



**National Treatment Agency  
for Substance Misuse**

**Issues surrounding drug use and drug  
services among the South Asian  
communities in England**



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This is the first of a series of publications to inform drug service planning and provision by presenting results from the *Department of Health's Black and minority ethnic drug misuse needs assessment project* that was conducted throughout England in three phases during 2000-2001, 2004-2005, and 2006. This project employed the Centre for Ethnicity and Health's Community Engagement Model to train and support 179 community organisations to conduct the needs assessments (Fountain, Patel and Buffin, 2007; Winters and Patel, 2003). Each community organisation was also supported by a steering group whose membership included local drug service planners, commissioners and providers.

This publication collates the findings from 65 reports on issues surrounding drug use and drug services among England's South Asian communities (Bangladeshi, Indian, Pakistani, and Sri Lankan). In total, 10,485 members of these communities provided the data for the reports, 48 of which were concerned solely with South Asians, while the remaining 17 included a substantial proportion of members of these communities in their samples.

## Foreword

This UCLAN series of reports – of which this is the first volume – examines knowledge of and information about drugs and drug services among a range of Black and minority ethnic groups in England.

Overall, the series has shown that various ethnic groups require more and better targeted information which not only enables community members to understand the impact of drugs on their communities more fully but also helps them to access and to trust drug services when needed.

The NTA endorses these reports.

One of the questions which the reports did not set out to answer was whether – *once they have entered drug treatment* – drug users from Black and ethnic minority backgrounds have different treatment experiences and outcomes as a result of their ethnicity.

An analysis of 2006/07 data from the National Drug Treatment Monitoring System (NDTMS) suggests that generally there is no ethnicity-related differential impact when it comes to drug treatment itself.<sup>1</sup> While different people respond to treatment differently, service user demographic characteristics do not have a major impact on the treatment provided to them – and this applies as much to gender and age as it does to ethnicity. The characteristics of the service provider and the service user's main drug of use are more likely to affect how an individual responds to treatment.

For instance, when compared to service users in general, Black service users (defined as Black Caribbean, Black African and 'other' Black) were half as likely in 2006/07 to be primary heroin users and five times more likely to be primary crack users.

One of the functions of being a primary crack user was that they were also found to have shorter waiting times for drug treatment as well as shorter treatment episodes. These differential impacts were reflected among Black service users, but it is the crack use and not the ethnicity *per se* which is the stronger driver of any difference.

As for discharge, the strongest factor which was linked to whether someone had a planned or unplanned discharge from treatment was also their drug of choice. In particular, the main factor that impacted negatively on planned discharge was the use of heroin and crack cocaine together, followed by opiate use alone then crack use alone.

That said, the range of possible factors which can impact on treatment outcomes is so wide and varied that even the main drug of use is not a particularly strong driver.

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<sup>1</sup> This analysis is available on the NTA website at website at [http://www.nta.nhs.uk/areas/diversity/docs/differential\\_impact\\_assessment\\_ndtms\\_0607\\_%20120309.pdf](http://www.nta.nhs.uk/areas/diversity/docs/differential_impact_assessment_ndtms_0607_%20120309.pdf)

What this means for the treatment sector is that we may need to intensify our efforts to ensure that staff and organisational competence is sustained and enhanced to ensure that drug services meet the needs of a range of drug misusers.

Evidence-based psychosocial interventions that promote freedom from dependence and a route towards recovery are of particular importance as the 'golden thread' that runs through all drug treatment. In turn, this will enable drug treatment services to improve their organisational functioning and have a greater impact on the outcomes of all their service users, whatever their ethnic background or primary drug of use.

In accordance with the Agency's Equality and Diversity Strategy, the NTA will therefore continue to conduct an annual analysis of the differential impact of drug treatment on different groups.

## **Key messages**

### **Drug service needs**

- This report represents the evidence and recommendations from 65 studies, which will help drug service planners, providers and commissioners to address the needs of South Asians. To be effective, however, this work should take place at a local level, in order that the heterogeneity of what are described here as 'the South Asian communities' is addressed. Cultural competence includes recognising the differences between, for example, Bangladeshis, Indians and Pakistanis: 'what works' for one of these groups may be inappropriate for another.
- The drug service needs presented in this report are interrelated: a 'pick and mix' approach to meeting them will be ineffective because other barriers to drug service access will remain.
- Meeting these needs relies not only on action by drug service planners, commissioners and providers, but also by the South Asian communities themselves.
- The overall picture painted by the results from 10,485 participating South Asians is that they are struggling to deal with drug use without sufficient knowledge of the issues, within the traditional immediate family support structure, and in isolation from mainstream drug services; and that drug services are unaware of the needs of South Asian communities and of how to meet them. It is clear that community members want support and that drug services want to be supportive, but both lack the capacity to progress these aims.
- The drug-related needs of South Asians are, above all, information about drugs and drug services. In addition, their trust in the confidentiality and the cultural competence of drug services must be built up. Engagement between and commitment from local South Asian communities and local drug service planners, commissioners and providers is essential for progress towards meeting these needs.
- Adaptation and flexibility are clearly required so that the barriers to drug service access by South Asians begin to be overcome. However, because trust and confidence in drug services is currently low, and some of their current methods of dealing with drug use will be challenged, increased access by South Asians is unlikely to be an immediate outcome of any changes.

### **Patterns of drug use**

- The British Crime Survey (Roe and Man, 2006) covers a representative sample of the whole population in England and Wales and provides details of the illicit drugs used and the characteristics of users. Although the sample of 10,485 South Asians from 65 studies was not representative of all South Asians, the results indicate that:

The pattern of illicit drug use among South Asians appears little different from that of the general population in terms of the drugs used and the age of users.

