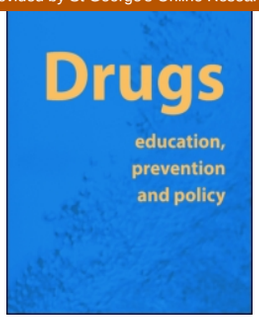

Drugs: Education, Prevention and Policy

ISSN: 0968-7637 (Print) 1465-3370 (Online) Journal homepage: http://www.tandfonline.com/loi/idep20

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To cite this article: Nadia Mantovani & Clare Evans (2018): Drug use among British Bangladeshis in London: a macro-structural perspective focusing on disadvantages contributing to individuals' drug use trajectories and engagement with treatment services, Drugs: Education, Prevention and Policy, DOI: 10.1080/09687637.2017.1421143

To link to this article: https://doi.org/10.1080/09687637.2017.1421143

Published online: 22 Jan 2018.

DRUGS: EDUCATION, PREVENTION AND POLICY, 2018
https://doi.org/10.1080/09687637.2017.1421143

Drug use among British Bangladeshis in London: a macro-structural perspective focusing on disadvantages contributing to individuals' drug use trajectories and engagement with treatment services

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ABSTRACT

Aims: The main aim of our study was to produce an understanding of factors contributing to drug-using trajectories among men and women from a Bangladeshi background living in East London.

Methods: Fifteen semi-structured, one-to-one interviews were conducted with male and female Bangladeshi drug users accessing treatment services. A macro-structural lens was adopted to interpret participants' accounts of their drug use and explored the intersecting factors that at a micro, meso, and macro level impacted on their drug-using trajectories.

Findings: Problem drug use (heroin and crack cocaine) among participants was the result of interrelated factors such as their friendship networks and the embeddedness of drugs in drug-using networks, the structural disadvantages participants experienced, and the need for concealment of their drug use which impacted on participants' effective utilisation of drug treatment services. Problem drug use was a functional way of responding to and dealing with social, economic, and cultural disconnection from mainstream institutions as participants faced severe multiple disadvantages engendering stigma and shame.

Conclusions: We propose a 'life-focused' intervention aimed at creating extra opportunities and making critically-needed resources available in the marginalised environment of the study's participants, which are key to restoring and maintaining agency and sustaining well-being.

ARTICLE HISTORY
Received 12 August 2016
Revised 18 December 2017
Accepted 21 December 2017

KEYWORDS
Drug use; British Bangladeshi; structural disadvantage; discrimination; dislocation; stigma drug use

Introduction

Bangladeshis are the most economically disadvantaged group in Britain: for example, high rates of poverty are characteristic of 65% of Bangladeshi households (Platt, 2007) with 40% of Bangladeshi working families depending on state benefits (Berthoud, 1998). Bangladeshi households have high unemployment rates amongst men who have the largest negative differential in unemployment rates compared to whites (Berthoud, 2000, Clark & Drinkwater, 2005). Explanations for labour market disadvantage in these groupings include geographical concentration in deprived areas, racial discrimination (Mason, 2003; Ratcliffe, 2004), and weak human capital as evidence shows that about 40% of Bangladeshi men have no formal education (National Statistics Online, 2004). Despite outperforming other ethnic groups to achieve rapid improvements at every level of education, primarily among young girls (Smart & Rahman, 2009), Bangladeshis are still significantly less likely to be employed in managerial or professional jobs than their white counterparts (Shaw et al., 2016). Living in poor housing that is classified as overcrowded (ONS, 2015) and located in the most deprived wards such as in London's Tower Hamlets (Dyson et al., 2009), taken together with the socio-economic disparities illustrated above, are determinants that impact on the general health of these groupings which is also marred by persistent health inequalities (Nandi & Platt, 2010), particularly among Bangladeshi women and the elderly (Joseph Rowntree Foundation, 2013). As a result of the aforementioned material conditions Bangladeshis suffer from a complex array of psychological difficulties, as the individual/familial income is more often than not at odds with their expectations, resulting in feelings of isolation and desolation. Dyson et al. (2009), for instance, found that high unemployment levels left men experiencing guilt, feelings of failure, and loss of manhood, arguing that dashed expectations are particularly pronounced among Bangladeshis. These psychological difficulties combined with the experience of material poverty may in part explain why Bangladeshis turn to drug taking to manage their experience of disconnection (Alexander, 2008) from mainstream institutions.

