

The Department of Health's
Black and Minority Ethnic
**Drug Misuse Needs
Assessment Project**

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Community Engagement

Report 2: The Findings



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The Department of Health's **Black and Minority Ethnic Drug Misuse Needs Assessment Project**

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

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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 complement 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 Centre for Ethnicity and Health outlining the implications for practice of these findings.

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Asian Community Forum (Lancashire)

Bangladeshi Youth League (Luton)

Black Health Agency (Manchester) formerly known as Black HIV and AIDS Forum (BHAF)

BME Housing Consortium (Wolverhampton)

Cabinda Community Association (London)

Chinese National Healthy Living Centre (London)

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Simba Community Alliance (London)

Smethwick Bangladeshi Youth Forum (Sandwell)

Somali Health and Mental Health Link (London)

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Supporting African Youth Development (London)

The Igbo and Tutorial School (London)

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The Department of Health's **Black and Minority Ethnic Drug Misuse Needs Assessment Project**

Report 2: **The Findings**

EXECUTIVE SUMMARY

The Black and Minority Ethnic Drug Misuse Needs Assessment Project involved forty-seven Black and minority ethnic community groups, which were funded through a Department of Health (DH) grant, to undertake needs assessments on drugs and related issues within their particular communities. The project was facilitated by the Centre for Ethnicity and Health, which is a department in the Faculty of Health, University of Central Lancashire.

The 47 community groups were selected on the basis of a variety of factors including ethnic group, region, areas of deprivation, focus of work and commitment from local partners and commissioners, and most importantly their ability to access their own community. 45 out of the 47 groups lie within the most deprived local authority districts in England.

A wide range of methods were utilised by the community groups including semi and unstructured interviews, survey questionnaires, focus groups, workshops and telephone interviews. Many groups used several methods together, often tailoring the approach and methods to the particular target group. In total, over 12,000 people have been consulted representing a diverse range of communities, ages, religion, languages and sexuality. A group also examined issues specific to Black and minority ethnic Deaf people. Within the total sample:

- There are 30 ethnic and national groups;
- 36 different languages are spoken;
- At least 36% are women;
- There are a range of religious faiths including Islam, Hinduism, and Sikh, Christian, Rastafarian and Zoroastrian faiths;
- Between them, the reports mention asylum seekers and refugees from 21 different parts of the world;
- There are 469 interviews with service providers and community or voluntary sector agency workers.

The breadth of different ethnic and national groups involved and the issue of diversity within communities is one of the central themes to emerge from the project.

THE FINDINGS

Levels of awareness and knowledge about drugs

- There are very low levels of awareness and knowledge about drugs across all of the communities, particularly across generations.

- Lack of awareness is perceived to be a problem both within communities through denial and resulting from lack of service responses.
- People reportedly get their information about drugs predominantly from the media and amongst friends rather than drug services or schools.
- Access to and increased availability of drugs are perceived as a factor in why people start to use them
- It is not solely in relation to knowledge about drugs that communities lack information. There also appears to be a generally poor level of knowledge about related health risks, particularly with regard to blood borne diseases such as HIV/AIDS and hepatitis B and C.
- The prevailing view amongst respondents is that drugs are easily obtainable and many describe dramatic increases in drug use.
- More than 40% of those asked (n = 1,138) report knowing drug users. The number of users known varies across groups.

The impact of drug use on families

- The impact of drug use on families is varied. This is described in terms of stress, worry, financial burdens, health and mental health problems, tensions, arguments and even violence.
- For many families, it is not a subject that can be discussed and families experience shame and isolation from the wider community.
- Family responses to drug use include sending the user to the home country of origin of the family or attempting to confine them so that other people in the community do not find out.
- Families are coping with both the fears and the realities of drug use in relative isolation.
- The lack of general drug education and little awareness about services confounds an already difficult situation, leaving many families feeling cut off from their communities and unable to cope.

Recommendations: There is a need for drug education to be focused on young people and that this should involve parents and families. Specific education programmes for older generations should also be provided. Many groups recommend that drug education needs to be communicated for a more diverse audience: able to be understood in different community languages; using formats for different abilities including sign language and audio visual resources; and utilising Black and minority ethnic media.

Some groups call for a fully integrated programme of drug education targeting particular community groups and encompassing wider issues. Others call for the involvement of

¹2, 743 Black African respondents; 865 Black Caribbean respondents; 101 Black mixed race respondents. (176 respondents are reported as 'Black African Caribbean'); 2, 301 Indian respondents; 2, 931 Pakistani respondents; 1,020 Bangladeshi respondents; 11 Sri Lankan respondents; (482 respondents are reported as 'South Asian'); 203 Iraqi respondents; 177 Yemeni respondents; and 12 respondents who are classified as 'Middle eastern'.

religious organisations in drug education work. Some groups recommend education about traditional substances that are predominantly used by those groups, in particular on khat. Further research into the potential harms of traditional substances is recommended.

Deprivation, disadvantage and discrimination

- Deprivation, disadvantage and discrimination in the context of drug use are themes that are raised repeatedly by respondents. This remains true even for those living in areas that are less strongly identified with disadvantage.
- Communities face a number of stresses in addition to general disadvantage such as racial discrimination, language barriers, immigration status and displacement. All of these are viewed as possibly leading to an increased risk of developing drug problems.
- Racial discrimination is a key factor in considering the needs of Black and minority ethnic communities.
- Discrimination and the experience of racism are in many instances linked directly to drug use and service provision.
- Despite the obvious stresses there is a lot of community resilience and strength.

Recommendations: Increased training, education and employment opportunities for young people to break the cycle of disadvantage, deprivation and associated drug use is recommended. Many respondents are concerned about young people and what is seen as a lack of recreational and sporting activities within neighbourhoods. This is viewed as resulting in boredom and heightened risks of drug use. Groups recognise that there needs to be more capacity building within communities to ensure they can participate fully in partnerships and contribute to service development and delivery.

Crime and drug dealing

- Respondents express a strong sense of fear and concern about increasing drug use and crime.
- Many were also acutely aware of an increase in dealing.
- Not all respondents using drugs report crime as the main source by which they obtained funds for drugs.
- In some areas there is a clear link between fears about drugs, the emergence of gang cultures and use of guns.
- Most respondents are keen to see better and more effective policing.
- There is a reluctance to report drug related incidents to the police.
- There is a desire to see a more visible police presence on the streets but this is tempered by concern that higher profile policing should not be seen to target Black and minority ethnic communities unnecessarily or inappropriately in a way that might be perceived of as racist.

Recommendations: There is a perception that the police do not communicate their strategies well and that they should do more to explain and publicise these. Many reports contain recommendations that the police, alongside other organisations should work in partnership with community groups. Some groups also recommend that the police receive training in cultural sensitivity.

Reported drug use amongst respondents

Eighteen percent of the sample of community respondents, that is 2078 people, reported using a wide variety of drugs. This constitutes the largest sample of Black and minority ethnic drug users in the UK.

- Nearly one in five reported use of cocaine and one in ten had used heroin.
- 18% reported use of khat and others reported using a wide range of traditional substances about which little is known.
- Comparisons of drug use by ethnic group suggest that there are distinct patterns of drug use amongst some ethnic groups, which has implications for the commissioning and provision of drug services.
- One in three of those reporting drug use are women.
- The largest concentration of female respondents reporting drug use is South Asian (29%).
- Two thirds of those reporting their age are under 21. The highest proportion of respondents (41%) is South Asian, 75% of whom are under the age of 21.
- The largest proportion of older respondents (47%) is Black African.
- Taken together, peer influence, experimentation and pleasure seeking account for 74% of respondents' reported reasons for starting to use drugs.
- 30% cite their reasons for drug use as being to avoid or help deal with problems.
- Most respondents report that they primarily obtain their drugs through friendship networks.
- Only 10% of respondents have experience of using drug treatment services and of these most report that their experience was negative.
- The waiting time is often reported as a key barrier to accessing services.
- There are misconceptions about what drug treatment services do.

Help seeking and awareness of services

There is a strong sense of frustration that not enough has been done to address service access.

- For the majority of respondents (80%), there is a general lack of awareness about what options there are for help with drug problems. This represents a fundamental barrier to service access, as it implies that only one person out of five would know where to seek help and what help was available.
- The most common response as to where people would go for help is their GP.
- There was also a perception that while there may be some services for the drug user, there was nothing for family members or carers.
- Stigma is one of the main reasons cited by respondents as to why they would not access services.
- For some respondents even the process of discussion about drug issues produced strong reactions.
- Suggestions made by respondents about how to increase the likelihood of them seeking help were to employ more Black and minority ethnic staff. Although there is also recognition that with training, all staff can provide an appropriate and accessible service, regardless of ethnicity.
- Amongst service providers one of the key barriers reported is language, including access to translated resources and trained interpreters.
- While service providers recognise that they did not employ many Black and minority ethnic staff, they agree with community respondents that they should do so.
- Ethnic monitoring systems are invariably found to be inadequate in identifying particular ethnic groups, yet commissioners report that they would only be able to increase resources for work with Black and minority communities if they had sufficient evidence of need.
- Some service providers acknowledge that they struggle to meet the needs of Black and minority ethnic clients.

- Workers in community agencies report needing greater knowledge about drugs.

Recommendations: Community groups are keen to be involved in disseminating information about drug services and how to access them. Mainstream services need to take responsibility for service provision to Black and minority ethnic communities. This should not be left to under funded and poorly supported community groups. Groups recommend a more pro-active response involving outreach services and greater advertisement and promotion of services. In addition:

- Increased representation of Black and minority ethnic communities on DATs and related forums.
- Employment of Black and minority ethnic workers.
- Training for drug service staff in diversity and cultural sensitivity.
- Better access to interpreters who are trained in drug misuse.
- Community orientated telephone helplines.
- Ensuring refugee and asylum seekers are aware of services and community groups are able to work in partnership with drug agencies to improve knowledge about drugs and options for help amongst these groups.
- Information and education for Black and minority ethnic drug users on the risks related to blood borne diseases.
- Targeting of services for crack and cocaine use within communities.
- Ensuring services are inclusive, and able to work effectively with diversity.
- Ensuring accurate and robust recording of client demography and ethnic monitoring that is sensitive to the full diversity in local communities.
- Developing services for family members and carers.
- Separate service provision for women that is located sensitively.
- Increased shared care with GPs.

CONCLUSION

Arguably, the process by which the project was undertaken and the model for Community Engagement that was employed are more important than the findings. (For a full description of the project processes and model see 'Report 1: The Process - Community Engagement' which accompanies this report). Nevertheless, the needs assessments provide a substantial contribution to understanding issues related to drug use within Black and minority ethnic communities and demonstrate the viability of the model of Community Engagement and the community led approach to needs assessment.

If drug service commissioners and providers are to achieve the national standards as set out in Models of Care; Dept of Health 2002 ensure greater diversity in those accessing drug treatment; and meet the requirements of the Race Relations (Amendment) Act 2000 they must have more information about the local Black and minority ethnic communities they serve.

Amongst the key recommendations made by the community groups is that the process and model of Community Engagement as it has been used in the production of the needs assessments is utilised to help achieve the national standards.

1. INTRODUCTION

The Department of Health's Black and minority ethnic drug misuse needs assessment project commenced November 2000 with forty-seven community groups following a model of Community Engagement involving local drug needs assessments that resulted in 51 reports. All of the reports were presented and produced in the local Drug Action Team (DAT) area where they were undertaken. This report provides a summary of the key findings from the reports.

In total, forty-seven Black and minority ethnic projects were funded through a grant from the Department of Health (DH), to undertake needs assessments on drugs and related issues within their particular communities. The project was facilitated by the Centre for Ethnicity and Health, which is a department in the Faculty of Health, University of Central Lancashire. The forty-seven projects represented thirty different ethnic and national groups and over 12, 000 respondents within the target communities have been involved in questionnaires, interviews, workshops, community events and focus groups.

Table 1: Breakdown of respondents by research activity (n = 12, 048)

Questionnaire	Focus group+	Interview community	Interview agency	Community event*/Workshops
6,234	1,968	3,158	469	870
51%	16%	26%	4%	7%

+ It is important to note that many projects did not record the number of people attending focus groups so the figure would actually have been much higher. The total number of focus groups conducted was 190.

*Community events included workshops, meetings and in one project health awareness events at the local Mela³.

Within the total sample figure there are 469 interviews with service providers and community or voluntary sector agency workers. The findings from this sample are explored separately (section 3.6.4) as it is the views and experiences of ordinary community members that are the concern of this report.

There are 11, 571 community respondents and the following tables provide a breakdown of these by region and ethnic groups.

Table 2: Community respondents by region (n = 11,579 community respondents)

	East	East Midlands	West Midlands	London	North West	Yorkshire & Humberside	South East	South West
Total	64	929	1,803	3,996	2,764	1,434	450	139
%	.5%	8%	15%	34%	24%	12%	4%	1%
% BME pop ⁴ .	5%	5%	13%	48%	8%	7%	7%	3%

According to the Census 2001, 87% of the population of England describe themselves as White British and since the 1991 census the proportion of Black and minority ethnic populations have increased from 6% to 9%. The largest Black and minority ethnic group is Indian (2% of the population) and London has the highest proportion of people from a Black and minority ethnic background, excluding those who cite their ethnic background as Pakistani who mostly live in

²BME Housing Consortium, Wolverhampton produced 4 main reports and one summary report. The four main reports are: (1) Young people; (2) Refugee and asylum seekers; (3) Dual Diagnosis; (4) Young offenders. The summary report has not been used for citation. ³'Mela' – a community gathering or festival.

Yorkshire and Humber and the West Midlands. (Source: National Statistics website: www.statistics.gov.uk)

Table 3: Community respondents by ethnic group

	Black African/Black Caribbean & Black mixed race	South Asian	Chinese	Greek & Greek Cypriot	Middle Eastern ⁵	Turkish & Turkish Cypriot	Other ⁶	White	Not Known ⁷	Total
No.	3,885	6,745	112	90	392	81	136	28	110	11, 579
% of total	33.5%	58.2%	1%	.7%	3.4%	.7%	1.1%	.1	1%	

There are 2, 743 Black African respondents; 865 Black Caribbean respondents; and 101 Black mixed race respondents. 176 respondents are reported as 'Black African Caribbean.'

There are 2, 301 Indian respondents; 2, 931 Pakistani respondents; 1,020 Bangladeshi respondents; and 11 Sri Lankan respondents. 482 respondents are reported as 'South Asian.'

The number of Iraqi respondents is 203; the number of Yemeni respondents is 177. There are 12 respondents who are classified as 'Middle eastern.'

Arguably, the process by which the project was undertaken and the model for community engagement that was employed are more important than the findings. For a full description of the project processes and model see 'Report 1: The Process - Community Engagement' which accompanies this report.

The needs assessments provide a substantial contribution to understanding issues related to drug use within Black and minority ethnic communities. The key literature relating to drug use in Black and minority ethnic communities is reviewed in Fountain et al, 2003 in which the authors note that:

"... 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." (1. Introduction, page 8)

Fountain et al conclude that:

"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." (6.5. Community Engagement, page 41)

The need for more detailed investigation of drug use within Black and minority ethnic communities is also recognised in 'Models of Care for Substance Misuse Treatment' (Department of Health, 2002). This document provides the National Standard Framework for the commissioning and delivery of drug services including the requirements that:

- the D(A)AT [Drug (Alcohol) Action Team] and each of its constituent agencies have developed strategies to tackle issues of racial/ethnic equality;
- gaps and priorities are identified;

- clear objectives and measurable targets are identified;
- time scales are attached;
- funding or other resources are available to tackle issues of racial/ethnic equality.

(Page 134)

It is clear that if drug service commissioners and providers are to achieve the national standards as set above they must have more information about the local Black and minority ethnic communities they serve. The Department of Health's Black and Minority Ethnic Drug Misuse Needs Assessment Project contributes to the available knowledge; demonstrates the viability of the model of Community Engagement and the community led approach to needs assessment; and identifies a number of key themes and specific issues relevant to a wide range of Black and minority ethnic communities.

In the next section, the methods utilised by the projects are discussed, including a description of the framework for conducting the needs assessments. The main body of the report contains the key findings in the form of a thematic analysis and the final chapter presents the conclusions and recommendations of the community groups who undertook the needs assessments.

2. COMMUNITY ENGAGEMENT – THE FRAMEWORK: CONDUCTING A NEEDS ASSESSMENT

'Report 1: The process - Community Engagement' sets out the process by which the project was developed and undertaken and describes how the model requires a framework within which work is carried out. The framework for this project was a needs assessment. These are traditionally designed by and for professionals working within broad population groups and most contain assumptions of heterogeneity within those population groups. This has invariably resulted in needs assessments and commissioning priorities that have neglected the concerns and issues of particular Black and minority ethnic groups.

There is also a sense within communities that research, under the guise of needs assessment, is often undertaken with little or no resultant change or improvement in local service provision (Fountain et al. 2003). This can lead to resentment and even resistance within communities when there is a subsequent attempt to determine their needs.

It can also be the case that, when attempting to explore a potentially controversial issue such as drug use within certain communities, resistance can arise as a result of a fear of negative stereotyping (Carrington 1993) or that lack of awareness and knowledge about the issue can itself present barriers to identifying needs (Fountain et al. 2003).

At the outset of the Department of Health's Black and Minority Ethnic Drug Misuse Needs Assessment Project, the Centre for Ethnicity and Health's team felt that it was important to address these issues. The model of Community Engagement uses as its framework an approach to needs assessment that is sensitive to particular communities, while

⁴Annual Local Area Labour Force Survey 2001/02. ONS.

⁵'Middle eastern' is comprised of Iraqi and Yemeni respondents

⁶Other is reported as being largely people of eastern European descent, mostly recent arrivals to the UK.

⁷Although classed as unknown this figure actually comprises a mixture of South Asian and Black African/Black Caribbean people who attended mixed ethnicity focus groups or events where ethnicity was not recorded.

at the same time remains flexible enough to incorporate a community awareness and education approach in relation to drugs information.

The framework formed the basis of a training programme for the community groups. It is accessible to non-professionals and seeks to encourage and build on the capacity of each organisation involved in the process, thus empowering community-based organisations. In this way the community projects were able to employ a range of strategies in their needs assessment work, as highlighted by one project, in Leicester:

"The research was successful in using a number of complementary strategies in order to get the best possible outcomes given the constraints of time and resources...For instance, one of the direct results of this research has been the staging of a debate about drugs in the Asian community by a local Asian T.V. station (MATV). Members of the research team participated in this and the programme will be broadcast sometime later in the year. Members of the research team have also taken part in radio chat shows about drugs." (Three Faiths, One Issue, Leicester. Page 22)

The Community Engagement model allows for a wide selection of research methods including the use of community education and awareness raising events as part of the data collection exercise:

"Given that the topic of drugs within the Asian community was a difficult one, the PG [partnership group] was determined to use different means to raise the issue within the community and also get different people to participate in the debates and awareness raising. Although interviews, using semi-structured questionnaires, were the main means of recording the research information, a variety of other methods were also used:

- postal questionnaires (where it was not possible to do face to face interviews with commissioners and service providers);
- health and drugs Melas ;
- carrying out drug awareness activities within local community settings;
- focus groups;
- desk research;
- a publicity flyer;
- press monitoring;
- video and photographic evidence;
- co-interviewing and shadowing;
- outreach and street-work;
- public information through press releases, posters and flyers;
- inter-agency collaboration."

(Three Faiths, One Issue, Leicester. Pages 21- 22)

As the model assumes the centrality of community researchers from the outset questionnaire design can be undertaken in a focused manner, with particular emphasis on the knowledge of the community researchers themselves:

"Questionnaires were created by brain storming and listing key themes branching off drug misuse in the community... A number of workshops, along with various discussions were held in order to formulise the structure of the questionnaire."

In order to aid this process, members of the team shared their past experiences and knowledge of the local community in deciding who to target, how to target them and what opposition if any they would face." (Yemeni Community Association, Sandwell. Page 28)

The distinct advantages of this approach are reported:

"First, although Consultants are academically qualified, many are not involved on a day to day basis with the subject of their studies within their respective communities and are not considered as 'one of us'. The subjects usually know they are dealing with 'strangers' and do not give them the 'real deal'... Second, most studies are not 'user led'. The community does not feel that the findings/recommendations of studies conducted will make a difference to their quality of life. For example the respondents felt that addressing drug misuse, although all well and good was just as important, if not more, to address the underlying causes of drug/alcohol misuse. Some of our respondents felt that external organisations use them more for the benefit of the academics than for their benefit or that of their communities. Third, the respondents felt a sense of 'Questionnaire/Focus Group' fatigue'. We were able to get a high percentage of completed questionnaires returned because our day to day work is client based and we were able to field the questionnaires during 'surgery' with our clients." (African Health for Empowerment and Development, Greenwich, London. Page 44)

Recruitment of community researchers was undertaken using local community networks, as it was more important to recruit people with knowledge and access to the community than people with prior research or drugs experience:

"The recruitment process for workers was a combination of targeting workers currently working with hard to reach groups and an open invitation for workers and volunteers advertised through local Bangladeshi networks. One of our key criteria for recruitment was to ensure that the workers recruited reflected, as accurately as possible, the differing target groups of the project i.e. Age, gender, ethnicity..." (Smethwick Bangladeshi Youth Forum, Sandwell. Page 12)

Access is a key issue for the work and ensuring that the target community is being contacted. Careful consideration of locations in which to seek interviews and hold focus groups are reported:

"Access to the community was mainly through the venue's identified where target respondents gathered including local mosque's, youth clubs, community centres and informal meeting places. In addition to this some questionnaires were facilitated within people's homes in order to ensure access to older Bangladeshi women...The majority of data was collected through facilitated questionnaire interviews, although this was not the original intention, it quickly became apparent that it was necessary due to language and comprehension barriers being experienced by researchers." (Smethwick Bangladeshi Youth Forum, Sandwell. Page 13)

"...An important factor in securing the co-operation of respondents was the appropriateness of the venue chosen to conduct the focus group discussions. Venues were carefully selected which were in a familiar environment for the group members. All the venues were accessible, and appropriate

⁸'Melas' – South Asian community festivals

facilities were provided such as crèche facilities for the women's group." (Ethnic Minorities Health and Social Care Forum, Blackburn. Page 19)

Building up local networks of contacts was also viewed as an integral part of the process:

"Following training, the volunteers, made contact with influential community groups, e.g. (advice centres, mosques, women's project, health centre, community centre, youth centre) to discuss the aims of the project. All these groups and resources were predominantly used by people from the South Asian communities in Blackburn...After making these contacts the group abandoned the idea of promoting wider publicity (i.e. posters/leaflets/translated materials) because it was felt that this may discourage key groups from coming forward as participants in the project. The method therefore adopted for encouraging the local community to participate was through personal contacts..." (Ethnic Minorities Health and Social Care Forum, Blackburn. Page 19)

Each group was encouraged to establish a steering group to help guide and support the work and ensure engagement of local stakeholders, particularly local commissioners and providers:

"A steering group was formed to help support and guide the project and ensure that the project was firmly rooted within the Borough strategy. Membership of the steering committee included representation of Sandwell DAT (co-ordinator), Sandwell Health Authority, Youth Offending Team, Drug Service, 2 community representatives and the UCL [sic] project support worker. The central role of the steering group was to agree the nature and structure of the questionnaire and, where possible, help facilitate access to the target respondent group. The intention was to ensure that the questions asked and subsequent results would have meaning for all concerned." (Smethwick Bangladeshi Youth Forum, Sandwell. Page 13)

A wide range of methods were utilised by the projects including semi and unstructured interviews, survey questionnaires, focus groups, workshops and telephone interviews. Many projects used several methods together, often tailoring the approach and methods to the particular target group of respondents, for example:

"As the research progressed, it was necessary to remain flexible in the approach and adapt to the particularities of the research subjects. For instance, it was inappropriate to carry out interviews in the nightclub, as planned. It was also difficult to access parents. To overcome this problem, a parent was recruited as a researcher. The data showed that, although the topics of discussion were the same, interviews and focus groups produced quite different information. Young people were less forthcoming about their opinions in focus groups, but spoke quite frankly during individual interviews. Conversely, parents expressed a preference for focus groups because they felt more comfortable in a free-flowing discussion rather than an interview where they were unsure of the next question. Older people seemed to respond equally well to focus groups and interviews. In response to this, a mix of methodologies was used." (Chinese National Healthy Living Centre, London. Page 29)

As part of the Community Engagement model all the groups received training to enable them to do the work. This included

basic drug awareness and research skills. The fact that all of the groups completed their projects and 51 needs assessment reports have all been produced is testament to the success of the model and the training and additional support that was provided. However, it should be borne in mind that the aim was to undertake a community led approach to needs assessment. It was never intended that the community groups should all dogmatically follow a single format. Nor that the final reports should provide common datasets to facilitate this to secondary analysis.