There may be a smaller proportion of South Asian females than females in the general population who have used illicit drugs, although some of the studies highlighted the reluctance of females to respond to questions on personal drug use.

- Drug use among the South Asian population is perceived to be increasing among young people, including females.
- Illicit drug use among young South Asians (particularly those born in the UK) is seen to result from the communities becoming '*more westernised*' as their adherence to traditional South Asian culture lessens, especially in relation to the preservation of family respect and behaving according to religious principles.
- The early onset of drug use is a risk factor for problematic drug use (for example, HAS, 2001). It is therefore a cause for concern that a growing proportion of young South Asians are perceived to be using drugs, as the South Asian communities have relatively larger proportions of young people compared to the rest of the population.

### **Tackling drug use**

- The findings from the 65 community organisations' studies strongly indicate that, compared to the white population, South Asians are under-represented as recipients of drug information, advice and treatment services.
- A major barrier to drug information, advice and treatment services is a lack of awareness of the range of services that exist and the help they can offer. This impedes access to information and advice for all members of the South Asian communities, including non-problematic drug users who would benefit from information about the substances they use and advice on harm reduction strategies. The lack of awareness also hinders access to treatment for problematic drug users, and means that, if it is accessed, there is an unrealistic expectation of what can be achieved and the process by which it is achieved.
- The majority of the drug users who had accessed mainstream drug treatment services rated them poorly, not only because their expectations were unmet, but also because of the perceived lack of cultural and religious competence in the service.
- The centrality of the family in South Asian culture means that family members expect and are expected to be involved in tackling the drug use of a close family member.

The major factors influencing families' reactions to drug use are the importance of maintaining the respect of the family within their community and their lack of awareness of drug services.

The result is that families often employ strategies that focus not on seeking professional help for the drug user, but on hiding and denying the situation from the extended family and the rest of their community.

Families' efforts to tackle the drug use of a member without seeking external help are largely unsuccessful.

When external help is sought for a drug user by their family, mainstream drug services are rarely considered.

### **Information needs**

- Although all 65 reports stressed that the South Asian communities needed information on drugs and drug services, there was less agreement on what this information should consist of, where it should be delivered, the media used to deliver it, who should deliver it, and to whom it should be delivered. This is indicative not only of the different samples the studies targeted, but also of the diversity within the South Asian communities, such as that between generations, genders, religions, ethnic groups and languages (scores of official, regional and tribal languages and dialects are used across South Asia). Therefore, initiatives need to be devised on a local basis.
- Raising awareness within the South Asian communities on drug-related issues means that the taboo on discussion on these must be overcome, and this requires sensitivity, persistence, time, and meaningful engagement with the communities in order to discuss, devise and deliver the most effective approaches.
- Raising awareness of drug services in order to improve access has to compete with the well-established methods of tackling drug use without external help; the negative experiences of those who have used these services; and, albeit diminishing, the denial by some community members that this information is needed because drug use is perceived to be *'what happens to other people, not us'*.

### **Confidentiality**

- The link between the stigma of drug use and a lack of trust in the confidentiality of drug information, advice and treatment services is a recurrent theme throughout this report, and cannot be over-emphasised as a barrier to their access by South Asians.

### **Cultural competence**

- A basic framework for cultural competence is provided in Section 7.
- As one report put it, to meet the unmet drug service needs of the South Asian population, *'services need to cater around the people and not the people around the services'*. In order to do this, the study reports variously recommended that drug service planners, commissioners and providers need to understand and address how

South Asian culture affects access to, and experience of drug information, advice and treatment services in terms of:

the diversity within the population;  
family involvement in addressing members' problems;  
religious beliefs;  
language;  
the ethnicity of drug service workers;  
women who prefer women-only environments;  
treatment modalities;  
the differential impact of services on ethnic groups; and  
fears of breaches of confidentiality.

- Only a few of the studies recommended specific drug services for South Asians. Rather, most called for cultural and religious competence by mainstream services:

*More specialist services could have an important role alongside other services, but it is important that mainstream providers develop appropriate ways of working with Black and minority ethnic communities. Some generic services showed many of the aspects of cultural competence and aimed to include the advantages of a specialist approach in a more general framework. Mainstreaming into a generic service allows for the systematic consideration of the particular needs and impact upon Black and minority ethnic communities at the point of planning, implementation and evaluation.*

## **Engagement and commitment**

- Engagement between, and commitment from the South Asian communities and drug service planners, commissioners and providers is essential for progress to be made. Partnerships between a wide variety of statutory and voluntary services were seen as key to this engagement, and the existing building blocks, such as the 65 community organisations that participated in this project, should be fully utilised in this process.
- As one report succinctly put it:

*Ultimately ... those responsible for drug services ... are faced with a decision ... Do they carry on as before, making a few token changes to make existing services more accessible? Or will they set out to engage proactively with [South Asian communities] to promote ownership and involvement at every level of such services?*

- It was stressed that the South Asian communities must also be committed to engaging with 'those responsible for drug services'.
- The continual improvement and responsiveness of drug services to the South Asian communities is a long-term process, and should be given local strategic consideration rather than being treated as an 'add-on' to services' core activities.