In a context in which individuals are influenced and constrained in various ways by their socioeconomic and geographical environment (Song, 2003) and social relations (Hunt & Kolind, 2017), this paper seeks to understand habitual heroin and crack use among Bangladeshis interviewed for this study. It deploys a macro-structural lens to focus on disadvantages that may contribute to vulnerabilities and impact

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on individuals' drug use trajectories and on their sense of identity. We conceive participants' ethnic identity as learned through the situations they experience in their day-to-day life where individual and group identities are performed, constructed, and reconstructed both by the individual and in society (De Kock et al., 2017) where resisting ethnic classification is possible (Lalander, 2017) through creating one's own version of identity.

According to Williams et al. (2017) paucity of knowledge in respect of drug use and patterns of consumption among ethnic groups still persists. While past trends indicated that drug use and its prevalence among South Asian men and women was increasing (Fountain et al., 2003; Patel & Wibberley, 2002), and particularly the use of heroin among Bangladeshis (White, 2001), more recent data from British Crime Surveys (BCSs) have reported the lowest levels of previous year drug use among Asian or Asian British compared to all other ethnic groups (Hoare & Moon, 2010). Though, this evidence is likely to be an underestimate of prevalence (UK Drug Policy Commission, 2010) as BCSs rely on self-reporting, with responses being influenced by factors such as presentation biases, social desirability, or a participant's ability to recall information (Napper et al., 2010). Despite Asian groupings featuring in national surveys there is a lack of small scale British research emphasising the diversity of Asian groups and their drug consumption (Williams et al., 2017), which this study seeks to address.

The main aim of our study was to produce an understanding of factors contributing to drug using trajectories among British Bangladeshi men and women living in the East End of London. It seeks to address the following questions: (a) to what extent the socio-economic situation participants found themselves in influenced their relationship to drug use trajectories and seeking treatment for drug use; (b) to what extent continued drug use was a way to mitigate the socially conditioned stigma/shame of a dysfunctional lifestyle induced by drug use.

Methods and data collection

A qualitative approach was adopted to address the aforementioned questions. We applied a convenience sampling strategy as participants were recruited by the second author (CE) who at the time of conducting this research was working in a drug treatment service as a substance misuse worker. Participants were purposively selected on the basis of key demographic characteristics such as gender, age (18+), ethnicity (being Bangladeshi), literacy, and understanding of English. All participants had been diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria for substance use subcategory, which enabled the treatment services to identify and treat habitual crack and heroin drug users as this was the services' main focus.

We interviewed 15 people out of the 20 potential participants fitting the criteria of the study in 2014, who initially agreed participation at first contact; three declined participation on second contact by the researcher to arrange the interview, and two did not turn up for the interview. Participants were recruited via two geographically adjacent drug services whose clients were referred through a self-referral system, the criminal justice system, and through their GPs. The service managers and workers within each site facilitated the recruitment process; they explained the purpose of the study to potential participants and the ethics of participation. They helped to gain consent and pass the participants' details onto the researcher (CE), who subsequently sent them an invitation letter together with a participants' information sheet (PIS), and contacted them to arrange for an interview.

A semi-structured questionnaire was devised to generate data on patterns of drug use, meaning of drug use, use of drug services, and understanding of drug use among Bangladeshis. The questionnaire was constructed based on (CE) practical knowledge, previous research (Cottew & Oyefeso, 2005; Uddin et al., 2008), and a pilot interview (not included in the analysis). Mindful of the complex relations between social difference and the production of sensitive topics (Lee, 1993) and their potential impact on the quality of research accounts that are generated (Dunne et al., 2005), during the research encounters (CE) sought to establish rapport, trust, and commitment with participants. A conversational and open style of interviewing was assumed to prevent the potential alienation of respondents in an attempt to produce greater trust and more truthful responses (Seale, 1998). Although alternatives were offered, all participants were interviewed at the drug services either in a soundproofed interview room or at the researcher's office.

