is relatively insignificant amongst BME populations, but it is important to recognise that fears about stigma within these communities may mean that drug use is not revealed to researchers. An additional limitation of such surveys is revealed by Sangster et al (2002) whose analysis of the 1996 British Crime Survey (BCS) results (Ramsey and Spiller, 1997) concludes that the proportion of Black and minority ethnic respondents is too small to conduct a meaningful analysis on the differences between ethnic groups. The 2000 BCS (Ramsey et al, 2001) included an ethnic booster sample and,
overall, revealed higher proportions of BME drug users than found by previous BCS surveys, although reported levels of drug use amongst Black and minority ethnic respondents remained lower than amongst white respondents.

Although the knowledge base on the prevalence of drug use within Black and minority ethnic communities remains sparse relative to that on the white population (Johnson and Carroll, 1995), over the last 13 years a growing body of evidence indicates that it exists and/or is increasing (ADP, 1995; Awiah et al, 1990, 1992; Bola and Walpole, 1997; Bridge Project, 1996; Chaudry et al, 1997; Gilman 1993; Oyefeso et al, 2000; Patel, 1998; Shahnaz, 1993; Sherlock et al, 1997).

2.1 Studies on perceptions of the prevalence of drug use

A number of studies have examined the perceptions of Black and minority ethnic communities on the prevalence of drug use. In some areas, within some communities, it is perceived to be increasing and as prevalent as it is within the white population. For instance:

- South Asian parents in Crawley interviewed by Bola and Walpole (1999) perceived drug use in their community to be as prevalent as in any other.

- A series of drug service reviews by the Centre for Ethnicity and Health, University of Central Lancashire, which include interviews with service providers and community members in Calderdale (Bashford et al, 2001), Bury (Prinjha et al, 2001a), Bedfordshire (Sheikh et al, 2001), Bolton (Prinjha et al, 2001b), Shropshire (Bashford et al, 2000), and Waltham Forest and Redbridge (Sheikh et al, 2002) point to perceptions of the increasing use of a range of drugs - including heroin - in South Asian communities, particularly amongst young men.

- Young South Asian women were reported to be using drugs in the above studies and Gilman (1993) reports on community concerns about cannabis use by South Asian women in Bradford.

- Maynard (1994) and Gilman (1993 - see also Carrington, 1993) report that the Black Caribbean communities in Newham and Bradford respectively were concerned about crack cocaine use amongst their members. Chaudry et al (1997) report the use of this drug as a growing phenomenon in BME groups in Oldham. Similarly, representatives of Black and minority ethnic communities in Greater Manchester interviewed by Chantler et al (1998) reported increases in crack cocaine use by Black Caribbeans (and by white people) and in heroin use by South Asian males.

- Drug service providers and the carers of drug users in Nottingham thought that younger South Asians in Nottingham were increasingly using heroin, steroids and cannabis (Goeden, 1999). South Asian parents interviewed in Southall (Dhillon, 2001; Winters and Dhillon, 2002) were concerned about the increasing use of heroin and crack cocaine in their community.

- A senior South Asian community worker in Cheetham Hill, Manchester reported “five or ten years ago I used to say it [drug use] was a white man’s problem...Asians are not involved. [I was] absolutely wrong.” (Patel et al, 1998:14).

2.2 Prevalence studies

Results from studies specifically designed to discover the actual drug use of members of Black and minority ethnic groups provide statistics to support the impressions that it both occurs and is increasing. The majority of these studies are concerned with young members of Black and minority ethnic groups, particularly South Asians. For example:

- ADP (1995) found that 60% of a sample of young people in Tower Hamlets (77% of whom were South Asian) had used an illicit drug at least once. Carey (2000) reports that heroin is the drug of choice amongst Bangladeshi youths on the Ocean Estate in the same borough.
A survey of young South Asian people in Wakefield (APANA, 1996) discovered that 57% had tried drugs and 34% of them used drugs regularly.

Eighty-three per cent of the young South Asians questioned by Patel et al (1996) said they knew a drug user, as did most of those interviewed by Chaudry et al (1997).

Khan et al (1998) interviewed two groups of young Glaswegian males - 120 South Asians and 120 white people - about their drug use. Although the drug use of the South Asians was lower than that of the white sample, it was still significant. The authors’ main explanation for the difference is that the South Asians had been less exposed to drugs than the white respondents.

Arora and Khatun (1998) report that, in Bradford, the prevalence of drug use amongst young South Asians matched that of the general population.

Bentley and Hanton (1997) interviewed 150 young South Asians in Nottingham and found relatively high levels of drug use, and, unusually, that more of their female than male respondents had ever used a drug. The Bridge Project (1996) looked specifically at the drug use of 146 young South Asian women (mainly Pakistani) and discovered 45% had ever used a drug and 82% claimed to know someone who did. Such findings negate the assumption that South Asian women do not use drugs because they have little access to money and rarely go out (for example, Brannen et al, 1994).

The Thames Regional Drug Misuse Database (CRDHB, 1999) shows a significant increase in South Asian heroin users - mostly males and under 20 years old - presenting for treatment (see also Sondhi et al, 1999).

Similarly, the 1997/1998 Regional Drug Misuse Database for Anglia and Oxford records that over 30% of new cases presenting for treatment were from Black and minority ethnic communities, mostly South Asian (Sheikh et al, 2001).

In Tower Hamlets, London, one drug agency reported that ‘five years ago Bengalis would have accounted for approximately 10% of the client base, now they are over 40% and this is expected to rise.’ In addition, Bengali clients were ‘considerably younger’ than other clients (Patel et al, 2001:16).

Taken together, the evidence from both quantitative and qualitative surveys strongly indicates that prevalence of drug use within Black and minority ethnic groups is increasing and that even where it is shown to be less than the white population, it is still significant. The social and economic position of many Black and minority ethnic communities is especially conducive to drug use, particularly amongst young people, and there are clear indications that whilst drug use may be more concentrated amongst young Black and minority ethnic men, it is increasingly being reported amongst young Black and minority ethnic women.
3 Patterns of drug use amongst Black and minority ethnic communities

This chapter examines the research investigating the substances used by members of Black and minority ethnic communities, factors influencing drug use, and injecting behaviour.

3.1 Substances used

Sangster et al’s (2002) analysis of the 1994, 1996 and 1998 British Crime Surveys and other statistics provides evidence of various forms of drug use within Black and minority ethnic communities and indicates that this is based on a similar range of substances used by white respondents (see also Ramsey et al, 2001). However, differing patterns and levels of drug use amongst the different Black and minority ethnic communities have been reported, by, for example, Oyefeso et al (2000) amongst Black and minority ethnic communities in Merton, London. Further evidence of these differences comes from Sangster et al (2002) in their analysis of the Regional Drug Misuse Database (RDMD) data covering April 1999 to September 2000. This analysis suggests differences in patterns of drug use between drug users from particular ethnic groups presenting for treatment. Both Sangster et al’s statistical analysis and results from the qualitative component of the same study suggest that presentations to drug services by Black Caribbeans are more likely to focus on crack cocaine than other ethnic groups (including white groups). Furthermore, problematic drug use amongst this group is more likely than amongst other ethnic groups to focus on cannabis. In terms of problematic drug use, the authors, with a concern to avoid stereotyping, note that these statistics are likely to reflect the nature of services provided rather than the extent of problematic drug use in the various ethnic groups.

3.1.1 Cannabis

Overall, the studies detailed in this chapter and in chapter 2 report that, as in the white population, cannabis is the most widely-used illicit drug amongst the younger members of Black and minority ethnic communities.

Harrison et al (1997) point out that an examination of compulsory hospital admissions distorts the statistics of problematic drug use amongst Black Caribbean and African males. The authors believe that this is due to the controversial use of ‘stop and search’ tactics aimed at the possession of cannabis by youths from these communities, and to the diagnosis ‘cannabis psychosis’ which was almost exclusively given to these groups in England (see also Ranger, 1989).

3.1.2 Heroin and crack cocaine

The inclusion of heroin and crack cocaine in the drug-using repertoires of some Black and minority ethnic drug users has been reported since 1993.

- Heroin is the drug of choice amongst young South Asians in some areas of England, particularly Pakistani, and Bangladeshi males. In some cases, heroin is also the first drug used (Chaudry et al, 1997; Gilman, 1993; Patel, 2000b; Patel et al, 2001; Perera, 1996, 1998; Sheikh et al, 2001; Sherlock et al, 1997; Webster, 2001).
- Heroin and crack cocaine was found to be used by a minority of young South Asians in Bradford (Arora and Khatun, 1998) and Sheikh et al (2001) report crack cocaine use by young Bangladeshis and Kashmiris in Luton.
- Class A drugs were reported to be used by young South Asians in areas of Crawley (Bola and Walpole, 1999).
Heroin was reported to be used by South Asian, Iranian, Vietnamese and Chinese people in Cheetham Hill, Manchester (Patel et al, 1998).

Heroin use has been further reported amongst Vietnamese people (Sangster et al, 2002; Whittington, 1999).

Cannabis and heroin were the most widely-used drugs amongst the BME population in South Birmingham (Hussain, undated).

The use of a range of solvents and crack cocaine has been found amongst some groups of young South Asians (Chaudry et al, 1997; Patel and Sherlock, 1997a; Patel et al, 1998; Sheikh et al, 2001; Sherlock et al, 1997).

Perera et al (1993) found that cocaine (mostly crack) was the main drug used by a small sample (N=27) of Black Caribbean drug users in North Westminster and that heroin use amongst crack cocaine users was increasing. Eight years later, Sheikh et al (2001) report this trend in Bedfordshire, and also that 17-35 year-old Black Caribbean males ‘have significantly moved on from cannabis to crack.’

Of 2000 drug service users in the North West Thames Regional Health Authority region during 1991-1992, 80% were categorised as white. Amongst the Black and minority ethnic groups, cocaine was reported as a main drug of use by more ‘Black’ (that is, Caribbean, African and ‘other’) than either South Asian or white drug users (Daniel, 1993).

3.1.3 Dance drugs

Evidence of the use of dance drugs (ecstasy, amphetamine and LSD) by young members of Black and minority ethnic communities is contradictory, although the reasons for this (such as the methods of data collection or the geographical locations of the studies) cannot be determined.

Stimulants have been reported to be used by Indians at Bhangra1 events (Patel et al, 1995) and Perera (1998) reports the use of dance drugs by young South Asians in North Hertfordshire. Sheikh et al (2001) report Black and minority ethnic groups in Bedfordshire using hallucinogens, LSD and ice (a smokeable form of amphetamine), and Bola and Walpole (1999) that South Asians in Crawley used ecstasy.

However, Patel et al (1998) report that these drugs were used less by South Asians in Cheetham Hill in Manchester than by the white community. Chaudry et al (1997) found that ecstasy, LSD and amphetamine were regarded as ‘white people’s drugs’ and use by members of Black and minority ethnic communities in Oldham and Tameside was limited. Gilman (1993) also reports that amphetamines and ecstasy were seen as ‘a white person’s thing’ by South Asians in Bradford.

3.1.4 Qat

Qat (or kat, khat) use appears to be restricted to certain Black and minority ethnic communities in England. Qat consists of the leaves and tender shoots of a plant and is chewed for its stimulant properties. Its use amongst the Somali community has been reported by Cunningham (1998), Fountain et al (2002), Griffiths (1998), and Nabuzoka and Badhadhe (2000); amongst the Somali and Yemeni communities in Liverpool by Leroy (2000) and Mohammed (2000); amongst Ethiopians (Fountain et al, 2002); and amongst Arabs from the Middle East (Iran, Iraq, Lebanon and Yemen) by Fountain et al (2002).


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1 The Bhangra music and dance scene has its origins in Punjab and emerged in the 1980s as a distinctive ‘Asian’ slant in the evolution of British youth culture and popular music (Baumann, 1990). It employs traditional Indian subcontinent musical forms and rhythms, adapted to developments in western pop music, and is enormously popular with young Asian people in various regions of the UK (Patel et al, 1995). Recently, the term Bhangra is not used by the young people who attend venues where this music is played: rather, they are simply ‘clubbing’ (Noreen Sheikh, personal communication).
3.1.5 Generational differences in patterns of drug use

Oyefeso et al (2000) and Patel et al (1995) usefully refer to generational classifications and their relevance to patterns of drug use, arguing that the first generations of migrants are likely to adopt drug-using patterns similar to those in their home countries, but that later generations will adopt those of the current dominant population. Others have also found some substances to be specific to the older generation of some Black and minority ethnic groups:


- The excessive use of tranquillisers (benzodiazepines) has been noted amongst older members of South Asian communities (Patel, 2000b) particularly women (ADP, 1995; Chantler et al, 1998), although the source of these (whether users are prescribed all they use or obtain them illicitly) remains uninvestigated. Members of a Turkish-speaking community (Awiah, undated) also expressed concerns about the use of prescribed tranquillisers.