## Population profile

The 2001 census reported that:

- 1.8% (1,053,411) of the UK population were Indian; 1.3% (747,285) were Pakistani; 0.5% (283,063) were Bangladeshi; and 0.1% (84,140) were Sri Lankan.<sup>[1][2]</sup>
- Indians comprised 22.7% of the UK's Black and minority ethnic population, Pakistanis 16.1%, Bangladeshis 5.3% and Sri Lankans 1.8%.<sup>[1][2]</sup>
- 54% of Bangladeshis in the UK lived in London, but the Indian and Pakistani communities were more widely dispersed: for example, 19% of Pakistanis lived in London, 21% in the West Midlands, 20% in Yorkshire and the Humber, and 16% in the North West.<sup>[3]</sup>
- 92% of Pakistanis and Bangladeshis in Great Britain described their religion as Muslim. Indians were more religiously diverse (45% Hindu, 29% Sikh, 13% Muslim).<sup>[4]</sup>
- The South Asian communities were relatively young. For example, 7.9% of the whole population of England and Wales were aged 10-15, whereas 9.3% of Indians, 12.2% of Pakistanis, and 13.6% of Bangladeshis were in this age range.<sup>[5]</sup>



## **1 Research methods**

Data for the needs assessments were collected by community researchers, most of whom were South Asian. They were selected by each community organisation and attended a series of accredited workshops run by the Centre for Ethnicity and Health (now part of the International School for Communities, Rights and Inclusion) on drugs and the related issues (including drug policy) and on research methods.

A variety of quantitative and qualitative data collection methods were utilised, with research instruments and methods that were appropriate to the aims and the target sample of each study, and to the issue they addressed. All the 65 studies incorporated a structured or semi-structured questionnaire (usually via a one-to-one interview but also by self-completion) into the data collection process, but many also conducted focus groups and a few included in-depth case studies.

Strategies to recruit samples of community members included the use of the community organisations' and community researchers' networks, but also an open day at a community centre which incorporated completing a questionnaire, and requests for participation via relevant conference and seminar workshops, at melas (community gatherings or festivals), and on appropriate radio stations and websites. The sample recruitment process therefore achieved one of the aims of the Centre for Ethnicity and Health's Community Engagement Programme – to raise the awareness of community members of the issue in question.

### **Note**

As the community organisations reported both qualitative and quantitative data, this publication sometimes uses the following terms to give an indication of proportion: small minority (around 5% or less); minority (around 10%-15%); significant minority (around 20%-30%); majority (more than 50%); and large majority (more than 75%).

## **2 The sample**

The total sample of South Asian community members was 10,485, whose ethnicity was Pakistani (3,712), unspecified South Asian (2,860), Indian (1,872), Bangladeshi (1,864), Sri Lankan (84), mixed: South Asian/white (47), and British Asian (46).

The sample's age range was wide (from 16 to over 70), although many studies targeted young people, and there were roughly equal numbers of males and females.

Geographically, the 65 studies were spread across England's regions: West Midlands (17), Yorkshire and the Humber (14), London (11), North West (9), South East (5), East Midlands (4), North East (3) and South West (2). Some studies were conducted across a whole county, city, borough, or town, while others concentrated on specific neighbourhoods, and one study was conducted among prisoners.

In addition to community members, 16 studies also interviewed a total of 265 individuals involved with the South Asian communities in a professional capacity. These were mainly drug service providers and commissioners, but also included community workers, youth workers, religious leaders, school teachers, taxi drivers, and pub landlords and doormen.

## 3 Patterns of drug use

See *Key messages* for a summary of this section

**It must be stressed that no inferences on the prevalence of illicit drug use among the South Asian communities should be made from the data presented in this section.** The *Department of Health's Black and minority ethnic drug misuse needs assessment project* was not intended to be a prevalence survey, but aimed to provide an overview of drug-using patterns and drug service needs.

Some studies did not intend to document the personal drug use of their samples, while others targeted current drug users and many studies were conducted among young people and/or in disadvantaged areas, where it is expected that the prevalence of drug use is higher than in the whole population of England. The proportion of South Asians who have used each of the substances discussed below is therefore intended to demonstrate only their relative popularity among those who reported this use.

### 3.1 Lifetime drug use

5,868 South Asians were asked whether or not they had ever used an illicit drug, and 1,316 (22%) had done so at least once. Initiation into drug use was invariably via experimentation with friends.

- The 1,316 drug users were far more likely to report having used **cannabis** (in herbal and/or resin form) than any other drug. This drug had been used by three-quarters (75%) of those who had ever used an illicit drug.
- Over one in five (21%) of the 1,316 drug users had used **cocaine powder**.
- Almost one in five of the drug users had used **heroin**.
- 17% of the drug users had used **crack cocaine**.
- 15% of the drug users had used **ecstasy**.
- 12% of the drug users had used **amphetamines**.
- Smaller proportions of the drug users had used other illicit substances: LSD (5%), hallucinogenic mushrooms (3%), and ketamine (2%). In addition, 3% had used amyl or butyl nitrite (poppers), 3% had used steroids that had not been prescribed for them, 2% had used solvents and 2% had used khat.

### 3.2 Current drug use

473 of those who had ever used an illicit drug were asked if they were still doing so, and 397 (84%) were currently using at least one. The proportion of these using each drug follows the same pattern as those who had ever used a drug, although slightly smaller proportions were currently using cannabis (70%), cocaine powder (19%), and amphetamines (8%), and slightly larger proportions were currently using heroin (21%) and crack cocaine (18%).

- Few studies asked drug users about their mode of administration, but those that did reported little **injecting drug use**.
- There was anecdotal evidence from a few of the studies that more South Asian women than those of other ethnic groups receive **sedatives, tranquillisers, and antidepressants** on prescription, and that these were shared with other women for whom they were not prescribed, as a gesture of friendship and support.
- The **gender** ratio of current drug users was around 3 males:1 female.
- The **age range** of the majority of current illicit drug users was 16-29.
- The **age of onset** of drug use was 16 and under in most cases. Almost all the drug users had used an illicit drug (usually cannabis) by the age of 18.