All interviews lasted between 45 and 60 min and recorded with the consent of the respondents and were transcribed verbatim. A thematic analysis was adopted as a method to identify, analyse, and report patterns (themes) within data (Braun & Clarke, 2006). In our analysis (NM, CE) engaged independently in the coding process which involves the following steps: initially reading through data for general meaning; dividing text into segments of information (we decided that our coding frame consisted of paragraphs) and determining what the person was saying in the coding frame; labelling segments of information with codes using *in vivo* coding such as words from participants; reducing overlap and redundancy of codes; we then collapsed codes into four themes. We reviewed discrepancies and resolved differences by in-depth discussion and negotiated consensus. To preserve anonymity the names of participants were replaced with other Bengali names from the BabyNamesDirect database.

All procedures contributing to this work complied with the ethical standards of National and Institutional Committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2013, and the Data Protection Act (TSO, 1998). The study was approved by the Tower Hamlets Adults Health and Wellbeing Directorate governing body.

Results

Participants' description – demographic background and drug use patterns

This section report on the demographic background of the study participants and their drug use patterns. The age of participants ranged between 26 and 41 years (mean age =

32), the majority of participants were born in Britain ($N = 13$), and had a general low level of educational attainment – primarily at GCSE level. Nevertheless, women had a higher educational attainment than men with only one woman with no qualifications at all, compared with five men with no qualifications. The employment circumstances were poor – all participants but one were unemployed and 11 received government benefits. Moreover, most participants lived either in council flats ($n = 6$), or in a hostel and/or temporary accommodation ($n = 5$), or lived with their family ($n = 2$), or were homeless/unknown ($n = 2$). The marital status of participants was complex; half of the men were married while all the women were either divorced or separated. Most participants had dependent children ($n = 11$) with four with no dependent children (two men and two women); however, three participants had 12 children between them. Of the 11 participants with dependent children, seven told us they did not have their children in their custody, whilst four did; none of the women had retained custody of their children.

In terms of the participants' drug use and drug-using trajectories, we found that participants started their drug-taking at a relatively young age and that men started earlier than women, with an age range at outset ranging from 11 to 25 (men) and from 15 to 25 for women. Participants were long-term drug users; ranging from a minimum of five years to a maximum of 21 years of drug use. The mean number of years participants had been using drugs was 13.86 years with men being users for a much longer time that women (M = 16.62 years; F = 10.7 years). At the outset of their drug use men and women mostly used cannabis which a few combined with alcohol, though, a sizeable number (three men and three women) initiated their drug using trajectory with Class A drugs such as crack cocaine or heroin. Their drug use began recreationally, to socialise, or to experiment. Regardless of the type of drug with which participants had initiated their drug-using trajectory, they all transitioned to and became habituated to poly-drug use. They consumed crack and/or heroin – which in this locality are often sold together in a single bag at each deal – and drugs were used to manage the effects of other drugs. The preferred method of administering drugs was smoking. Most participants had made multiple attempts to stop using drugs and had sought help from a variety of treatment services, including treatment programmes in Bangladesh. At the time of the interview nine were on a methadone maintenance programme, two were waiting to start a new programme, one had finished an abstinence programme five months earlier but had had a little relapse in between, and three had been off drugs since completing treatment.

The following sections report on three key themes identified in the data: social networks and their impact on drug-using trajectories and recovery, structural disadvantages contributing to vulnerability and impact on drug use trajectories, and engaging with treatment services and the public exposure to stigma.