3.2 Factors influencing drug use

As noted in chapter 2, the links between social deprivation, social exclusion and drug use are well established. It has been shown that Black and minority ethnic groups suffer disproportionately from social exclusion by, for example, Khan (1999a); Pearson and Patel (1998) and Gilman (1993), who discuss this issue in relation to the Pakistani population in Bradford; and by Carrington (1993) in relation to the Black Caribbean community in the same city. ADP (1995) also makes the link between the drug use and the social deprivation of young Bengalis in Tower Hamlets and Gooden (1999) with the Black Caribbean and South Asian communities in Nottingham.

Research which has examined the reasons why younger members of Black and minority ethnic groups use drugs show that these are the same as for the white population (Arora and Khatun, 1998; Bola and Walpole 1997, 1999; Chaudry et al, 1997; Ganchi et al, 1997; Gilman, 1993; Khan et al, 1998; Patel et al, 1996; Pearson and Patel, 1998) - curiosity, boredom, peer influence, and pleasure - with the significant additions that drugs are used to gain acceptance from, or 'fit in with' white peers (Patel et al, 1996; Pearson and Patel, 1998; Singh and Passi, 1997) and to cope with the tension of being non-white in a predominantly white community (Khan and Ditton, 1999).

Abdulrahim et al (1994a) discuss the associations between drug use and ‘western behaviour’ made by Greek and Turkish Cypriot communities. The white British culture was also one of the main factors given as influencing drug use in their community reported by South Asian community workers, parents and religious leaders (Singh and Passi, 1997). However, this influence may be temporary: the young South Asian boys interviewed by Bola and Walpole (1997) thought that their age group (11-14) were more likely to use drugs than older boys because the latter had more family responsibility, the pressure of exams and were more concerned about family honour.

Khan and Ditton (1999) found that although young members of Black and minority ethnic groups were more cautious about drug use than their white counterparts, they were initiated into it in the same ways, and Hothi and Belton (1999) report that the drugs and patterns of use amongst young South

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2 Bhang, a drink made of yoghurt and fresh milk, together with herbs, sweets, sesame seeds, almonds and sultanas crushed in a mortar and pestle, is a common beverage in areas such as the North West Frontier in Pakistan and other parts of the Indian subcontinent, known colloquially as a ‘milk shake’. Depending upon the social event, the drink also contains cannabis (‘bhang’) or opium.
Asians are the same as those for other groups of drug users. Pearson and Patel (1998) report that the South Asian heroin scene in Bradford displays direct similarities with that of the white heroin scene, with the added ‘holiday habit’ factor - when those who had already experimented with heroin visited Pakistan, they returned dependent on the drug due to its cheapness and wide availability there.

Regarding drug use amongst recently-established Black and minority ethnic communities in the UK, Sangster et al (2002) note the link between drug use and the experiences of war, torture and trauma prior to coming to this country. Sheikh et al (2001) were told that Iranian asylum seekers who were using opium in Iran have switched to heroin in the UK. Heroin use amongst Vietnamese people has been found to have begun in refugee camps in Hong Kong and is continuing amongst those now living in the UK (Sangster et al, 2002; Whittington, 1999).

### 3.3 Injecting drug use

Injecting by Black and minority ethnic drug users is generally reported to be less prevalent than amongst white drug users, largely because of the lack of BME drug users’ presentations at needle exchanges. Indeed, Fernandez (2002), in a study of service users in South Camden, London, found that 95% of the South Asian clients presenting for treatment for heroin use had never injected.

In 1992, Siddique argued that Pakistanis may have a strong preference for smoking heroin rather than injecting it, partly explained by this being the traditional way of using the drug in Pakistan. Supporting this finding, Daniel (1993), found low rates of injecting amongst Black and minority ethnic drug users presenting for treatment during 1991 and 1992. Later, however, South Asians have been reported to be injecting heroin by Patel et al (1995, 1998, 2001); Chaudry et al (1997); Pearson and Patel (1998); Sangster et al (2002); Sheikh et al (2001); and Webster, 2001. Ram (2000), Sheikh et al (2001), and Patel (2000a,b) also found young South Asian males injecting steroids.

Sangster et al (2002) report injecting amongst Black Caribbean heroin users in London, suggesting that this may be linked to the tendency for drug users to switch to heroin whilst in prison.

Patel (2000a,b) points out that there is a belief amongst South Asian communities that injecting drugs is only practised by white people, but argues that, in the same way that there is no reason why South Asians should not use drugs, neither is there a reason why they should not inject, as they do in India, Nepal and Pakistan (Wodak al, 1993). South Asian males have been shown to access injecting equipment via white friends or white girlfriends by Pearson and Patel (1998); Patel (2000b); Patel et al (1998); and Sheikh et al (2001).

Chaudry et al (1997) and Patel (2000b) see the consistently low uptake of needle exchanges by South Asian drug injectors as a matter of urgent concern. Coupled with a lack of knowledge about the transmission of blood-borne diseases, it implies that dangerous injecting practices are occurring, particularly amongst South Asian female drug-injecting sex workers (Hall, 1999).
4 Drug service issues

This chapter examines the issues raised by the literature on the subject of drug service provision for Black and minority ethnic communities. These can be categorised as:

- an acknowledgement of need
- ethnic monitoring
- anti-discriminatory strategies
- publicity
- drug services for Black and minority ethnic women
- services for the carers of drug users
- barriers to service access.

Barriers to service access are identified by the literature as:

- the lack of acknowledgement of drug use by Black and minority ethnic communities themselves
- ethnicity of staff
- a lack of understanding of Black and minority ethnic cultures
- language
- lack of awareness of services and their functions
- fears about breaches of confidentiality.

4.1 Acknowledgement of need

Chantler et al (1998) report that 45% of 22 drug service managers they interviewed felt that the lack of provision of services to Black and minority ethnic groups was linked to a lack of information about their patterns of drug use and service needs. However, the authors argue that “This smacks of double standards” (p37) as it assumes that white communities need drug services, whereas others must prove the need. The majority of the service providers interviewed by Patel and Sherlock (1997b) and Bentley and Hanton (1997) acknowledged the need to address the issue of inadequate service provision and development for drug users from Black and minority ethnic communities. However, ADP (1995) reports overt resistance from service purchasers and providers to the development of culturally-specific drug services in Tower Hamlets, even when they were presented with evidence of increased opiate use amongst young Bengalis in the area.

More recently, drug action teams across England have commissioned detailed needs assessments and service reviews focusing on Black and minority ethnic communities: examples include Bashford et al (2000, 2001), Dhillon et al (2002), Prinjha et al (2001a,b) and Sheikh et al (2001, 2002), and concrete action has been planned following these reports’ recommendations.

Fountain et al (2002:8) comment on the issue of the lack of acknowledgement by drug service commissioners and providers of drug use amongst Black and minority ethnic communities as follows:

“Reasons for this include a fear of accusations of racism by drawing attention to drug use in these communities, and a desire to avoid increasing stigmatisation of them. This stance is misguided. Ignoring or hiding a problem does not make it disappear: it must be confronted in order that appropriate responses can be developed. Many Black and minority ethnic groups are already stigmatised as drug users or dealers, yet refusing to accept that this behaviour may occur amongst them does nothing to decrease the stigmatisation, and obstructs consideration of their drug service needs by policy-makers and service planners and commissioners.”
4.2 Ethnic monitoring

Ethnic monitoring is necessary to:

- determine current use of services
- identify gaps
- assess needs
- improve quality
- evaluate changes
- achieve equal access
- provide a baseline for planning
- allocate resources more equitably
- to measure improvements.

(ADP, 1995; Chaudry et al, 1997; Dale-Perera and Farrant, 1999; Johnson and Carroll, 1995; Khan, 1999a; Patel and Sherlock, 1997b; Patel, 2000b; Oyefeso et al, 2000; Prinjha et al, 2001a, b).

However, Khan (1999a) emphasises the importance of using the results of ethnic monitoring in the context of the whole dataset from which it comes, in order to avoid demonisation and negative stereotyping of Black and minority ethnic drug users.

Ethnic monitoring by drug agencies has been found to be inadequate (Bashford et al, 2001; Chantler et al, 1998; Chaudry et al, 1997; Khan and Ditton, 1999; Passi, 1999b; Patel and Sherlock, 1997b; Sheikh et al, 2001). Many agencies do not undertake ethnic monitoring and some members of staff are uncomfortable or embarrassed asking drug service users for their ethnic origin (Bashford et al, 2001; Prinjha et al, 2001b). Patel and Sherlock (1997b) found agencies that were unsure of the reliability of their ethnic data, and, in some cases, where to find it. In addition, the authors report that there were different interpretations of the country of origin of those termed ‘Asian.’

An example of poor ethnic monitoring comes from Bashford et al (2001), who found that of 137 attendances at a drug service, the ethnic origin of 98 (72%) was recorded as ‘Not known’. Another is from Sheikh et al (2001) who report on a police force’s statistics for the number of ‘non-European’ arrests for drugs offences, in which an arrestee is assigned to one of four categories, based on the opinion of a police officer. These categories are ‘Unknown,’ ‘Afro Caribbean,’ ‘Asian,’ and ‘Dark European,’ although the system was recognised as inadequate and changes were planned.

Perera (1998) found that the socio-demographic indices of various datasets in North Hertfordshire - including the Regional Drug Misuse Database (RDMD) and specialist service provider reports - were not sufficiently broken down to make any analyses meaningful, although as shown earlier (section 3.1), Sangster et al (2002) were able to obtain some data from the RDMD on the differences between the drugs used by members of different Black and minority ethnic groups.

4.3 Anti-discriminatory strategies

Anti-discriminatory strategies should go beyond the writing of equal opportunity statements (Adebowale et al, 1992; Shahnaz, 1993). For example, Prinjha et al (2001b:8), in a review of drug service provision, comment that “staff groups shared little or no ownership of the development of equality strategies within [drug] agencies and there was a low level of awareness or knowledge about existing policies”. Many commentators on this issue propose a dedicated response to the drug service needs of Black and minority ethnic groups, with the creation of a ‘more lively agenda’ (ADP, 1995) around race.
Prinjha et al (2001b) usefully list the issues they identified in relation to the implementation of a race equality policy in drug services:

- no ownership or involvement in design and initiation
- lack of knowledge of the existence of the policy
- no practical implementation of the policy
- no review
- no requirement to demonstrate the implementation of the policy
- and that it is seen as a paper exercise.

Training in anti-discrimination strategies for all management (purchasers and providers) and drugs workers should be implemented and cover all aspects of service provision and delivery (Awiah, undated; Chantler et al, 1998; Chaudry et al, 1997; Prinjha et al, 2001b; Ram, 2000). One such aspect is overt racism from white drug service clients (Khan and Ditton, 1999; Sheikh et al, 2001). Another is when the needs of drug users from Black and minority ethnic communities are added to the service as an afterthought or as ‘extras,’ often with no long-term strategic commitment from senior managers (Chaudry et al, 1997; Gooden, 1999; Johnson and Carroll, 1995; Passi, 1999b; Patel, 2000b).

Khan (1999a: 87) urges that purchasing bodies within drug action teams (DATs) are issued with guidelines to ensure that needs assessments are carried out amongst Black and minority ethnic groups “and that these are contractually negotiated by relevant service providers”.

No literature evaluating the outcomes of culturally-sensitive initiatives in the field of clinical drug treatment in the UK has been found, but in the US, Ellis (1999) and Finn (1994), for example, have shown the value of this approach: culturally-competent and culturally-responsive treatment and programme development often are associated with greater treatment retention and longer treatment tenure. In the UK, Gooden (1999) deplores the lack of imagination and effort by drug services to contact Black and minority ethnic communities and identify specific issues, such as recognising that families and other carers can play a role in the recovery process if services facilitated this. Other commentators also stress the need for existing methods of delivering services to be culturally appropriate. For example:

- Mistry (1996) points out that counselling may not be welcomed by South Asian clients and Awiah (undated) that many Turkish, Turkish Cypriot and Kurdish people are not familiar with the concept of counselling.
- Shahnaz (1993) suggests men-only and women-only drug education groups for members of the South Asian communities.
- NWLHPU /GMLCA (1997) propose group work and complementary therapies for South Asians.
- Khan and Ditton (1999) report that young South Asian women discussed how the sense of shame felt by someone who was discovered to be using drugs was not experienced by the white community, and stress that the delivery of services should take this into account.