Nevertheless, the overall quality of the needs assessment reports is high and the number of respondents is substantial. Given the large number of reports, differing research methods employed, and the number of respondents, it is only possible to provide a thematic synthesis of the data contained in the reports. The identified themes are presented as the findings in the next chapter.

3. THE FINDINGS – DRUGS AND BLACK AND MINORITY ETHNIC COMMUNITIES

A total of 51 needs assessment reports have been produced with a collective sample in excess of 12,000 people. While the reports were produced for local dissemination and use, the scale and uniqueness of this sample of respondents is of much wider interest. It is worth considering in this context that the Black and minority ethnic booster sample for the British Crime Survey 2000 consisted of 3,874 people.

In interpreting the findings it is important to bear in mind:

- The reports are based on local community led needs assessments. All of the groups received basic training in research techniques and the framework for the needs assessment. Each group identified which methods they would use and the subject areas of their investigations.
- There is immense diversity within the communities reported on, for instance, 30 different ethnic and national groups are represented in the total sample in 47 localities across eight of the nine English regions⁹.
- All of the reports focus on issues with respect to drug education, prevention and treatment. Some reports are concerned with a particular issue or community for instance, one report addresses this in the context of the Black lesbian, gay and bisexual community (Black Health Agency, Manchester); one report is focused on the Black and minority ethnic Deaf community (LEMDA, London); One report solely addresses the needs of young Black and minority ethnic offenders (BME Housing Consortium, Wolverhampton (4) Young offenders).
- Some reports make use of quantitative data from large-scale surveys while others rely on qualitative data from a smaller sample of in-depth interviews. It is also important to recognise that the groups had an absolute maximum of six months in total to recruit workers, do preparatory work, create links with partners, undergo training, undertake the fieldwork, analyse the data and write them up. While it is an achievement that all of the groups completed their work on time and a total of 51 reports have been written and disseminated locally, some reports lack more in-depth analysis as a result of these very tight timescales.

⁹A project was selected in the north eastern region but they were unable to complete the work due to unforeseen circumstances.

The findings are best understood and presented as a series of themes. The themes have been identified if they are common to most or all of the reports, or if a theme is particular to just one or a small number of communities in a significant way.

The themes are identified as follows:

Diversity (3.1) - language; gender; sexuality; Deaf people; new communities and refugee and asylum seekers.

Levels of awareness and knowledge about drugs (3.2) in particular, differences across generations; why people use drugs; the provision of drug education; drug related health risks; and the impact of drug use on families.

Religious perspectives (3.3) on drug use and whether religion acts as a protective factor.

The links between drugs, deprivation, disadvantage and discrimination (3.4) drug use and declining neighbourhoods; racism and discrimination.

Crime and drug dealing (3.5) Access to drugs and drug dealing; gangs, violence and guns.

Help seeking & awareness of services (3.6) stigma and shame; the employment of Black and minority ethnic staff within services; the role of community organisations; the perspectives of service providers and community workers.

Drug users and the experiences of services (3.7) drug users within ethnic groups and across regions; substances used by ethnic groups; the use of traditional substances; gender; age; why people say they use drugs; and access to and use of drug treatment services.

The final chapter presents the conclusions and recommendations from the reports as four linking themes: drug education and awareness; increasing access to drug treatment services; community safety; diversity, communities and neighbourhood renewal.

3.1 Diversity

It is important to acknowledge the wide levels of diversity amongst the respondents. For instance, there are 30 ethnic and national groups represented, as well as diversity in age, gender, sexuality, physical ability, refugee and asylum seeker status and religion.

The Black African group alone consists of people from 15 countries:

Uganda	Somalia
Kenya	Sudan
Zimbabwe	Egypt
Zambia	Democratic Republic
Sierra Leon	of Congo
Angola	Rwanda
Eritrea	Burundi
Ethiopia	Kenya

There are also distinct Black African ethnic groups such as the Cabinda, the Igbo and the Simba communities. Many of these groups do not show up in national or local statistics as their numbers are small compared to the general population

and ethnic monitoring systems are rarely sophisticated enough to record particular ethnic groups within wider categories such as Black African.

Similarly, amongst the South Asian respondents, there are wide differences in culture, ethnicity, religion and language.

There is diversity in migration and settlement patterns with some communities crossing four generations living within the UK:

"Second and third generation young Asian Muslims, for instance, have particular problems as they grow up, one of the most important being the disenfranchisement from their cultural identity, where the Asian self is often subordinate to their Britishness. Thus they regard themselves as British Muslims rather than as Asian Muslims." (Mushkil Aasaan, London. Page 8)

3.1.1 Language

Language is a good example of how many different aspects of diversity interact and why any consideration about how to improve services and raise awareness about drugs within Black and minority ethnic communities must take account of diversity.

The languages spoken amongst the respondents, included:

- Albanian
- Amharic
- Arabic
- Bengali - including Sylheti dialect
- British Sign Language
- Cantonese
- Dari
- English
- Farsi
- French
- Greek
- Gujerati
- Hindi
- Igbo
- Kalanga
- Koke
- Kurmanji
- Kurdish
- Kutchi
- Lingala
- Luganda
- Mandarin
- Ndbeli
- Nyanja
- Pashto
- Portuguese
- Punjabi - including Mirpuri dialect
- Punjabi (Gurmukhi)
- Serbo-Croatian
- Shona
- Swahili
- Tamil
- Tonga
- Turkish
- Urdu
- Venda

Issues surrounding language complicated by factors such as age and generation:

"There is a marked difference between the younger and the elderly generation, with much of the latter, in spite of having been in the country for a while, having generally failed to take in language skills. Amongst the younger age groups it is common for them to be able to speak English and majority of them are comfortably fluent." (Yemeni Community Association, Sandwell. Page 20)

"For some older residents who only speak Turkish there is the problem of their language becoming dated against modern Turkish as spoken in Turkey." (Day Mer Turkish and Kurdish Community Centre, London. Page 4)

"The elder Asian group that we spoke to told how frustrating it was for some of them for not being able to communicate with their grandchildren because of language barriers, understanding and cultural indifferences." (Southall Community Drugs Education Project, London. Page 31)

"The problem which arises here is that a majority of children who have been born and brought up in England class their first language as English and therefore a language barrier develops between the parents and the child, as the majority of the parents in Halifax see their first language as Punjabi." (Asian Anti-Drugs Initiative, Halifax. Page 30)

"Some Black and Ethnic Minority Deaf people may have acquired their own native Sign Language, which may not be British Sign Language (BSL). In the UK, it may be harder for them to express themselves, until they learn BSL and some English. For some Deaf Ethnic Minority people born in Britain, there may be other issues. The home language of their families may not be English." (LEMDA, London. Page 6)

High levels of illiteracy within some communities are reported, even in first languages:

"...most people can't read and write Bengali. Parents will not read information as they'll believe it doesn't affect them. Male, 18." (Marylebone Bangladesh Society, London. Page 30)

"Even though some of the Asian community is illiterate, respondents felt they would recognise the Urdu writing and see pictures, which would at least show something is being done locally." (Holy Trinity Community Network Forum, Tameside. Pages 29 - 30)

African culture is described as being mainly 'oral' which has implications for communicating drug information in these communities:

"The fact that African culture was described as mainly an 'oral society' means that information which was provided verbally at social gatherings and in focus group settings was a better way of communicating the 'drug' message rather than through leaflets and literature. However, it was felt that literature should also be available." (The African Community Involvement Association Croydon, London. Page 4)

Language is an integral component of ethnicity but it is far from being a straightforward one:

"Not all Chinese speaking people refer to themselves as ethnic Chinese. For example, many Vietnamese are fluent in spoken Chinese, and take part in Chinese culture habits and festivals, but they refer to themselves as Vietnamese." (Chinese National Healthy Living Centre, London. Page 10)

"The Igbo language is not identified as one of the languages for official translation and use in these Boroughs although the need was demonstrated by the Department of Health in 1996 when one of our Field Workers... was given a contract to help in translating the Patients Charter into Igbo Language." (The Igbo and Tutorial School, London. Page 12)

"A large proportion of the Indian population are Muslims living in south-east of the area. Most of these people arrived from the Gujerat state of India during 1960's – mainly from Surat and Bharuch districts. The home language of this community is often Gujerati. They speak and write in Gujerati in their everyday activities but the language of the mosques is often Urdu and Arabic." (Ethnic Minorities Health and Social Care Forum, Blackburn. Page 15)

Communication is further complicated by the number of different languages within single ethnic groups and different dialects:

"The... Chinese worker also talked about the difficulties

clients face with regard to language. She is able to speak fluent Cantonese, but there are more and more users coming forward who speak other dialects, for whom an interpreter is required." (National Chinese Healthy Living Centre, London. Page 85)

"Furthermore, the Zimbabwean population shows linguistic differences (Shona, Ndebele, Tonga, Kalanga, Venda and Nyanja). The population also displays tribal / ethnic diversities that largely reflect the population in Zimbabwe itself. In Zimbabwe the tribal / ethnic diversity largely shows that the Ndebele speaking population consists of 19% while the Shona speaking forms 79% with the others consisting of Zimbabweans of European descent, Kalangas, Vendas, Tongas and immigrant workers from Malawi and Mozambique. Similar distributions are broadly expected to reflect these population structures of Zimbabweans in London and Luton. Latest estimates of Zimbabweans gleaned from several data sources and based on the 1991 census would suggest that there are well over 100, 000 resident in London and Luton." (Simba Community Alliance, London, Page 15)

"The main language spoken by this community is a Mirpuri dialect of Punjabi. This is an unwritten language. The main written language used, other than English, is Urdu." (Saaf Dil, Rotherham. Page 12)

The single issue of language has highlighted issues related to identity, religion, age, generation, legal status and recognition. Such diversity is a complex issue, but it goes to the heart of understanding many of the key messages within this report.

3.1.2 Gender

Gender recorded for 80% of the community respondents:

Table 4: Gender – Community respondents (n = 11,579)

Gender	Numbers	% of recorded respondents	% of all respondents
Male	5025	55%	43%
Female	4185	45%	36%
Total	9,210	-	-
Not recorded	2, 369	-	20%

The reason why gender has not been recorded for all respondents is largely due to mixed gender focus groups and community events where a precise breakdown of gender was not provided. The gender breakdown is fairly even with 45% of those recorded being women. Even if all of the remaining respondents were men this would still mean that women accounted for 36% of respondents.

Gender is frequently discussed in the reports. For instance, many explore whether drugs is perceived to be more or less of an issue for men than women:

"Some respondents felt that in the main, drugs were used by males and not females. Others had only heard of males taking drugs and not females... However this was disputed by respondents who attended the local college who felt both Asian males and females smoked cannabis openly." (Holy Trinity Community Network Forum Tameside. Page 31)

"I've even heard, that now girls are taking it (drugs) –Bengali girls." (Marylebone Bangladeshi Society, London. Page 36)

As will be seen in the chapter on Black and minority ethnic

drug users (section 3.7) the community groups did find evidence of drug use amongst Black and minority ethnic women. In fact at least 17% of the respondents reporting drug use are female. Khat use is also discussed from a gender perspective with the suggestion that there may in fact be more problematic use of khat amongst women. (See section 3.7.5)

Even talking about drug use is reported as being problematic amongst women:

“Older women were not prepared to give names and details they are afraid of problems that may be caused in the homes as a result of sharing information.” (EMDA, Blackburn. Page 50)

There is also a suggestion that South Asian boys may have greater access to drug education than girls:

“72% of Bangladeshi females and 50% of Pakistani females had not attended a drugs education session. 75% of males had.” (Youth Development Partnership, Bradford. Page 11)

3.1.3 Sexuality

One project focused on the Black and minority ethnic lesbian, gay and bisexual community, (Black Health Agency, formerly Black HIV and AIDS Forum, Manchester). Thirty-seven people were interviewed and one of the issues discussed in the report is whether respondents thought there were differences in drug use between the heterosexual and the lesbian, gay and bisexual Black and minority ethnic communities:

“Even though we cannot generalise whether the BLGB¹⁰ community, as a whole, identifies differences between the BLGB and the heterosexual black community drug usage. Nor can we say whether they think differences between the WLGB¹¹ and the BLGB drug use exist. We can certainly state that that some “individuals” put forward that there are differences between those groups. They regard sexuality and race as an issue identified in drug use. At this point, however, it is clearly identified that the definition of “black” and gay was not fixed. In other words certain interviewees identified themselves as black and gay but others did not wish to identify themselves in terms of race/colour or sexuality.” (Black Health Agency, Manchester. Page 22)

In particular the report finds:

“That there is both recreational and problematic drug use amongst the BLGB community; Drugs were being used to have sex; More than one drug was taken at a time usually in combination with alcohol; Nearly all those interviewed felt that drugs and alcohol had affected their work; There was little awareness of the affects of drugs; There was little awareness of drug services and agencies.” (Black Health Agency, Manchester. Page 23)

While many of the findings from the Black Health Agency are broadly similar to other reports, there was a perception amongst some respondents that services would be ‘homophobic’ and that the discrimination faced by lesbian, gay and bisexual people was an additional factor to discrimination on the basis of race. The respondents

recommend that there should be more Black and minority ethnic lesbian, gay and bisexual workers and the Black and minority ethnic communities themselves needed to address discrimination on the basis of sexuality.

3.1.4 The Black and minority ethnic Deaf community

One project, (London Ethnic Minority Deaf Association, LEMDA) focused on the needs of the Black and minority ethnic Deaf community. This was the only project to specifically address issues regarding people who are Deaf. One of the key features raised by the report is in relation to language:

“It is also very important that we acknowledge that for many Ethnic Minority Deaf people the language issue is intensified. Firstly, they may not have been exposed to English until arriving in the United Kingdom. They may not have had any Sign Language exposure at all therefore some may have limited language acquisition.” (LEMDA, London. Page 6)

It is the case that many Black and minority ethnic Deaf people face additional problems:

“There are Ethnic Minority Deaf people who also have other disabilities, such as visual, learning and physical disabilities, or Mental Health problems. Some have combinations of Deafness, Disability and Mental illness. The needs of these people are also often overlooked. They may be on various drug treatment programmes, but may not necessarily have information about their treatment. Deaf people are generally potentially very isolated and often vulnerable. For Black and Ethnic Minority Deaf people this is even more likely to be the case.” (LEMDA, London. Page 7)

A total of 53 people were interviewed, 41 Deaf adults, 11 Deaf children and one service provider. All lived within the Greater London area, 27 were female, 26 male and the sample was of mixed ethnicity including Black African, Black Caribbean, South Asian and Mixed Race.

While many of the findings are similar to those of other groups, there are distinct issues identified in relation to drug use and the Black and minority Deaf community:

“Deaf people involved in drug misuse are thought to be more isolated than hearing people who drug misuse. This is because they are more cut off from their environment or support services because of their Deafness and the fact that few people can communicate with them. For Deaf Black and Ethnic Minority Deaf people this is thought to be even worse because they are highly likely to experience a ‘double oppression.’ ” (LEMDA, London. Page 58)

In particular the report recommends that:

“...the main issue about mainstream provision is that it needs to be inclusive of Deaf people. It is vital that such support and information services are accessible to Deaf people in terms of: staff having had Deaf Awareness Training; on every shift a member of frontline staff who has Sign Language skills; a policy that interpreters will be provided for counselling or meetings; that the service is accessible by text phone, fax, possibly e-mail and or videophone; the installation of induction loops in public areas and in any counselling rooms;

¹⁰BLGB = Black Lesbian, Gay and Bisexual

¹¹WLGB = White Lesbian, Gay and Bisexual

¹²“The convention of using a capital “D” when describing Deaf people is also followed to pay respect to the identity of being Deaf”. (LEMDA, London. Page 9)

the 'signing up' to the 'sympathetic Hearing Scheme'¹³ for Hard of Hearing people by organisations. Information essentially must be presented in British Sign language." (LEMDA, London. Page 58)

While the LEMDA report is unable to draw any conclusions about the extent of drug use within the Black and minority ethnic Deaf community, it stresses the importance that Deaf people are not excluded from drug education:

"More needs to be done to promote equality for Black and Ethnic Minority Deaf people and Deaf people generally in terms of provision from existing services and in accordance with the DDA. (Disability Discrimination Act)." (LEMDA, London. Page 59)

3.1.5 'New communities' - refugee and asylum seekers

Within the wide range of ethnic and national groups involved in the project there are a number of communities that have more recently arrived in the UK and many are refugee and asylum seekers. Some of the community groups, such as the Day-Mer Turkish and Kurdish Community Centre, London and Cabinda Community Association, London were specifically set up to work with refugees:

"Day-Mer was established in 1989. It is a registered charity and limited company that works as a refugee community organisation with a specific concern for Turkish and Kurdish refugees. Day-Mer offers a range of services covering a daily drop-in for refugees; social and cultural activities and outreach work in schools." (Day Mer Turkish and Kurdish Community Centre, London. Page 2)

"Cabinda Community Association is a registered charitable organisation that was established in September 1994 to deal with a growing number of Cabindan Refugees/Asylum seekers in the UK." (Cabinda Community Association, London. Page 5)

There is recognition of the numbers of refugee and asylum seekers within local areas across the reports:

"Southall has a high number of refugees and asylum seekers. This was estimated in 1996 at 5000 out of an Ealing borough total of 8000. Current estimates of refugees in Ealing borough are between 15,000-20, 000." (Southall Community Drugs Education Project, London. Page 12)

"The borough (Greenwich) has a refugee population of 8,000 to 10,000 and rising. The vast majority are women and children. Unemployment for Refugees is 60% with 5% in long term work." (African Health for Empowerment and Development, London. Page 8)

"Brent is one of the most deprived areas in London...it's the most popular borough for refugee communities from all different backgrounds and cultures, it has 137 different Languages, and many voluntary and refugee organisations have been established to assist in capacity building and community development." (Iraqi Welfare Association, London. Page 6)

"There is also an increasing number of asylum seekers particularly Africans, being integrated into the community."

(African Caribbean Community Action Network, Oxford. Page 17)

Between them, the reports mention asylum seekers and refugees from 21 different parts of the world:

- Sierra Leone
- Somalia
- Eritrea
- Middle East
- Kenya
- Uganda
- Zambia
- Zimbabwe
- Democratic Republic of Congo (formerly Zaire)
- Rwanda
- Angola
- Algeria
- Burundi
- Iraq
- Afghanistan
- Turkey
- Kurdistan
- Cabinda
- Baltic States
- Eastern Europe
- Ethiopia

While the issue of drugs and Black and minority ethnic communities remains largely under researched and has lacked prominence within local and national debates about drug use, it is even less well recognised for refugee and asylum seeker communities:

"The population projection data does not take into consideration any major changes that may occur in any one year such as an influx of refugees from one particular African community. It is therefore important for policy makers to keep a watchful eye on the influx of refugees and asylum seekers to ensure appropriate representation in terms of services." (African Community Involvement Association, London. Page 26)

It is important that service planners and providers understand the histories of the different refugee communities who live within their area. These histories are diverse. Some people arrive in this country having already been exposed to drugs use, sometimes as a direct result of their experiences of war. Some will have been tortured, or will have seen members of their family killed.

Many refugees and asylum seekers have feelings of hopelessness and despair, which may place them at increased risk of substance misuse:

"Many newly arrived Refugees and Asylum seekers are desperate, vulnerable and disorientated with some having been tortured. Their relatives and friends may have been killed or disappeared. Many arrive with nothing except what they have been able to carry. Furthermore, there are practical and emotional difficulties as they try to come to terms with a complex and in many ways an inhospitable society. Racial intolerance and institutional racism are often encountered. Housing is difficult to obtain and tends to be of poor standard and often temporary..."

...This coupled with language difficulties and poor employment opportunities makes arrival in the U.K. particularly difficult and traumatic, given their experiences prior to arrival. Many seek asylum to build a new life with the aim of returning home one-day, if at all possible. Refugees and Asylum Seekers are not a homogeneous group. They will have been exposed to widely differing experiences in their countries of origin prior to the situation that drove them into temporary or permanent exile. These experiences will depend upon their ethnicity, political and religious beliefs." (Black and Minority Ethnic Housing Consortium, Wolverhampton. Pages 13 - 14)

¹³The 'Sympathetic Hearing Scheme' is a set of guidelines for good practice in service provision for Hard of Hearing People.

"When the rebels captured me in Sierra Leone, they cut a wound on the back of my hand and pushed cocaine into the wound. Every morning, from there on, they deliberately open the wound everyday and put cocaine into it. I became an addict in next to no time." (African Health for Empowerment and Development, London. Page 42)

There is some evidence of service development for more established Black and minority ethnic communities such as the South Asian communities (Sangster et al. 2002), but there is even less capacity within both generic and drug specialist services to meet the needs of refugee and asylum seekers:

"6.4 % of the respondents identified themselves as asylum seekers and stated that they would not be entitled to any provision and/or would not want to present themselves to drug agencies for fear of being reported." (Three Faiths, One Issue, Leicester. Page 45)

"The second treatment centre revealed they are currently dealing with crack, cocaine and heroin cases of two males and two females... However this problem is related to the painful memories, cultural adjustment difficulties, being forced to leave Iraq, family left behind and ending up living in a foreign country like the United Kingdom." (Iraqi Welfare Association, London. Page 29)

"Ethiopian Refugees and Asylum seekers come to the centre with a variety of stresses, depression, frustration and confusion due to the challenging new life style, language, culture, education, employment, and housing and immigration matters. The uncertainty of the future, compounded by such stress and confusion could lead a person to a variety of outlets including misusing drugs." (Ethiopian Community in Lambeth, London. Page 6)

As the above quotes illustrate, respondents report that there is drug use amongst refugee and asylum seekers. Respondents also report that refugee and asylum seekers face a number of additional problems:

"...just to get registered to a Doctor was a battle in itself. Remember when you try to get me registered; they would not register me because I did not have Home Office Documents. I was an addict and suffering withdrawal symptoms. I had to wait for a week until we could lodge an application to the Home Office." (African Health for Empowerment and Development, London. Page 42)

"lot of people were well off before coming in this country, some of them lost their loved ones, some of them killed in the war, other had to sell their properties to escape persecution. Lack of integration and despair in the future has put another weight on the misuse of the drugs, we did not have Immigration and housing problem back home." (Cabinda, London. Page 11)

The long history of denial and lack of recognition of drug problems emerging within the more established Black and minority ethnic communities has inhibited drug education work and service development (Fountain et al. 2003;). It is important that a similar pattern of neglect is not repeated with those communities that have more recently arrived in the UK.

3.1.6 Summary

Some academic researchers will question the methods and the validity of the findings presented in the community

groups' reports. To dwell on these issues would, however, ignore that it is the diversity and size of the sample that make the project and its results so significant.

The tendency amongst drug service providers and planners has been to approach populations as homogenous, with the result that most services have been designed largely for white, male heroin users. This has been further reinforced by an approach to needs assessments that has often neglected the diversity within larger population samples. As a consequence of this Black and minority ethnic communities have not received adequate drugs education and awareness; drug users, their families and carers have not accessed services; and those that have report that they experienced poor and often inappropriate responses to their problems.

The needs assessments are most relevant at local levels in terms of ensuring the voices of Black and minority ethnic communities are included and heard within drug service planning and providing structures. However, at a national level, it is even more important that the voices of these diverse communities are heard and listened to and that the fundamental need for greater diversity in drug service provision is recognised and given prominence within the national drug strategy.