### 3.3 Perceptions of drug use

Most of the 65 studies asked their samples for their perceptions of drug use among members of their communities.

- Perceptions of drug use did not change over the seven-year period of the project (2000-2006).
- A large majority believed that illicit drugs are used among their local South Asian communities, including among those who follow a religion (the majority of the sample reported their faith as Hindu, Muslim or Sikh). The remainder of the sample either disagreed or said they were unaware of the nature and extent of drug use: these study participants tended to be from the older generations, particularly women, some religious leaders and those drug service providers who had no (or very few) South Asian clients.
- Drug use was usually perceived as a problem by community members, variously expressed as the crimes committed to fund it; stress on the family (especially mothers) and the breakdown of family relationships; the negative effects on users' physical and mental health; and the high visibility of drug users and dealers leading to community safety concerns, especially the perceived easy availability of drugs to young people.

- While some community members believed drugs were used by all age groups, the majority thought that young people were most likely to be using them.
- A significant minority of study participants thought that drug use among South Asian communities was increasing, especially among young people.
- A majority thought that young males were far more likely to use drugs than females, although a minority thought that the proportion of young females was increasing.
- Cannabis was perceived to be the drug most often used, followed by heroin, cocaine powder, crack cocaine, and ecstasy. This perception broadly concurs with the pattern of lifetime and current drug use reported to the study by illicit drug users.
- Several reports interpreted the findings above as showing that the younger generations of South Asians in England are 'more westernised' than the older generations. For example:

*[Young people] have adopted much more western standards and values and terms of references and are much more exposed to a 'drug culture ... the use of cannabis is widespread amongst this age group. This we believe is similar to the usage of cannabis amongst other communities.*

*It is obvious that young Asian communities are fully conversant and have direct experiences and contact with drugs. Therefore their experiences and knowledge seem no different to those in the indigenous white community.*

- While a small proportion of the sample were aware of the factors associated with experimentation with drugs among young people (for instance, peer influence and aspects of social exclusion such as unemployment), far more put the responsibility on drug dealers and/or parents' failure to bring up their children 'properly'.

## **4 Tackling drug use**

See *Key messages* for a summary of this section

Most of the 65 studies included questions about sources of help-seeking. This section will report how drug users, their families and South Asian communities deal with drug use, showing why drug services are rarely considered.

### **4.1 Help-seeking by drug users**

Drug service providers reported that, compared to the white population, South Asians are under-represented as recipients of drug information, advice and treatment services (many adding that this was particularly the case for females), although a few reported a recent increase. Most of the 1,316 lifetime and current drug users were asked if they had ever sought information, advice or treatment from a drug service, but only a small minority had done so.

Help-seeking will be examined here by dividing the drug users into three groups: once-only or irregular drug users, more frequent drug users, and problematic drug users (those whose drug use led them to experience social, psychological, physical or legal difficulties and caused harm to them, their significant others, or the wider community).

#### **4.1.1 Help-seeking by once-only or irregular drug users**

Not surprisingly, help-seeking from drug services was not considered necessary by those who had used a drug (usually cannabis) only once or very irregularly, and had not experienced any problems. A typical comment from this group was:

*I am not a hard [drug] user, it is once in a blue moon, and when I want I can say no to drugs.*

However, many in this group had little knowledge about drugs, including those they had used, and if they wanted advice and information, most asked the friends with whom they had used drugs: their drug service needs therefore consist of information about drugs and about harm reduction measures.

#### **4.1.2 Help-seeking by more frequent drug users**

The 'I can handle it/I could stop if I wanted to' response was also reported by some of those who used a range of drugs and/or used them frequently. Many of this group had not considered seeking help from drug services because drug use requiring intervention was defined by them as addiction only and/or drug services were seen as being for only heroin and crack cocaine users and injectors. This attitude was despite them experiencing some problems related to drug use, such as censure from their family when it was discovered and difficulty paying for the drugs they used. Therefore, this group have information needs, not only about drugs and harm reduction measures, but also about drug services.

A small minority of this group had sought information and advice, mainly from the FRANK website and telephone helpline and/or their GP. Some of those injecting steroids to enhance their physical performance obtained clean injecting equipment from a needle exchange: they stressed that they went there only because there was nowhere else to get the equipment and did not use any of the other services offered there because they did not consider themselves to be drug users like the other clients, who they described as *'junkies'*.

#### **4.1.3 Help-seeking by problematic drug users**

Those who used more drugs, more often than the previous groups – particularly those who reported being dependent on heroin and/or crack cocaine – reported various drug-related problems:

- poor mental and physical health;
- the breakdown of partner and/or family relationships;
- exclusion from the family home;
- loss of friends;
- financial debt;
- unemployment;
- stigmatisation of themselves and their families among their local South Asian community; and
- committing crimes to fund drug use, leading to arrest, conviction and imprisonment in some cases.

While some of this group believed they could stop using drugs if they wanted to, a majority said they were worried about their use and/or wanted to stop using and/or needed treatment. However, many reported that they did not know how to access drug services, and only a minority had done so.

Of those problematic drug users who had not accessed any drug service, some had made no other attempt to tackle their drug use. The strategy reported most often by the remainder was attempting to stop by willpower alone, and any support they received usually came from friends and/or other drug users.

A minority of problematic drug users had accessed treatment such as counselling, substitute prescribing and detoxification; obtained clean injecting equipment from a needle exchange; or received advice and referral from GPs and street agencies. In a few cases, detoxification treatment had been obtained from a private clinic, paid for by their families.