ADP (1995) lists the characteristics of young Bengali heroin users in Tower Hamlets in relation to culturally-sensitive service provision. Firstly, they and their peer group are likely to be the first generation of heroin users in their community. This group therefore does not have the history of information about drugs, drug use and drug services to which the white community in the area has access. Secondly, many young Bengalis are not interested in a treatment that substitutes one drug (methadone) for another (heroin). Thirdly, ADP believes in-patient detoxification may not be the most appropriate way of treating young Bengali drug users. ADP concludes that this group therefore have different treatment needs from the more entrenched, white opiate users. That said, Bashford et al (2001), Prinjha et al (2001b), Sangster et al (2002), and Sheikh et al (2001) provide evidence that it is not detoxification per se that South Asian drug users reject: they found that private, in-patient detoxification facilities are popular with South Asian families, who pay for this because they feel that mainstream drug services either cannot help or do not respond quickly enough.
4.4 Publicising drug services

Many commentators have stressed that drug services should be publicised to the targeted Black and minority ethnic communities, using appropriate communication tools, including the media - especially South Asian radio and TV, videos, audio tapes, dramas, roadshows and music events (ADP, 1995; Awiah et al, 1990, 1992; Bentley and Hanton, 1997; Bola and Walpole, 1997, 1999; Chantler et al, 1998; Chaudry et al, 1997; Dhillon et al, 2002; Hothi and Belton, 1999; Johnson and Carroll, 1995; Mistry, 1996; Patel, 2000b; Patel and Sherlock, 1997b; Patel et al, 1995; Ram, 2000; and Singh and Passi, 1997).

Recommendations to address this issue include that publicity should promote anti-discriminatory images of service staff and facilities (Awiah et al, 1990, 1992), use images of the target group (Dhillon et al, 2002; Johnson and Carroll, 1995), and reinforce the message that drug services do not exist only for white people (NWLHP/GMLCA, 1997; Sangster et al, 2002). NWLHP/GMLCA (1997) add that drug service provision should not be publicised as a secular issue, but as a mainstream religious issue, thus making it more ‘religion-friendly’.

4.5 Drug services for Black and minority ethnic women

The development of drug services for Black and minority ethnic women drug users is rarely discussed in depth in the relevant literature, although the issue is noted by Khan and Ditton (1999); Mistry (1996); and Patel and Sherlock (1997b). BDWF (1998) questions the quality of drug-related service provision for Black mothers.

In their survey of drug services in 1997, Patel and Sherlock (1997b) point out that the majority of service development and action research projects amongst Black and minority ethnic communities targeted young South Asian males, and Mistry (1996) reports that accessing even non-drug-using South Asian women in the community to obtain their views on local drug services was difficult. The sense of shame which can act as a barrier to Black and minority ethnic groups accessing services (Sangster et al, 2002) has been shown to be a particular issue for women (Abdulrahim et al, 1994a; Awiah et al, 1990, 1992; Khan and Ditton, 1999). Chantler et al (1998) discuss this issue in terms of Black and minority ethnic women’s position and expected role in both their own ethnic group and in the wider society.

Sheikh et al (2001) report a rising concern about young Pakistani female heroin and crack cocaine users being recruited into prostitution. Assumptions that South Asian women do not use drugs is also shown to be erroneous by, for example, Bashford et al (2001), the Bridge Project (1996), Prinjha et al (2001b) and Shahnaz (1993), although Chaudry et al (1997) found little evidence of this phenomenon. Heneghan (2000) raises the issue of women from Black and minority ethnic groups who are in the criminal justice system. She points out that they account for less than 3% of the British population but almost 15% of those in female prisons, where she reports drug use is rife and drug services are inadequate. In addition, women from Black and minority ethnic groups represent only 3% of those placed on drug treatment and testing orders (DTTOs). Heneghan also reports that of 192 full-time, part-time and volunteer workers in non-residential drug projects, only 13 were from Black and minority ethnic groups and only three of these were women.

4.6 Services for carers

The literature dealing with services for the carers of drug users (partners and families) is sparse generally and especially concerning Black and minority ethnic communities. Young South Asian people in Southall suggested that families are encouraged to become involved in the treatment of their members, although they recognised that this has implications for confidentiality (Dhillon, 2001). Conducting a needs analysis for the carers and parents of drug users from Black and minority ethnic
communities in Nottingham, Gooden (1999) reports that 15 of 17 drug agencies said they provided services for carers (defined by the author as any significant person in a drug user’s life, such as partner, child, parent, sibling, other relative or friend). However, closer investigation revealed that only half of these provided structured services and fewer were prepared to allocate resources to their meaningful development. In many cases, carers were not seen as clients nor as having any role to play in services for drug users. As one respondent said “Because most drugs work is to do with harm reduction, these services are not directly relevant to carers...we are only funded as a drug user agency”. (p29).

4.7 Barriers to drug service access

Drug users from Black and minority ethnic communities do not feature significantly as clients of most drug treatment services. Very few mainstream or specialist drug services - especially needle exchanges - have managed to attract or work with these groups of drug users. Recent conclusions and recommendations remain the same as those made throughout the last 12 years. For example:

- In 1991, Mirza et al recommended, as an ‘obvious requirement’ (p17), outreach work, the development and extension of ethnic monitoring, equal opportunities policies, and anti-discriminatory practices in order to reach drug users from Black and minority ethnic groups in Lewisham, London.

- In the same year, Penfold (1991) notes that Black and minority ethnic groups were under-represented at a drug service in Southwark and made recommendations that included the appointment of Black workers and the development of appropriate publications.

- In 1992, Adebowale et al reported on a study day held by Northamptonshire Council to discuss issues facing drug services in responding to the needs of Black and minority ethnic communities. One of the main topics was the lack of service uptake by members of these communities and how it could be remedied. Again, recommendations are mirrored by those made in later studies.

In 1998, the ACMD (p41) suggested that “The under-representation of Black people among populations of drug users known to agencies might, for example, be a consequence of the failure of agencies to make themselves accessible and meaningful to all members of a multi-cultural society.” However, the picture that emerges from the literature is that drug service development for Black and minority ethnic groups is ad hoc, patchy and uncoordinated, and the less well-established Black and minority ethnic groups are even more marginalised in terms of drug services (Sangster et al, 2002). Whilst service providers may be keen to develop their service to include members of Black and minority ethnic groups, they lack the experience, expertise and clear guidance to effect change (Johnson and Carroll, 1995; Patel and Sherlock, 1997b). Thus, many drug services are seen by many members of Black and minority ethnic groups as being only for white people, and a negative experience at a drug service can not only dissuade a drug user from attending again, but the experience is related to other drug users, who may also be dissuaded from attending (ADP, 1995; Awiah et al, 1992; Chaudry et al, 1997; Gooden, 1999; Perera et al, 1997).

Chantler et al (1998) critically evaluated the drug service delivery to Black and minority ethnic communities in Greater Manchester. They concluded that "’race’ issues are very seldom given any priority either in service planning or delivery” and that purchasers and providers “need to understand how their policies and practices serve to exclude or marginalise Black people, and to take constructive action to redress the balance” (p7). To achieve this, the needs not only of drug users from Black and minority ethnic groups must be addressed, but also those of their community and of service providers themselves (Johnson and Carroll, 1995; Maynard, 1994). The overall findings of Chantler et al (1998), presented in a detailed report, were that those interviewed (including over a third of service managers) thought that the quality of drug services provided to Black and minority ethnic communities was poorer than it was for white people. Nevertheless, however willing drug
service managers are to provide services for Black and minority ethnic groups, the following obstacles have been cited:

- Limited resources (Bentley and Hanton, 1997; Chantler et al, 1998; Gooden, 1999; Johnson and Carroll, 1995; Patel, 2000b; Patel and Sherlock, 1997b).
- Low numbers of BME groups in the area, so provision was not a priority (Chantler et al, 1998; Patel and Sherlock, 1997b). However, Patel and Sherlock discovered that many agencies were unaware of the demographic composition of the local population.

4.7.1 Lack of acknowledgment of drug use by Black and minority ethnic communities

Perera (1998) points out that the lack of awareness - or denial - about the prevalence of drug use in their community meant that South Asian parents interviewed in North Hertfordshire were unsure about the need for services specifically for South Asian drug users. Perera adds that in the case of the South Asian community, denial of drug use helps maintain the desirable stereotype of a quiet and non-problematic community. Prinjha et al (2001a) stress that the denial of a drug problem by religious and community leaders is a barrier to service development, and Ram (2000) reports on an initiative to publicise a local drugs service which had the approval of the local mosque's Imam, and therefore “individuals who had once ‘buried their head in the sand’ were forced to consider the possibility that members of their community use drugs” (p51). Passi (1999a) believes that Black and minority ethnic communities in Preston have progressed further, and that it cannot be claimed that they are not facing up to the realities of drug use. Dhillon et al (2002) also report that, in Hertfordshire, the South Asian and Black Caribbean communities accepted that drug use is as prevalent amongst their members as it is amongst the white population, although members of the Italian and Roma communities there vehemently denied drug use occurred amongst them.

Collecting data on the drug use of a Black and minority ethnic population is not unproblematic. Carrington (1993) reports that the Black Caribbean population in Bradford was suspicious that data she was collecting would negatively target that group (as did Gooden, 1999, in Nottingham), with the result that the overall impression given by the data was that “the majority of Black people shunned the drugs which made you physically dependent” (Carrington, 1993:7).

4.7.2 Ethnicity of staff

Many of the studies that have asked members of Black and minority ethnic groups for their perception of drug services and/or the reasons that drug users from their communities do not use these services have resulted in comments that there is no worker there who is from the same ethnic group as themselves. The literature reveals that service providers also recognise that the ethnicity of drug workers is an important issue. However, the literature also shows that the solution is more complex than simply employing workers who are from the same ethnic group as their potential clients.

Commentators are in agreement that staffing should reflect the target communities (ADP, 1995; Awiah et al, 1990, 1992; Awiah, undated; Chantler et al, 1998; Chaudry et al, 1997; Coomber, 1991; Gilman, 1993; Gooden, 1999; Hotni and Belton, 1999; Hussain, undated; Khan and Ditton, 1999; Mistry, 1996; Patel, 2000b; Perera et al, 1997; Shahnaz, 1993; Southwell, 1995). That said, most do not see the solution as a worker employed solely to deal with members of their own ethnic group - rather, they should be generic workers. Some commentators plead for cross-cultural training and support for all drug workers, including Abdulrahim et al (1994a); ADP (1995); Bentley and Hanton (1997); Chaudry et al
Johnson and Carroll (1995) argue that the ethnic origins of workers of a service team will affect its image as perceived by outsiders, and conclude that the evidence they collected “suggests that image may be as much a barrier in the minds of the team as elsewhere in the views of the community” (p17).

A South Asian psychiatrist interviewed by Khan and Ditton (1999) felt that drug workers may not be as sympathetic to a drug user from their own ethnic group as hoped, because of their own belief and faith - an issue also reported by Bentley and Hanton (1997) - and that training for Black and minority ethnic drugs workers needs to address this.

Gooden (1999) found that in drug agencies in Nottingham, workers from Black and minority ethnic groups tended to be volunteers rather than paid workers, and Khan (1999b,c) and Ram (2000) deplore that Black and minority ethnic drugs workers are often employed on short-term contracts. As Khan (1999c) points out changes “tend to vanish when the employee who initiates them leaves the agency because they have not been embedded into planning and operational structures”.

The employment of South Asian drugs workers was examined by Patel (2000b) and by Patel and Sherlock (1997b) in their audit of drug services for South Asian drug users. The authors conclude that, whether in targeted or generic posts, such appointments appear to facilitate uptake of services by South Asian drug users. However, they - and ADP (1995) - add that where there is an expectation that this worker will be expert at providing a service to all South Asian drug users, single-handedly, without appropriate and adequate support, the strategy has not been a success. The personal experiences of such a worker are discussed by Ram (2000).

Gooden (1999), Khan and Ditton (1999) and Patel (2000b) point out that some young people do not identify themselves as members of a Black or minority ethnic group, which adds to the complication of the ethnicity of drugs workers. A choice of worker was a solution proposed by some of the young South Asian drug users interviewed by Hothi and Belton (1999).