3.2 Levels of awareness and knowledge about drugs

3.2.1 Knowledge and awareness between generations

The overwhelming impression from the needs assessments is that there are very low levels of awareness and knowledge about drugs across all of the communities, particularly across generations:

"There was a general consensus that Greek and Greek Cypriot parents are not well informed about drugs. Some young people reported that Greek parents do not want to acknowledge that their child may be taking drugs." (Greek and Greek Cypriot Community of Enfield, London. Page 15)

"We have no idea about drugs, they are totally new to us." (Asian Community Forum, Lancashire. Page 32)

"Voluntary community organisations have voiced concern over the lack of drug awareness in their communities. This concern has also been voiced by the DATs. This suggests that there is a need for some primary awareness initiative targeted at the African community. Parents need to be educated so that they can be more aware of the drug issues that may affect their children, or even themselves. By making the community aware of drugs and the associated problems then people will make more informed decisions as they will be more aware of the possible implications." (ACIA, London. Page 33)

"Throughout this research what has been apparent is the different levels of knowledge possessed by children and the elders of their respective communities in regards to substance misuse and it's effects." (Project 8, Liverpool. Page 19)

The Asian Anti-Drugs Initiative (AADI), Halifax found that 72% of the under 25 year olds they interviewed had not received any formal information on drugs and that this was even higher amongst those over 25 years old (83%). (AADI, Halifax. Page 42)

The Black Drugs Project, Sheffield make the point that despite being able to name many different drugs, the young people who they interviewed were unable to describe any of their effects:

"A key learning point from this data is the danger in assuming that young people have detailed knowledge of a drug's effects, simply because they are able to state the name of a particular drug." (Sheffield Black Drugs Service. Page 36)

3.2.2. Lack of service response and community denial

Lack of awareness is reported as resulting from denial within communities and lack of appropriate service responses:

"...there is an obvious lack of awareness either through the type of client group agencies focus their work on, or their publicity, or in deed language and denial of problems existing." (Saville Town Community Association, Dewsbury. Page 32)

"we could clearly see there is recognition in the community of their lack of understanding, knowledge and awareness of the extent of class A drug taking particularly and how old people are when they start using." (Congolesse Refugee Women's Association, London. Page 19)

"...The lack of Chinese speaking services can be seen to be a major gap in current drug service provision. It would appear that apart from the mainstream schools, there is very little drug education available for the Chinese young people and their families." (Wai Yin Chinese Women Society, Manchester. Page 26)

3.2.3 Formal education programmes and the role of parents

The majority of respondents highlight that drug education and prevention programmes for the young need to include parents and families:

"...Young people tended to already have more knowledge, we need to get the parents thinking about this issue so they can instill it into their children." (Project 8, Liverpool. Page 21)

"Four of the respondents felt that the parents and family had a responsibility to educate and support their children so that they were fully aware of the dangers of drug use. This they hoped would prevent their children from using drugs." (Bangladeshi Youth League, Luton. Page 25)

"To educate both parents and young people in the dangers of long-term drug misuse. There is a need to develop further strategies to actively engage and encourage both parents and their children along with service-providers to jointly discuss and evaluate the extent of drug misuse within their communities, thus enabling them to identify areas of improvement." (BME Housing Consortium (4) Young Offenders. Page 36)

While there are reportedly generational differences, with more young people saying that they had knowledge of drugs than older people in the community, there still appear to be concerns regarding young people's access to drug education in schools. For instance, amongst 329 respondents, who were asked whether they have received any drug education: over half stated that they had not; and more than 70% said they

did not get enough. (Smethwick Bangladeshi Youth Forum, Sandwell. Page 25)

Similar findings are reported elsewhere:

"A small percentage of the total surveyed [85 young South Asian people] said that they had received advice or education on drugs, but the majority said they had not." (Navjyot, London. Page 20)

3.2.4 Sources of information about drugs

Many of the reports explore the sources where people get their information about drugs. This is reported to be predominantly from the media and amongst friends rather than drug services or schools:

"Members of focus group 1, however, claim they have never received any drug education at school and obtain most of their information from the television." (The Chinese National Healthy Living Centre, London. Page 58)

"The young people interviewed are gaining information about the effects of drugs from the media (rather) than from actual drug awareness campaigns or leaflets produced specifically about drugs. It is also interesting that 13 of the 122 responses (10.6 %) stated they had "seen people on the streets on drugs and that's how they were aware of the effects of drug use." (BME Housing Consortium, Wolverhampton. (1) Young People. Page 38)

BME Housing Consortium, Wolverhampton (2) Refugee and Asylum Seekers (page 31) states that refugee and asylum seekers rely on TV, newspapers and friends for drugs information.

Mushkil Aasaan, London (page 36) report on a sample of 330 respondents, half of whom stated in questionnaires that they received information about drug use from friends and nearly one fifth from the media such as television.

Summary

There are very low levels of awareness and knowledge about drugs across all of the communities, particularly across generations. Lack of awareness is perceived to be a problem both within communities through denial and resulting from lack of service responses. Drug education and prevention programmes for the young need to include parents and families. Specific education programmes for older generations should also be provided. People reportedly get their information about drugs predominantly from the media and amongst friends rather than from drug services or schools.

3.2.5 Community perceptions about why people use drugs

Access to and increased availability of drugs are perceived as a factor in why people start to use them. Data from eleven reports contains the responses from 1,465 respondents who were asked specifically why they thought people used drugs.

Amongst these respondents 36% say that it is a result of peer influence:

"All four groups could suggest motives for drug taking within the Chinese community. Peer influence was the most

common reason for the two Chinese young people groups. This was out of choice and curiosity rather than coercion." (Wai Yin Chinese Women Society, Manchester. Page 22)

"All groups saw increased peer pressure as a main factor in increased drug use, as members of the peer group were both users and suppliers." (Youth Awareness Programme, Leeds. Page 32)

"To the question "If you know someone who is taking drugs, why do you think they are taking drugs?" - a wide variety of reasons were given the most common was peer pressure, this was particularly noted in the case of young people." (Ethnic Minority Health and Social Care Forum, Blackburn. Page 41)

5% of respondents said that it was to escape pressure within the family:

"Most participants identified family conflicts as one of the main reasons for drug misuse. They sighted [SIC] arguments between young people and their parents, family breakdowns, loss of family member or a friend." (Greek and Greek Cypriot Community of Enfield, London. Page 12)

"Parents were also prone to taking drugs to help them cope. The group discussed the fact that parents were often working so hard that drugs were used to physically cope i.e. to keep awake or to sleep less and work more. Stimulants were being used as a means to keeping alert for as long as possible." (ACIA, London. Page 29)

2% said that drug use was related to experimentation:

"...will experiment with drugs and alcohol. It is not seen as a taboo subject by these young people as it is seen by the first generation of South Asian people in this country...There is a stereotype that an Asian drug user would not take speed, ecstasy, heroin and cocaine as they are classed as a 'white man's' drugs. The Asians prefer to use cannabis. But this image is fast disappearing as Asians experiment with the so-called 'white man's' drugs." (Asian Anti-Drug Initiative, Halifax. Page 21)

14% of respondents said it was to avoid or help deal with problems such as depression, stress and anxiety:

"You take drugs to ease the pressure man..." (Holy Trinity Community Network Forum, Tameside. Page 27)

14% say it the result of unemployment and other factors related to deprivation:

"Unemployed and frustrated, some people think they can escape this misery by using drugs...When you can't get a job, you become demoralised then easily you could get involved in drugs." (Nilaari Agency and Black Orchid, Bristol. Page 46)

22% say people use drugs for pleasure a further 10% cite boredom, and 1% state that it is due to the influence of films and TV.

Some respondents discuss cultural influences on young people:

"...an interesting theory seemed to emerge: that Greek/Greek Cypriot youth take drugs in order to 'look hard'. Many of the participants in the boys focus group (..... School) described this phenomenon thus; 'A lot of them [Greek youths who take drugs] think they are black. They try to act black; they try to portray the image of the black man in an American

ghetto...The girls focus group (..... School) explained this in terms of pride. They reported that Greek people have a lot of pride and appear to be hard so that other people will not 'mess about with them.'" (Greek and Greek Cypriot Community of Enfield, London. Page 12)

"Interestingly, Pakistani and Bangladeshi adults felt in particular that young people of today had given way to the Western influence and had lost sight of what their Islamic values are." (Holy Trinity Community Network Forum, Tameside. Page 27)

"We discussed the factors for that motivate the Iraqi's to become a drug misusers...On one hand the significant differences between the British culture and the Iraqi culture increase family pressure upon the children by imposing background values, faith and beliefs strongly, can strengthen the effect of peer pressure. This can cause a lot of misunderstanding, increase the gap between generations, withdraw of the children, and increase the effects of peer pressure..." (Iraqi Welfare Association, London. Page 17)

Summary

A third of respondents who were asked for reasons for drug use report that it is due to peer influence and 22% say it is for pleasure. Other reasons include unemployment, experimentation, to cope with problems and to escape family and other pressures. Some respondents describe cultural reasons such as mixing with white peers and wanting to be part of the wider cultural scene.

3.2.6 Health risks and blood borne diseases

It is not solely in relation to knowledge about drugs that communities lack information. There also appears to be a generally poor level of knowledge about related health risks, particularly with regard to blood borne diseases such as HIV/AIDS and hepatitis B and C.

When asked about the health risks associated with drugs respondents identified a wide range including: headaches, mood swings, hallucinations, dizziness, pain, loss of appetite and death. Generally though, respondents lacked detailed knowledge about specific health risks and there were also misconceptions.

For instance, when asked about health risks associated with drug use only 3 out of 25 non drug using Bangladeshi respondents in Luton mentioned the risk of HIV/AIDS from sharing needles compared to a quarter who mentioned brain damage. (Bangladeshi Youth League, Luton. Page 23).

Others confirm the general lack of knowledge about communicable diseases:

"All sections of the community have very little knowledge, if any, about health risks associated with drug misuse. It was noted that especially amongst the youth a lot of the information they had was inaccurate or mis-information. For instance, they knew nothing of the rise in airborne diseases such as TB [Tuberculosis] and they were very ill-informed regarding diseases such as HIV, AIDS and hepatitis." (Project 8, Liverpool. Page 22)

Tuberculosis (TB) is also raised in relation to khat use and the particular environments in which is khat is used:

"The Somali community, are being particularly affected by this

resurgence in TB. Community Field Researchers identified users who were suffering from TB, many of whom themselves believe, have caught TB from fellow users in khat using sessions, in closed environments, without adequate ventilation, for prolonged time.” (Somali Health and Mental Health Links, London. Page 26)

(See also section on khat use 3.7.5)

Many of the community groups were involved in work related to HIV and AIDS, particularly those groups based in London. Indeed many of these groups had been set up mainly, or at least in part, to deal with HIV and AIDS. Thus, the African Community Involvement Association (Croydon) describes itself as ‘mainly an HIV/AIDS organisation’ and The African Health for Empowerment and Development, London states that it was:

“Founded in 1992 as the Uganda Health Project (UHP) to address the grave difficulties facing Ugandan Refugees infected or affected by HIV/AIDS.” (African Health For Empowerment & Development, London. Page 5)

The Congolese Refugee Women’s Association point out that:

“Refugees from (former Zaire) bear the additional burden of a high incidence of people affected by HIV and AIDS.” (Congolese Refugee Women’s Association, Newham. Page 8)

The Simba Community Alliance, London similarly point to the:

“Fast growing vulnerable numbers of Zimbabweans suffering from HIV/AIDS in London.” (Simba Community Alliance, London. Page 17).

Despite the fact that so many of the groups had been set up mainly, or at least in part, to deal with HIV and AIDS, very few of them specifically went on to address the issue of HIV and AIDS, or of other blood borne diseases in their reports. One of the few that did address these issues specifically is Saaf Dil in Rotherham, whose project interviewed 169 respondents:

“Our impression when administering the questionnaires was that the majority did not really understand what these diseases are. This is especially true for Hepatitis B and C. This is because although people who answered the question ‘Have you heard of Hepatitis B & C’ ticked ‘Yes’, when we asked them if they knew anything about it, people did not know very much at all. For example, when working with a group of school children to fill in the questionnaire, we observed that the majority had ticked Yes they had heard of Hepatitis B and C. We asked them – ‘you’ve heard of this, but do you know what it actually is?’ and none of the group knew anything about it. Young women’s and men’s focus group findings also back up this point – i.e. people said they had heard of HIV, Hep B and C but had little other knowledge about any of these diseases.” (Saaf Dil, Rotherham. Page 64)

3.2.7 The impact of drug use on families

Many respondents report the impact of drug use on families. This is described in terms of stress, worry and financial burdens:

“A large number of family members were affected by the behaviour of the user - these included other adults in the household, grandparents, wives and children...There was a lot of tension in these families with arguments and both verbal and physical abuse taking place...Families were in

very stressful situations, with the women especially being affected emotionally. Not being able to sleep, depression, worry, fear were all mentioned.” (Saaf Dil, Rotherham. Page 46)

“...my dad doesn’t show it or discuss it, but it must really hurt him and he asks him for money all the time and he gives on occasion. Also affected my step-mum as she doesn’t stay with my brother as much she prefers to sleep elsewhere if she explains has not got money he would still persist and persist and never pays back. It affects us financially. His niece is 14 years old she was also begged for money at one time it puts them in confusion a little because an adult asking a child for money is strange.” Pakistani Female 26-50+

“We are always having to pay for him (user) and even still he steals from us, even his grandmother.” Pakistani male 16-25 (Youth Awareness Programme, Leeds. Page 63)

“The impact on the user’s children, and on other children in the household, was very worrying. The children’s emotional well being was put at risk; they were scared, lacking in confidence and their relationship with the user was affected.” (Saaf Dil, Rotherham. Page 46)

“Throughout the interview, the issue of family is raised again and again and is evidently of major concern to D. He described how his family feel “so burdened and troubled” whenever he is mentioned.” (Chinese National Healthy Living Centre. Page 73)

Others report health and mental health problems resulting from drug use within the family:

“My husband has a health problem. My family and I tried to protect him from the truth and not face the problem because of fear of what it might do to my husband he may have another heart attack.” (Asian Anti-Drugs Initiative, Halifax. Page 44)

“I worry a lot because my full brother used to use drugs and nearly overdosed. He still uses, has been using for 10 years. He tries to stop. Currently he is in jail and is trying to stop while in prison. He was also using class A but I don’t know the name he was injecting also...” Pakistani female 26-50. (Youth Awareness Programme, Leeds. Page 64)

“Very bad effects - my sister who was his main carer has gone into depression. Also I found it hard to accept it. Also we had no other support from anybody as we had to conceal the fact that he took drugs.” A Muslim parent (Three Faiths One Issue, Leicester. Page 63)

Some talked about conflict and violence at home:

“It has affected my family very badly, it has put us through bad arguments leading to violence with various relationships.” (Asian Anti-Drugs Initiative, Halifax. Page 44)

“It causes too much conflict and arguments with in the family.” Bengali Female 26-50 (Youth Awareness Programme, Leeds. Page 63)

“Participants were firstly asked what they perceived to be the effects of drugs in the community upon the family. The majority of respondents (47%) believed it hurt and destroyed families. A significant effect was fear, fear for the safety, well being and future of children and fear of drugs and the problems associated with them.” (Sheffield Black Drugs Service. Page 64)

The stigma and taboo nature of drug use means that for many families, it is not a subject that can be discussed:

"People are isolated and cannot talk to family and friends, as the subject of drugs is still a taboo subject within the community." (Southall Community Drugs Education Project, London. Page 52)

"There was very much concern about the strained relationship between parents and children when it came to topics like drugs and alcohol." (Supporting African Youth Development, London. Page 31)

"No one from my family knows I'm using drugs." Female, 15. (Marylebone Bangladeshi Society, London. Page 41)

"I try and speak to him about it, but my son does not feel open enough about it with me." Bengali Female 26-50. (Youth Awareness Programme, Leeds. Page 67)

Respondents report that drug use brings shame upon the whole family:

"My family knew I had a problem...my brother couldn't get married because of my problem. It's caused a lot of distress for my family." (Male, 22)

"My family felt humiliated." (Male, 24)

"As the eldest son they think I have let them down – an embarrassment to the family." (Male, 19) (Marylebone Bangladeshi Society, London. Page 33)

"The community does not want to know you basically they look down on you." Pakistani Male 50+

"You can't talk to the community openly." Bengali Female 26-50

"They stigmatise you and basically distance themselves from the user and the family." Pakistani Female 26-50 (Youth Awareness Programme, Leeds. Pages 69 - 70)

"If a family has a member who uses drugs, of course it's not a good thing for it to be known by others." (Chinese National Healthy Living Centre, London. Page 73)

For many families, attempts are made to isolate, confine or remove the drug-using member of the family:

"Many people mentioned the extent to which parents can go...take you to India or Pakistan." (Ethnic Minorities Health and Social Care Forum, Blackburn. 23)

"It is common at the moment in our community at least that parents usually would send their children to their own homeland of Pakistan or Kashmir if there was a drug problem. This only serves to increase the problem because of the availability of drugs and the cost which is very cheap so when these children come back from Pakistan/Kashmir the problem would have multiplied." (East Birmingham Community Forum, Birmingham. Page 36)

"...his mother is adamant that he seeks help for his addiction in North West London, away from members of the community who may recognise him." (ACIA, London. Page 27)

"One Focus group did touch on the issue of how parents would usually discipline their children through administering corporal punishment and confinement if they were found to

be using drugs." (Congolese Refugee Women's Association, London. Page 20)

Summary

The impact of drug use on families is described in terms of stress, worry, financial burdens, health and mental health problems, tensions, arguments and even violence. For many families, it is not a subject that can be discussed and families experience shame and isolation from the wider community. Family responses to drug use include sending the user to the home country of origin of the family or attempting to confine them so that people do not find out.

Families are coping with both the fears and the realities of drug use in relative isolation. The lack of general drug education and little awareness about services compounds an already difficult situation, leaving many families feeling cut off from their communities and unable to cope.

3.3 RELIGIOUS FAITH AND PROTECTION AGAINST DRUG USE

Religion features prominently in most of the reports. A range of religious faiths is reported amongst respondents including Islam, Hinduism, and Sikh, Christian, Rastafarian and Zoroastrian faiths. One of the reasons that religious faith features so prominently may be that it has specific prohibitions against drug use:

"Any substance, which has the effect of impairing the faculties of reasoning, perception and discernment is forbidden in Islam...Before it was alcohol that was haram and discussed, now it is drugs." (Asian Anti-Drug Initiative, Halifax. Page 26)

"Islam, the religion that all the respondents follow, forbids drug misuse." (Yemeni Community Association, Sandwell. Page 57)

"The religious texts of all three faiths – Sikh, Muslim and Hindu – are explicit about the harm done by drugs and in fact, any intoxicating substance." (Three Faiths One Issue, Leicester. Page 81)

That said, drug use is also reported as being associated with religious faith and practices i.e. some Black Caribbean respondents refer to the use of cannabis as being part of their religious culture:

"Jamaicans' religious cultures - People grown up using it, comes with the faith..." (Nguzo Saba, Preston. Page 33)

Khat use is also referred to as being part of a religious culture:

"Khat is used for religious purposes...to bring people together, to make a collective discussion..." (Ethiopian Community in Lambeth, London. Page 31)

Differences on the degrees to which faith groups adhered to prohibitions are also mentioned:

"...the Sikh Punjabi community, have more of tolerance for drugs and in particular the use and consumption of alcohol (even though this is forbidden within the Sikh faith)." (Integrated Asian Alcohol Service, London. Page 29)

For many though it is strong religious prohibition that leads

them to believing that religion can be a protective factor against drug use:

"Many also believed that it was important to understand and explore the role of religion and spirituality in the fight against drugs." (Three Faiths One Issue, Leicester. Page 65)

"The majority 62.3% stated that religious belief had influenced their decision not to take drugs." (Yemeni Community Association, Sandwell. Page 57)

"My immediate family as well as my extended one have strong religious understanding. This not only influenced me to have negative attitude to drugs, it helped me to distance myself from associating with drug users." (Nilaari Agency and Black Orchid, Bristol. Page 38)

"My religion encourages me not to take drugs." Indian Female 26-50. (Youth Awareness Programme, Leeds. Page 31)

Others report that religion offered no protection and that young people would actually use drugs in order to rebel against their religion:

"By the fact it is against their religion they try to rebel." (Black and Minority Ethnic Housing Consortium, Wolverhampton, Young People. Page 39)

For some respondents it is the lessening of strong cultural and religious associations in the UK that is creating a situation where young people are more vulnerable to drug use:

"Youngsters have too much freedom and turn to drugs and things because they lack an Islamic education and because they start to adopt Western values...the problem is in Western values." (Marylebone Bangladesh Society, London. Page 36)

"...98% of the Turkish community is Muslim. Evidence suggests that many children brought up in the UK are not aware of their religion." (Day Mer Turkish and Kurdish Community Centre, London. Page 4)

"Yes, more Asians are becoming involved with drugs, as there are ongoing reports in newspapers. However older people despise drugs. Older people (traditionalists) believe there is no reason for it and to relax from stress you can meditate and read religious scriptures." A Hindu parent. (Three Faiths One Issue, Leicester. Page 61)

It is not possible to draw any firm conclusions about the role of religion as a protective factor against drug use. While some clearly state that their religious faith prevents them from using drugs, it is also clear that others with the same religious affiliations do use drugs. Some respondents recognise these tensions and advocate a middle ground:

"Faith groups have to explore how spiritual guidance and religious education can contribute towards drug awareness. They may also wish to explore how religion, spirituality and faith can help some of the damage caused by the use of drugs." (Three Faiths One Issue, Leicester. Page 92)

"...negotiating the contradictions of adhering to religious observance, knowing that drugs are not allowed, yet wanting to be better informed about them and their effects also presented respondents with a dilemma." (Walsall ACIDS. Page 16)

"Our findings are that this activity (drug education and awareness) has not been facilitated at the Islamic schools.

Their assumption is that using drugs apart from tobacco are already acknowledged as a prohibited act. Unlike the schools that run by the government, where the information had been introduced and demonstrated satisfactorily." (Iraqi Welfare Association, London. Page 20)

For many respondents there is a view that religious organisations and centres should be more involved in disseminating information about drugs and providing drug education:

"More use needs to be made of these institutions as they are used far more widely than the perceptions of them just being places of prayer." (East Birmingham Community Forum, Birmingham. Page 41)

"I think that the mosques are in the best position to educate children, because we send our kids to mosque everyday and the molvis (Imam) have their attention." (Ethnic Minorities Health and Social Care Forum, Blackburn. Page 31)

"We should have people to come to centres like Mosques, Gurdwaras, Mandirs and speak about resources available and facilities in the local council." (Integrated Asian Advice Service, London. Page 28)

"Religious centres and organisations should also take responsibility for drug education. There could be discussions on Sunday Schools for example. Leaders and priests should have drug awareness training as they talk to parents more than children." (Southall Community Drugs Project, London. Page 56)

However religious prohibition is also identified as a potential barrier to drug education:

"We have learnt through this process that the issues of drug taking within the Indian sub continent community are difficult to address because of social, cultural and religious barriers that make it difficult for members of the community to confront these issues and to have open debate about them." (Integrated Asian Advice Service, London. Page 6)

The fact that religion features so prominently in the reports begs the question whether religious faith would be an issue if the reports had been carried out by white researchers into the needs of white drug users. It is highly unlikely that it would, but for many respondents, particularly although not exclusively, Muslim respondents, religious faith is viewed as a key protective factor against drug use. In a wider sense, this is also linked to the positive cultural and community functions of religious centres:

"...religious organisations are membership organisations, they also serve the needs of the wider community. These places act as the focus for important social, cultural and religious gatherings (e.g. weddings, prayers, family celebrations, religious festivals and so on) as well as acting as a forum for the exchange of views, ideas, community information and "gossip". Many people from the community also approach these organisations, especially the religious ones, for help and support." (Three Faiths One Issue, Leicester. Page 67)

Summary

Religion features prominently in the reports. Some respondents view religion as a protective factor against drug use, usually due to strong religious prohibitions. Some drug use is also reported as being associated with certain religious faith and

practices. There are mixed views about whether religion protects against drug use, but most respondents report that more religious organisations and leaders should be involved in drug education work.