Social networks and their impact on drug-using trajectories

There is a substantial literature on the role of social networks (particularly drug use in the social networks) as determinants of initiation of drug use and later misuse (Bohnert et al., 2009; Neaigus et al., 2001). Social networks are those relational connections and ties that participants had with family, friends, and spouses. This analysis uncovered that friendship networks were key to initiating drug use among our research participants; none said they went searching for it but rather they accepted the drug(s) that were offered to them. In the extract below Maliha reveals that her affiliation with the 'boys' was the beginning of her drug-using trajectory which spanned 14 years, emphasising her grasp of drugs at the outset of her drug use:

> I started smoking crack, nobody forced me into it I wanted to try it out. I am not going to lie about it, I looked into it and thought I had a good understanding about what it is about, socialising and that. In them days it was about getting high and I was brought up sort of like a tomboy. I was always hanging out with the boys and I wanted to try it, I never stole off anyone just always had a good time … So, I started smoking crack when I was about 15 years old, has been about 14 years now (Maliha).

The idea of 'hanging out' was a recurring theme in the participants' accounts, which describes their friendship networks where drugs were consumed and in a number of cases sold. The proximity with people who were drug users impacted on the participants' drug initiation and trajectories as they yielded to group pressure. Male participants were especially attracted to and wanted to gravitate around a particular circle of friends because of a need to be liked, fit in, or because being part of that circle meant observing, hearing, and learning about drugs, henceforth graduating to other drugs and/or becoming dealers themselves. This pattern is described below.

> I liked the attention people was giving me, 'cos you think it's a good attention at first but after, it's not […] they were older friends, they were drug dealers and I started helping these guys out, and I mean I just wanted to be around them. At 15 I started dabbling and by 16 I had a habit of heroin … and because of the people I was around with, they were addicts, I wanted to fit in. Basically, I would lie and say I was addicted as well so I could be around them (Dabir).

Friendship networks were also important to women's drug-using trajectories, though, according to Akthar 'Asian women do it (take drugs) a bit more discreetly, they do it within the circle that they can rely on and trust'. Rabia, for instance, told us that she had started using drugs because her 'brother was using and then (she) started' but also because her 'boyfriend was a drug user'. Being in a trustworthy circle of friends, with a boyfriend and his friendship networks was key to women initiating drug use and transitioning to dangerous drugs. For instance, Badia told us she had been 'experimenting with a bit of drugs and alcohol but it wasn't that extreme' and that 'eventually (she) fell in love with him and let him do it', explaining: 'The drugs that I was doing were given to me by my ex-boyfriend. I never had to do anything for it'. Other female participants framed their account of drug initiation and trajectory to other drugs as celebratory – denoting an occasional activity done for fun and pleasure, to which they were invited to take part by their partners.

'Mixing with the wrong crowd' was detrimental to the participants' ability to stop using drugs. For example, Fathima

said: 'You make progress only when you change your crowd, your friends. You've got to make a lot of changes.' Similarly, Dabir spoke of his many resolutions to stop using drugs and seek treatment which he perceived were sabotaged by 'a few drug using friends who tried to' draw him back to using. It was only when he 'moved to his own property' and 'left (his) area and friends' behind that he was able to seek treatment for his addiction.

Structural disadvantages contributing to vulnerabilities and their impact on drug use trajectories:

When participants accounted for the structural disadvantages existing in the locality where they lived, they cited lack of employment opportunities and neighbourhood investment as being responsible for drug use in their area. The weight of structural marginalisation on those experiencing it was seen to be a factor pushing individuals towards selling drugs to earn a living and/or to maintain their families. The excerpts below illustrate this from different viewpoints:

> I think, in the Asian community we are the first generation of Class A drug users. The area needs something for the young generation to do instead of sitting on the block, smoking spliffs or having a drink or cruising in the car. Like getting easy money, working for a drug dealer, do you get what I am saying? What we need is a club that teaches things like martial arts 'cos doing things like that … means you are more disciplined (Danish).

On commenting on the lack of opportunities in the area where she lived and the heavy presence of drugs, Rabia explained:

> There are more drugs now, more people work as drug dealers now 'cos there is nothing else, no other jobs or they have to fund their use or feed their families. Before … they had jobs, jobs were there but now (there is) nothing. Also, they were always going back to Bangladesh or sending money, so, there was no money to spend on drugs then. But now people don't send money any more 'cos we live here, we are here (Rabia).