Prinjha et al (2001b) detail initiatives by drug services in Bolton, which have targeted recruitment drives at Black and minority ethnic communities. These have included establishing networks of Black and minority ethnic workers to whom details of new posts were sent and holding open evenings in partnership with local Black and minority ethnic agencies. However, Prinjha et al report that although these activities have increased the numbers of Black and minority ethnic drug workers, they have not increased the overall pool of potential applicants, and where agencies have been successful in recruiting Black and minority ethnic workers, there have been problems of retention.

Khan and Ditton (1999) and Bentley and Hanton (1997) discussed the ethnic origin of workers with their samples of drug users, non-users and drug workers. They also found the issue was not straightforward. Their respondents voiced concerns that, although a worker of the same cultural background as their client would understand the cultural factors surrounding their drug use, confidentiality may be compromised in communities with an efficient ‘gossip network.’ Gooden (1999) points out that this is a problem in a small city and, particularly, in rural areas. Nevertheless, ADP (1995:16) believe that the service providers’ belief that South Asian drug users are reluctant to approach South Asian drug workers is “probably based on racial stereotypes”.

The conclusion of Khan and Ditton (1999:64) on the dilemma of employing workers who understand the cultural background of the young drug user but are not trusted to keep their drug use a secret from their parents is worth quoting in full as a summary of the issues surrounding the ethnicity of drug service staff:
“...it seems that...drug workers of some sort - if they are bilingual - might function as useful go-betweens helping children liaise with their parents. However, they would have to be young enough to be trusted by the drug users, and old enough to be trusted by the parents. They would have to be liberal enough to keep quiet about the clients’ drug use, yet sufficiently religious and respected in the minority ethnic community to win the respect of the elders. This is a tough challenge, but the possibility of using white workers with a working grasp of minority ethnic languages and an intimate knowledge of the minority ethnic customs may be worth exploring.”

4.7.3 Lack of understanding of Black and minority ethnic cultures

A major outcome of the study by Sangster et al (2002) was the identification of the basis for cultural competence (defined as the ability to meet the diverse needs of a given community) in the context of drug services for Black and minority ethnic communities. One of the reasons the young South Asian drug users interviewed by Hothi and Belton (1999) had stopped attending drug services was because of the lack of respect shown to them and their perception of workers’ lack of awareness of their culture. Awiah et al (1990, 1992) and Bentley and Hanton (1997) report that their samples would not attend a drug service because of a fear that their culture would be misunderstood. There are reports that drug users did not use a drug service because they anticipated and/or had experienced racism. This is reported by Adebowale et al, 1992; Awiah et al, 1990, 1992; Khan and Ditton, 1999; and Perera et al, 1993. Gooden (1999:30-31) reports “blatantly bigoted and racist views on the lifestyles and behaviour within Black communities” from senior managers of drug services in Nottingham and was told by one of them “I’ve never known White people to be put off coming to see us because of any Black person in the front office”. Gooden also reports the view of service providers that the onus to access services is on members of BME communities, rather than on service providers.

Drug service managers and workers interviewed by Chantler et al (1998) identified the lack of understanding of different cultures as a major factor hindering the development of service provision for Black and minority ethnic drug users. The majority of their sample of representatives from these communities felt that their members were excluded from drug services on the basis of language, culture and values. These barriers are also reported by Awiah et al (1992), Chaudry et al (1997), Patel (1993), and Pearson and Patel (1998).

From the point of view of service providers, Bentley and Hanton (1997) found that there was a belief that South Asian drug users received help from their family and community, and that they were less likely to ask for help from drug services because of ‘historical and cultural’ reasons. This included being shamed in the community (Abdulrahim et al, 1994a; Awiah et al, 1990, 1992; Chaudry et al, 1997; Johnson and Carroll, 1995; Khan and Ditton, 1999) and the loss of pride in oneself by admitting a drug problem, which Gooden (1999:40), in a plea for more research into this issue, believes “is often the last thing that is given up within the African Caribbean and Asian cultures”.

Khan and Ditton (1999) talked to a white drugs worker about the perceived difficulties of group work with drug users from Black and minority ethnic communities: the worker was unsure whether, for example, Muslims and Hindus or people from different castes would be prepared to sit in the same room. The young South Asian drug users interviewed by Hothi and Belton (1999) also raised this issue: they suggested the provision of rehabilitation centres especially for Muslims and Sikhs. Service providers interviewed by Bashford et al (2001) believed that South Asian clients were “uncomfortable” attending groups in which the majority of participants are white. Sangster et al (2002) are also concerned about the suitability of residential treatment settings for members of Black and minority ethnic communities.
Services that aim to be culturally appropriate need to consider their accessibility. Johnson and Carroll (1995) note that many members of Black and minority ethnic communities are employed as shift workers, which makes it impossible for them to attend services during conventional office hours; that racial attacks are a real possibility in certain areas; and that some women may not wish to enter places mainly used by men. NWLHPU / GMLCA (1997) suggest that drug services are open at the same times as community centres and youth clubs (that is, outside 9am - 5pm).

4.7.4 Language

Awiah (undated) found that there was little information in Turkish for the Turkish-speaking target group of a drug prevention and awareness initiative she reports on, and that language was the main barrier to service access. Johnson and Carroll (1995) report that some members of Black and minority ethnic groups cannot communicate in English, yet few service providers and educators can function in other languages. It has been shown that, in such cases, the use of interpreters can be a helpful resource in drug services (Mistry, 1996; Patel and Sherlock, 1997b). This is particularly important in areas where levels of illiteracy - in any language - are high (Arora and Khatun, 1998; Patel, 2000b).

Bashford et al (2000) report on the undesirable situation where children are asked to interpret information about drugs for their mothers, and the authors, and also Sheikh et al (2001) stress that interpreters should have the appropriate training in drug-using issues, especially in the assessment process.

Awiah (undated) demonstrates how local drug services cannot deal with the Turkish-speaking community unless they also speak English, and Shahnaz (1993) and Prinjha et al (2001b) see the provision of information in appropriate languages as an essential component of any drug service development. Not all members of a community may want translated or interpreted information, however. The young South Asian boys interviewed by Bola and Walpole (1997) wanted information for themselves in English, but thought that for their parents it should be in their native tongue. The mothers interviewed in the same study agreed. Perera (1998) reports that some South Asian parents would feel patronised by having information delivered in their own language and suggests that material is prepared in both the language of the targeted group and in English, so that they have a choice. Nevertheless, Perera recognises the difficulties for South Asian parents in understanding some of the English terms used in drug education.

Johnson and Carroll (1995) and Patel and Sherlock (1997b) found that some of the agencies they surveyed had successfully used translated information, whilst others experienced problems. However, not all agencies provide translated materials (Johnson and Carroll, 1995; Mistry, 1996), and in any case, as Patel (2000b) points out, less than 28% of South Asians in Bradford can read or write in their mother tongue (see also Arora and Khatun, 1998; Bashford et al, 2000, 2001). An additional problem with translated materials is that not all concepts or technical terms can be directly translated or understood without interpretation (Bashford et al, 2000; Johnson and Carroll, 1995). For example, Shahnaz (1993:13) points out that there are no words in Urdu for ‘oral sex’ and when this was translated from the English, the term became ‘sex talk’: “Thus it is premature to believe that translating leaflets...will lead to an increase in the number of black people getting appropriate information and accessing services.”

Dale-Perera and Farrant (1999) report that in the borough of Haringey, London, 193 different languages are spoken, and accept that it is unlikely any service could employ staff in a completely representative manner. They suggest that a pool of sessional workers is employed as a solution. It should be noted here that the National Drug Helpline provides a 24-hour service and advertises services in Bengali, Urdu, Hindi, Punjabi and Cantonese. However, at the time of writing, these are available only for four hours a week each
(although services in Welsh are available 12 hours a day) (www.ndh.org.uk/helpline_languages.html). Moreover, the helpline uses interpreters from the Language Line service if bilingual speakers are unavailable: if these interpreters are not trained in drug issues, the problems regarding concepts and technical terms discussed above may arise.

### 4.7.5 Lack of awareness of drug services and their functions

The lack of awareness of drug services by Black and minority ethnic groups (whether or not they are drug users) is frequently noted in the relevant literature (Adebowale et al, 1992; ADP, 1995; Arora and Khatun, 1998; Awiah et al, 1990, 1992; Awiah, undated; Bentley and Hanton, 1997; Chantler et al, 1998; Chaudry et al, 1997; Dhillon et al, 2002; Gooden, 1999; Khan and Ditton, 1999; Mistry, 1996; Patel, 2000b; Perera et al, 1997; Prinjha et al, 2001b; Shahnaz, 1993). In addition, some who are aware of the nature of drug services have been reported to think they were only for ‘junkies’ (ie heroin users) (Gilman, 1993; Khan and Ditton, 1999; Perera et al, 1997).

Chaudry et al (1997), Khan and Ditton (1999) and Patel (2000b) report that South Asian drug users would be more likely to approach their general practitioner (GP) for help than a drug service. Awiah (undated) also reports the reliance on GPs for help with drug use by a Turkish-speaking community. Bentley and Hanton (1997) found that, amongst their sample of young South Asians, the main source of information about drugs was their GP, although it was not ascertained whether this was via consultation or merely from a leaflet or poster in the surgery. Sangster et al (2002) however, express concerns about the capabilities of many GPs to deal with drug users.

Awareness of drug services does not mean that drug users will ask them for help. Hothi and Belton (1999) found that three-quarters of the 20 South Asian drug users they interviewed were aware of the drug services available to them, but only five (25%) had used them, despite encouragement by family, friends, youth workers, the police and GPs, and despite having tried and failed to stop using drugs. Abdulrahim et al (1994b) also found a high level of awareness of drug services amongst their sample of 41 Black and minority ethnic opiate and stimulant users (approximately half of whom were currently injecting), but none of them were in contact with any such service.

Mistry (1996) raises the issue of the South Asian perception of ‘treatment’: a respondent reported that “many Asians think going to the doctor and coming out with a prescription will make them better”. Bashford et al (2001) also point out the perception by older members of Black and minority ethnic communities that drug treatment must involve medication in order to be effective, although Nefertari and Ahmun (1999) argue that “the Eurocentric and the clinical approach” to drug treatment is at odds with the cultural and spiritual traditions of many Black and minority ethnic communities. Service providers interviewed by Prinjha et al (2001b) thought that South Asian drug users did not access drug services because they did not understand the nature and purpose of treatment. The type of treatment offered to drug users from Black and minority ethnic groups has also been discussed by ADP (1995), who believe that, if they have limited awareness and experience of drug services, they may enter treatment without being fully aware of its implications, including ‘care as control.’ ADP believe that a treatment experience perceived as control and punishment may promote rebellion (by selling the prescribed methadone to buy heroin, for example), and/or deter clients from further help seeking.

Perera et al (1993) report on a different aspect of drug treatment services: the Black Caribbean drug users they interviewed did not attend drug services because of the lack of practical solutions in meeting other, non-drug-specific needs. On the other hand, Abdulrahim et al (1994b) notes that some of their sample of members of Black and minority ethnic groups who used drugs did not seek help from drug services because of what they perceived as workers’ interest in ‘personal matters.’
The BME drug users interviewed by Abdulrahim et al (1994a), Arora and Khatun (1998), and Khan and Ditton (1999) did not attend drug services because they did not see (or did not want to admit) their drug use as a problem. In this situation, of course, a drug service is not seen as a solution.

4.7.6 Confidentiality

The fear that drug services will not maintain the confidentiality of their clients is discussed by many commentators, including Abdulrahim et al (1994b); rora and Khatun (1998); Awiah (undated); Bola and Walpole (1999); Chaudry et al (1997); Dale-Perera and Farrant, 1999; Hothi and Belton (1999); Khan and Ditton (1999); Mistry (1996); Patel (2000b); Patel et al, 1998; Perera et al (1993, 1997); Ram (2000); and Shahnaz (1993). For example, the young South Asians interviewed by Khan and Ditton (1999) believed - with some supporting evidence - that a visit to an agency or a GP about their drug use would result in, not only their parents, but the whole community finding out via an efficient gossip network and lead to their family getting a ‘bad reputation.’ This situation illustrates the conflict between family needs and client needs (Mistry, 1996).