3.4 DEPRIVATION, DISADVANTAGE AND DISCRIMINATION

3.4.1 Drugs and disadvantage

Much of the literature on drug use and Black and minority ethnic communities supports the view that there is a link between deprivation and poverty in Black and minority ethnic communities and subsequent drug use:

"...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." (ACMD, 1998:25)

Others have suggested that drug use amongst Black and minority ethnic communities is linked to the experience of social exclusion and racism:

"... problematic drug use may be seen as a way of escaping painful experiences associated with disadvantage and marginalisation." (Sangster et al. 2002. 4.4 Page 35)

Deprivation, disadvantage and discrimination in the context of drug use are themes that are raised repeatedly by respondents. This is not surprising considering that 45 out of 47 of the needs assessment projects are located amongst the 88 most disadvantaged local authority areas in England:

"Housing is seen as a significant contributory factor in drug misuse and supply. In particular it was felt that there was a large number of poor quality housing that attracted both drug suppliers and users into the area. This view was expressed by 56% of older male respondents who were owner-occupiers in the area and felt that property prices in the area had suffered because of the image of the area and that the large number of boarded up houses in the area affected community safety." (Youth Awareness Project, Leeds. Page 27)

"Respondents were concerned that the drugs situation was impacting their local area to get a 'bad name' which resulted in families moving out, unemployment and businesses closing." (Holy Trinity Community Network Forum, Tameside. Page 37)

"...the physical environment in which drug taking and peddling take place needs to improve and regeneration strategies need to be more cohesive and ambitious." (Three Faiths One Issue, Leicester. Page 65)

"Participants consistently identified this 'social impact' of drug use on communities as a major area of concern. That is not to detract from the concern expressed for drug users who had gotten into difficulties as a result of problematic use; however, it was felt that the areas in which respondents lived had become economically and socially impoverished as a result of both the increasing presence of drugs and the subsequent belief in Walsall that certain wards have become 'no go areas'." (Walsall ACIDS. Page 15)

Concerns about declining neighbourhoods and disadvantage

are also expressed by the two community groups not located in one of the 88 most deprived areas:

"...they come in and do the houses up...but the kids are mental, and they break the new windows that have been put up." (Asian Anti-Drug Initiative, Halifax. Page 19)

"It causes a breakdown of the economy because houses in affected areas are sold for less than they are worth. People are sometimes refused work because of association with these areas." (ACCAN, Oxford. Page 38)

The evidence supporting linkages between deprivation and disadvantage and drug use have long been recognised and as many of the respondents point out, these risk factors are particularly relevant to many Black and minority ethnic communities:

"The over representation of Black people in statistics on young offenders, those in care, school truancy records is well documented. Black and minority ethnic families tend to live in more economically deprived areas with poor housing and low employment. All these factors have been shown to contribute to a greater risk of developing a drug problem." (African Community Involvement Association, London. Page 7)

"The reasons and predictors for drug misuse are well documented, with high unemployment, stressed housing conditions, boredom, lack of opportunity, feelings of exclusion all being key predictors which generate a ready breeding ground for such misuse. Study after study has concluded that these conditions are present in proportions significantly higher than the wider population in the more recent immigrant communities. The Bangladeshi community sits squarely at the top of all such studies as the most deprived of all minority communities." (Smethwick Bangladeshi Youth Forum, Sandwell)

There is also recognition that, in addition to the risk factors faced by any community living in a deprived area, Black and minority ethnic communities may face a number of other stresses such as racial discrimination, language barriers, immigration status and displacement, all of which may further increase their level of risk:

"The profile of Yemeni families in the area tends to be one of low employment and a low skills base. These disadvantages are compounded by cultural and language issues, which often makes it difficult for the Yemeni community to access mainstream services and organisations." (Yemeni Community Association, Sandwell. Page 14)

"Although peer pressure was an influencing factor for drug use, these young people all had other underlying problems. All had been born and spent part of their young lives in Africa. Coming to Britain would have certainly meant a cultural change. It may have been that these young people found it difficult to cope with their dual nationalities; additionally the family structure would have changed immensely. The African family is very much focused on the extended family; this would therefore suggest that the youngsters would have lacked the support of the extended family whilst in Britain." (African Community Involvement Association, London. Page 27)

"Ethnic minority communities are particularly vulnerable because of the socio-economic circumstances. Living in a society that discriminates against them and devalues them as second class citizens, with no job to go to leaves them with very little option but to see themselves as losers in the society."

Once a person has nothing to lose all pursuits of gain, be it legal or illegal, can be an attractive option.” (Nguzo Saba, Preston. Page 10)

Some respondents also recognise that despite the obvious stresses of living in a deprived area there is community resilience and strength:

“Although the areas...that were covered during the research are considered to be areas of ‘social deprivation’ there has been a difference in perception by residents. Local residents have described the areas as having a sense of being connected and of security, where the community is facing and tackling problems especially oppression and racism together. Many have stated that Church, Temple and Mosque through the strong spiritual life of the various communities support this. This is further enhanced by the many public events and festivals arranged by community groups to celebrate their various cultures and traditions.” (Derby Millennium Network, Derby. Page 9)

3.4.2 Racism and discrimination

Discrimination and the experience of racism are, in many instances, reported to be linked to involvement in drugs:

“Having been labelled as an underachiever in school with constant harassment from police, African Caribbean young men do not stand a chance of a better life in British society. A status where one has nothing to lose, getting involved in the drug business becomes an attraction to the disenchanted...” (Nguzo Saba, Preston. Page 10)

This research confirms that it is this cultural dislocation within the Somali refugee community, and racism within the wider community, which may lead individuals to see khat as a refuge, either as an escape or as a means of boosting self-esteem. (Somali Health and Mental Health Links, London. Page 9)

Referring to Henegham (2000), Wai Yin Chinese Women Society comment on the fact that:

“48% of Chinese women appearing before the Courts for drug offences in 1998 were sentenced and this compared with only 24% for white women...As a result Chinese women are relatively over represented in the criminal system and underrepresented in the use of drug services.” (Wai Yin Chinese Women Society, Manchester. Page 10)

Racism, particularly institutional racism is also referred to in the context of service provision:

“Racism in British society supports the mistaken assumption that the Chinese community does not want service provision because of their own racial culture. Consequently, the Chinese community is the scapegoat for the inadequate service provision.” (Wai Yin Chinese Women Society, Manchester. Pages 15 - 16)

“Drugs education which is delivered needs to be placed in the context of an individual’s life not in isolation, looking at the impact of living in a deprived area, facing racism, family pressures and the lack of employment opportunities.” (Holy Trinity Community Network Forum, Tameside. Page 37)

This is especially pertinent when considered in light of the Race Relations (Amendment) Act 2000, which requires public authorities (and voluntary sector agencies in receipt of public

authority funding) to address issues of differential access to services and information amongst Black and minority ethnic communities:

“[Organisation A] explained that the 1991 census indicated that 25% of Westminster’s residents are BMEs, but that 95% of their clients were white, male opiate users.” (Chinese National Healthy Living Centre, London. Page 85)

“...services currently do not meet the needs of local immigrant communities.” (Congolese Refugee Women Association, London. Page 23)

“Data collated from several drug agencies indicate the lack of treatment accessed by BME young offenders.” (Black and Minority Ethnic Housing Consortium, Wolverhampton(4) Young Offenders. Page 17)

Racial discrimination is a key factor in considering the needs of Black and minority ethnic communities:

“Despite successive government efforts to promote equality of opportunity among all citizenry it is still far from realisation. Racism of all forms from individual racism through cultural racism to institutional still remains within the same ethnic minority communities in Britain. Every individual has his/her own story to tell when it comes to experiences of racism.” (Nguzo Saba, Preston. Page 11)

Summary

Deprivation, disadvantage and discrimination in the context of drug use are themes that are raised repeatedly by respondents. This remains true even in areas that are less strongly identified with disadvantage. The risk factors for drug use and disadvantage are established and are particularly relevant to Black and minority ethnic communities. In addition, these communities may face a number of stresses such as racial discrimination, language barriers, immigration status and displacement. All of these may further increase the risk of developing drug problems. Despite the obvious stresses there is a lot of community resilience and strength.

Racial discrimination is a key factor in considering the needs of Black and minority ethnic communities. Discrimination and the experience of racism are in many instances linked directly to drug use and service provision. The Race Relations (Amendment) Act 2000 requires public authorities (and voluntary sector agencies in receipt of public authority funding) to address issues of differential access to services and information amongst Black and minority ethnic communities.

3.5 Crime and drug dealing

One of the strongest themes to emerge from the reports is the sense of fear and concern about increasing levels of drug related crime in neighbourhoods and recognition of drug dealing:

“...it was also perceived that drug selling is taking place in less covert ways than previously. Fear of drugs and the impact of drug sellers were felt to be real issues for respondents.” (Walsall ACIDS. Page 15)

“The prevalence of hard drug supply was also felt linked to increased street crime and burglaries in the area as individuals needed to finance their drug habit.” (Youth Awareness Programme, Leeds. Page 27)

"Crime and family were dominant themes in discussions about the impact of drug use on the community. Participants closely linked drug use and crime rates." (Chinese National Healthy Living Centre, London. Page 60)

"Opinion was split as to whether drugs were deemed a problem in the area or not. ...Those that stated it was a problem, quoted drug related crime and violence as the most common reason why..." (Yemeni Community Association, Sandwell. Page 51)

"The adult community members who attended the meeting unanimously expressed concern about the increasing misuse of illegal drugs and the escalating crime rates connected with this." (Supporting African Youth Development, London. Page 31)

Not all respondents cited crime as the main source by which they obtained funds for drugs, however:

"7 out of 20 respondents stated that they financed their drugs habit through money they earn through their work. This goes against the trend, which centres on drug problems being associated with unemployment. A further 6 out of 20 borrowed money to fuel their habits. Although the majority of users expressed that they are feeding their habit through work, loans, borrowing, and dole others showed problematic and criminal behaviour to feed their habit for example: 4 people were selling stolen goods, 3 stealing money from family. No one however reported resorting to crimes such as mugging people, although 2/20 did state that they burgled homes." (Yemeni Community Association, Sandwell. Pages 64 - 65)

Most respondents report an increase in drug use within their communities and many were also acutely aware of an increase in dealing:

"Congolese parents spoke about groups of youths hanging around the estate where they lived, dealing drugs and perpetrating petty crime. They fear that Congolese young people will be drawn into it." (Congolese Refugee Women's Association, London. Page 9)

"It was felt that the number of people supplying drugs in recent years had increased dramatically." (Youth Awareness Project, Leeds. Page 33)

"When asked if the young people were aware of drug dealing in Burngreave 84% responded that they were..." (Sheffield Black Drugs Service. Page 42)

"Young people felt that the main dealers sold drugs to the young people to recruit them as drug pushers. These drug pushers are usually young and are not aware of the legal penalties they face if caught in possession or intending to sell." (Kirklees, REC. Page 24)

"There seems to be a belief that drugs misuse can lead to the advent of other forms of criminal activity and that the lack of employment and career opportunities generate conditions which allow the major pushers to manufacture a selling hierarchy based in the area. The housing situation and the high number of cheap rented accommodation available support this drugs market." (Asian Anti-Drug Initiative, Halifax. Page 55)

For many respondents there is a clear sense of fear about drug use, dealing and crime:

"Whilst...the majority (54%) stated that this did not effect

their lives as young people living in the area; 24% (12) stated that it did; ...Fear...was the predominant theme to emerge." (Sheffield Black Drugs Service. Page 42)

"It's just that we are scared, too. I mean; they are in our building. I mean they know us, but even so, you just personally – in your mind – feel a little scared." (Marylebone Bangladeshi Society, London. Page 35)

"I remember in Walsall you could have left your house open and no one would walk in and take anything but today you can't even walk the street because somebody with a drugs problem would tap you over the head to get money to buy drugs. Things are worse. There are more drugs pushers and users than even 3 years ago." (Walsall ACIDS. Page 14)

In some areas, notably Birmingham, Manchester, Liverpool and Leeds there is a clear link between fears about drugs, the emergence of gang cultures and use of guns:

"Responsible citizens in the described communities are very concerned, and frightened, with regard to the ballistic affairs (gun law) and temperament of the local youth. They inform us that concerns are highest relating to police detection rates of firearm offences. There have been several well-publicised shootings over the past 10-15 years and people in inner city communities become suspicious when detection results are so low. Some will not act as a witness for obvious reasons but, overall, many felt more could be done to combat these persons and ease local peoples fear of guns." (Project 8, Liverpool. Page 25)

"However, there was concern not simply that these drugs were being used by a greater number of people, but also that "gang cultures", "violence" and conflict between groups of young people as a result of drug selling were also becoming more prevalent." (Walsall ACIDS. Page 14)

"Young males also mentioned that white opiate users in their areas were often victims of violent attacks from young Asian males who would target them specifically as there was a strong feeling that they should not be allowed to live in the areas, as they were responsible for crime and undermining the safety and security of the area." (Youth Awareness Programme, Leeds. Pages 27 - 28)

"Drugs are generally related with the Triads ..." (Chinese National Healthy Living Centre, London. Page 56)

Alongside the fears about increased levels of drug dealing, and other crimes, there is a prevailing view that not enough is being done by the police:

"...in Europe the law about drugs is not in force, people use drugs on the bus and on the street but the police are not interested about the smokers, instead they are after the suppliers. Back home the authorities are tough on drugs punishment." (Cabinda Community Association, London. Page 11)

"The respondents felt that there was no response from the police when reporting a crime... The respondents felt let down by the legal system." (Asian Anti-Drugs Initiative, Halifax. Page 27)

"... the apparent ineffectiveness of the policing of the matter overall probably contributes to the attitude, among three out of four interviewed, that there is no legal risk in Drug taking." (Mushkil Aasaan, London. Page 7).

"90% of the respondents thought that the government and the police were not working hard to crack down on drugs. Some said that drugs were sold in the streets. Some said that drugs were easily available everywhere." (Day-Mer Turkish and Kurdish Community, London. Page 26)

There is also a reluctance to report incidents to the police:

"The police will fail to pay adequate attention to the problem of drugs on the estate There is also the fear that once police do arrive at the incident the 'informant' may well be identified – increasing personal safety fears." (Marylebone Bangladeshi Society, London. Page 7)

"When asked to report these incidents, they felt that they were under pressure not to do so, because they live in a tight knit community where almost everyone knows each other's business. They are aware of crimes being committed, but they felt powerless to do anything about it for fear of any consequences." (Ethnic Minorities Health and Social Care Forum, Blackburn. Page 26)

Most respondents are keen to see better and more effective policing. This is expressed as a desire to see a more visible police presence on the streets, and the arrest of drug law offenders. Some respondents express concern that higher profile policing should not be seen to target Black and minority ethnic communities unnecessarily or inappropriately in a way that might be perceived of as racist:

"...in order to be seen to be responding to this perceived increase in drug-selling activities robustly, some respondents were concerned that the Police may inappropriately target innocent residents rather than the drug sellers who come to Walsall from other areas. Concern was raised that this approach could set back the good community relations that currently exist in the Borough... Whilst those participating in the consultation welcomed a greater Police presence to combat this, they also wanted reassurances that the Police would continue to target drug dealers effectively and appropriately." (Walsall ACIDS. Page 15)

Summary

Respondents express a strong sense of fear and concern about increasing drug use and other crime. Many were also acutely aware of an increase in dealing. Not all respondents using drugs report crime as the main source by which they obtained funds for drugs. In some areas, notably Birmingham, Manchester, Liverpool and Leeds there is a clear link between fears about drugs, the emergence of gang cultures and use of guns. Most respondents are keen to see better and more effective policing. There is a reluctance to report drug related incidents to the police. A desire to see a more visible police presence on the streets, and the arrest of drug offenders is tempered by concern that higher profile policing should not be seen to target Black and minority ethnic communities unnecessarily or inappropriately in a way that might be perceived of as racist.

3.5.1 Access to and availability of drugs

Although respondents report concerns about the perceived rise in drug use and dealing, there are many who report knowing drug users. Amongst all respondents who were asked if they knew a drug user 43.6% said that they did (n = 1,138):

"Just over 73% of the sample knew approximately 15 other young people taking drugs. Two of the young people made the comment that they only "knew a few" which they quantified as being 10." (BME Housing Consortium, Wolverhampton (1) Young People. Page 17)

"Participants were then asked if they knew of anyone who took drugs. Twenty six percent of respondents stated that they did. Of these, 10 said that they knew of 13 people taking cocaine/crack, 34 marijuana/cannabis, 7 heroin and 3 speed." (African Community Involvement Association, London. Page 22)

The number of drug users known varied across groups; for instance, amongst refugee and asylum seekers in Wolverhampton people reported knowing 11 – 15 on average. (BME Housing Consortium, Wolverhampton (2) Refugee and asylum seekers. Page 31).

The prevailing view amongst respondents is that drugs are easily obtainable. In one sample of 329 people in Sandwell, 56.8% had ever been in an environment where drugs were being used. More than a third reported that they had been offered drugs. This was an almost entirely Muslim sample half of which were under the age of 25 years. (Smethwick Bangladeshi Youth Forum, Sandwell)

Of 25 non-drug using young Bangladeshi's, fifteen reported that they had been offered drugs, mostly cannabis and mostly by their friends. (Bangladeshi Youth League, Luton. Page 22).

"A consistent finding of the Focus Groups with young people was the ready availability of a variety of Class A and Class B Drugs and the knowledge of how to access such Drugs if required. Drugs were available through school and college networks and, it was claimed in one group that Drugs were taken by some during the school day. Comments such as, "you can get everything" and "you just have to go to Tooting", were frequent." (Mushkil Aasaan, London. Page 28)

Amongst 103 respondents in another sample 67% said that drugs are easy to get hold of (African Health for Empowerment & Development, London. Page 25)

Respondents describe dramatic increases in drug use and availability:

"Most Young People felt that there had been a dramatic increase to the amount of Illegal substances coming into the community and that it was an escalating problem. Young people felt if something was not done soon this would be an epidemic that would spiral out of control and in time there would be nothing we could do to stop it." (Kirklees REC. Page 23)

"Drugs are everywhere...Drugs are in high demand and easily available...More acceptance of drugs taking by younger people... "Problem has increased in the last 5/10 years more people experimenting with drugs...More easily available and cheaper." (Saville Town Community Association, Dewsbury. Page 26)

Some respondents highlight the cheapness of drugs as a factor in their increased availability:

"Drugs were seen as easy to buy in the local area, and the price having significantly dropped in the last couple of years... 'Weed is like buying fags from the shop'... 'It's so easy now to afford which ever drugs you want.'" (Holy Trinity Community Network Forum, Tameside. Page 33)

"35% of the respondents interviewed mention that it is due to easy access that drugs are taken." (Asian Anti-Drug Initiative, Halifax. Page 38)

Summary

The prevailing view amongst respondents is that drugs are easily obtainable and many describe dramatic increases in drug use. Many respondents have direct knowledge of knowing drug users. The number of users known varies across groups. Some respondents highlight the cheapness of drugs as a factor in increased use.

3.6 Help seeking and awareness of services

1,667 respondents were asked if they were aware of any services to help people with drug problems. Only 20% (341) said that they were aware of services. That only one in five knew where to seek help indicates a fundamental barrier to service access, by Black and minority ethnic communities.

For the majority of respondents (80%) there is a general lack of awareness about what options there are for help:

"Again, amongst younger and older members of the community lack of knowledge about the full range of health service provision is an issue for concern. Although younger members do not have language or literacy barriers, they still were not accessing or fully aware of services available. This demonstrates the need for culturally sensitive services as many young people felt that they were not understood." (Ethnic Minorities Development Project, Wakefield. Page 59)

"Most respondents expressed the opinion that they were not aware of any available services relevant to their needs..." (Navjyot, London. Page 5)

The most common response as to where people would go is the GP:

"...the first port of call would be their GP..." (Smethwick Bangladeshi Youth Forum, Sandwell. Page 31)

"Personally I would go to the family GP..." (Walsall ACIDS. Page 15)

"Most people didn't know where to go for help. Of those who did know, GPs seemed to be the main point of contact and resource." (Ethnic Minorities Development Project, Wakefield. Page 59)

"Many respondents could not name any local specific services and felt that the only option available was their local GP..." (Holy Trinity Community Network Forum, Tameside. Page 34)

To the question, "If you or somebody you know has a drug misuse problem what organisation, if any, would you like to receive treatment from?" the following response was received. "Out of the 289 options recorded, 70 (24.1%) would like to be treated in GP Surgery." (The Igbo and Tutorial School, London. Page 38)

However, not all respondents agreed:

"The figures for where people would go for advice and help on drugs varied. Twenty-one Sikh respondents stated that they would go to their GP whilst none within the Hindu and Muslim community stated that they would use this route. The majority of respondents within the Hindu community stated

that they would go to their friends for advice and the majority of the people in the Muslim community stated that they would go to independent advice centres." (Three Faiths One Issue, Leicester. Page 51)

"While 6 (59 %) out of 10 respondents are willing to discuss drug problem with GPs, 4 (41 %) out of 10 expressed their unwillingness to discuss it with their GPs." (Ethiopian Community in Lambeth, London. Page 28)

Some respondents report that while there may be some services for the drug user, there was nothing for family members or carers:

"There's nothing available for the family to cope with a family user in the home, especially if they don't want to give up." (Holy Trinity Community Network Forum, Tameside. Page 35)

Holy Trinity also report that when respondents were told of the local drug services many were angry that they did not know about them:

"Why weren't we informed."

"Why has no-one ever told us."

"The organisations assume because we don't use the services we didn't need them." (Holy Trinity Community Network Forum, Tameside. Page 35)

Many respondents say that they would only seek help from an agency that appeared culturally sensitive and in particular, had Black and minority ethnic workers. For instance, Navjyot, London report that of 94 people asked if they knew about drug services would they access them, all agreed they would only do this if there were South Asian services. (Navjyot, London. Page 19)

This view was similarly expressed amongst service providers in Leicester and Sheffield:

"I think that there are not enough services in Leicester. I think it is important to have an Asian drug counselling service as knowledge of culture and background can be an advantage in helping counsel a drug user." (A Hindu respondent) (Three Faiths One Issue, Leicester. Page 52)

"The group felt that in order for Black and Ethnic Minority communities to access services that there should be more Black and Ethnic Minority (BEM) people working in drug services. So that services can be more sensitive to their needs and who BEM people can relate to on a cultural and religious level." (Sheffield Black Drugs Service. 69)

3.6.1 Stigma and shame

One of the main reasons cited by respondents as to why they would not access services, is stigma:

"In many sections of the local Asian community in Leicester the issue of drugs is seen to be taboo." (Three Faiths One Issue, Leicester. Page 14)

"There was one particular view from a lady in the focus group that was shocking to me. She said that if she ever found out that her son or daughter was a drug user, and she knew she could get help, she wouldn't. She would not because of the fact that she would be ashamed." (Marylebone Bangladeshi Society, London. Page 39)

"The 7 female respondents said they would not seek help because of community pride; people gossip, family honour, extended families and leakage of information would bring shame to their families (they believed they would not receive strict confidentiality), and cultural sensitivity." (Asian Community Forum, Lancashire. Page 25)

"Stigma, the concept of bayzti (dishonour) and izzat (honour) also played a role in people not accessing the services. Children are often sent back to Pakistan as a way of avoiding bayzti. Izzat is often maintained by a complete denial on the part of the users' families." (Ethnic Minorities Development Project, Wakefield Page 59)

Although the concept of stigma and the taboo nature of drug use featured most prominently amongst South Asian communities, it was by no means restricted to them:

"In Focus groups people stated drug taking is a taboo for the community and that anyone known to be a drug mis-user would be socially excluded." (Congolese Refugee Women's Association, London. Page 20)

"...the fear of stigmatisation is present if they were to approach such services." (Black Health Agency, Manchester. Page 22)

"African culture is a culture of silence. Silence is part and parcel of the culture. Therefore, when one's child or relative is into drugs, denial is not the only defence used but withholding of this information too. People do not share information." (ACIA, London. Page 29)

"... 'mavakuvunza zvakawanda manje' i.e. Shona language for saying You are now asking too many questions or you are now prying too much into drug misuse issues that should remain taboo." (Simba Community Alliance, London. Page 54)

For some respondents even the process of discussion about drug issues produced strong reactions:

"Though confidentiality was promised, some would not even hold the paper [questionnaire] for fear of leaving his or her fingerprints this throws more light on the stigma attached to drugs in the community." (Nguzo Saba, Preston. Page 20)

"The Field Workers found interviewing Igbo people on Drug misuse often challenging. Drug misuse was perceived as a taboo and there seemed to be reluctance to discuss it. In spite of telephone appointment and assurance of confidentiality the interviewers still experienced considerable initial difficulty with the interviewee once the issue of Drug misuse was raised..." (The Igbo and Tutorial School, London. Page 8)

It is worth noting however, that within young people's peer networks, drug use may have a different meaning; rather than stigmatising it can be perceived as enhancing reputations and popularity:

"One of the members mentioned that they saw and heard of the popular people doing it [taking drugs] which made them curious to try." (Navjyot, London. Page 13)

Telephone advice lines are mentioned as a service that people would find less stigmatising:

"Given the choice most people would ring an advice line. They felt that the confidentiality and anonymity offered by such services played a very important part in their decision to use one. Although most of the people we interviewed were

aware of drugs advice lines few people knew the number for one." (Derby Millennium Network, Derby. Page 19)

"The respondents were asked if they would access a drugs help line for assistance and information. 69% of the respondents stated that they would; 24% (11) said no and 7% did not respond." (Sheffield Black Drugs Service. Page 62)

"...the extent of drug use in the community is as yet unknown and will remain so until all drug services are made more accessible to Chinese drug users...the service could be made more accessible still by setting up a direct line for Chinese users." (Chinese National Healthy Living Centre, London. Page 87)

3.6.2 Black and minority ethnic staff

One of the suggestions made by respondents about how to increase the likelihood of them seeking help from the drug services was to employ more Black and minority ethnic staff:

"The local authorities need to employ more people from the Asian community to help the Asian community there are too many barriers and language problems." Bengali Female 16-25 (Youth Awareness Programme, Leeds. Page 50)

"Services need to have workers from different communities and not treat everyone the same, but according to the needs they are presenting with...Black staff would be culturally appropriate, as they would be able to break down the language barriers..." (Walsall ACIDS. Page 22)

"This view was not universal however: 5 respondents felt that a non-Asian counsellor would be preferred as Asian youngsters would prefer to see someone outside of their community. A respondent commented." (Bangladeshi Youth League,, Luton. Page 24)

There is also recognition that with training all staff can provide an appropriate and accessible service, regardless of ethnicity:

"Concern was expressed at the need not to segregate people or services. Instead, a cultural understanding was needed alongside proactive working approaches that enable barriers to be broken down. It was felt that Black workers would be able to do this, as well as appropriately supported white staff." (Walsall ACIDS. Page 22)

"Eight respondents felt it didn't matter whether the counsellor was Asian or Non-Asian as long as the counsellor was an expert and respected confidentiality." (Bangladeshi Youth League, Luton. Page 25)

3.6.3 The role of community organisations

Some projects asked respondents about community organisations that were able to assist with drug problems:

"The respondents were asked whether they knew any Turkish, Kurdish and Turkish Cypriot community organisations, which were providing services for drug users in the community. 43% of them said they did not know of any." (Day-Mer Turkish and Kurdish Community, London. Page 24)

"A significant trusting relationship has been formed between CRWA and Congolese people – this is an essential factor in building the bridge that is needed so the community can

access mainstream services...The findings consistently reflect the wishes of the respondents that services should not be high profile because of the stigma attached to admitting to drug use...Another reason why so many people requested CRWA to be a provider is because people felt uncertain about the possibility of lack of confidentiality and use of legal powers by statutory services.” (Congolese Refugee Women’s Association, London. Page 20)

Not all agreed that community groups should provide services:

“The large majority of interviewees (68), both male and female, would prefer to use integrated mainstream services... The overall feeling was that separate services become inaccessible and cause isolation...A large number of participants (52) expressed the need for services away from the Asian community.” (RAIS Academy, Rochdale. Page 25)

3.6.4 Services and community agency interviews

There were 469 interviews with drug service providers and community group workers. These respondents were asked about their views on whether there is a drug problem in certain Black and minority ethnic communities and how well they think they could respond to it.