Participants spoke of the 'boredom everyone experienced' specifying that there was 'nothing to do – no jobs,' with Akthar stating that: 'There is not much you can do out there except go sit in parks, and if you get bored you do drink and do drugs'. Boredom also impacted on those participants who had sought treatment for their drug use. Nazeera, for example, said: 'When I came back from detox programme I was nothing but bored and started using again'. Sitting in the park doing nothing meant that participants were vulnerable 'to become a target of drug dealers' who turned them into pedlars and 'work for them' (Emran). Repeatedly, participants noted how drug dealers approached young people in public spaces offering 'free drugs' to those they 'knew were not users' and 'had money' (Danish). Similarly, Jabbar said:

> What happened was the older Pakistani boys got me onto the drugs 'cos some of them got me onto heroin. I never knew what it was, I was 13. I used to be playing football and they used to say: 'Come over here, try some of this'. I used to say: 'What is it?' They would say: 'Just try it' and I just had one line. When we used to play football they used be in the garages smoking drugs, so from then on (I started using) (Jabbar).

Male participants perceived that that 'heroin had spread quickly in a few years because a few Asians (had) started bringing it in' their community (Ghalib). Some of them disclosed that dealing drugs had become a necessity to sustain their habit and to support their family economically. For instance, Hafiz said that it was only 'when (he) stopped selling drugs and finances were getting low, and every day was a struggle', that he 'realised the effect drugs had on (him), and what it was literally doing to' him and his 'family'.

The experience of every-day racism young Bangladeshi men experienced was said to have been pivotal to young men resorting to drug use and criminal enterprise as a way to overcome it, but also to give themselves street credibility and a name:

> I think, Asians started using drugs because there was a lot of racism going on at that time and you had to belong to some kind of group of friends to have a night life or … I think a lot of people started using to get themselves a name, be out there, be known (Hafiz).

The relation between neighbourhood social factors and initiation of drug use has been evidenced where neighbourhood disadvantage is associated with drug initiation (Crum et al., 1996). Participants articulated their understanding of reasons for problem drug use in the area where they lived and their perception of the persisting structural discrimination of British Bangladeshis, and how drug use was being adopted as a coping and survival mechanism. Drug use was a functional way of responding to and dealing with dislocation (Alexander, 2008) which can be described as the participants' experience of psychological and social separation from mainstream society resulting from their lack of employment, lack of educational attainment and job skills, and poor future economic prospects.

Engaging with treatment services and the public exposure to stigma

This section discusses how participants were exposed to public stigma on engaging with treatment services which may be detrimental to seeking further care. But before we do that it is necessary to underscore the role of knowledge about drugs and treatment services that participants said they lacked when they started using drugs. Ghalib, for instance, noted that generally Bangladeshi people knew nothing about 'any kind of drugs' and that they did 'not even understand that there were different types of drugs, and that heroin was different, that alcohol was different'. With regard to knowledge about treatment services participants claimed it was through their friendship networks they were informed of methadone programmes which were suggested to them as a solution to their pressing financial problems resulting from their habitual use of heroin.

Most participants accessed treatment services at a crisis point. For example, four participants started a methadone maintenance programme because they had received a criminal justice court-mandated intervention for the felony they had committed. Others sought treatment because they had 'hit rock bottom' which was when they either had become destitute or homeless, or they had an out-of-control drug use habit. Participants spoke of 'the destructions' they had 'left behind' (Akhtar), they mentioned the 'incredible amount of

loss' they had 'experienced' as they had 'lost anything that meant anything to' them (Latifah), and talked about 'the devastating changes that drugs had on' them (Maliha) which they acknowledged were low points in their lives where they had recognised they had to come off drugs and seek treatment. The experience of 'not being human anymore' (Emran) was a tipping point whereby participants were at their most vulnerable.

However, the threat of being labelled as a drug user when accessing and engaging with public treatment services was said to bring about huge anxieties. In this respect Badia said: 'See if you are seen in that building, it would affect you even more. With me, when I go to my counselling I am always looking around to see if anyone has seen me'. According to Hafiz people would rather buy street methadone than be registered as drug users when accessing services:

> A lot of drug users are too shy to come to these services 'cos they fear they are going to be registered as a drug user, and that is a big issue for a lot of people I have noticed. They would rather go out on the streets and buy their medication, which they don't even know how it works (Danish).