It has been suggested that a distrust of ‘officials’ leads to an unwillingness of members of Black and minority ethnic groups to access drug and other health services (Abdulrahim, 1994a,b; ADP, 1995; Awiah, undated; and Patel, 1993), although Johnson and Carroll (1995) report finding little evidence of this. However, Sheikh et al (2001) point out that this distrust may be a particular issue for refugees and asylum seekers who may be worried about their legal status or in hiding. Bashford et al (2000) also note a high level of distrust of, and a reluctance to access, health services amongst the Black Caribbean population in Shropshire, compounded by fears of the use of the Mental Health Act in relation to those with drug problems.

Ensuring client confidentiality is clearly a significant issue concerning the credibility of drug services and Awiah (undated) points out that, amongst a Turkish-speaking community, the concept of confidentiality in the context of drug services is simply not understood. The action research project reported by Patel (2000a) stressed the confidentiality of drug services on all its publicity, a strategy also called for by Shahnaz (1993) and NWLHPU / GMLCA (1997). Khan and Ditton (1999), Gooden (1999) and Dhillon et al (2002) collected suggestions for services that include the provision of an anonymous telephone helpline. Support for this comes from Bola and Walpole (1997): the young South Asian boys they interviewed all knew about such a service.
5 Drug awareness amongst Black and minority ethnic communities

This chapter examines the literature on drug awareness amongst Black and minority ethnic communities. Reports on drug prevention and education initiatives for Black and minority ethnic young people, families and parents, and for communities are examined, highlighting the factors that have been identified as influencing the delivery of these services.

5.1 The generation gap

Increasing drug use amongst young people from Black and minority ethnic communities has been attributed to differences between the cultural norms of different generations.

Bashford et al (2001), for example, found increasing numbers of young Muslims leading ‘street based’ lives, including using drugs, and not attending a mosque or youth centre. Ganchi et al (1997) surveyed 13-16 year-olds in Nottingham, and also report that the South Asians who did not identify closely with their cultures were more likely to use drugs than those who did. South Asian mothers interviewed by Bola and Walpole (1997:34) agreed:

“[Our children] like English [TV] programmes and food - their ways are different. The children are not bothered: there is nothing in the culture that will stop them [using drugs]. They don’t talk about Indian culture.”

“We constantly tell them about ezit / izzet [family and community honour], but they say that ‘it relates to a different time’, ‘it doesn’t apply to us’, they say ‘it’s not our way.’ The religion stops them [using drugs], religion checks on them, it’s those children who don’t go [to religious services] who are at risk. The Muslims come in at sunset, it’s the children that stay out at night [who are at risk].”

Bola and Walpole (1999) discovered that whilst young South Asian boys, older male drug users and community representatives did not perceive their information and communication needs to be different from those of the white population, mothers and professionals working with local Black and minority ethnic groups disagreed.

Some Black and minority ethnic community members interviewed by Dhillon et al (2002) welcomed drug education sessions in schools, but these may not be welcomed by all those in a Black and minority ethnic community. School teachers interviewed by Prinjha et al (2001b) identified parents’ negative responses as a factor in preventing drug education to South Asian children, although the authors’ comment that it was unclear whether there was actual resistance from parents or that this response was merely anticipated.

5.1.1 Young people

The research conducted on drug awareness implies that younger members of BME communities are more knowledgeable than the older generations. For example, some of the young South Asian respondents interviewed by Chaudry et al (1997) knew where to buy drugs, their prices, and their street names, displaying a high level of ‘street knowledge.’ That said, overall, even the knowledge of the drug users amongst them was patchy and confused, with most information obtained from the media.

Bola and Walpole (1997, 1999) also report a high level of knowledge about drugs amongst the South Asian boys they interviewed, and South Asian mothers told the authors that they believed their children knew more about drugs than they did because of television and school lessons. These mothers also thought separate campaigns should be designed for children. The boys wanted information to be incorporated into their favourite television programmes, and stressed it should be realistic about the effects of drugs.
In terms of drug treatment, Sangster et al (2002) make the point that those Black and minority ethnic drug users who present to drug services are those who have reached a late stage in their drug using problems. Such clients may be relatively young, however, Fernandez (2002) found that earlier onset of drug use amongst South Asian clients presenting for treatment in South Camden had resulted in demand for drug treatment services from them, especially detoxification. Of course early experimentation with drugs does not always lead to problematic drug use. Bentley and Hanton (1997) report that, in their study of young South Asians, few appeared to have reached a stage of problematic drug use, although the majority had experimented with a number of substances. Whilst their current service needs were not therefore drug treatment, they still had information needs.

### 5.1.2 Families and parents

Several studies have highlighted the low level of drug awareness amongst older members of Black and minority ethnic communities, including Arora and Khatun (1998); Awiah (undated); Bola and Walpole (1997, 1999); Carrington (1993); Chaudry et al (1997); and Patel et al (1998). The young South Asians interviewed by Bola and Walpole (1997) and by Perera (1998) emphasised the ease with which young people could conceal their use of drugs from their parents, not only because of parents’ lack of awareness of drugs and how to help, but also because parents are reluctant to acknowledge drug use due to the associated shame. Thus, as Patel et al (1996) and Ram (2000) point out, there is a gap between young South Asian people using drugs and the knowledge that parents require to respond. Support for parents is necessary to serve as a tool to empower them to cope with drug use in their family.

Arora and Khatun (1998), Dhillon et al (2002) and Prinjha et al (2001a) report that, in recent years, the denial by South Asian communities that there is drug use amongst their members has been replaced, in most cases, with a general acceptance that drug use does occur, although Arora and Khatun found that parents still do not believe that their own children will become involved. Bola and Walpole (1997) also report that although parents are worried about the influence of peers, they do not see their own children as making a choice to use drugs. However, Bola and Walpole found differences between South Asian mothers in their perceptions of the influence of culture on drug use. Whilst Punjabi Muslim and Gujarati Hindu mothers thought that cultural barriers would prevent their children using drugs, Punjabi Sikh mothers did not. The Italian and Roma community members interviewed by Dhillon et al (2002) also believed that their cultures and strong family bonds would prevent drug use.

The relatively poor knowledge about drugs by the older generations of Black and minority ethnic communities, and their unwillingness to discuss the issue, contributes to drug use amongst some Black and minority ethnic communities remaining hidden (Bola and Walpole, 1997; Khan and Ditton, 1999; Patel et al, 1996). Khan and Ditton report that whilst hiding drug use from parents is not culturally specific, their respondents from Black and minority ethnic groups reported higher parental expectations of them than the white respondents, even where the use of some drugs in their home countries is culturally acceptable.

Chaudry et al (1997), Patel and Sherlock (1997b), Patel (2000b), Patel et al (1998), and Perera (1998) stress that drug awareness initiatives should include supporting parents of drug users, including making them aware of their own drug use (for example the excessive use of tranquillisers). These authors stress this support should also cover the dangers of sending drug users to the family’s country of origin if heroin is widely and cheaply available there (as it is in Bangladesh, India and Pakistan) and ensure that families have sufficient information to offer support to a drug-using member rather than, for example, attempting a ‘home detox’. Bashford et al (2000, 2001) and Prinjha (2001b) point out that these coping strategies are employed by South Asian families when other attempts to contain a drug problem in the early stages - including supporting drug use by financial assistance - fail.
Bashford et al. (2001:22) argue convincingly that these strategies are a result of a perception that drug services do not respond adequately, but suggest that they may prolong drug use and prevent entry into treatment:

“A stark dichotomy opens up here between professional and community views, as on the one hand professionals say that expectations are too high and there is a desire for a ‘quick’ fix that is not realistic in relation to problems with drugs, and on the other family members say that they are left to deal with problems alone and that services do not appear to want to address their needs.”

It was reported to Sangster et al. (2002) that South Asian families accompanied a drug-using member to drug services more often than white parents did. Sheikh et al. (2001) provide evidence of the ensuing inadequate response that encourages parents to either turn to private treatment agencies (many of which offer inadequate aftercare services) or employ their own coping strategies. One respondent told the authors that “my father was asked to leave the room when he went [to a drug service] with my brother. When he got angry they asked him to leave the building - all he wanted to do was talk to someone and find out what he could do as a parent” (Sheikh et al., 2001:40).

Many of the above issues are addressed within a series of five videos aimed at South Asian parents; the first two (in Urdu and Bengali) were evaluated by the Home Office Drugs Prevention Initiative in Northumbria, (DPI, 1998; Patel, 1999b). The evaluation recorded that the video was very well-received and identified it as a useful tool to raise awareness of drug issues amongst South Asian parents when shown by specially-trained workers in a group setting (DPI, 1998).

5.1.3 Bridging the generation gap

The young South Asians interviewed by Perera (1998:11) welcomed education for parents about drugs because, as one of them put it “Most of the information they have and they think are facts are from the media, like telly and the tabloids, and that’s just crap”. Perera suggests that schools may be the most appropriate venue for drug education, as parents would make the association with their children’s general education and be more likely to attend. A major advantage of educating parents about drugs is pointed out by Perera (1998), whose sample of young South Asians, community representatives and parents were enthusiastic about this leading to a situation where young people could openly discuss drugs within their family. The South Asian boys and mothers interviewed by Bola and Walpole (1997) agreed, suggesting that the best media for transmitting information about drugs and drug services to their community was television - particularly those programmes targeting Black and minority ethnic communities - because it prompted family discussions. The young South Asians participating in the project reported by Dhillon (2001) thought that drug education for parents should include the types of drug treatment and their timescales, in order that they could be fully informed in the event of a member of their family undergoing treatment.

However, some of the young people from a variety of Black and minority ethnic groups interviewed by Khan and Ditton (1999) were ambivalent about the effect of increased parental knowledge. Whilst it was thought that the message “Don’t freak out” would be useful, it was also thought that increased parental awareness would “cause hassle for their teenagers” because more knowledgeable parents would ‘know what [drugs] you’re on’.

Patel et al. (1998) report differences between community workers who thought that the South Asian community is ‘family-orientated’ and so families should learn about drugs together, through recognised community leaders and organisations, and those who thought that young people’s sessions should be separate from those for adults. NWLHPU / GMLCA (1997) believe that a parents-youth workers link would be a useful addition to drug awareness initiatives, whilst Carrington (1993) suggests self-help groups involving both parents and children as one solution to the gap in knowledge between the generations.
5.2 Drug education for Black and minority ethnic communities

Many commentators argue that drug education is necessary for all members of a Black and minority ethnic community (Abdulrahim et al, 1994a; ADP, 1995; Awiah et al, 1992; Awiah, undated; Bentley and Hanton, 1997; Bola and Walpole, 1997; Chantler et al, 1998; Chaudry et al, 1997; Hothi and Belton, 1999; Mistry, 1996; Patel et al, 1996; Patel, 2000b; Patel and Sherlock, 1997b; Prinjha et al, 2001a; Shahnaz, 1993; Singh and Passi, 1997; Southwell, 1995). Khan and Ditton (1999) point out this is compatible with the belief that a community can solve its own problems without formal interference from ‘officials’.

Mistry (1996) notes that before community drug education initiatives begin, it may first be necessary to explain how they can help solve problems. ADP (1995) provides an example: they had difficulties getting co-operation from schools for drug education sessions. Where a community denies drug use is taking place within it (at least to researchers), NWLHPU / GMLCA (1997) and Shahnaz (1993) propose that culturally-relevant workshops, seminars and discussions should be provided to give BME community members the space to acknowledge it.

One strategy to base drug education in the community is by the identification of key individuals and training them to deliver the awareness-raising activities (‘training the trainer’) (Carrington, 1993; Gilman, 1993; Singh and Passi, 1997). Another is a recommendation by NWLHPU / GMLCA (1997): to recruit influential families in a community and get their support for local campaigns. A third comes from Dhillon (2001); GMBA (1995); Ram (2000); and Sangster and Mistry (1997), who stress the value of peer education projects, particularly amongst young people and women.

As discussed earlier (section 5.1), research has shown that younger members of Black and minority ethnic groups are more knowledgeable about drugs than the older generations. These differences need to be taken into account when designing awareness-raising initiatives for a whole community. For example, Bola and Walpole (1997) conclude from their study of South Asians in northwest London that information for young people needs to highlight the negative aspects of drug use, allay the fears of parents, and appeal to the rationality of schoolteachers. The authors therefore recommend that clear and relevant information on drugs and their consequences is an essential starting point, and initiatives should include both the positive and negative aspects of drug use. Dhillon (2001), however, reports that young South Asians in Southall wanted ‘harsher’ videos and literature, showing drug users in withdrawal in order that young people are fully aware of the implications of drug use before initiation. Patel (1999a) also found that South Asian parents thought a video on drug use prepared for them should not present a balanced view but contain ‘dire warnings’ about drug use.