One of the key barriers to service access cited by these respondents was language:

“Communication difficulties were highlighted as a major barrier to Chinese clients accessing services....worker explained that, once the client had reached the service, a Chinese worker was available, but that it was the initial accessing that was the problem. This was reiterated by...who said that clients simply did not know where to go because of the language problem...Chinese worker also talked about the difficulties clients face with regard to language.” (Chinese National Living Centre, London. Page 85)

Some respondents said they would not be able to obtain translated materials:

“The drug agencies were asked whether they had or could get hold of written materials about the misuse of drugs in Turkish and Kurdish. 67% of them (six out of nine agencies) said no...” (Day-Mer, London. Page 46)

The service providers recognised that they did not employ many Black and minority ethnic staff, and agreed with community respondents that they should do so. For instance six out of nine service providers interviewed by Day-Mer said that they did not employ any Turkish, Kurdish or Turkish Cypriot workers and amongst the three who did there was recognition of the value of this:

“...(three agencies) who had already Turkish/Kurdish speaking workers argued how beneficial it was to have Turkish/Kurdish speaking workers in their agencies: the services they provided were accessible to the Turkish/Kurdish speaking communities; the services they provided were culturally appropriate to those communities; there were also users’ demand for the employment of Turkish/Kurdish speaking workers.” (Day-Mer Turkish and Kurdish Community, London. Page 46)

Ethnic monitoring

Service providers were asked about the sensitivity of their ethnic monitoring systems and this was invariably found to be

inadequate in identifying particular ethnic groups:

“When the drug agencies were asked whether they monitor users for Turkish, Kurdish and Cypriot ethnicity, 56% of them said yes. 33% of them said that they did not monitor them specifically. They classified and put Turkish, Kurdish and Cypriot ethnicities in others category.” (Day-Mer Turkish and Kurdish Community, London. Page 46)

“They reported, that they classify them not according to their country of origin, but used different categories, such as Arabs or White others. In addition, the system would not include the Arabs whom born in Britain.” (Iraqi Welfare Association, London. Page 27)

“Most service-provider respondents said that they had a proportion of African origin ranging from 10 to 30%. When the questions were asked whether there was Zimbabweans. The Service Provider responded by saying they did not know.” (Simba Community Alliance, London. Page 46)

“Monitoring of ethnicity was scant in many services and where it was being conducted was often generalized in terms of groupings.” (Smethwick Bangladeshi Youth Forum, Sandwell. Page 40)

However, commissioners indicated that they would only be able to increase resources for work with Black and minority communities if they had sufficient evidence of need:

“As with services for all Sheffield communities we will continue to address needs, look at gaps in services and plan to refigure resources when information supports that. A commissioner.” (Sheffield Black Drugs Service. Page 108)

However, one commissioner indicated that communities turned inwards to meet their own needs:

“They turn to their own; turn inwards rather than outwards. They’ll ask their own communities first ...” (Chinese National Healthy Living Centre, London. Page 88)

Cultural sensitivity and meeting diverse needs

The general impression from interviews with service providers is that they would struggle to meet the needs of those Black and minority ethnic communities that are not currently accessing services:

“Services are generally aimed at white community, no special provision for other cultures...Services are not culturally sensitive, no local access point, opening times not appropriate...white staff have low confidence when dealing with ethnic minority communities”. (Saaf Dil, Rotherham. Page 49) “There was a need to overcome the stigma barriers and this was coupled with the requirement for access to honest education on substance misuse issues... More support and help for communities is required, with dedicated workers and there is a need for better awareness amongst statutory providers with information provided not only about drugs awareness but also concerning the available services and how to access them.” (Sheffield Black Drugs Service. Page 102)

Some service providers appeared sensitive to the suggestion that they could not meet the needs of Black and minority ethnic clients, with many reporting that the service is open to all people regardless of ethnicity:

“The majority of the Service Providers said that they were trained to deal with any individual irrespective of their

background.” (Simba Community Alliance, London. Page 45)

“...We have found no instances of leaflets in the Chinese language, interagency team work with Chinese organisations, outreach work to Chinese young people, employment of Chinese Drug Workers or ethnic monitoring of Chinese drug users... There appears to be a lack of data and prior drug research on the Chinese community. The colour-blind approach still exists generally.” (Wai Yin Chinese Women Society, Manchester. Page 28)

There was disagreement with this claim. Other service providers, especially those with existing Black and minority ethnic staff stressed the value of working with diversity rather than assuming all clients have the same needs:

“...The Chinese interviewee from [organisation A] explained that her non-Chinese clients have very different needs to her Chinese clients in terms of family. The families of her non-Chinese clients do not tend to get involved whereas the Chinese families need a lot of support... families obtain most of their information from the media and that the information they have is often inaccurate, so a lot of time has to be devoted to explaining the problems and treatments to the family members.” (Chinese National Healthy Living Centre, London. Page 86)

“Another identified service gap was the assistance for family members, this resulted in additional pressure on an already overstretched service. Often individuals did not want letters sent to their home in fear of reprisals from their family.” (Southall Community Drugs Education Project. London. Page 36)

“There is a real need for drug services in general as what we have tends to be focused and equipped to meet the needs of white male opiate users, serious thought needs to be given to the configuration of services for the Asian community and not just assume that employing an Asian worker will suffice.” (Smethwick Bangladeshi Youth Forum, Sandwell. Page 39)

“We did not encounter any scapegoating of the issues from the mainstream interviews. They acknowledged their lack of experience and data about Chinese people and they were keen to gain any information or assistance that we could provide...” (Wai Yin Chinese Women Society, Manchester. Page 27)

Community agency workers report needing greater knowledge about drugs so that they could provide more assistance:

“All community organisations surveyed in this project agreed that the community organisations’ staff should be trained in order to provide these services properly. When the organisations were asked what advantages and disadvantages the organisations would gain if they provided these services, all agreed that these services would be beneficial the communities they served. Some thought that these services would be able to make the community aware of drugs and their misuse and prevent the members of the community from using drugs.” (Day-Mer Turkish and Kurdish Community, London. Page 38)

Summary

For the majority of respondents (80%) there is a general lack of awareness about what options there are for help with drug problems. The most common response as to where people would go is the GP, although not all respondents

agreed that this would be the case. There was also a feeling that while there may be some services for the drug user, there was nothing for family members or carers. When some respondents were told of the local drug services they were angry that they had not been told of these before. Some respondents would only seek help from an agency that appeared culturally sensitive and in particular, employed workers from the same ethnic group as themselves.

Stigma is one of the main reasons cited by respondents as to why they would not access services. Although the concept of stigma and the taboo nature of drug use featured most prominently amongst South Asian communities, it was by no means restricted to them. For some respondents, even the process of discussion about drug issues produced strong reactions. Telephone advice lines are mentioned as a service that people would find less stigmatising. For some young people however drugs can be perceived as enhancing reputations and popularity rather than stigmatising them.

Suggestions made by respondents about how to increase the likelihood of them seeking help were to employ more Black and minority ethnic staff. There is also recognition that with training, all staff can provide an appropriate and accessible service, regardless of ethnicity. Not all agreed that community groups should provide services.

Amongst service providers, one of the key barriers to service access is reported to be language, including access to translated resources. While service providers recognised that they did not employ many Black and minority ethnic staff, they agreed with community respondents that they should do so. Ethnic monitoring systems are invariably found to be inadequate in identifying particular ethnic groups. Commissioners report that they would only be able to increase resources for work with Black and minority communities if they had sufficient evidence of need.

The general impression from interviews with service providers is that they would struggle to meet the needs of Black and minority ethnic clients. Some service providers appeared sensitive to this suggestion and report that the service is there for all people. Other service providers with existing Black and minority ethnic staff reported that it was important to work with diversity. Workers in community agencies report needing greater knowledge about drugs.

3.7 RESPONDENTS REPORTING DRUG USE

3.7.1 Sampling and description of ethnic group categories

There are 2, 078 respondents who report using drugs. While it is possible to describe the ethnicity and regional location for most of this sample, more detailed analysis is not possible due to differences in the presentation of data across reports. For instance, while some reports contain a detailed breakdown of data on drug using respondents, others do not.

However, it is possible to generate sub-samples of respondents reporting drug use and by combining data in those reports that do ask the same or similar questions. The following sub-samples have been generated in this way:

1. Respondents reporting which substances they have used (n = 1, 571)

2. Respondents reporting gender (n = 1, 156)
3. Respondents reporting age (n = 643)
4. Respondents reporting knowledge and experience of drug treatment services (n = 421)

Selection of ethnic categories

Ethnicity is not recorded in the same way in all the reports. For instance, only a small number of reports provide details about numbers of Indian, Pakistani and Bangladeshi respondents. Similarly, 239 respondents reporting drug use are from reports containing data on Black African and Black Caribbean respondents but data is not provided by separate ethnic categories. Ethnicity is unspecified for a further 237 respondents, although it is known that these comprise South Asian, Black African and Black Caribbean respondents.

Therefore, where data are not precise, respondents are grouped according to the broader ethnic category. South Asian encompasses all Indian, Pakistani and Bangladeshi respondents. Where it is known that respondents are either Black African or Black Caribbean these have been placed in one mixed category. Those ethnic groups with smaller numbers of respondents have been categorised as 'other'.

3.7.2 Respondents reporting drug use and ethnicity (n = 2, 078)

There are 2,078 respondents reporting drug use. The sample is drawn from 38 reports (80% of all needs assessments). Respondents reporting drug use represent 18% of the total sample of community respondents (n = 11, 571).

Table 5 shows the numbers of respondents by ethnic group. The largest proportion is South Asian (40%) followed by Black African (29%).

Table 5: Respondents reporting drug use and ethnicity (n = 2, 078)

	Black African	Black African & Black Caribbean	South Asian	Middle Eastern	Other*	Unspecified	Total
Number	605	239	831	124	42	237	2,078
% of total	29%	12%	40%	6%	2%	11%	100%

*Other = Chinese (16); Greek/Greek Cypriot (19); and Turkish/Kurdish (7)

The particular ethnic and national groups included in the Black African group are as follows:

Ugandan	Simba
Kenyan	Somali
Zimbabwe	Sudanese
Zambian	Egyptian
Sierra Leone	Democratic Republic of Congo
Cabinda	of Congo
Congolese	Rwanda
Eritrean	Burundi
Ethiopian	Kenya

The South Asian group consists of Indian, Pakistani and Bangladeshi respondents.

The Middle Eastern group consists of Iraqi (50) and Yemeni (74) respondents.

3.7.3 Respondents reporting drug use by region (n = 2, 078)

Table 6 shows the same sample of respondents reporting drug use and ethnicity by their regional location. This is not intended to be used as an indication of prevalence but rather to highlight the geographical spread of respondents reporting drug use.

Table 6: Respondents reporting drug use by region (n = 2, 078)

	East	East Midlands	London	North West	South East	West Midlands	Yorkshire & Humber	Total
Drug Users	17	184	1,121	251	51	386	68	2,078
% of total	1%	9%	54%	12%	2%	18%	4%	
% BME ¹⁴ population	5%	5%	48%	8%	7%	13%	7%	

The largest concentration of respondents is in London (54%) followed by the West Midlands (18%) and the North West (12%). These are the areas from which most existing data on drug use within Black and minority ethnic populations have been gathered (Sangster et al. 2002; Fountain et al. 2003). They are also the areas of England with the largest numbers of Black and minority ethnic resident populations.

In summary, respondents reporting drug use are from 24 ethnic and national groups and are located in eight of the nine English regions. The largest concentration of respondents reporting drug use is in the South Asian communities (40%) followed by Black African (29%). The largest concentrations of respondents are in London, the West Midlands and the North West, which corresponds to the resident concentrations of Black and minority ethnic populations.

3.7.4 Respondents reporting substances used and ethnic group (n = 1, 571)

This sample is drawn from 29 reports in which data are provided on substances used and ethnicity. Table 7 shows these respondents by ethnic group.

Table 7: Respondents reporting substances used by ethnic group (n = 1,571)

	Black African	Black Caribbean & Black African	South Asian	Middle eastern	Chinese	Greek/Greek Cypriot	Unspecified	Total
Number	525	63	587	124	16	19	237	1, 571
% of total	33%	4%	37%	8%	1%	1%	15%	

The largest group of respondents is South Asian (37%) followed by Black African (33%).

In comparison to the data in the previous section on all

¹⁴Annual Local Area Labour Force Survey 2001/02. ONS.

respondents reporting drug use (table 5) this sample contains: 87% of the Black African respondents (n = 605)

26% of the combined Black African and Black Caribbean respondents (n = 239)

70% of the South Asian respondents (n = 831)

All of the Middle Eastern, Chinese, Greek/Greek Cypriot and those whose ethnicity is unspecified are included.

The largest difference between the two samples is within the combined Black African and Black Caribbean category, which is three quarters reduced.

NB. There are 194 Black African and 75 Middle Eastern respondents reporting khat use. Khat is a legal substance in the UK but is included here owing to the number of respondents reporting its use.

3.7.5 Substances used

For the most part respondents were asked an open question about which substances they had ever used. Caution should be exercised in drawing any firm conclusions about substances that are not mentioned as there are various reasons why respondents may have chosen to omit them. For example, 10 respondents reported use of methadone and 158 report using heroin. As methadone is the primary treatment for heroin addiction it might have been expected that more of those using heroin would have reported methadone use. However, it may be that these respondents did not consider methadone as a 'drug' but rather as a medicine. Respondents may also be reluctant to reveal use of substances that are viewed as carrying greater risk or stigma such as heroin and crack.

Table 8 shows the percentage use of substances amongst the respondents. Only those substances that are reportedly used by 5% or more respondents are included in the table.

Table 8: Substances reported to have been used by respondents (n = 1,571)

	Cannabis	Cocaine	Heroin	Khat	Crack	Amphetamine	Ecstasy	Other*
% use	51%	19%	10%	18%	5%	6%	10%	9%
Number	804	306	158	287	75	89	160	138

*The category 'other' includes LSD (56); poppers (29); magic mushrooms (15); Ketamine (12); methadone (10); paan (9); steroids (4); GHB (2); ice (1)

Cannabis is the most widely reported drug used (51%) followed by cocaine (19%) and khat (18%). Heroin use is reported by 10%.

The following sections describe substance use by ethnic group.

Cannabis

Cannabis use is reported by more than half the sample of drug users. It is also the substance that receives most attention in the reports, usually in the context of debate about its legalisation or decriminalisation:

"The group felt that it is not a big issue to take cannabis now

a days. They highlighted that it is so common... Most people in the group agreed that cannabis should be legalised." (Ethnic Minorities Health and Social Care Forum, Blackburn. Page 22)

"The young people felt that there were certain drugs that should remain illegal and others that should be made legal; the one that most young people felt should definitely be taken into consideration was cannabis." (Kirklees Racial Equality Council, Huddersfield. Page 19)

"None of the young people participating felt that the illegality of Cannabis had any influence on the way young people perceived the substance." (Walsall ACIDS. Page 28)

"For a significant proportion of the population, it seems to be apparent that legalising cannabis is at the forefront of any discussion around drugs. However, within the Muslim community it would seem that cannabis is put in the same bracket as heroin/crack." (Project 8, Liverpool. Page 23)

Some respondents expressed concern that the policy on cannabis was confusing:

"The recent relaxation of the law in Lambeth, South London... in a way is implying that there is a split between policy makers regarding cannabis. Some Members of Parliament have been recently speaking openly about the need to legalise cannabis, whilst others vehemently oppose this suggestion. There is a need for officials to make up their minds as they may be sending mixed signals to people, particularly the young." (African Community Involvement Association, Croydon. Page 64)

Use of cannabis and racial stereotyping is reported. For example, that males within the Black Caribbean community are frequently perceived to be cannabis dealers:

"Black men are often approached by a substantial number of whites and other ethnic groups on several occasions asking for cannabis or where they can get some to buy." (Nguzo Saba, Preston. Page 11)

Table 9 shows cannabis use by ethnicity amongst the respondents:

Table 9: Reported cannabis use by ethnic group (n = 804)

	Black African	Black African & Black Caribbean	South Asian	Middle eastern	Chinese	Greek/Greek Cypriot	Unspecified
Number	237	54	380	21	7	19	86
% use of own ethnic group	45%	86%	65%	17%	44%	100%	36%
% use of all ethnic groups	29%	7%	47%	3%	1%	2.5%	10.5%

Table 9 enables comparisons to be made between the percentage reported use of cannabis within ethnic groups against the percentage reported use of cannabis amongst all cannabis users. Thus, it can be seen that while 45% of Black African respondents report using cannabis, they account for 29% of all its reported use. Amongst the combined Black Caribbean and Black African respondents 86% report cannabis use and they account for 7% of all users.

Cannabis use is more concentrated in the mixed Black African and Black Caribbean group. There is nearly double the amount of reported use in this group compared to the Black

African group. This may suggest that the Black Caribbean respondents account for this difference.

All of the Greek/Greek Cypriot respondents report using cannabis. Owing to the small number of respondents in the Chinese (16) and Greek/Greek Cypriot (19) groups it is not possible to draw any firm conclusions on comparative use for these groups.

Cocaine

Cocaine use is reported by 19% of respondents.

Cocaine use is not discussed in any depth within the reports, although the lack of services for non-opiate users is referred to in one (BME Housing Consortium (4) Young offenders, (page 36).

Table 10 shows reported use of cocaine by ethnic group.

Table 10: Reported cocaine use by ethnic group (n = 306)

	Black African	Black African & Black Caribbean	South Asian	Middle eastern	Chinese	Greek/Greek Cypriot	Unspecified
Number	117	19	130	1	1	5	33
% use of own ethnic group	22%	30%	22%	-	6%	26%	14%
% use of all ethnic groups	38%	6%	42%	-	-	1.6%	11%

Table 10 shows that cocaine use is more concentrated amongst the mixed Black African and Black Caribbean group (30%). Reported use is the same for South Asian and Black African respondents (22%).

While nearly one third of the combined Black African and Black Caribbean respondents reporting drug use are cocaine users, these respondents account for 6% all reported cocaine use.

More than one quarter of the Greek/Greek Cypriot respondents report using cocaine.

Crack

Crack use is reported by 5% of respondents.

Table 11: Reported crack use by ethnic group (n = 75)

	Black African	Black African & Black Caribbean	South Asian	Middle eastern	Chinese	Greek/Greek Cypriot	Unspecified
Number	25	6	22		2		20
% use of own ethnic group	5%	9%	4%		12.5%		8%
% use of all ethnic groups	33%	8%	29%		2%		26%

Table 11 shows that crack use is concentrated amongst Black African (33%) and South Asian (29%) respondents. The combined Black African and Black Caribbean group report using nearly twice the percentage of crack use (9%) than in the Black African group (5%). This may indicate greater use of crack amongst Black Caribbean respondents.

Ethnicity is unspecified for a quarter of all those reporting use of crack, although it is known that these respondents will be

in the Black African, Black Caribbean or South Asian groups. Crack use is not reported by Middle Eastern or Greek/Greek Cypriot respondents.

Amphetamine

Amphetamine use is reported by 6% of respondents.

Table 12: Reported amphetamine use by ethnic group (n = 89)

	Black African	Black African & Black Caribbean	South Asian	Middle eastern	Chinese	Greek/Greek Cypriot	Unspecified
Number	21	13	28	1	0	5	21
% use of own ethnic group	4%	20%	5%			26%	9%
% use of all ethnic groups	23%	14%	31%	1%		5%	10%

Table 12 shows that amphetamine use is concentrated amongst South Asian (31%) and Black African (23%) respondents. One in five Black Caribbean/Black African respondents report use of amphetamines. There is a much higher proportion of amphetamine use amongst the Combined Black African and Black Caribbean group (20%) than in the Black African group (4%). This may indicate greater use of amphetamine amongst Black Caribbeans.

Heroin

Heroin use is reported by 10% of respondents.

Table 13: Reported heroin use by ethnic group (n = 158)

	Black African	Black African & Black Caribbean	South Asian	Middle eastern	Chinese	Greek/Greek Cypriot	Unspecified
Number	54	8	68	-	3	3	22
% use of own ethnic group	10%	13%	11%	-	19%	16%	9%
% use of all ethnic groups	34%	5%	43%		2%	2%	14%

Table 13 shows that most reported heroin use is by South Asian respondents but only 11% of all the South Asian respondents report using heroin. Similarly, while 10% of Black African respondents report heroin use they account for one-third of all reported heroin use. The reported level of heroin use for South Asian and Black African respondents is similar.

Ecstasy

Ecstasy use is reported by 10% of respondents

Table 14: Reported ecstasy use by ethnic group (n = 160)

	Black African	Black African & Black Caribbean	South Asian	Middle eastern	Chinese	Greek/Greek Cypriot	Unspecified
Number	16	27	73		5	6	33
% use of own ethnic group	3%	42%	12%		31%	31%	14%
% use of all ethnic groups	10%	17%	45%		3%	4%	20%

Table 14 shows that ecstasy use is most concentrated amongst the South Asian respondents (45%). Ecstasy is reported as being used by 42% of Black Caribbean respondents. Nearly one third of the Greek/Greek Cypriot respondents report use of ecstasy.

There is no reported use of ecstasy by Middle Eastern respondents.

Summary

What all of the above tables show is that there are distinct patterns of drug use reported amongst respondents by ethnic group. South Asian reported drug use is more characterised by use of heroin (43% of all users) than crack (29%). Reported South Asian drug use is also characterised by use of a wider range of substances e.g. 45% of ecstasy use is reported by South Asian respondents. (45% of all reported LSD use is also by South Asian respondents).

Black African reported drug use is characterised by both crack and heroin. Comparative differences between Black African respondents and the combined Black Caribbean and Black African group may indicate that Black Caribbean drug use is characterised by crack, amphetamine and ecstasy.

There is no reported use of crack, heroin or ecstasy by Middle Eastern respondents.

Khat

In total there are 287 khat users amongst the sample of respondents reporting drug use (18%). Most of these report use of khat as the only substance used, although some respondents report using it with alcohol and other drugs.

Table 15: Reported khat use by ethnic group (n = 287)

	Black African	Middle eastern	South Asian	Unspecified
Number	194	75	14	4
% of own ethnic group	37%	60%	2%	-
% of all ethnic groups	67%	26%	5%	-

Khat use is not reported as being used amongst Chinese, Black Caribbean and Greek/Greek Cypriot respondents.