The geographical proximity of the services to the locality where participants lived increased men and women's worries about confidentiality and anonymity. For instance, Latifah, Rabia and Nazeera spoke of the 'embarrassment' they had experienced when they 'went to see their doctor' because the 'workers were Bengali'. 'Everywhere you go there are Bengali workers and they may talk'. Experiencing public shame when engaging with services is demonstrated below:

> Going there to the doctors to get my script … there are a lot of Bengali girls that work there, so, as soon as I walk in and there's a surgery full of people: 'Are you here for your script?' It would be so loud that everyone would hear and they know the difference between a prescription and a script. And I would be like: 'Oh, my God!' trying to hide my face from them, thinking: 'I hope they didn't hear it'. Because they work in the surgery they know you're on the script, so, they might know somebody that I know' (Nazeera).

Moreover, in an attempt to protect the drug-using family member from public exposure, help-seeking from treatment services was discouraged by the family, which may also explain why five participants were sent to Bangladesh to seek drug treatment (Riaz, 2013). Familial denial can be gauged here:

> My family would rather you die in silence … instead of you asking for help and (rather) keep everything is hush, hush because they can't allow the community to know what is going on (Akthar).

Stigma is a debated theme in literature in relation to drug use and help-seeking from treatment services (Barry et al., 2015; Livingston et al., 2012). The fear of being labelled a drug user and the effect that this had on their family was important for participants' own understanding of reasons for delaying seeking help from drug services. They understood why families rejected them and articulated the stigma and alienation they experienced from their communities and internalised sense of self-stigma.

Discussion

This study analyses problem drug use and treatment among British Bangladeshis accessing treatment services for their drug use. Problem drug use among participants in this study can be understood in the light of a number of intersecting factors both at a micro, meso, and macro level. For example, at the individual level the participants' long-term pattern of use can be linked to their socio-economic status which is characterised by unemployment, low educational attainments, a lack of formal job skills, and living unstably in transitional housing, and might be considered as an adaptive response to their lack of societal participation. It is possible that the disjuncture between socially formatted expectations (achieving the goal of economic success) and structural arrangements (socioeconomic resources) inherent in inequality produced feelings of marginalisation, boredom and of lacking in self-sufficiency among participants who turned to self-destructive means to cope with dislocation. In Britain problem use of heroin and crack cocaine is linked to poverty, deprivation, widening inequalities, and few community resources (Buchanan, 2004; May et al., 2005), and remains hidden among Bangladeshi groups (Cottew & Oyefeso, 2005) who often have a pre-existing social disadvantages that places them at risk for drug taking (Eade & Garbin, 2002) corroborating the findings of our study. However, although Bangladeshi drug users in our study were identified on the basis of ethnicity, their drug use trajectories or careers very much mirror those of drug users in general, regardless of ethnic identification (see Bourgois, 2003; Darke, 2011) in terms of onset of drug use, acceleration, regular use, cessation and relapse, and contact with multiple service systems (e.g. drug treatment, criminal justice, mental health, welfare, primary health care).

At the meso level drug initiation and patterns of drug use among participants can be related to the characteristics of their social networks. In the pursuit of a sense of belonging participants turned to friendship networks where drugs were consumed, sold, and encouraged through the offer of free sampling. Characteristics of social networks, particularly drug use in the peer network, are regarded as social determinants of initiating drug use (Neaigus et al., 2001). Studies have documented a relationship between initiation of drug use and social network drug use in individuals (Latkin et al., 1995, 1999), and provided evidence supporting both social influence and social selection processes in the persistence of drug use among adults (Bohnert et al., 2009). Observing drug use by network members together with wanting to 'hang out' with people consuming and dealing drugs, all contributed to changes in drug use among our study participants in terms of drug initiation, graduation to other drugs, and selling drugs. The embeddedness of drugs in a drug-using network made it difficult for participants to stop using them.