Awiah (undated), Patel (2000a,b) and Ram (2000) stress that drug awareness initiatives in Black and minority ethnic communities need to be adequately funded and long-term. In the five-month project amongst Turkish-speaking people in Hackney and Haringey reported by Awiah, for example, the first two months were spent training outreach / research workers, and interest in the project from the community grew only as it was ending. In addition, there were not enough resources to support the workers adequately.

Awiah (undated) shows that drug awareness training is necessary not only for members of the target community. Training sessions in drug awareness to non-drug health and social care professionals working with Turkish-speaking people in Hackney and Haringey led to an increase in them referring members of that population to drug services.

5.2.1 Drug education and cultural appropriateness

As demonstrated throughout this review, many commentators put cultural appropriateness - including community consultation and drug awareness training - at the centre of policy and planning initiatives to provide drug services to Black and minority ethnic groups (Abdulrahim et al, 1994a; ADP, 1995; Bola and Walpole, 1997; Gooden, 1999; NWLHPU / GMLCA, 1997; Patel et al, 1996; Sangster et al, 2002; Shahnaz, 1993; Singh and Passi, 1997; and Southwell, 1995). For example:
Distinctive cultural and religious beliefs were identified by professionals in the drugs field and by a community consultation exercise in a study conducted by Sangster et al. (2002) as having important implications for drug prevention, education and treatment services. The authors conclude that it is vital that drug education does not occur in isolation from the wider community group and parents.

Gilman (1993) and Carrington (1993) agree that existing community beliefs about drugs must be considered in drug education activities: Black Caribbean respondents in Bradford believed that the ‘just say no approach’ was unlikely to be successful, and a better strategy would be to encourage members of their community not to use ‘hard’ drugs.

Gilman (1993) argues that a campaign to highlight the dangers of crack cocaine amongst Black Caribbean users in Bradford would not have the same cultural resonance as it might amongst a non-drug using population in rural England.

Bashford et al (2000) point out that the appropriateness of the literature taken home from school by children must take into account the cultural beliefs of parents, and Sangster et al (2002) report South Asian parents reacting very badly to the messages and presentation of such literature (although the content of this literature is not revealed by the authors).

A conclusion of a conference on drug and alcohol use and service provision for South Asians in Preston (NWLHPU / GMLCA, 1997) was that service providers should also learn from the community and develop a forum to share information and awareness on cultural issues, such as the strength of religious leaders’ influence on their community and whether or not community leaders could be realistically used in drug awareness and prevention initiatives. The authors add that it should be recognised that a community will be suspicious of these initiatives if there is no link to abstention, as this may be part of their religious beliefs.

Chaudry et al (1997) stress that minimising drug-related risk-taking behaviour should be included in drug awareness initiatives, but also point out that such harm reduction interventions may seriously conflict with religious and cultural beliefs: Sheikh et al (2001), for example, report that the reaction of some mosques in Bedfordshire to drug users was to ‘name and shame’ them, which resulted in not only drug users, but also their families, being ostracized from their community. Ram (2000), however, discusses a project that, with the local mosque’s Imam approval, distributed a Ramadan calendar to a Muslim community which included an advertisement for a local drugs service. Passi (1999a) too, reports on meetings with Imams in Preston to discuss areas of concern and ways forward. The resulting two-day drug training session was attended by the Preston Board of Imams, and included the role of Imams as drug educators, the current situation regarding drug use in their community, and harm reduction and its relationship to the Muslim faith.

Other commentators have also discussed the relationship between religious beliefs and drug use. For example:

Bola and Walpole (1997) and Patel et al (1996) point out that some religious faiths have a clear position against the use of alcohol and tobacco, but if religious leaders do not recognise illicit drug use in their community and/or do not discuss it, it is difficult and confusing for that community to relate drug use to their cultural background. This issue was also raised by the Jewish informants interviewed by Dhillon et al (2002).

That religion may have little influence on preventing drug use illustrates, as Patel et al (1996:11) put it “a major gap in the transformation of core concepts of religion from generation to generation”. Patel et al add that although the young South Asians they interviewed knew their religion forbade drug use, they were unsure of the underlying philosophy.
Khan and Ditton (1999) identify a major concern about drug users who are members of a strict religious community: they keep their drug use secret and may therefore be deterred from seeking help.

Sangster et al (2002) stress it is vital that religious and community leaders are not bypassed in the process of the development of drug education initiatives. The authors identify successful drug education projects with South Asian communities, with mosques described by some respondents as the ideal place to access and work with people from a wide range of age groups. It should be noted that drug workers interviewed by the authors felt that involving the wider community in the development of interventions “was likely to take much longer with South Asian communities than with white groups because of the particular sensitivity of cultural and religious issues involved” (Sangster et al, 2002:28).
6 Developing appropriate drug services for Black and minority ethnic communities: the way forward

This chapter identifies the literature on research and initiatives which map the way forward for the development of appropriate drug services for Black and minority ethnic communities. The chapter begins by identifying the key methods on how to make services more accessible to Black and minority ethnic communities: multi-agency working; specialist versus generic service provision; and outreach work and action research. It goes on to review the implications for service development against the requirements of the Race Relations (Amendment) Act 2000 and by addressing the way forward through examination of the concept of community engagement. Finally, the NTA’s Models of care is reviewed in the context of the findings of this literature review.

6.1 Multi-agency working

Several commentators argue that multi-agency partnerships - including community organisations and local health promotion initiatives - will aid the development of services by enabling resources to be shared and duplication minimised, whilst addressing a range of drug-related issues. The multi-agency approach is an ideal way to access, consult, and assess the service needs of hard-to-reach groups (ADP, 1995; Awiah, undated; Chaudry et al, 1997; Dhillon, 2001; Gooden, 1999; Gilman, 1993; Johnson and Carroll, 1995; NWLHPU / GMLCA, 1997; Patel, 2000b; Shahnaz, 1993). The approach may, however, involve initiating co-operation between agencies already working in the drugs field, not only to avoid duplication but also competitiveness, and antagonism towards those that are well-funded by those that are not (Sheikh et al, 2001). Southwell (1995) notes that some drug agencies share the resources and contacts in order to dominate small Black and minority ethnic community groups, and makes a plea for equity in the development of future partnerships.

Gilman (1993:25) discusses the issues raised by seven action research studies in Bradford, and stresses: "Many of these issues will need to be tackled on a multi-agency basis. No one agency can deal with all the issues on their own. What is required is a commitment to formulate comprehensive strategies that outline the parts that different agencies can play in drugs prevention."

Gilman outlines the different roles played by the various drug agencies involved:

- the police (reducing the supply of drugs)
- drug prevention and education organisations (reducing demand and harm)
- and treatment agencies (treating problematic drug use).

A multi-agency approach also enables organisations to respond to drug-related problems in the context of broader health service provision (Awiah et al, 1990, 1992). For example, Patel et al (1995) point out that female South Asian drug users would benefit from drug-related work conducted at general health, maternity and health promotion agencies. NWLHPU / GMLCA (1997) add that mutual trust and understanding of all the partnership organisations is essential, and they and the community in question should be kept involved and informed of developments.

Other recommendations on the multi-agency approach to service development for Black and minority ethnic communities include aftercare services as an integral component of drug service development plans (ADP, 1995); drug education campaigns incorporating advice and information about arrests for drug offences (NWLHPU / GMLCA, 1997); and training for members of the criminal justice system in cultural sensitivity (NWLHPU / GMLCA, 1997).
6.2 Specialist or generic services?

There is a debate within the literature about the need for, and the role of, specialist Black and minority ethnic drug services as opposed to increasing access for Black and minority ethnic drug users to generic services. Specialised drug services are not necessarily thought by all to be the most appropriate way to treat drug users from some Black and minority ethnic groups (Hothi and Belton, 1999; Mistry, 1996) and young people may require a different approach. Those involved in a project reported by Dhillon (2001), for example, suggest services that are ‘not too clinical’ for young drug users, held at youth centres.

The debate over whether drug services for Black and minority ethnic communities should be specialist (only for a targeted community) or generic (theoretically open to all communities) is discussed by Sangster et al (2002). Their respondents perceived specialist services as including cultural ownership and an understanding of cultural needs, but also as expensive, impractical and with limited opportunities for sharing expertise. Generic services were perceived as equated with ‘mainstream’ services, with implications of longevity and funding by statutory commissioners as part of their core service provision. The balance of opinion amongst Sangster et al’s respondents was that specialist services for Black and minority ethnic communities could have an important complementary role, and the authors cite examples of generic services that have sought to integrate the advantages of the specialist approach.

The disadvantages of successful specialist services have been pointed out by Bashford et al (2001) and Prinjha et al (2001b) who, whilst not denying that some of those they cite represent examples of good practice, believe that mainstream providers may see them as a justification for not addressing their own service responses. Similarly, ADP (1995) also fears that increasing attendance at existing drug services by Black and minority ethnic drug users after awareness-raising activities, could be used to argue that the problem of access has been resolved, and act as a barrier to the development of more culturally-specific services.

An example of difficulties of establishing specialist agencies for Black and minority ethnic communities comes from Patel et al (2001). They report that in the London borough of Tower Hamlets, no agency, commissioner, nor service provider contested that there was a serious and deteriorating heroin problem amongst Bengalis in the area. Nevertheless, perceiving a proposed drug service for this population as based on an Islamic model, they were unsure what it could offer, assuming that it would preclude advocating or using medical interventions. When the service was established, these doubts were allayed somewhat as it became clear that the agency saw treatment with methadone not as ‘the answer,’ but rather as sometimes the best solution available, and that the service incorporated elements of faith in the treatment programme in order to achieve cultural sensitivity. After the initial scepticism, other drug agencies in the area began to request joint working with the new agency.

The development of GP-based drug services has been proposed (Awiah, undated; Chaudry et al, 1997; Mistry, 1996; NWLHPU / GMLCA, 1997; Patel, 2000b), on the basis that GPs have respect from some Black and minority ethnic communities and there is no stigma attached to visiting them. GP-based drug services are suggested particularly as a method of attracting those women whose movements are restricted by their culture (Johnson and Carroll, 1995; Mistry, 1996).

6.3 Outreach work and action research

Many commentators stress that outreach work is necessary to access Black and minority ethnic drug users and those at risk of drug use (ADP, 1995; Awiah, undated; Bentley and Hanton, 1997; Chantler et al, 1998; Chaudry et al, 1997; Gooden, 1999; Hothi and Belton, 1999; Mistry, 1996; NWLHPU / GMLCA, 1997; Patel et al, 1995; Pearson and Patel, 1998; Prinjha et al, 2001a; Singh and Passi, 1997). Action research, which includes outreach work, can be broadly defined as combining needs assessment, awareness-raising and the development of services, with a focus on community consultation. As Awiah (undated) and NWLHPU / GMLCA (1997) conclude, drug service purchasers
need to recognise that outreach work is needed in order to show members of Black and minority ethnic groups that there are drug services for them.

Patel (2000a,b) and Ram (2000) caution that outreach work and action research should not consist of drugs workers and researchers simply ‘parachuting’ into a community to fulfil their project aims and then disappearing leaving only raised expectations. As one of the project workers of such a drug prevention and awareness project aimed at Turkish speakers reported by Awiah (undated:24) commented:

“The relevance and importance of this project will be curtailed if it is not followed up by long-term teamwork. If the needs of the Turkish-speaking communities within this area are not incorporated into the strategic planning of drug services and prevention, then to carry out a project like this [with a time limit]...could render the work useless or even counter effective. This is because you are raising people’s expectations of drug services but there is nothing to pick people up.”

Gilman (1993) reports on seven action research studies in Bradford, two of which focused specifically on Black and minority ethnic communities: South Asians in the Manningham area and Black Caribbeans across the whole city. Support for action research projects also comes from ADP (1995) and Singh and Passi (1997). Johnson and Carroll (1995) provide a checklist (p40) and useful examples of good practice in action research which combine many of the elements necessary for the development of services that have been identified as the way forward throughout this review.

Patel (2000b) and Bentley and Hanton (1997) make the point that active outreach not only raises the awareness of services but also enables a comprehensive needs assessment to be conducted. Different Black and minority ethnic groups - and different generations within the same Black and minority ethnic group - have different patterns of drug use and it is essential that these are understood in order that the appropriate service responses are developed (Oyefeso et al, 2000; Ram, 2000; Sangster et al, 2002).