Table 15 shows that a little over one third (37%) of all Black African respondents report using khat and that two thirds of all reported khat use is within this group. The second largest group reporting use of khat is Middle Eastern (26%). Amongst this group 74 respondents are Yemeni and there is one Iraqi respondent reporting use of khat.

The table shows that 5% of all khat use is reported by South Asian respondents.

As there is generally less attention given to khat use than other substances in the literature on drugs (Fountain et al. 2003) and given the number of respondents reporting khat use a more detailed exploration of khat use is provided here. The majority of respondents reporting khat use are Yemeni, Somalian, Eritrean and Ethiopian. There is a mixed attitude to khat amongst respondents. Some are reported as regarding khat negatively while for others it is an important and functional part of the culture:

"I take khat mostly for a purpose, that is to study and to

focus my attention to a particular thing. I was grown up with khat, I do not see khat as a drug at all." (Ethiopian Community in Lambeth, London. Page 31)

"They did not see khat as a drug. They saw khat as a cultural thing... Anything which is part of culture is permissible and right." (Nilaari Agency and Black Orchid, Bristol. Page 56)

"...the use of khat is a significant health risk within the Somali, Eritrean and the Arabian Peninsula Community in Greenwich." (Eritrean Community in Greenwich and Lewisham, London. Page 9)

"This drug (khat) is eating at the fabric of society at every level. It is an economic drain as well as social ill that has a devastating effect on the nucleus of society – the family. What once was considered leisure has now become a necessity, even more necessity than food." (Yemeni Community Association, Sandwell. Page 116)

The Eritrean Community in Greenwich and Lewisham, London provide some useful background information:

"The plant khat can now be purchased legally throughout major European capitals. Chewing fresh leaves of the khat shrub is a common social tradition in certain countries of East Africa and the Arab peninsula, and is a socially accepted as drinking in Western countries. In Somali, homes often include rooms called 'mufrage' where family and friends, male and female, come together for discussions or to listen to music while they chew chat." (Eritrean Community in Greenwich and Lewisham, London. Page 11)

The majority of respondents reporting khat use are Muslim. Although khat is legal in the UK there are different views about its relationship with Islamic law:

"Chewing of Chat is against the Islamic religious belief." (Eritrean Community in Greenwich and Lewisham, London. Page 23)

"Majority of participants believed that Islamic law does not prohibit Qat use..." (Yemeni Community Association, Sandwell. Page 116)

Some respondents suggest that khat has been used within religious practices:

"...the Muslim religion leaders were also known for using khat to concentrate on their meditation. Hence, drugs such as Cannabis and khat have a long history in connection with the Ethiopian most ancient religions...." (Ethiopian Community in Lambeth, London. Page 4)

Respondents express concerns about the time and money that (particularly men) spend on using khat, and the impact that this had upon women and families.

"The Somali women however, feel that khat was causing considerable harm to their families and the community in Greenwich and that it should be banned." (Eritrean Community in Greenwich and Lewisham, London. Page 25)

That said, some respondents report an increase of khat use amongst women:

"While questionnaires suggest that there has been a recent shift of attitude towards the casual use of khat by Somali women, and an increase in usage by this group, there still remains a stigma against female usage, making khat use

'hidden' addiction among Somali women. 61% of men disagree with the statement 'It is alright for women to chew khat', in contrast to 16% of women.' (Somali Health & Mental Health Link, London. Page 28)

Others suggest that gender differences in attitude towards khat use may be attributable to different ways in which men and women use khat:

"... Traditionally khat has been associated with male sub-culture and group interaction. This state of affairs is compounded by the use of khat as a male 'rite-of-passage' from father to son, upon impending manhood, from the age of 14 (approximately). In contrast, far from being introduced to khat by parent females have tended to keep their khat use secret from their parents, and wider society." (Somali Health & Mental Health Link, London. Page 29)

Women are reported as being 12 times more likely to use khat regularly on their own than men. Twice the number of male users than female said that they had never used alone. (Somali Health & Mental Health Link, London. Page 29). Solitary use of khat is seen as indicative of more problematic use:

"Traditionally, khat has been a feature of Somali social occasions, at Weddings Funerals, Parties, and Religious ceremonies... Male and female solitary use is consistent with the perception of an increase in 'problematic' usage of khat by the community." (Somali Health & Mental Health Link, London. Page 30)

The authors of the above, conclude that higher levels of solitary khat use amongst women is partly a result of the extra stigma they face. Other factors reported include, higher rates of employment and child care responsibilities all of which are thought to limit the scope for more social and peer orientated use.

More women than men are reported as feeling that their khat use is out of control:

"Male-Female comparisons yielded some interesting outcomes, which suggests that women (70%) feel their usage to be out of control to a greater extent than their male counterparts (56%). Higher rates of women (76%) worried about their khat use than men (52%), and more women wished they could stop usage (72%) than men (52)." (Somali Health & Mental Health Link, London. Page 15)

Respondents state that people are introduced to khat at a young age:

"...33.3% of the male gender respondents stated that they were introduced to Qat when they were less than 16 years old. This is quite disturbing...It suggests that it is the youngest members of the community that are more vulnerable to Qat use and that any programme of action must take into account this factor." (Yemeni Community Association, Sandwell. Page 75)

"They expressed concern regarding the use of khat and cannabis amongst the youth in their community." (Project 8, Liverpool. Page 18)

Problematic use of khat is reportedly a financial burden:

"...many people in the Community are unemployed, and are on Income Support. Chat was a drain on this little family income leaving most families in financial difficulties and

unable to afford other household essentials such as food, clothes etc." (Eritrean Community in Greenwich and Lewisham, London. Page 23)

"The greatest problems of Qat are of social and economical nature..." (Yemeni Community Association, Sandwell. Page 116)

"Most respondents tended to spend less than £16 a week, on average. On the other end of the scale, approximately 5 individuals stated spending between £50 and £101 a week." (Yemeni Community Association, Sandwell. Page 78)

More women than men report spending large amounts of money on khat use:

7% of women reported to spending over £150.00 per month on khat as opposed to 2% of men. (Somali Health & Mental Health Link, London. Page 36)

Khat is said to have a detrimental impact on employment prospects by some respondents:

"Prolonged use of khat by Somali men could be seen as one of the barriers to the unemployed men seeking employment." (Eritrean Community in Greenwich and Lewisham, London. Page 25)

Khat use is also reported as time consuming and an activity that can leave the user drained and tired:

"Majority 75.9% of the respondents stated that they use Qat for between 4-6 hours every time, while just fewer than 18.5% stated usage of over 6 hours... Add this to the effect caused by Qat such as tiredness and sleeplessness and then collectively you have a fairly disruptive form of living, largely dominated by chewing sessions and subsequent after effects." (Yemeni Community Association, Sandwell. Page 79)

In addition, a number of specific health concerns were raised. These included: sleeplessness; malnourished children; mouth problems; paranoia and hallucinations; loss of appetite; diarrhoea; stomach aches; high blood pressure and constipation. There is some suggestion that these symptoms may be linked to the use of pesticides if the khat is not washed thoroughly.

Some respondents report use of other substances in addition to khat:

"It also should be stated that Alcohol abuse sometimes goes hand-in-hand with khat use. Alcohol is sometimes imbibed after prolonged khat sessions." (Somali Health and Mental Health Link, London. Page 26)

"In the last month (prior to questionnaire), 28% of women took cannabis, as opposed to 14% of male respondents. While 7% of women took Ecstasy, as opposed to 2% of men." (Somali Health & Mental Health Link, London. Page 39)

"With regard to drug usage, men seemed to be more experimental with an entire range of other drugs (Drugs Listed: Cannabis, Coke Powder, Crack Cocaine, Amphetamines, Ecstasy and Heroin), besides khat, women seemed to be relatively heavier users of cannabis and ecstasy." (Somali Health and Mental Health Link, London. Page 39)

In summary, there is high proportion of khat users amongst the respondents who reported drug use (18%). Khat use is concentrated amongst Yemeni, Somalian, Eritrean and

Ethiopian respondents. There is some khat use (5%) reported amongst South Asian respondents.

Khat use is associated by many - but not all - respondents with a wide range of social, economic and health related harms.

Traditional substance use

While there is only limited reporting of traditional substance use other than khat amongst the respondents (9 report using paan¹⁵) it is reported that use of traditional substances is common amongst some communities or groups:

"...98 of the 160 respondents (61.3%) were aware that Igbo people took traditional substances..." (The Igbo and Tutorial School, London. Page 26)

The most commonly reported traditional substances are khat and paan but there are others about which very little is known in the UK. In excess of thirty traditional substances are reported as being used by the Igbo community including home brewed and traditional alcoholic beverages. (The Igbo and Tutorial School, London. Page 26)

Traditional substances are often associated with patterns of drug use in the home countries of the respondents.

"...There is a lot of Phang¹⁶ in Pakistan, especially Mirpur area and people carry on using it there." (Asian Anti-Drugs Initiative, Halifax. Page 30)

Some respondents report that use of traditional substances is medicinal such as the use of herbs to treat malaria.

Respondents report that little is known about the affects of some of these substances:

"There is even less literature or research on the effects and patterns of use of other drugs that are prevalent within the Asian community. Examples of such drugs that are used on a daily basis include tobacco chewing products, betel nuts, gutkha¹⁷ and paan." (Three Faiths One Issue, Leicester. Page 36)

It is unclear what is known about the affects of these substances and what, if any potential there is for recreational or problematic use. For instance, amongst 98 Igbo respondents reporting on traditional substance use: 25 say they are used for recreation or entertainment; 7 to make themselves high; 12 for stimulation; 5 for a 'buzz'; and 4 to lift their mood. (The Igbo and Tutorial School, London. Page 27)

The Igbo and Tutorial School conclude that:

"The extent and characteristics of the misuse seem to suggest the possibility of a greater underlying problem than is apparent..." (The Igbo and Tutorial School, London. Page 42)

Respondents in other groups report that use of traditional substances is harmless:

"... However, Asian drugs were not perceived as being addictive or harmful but taken for medical purposes. These

were also seen as being socially acceptable." (Ethnic Minorities Development Project, Wakefield. Page 61)

Three Faiths One Issue, Leicester make the point that the lack of knowledge about traditional substance use amongst primary care workers and service providers means that these substances receive very little attention and there are no developed service responses to addressing problems:

"...it appears that very few service providers including GPs appear to have prioritised the treatment of the type of drugs that are in daily use within the Asian community. This implies that apart from some limited health promotional work that is being done, there appear to be no effective services for counselling around these dependencies, until perhaps it is too late." (Three Faiths One Issue, Leicester. Page 37)

In summary, there are respondents using traditional substances and they report mixed views about whether this is harmful or not. There are a number of substances about which little is known and there has been limited investigation of the potential for their problematic use.

3.7.6 Respondents reporting drug use and gender (n = 1, 124)

This sub-sample is derived from 20 reports that contain data on respondents reporting drug use and gender.

Table 16: Gender of drug users (n = 1, 124)

	Number	% of total	% of all those reporting drug use (n = 2, 078)
Men	758	67%	36%
Women	366	32%	17%

Nearly one third (32%) of respondents reporting drug use and gender are women.

The ethnicity of the female respondents reporting drug use is as follows:

Table 17: Female respondents reporting drug use by ethnicity (n = 366)

	Black African	Black Caribbean	Chinese	Greek & Greek Cypriot	Middle eastern	South Asian	Unspecified
Number	101	27	1	12	17	107	101
% of total	27%	7%	-	3%	5%	29%	27%

Amongst the female respondents reporting drug use, most are South Asian (29%) followed closely by Black African (27%) and those who have not specified ethnicity (27%). As the unspecified group are known to contain respondents from the Black African, Black Caribbean and South Asian groups it can be said that, 84% of all female respondents reporting drug use are from these three groups.

Although the sample size is small, the Greek and Greek Cypriot group contains a high number of female respondents reporting drug use (12 of 19).

¹⁵Paan – a green leaf preparation filled with either tobacco or betel nut. Paan is normally chewed or masticated in the corner of the mouth.

¹⁶An intoxicating leaf with similar effects to that of cannabis available in the sub continent. Normally drunk in milk or smoked.

¹⁷Gutkha contains a tobacco mix and is available in small packets or tins (Three faiths One Issue, Leicester. Page 36).

It is repeatedly reported that more Black and minority ethnic men than women are using drugs:

“The extent of drug use amongst females was felt to be considerably lower than males...” (Youth Awareness Programme, Leeds. Page 30)

Some female respondents reporting drug use link this to experimentation and rebellion:

“ Our parents believe that they brought us up in the best possible way, but when you are out with your friends, you are in a different environment and you lead a different lifestyle. You are growing up and developing yourself, and as soon as you hit puberty, you want to explore or rebel. This is a general feeling, it isn’t just about wanting to experiment with drink and drugs.” “I’ve taken drugs but it was just curiosity. I wanted to know what it would be like. I’d grown up hearing all sorts of stories, but although I was a strong person, I was tempted to find out what it would be like.” (Ethnic Minorities Health and Social Care Forum, Blackburn. Page 26)

The African Community Involvement Association (Croydon) report on the role that women may play in carrying drugs for male friends:

‘There was some discussion about drugs often being carried by girls or young women for their male friends, as women were less likely to be searched before going into clubs, by the club door assistants or the police.’ (African Community Involvement Association, London. Page 31)

A few respondents report injecting by female drug users:

‘We interviewed a local pharmacist based in...He also told us that he had seen a lot of young Asian women who were injecting Heroin for reasons that he could not specify.’ (Southall Community Drugs Education Project, London. Page 35)

“My first experience was with a spliff (cannabis) when I was 17 years old...It was offered to me by a school friend...I was a young Arab, Muslim girl... torn between two worlds ...I started increasingly to withdraw within myself and cannabis was a good release for this...Escapism and denial, I believe was a large reason for my use of that substance...I ended up in an Asian women’s refuge...I had ended up on the streets... mixed with squatters in London, who took all sorts of drugs one of which was heroin. That was the start of the worst decline of all...You are constantly on a mission to get it - this takes time, effort and concentration and at the end of it, once you inject it into your blood stream – it takes over your whole being – it switches off your brain – you are comatose ‘till it wears off then you have to be on another mission to get it – you have no time to think.” (Iraqi Welfare Association, London. Appendix V)

Some respondents report that heroin use amongst women is increasing:

“Many young Black Minority Ethnic women are slowly taking up this habit. Much more understanding into some of the hardships that young women face needs to be understood. Young women don’t face hardship from family only but from the whole culture and community and it can get very stressful and sometimes women choose the easy way out and it is not always the right way out.” (Kirklees REC. Page 29)

In summary, the proportion of female respondents reported to be using drugs is lower than that of men (32%).

Approximately one in three respondents reporting drug use are women.

The largest concentration of female respondents reporting drug use is South Asian (29%).

While most respondents report that there is less drug use amongst women, others acknowledge that this is changing.

Some respondents report injecting by women drug users.

Some report that heroin use is increasing amongst Black African women.

3.7.7 Respondents reporting drug use and current age (n = 643)

Table 18 shows the numbers of respondents reporting drug use and current age. The data comes from 18 reports.

Table 18: Respondents reporting drug use and current age (n = 643)

Age range	11 – 16 years	17 – 21 years	22 – 31 years	32 – 41 years	42 – 51 years	Above 52 years
Number	82	333	148	40	24	16
% of recorded	13%	52%	23%	6%	4%	2%

The majority of respondents reporting drug use and current age are under the age of 22 years (65%). 12% of respondents report being over the age of 31.

Table 19 shows the age range of respondents by ethnic group.

Table 19: Respondents reporting age and ethnic group (n = 643)

	11 – 16 years	17 – 21 years	22 – 31 years	32 – 41 years	42 – 51 years	Above 52 years	Total	% of total
Ethnic group								
Black African	12	39	45	25	16	3	140	22%
Black Caribbean	16	13	17	11	3		60	9%
South Asian	12	186	46	2	5	13	264	41%
Turkish			5	2			7	1%
Chinese	1	2					3	.5%
Middle Eastern		44	6				50	8%
Unspecified	22	49	29				100	15.5%
Greek	19						19	3%
Total	82	333	148	40	24	16		
% of total	13%	52%	23%	6%	4%	2%		

The largest group for which age is recorded is South Asian (41%). Most of these are under the age of 21 (75%).

47% of Black African respondents are over 41 years of age.

All of the Greek/Greek Cypriot respondents are under the age of 17.

13% of respondents are under the age of 16.

Three quarters of respondents reporting drug use are between 17 and 31 years old.

Age of first use

205 respondents report age of first drug use:

- 69% state this was under the age of eighteen (of these 33% state their age of first use as under 15).

Only 17% stated that they commenced using drugs over the age of 20.

Some reports provide data from interviews with respondents in which they describe their first drug use:

Pakistani User 16-25

"I started with cigarettes when I was 14-15 years old. I moved on to weed at the age of 16 and then heroin...I went on to injecting but mainly stuck to smoking..."

Pakistani User 26-50

"I started with cigarettes and glue when I was 14 and then up to the age of 25 I had used weed, speed, Es, and cocaine on and off. Since then I have used heroin constantly and am still using it."

Bengali User 16-25

"When at school peer pressure from older friends. I wanted to be in with the crowd. Older friends offered me cannabis so I took it. I don't blame my friends. I started with cigarettes at 12 went cannabis at 15 used it heavily till 18. 16-18 tried cocaine once. I spent £120 in 5 minutes. So I just stuck to cannabis and I used to spend £90 a week on it and my two friends spent the same amount, so totally £180 a week on cannabis." (Youth Awareness Project, Leeds. Page 75)

Reported reasons for drug use

243 respondents reported the reasons why they started to use drugs.

36% state their drug use was for pleasure:

"Recreational use was the main reason given for taking drugs, with ecstasy being taken to feel good, to have a good dance and to loose inhibitions...More of my drug taking these days is based around taking cannabis/ecstasy at home and having sex. Taking drugs is not always about being in a club. Or sometimes I will just go to a party at a house and it will turn into a sex party as everyone is there with their boyfriends or girlfriends and it tends to happen on the drugs." (Black Health Agency, Manchester. Page 16)

"Basically people take it to get a buzz out of it, like a – I don't know – some fun they get out of it." (Bangladeshi Youth League, Luton. Page 17)

30% related their drug use to trying to avoid or deal with problems:

"The majority of the drug users said that family pressures, recreational use and unemployment pushed people to use drugs. The drug user who used the services provided by drug agencies said that financial problems as well as family problems pushed people to use drugs. He continued to say that the reason he started using drugs was as result of the death of a family member." (Day Mer Turkish and Kurdish Community, London. Page 31)

22% said that they started using drugs for experimentation and 15% linked their drug use to peer influence:

"All of the respondents commented that they had first used drugs in the presence of friends. Two illustrative comments... 'Through friends. But never pressurised. Just wanted to see what it was all about – interesting/new... 'Friend got some from his older brother's friend. And all the guys in our gang just tried it.'" (Bangladeshi Youth League, Luton. Pages 17 - 18)

"A majority of the respondents said that they started because their friends took drugs and due to peer pressure." (Asian Anti-Drugs Initiative, Halifax. Page 51)

"...respondents to this research were introduced to drug taking by a close associate. If we total up the numbers of family and friends we see 154 people (71%) of the respondents made contact with drugs via their intimates." (Congolese Refugee Women Association, London. Page 20)

Reported sources for obtaining drugs

The majority of drug users state that they were first introduced to drugs by friends and close associates:

"The majority of the respondents bought their drugs through personal contacts. Nearly one-third (32.3 %) bought them from their friends and the same number bought them through other contacts that they had." (Three Faiths One Issue, Leicester. Page 43)

"The drug users were asked who they approached when they could not have drugs. All of them said that they approached their friends who were drug users." (Day-Mer Turkish and Kurdish Community Centre, London. Page 29)

"The most common factor in this was very clearly the category friends. A large majority of the people interviewed, both males and females placed friends as one of the most, if not the most, influential factors in their introduction to alcohol/substance use." (Derby Millennium Network, Derby 16)

African Health for Empowerment and Development, London. (Page 22) report that 66% of current drug users stated that they were first introduced to drugs through friends, at parties and social gatherings or at school.

BME Housing Consortium Wolverhampton (4) Young offenders. (Page 18) report that 78% of respondents obtained their first drugs from their friends.

Siblings are also cited by some respondents as being the source of first contact with drugs:

... in the focus group discussion it was highlighted the means of obtaining drugs is not necessarily through the highly publicised social belief of drug dealers waiting at school entrances, but rather from an immediate member of the family. The majority had obtained drugs from elder 'sisters' and 'brothers', and some had witnessed 'cannabis smoking' by their parents." (BME Housing Consortium, Wolverhampton (4)Young offenders. Page 33)

In summary, respondents reporting drug use and age are predominantly young; two thirds are under the age of 21. The highest proportion of young respondents (41%) is South Asian, 75% of whom are under the age of 21. The largest proportion of older respondents (47%) is Black African. Taken together, peer influence, experimentation and pleasure seeking account for 74% of respondents' reported reasons for starting to use drugs. Most respondents report that they primarily obtain their drugs through friendship networks.

3.7.8 Respondents reporting knowledge and experience of drug treatment services (n = 421)

421 respondents reporting drug use were asked about their knowledge and experience of drug treatment services. These data are not reported by ethnicity.

12% report that they have no knowledge about or experience of drug treatment services:

"None of the people in this group stated that they had ever used or approached services. The reasons given for not accessing services included not knowing that the services existed (6 stated this), not believing that the services could help them (7 stated this), feeling that they could handle the problem themselves and did not need help (5 people stated this)." (African Community Involvement Association, London. Page 25)

"There's lots of drugs around but not enough places you can go to talk to. If there was help locally, maybe I would, you never know." (Bangladeshi Youth League, Luton. Page 20)

Most respondents (78%) report having some knowledge about drug treatment services but this is limited to knowing a service exists. There is confusion about what drug treatment services are for:

"When asked if they were aware of the drug provisions in prison many were aware of CARAT¹⁸, but had very little knowledge of what the service entailed." (BME Housing Consortium, Wolverhampton (4) Young offenders. Page 30)

"...they were also unaware of the existence of many of the agencies or of what they did. There was a perception of drugs agencies being solely a place where methadone was dispensed." (Black Health Agency, Manchester. Page 18)

"A majority of the respondents had not used a drug service provider. One had a misconception about drug services and said that he didn't need to go to them because he didn't use needles." (Asian Anti-Drugs Initiative. Page 53)

10% of respondents report using a drug treatment service. Most report that in their experience the services did not meet their particular needs:

"Those who had requested for intervention were deeply disappointed, 'seen three CARAT workers, not helpful', another said 'they don't help you...problem with waiting list...'. A few respondents expressed, 'only you can help yourself.'" (BME Housing Consortium, Wolverhampton (4) Young offenders. Page 30)

Southall Community Drugs Education Project, London. (Page 27) report that half of the respondents reporting use of a drug treatment service said that it had not been successful.

That said, some drug users who had accessed services reported that their experience had been good:

"Those that had accessed these services felt that the help, advice and information they had received was very good." (Derby Millennium Network, Derby. Page 18)

Some respondents expressed a preference for a worker from their own ethnic group:

"Prefer it to be Asian because it's easier that way. You won't feel like he's laughing at you behind your back like it would if it was a non-Asian counsellor. You just feel like he's on your side and he really wants to help you out of it."

"Because then I'd be able to speak without being tight." (Bangladeshi Youth League, Luton. Page 20)

This opinion was not universal however:

"...one interviewee would not want to see a black worker while living in Manchester as she felt that her family would find out." (Black Heath Agency, Manchester. Page 20)

"There was further contradiction when respondents were asked whether there should be more 'black workers' in the field of drugs work. Over a half of respondents felt it was not a necessity to have a 'black focused' service, but later commented 'more black workers.'" (BME Housing Consortium, Wolverhampton (4) Young offenders. Page 31)

Some respondents report that they had not thought about seeking help or did not perceive of themselves as being in need of any help:

"Many of the people that we spoke to did not really see their substance use as excessive and that could be a contributing factor that prevents people from seeking support." (The Derby Millennium Network, Derby. 18)

"When the issue of treatment was raised majority of respondents did not consider asking for help. Only two respondents had asked for advice, moral support and practical help..." (BME Housing Consortium, Wolverhampton (4) Young offenders. Page 30)

"A few of the people we interviewed had been referred to services. This was either to agencies or personal councillors at colleges and university. Very few people had accessed services on their own initiative for treatment for addiction." (The Derby Millennium Network, Derby. Page 18)

In one report, 99% (54) of respondents who use khat report never having accessed a drug service. (Ethiopian Community in Lambeth, London)

In summary, there are a small number of respondents reporting experience of using drug treatment services (10%). Of those who have used a service their experience is mostly reported as negative.