#### **4.1.4 Drug users' knowledge, expectations and experiences of drug services**

Throughout the project, the needs assessment reports recorded that a high proportion of drug users had little or no idea of what drug services entailed, nor of how to access them. Many of those who had accessed treatment services therefore had unrealistic expectations of what drug treatment could achieve and the process by which it is achieved. For example:

*I don't want to chat about other people's problems all day ... I just couldn't adapt ... I mean, some people went on for half-an-hour – I can't listen to that – just help me! I don't see how it helps if you just go round telling people your problems.* (Drug user who had stopped attending group counselling sessions)

*[Ameliorative prescribing] has not helped me to deal with my drug problem. By putting me on Valium, it has made me dependent on another drug.* (Crack cocaine user)

While some drug users were satisfied with the drug services they received and felt that their needs had been met, more drug users rated services poorly (including those in prison), particularly because of:

- too long waiting times for treatment;
- the lack of follow-up support, particularly after detoxification;
- the services' lack of understanding of South Asian clients' cultural and religious traditions; and
- in a few cases, racism.

#### **4.2 Family and community responses to drug use**

The main reported effects of drug use on users' families included the loss of respect within the family and community; extreme stress on – and breakdown of – family relationships; and financial difficulties because the drug user stole from the family to pay for drugs and/or the family gave them money to buy drugs.

The responses of many South Asian families to the drug use of a member (whether or not it can be defined as problematic) must be understood in the context of the centrality of the family and of respect in the traditional cultures of South Asian communities. The family's role is to maintain a close network of family relationships and the wider community's cultural and religious values.

Thus, the stigma attached to the use of drugs, rather than being directed at the individual only, is also felt among the family, the extended family and family friends. In those communities where this tradition continues, the family of a drug user expects and is expected to play a key role in tackling the situation.

The majority of study participants believed that news of drug use in a family quickly reaches the rest of their community, with the result that:

*It brings so much shame to the family within the community, people just look down on you, they think the whole family is bad. The drug user won't get a marriage proposal, and neither will the sisters if their brother is a drug user.* (Drug user's sister)

*We noticed severe criticism of the [drug users'] families and individuals [drug users] at the hands of community leaders and alienation and estrangement of*



*those involved in drug misuse from the rest of the community and the neighbourhood.* (Community organisation's final report)

Avoiding these consequences is, therefore, the major influence on South Asian families' responses to the drug use of a member.

Most of the studies asked at least some of their sample about drug services providing information, advice and treatment, and many reports emphasised that the level of knowledge of these was extremely low. Therefore, as well as the desire to maintain respect, an additional driver of responses to drug use is that a high proportion of South Asians are unaware of the existence of drug services and the help they can provide, and/or do not know how to access them. The responses most often given to questions about the perceived and actual reaction to drug use in a family (Sections 4.2.1 – 4.2.5) did not therefore include seeking external help.

#### **4.2.1 Deny drug use is occurring**

As many study participants pointed out, the avoidance of stigma and the lack of knowledge of drugs, drug use, and where to go for help means that many South Asian families tolerate and hide drug use. Comments such as the following were common:

*An awful lot of parents completely deny any knowledge [of drug use in the family] ... They don't want to know, they have no experience, they don't know where to go for help, they feel very out of their depth. [Parents' attitude is] like a horse wears blinkers – 'if I don't acknowledge that my child has got a [drug] problem, then I don't have to deal with it – I don't have to feel inadequate because I can't deal with it.'*

*[A drug user's parents] don't know what to do. They don't speak English and aren't educated to tap into any services that could help them, and the rest of the family don't want to know. Everybody is just going around pretending that he doesn't exist.*

However, many thought that '*burying their heads in the sand*' was no match for what they saw as the efficient South Asian 'gossip network', and that drug use in a family could not be hidden from others. In addition, trying to keep drug use hidden was reported to have put a great deal of stress on families, especially mothers.

#### **4.2.2 Send the drug user '*back home*'**

A common response from community members when asked what they would do if someone in their family used drugs was to send the drug user to the parents' or grandparents' country of origin, in some cases to be '*married off*', in the hope that a different environment or the acquisition of responsibilities would distract them from drug use.

There was some disagreement over the effectiveness of this strategy, however. Some study participants recognised that drugs were more widely available and cheaper in South Asian countries than in England, but also maintained that it would be more difficult than in England for the drug user to obtain them, because they were separated

from their usual supply networks and drug-using lifestyles, and that dealers 'back home' would be reluctant to sell to strangers. Others disagreed, and said the drug user would have no problems obtaining drugs and the strategy was therefore completely ineffective.

Most of those the families who had employed this strategy reported that it had been successful (as did several drug users who had experienced it), but usually only until the drug user returned to England, when drug use began again.

#### **4.2.3 Provide emotional support**

A significant minority of community members – particularly the older generations – thought that drug use occurred among young South Asians because their families had not spent enough time with them, neglected to transmit honourable values and beliefs, and been insufficiently strict.

Reflecting this strongly-held view of the role of the family, a common response to questions on dealing with the hypothetical drug use by a member was to support them with love and care by spending time talking and listening to them, in the hope that this would dissuade them from using drugs.

However, most of those who had tried this strategy acknowledged that it had little effect on the drug use of their family member. Limitations of the method were that:

- many parents' lack of understanding of drug use restricted the support they were able to give;
- the majority of young people were reluctant to talk about drugs with their parents because they shared (or at least appreciated) the older generations' concern to maintain respect and did not want to jeopardise it; and
- parents were unwilling to discuss drug use even if asked, because the stigma of drug use meant that talking about drugs in the home was taboo.