Patel (2000a) discusses in depth an action research project in Bradford, which successfully used a multi-dimensional approach to reach South Asian drug users, but also employed interventions which reached the whole community. The project dramatically increased the number of South Asians attending a drug service, from only a handful a year to several hundred. Awiah, (undated) also reports an increase in referrals to local drug agencies during a similar project aimed at the Turkish-speaking communities in Hackney and Haringey. Patel (2000a) attributes the success of the Bradford initiative to many factors, including that:

- the project followed a previous study (Awiah et al, 1992; Pearson and Patel, 1998), which involved a significant amount of community development and action research
- the simultaneous development of the drug service (which took a total of five years)
- and that the project was conducted over a two-year period.

Nevertheless, Patel et al (1995) stress that such initiatives should be continuous and address issues such as falling referrals when the project ends. The authors conclude (p.48) that:

“...it is our view that the activities might be better thought of in their entirety, since activities with different target groups and at different levels of intervention tended to interact, producing ripple-effects which could sometimes produce unanticipated outcomes. Quite apart from raising the awareness of drug issues within Bradford’s Asian communities, and widening service access and service use among the target population of drug users and injectors, there have been significant developments at a district level in terms of service planning and delivery.”

Johnson and Carroll (1995:20) discuss the personnel involved in conducting action research projects: they need to be carefully chosen because problems have arisen when they are ‘overly-academic’ and the research is not practice-orientated, but also when they are ‘community-led’ and produce reports which make useful points but lack supporting evidence.
6.4 Race Relations (Amendment) Act 2000

The Race Relations (Amendment) Act 2000 came into force in April 2001 and places a general duty on public authorities to promote race equality. It creates a clear expectation that these public bodies will review their functions and identify steps to be taken to comply with the new provisions. In addition, the Commission for Racial Equality (CRE) has produced a series of codes of practice on the formation of equality frameworks and will be responsible for the monitoring and implementation of the new Act (CRE, 2001a,b).

The Act challenges all public services to eradicate discrimination and disadvantage and it requires public organisations to have clear race equality action plans. This provides the impetus for drug services to address the shortfalls in the provision of appropriate and accessible services for Black and minority ethnic groups. The Act specifically seeks to address institutional racism, which is defined by Macpherson (1999:9) as:

“The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.”

In relation to drug services, this definition provides a benchmark from which to examine the current situation: an understanding of the social, political and economic structures within which racism is constructed and experienced, is crucial when planning service delivery.

The key organisational features for promoting good race relations are detailed in box 1 and can be summarised as follows:

- steps should be taken to monitor the workforce
- steps should be taken to ensure fair treatment of people from Black and minority ethnic groups
- Black and minority ethnic groups should be consulted on the activities undertaken by the public authority and in the review process
- there should be a robust assessment of policies and programmes that could affect people from Black and minority ethnic communities
- areas that have the potential for adverse differential impact should be identified and steps taken to remedy these.

Taken together, these activities ensure that the implementation of policies and procedures is monitored for the extent to which the needs of Black and minority ethnic groups are being met. Lastly, public authorities are required to have a publicly-stated policy on race equality. The approach to race equality is expected to be embedded within the overall modernising government policy arena and as such should be part of a broad organisational culture change. A ‘tick box’ approach will not be acceptable under the monitoring arrangements for the Act.

The duty to promote race equality is not the same as the provisions for outlawing discrimination. This is an important distinction, as the Act seeks to drive up standards from which whole populations and particular groups will benefit, rather than result in particular outcomes for individuals.
Sangster et al (2002) call for practical guidelines on how drug services may seek to ensure cultural competence and for national lead strategic drug agencies to work directly with the Commission for Racial Equality on the creation of guidelines for service provision and funding. Other recommendations by Sangster et al include the need to tackle institutional racism through the funding of initiatives that seek to address issues such as Black and minority ethnic representation, community attachment and ownership, capacity building and cultural sensitivity. The importance of capacity building is particularly emphasised and includes:

- the development of partnership services with community groups
- the establishment of satellite services
- community volunteer schemes
- training and mentoring schemes
- secondments from community organisations.

Indeed, the concept of what may be called ‘community engagement’ is likely to be the key to meeting the requirements of the Race Relations (Amendment) Act 2000 and provides a clear direction for drug service development.

Box 1

Action by public authorities to meet the requirements of the Race Relations (Amendment) Act 2000

**Definition**

Define all your functions - what you must do, and what you can do. Then identify - by ethnicity and other relevant criteria - the people for whom you should be providing various services.

**Consultation**

Talk to your employees and to the people affected by your policies and practices, including people from ethnic minorities. Listen to their concerns and pay attention to their perceptions of your organisation’s stand on racism and racial equality.

**Monitoring**

Set up systems to monitor your workforce and the outcomes of your policies and practices.

**Assessment**

Examine the impact of your policies and ask whether all ethnic groups are being treated fairly. Do they have equal opportunities and equal access to benefits, facilities and services? If not, why not?

**Change**

Where the evidence from monitoring shows unequal outcomes between different ethnic groups, consider what changes are needed, and take action to prevent direct or indirect discrimination and to promote greater equality.

**Implementation**

Where your organisation already has good policies on racial equality, make sure they are understood and put into practice at every level within the organisation. The policies should also be reinforced through staff performance appraisals and disciplinary procedures.

(CRE, 2000)
6.5 Community engagement

It is clear from this review - particularly from the more recent literature - that one of the most significant ways forward in terms of the development of drug services for Black and minority ethnic communities is via the communities themselves. Many of the findings reported in chapters 2 and 3 provide evidence of a very real need amongst these communities for responsive and culturally appropriate drug services. Chapter 4, whilst reporting the acknowledgement of this need by some service providers, also shows the inability of services alone to respond adequately. In chapter 5, the literature on drug awareness initiatives is discussed, including the denial, shame and stigma surrounding drug use reported in many Black and minority ethnic communities, illustrating just some of the difficulties facing both drug service providers and those in need of drug services.

This chapter has so far reported initiatives that have attempted to overcome the barriers faced by Black and minority ethnic communities around drug use and the related services, and also those faced by drug services in their attempts to access BME communities. These initiatives have tended to focus on communities and have been characterised by the terms ‘involvement,’ ‘development’ and ‘participation.’ However, ‘collaboration’ and ‘partnership’ have also featured in the more recent literature, suggesting a move away from initiatives in which communities are passive recipients to those in which communities are taking an active and, theoretically, an equal role. The terms ‘empowerment’ and ‘capacity building’ are recurrent terms, implying that communities lack knowledge at the outset of the initiative and can be given power during the process. Clearly, although still in development in some areas, the ingredients necessary for initiatives which are currently being described as ‘community engagement’ are being compiled.

Engaging communities has become a central theme in national government policy, particularly in the area of social exclusion (SEU, 2001), although much of the literature on this issue is concerned with regeneration initiatives and focuses on disadvantaged groups in general, rather than specifically on BME groups. However, the paucity of practical examples of successful community engagement which go beyond short-term, tokenistic gestures suggests that the concept has yet to become a reality. Taylor (2000) notes that many voluntary and community organisations feel that they are consulted only to fulfil central government requirements, and she, Awiah (undated), Patel (1997), and Sheikh et al (2001) deplore that many initiatives allow too little time for capacity building.

Strategies purporting to be ‘community consultation’ or ‘community involvement’ are likely to be perceived as useful by the community in question only if they form part of wider strategy to plan, develop and deliver appropriate services. Otherwise, they are merely tokenistic (Prinjha et al, 2001a; Sangster et al, 2002). For example, whilst representation of local Black and minority ethnic groups on drug action teams (DATs) is clearly necessary, Prinjha et al (2001a,b) report a concern that that such DAT members should not become, or be viewed as, representatives of, and responsible for, their whole community, and that white decision-makers also need to be aware of the needs of Black and minority ethnic communities.

It is clear from the above that community ‘involvement,’ ‘consultation,’ ‘participation’ and ‘engagement’ are coterminous in the eyes of many commentators, and a number of organisations have devised strategies and toolkits of ‘community engagement’ as perceived by them. From the USA, Fawcett et al (1995), for example, define the concept as the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest or similar situations to address issues affecting their well-being. Others stress the different stages of engagement and its varied techniques (Leeds Initiative, 2000). Patel et al (2002:12) offer the following definition:

“Community engagement can be broadly defined as the simultaneous and multifaceted engagement of supported and adequately resourced communities and relevant agencies around an issue or set of issues in order to raise awareness, assess and articulate need, and achieve sustained and equitable provision of appropriate services.”

Many models rely on ‘key informants’ or ‘community leaders’ to access communities, although Patel et al (2002) warn of over-reliance on those who may, in order to protect their community from
stigmatisation by the exposure of issues they perceive as sensitive, discourage access to those who could provide information.

In England, the Leeds Initiative (2000) has produced a framework that usefully outlines the principles of community engagement to “ensure that we engage with our communities in a way that is co-ordinated, consistent and coherent” (p.4), and in the USA, the Committee on Community Engagement (1997) outlines similar principles, with practical examples. Todhunter (2001) points out potential pitfalls, including that commissioning bodies must fully appreciate that “the impact of subsequent ‘community involvement’ may not fall within the parameters envisaged at the outset”. As Dhillon (2001) found, the Southall Community Drug Education Project was regarded as “a thorn in the side” by the local commissioners. Foreman (1996), whilst advocating that community engagement is the way forward in terms of ‘hard to reach’ groups warns that it can have only limited impact on the policy-making process unless it has allies amongst the policy ‘experts’.

The result of a lack of community engagement is illustrated by Bashford et al (2001:23) when, as detailed earlier (section 5.1.2), discussing the strategies South Asian families have been shown to employ to cope with a drug user (sending them to the family’s country of origin, paying for private treatment, and an enforced home detox):

“It is difficult to confront this issue without seeming to blame the community or family, especially given the high degree of expressed anger among parents and family groups with the drug services. Within a context of institutional racism these maladaptive community responses are more the consequence of the failure of agencies to educate and inform the community rather than a failure within the community itself.

“This is essentially a capacity building issue, highlighting as it does, the low levels of understanding about drug issues and services within the community and the need for educational and awareness raising work. Some of this...has been taking place...there is, however, a long way to go before there will be an impact at a community level that may lead to changes in perceptions and service use.” (Bashford et al, 2001:23).

An initial step in that ‘long way to go’ is that drug services need to obtain the confidence and trust of, and credibility with, the target client groups (Chaudry et al, 1997; Hothi and Belton, 1999). This involves attending to specific cultural needs and working with a community, on an on-going basis. Oyefeso et al (2000) propose a community-wide model of service provision: staff competency and cultural competence, contribution of Black and minority ethnic communities, and the role of the council and other authorities in improving community resources, ethnic monitoring and outcomes.

6.5.1 Getting engaged

Black and minority ethnic community groups can be a starting point for effective community engagement. McLeod et al (2001) estimate that there are over 5,000 Black and minority ethnic voluntary and community organisations in England and Wales, arguing that they are an integral part of the infrastructure required for tackling social exclusion and deprivation. The authors insist that capacity building of community groups is an essential ingredient of capacity building of Black and minority ethnic communities as a whole. Passi (1999a) concurs; interviews with six community groups revealed that they were interested in their potential role in becoming involved in drug service provision, although lack of resources - especially in terms of staff time - meant that substance use was not high on their agendas. In addition, members of the communities they served did not see these groups as drug services, so interviewees thought it unlikely that they would be asked for help in relation to drugs. Nevertheless, all the groups felt they had a future role: some working with young people on drug issues, others as a first point of contact for those looking for advice. All the community groups wanted more information on drug use and drug services.

In terms of funding, Oyefeso et al (2000) and Southwell (1995) are amongst those who plea for the improvement of community resources, although Khan (1999c:10) insists that funding community groups “can help only if they become effective pressure groups to change...
discriminatory or culture-blind practices”. McLeod et al (2001) recommend that the current Home Office grants to strengthen Black and minority ethnic organisations continue and be extended, noting that their recommendation had the support of mainstream organisations, in part because of the guidance that community organisations could give to those trying to engage with services.

The literature above illustrates the manner in which the process of capacity building in community engagement initiatives is not solely an outcome for communities, but directly benefits service providers and commissioners as they learn and gain experience working alongside community members. In some areas of England, it has been recommended that this approach is combined with the development of a strategic race equality framework that seeks to develop capacity simultaneously within the drug action team across agencies and within the local Black and minority ethnic communities (Sheikh et al, 2001).