Some respondents report that they would not use a service because they do not perceive themselves as having a drug problem.

There are misconceptions about what drug treatment services do.

¹⁸CARATS Care, Assessment, Referral, Advice and Throughcare Services.

4. THE CONCLUSIONS AND RECOMMENDATIONS

The following sets out the main conclusions and recommendations from all of the reports. They have been grouped as follows: drug education and awareness; increasing access to drug treatment services; community safety; diversity, communities, and neighbourhood renewal.

4.1 Drug education and awareness

One of the overwhelming issues to arise from the needs assessments is the relatively low level of awareness about drugs within the communities that were involved and this is reflected in all of the reports' recommendations:

"The need to raise awareness of drug use, signs and symptoms amongst the BME community as a whole is essential as young people are turning to their family and peers for support." (BME Housing Consortium, Wolverhampton (1) Young people. Page 44)

"The development of drug awareness campaigns so that local communities know facts rather than fiction about drug misuse. These should be delivered in a way that is sensitive to the culture and religion of the local communities." (Ethnic Minority Health and Social Care Forum, Blackburn)

"A campaign to raise awareness about drug use/misuse is urgently conducted within the Greek and Greek Cypriot Community, particularly amongst parents." (Greek and Greek Cypriot Community of Enfield, London. Page 24)

Many reports highlight the need for drug education focused on parents:

"...One to one and group sessions on drugs related issues for the parents in relevant community languages, on drug names, effects and symptoms so they can better help their children against drugs...." (Asian Community Forum, Lancashire. Page 45)

The value of drug education involving elders in the community is highlighted:

"There should be a concerted effort to engage Elders in discussions and training around issues of drugs misuse. This could not only help to broaden their personal knowledge base, but as pointed out by the elders, the knowledge base of the wider Caribbean and multi-cultural society." (BME Housing Consortium, Wolverhampton (3) Dual Diagnosis. Page 38)

Many groups recommend that drug education materials need to be produced in community languages:

"Also to consider and investigate ways of making health educational information more relevant to the Arabic / Muslim communities..." (Iraqi Welfare Association, London. 38)

"Findings suggest that there is need to develop appropriate leaflets and education materials for both Youths and their Parents, in order to help them understand what drugs education is for and why it takes place." (The Igbo and Tutorial School, London. Page 44)

"There is a need for more leaflets about drug misuse, health risks and service providers in Kurdish and Turkish." (Day-Mer Turkish and Kurdish Community, London. Page 53)

"Another important factor to consider is that the material needs to be in the relevant languages and in a format that can be understood." (Derby Millennium Network, Derby. Page 24)

"To provide literature, publications & videos on drugs & alcohol misuse in different community languages." (Saville Town Community Association, Dewsbury. Page 35)

"To make available information that would be accessible to the whole community. This means translating it into the appropriate languages and making it culturally sensitive." (Project 8, Liverpool. Page 26)

Asian Community Forum, Lancashire and others also recommend drug education using different media including the Black and minority ethnic media:

"A wider dissemination of information for example, through relevant community newspapers, Asian radio and television programmes and community gathering and festivals." (Asian Community Forum, Lancashire. Page 46)

Drug education resources in non-written formats recognising levels of illiteracy in some communities is recommended:

"Varying levels of literacy amongst community members should be catered for with a range of written, audio and visual information sources." (Chinese National Healthy Living Centre, London. Page 99)

Some groups call for a fully integrated programme of drug education targeting particular community groups and encompassing wider issues:

"The programmes should cover a wide range of issues including health risks, agencies, drug service providers, service access etc. They should particularly aim to make drug issues discussable in the community and overcome the existing taboos. These programmes should be run for both specific groups such as school children, parents, drug users etc and general groups to develop a wider understanding." (Day-Mer Turkish and Kurdish Community, London. Page 53)

"Drugs education should include issues, which are affecting young Asian youths of today such as racism, identity, family and peer pressures." (Holy Trinity Community Network Forum, Tameside. Page 39)

Others, particularly amongst Muslim communities, call for the involvement of religious organisations in drug education work:

"The mosques to take a key role in educating all against drugs & alcohol misuse in a religious perspective." (Saville Town Community Association, Dewsbury. Page 35)

"We recommend that local service providers and planners use places like mosques to cascade their messages across so that these institutions will instil into the local population the message of the harm that drugs do both from a health and religious point of view." (East Birmingham Community Forum, Birmingham. Page 42)

"Encourage guidance and support through the mosques and schools and other relevant organisations or bodies...All religious groups should work together, i.e. through inter-faith councils." (EMDA, Blackburn and Darwen. Page 57)

Some groups recommend education about traditional substances:

"We strongly recommend in the Qat issue that the Government should enable Yemeni communities in the UK and other groups concerned with the Qat issue to start addressing this problem in the community level through education, activities and awareness campaigns." (Yemeni Community Association, Sandwell. Pages 38 - 39)

"The Drugs Action Team and Health Authority needs to work in partnership with the two communities to ensure that appropriate translated leaflets in the two community languages relating to drugs misuse (particularly khat within the Somali Community); are produced and distributed within the two communities." (Eritrean Community in Greenwich, London. Page 26)

"Findings suggest that further work is needed to look closely at the traditional substances." (The Igbo and Tutorial School, London. Page 45)

"The Asian community wants more preventative and awareness raising work done and also wants treatment to focus on Class B and legal drugs such as tobacco chewing products." (Three Faiths One Issue, Leicester. Page 82)

Respondents recommend the development of campaigns and more research on khat use to try and prevent or reduce problems:

"The needs of these communities, particularly in putting in place a comprehensive preventative khat and other drugs misuse measures, must be met if we are to enable the relevant communities to live meaningful lives in Greenwich..." (Eritrean Community in Greenwich and Lewisham, London. Page 1)

"It is recommended that the research and development of the needs of BEM communities by services and commissioners, including a nation-wide research project on khat and its use in the UK." (Sheffield Black Drugs Service. Page 123)

4.2 Increasing access to drug treatment services

There is a strong sense of frustration that not enough has been done to address service access:

"The results of the findings were not really a surprise to those involved, however what is surprising is that although most of those in positions of authority are aware of issues relating to the community, nothing constructive has been done about changing the situation." (EMDA, Blackburn and Darwen. Page 53)

"The research has highlighted a potential gap between what local communities perceive the drug problem to be within the community and what local providers and commissioners prioritise. It seems that local drug priorities are led by the needs and demands of white clients, which mean that in practice, drug services largely focus on drugs such as heroin." (Three Faiths One Issue, Leicester. Page 82)

It is recommended that commissioners address service development for Black and minority ethnic drug users:

"The DAT needs to reflect in its future funding policy the diverse and unique needs of the Black and minority ethnic communities." (Southall Community Drugs Education Project, London. Page 58)

"It is important to link into the Joint Commissioning process and decisions on the spending of new monies for drugs. This should be the responsibility of the DAAT representative on the Needs Assessment Steering Group/ Black and Asian Reference Group." (Saaf Dil, Rotherham. Page 76)

"The evidence shows that a lot more systematic and strategic work needs to be done by providers and commissioners in order to create and develop more culturally appropriate services for the Asian community. This may include paying greater attention to commissioning arrangements and ensuring that as part of the contract providers are meeting the needs of the Asian community." (Three Faiths One Issue, Leicester. Page 85)

Other recommendations concern the representation of Black and minority communities on DATs and related forums:

"Restructure the DATs so that members from the Black and Ethnic Minority community and organisations can sit on the DAT boards to help them go beyond 'the tokenism.'" (Simba Community Alliance, London. Page 58)

"The development of a forum to represent the needs of black and minority ethnic communities and lobby the DAT for action to be taken..." (Smethwick Bangladeshi Youth Forum, Sandwell. 53)

Most groups recommend that services employ more Black and minority ethnic workers:

"In order for drug support agencies to provide an effective and culturally sensitive service for BME young people – they need to ensure that the composition of its staff is reflective of the BME community." (BME Housing Consortium, Wolverhampton (1) Young people. Page 44)

"Drug agencies need to employ more Kurdish and Turkish speaking staff in order to make their services more accessible to these communities." (Day-Mer Turkish and Kurdish Community, London. Page 53)

"...vigorously expand the employment of drug workers from Black and Ethnic Minority Communities in the drug misuse services, to enhance the cultural competency of drug misuse related service provision." (Simba Community Alliance, London. Page 59)

Community groups should be recognised as being able to play an important role in helping to disseminate information about drug services and how to access them:

"At present, Chinese community organisations have minimal provision for people seeking drug information and advice. These organisations, as key influences in the community, should be provided with adequate training in providing drug-related information and advice and in dealing with, and referring, drug users and their families." (Chinese National Healthy Living Centre, London. Page 100)

"CRWA needs to work with both sides of the bridge, on the one side providing a confidential and professional service for the community and, on the other, assisting expert services to help Congolese people into prevention and rehabilitation treatment." (Congolese Refugee Women's Association, London. Page 25)

"Stigma about drug use and using services amongst the black community may be addressed through, for example, providing information/drugs education; or through networking with

black groups and organisations to promote confidence in drugs services.” (Black Health Agency, Manchester. Page 25)

“Ensure that partnerships and networking are a reality between services, agencies and the voluntary sectors and that available resources and expertise are maximised.” (Youth Development Project, Bradford. Page 22)

There are recommendations regarding the use and availability of interpreters, particularly that they should be trained in issues in relation to drug misuse:

“Interpreters need training in terms of drug misuse....” (LEMDA, London. Page 60)

“Because of the language barrier, more of interpreting services is needed...” (Iraqi Welfare Association, London. Page 38)

Many groups recommend the introduction of telephone helplines as a way of increasing contact with Black and minority ethnic drug users and their carers or family members:

“As helplines are known amongst BME for advice and support for drug misuse – the possibility of a local drugs helpline where young people can then be referred to local agencies for further support needs to be investigated.” (BME Housing Consortium (1) Young people. Page 44)

“A phone line, to ensure even greater confidentiality, where good quality advice can be accessed is another possibility.” (Project 8, Liverpool. Page 26)

“Development of a bilingual Cantonese and English telephone help-line for Chinese young people and their parents.” (Wai Yin Chinese Women Society, Manchester. Page 38)

The following recommendations are made in relation to refugee and asylum seekers:

“There is a need for drug service providers to develop further partnerships and work with other agencies in the statutory, voluntary and community sectors, especially BME community organisations given the reluctance of Refugees and Asylum Seekers to approach statutory service providers directly, and as a consequence make serious contributions to reducing drugs misuse from a multi-agency perspective.” (BME Housing Consortium (2) Refugee and asylum seekers. Page 60)

“Drug service providers also need to advertise and make themselves more visible and accessible to the Refugee and Asylum Seeker communities.” (BME Housing Consortium (2) Refugee and asylum seekers. Page 61)

“...Young and unaccompanied Ethiopian minors are vulnerable and forced to pick up undesirable practices such as drug misuse due to their age, lack of experience, peer pressure and lack of guidance. They can be protected and get culturally appropriate guidance, if they are linked to their community.” (Ethiopian Community in Lambeth, London. Pages 44 - 45)

The need for more direct work with Black and minority ethnic drug users on the risks related to blood borne diseases is highlighted:

“Health and risk awareness amongst drug users was found to be lacking. Information about specific health issues (particularly HIV and hepatitis B and C) and other risks would enable those unwilling or unable to give up their drug use to practise harm minimisation.” (The Chinese National Healthy Living Centre, London. Page 101)

Some groups recommend that services should target crack and cocaine use within communities:

“...services need to be targeted at young Congolese people who are becoming increasingly involved in taking Class A drugs, particularly stimulants such as cocaine and crack cocaine.” (Congolese Refugee Women’s Association, London. Page 25)

Recommendations by some groups are focused on the need for services to be inclusive, recognising the diversity that exists within communities:

“Services provided in the community and published information ought to be inclusive of the Deaf Black and Ethnic Minority group. It seems that there is a lack of information available and that services may not realise they are inaccessible. This needs better investigation and the likely gaps identified with appropriate development for resolving this.” (LEMDA, London. Page 58)

“African society is an ‘oral society’, and therefore the most effective ways in which to raise awareness are through social events and gatherings, focus groups or drama, rather than through literature. However, information should also be made available, in English and other appropriate African languages where possible.” (ACIA, London. Page 36)

“The Chinese community is not homogeneous. Information and advice services should be sensitive to difference and flexible enough to cope with a diversity of needs.” (Chinese National Healthy Living Centre, London. Page 99)

“Therefore, the DAT have to acknowledge that there is diversity within communities, rather than there being an African – Caribbean and Minority Ethnic Community, there are in fact communities within communities who each have specific and diverse needs and deserve to have their views and perceptions reflected and heard.” (Walsall ACIDS. Page 24)

Many groups recommend that services ensure accurate recording of client demography and ethnic monitoring that is sensitive to the full diversity in local communities:

“Service-providers need to ensure data collated and kept include all ethnic breakdowns, as this indicates as to whether BME communities are accessing their services... A collective tracking system needs to be operated within all networking drug agencies to ensure a co-ordinated approach is delivered. There have been concerns with agency referral systems, where many referrals have slipped through the net as a result of poor co-ordination.” (BME Housing Consortium (4) Young offenders. Page 37)

“Perhaps statistics ought to be officially kept by Social Workers and other professionals so that they are monitoring how many Deaf Black and Ethnic Minority people and how many Deaf White people are drug misusing in order that comparisons can be made.” (LEMDA, London. Page 60)

Most groups recommend that services are needed for family members and carers:

“Drug service providers must recognise the influence and importance of the family in Chinese culture and be prepared to see the family as an inherent component of the drug treatment and support package, not as an additional extra.” (Chinese National Healthy Living Centre, London. Page 101)

"the need to have some type of separate service for family members." (RAIS Academy, Rochdale. Page 50)

"Increased number of family support workers, the needs analysis found that family members were often left alone to cope under extreme pressure and could not rely on the community for support for fear of stigma. Workers can provide often essential practical and emotional support in times of high need." (Southall Community Drugs Education Project, London. Page 54)

Most groups recommend more outreach services; greater advertisement of and promotion of services; and a pro-active response to contacting and engaging with communities:

"Outreach surgeries for those individuals that do not utilise services for fear of the community finding out they have drug problems." (ACIA, London. Page 37)

"Agencies who provide specific support for drug use need to publicise their services to the BME community and in particular to young people through relevant channels." (BME Housing Consortium (1) Young people. Page 44)

"Outreach work and education with young people. This could be developed with the Youth Service....Outreach work and elders. This could possibly be developed with Community Development and/or the police." (Saaf Dil, Rotherham. Page 75)

"I think we have to start with some form of outreach work, and then engage with the community both as volunteers or as mentors. I think it's almost a three-tier development process that will impact on the community's ability to link with main stream provision and main stream service providers/statutory organisations, then the communities delivery based on knowledge of it's own parent group, family group. Then there's the education side with young people prior to preventative work, outreach to them and allow them to access the knowledge base of breaking down the stereotypical boundaries, barriers and also creating space for their attainment." (Walsall ACIDS. Page 24)

"We need to provide street based support in the relevant localities reaching those considered hard to reach." (ACCAN, Oxford. Page 43)

Some groups recommend separate service provision for women that is located sensitively:

"Separate services for women which should be a place where they can seek advice and help with any drug related problems. The location for this place should not be in a busy place perhaps off the High Street." (East Birmingham Community Forum, Birmingham. Page 42)

The importance of primary care and involving GPs is emphasised:

"To look at whether services can be offered via GP surgeries." (Holy Trinity Community Network Forum, Tameside. Page 40)

"Increased education for GP's and additional funding/resources for those GP's with a high caseload of drug users...The drug user is often at a crisis point in their life and cannot wait a further 6 weeks for an assessment they need assistance 'there and then.'" (Southall Community Drugs Project, London. Page 55)

"Review of GP services for South Asian drug users..." (Youth Awareness Programme, Leeds. Page 91)

"...raise these issues with the physicians and the General Practitioners who are directly taking care of the local community members." (Supporting African Youth Development, London. Page 33)

Many reports recommend that workers in drug services receive training in diversity and cultural sensitivity:

"A programme of diversity training for existing professionals to highlight strategies for reaching minority ethnic groups in relation to drugs." (Smethwick Bangladeshi Youth Forum, Sandwell. Page 53)

"As service providers, schools, and police are not aware of the cultural and racial issues of the Black Minority Ethnic communities therefore this training should be adapted to enable them to perform an effective and efficient service." (Kirklees REC. Page 33)

"There is a need to develop and implement training programmes for all staff and drug workers, which include issues of drug misuse within the Refugee and Asylum Seeker communities." (BME Housing Consortium (2) Refugee and asylum seekers. Page 61)

"People running drug care services need to be trained in how to better provide services African-Caribbean people can access." (BME Housing Consortium (3) Dual diagnosis. Page 38)

"Devise a training programme for current service providers to enable them to provide culturally sensitive services." (Ethnic Minorities Development Project, Wakefield. Page 66)

"All workers, both BME and white, need to deal with personal and organisational issues around prejudices and ignorance around race and diversity. This should be done in the context of training sessions facilitated by specialist race awareness trainers." (Asian Anti-Drug Initiative, Halifax. Page 61)

Some groups recommended that mainstream services need to take on the responsibility for service provision to Black and minority ethnic communities and not just leave it to under funded and poorly supported groups to do this work:

"It is important that mainstream services take on their responsibilities fully and do not leave the work to under funded community organisations." (Saaf Dil, Rotherham. Page 75)

4.3 Community safety

Concerns about crime and disorder and drug dealing in particular were paramount amongst community respondents. This is combined with a sense that not enough is being done by the police and that communities are afraid to report drug related crime for fear of reprisals:

"...many residents and workers took the opportunity to raise concerns around what they perceived to be the inadequate and inappropriate levels of Policing in their communities." (Walsall ACIDS. Page 25)

"CCTV and police presence within the communities, which would provide more security and prevent the dealing of drugs on the streets." (Ethnic Minorities Development Project, Wakefield. Page 65)

This concern is particularly apparent in many of the northern towns:

"...The community needs to be aware of what issues affect the police as it does ultimately have an impact on the community as a whole. The Police only result in becoming a target for the community if they do not work with their local communities as has recently been highlighted in many of the race related riots in towns like Oldham and Burnley." (EMDA, Blackburn and Darwen. Page 56)

Many groups recommend closer working relationships and partnership between the police and communities:

"Discussions with the Police about their role in relation to drug misuse." (Ethnic Minority Health and Social Care Forum, Blackburn. Page 56)

"Create better working relations with the Police and Black Minority Ethnic Young People." (Kirklees REC. Page 33)

"To promote multi-agency working and involve organisations such as Community Safety and the Police to look at how residential areas can be made safer and how to improve relations between the police and communities." (Holy Trinity Community Network Forum, Tameside. Page 40)

There is a perception that the police do not communicate well with local Black and minority communities and that they should do more to explain and publicise their actions:

"The police need to make the community more aware of their strategy if it is in fact a strategy that is being implemented, or if it is the lack of resources, be they physical presence or merely financial resources." (EMDA, Blackburn and Darwen. Page 56)

"The police should adopt a strategy for tackling the perceived blatant drug dealing within the area and help prevent any community fear, recognising the fear of reprisals and reluctance of people within the community to address the drug issues... It is recommended that police initiatives to tackle both crime and community safety are publicised at a grass roots level, to build and instil confidence within the community." (Sheffield Black Drugs Service. Page 122)

"...there was little knowledge about the police drug education programme currently being undertaken in Mosques." (Ethnic Minority Health and Social Care Forum, Blackburn. Page 56)

"The police need to engage with the community, explain current strategy and identify, in partnership with the community, future steps to address the problems of supply." (Asian Anti-Drug Initiative, Halifax. Page 62)

Many reports contain recommendations that the police, alongside other organisations, should work in partnership with community groups:

"It is recommended that all organisations involved in the drugs field including the police undertake effective community development and outreach initiatives to allay the fear of the Asian community about the use of drugs." (Three Faiths One Issue, Leicester. Page 88)

"In order to reduce the availability of drugs and increase the awareness about drugs amongst the vulnerable groups, community organizations, police, and local drug action team should be working together to achieve mutual targets." (Yemeni Community Association, Sandwell. Page 38)

Some groups also recommend that the police receive training in cultural sensitivity:

"Police also need to receive further training in regards to cultural issues, with the inclusion of community organisation providing essential basic information." (Southall Community Drugs Education Project, London. Page 57)

4.4 Diversity, communities and neighbourhood renewal

The breadth of different ethnic and national groups involved and the issue of diversity within communities is one of the central themes to emerge from the project. There is recognition from Black and minority ethnic communities that they are changing and that the concepts of 'community' and 'ethnicity' are themselves complex and subject to change:

"There is a tendency amongst African people to see themselves still 'in transit' i.e. in Britain on a temporary basis (even when they have been living in the country for a number of years). Participation at a higher level in policy and decision-making does not occur, it is therefore imperative that it is encouraged." (ACIA, London. Page 37)

"The discussion is rendered more difficult by the complexity of the concept of culture itself; looking at the whole relationship between culture and drug use, and the role of the community in the development and transition of culture." (Nilaari Agency and Black Orchid, Bristol. Page 60)

"The Bangladeshi community are one of the last groups to come to Britain from the South Asian continent, in addition to being one of the poorest, and as such are having to adapt to cultural transition at a feverish pace. It is well documented that many drug problems are experienced and get a 'foothold' where a culture is in 'transition'." (Smethwick Bangladeshi Youth Forum, Sandwell. Page 46)

Within the changing context of communities there is recognition that young people are moving between two cultures and that this can be related to drug use:

"Second, third and now fourth generation members of this community have adopted much more western standards and values and terms of references and are much more exposed to a "drug culture". Their understanding of drug issues are much more broader and our study reveals that drug taking and in particular the use of cannabis is widespread amongst this age group. This we believe is similar to the usage of cannabis amongst other communities within a similar age group." (Integrated Asian Advice Service, London. Page 29)

"The young people from the ethnic minority communities face a dilemma in many ways and are torn between the two cultures in attempting to fit in within a diverse society... The children and youngsters of today's generation are in many ways creating their own sub-culture that takes the best from both the two main ways of living. It is what suits them. The older communities see this as the kids doing what they want when in reality all they are doing is surviving in a world full of confusion." (EMDA, Blackburn and Darwen. Page 57)

Families, particularly amongst more recently arrived communities, are seen as needing more support to compensate for the loss of extended family structures:

"Parenting skills workshops are needed to aid African parents on how to parent their children without all the extended

family structures that Africa has to offer.” (ACIA, London. Page 36)

Many groups recommend increased training, education and employment opportunities to break the cycle of disadvantage, deprivation and associated drug use:

“One recurring theme is the lack or perceived lack of opportunities for young people, specially young men, to access decently paid jobs with good career options and stability... There needs to be better access to second chance education and training for young people, especially young men, who have not been able to make the grade academically first time round. Many in this cohort are isolated due to a period of underachievement in their teenage years. This cycle needs to be broken by targeted support to access employment.” (Asian Anti-Drug Initiative, Halifax. Page 61)

“Training programmes and initiatives for example, training for new skills to increase job prospective/s for individuals.” (Asian Community Forum, Lancashire. Page 46)

“To provide quality training and employment to those from the Black and visible minority community who are seeking a career in this field, to enable them to work within their own communities and have an impact on their future direction.” (Project 8, Liverpool. Page 26)

“Drug dealers in the poor community, as acclaimed by our participants, do so largely because they have to survive this materialistic society without gainful employment. Anti-drug projects should aim to give some kind of training to the unemployed in the community and engage them in anti-drug activities in the same community.” (Nguzo Saba, Preston. Page 41)

Many recommendations are concerned with young people and what is seen as a lack of recreational and sporting activities within neighbourhoods, resulting in increased boredom and heightened risks of drug use:

“To develop sports programmes and career advice aimed at the young South Asian people. Such programmes will help to decrease demand for drugs amongst the young.” (Asian Community Forum, Lancashire. Page 46)

“More recreational activities need to be provided to relieve boredom to reduce the number of BME young people using drugs.” (BME Housing Consortium, Wolverhampton (1) Young people. Page 44)

“More recreational facilities in all areas to enable young people to engage in constructive activities. There is a need to recruit and train mentors to work with young people in schools to identify any drug misuse problems at the early stages to prevent them engaging in criminal activities to feed their drug habits and to address other drug related issues.” (BME Housing Consortium, Wolverhampton (4) Young offenders. Page 37)