At a macro level participants faced structural barriers and social isolation from mainstream institutions as they experienced racial discrimination in terms of employability: all were unemployed and mostly in receipt of state benefits. They endured dysfunctional lifestyles induced by drug use, loss of hope, and a diminished sense of locus of control which

resulted in prolonged dislocation. Participants' drug use can therefore be seen in the light of the best available response they could exercise when faced with debilitating and painful environmental circumstances (Alexander, 2008). Participants responded as well as they could, given limited environmental and psychological resources. However, not all people will turn to self-destructive means to cope with dislocation, as social discrimination may isolate drug users into higher risk relationships (Crawford et al., 2013).

In our study participants did not achieve a level of social acceptance, competence, self-confidence, and personal autonomy as a result of which they faced an intense and protracted sense of being shamed by their family. It is possible that continued drug use was a way to mitigate socially conditioned stigma and shame derived from their inability to enact their gender roles and parental expectations (Matthews et al., 2017). For instance, male and female participants did not fulfil parental role duties, with women suffering the indignity of having their children taken in to custody. Participants were unable to provide for their family and relied on government benefits or in some cases turned to illicitly dealing drugs. Others were unable to be a role model to their younger brothers or sisters. Thus, stigma and shame manifested on a continuum mediated by all the aforementioned factors. Evidence indicates that functional drug users – those not addicted to class 'A' drugs and meeting cultural expectations (beside drug use) – do not face the same shaming behaviours (Lloyd, 2010).

Problem drug users often face stigmatisation on accessing services (Lloyd, 2010). In our study, participants were at risk of jeopardising their anonymity and confidentiality when accessing services as these were geographically proximate to where they lived. Thus, being 'named and shamed', reflects other studies on barriers to help-seeking from a GP for mental health problems among Asian women (Newham Inner City Multifund and Newham Asian Women's Project, 1998) and Muslim groups (Ciftci et al., 2013). Due to cultural imperatives (Cottew & Oyefeso, 2005) drug use among our study's participants was shrouded in secrecy whereby shame and the need to conceal their drug use prevented the participants' effective use of drug treatment services. Not wanting to be labelled as a drug-user which implies accepting a stigmatised identity was a barrier to engaging with treatment services. This finding echoes other sensitive research on gonorrhoea and HIV screening where stigma posed a barrier to help-seeking (Fortenberry et al., 2002).

Policy implications and recommendations

This study aimed to produce an understanding of factors contributing to drug using trajectories among British Bangladeshi men and women living in the East End of London. Our policy recommendations entail a life-focused intervention aimed at creating extra opportunities and making critically-needed resources available in the marginalised environment where participants lived. Human capabilities should be built as a means to restore and maintain agency and sustain well-being through, for instance, the adoption of aspirational approaches (developing a range of skills), physical and economic regeneration, and information and inspiration approaches (to raise awareness of issues around drug (mis)use and/or advising and guiding young people on careers). In addition to this, to address the concerns about confidentiality in accessing treatment services which is a common source of concern for substance users (Tucker et al., 2004), and stems from treatment providers' lack of sensitivity to stigma and shame, we suggest changes in practice.

For example, through patient and public involvement improvements could be made to access to treatment, including better privacy practices to maintain the anonymity of service users. Good practice guidelines should also be introduced to maintain the anonymity of service users and enable staff to uphold standards in their professional Code to meet quality and safety requirements of service users and regulators. Ways forward in future research should examine effective ways of reducing stigma related to drug use among Bangladeshis to improve engagement with drug treatment services.

Study's strengths and limitations

When doing research we have to take into account the shortcomings of doing research with ethnic groups where research encounters are limited by social distance imposed by social relations (Anderson, 1993). Although we conceived research interactions as psycho-social spaces (Gunaratnam, 2003) within which sensitive topics are co-produced, it might be that the status of the health professional of the interviewer had an impact on participants' responses on their drug use. However, Fathima felt she could challenge potentially authoritative forms of power relations and exercised her right to terminate the interview on the ground she 'had another appointment'. The fact that we were not able to access younger service users (18–25) may be an indication of refusal to participate as participants' sense 'safety' (anonymity) may have been compromised by the research setting.

Acknowledgements

We are indebted to the reviewers of this paper for their helpful comments on previous drafts.

Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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