The combination of communities, drug service providers and commissioners working with and alongside each other to address the problems related to drug use is clearly the way forward. However, the need for confidence-building between communities and mainstream organisations is also seen as essential. One commentator recommends that community engagement is facilitated by an intermediary - an honest broker - to cut through bureaucracy, build confidence and trust between agencies, and develop networks (Ward, 2001).

6.5.2 Examples of good practice

Examples of projects that have successfully engaged communities whilst utilising a capacity-building approach through an outside facilitator include:

- **The Southall Community Drug Education Project** that takes a broad community approach and works predominantly with the South Asian communities in Southall. The project consists of three main interrelated elements in assessing and responding to the needs of a number of local community BME groups:
  - work with families - to educate and raise awareness on drug-related issues
  - work with young people
  - work with professionals, business leaders, and with voluntary and religious groups (Dhillon, 2001; Winters and Dhillon, 2002).

- **The Making Things Equal Project** in Lancashire targets South Asian communities (particularly Pakistanis, Indians, Bangladeshis and Pathans) that is, in effect, a specialist service located within a generic project. The project utilises a network of trained community interacters who work within their own communities to raise the issues related to drug misuse and help those communities develop their own solutions (Sangster et al, 2002).

- **The Black and Minority Ethnic Community Drugs Misuse Needs Assessment Project**
A Department of Health funded initiative in which 47 projects, representing 25 different ethnic groups, were recruited, trained and supported to conduct drugs needs assessments in their communities. The approach aimed to inform an effective strategic approach by drug policy-makers, service providers and planners at local levels. Capacity building amongst the participants was a key aim of the project (Centre for Ethnicity and Health/Department of Health, forthcoming). Further details are outlined in box 2.

3 Individuals whose position in the community gives them unique access to target groups, but not necessarily those who would be usually perceived to be community leaders. Community interacters provide a conduit for distributing information, advocacy and support for individual community members, and opportunities for project development through community feedback on project initiatives. The community interacters model is based on a capacity building approach that ensures those recruited as interacters receive training, skills development and support.
Box 2

Black and Minority Ethnic Community Drugs Misuse Needs Assessment Project

A brief description of the Black and Minority Ethnic Community Drugs Misuse Needs Assessment Project is appropriate here, as the forthcoming publication of the 47 individual project reports and the final overarching project report will not only provide a significant contribution to the literature on Black and minority ethnic groups and drug use, but will also lay the foundations for a model of effective community engagement.

The final project report describes the process and aims of the project in detail. The project was commissioned by the Department of Health in November 2000 and the 47 projects that were finally selected were carefully chosen as being representative of a wide range of ethnic groups and communities and geographical spread. Importantly, the community groups who proposed these projects had secured the commitment and support of their local drug commissioners within their local drug action team (DAT). This was part of the strategy to ensure the individual projects would be part of the mainstream planning and commissioning cycle and applicants were given support and advice from the outset of the recruitment process to help them establish links with DATs.

The whole process involved the establishment of a number of key partnerships. The Department of Health was the driving force behind the project, generating the original idea and funds whilst the Centre for Ethnicity and Health at the University of Central Lancashire managed the project on its behalf. The Commission for Racial Equality, the United Kingdom Anti Drugs Co-ordination Unit (UKADCU), the Home Office Drugs Prevention Advisory Service (DPAS), and the drugs charity DrugScope strongly supported the approach. Lifeline (a regional drug service provider) offered training support to the community groups and seconded a member of staff to the project.

A diverse range of Black and minority ethnic groups responded to the call for applications, including a number of groups about whose drug use little is known, such as Igbo, Eritrean, Congolese, Sierra Leone, Greek Cypriot, Turkish, Kurdish, Yemeni, Iraqi, Somali, and Cabindan. The significance of the project can be measured not only by the wide range of different BME groups involved, but also in terms of gender, age profiles, sexuality and disability.

A formal training programme was supplied to the community groups through the University of Central Lancashire and included drug awareness, information on the national drug strategy and techniques in completing needs assessments. A total of 204 people participated in the formal training programme and, through supplementary training provided via many of the individual projects, more than 350 community volunteers had received training by the end of the project.

Support workers maintained regular contact with each project and were available throughout the project to offer advice and information as needed. The Department of Health remained involved and a representative visited every project at the half-way stage in order to discuss arising issues and progress, and to demonstrate the Department’s high level of commitment to the work.

The project outcomes reported by Centre for Ethnicity and Health / Department of Health (forthcoming) reveal that a total of over 12,000 BME community respondents participated in the needs assessment through interviews, surveys and focus groups. Various success stories in terms of capacity building, both amongst individuals and community groups, is reported including that some individuals have acquired employment in the drugs field and that further needs assessments and service development work has been commissioned from the community groups by local DATs. The project is reported as having raised awareness within communities, and, by ensuring there is a firm link with local commissioners, the work is not perceived as ad hoc nor piecemeal. Each of the final project reports is being published by the Department of Health on the internet and the long-term impact of the project work is being assessed through a three-year PhD study that will look in particular at the sustainability of the community engagement process. This PhD and the contribution of the project reports to the literature on Black and minority ethnic groups and drug use in England will provide a firm basis for updates to the knowledge base provided by this literature review.
Models of care has been issued by the National Treatment Agency (2002) in order to provide a common framework for the commissioning and delivery of drug services “that is intended to achieve equity, parity and consistency in the commissioning and provision of substance misuse treatment and care in the UK” (NTA, 2002:2). Models of care has similar status to a national service framework. The emphasis on equity, parity and consistency is particularly important for Black and ethnic minority communities and the specific issues they face are recognised throughout. For instance:

“Certain groups of substance misusers, such as stimulant users, rate information as being an important part of service provision...Other groups require information in an accessible format (eg culturally appropriate literature for those from minority ethnic populations)” (p.8).

“...black and minority ethnic stimulant drug users face barriers to accessing treatment and care services” (p.112).

‘Black and South Asian’ drug users are identified as needing to be prioritised for entry to structured day programmes, including targeted services (p.70).

South Asian and Turkish drug users are highlighted for specific prevention initiatives with regard to injecting:

“There is now increasing interest in the development of interventions aimed at preventing and curtailing injecting and in ‘route transition interventions’ (RTIs) (Hunt et al, 1999 and 1998). It has been argued that policy must focus on encouraging people away from injecting in order to control HCV [hepatitis C virus] and overdose death. (Wodak, 1997; Strang et al, 1997). The development of interventions that prevent transition to injecting are also particularly needed among Bangladeshi and other South Asian heroin users and other minority ethnic groups who exhibit much higher prevalence rates of smoking than injecting heroin.” (p.58).

Model of care’s specific section on Black and minority ethnic communities (pp.130-138) draws on some of the evidence also presented in this literature review and identifies many of the same issues to be addressed. For example:

- It is specifically recommended in Models of care that commissioners of drug services should require, through the use of service specifications, that treatment agencies improve their collection of data (p.125). This reflects the findings reported in section 4.2 of this review.

- Models of care highlights that Black and minority ethnic women may miss out on harm minimisation interventions due to late entry to treatment (p.127).

- Chapter 4 of this review presents the literature that explains why Black and minority ethnic drug users generally, and Black and minority ethnic women in particular, are under-represented as drug service clients.

- In the context of care pathways, Models of care recognises that Black and minority ethnic communities especially require a multi-agency approach, and that this may need to include particular external agencies such as community organisations and those providing advocacy and interpreting services (p.130). This review discusses the literature dealing with these issues throughout chapters 5 and 6.

6.6.1 Needs assessments and commissioning practice

Models of care calls for research into Black and minority ethnic drug users’ retention rates in treatment and the impact of retention on treatment outcome (p.131), and, in relation to the results of needs assessments stresses that (p.131):
“The particular service needs of minority ethnic problem alcohol and drug users are reflected in service agreements, service specification and broader purchasing agreements and monitoring requirements.”

The literature cited in chapters 4 and 6 of this review wholeheartedly supports this need, although the sheer wealth of data the review presents on the drug use and related service needs of some Black and minority ethnic communities - particularly South Asians - should not be ignored when allocating resources to future needs assessments.

6.6.2 Racial and ethnic equality

One of the most significant recommendations contained within Models of care is that DATs and all drug agencies give detailed consideration to racial and ethnic equality. In particular (p.134):

“The D(A)AT and each of its constituent agencies have developed strategies to tackle issues of racial/ethnic equality. The strategy:

- identifies gaps and priorities
- identifies clear objectives and measurable targets
- includes timescales
- Funding or other resources are available to tackle issues of racial/ethnic equality.”

Again, the literature cited in chapters 4 and 6 of this review supports this recommendation.

6.6.3 Working with communities

Sections 6.3 and 6.5 of this review detail the literature on working with communities as the way forward for the development of drug services for Black and minority ethnic communities, and Models of care (p.132) also recognises the significance of this strategy, citing the National Framework for Mental Health (Department of Health, 1999b) as an example:

“The mental health national service framework states that all services must be planned and implemented in partnership with local communities and must involve service users and carers. If services are to match the needs of black and minority ethnic communities and reduce the present inequities, this principle is especially important. This is equally true for the field of substance misuse.”

6.6.4 Moving through the Tiers

One of the central aspects of the framework outlined in Models of care is the tiered approach to drug service provision (pp.16-20).

The tiers can be summarised as

Tier 1: Non-substance misuse specific services
Tier 2: Open access drug and alcohol treatment services
Tier 3: Structured community-based drug treatment services
Tier 4a: Residential drug and alcohol misuse specific services
Tier 4b: Highly-specialist non-substance misuse specific services.

“At any given time there are likely to be many more substance misusers in contact with Tier 1 and 2 services (the base of the ‘pyramid’) than Tiers 3 and 4 (the apex). However, as the aim of the treatment system is to engage substance misusers in specialist treatment, the more effective and more comprehensively funded the system, the ‘broader’ the apex.” (NTA, 2002:22).

Models of care suggests that the Tier system will be experienced as ‘seamless,’ with service users being ‘unaware’ that they are moving within and across the Tiers (p.22).
However, this literature review has shown that drug services that can appropriately meet the needs of Black and minority ethnic drug users are so poorly developed that the Tier system will have a very real impact on the capacity of the individual Black and minority ethnic drug users to move within and across the Tiers. There is a risk that they will be identified in Tiers 1 and 2 but be unable to access Tiers 3 and 4. The discussion on barriers to drug service access identified by the literature in section 4.7 of this review particularly highlights this risk.

6.6.5 Needs-led drug services

*Models of care* states that commissioning should be needs led rather than based on historical precedent stressing that “It is the responsibility of DATs through their joint commissioners and joint commissioning groups (JCGs), to ensure that the diverse range of drug and alcohol misusers within their locality are catered for. Local variations in provision will include: demographic and socio-economic factors (e.g. population, age, ethnic diversity, levels of deprivation; substance misuse trends and patterns.... and geography” (p.22). The risk here is that the result may be that needs assessments are conducted only in areas with significant Black and minority ethnic communities (such as London) and/or those that have developed appropriate services and can demonstrate demand. As discussed earlier in this review (section 4.7) this may mean that commissioners in areas of relatively low numbers of Black and minority ethnic populations do not undertake needs assessments nor develop appropriate services.

Despite the reservations above, *Models of care* provides a significant support to the evidence in this review and should result in more services and commissioners addressing the drug-related needs of Black and minority ethnic communities.
Further details of how to acquire copies of the grey literature listed in this section can be obtained from:

The Centre for Ethnicity and Health
Faculty of Health
University of Central Lancashire
Preston PR1 2HE
Tel: 01772 892 780
Fax: 01772 892 964
Email: ehunit@uclan.ac.uk


Bentley C, Hanton A (1997): A study to investigate the extent to which there is a drug problem amongst young Asian people in Nottingham. How effective are drugs services in providing assistance for such minority ethnic groups? Report: ADAPT, Nottingham.


CRDHB (Centre for Research on Drugs and Health Behaviour) (1999): Thames Regional Drug Misuse Database. Short paper no. 3: Trends in reports of Asian heroin smoking. London: Centre for Research on Drugs and Health Behaviour, Imperial College School of Medicine.


Hussain S (undated): Mary Street Information, Training, Research and Education project. Birmingham: Mary Street Community Drug Team.


Passi P (1999b): Accessing substance misuse services: a review of the availability and accessibility of substance misuse services to the ethnic community in the Preston area. Manchester: North West Lancashire Health Promotion Unit.