“Community youth projects/community centres should be encouraged, and enabled, to provide activities for young people, promoting positive living, to reduce the factors of boredom and peer pressure.” (Chinese National Health Healthy Living Centre, London. Page 100)

“Create and establish several leisure centres or youth centres designed appropriately to attract the Iraqi youth of both genders in order to fulfil their satisfaction in enjoying their free times decently and based according to the boundaries

of the Arabic culture and Islam.” (Iraqi Welfare Association, London. Page 39)

“Look for a way of providing safe facilities and activities for Asian young people. Several respondents felt that there was a need for social and leisure activities, more youth clubs and community centres specifically towards the young Asian people.” (Ethnic Minorities Development Project, Wakefield. Page 64)

Groups recognise that there needs to be more capacity building to ensure they can participate fully in partnerships and contribute to service development and delivery:

“More work needs to be undertaken with African organisations to encourage more community involvement... African Counselling and drug Services should be developed in partnership with an African community agency. This would encourage African people to seek help and utilise services as they may find the services more culturally appropriate.” (ACIA, London. Page 37)

“The development of the strategy with respect to Refugees and Asylum Seekers will need to take account of the profile of the Refugee and Asylum Seeker communities in Wolverhampton, and the multiple problems facing these communities across a range of deprivation issues.” (BME Housing Consortium, Wolverhampton (2) Refugee and asylum seekers. Page 59)

“I want to say that one of the areas that we have been struggling with for some time is that the main budget holders have neglected us when it really matters... The big agencies need to trust small players... there is a role to be played by small groups.” Male, 30+, Black & Female, 20-30, Black. (Walsall ACIDS. Page 24)

“It is necessary to establish networks and partnership working between drug agencies and the Kurdish, Turkish and Turkish Cypriot community organisations.” (Day-Mer Turkish and Kurdish Community, London. Page 53)

“As a community we could work together to tackle drugs in our area. Female, 18, Muslim.” (Walsall ACIDS. Page 23)

“To understand the Somali community with the hope of working together to develop this community. It also important to start by building up a partnership with them, consulting with them and unwrapping all the stigmas and myths that surround them.” (Nilaari Agency and Black Orchid, Bristol. Page 59)

Respondents recommend that engagement with communities should not always be mediated through ‘so-called’ community leaders:

“Agencies must stop merely listening to the view of those in positions of power... The main reason for this appears to be ‘political correctness’ going slightly too far as statutory organisational figures dare not upset those in positions of authority for fear of appearing to be racist or discriminating against the minority communities. The excuse given to pacify the remainder of the community is that there is no validated evidence or awareness of the other issues that are alleged to exist in the community.” (EMDA, Blackburn and Darwen. Page 53)

“...there can be little doubt that the people that we interviewed... felt uncomfortable with the role of so called Community Leaders and Development Workers. Issues about

confidentiality, gossip, the abuse of power and lack of empathy were stressed time and time again throughout the research. Any successful intervention within these communities needs to take note of this and also needs to begin to look at providing alternative contacts with the communities." (RAIS Academy, Rochdale. Page 49)

"I think that you need to start engaging with credible people from the local community whether it is elected leaders or role models, you need to get them on board and then start to work with them... We need credible role models from day one involved in a steering group, we also need to bring in people from the youth councils and community. People will only come along if they see people there who know what they are talking about and who they can identify with." Male, 30, Black. (Walsall ACIDS. Page 23)

Most of the groups make some recommendation regarding the process and model of Community Engagement and what will subsequently happen after the completion of the research:

"Although this Project has now ended, the real work has not yet begun. As indicated elsewhere in this report, effective, relevant and workable strategies for future initiatives will best arise if relevant agencies and individuals capitalise and work on the issues raised by local people during the review." (Walsall ACIDS. Page 23)

"Follow up after research project - setting up of an Asian Youth Forum consisting of young people who took part in the research and supported by representatives the Police, Health, Probation, Education, Drugs action team and community members in which young people can come together and share ideas for preventing drug misuse." (Ethnic Minorities Development Project, Wakefield. Page 63)

"Attention to the findings and implementation of some of them will lead to involvement of the Community, the Churches, the Voluntary Sector, the Schools and Colleges in the delivery of Drug Misuse Service. By responding to the needs of Igbo Community, the NHS will shape services around the needs and preferences of individual patients, their families, and their carers, which is one of the core principles in the NHS Plan." (The Igbo and Tutorial School, London. Page 44)

The model of Community Engagement (Winters & Patel 2003) is itself viewed very favourably:

"The research will have shown the power of community development and the importance of involving community and religious groups in issues that affect their members and beyond. Such organisations have a crucial role to play not just as conduits for drugs research or public relations but also have the potential to act as deliverers of services...." (Three faiths One Issue, Leicester. Page 86)

"This type of engagement enables more of an overview of issues to take place contextualising it within best practice and informed through experiences of other agencies across the country. Also it is useful to work with an "independent" agency that allows for the organisation to build its credibility without having to rely on "local leverage" to gain access to decision-makers and planners. This will allow for the organisation to build its capacity and continue its work in an objectively oriented and professional way." (Integrated Asian Advice Service, London. Page 32)

"The model of peer involvement used by this project be adopted when conducting drug education campaigns (young

people to be involved with educating other young people, and parents to educate other parents)." (Greek and Greek Cypriot Community of Enfield, London. Page 24)

There is a strong call for the model of Community Engagement to be further used:

"Investigate how the skills and knowledge of the volunteers employed in this project be utilised further so that their capacity skills are not wasted." (Ethnic Minority Health and Social Care Forum, Blackburn. Page 56)

"Develop a 'public engagement' strategy with a view to involving the voluntary sector/subject groups right from the on-set, at the design stage through to implementation of new initiatives/projects and in the decision making process to ensure effective involvement and ownership." (African Health For Empowerment & Development, London. Page 49)

"Urge the DOH [Department of Health] to consolidate the current participatory research model i.e. "the community engagement programme" as the most cost effective way of engendering innovative visions, the mobilisation of the wide repertoire of skills and capacities within Black and Ethnic Community Organisations as an effective way of tackling the ad hockery, amateurism and the obscurity and denial of the gravity of drug addiction widely highlight by our research." (Simba Community Alliance, London. Pages 60 - 61)

"The volunteers who took part in the research have acquired new skills and are now able to take part in peer education. These sustainable skills will enable further needs assessments to be carried out by the community." (Chinese National Healthy Living centre, London. Page 102)

4.5 SUMMARY

Drug education and awareness

The low level of awareness about drugs within communities is reflected in all of the reports' recommendations. There is a need for drug education to be focused on young people and that this should involve parents. The value of drug education for elders in the community is particularly highlighted.

Many groups recommend that drug education needs to be communicated for a more diverse audience; able to be understood in different community languages; using formats for different abilities including sign language and audio visual resources; and utilising Black and minority ethnic media.

Some groups call for a fully integrated programme of drug education targeting particular community groups and encompassing wider issues. Others, particularly Muslim respondents, call for the involvement of religious organisations in drug education work. Some groups recommend education about traditional substances that are predominantly used by those groups, in particular khat. Further research into the potential harms of traditional substances is recommended.

Increasing access to drug treatment services

There is a strong sense of frustration that not enough has been done to address service access. Community groups are keen to be involved in disseminating information about drug services and how to access them. Mainstream services need to take responsibility for service provision to Black and minority ethnic communities. This should not be left to under

funded and poorly supported community groups. Groups recommend a more proactive response involving outreach services and greater advertisement and promotion of services. This is linked to calls for:

- increased representation of Black and minority ethnic communities on DATs and related forums.
- employment of Black and minority ethnic workers
- training for drug service staff in diversity and cultural sensitivity
- better access to interpreters who are trained in drug misuse
- community orientated telephone helplines
- ensuring refugee and asylum seekers are aware of services and community groups are able to work in partnership with drug agencies to improve knowledge about drugs and options for help amongst these groups
- information and education for Black and minority ethnic drug users on the risks related to blood borne diseases
- targeting of services for crack and cocaine use within communities
- ensuring services are inclusive, and able to work effectively with diversity
- ensuring accurate and robust recording of client demography and ethnic monitoring that is sensitive to the full diversity in local communities
- developing services for family members and carers
- separate service provision for women that is located sensitively
- Increased shared care with GPs

Community safety

Concerns about community safety and drug dealing in particular were paramount amongst community respondents. This is combined with a sense that not enough is being done by the police and that communities are afraid to report drug related crime for fear of reprisals. This is more pronounced amongst respondents from towns in the north of England.

There is a perception that the police do not communicate their strategies well and that they should do more to explain and publicise these. Many reports contain recommendations that the police, alongside other organisations should work in partnership with community groups. Some groups also recommend that the police receive training in cultural sensitivity.

Diversity, communities and neighbourhood renewal

The breadth of different ethnic and national groups involved and the issue of diversity within communities is one of the central themes to emerge from the project. There is recognition that communities are changing and that the concepts of 'community' and 'ethnicity' are themselves complex and subject to different interpretations.

Within this changing context there is recognition that young people are moving between two cultures and that this can be related to drug use. Families, particularly amongst more recently arrived communities, are seen as needing more support to compensate for the loss of extended family structures.

Increased training, education and employment opportunities for young people to break the cycle of disadvantage, deprivation and associated drug use is recommended. Many respondents are concerned about young people and what is seen as a lack of recreational and sporting activities within neighbourhoods. This is viewed as resulting in boredom and

heightened risks of drug use. Groups recognise that there needs to be more capacity building within communities to ensure they can participate fully in partnerships and contribute to service development and delivery.

Respondents recommend engagement with communities and that this is not always best mediated through community representatives. Most of the groups make some recommendation regarding the process and model of Community Engagement as it has been used in the production of the needs assessments. Community Engagement is viewed very favourably and there is a strong call for this work to be continued.

REFERENCES

- Abdi, O. Hyman, B. Linehan, D. Rifhat, A. Wisdom, L. (2001) Report of the Drugs Misuse Needs Assessment carried out by Sheffield Black Drugs Service amongst the Afro-Caribbean Pakistani, Somali, Yemeni & Bangladeshi Communities in Burngreave, Sheffield, Sheffield Black Drugs Project
- Abdullah, A. Ahmed, S. Clarke, D. Varley, C. and Vaz, A. (2001) Report of the Needs Assessment carried out by the Community Drugs Participatory Assessment Programme (CDPAP) into the Needs of the visible Minority substance misusers of Granby Toxteth, Liverpool, Merseyside Liverpool, Project 8
- Abdullahi, F. Ali, F. Didar, M. Elmi, M. Field-Thorne, J. Kumbin, C. Smith, J. (2001) Report of the Needs Assessment carried out by the Nilaari Agency and Black Orchid amongst the Somali community in Bristol, UK, Bristol, Nilaari Agency/Black Orchid
- Abera, M. Asfaw, W. Asmelash, M. Gatiso, Y. Jembere, W. S. Teshome, S. (2002) Report of the Drugs Misuse Needs Assessment carried out by Ethiopian Community in Lambeth amongst the Ethiopian Community in Lambeth, South London, London, Ethiopian Community in Lambeth
- ACMD (Advisory Council on the Misuse of Drugs) (1998): Drug misuse and the environment, London: The Stationary Office
- Agathocleous, M. Costi, C. Papadopoulos, I. Philippou, E. Worrall, L. (2001) Report of the Drugs Misuse Needs Assessment carried out by the Greek and Greek Cypriot Community of Enfield, Enfield London, Greek and Greek Cypriot Community of Enfield
- Ahmed, A. (2001) Report of the Drugs Misuse Needs Assessment carried out by Somali Health & Mental Health Link amongst the Somali Community in Brent, London Somali Health and Mental Health Link
- Ahmed, A. Begum, G. Choudhry, A. Karmani, A. Khan, S. Malik, M. Razaak, A. (2001) Report of the Drugs Misuse Needs Assessment carried out by the Youth Awareness Programme amongst the South Asian communities residing in Beeston and City & Holbeck of South Leeds Leeds, Youth Awareness Programme
- Ahmed, M. (2001) Report of the Drugs Misuse Needs Assessment carried out by the Asian Anti Drugs Initiative amongst the Pakistani and Bangladeshi Communities of West Central Halifax in the Metropolitan Borough of Calderdale, Halifax, AADI
- Ahmed, A. Ahmed, S. Ahmed, W. Anwar, A. and Koyes, S. (2001) Report of the Drugs Misuse Needs Assessment carried out by the Bangladesh Youth League into the needs of the Young Bangladeshi and Pakistani people of Luton, Luton, BYL
- Ahmed, G. Akhtar, N. Akinyemi, J. Bano, S. Bhatti, A. Wani, A. Williams, E. (2001) Report of the Drugs Misuse Needs Assessment carried out by the Derby Millennium Network amongst the Pakistani, White, Indian & African Caribbean communities in Derby, Derby, The Derby Millennium Network
- Ahmed, M. Darwan, H. Mahmood, S. Patel, A. (2001) Report of the Drugs Misuse Needs Assessment carried out by Savile Town Community Association amongst the Pakistani & Gujarati Community in Savile Town, Dewsbury, Savile Town Community Association
- Ahmed, M. Mahmood, K. Patel, M. Piracha, A. H. Qureshi, A. Salam, S. (2001) Report of the Drugs Misuse Needs Assessment carried out by The Ethnic Minority Health & Social Care Forum amongst the South Asian Communities in Brookhouse Blackburn, Blackburn Lancs, Ethnic Minority Health and Social Care Forum
- Ajid, A. Baset, A. Begum, P. Begum, S. Choudhury, A. France, T. Khan, F. Khan, M. A. Uddin, J. Uddin, T. (2001) Report of the Drugs Misuse Needs Assessment carried out by Smethwick Bangladeshi Youth Forum amongst the Bangladeshi Community in Sandwell, Smethwick, Smethwick Bangladeshi Youth Forum
- Akhtar, N. Gardner, B. Garratt, D. Ali, A.; Houslin, M. Sidhu, K. (2001) Report of the Drugs Misuse Needs Assessment carried out by Walsall ACIDS, Walsall, Walsall ACIDS
- Al-Hassani, S. Elsaid. A. Field, H. Hassan, T. (2001) Report of the Needs Assessment carried out by the Iraqi Welfare Association amongst the Iraqi community in London Borough of Brent, London, Iraqi Welfare Association
- Al-Kash, N. Osaimi, A. Yafai, M. Yafai, H. (2001) Report of the Drugs Misuse Needs Assessment carried out by Yemeni Community Association (YCA) amongst the Yemeni Community in Sandwell Birmingham, YCA
- Ali, I. Houghton, A. Shakoor, A. (2001) Report of the Needs Assessment carried out by the Rais Academy and Age Concern amongst the Pakistani and Bangladeshi Community in Rochdale, Rochdale, Rais Academy/Age Concern
- Ashraf, S. Mohammed, Z. (2001) Report of the Drugs Misuse Needs Assessment carried out by the Ethnic Minorities Development Project amongst the Asian Community in Wakefield, Wakefield, EMDP
- Aslam, Z. Hussain, M. Kossar, S. Parveen, N. (2001) Report of the Needs Assessment carried out by the Saaf Dil amongst the Pakistani community in Rotherham, Rotherham, Saaf Dil
- Atwal, G. Azad, U. Bector, A. Clacken, C. Legister, L. Mitchell, M. Northcote, J. Quintyne, V. Rowe, H. Singh, R. Smith, B. Spence, A. (2001) Report of the Drugs Misuse Needs Assessment carried out by Wolverhampton Black Minority and Ethnic (BME) Drugs Misuse needs Assessment Steering Group amongst the Refugees and Asylum Seekers Communities, BME Criminal Justice System, BME young People and BME Mental Health and Dual Diagnosis Communities in Wolverhampton, Wolverhampton, BME Housing Consortium
- AWAAZ (2001) Report of the Drugs Misuse Needs Assessment carried out amongst Black Minority and Ethnic (BME) Young People in Wolverhampton – Asian Womens Adhikar Association (AWAAZ), Wolverhampton, BME Housing Consortium
- Bector, A. (2001) Report of the Drugs Misuse Needs Assessment carried out by the Black Minority and Ethnic (BME) Housing Consortium amongst the Refugee and Asylum Seeker Communities in Wolverhampton, Wolverhampton, BME Housing Consortium

- Bektas, A. Cathel, P. Demir, G. Kangulec, S. Ozdemir, S. Tavsanoglu, S. (2001) Report of the Drugs Misuse Needs Assessment carried out by Day-Mer Turkish and Kurdish Community Centre amongst the Kurdish, Turkish and Turkish Cypriot Communities in London, London, Day-Mer Turkish and Kurdish Community
- Bennitt, P. Codner, R. Coleman, G. Gonzalves, Mitchell, M. Quintyne, V. Robinson, M. Simpson, V. Smith, B. Walker, W. (2001) Report of the Drugs Misuse Needs Assessment carried out by (SPEG) St Peters Elders Group, Sweatbox Youth Group and African-Caribbean Community Initiative (ACCI) amongst the African Caribbean Community in Wolverhampton, Wolverhampton, BME Housing Consortium
- Blackstock, P. Green, P. Mitchell, C. Obhiozele, D. Obhiozele, J. Okeke, A. and Okeke, O. (2001) Report of the Drugs Misuse Needs Assessment carried out by ACCAN among the African and Caribbean Community in Oxford, Oxford, ACCAN
- Brako, M. Saleh, A. (2001) Report of the Drugs Misuse Needs Assessment carried out by African Health for Empowerment and Development (AHEAD) amongst the Sierra Leoneans and Ugandans Community in Greenwich and Bexley Borough London, AHEAD
- Carrington A (1993): An action study report on drug misuse and the African-Caribbean community. Bradford: Bradford Drugs Prevention Team / Bradford West Indian Community Centre Association
- Chan, M. Chung, A. Fong, A. Mok, L. Pang, G. Sham, S. Steel, C. Yim, Yee Ling. (2001) Report of the Drugs Misuse Needs Assessment carried out by the Wai Yin Chinese Women Society into the needs of the Chinese Community in Greater Manchester, Manchester, Wai Yin Chinese Women Society
- Chauhan, V. (2001) Report of the Drugs Misuse Needs Assessment carried out by The Three Faiths – One Issue Partnership Group into the needs of the Hindu, Muslim and Sikh communities of Leicester, Leicester, Lotus Management Consultancy
- Chikomba, T. Chiremba, C. Chituku, T. Dawanyi, T. Madolo, C. Mafunga, E. Mafunga, P. Meanzanise, F. Momberume, T. Mutasa, A. Ndanga, T. Sisimayi, L. (2001) Report of the Drugs Misuse Needs Assessments carried out by the Simba Community Alliance Amongst the Zimbabwean Community in London and Luton, London, Simba Community Alliance
- Chow, S. M. Curry, N. Lai, K. K. Leung, C. Tham, S. and Wan, S. (2001) Report of the Drugs Misuse Needs Assessment carried out by the Chinese National Healthy Living Centre in partnership with the Hungerford Drug Project Amongst the Chinese community in the London Boroughs of Westminster, Camden and Islington London, Chinese National Healthy Living Centre
- Clarke, R. and Smith, B. (2001) Report of the Drugs Misuse Needs Assessment carried out by N.A.C.R.O and Prison Link amongst the Young Offenders in the Criminal Justice System in Wolverhampton, Wolverhampton, BME Housing Consortium
- Costa, L. D. Kasu, M. and Lebila, J. (2001) Report of the Drugs Misuse Needs Assessment carried out by Cabinda Community Association amongst the French, Portuguese and Lingala Speakers in North London, London, Cabinda Community Association
- Cunningham, C. and Marathefti, I. (2001) Report of the Drugs Misuse Needs Assessment carried out by Black Health Agency amongst the Black Lesbian Gay and Bisexual Community in Greater Manchester, Manchester, BHA
- Dasani, J. Ghatore, K. Harbhajan, Kohli, R. Sahib, K. Suman, D. Wariabharaj, K. (2001) Report of the Drugs Misuse Needs Assessment carried out by the Southall Community Drugs Education Project amongst the South Asian Communities in Southall. London, Southall Community Drugs Education Project
- Department of Health (2002): Models of Care for substance misuse treatment. Promoting quality, efficiency and effectiveness in drug misuse treatment services. Full report for consultation, February 2002. London: Department of Health
- Dye-Sharp, M. (2001) Report of the Drugs Misuse Needs Assessment carried out by Bradford Youth Development Partnership amongst the Pakistani, Bangladeshi, and African Caribbean Communities in Bradford, West Yorkshire, Bradford, BYPD
- Edgeley, S. (2001) Report of the Drugs Misuse Needs Assessment carried out by the Congolese Refugee Women Association (CRWA) into the needs of the Congolese people of the London Boroughs of Hackney and Newham, London, CRWA
- Ekinu, W. Tewolde, G. Zerihun, B. (2001) Report of the Drugs Misuse Needs Assessment carried out by Eritrean Community in Greenwich and Lewisham amongst the Somali and Eritrean Communities in Greenwich, London, Eritrean Community in Greenwich and Lewisham
- Fountain, J; Bashford, J; Patel, K; Winters, M (forthcoming): Black and minority ethnic communities in England. A review of the literature on drug use and related service provision. London: NTA
- Gul, M. and Siyani, M. (2001) Report of the Needs Assessment carried out by the Integrated Asian Advice Service amongst the Indian Sub continent in community in the London Borough of Greenwich, London, IAAS
- Harkin, K. Ismail, H. Madigan, M. A. Saima, A. (2001) Report of the Drugs Misuse Needs Assessment carried out by the Ethnic Minorities Development Association amongst the ethnic minority community in the Borough of Blackburn with Darwen, Lancs, Ethnic Minorities Development Association
- Henegham M (2000): Race, women and treatment: alternative to custody. *Druglink*, 15(5):21-23
- Hussain, S. Irfan, M. Rahman, S. H. and Rehman, A. (2001) Report of the Drugs Misuse Needs Assessment carried out by the Asian Community Forum amongst the South Asian Community in Hyndburn. Hyndburn, ACF
- Igboaka, G. & Maduako, K. (2001) Report of the Drugs Misuse Needs Assessment carried out by The Igbo and Tutorial School into the needs of the Igbo people of London, London, Igbo and Tutorial School
- Kaur, R. Njoku, J. Patel, S. (2001) Report of the Needs Assessment carried out by the Kirklees Racial Equality Council – Youth Forum amongst the African-Caribbean and Indian communities in Kirklees, Kirklees, Kirklees REC

Khan, S. (2001) Report of the Drugs Misuse Needs Assessment carried out by East Birmingham Community Forum into the needs of the Pakistani/Kashmiri People of Saltley, Birmingham, East Birmingham Community Forum

Kikambi, M. Kyazzi, C. Mhonda, J. Natala, M. Sindiyo, S. (2001) Report of the Needs Assessment carried out by the African Caribbean Community Involvement Association (ACIA) into the needs of the Ugandan, Kenyan, Zimbabwean and Zambian communities in the London Boroughs of Merton, Sutton, Wandsworth and Croydon London, ACIA

London Ethnic Minority Deaf Association (2001) Report of the Needs Assessment carried out by the London Ethnic Minority Deaf Association (LEMDA) into the needs of the Black Ethnic Deaf Community in London, London, LEMDA

Mushkil Aasaan (2001) Report of the Needs Assessment carried out by Mushkil Aasaan into the needs of the Tooting community, London, Mushkil Aasaan

Navjyot Organisation for Asians (2001) Report of the Needs Assessment carried out by the Navjyot Organisation for Asians amongst the community in the areas of the London Boroughs of Brent & Harrow, London, Navjyot Organisation for Asians

Nguzo Saba Centre (2001) Report of the Needs Assessment carried out by the Nguzo Saba Centre into the needs of African Caribbean people of Preston, Preston, Nguzo Saba

Oloya, M. Oloya, S. Othol, D. (2001) Report of the Drugs Misuse Needs Assessment carried out by Supporting African Youth Development (SAYD) amongst the Black community in the neighbourhood of Tolworth/Surbiton, Royal Borough of Kingston upon Thames, London, SAYD

Puri, A. (2001) Report of the Needs Assessment carried out by Holy Trinity Community Network Forum into the Needs of the South Asian Communities of Tameside, Manchester, Holy Trinity Community Network Forum

Roaf, M (2001) Report of the Needs Assessment carried out by the Marylebone Bangladesh Society and the Hungerford Drug Project amongst the Bangladeshi Community in Lisson Grove, London, London, Marylebone Bangladesh Society/ Hungerford Drug Project

Sangster D, Shiner M, Sheikh N, Patel K (2002): Delivering drug services to Black and minority ethnic communities. DPAS/P16. London: Home Office Drug Prevention and Advisory Service (DPAS).
Also available on <http://www.drugs.gov.uk>



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