#### **4.2.4 Provide financial support**

Many families had supported a drug user financially by giving them money they knew would be spent on drugs. In some cases, this strategy had led to financial hardship for the family:

*It has been a financial burden. Sometimes we are compelled to give him money even though I know what he will spend it on, although he claims he needs it for something else. Also, our son is not supporting us as he should because his wage goes on drugs, which is a problem as I am retired. (Drug user's father)*

*My mum is always skint, she is giving him money all the time ... there's nothing left for herself. (Drug user's sister)*

#### **4.2.5 Ostracise the drug user and their family**

Many drug users and their families had experienced the loss of respect and subsequent shunning of the drug user's immediate family by the extended family, and of the family by the community of which they are a member:

*My wider families have disconnected from us and we have lost respect among them. (Drug user's parent)*

*It makes it difficult to show your face in the community. Community members speak behind your back. The family is black marked and the family's respect in the community is brought down. People are not willing to help. (Community member)*

*[The community] frowns upon me and my family as if we are criminals or completely dysfunctional. (Drug user's parent)*

Some families had ejected the drug user from the family home (and, in a few cases, wives had left drug-using husbands). This was usually a last resort, in an attempt to make the drug user realise what they had lost and stop using.

#### **4.2.6 Seek help**

The 'do-it-yourself' strategies discussed above were reported to be largely unsuccessful in terms of tackling the drug use of a family member, and many of those who had attempted them continued, as one study participant put it, to '*suffer in silence*'. In some cases, however, external help had been sought because a crisis point had been reached, such as the drug user being arrested or experiencing severe health consequences, or because family members could no longer cope alone. Those who had not been in this situation were more likely than those who had to say that they would seek external help. One explanation for this is that they had not experienced the stigma of having a drug user in the family, and their reactions may be different if actually faced with the drug use of someone close to them.

- **GPs** were the most frequently-cited source of professional help that community members (particularly women) said they would access if a family member needed help with a drug problem, because '*they understand what it is we need*' and:

*In Asian communities, doctors [GPs] are seen as good and knowledgeable persons. Their role is to help us. They know where to get help and make sure we are properly looked after.*

However, there were concerns whether the reason for the visit would remain confidential, especially if the GP was South Asian. Young people were worried that a GP would tell their parents and families about their drugs-related visit, and many study participants believed that the news would travel further:

*The fact is that people think ... 'I know he [GP] knows the rest of the family and all the other Asians in [town] ... he might just slip it out, mention it'.*

However, few of those who had a drug user in the family had actually gone to a GP for help (other than some drug users' mothers, to be treated for the stress of dealing with this issue), and most of those who had done so reported that their GP had not been helpful.

- Very few of those who had sought external help for a drug user in the family had approached a **mainstream drug information, advice, or treatment service**, and few imagined that they would do so if a member of their family was using drugs. Some said that they would try and get a counsellor for the drug user, talk to a drug worker, go to a clinic or a hospital, or *'ask around to see if someone could recommend a good service'*, but they appeared to have little idea of the nature of the services that could be provided through these sources.
- A few community members said they would consider paying for **private treatment** for a drug-using member of their family, and, among those who had followed this course of action, private treatment was rated highly.
- Only a small proportion of study participants considered **religious leaders** to be a potential source of help for a drug user. Most thought that they would condemn or not understand drug use:

*They have a chapter and verse to quote at you for everything, but they don't understand the terrain.*

In an attempt to address a family member's drug use, a minority of families had turned to religious leaders for support, and their experiences confirmed this view. Religious leaders had shown disapproval of the drug user and their family and their only solution had been that the religion's principles should be followed. As a Muslim study participant put it:

*An addict cannot automatically stop [using drugs] just because it is anti-Islamic and bad.*

- Only a few studies reported that a proportion of their sample would approach (or had approached) a **community organisation** for help for a family member with a drug problem. Those who would not said this was because they expected disapproval or feared the approach would not be kept confidential.
- Some study participants (especially young people) said that they would search for information on the **internet** for help with the drug use of a family member. The FRANK website and **telephone helpline** were mentioned most often because not only was the information considered to be reliable, but also because anonymity was guaranteed.
- A small minority of community members said that if a member of their family was using drugs, they would report their dealer to the **police**.
- Many young people imagined that they would ask their **friends** for help if they had a problem with drug use, although some recognised that their friends may not always want to be associated with them, not only because of the stigma of drug use but also:

*If people see me talking to a friend who is involved with drugs, then they will assume that I am involved as well.*

The remaining sections report on the drug service needs of the South Asian communities as identified by the 65 community organisations on the basis of their findings. These needs are categorised as **information, confidentiality, cultural competence**, and **engagement and commitment**. Of course, not all the drug service needs identified in this publication apply exclusively to South Asians, nor indeed only to members of Black and minority ethnic communities. However, although the data collected during this project indicate that the drug-using patterns among South Asian communities are not different from those of the general population, it does not follow that South Asians can simply 'slot into' existing drug services. Responses may have to be different in order that the barriers to drug service access that they face can be overcome.

The concentration on unmet needs in the following sections is not intended to deny that there have been some creditable efforts by some drug service planners, commissioners and providers to address the needs of drug users from Black and minority ethnic populations as clients of mainstream drug services – including the adoption of some of the measures detailed below.

**That said, over the seven years of this project, almost identical conclusions and recommendations for drug service development were presented by the 65 needs assessments. This is a serious concern. The repetitious demands for change devised after research with 10,485 South Asians indicate that drug information, advice and treatment services continue to be as hard for them to reach today as they were in 2000.**

## **5 Information needs**

See *Key messages* for a summary of this section

Without exception, the 65 studies cited information on drugs and drug services as a major need of the South Asian communities. It was clear that the majority of the members of these communities (especially parents) wanted to address drug use and help to do this, but their lack of information was a key obstacle. There was a strong correlation between age, gender and drug awareness, with young men knowing more than other community members, but even this group's knowledge, including that of drug users, was limited.

Overall, the studies concluded that South Asians need information about drugs (including harm reduction strategies) and drug services in order to increase their confidence in discussing drugs so that the taboo on this would begin to be broken, and that trust in drug services is acquired. As one report put it:

*The shame and dishonour ideology is strongly held and works against accessing services.*

### **5.1 The message**

In addition to comprehensive information about drugs and drug services, some studies also recommended that:

- the findings from local needs assessments be widely disseminated so that drug education can be given in the context of local drug use;
- the views of the South Asian communities (particularly of young people) on aspects of illicit drug use that they consider 'acceptable' and risk-free should be challenged;
- drug education should be enjoyable and creative, especially for young people; and
- parents are taught how to talk to their children about drugs.

A small number of the reports called for an approach to drug education that is aimed solely at preventing drug use and that teaches young people the techniques to resist it. They wanted drug education to emphasise that drugs are illegal; that the target groups' religions prohibit their use; and that drug use causes harm to the user and their friends, family and community.

In terms of drug services, the reports agreed that the South Asian communities need explicit information about what drug services provide in terms of information, advice and treatment, and how they can be contacted. Many reports emphasised that drug services need to be actively promoted because when a drug user and/or their family decide to seek help, they do not know where to obtain it, and because many think that drug services provide only clinical treatment for problematic drug users. If this situation continues, as one report put it:

*The gap will widen between those who are catered for within mainstream services and those who are marginalised.*

If raising awareness of drug services is to encourage service contact by South Asians, the studies' reports on this issue made it clear that explicit information is required, such as:

- explanations of addiction;
- what counselling and detoxification involve;
- drug service processes (especially how they are accessed and waiting times for treatment); and
- the length of treatment programmes.

In this way, realistic expectations of what drug services can achieve, and how they achieve it, will be conveyed.

## **5.2 Venues**

A very wide variety of venues for the delivery of information and advice was recommended by the participants in this project, in total covering every place that community members might ever visit.

A common recommendation was that information and advice should be delivered in community-based, familiar venues and where referral to drug services could be made if necessary. These included community centres, health centres, places of worship and GP surgeries. Many reports proposed drop-in facilities that advertised themselves as giving advice on a variety of issues, so that those visiting them would not be identified as seeking information on drugs.

For young people, youth clubs, schools (including religious schools), colleges, universities, and sports and leisure centres came into this category. For their parents, parents' evenings, parent-teacher association meetings, and school governors' meetings were suggested. For those women for whom it is culturally unacceptable to mix with men, women-only venues or their homes were thought most appropriate.

Other suggestions for sources of information and advice included local shops, libraries, mailshots to every household, Yellow Pages, community organisation open days, bus stops, community seminars and conferences, and community events, including festivals and melas (although not advertised as drug-related events). The concern to avoid the stigma of drug use meant that telephone helplines and the internet were also popular recommendations because the inquirer's anonymity is guaranteed and they can be accessed in private.

### 5.3 Media

A wide variety of media was recommended to transmit information on drugs and drug services to the South Asian communities. These included **oral and visual media** in locally-used languages and dialects, which can be used in private and/or do not require reading skills:

- videos, DVDs and CDs;
- South Asian and local community radio and television channels;
- incorporating drug-related information into South Asian music and drama;
- locally-made films, so that the issues could be set in a local context; and
- television programmes about drugs and drug services featuring South Asians.

It was also recommended that family, friends and community networks should be encouraged as channels for transmitting information.

Suggested **written media**, again in locally-used languages and dialects, included community and local newspapers, community organisation newsletters, and billboards, posters and leaflets.

### 5.4 Educators

Many of the study participants wanted 'experts' to deliver information to their community, although there were different opinions regarding who could be defined as such. Many thought that **South Asian drug users and ex-users** were the 'real' experts, and that sharing their personal experiences with the community would also help overcome the stigma of drug use. Others suggested **local drug or health service staff, GPs, and police officers**.

A majority of the reports, especially those concerned with the Muslim population, recommended that **religious leaders and establishments** should play a bigger role in tackling drug use, especially where places of worship are more widely used than for prayer only. This recommendation came particularly from those study participants who wanted drug education aimed only at preventing drug use.

However, there was no overall consensus over whether or not religious leaders should deliver drug education. Many other study participants thought that religious leaders, although respected, were too remote from the day-to-day lives of their community due to their total commitment to the observation of religious beliefs, and that they would not understand the issues surrounding drug use. Nevertheless, it was generally agreed that if religious leaders became involved, the stigma and taboo surrounding drug use would be lessened, particularly among the community elders.

A common recommendation was that highly proactive **drug outreach workers** deliver drug education 'on the streets', especially targeted at young people vulnerable to drug use. It was stressed that this work should incorporate early interventions and referrals to drug services because currently help from services was sought only in times of crisis.



Several other professionals were thought by many study participants to be best-placed to deliver information, after they had been trained in drug-related issues: **community organisation workers, community leaders** (including elders), **teachers and school counsellors, development workers, and health workers**.

Drug education delivered by **peers** was a popular recommendation, and the most frequently suggested peer educators were young people, parents and women. In addition, a few reports recommended that ex-drug users act as 'buddies' or mentors to drug users, particularly those who become estranged from their friends and family because of their drug use. A few reports also suggested that celebrities should be used to attract the attention of young people.

## 5.5 Recipients

A few of the studies' recommendations on who should receive information on drugs and drug services reflected only the needs of their specific sample, but most recommended that every member of their community was targeted. In this way, it was stressed, families and the community can support drug users and each other.

All the reports agreed that **young people** should receive drug education, and most thought this should begin at the age of 10 or 11.

Many reports recommended that **drug users** (especially of heroin and crack cocaine) should be targeted by drug education initiatives in order that they are made aware of the indicators of problematic drug use, and where they could seek help.

Many reports stressed that South Asian **women** need drug education, as they are the ones who have to deal with drug use in a family but who are currently doing so without information and support. It was thought that those women who lead '*sheltered lives*' were in particular need. A few studies stressed that – although many community members found it difficult to accept that some young South Asian women (especially Muslims) used drugs – this group should not be exempted from drug education.

Drug education for **parents** was a popular recommendation, so that they can talk confidently to their children about drugs. Some reports recommended sessions for the **whole family**, to improve inter-generational communication on this issue while maintaining the traditional method of family involvement in solving problems:

*Families of drug users form a crucial support network within the community ... but feel they are not equipped to deal with [drug use] ... The family support network is thus experiencing a crisis in its ability to find a coping strategy, that must be addressed through education and information given to families.*

**Religious leaders** and **community elders** were also felt to be in need of drug education so that they could advise community members and mobilise their support for drug education for their community.

## **6 Confidentiality**

See *Key messages* for a summary of this section

The majority of study participants believed that, in the close community settings in which many South Asians live, nothing can be kept private for very long. The studies reported that rumours spread quickly throughout the neighbourhood and individuals and families with problems will be 'named and shamed'. Therefore, if access to drug services is to be increased, it is essential that community members trust that confidentiality will not be breached. This demands consideration in terms of the location of drug services, the belief that South Asian drug workers would breach confidentiality and how the service's confidentiality policy is explained to clients and potential clients.

### **6.1 Location of drug agencies**

Many study participants said they would not visit a specialist drug agency that is located in a very public place:

*Friends and family would see me going into them and think what am I doing there, will start to ask questions.*

The majority of those who discussed the location of drug agencies therefore recommended that they should be sited in inconspicuous buildings, away from busy streets and residential areas, and, in some cases, several miles away from their neighbourhood. The importance of this is underlined by the findings from one study, which discovered that more of their drug-using sample had sought help from a drug agency outside their own town rather than locally.

### **6.2 South Asian staff**

As discussed in Section 7, the majority of studies wanted more South Asian drug workers because of their understanding of the South Asian culture. However, many study participants also thought that this could compromise confidentiality because they believed that, as one study participant put it, '*this Asian knows every other Asian and they are going to go out and tell others*'. Another explained the process:

*The problem is that if you go and see an Asian doctor ... the next day you bump into him and his wife [in the local shop]. If he says hello, she will ask him how he knows you and what you might have been to see him for. It will be very difficult for him to lie to her and very difficult to keep the truth from coming out. I must admit I am scared of telling my family problems to an Asian doctor.*

A few reports recommended that the solution was to give South Asian clients a choice over whether or not they see a South Asian worker. However, this solution risks undermining the professionalism of those who are not chosen and supporting the perception that South Asian health workers breach confidentiality. It should be stressed here that while many study participants believed that this was the case, there was no evidence that it had actually occurred.

### **6.3 Confidentiality policy and practice**

South Asian drug service clients and potential clients need to trust that the service's confidentiality policy operates as intended in the context of a culture that believes otherwise, and in which, as one report put it:

*The social risks of disclosing one's drug use is seen as more significant than personal health risks.*

Information about drug services in drug education sessions, and that given to drug service clients, should include unambiguous statements about confidentiality: clearly, 'we operate a strict confidentiality policy' or 'this is a confidential service' is insufficient.

Rather, statements such as 'we will not tell your parents, any member of your family, the police, nor anyone else that you have contacted us' and, where appropriate, 'we will not ask you for your name and address' should be made and reinforced. Reassurances that 'we won't be asking you if you have used drugs, nor if anyone in your family has' and 'we will not be asking you to tell us the names of any drug users' would facilitate attendance at drug education sessions.

## 7 Cultural competence

See *Key messages* for a summary of this section

Cultural competency is a term that is being increasingly used within the public sector, but there is little agreement over what it means and how it can be implemented. While most organisations conduct some training around race, culture and diversity, the content of their training programmes varies considerably (Tamkin *et al.*, 2002). Moreover, the diverse meanings of 'cultural competence' are often highly dependent on local contexts:

*Cultural competency of care and services may be proposed in quite diverse ways depending on the local context. This mandates the need for careful research and quality checks on what is proposed and implemented and applied. (Bhui et al., 2007 p.14)*

There are no nationally recognised standards by which cultural competence can be measured, let alone defined. However, a basic framework for assessing cultural competence can still be developed. The following framework is intended as a guide and contains only examples of the various skills, processes and abilities that are involved.

It is based on both individual and organisational competence. As detailed below, individual competence is skills-based and relates to individual practitioners' professional practice in working with diverse communities and individuals. Organisational competence, on the other hand, is defined by the level of maturity in the organisation for addressing equality and diversity across the full range of its functions and policies.

### Individual competence

Individual competence is based on the skills of acknowledging, accepting and valuing cultural difference in others – that is, between and among culturally diverse groups and individuals. Individual competence is built up through a developmental process that includes:

- **Improving knowledge of local communities**, such as demographics, religious beliefs, sects and practices, common languages, migration and settlement patterns, health and social care needs, diet and cultural norms.
- **Developing skills in reflective practice** including empathy, the ability to challenge assumptions and prejudices in self and others, and the ability to work through communication difficulties and differences with a sensitive aptitude and attitude.
- **Developing communication skills** in working with people whose first language is not English and the ability to work sensitively and competently with interpreters.

### Organisational competence

Organisational competence is demonstrated through a clear commitment to recognising diversity and the development of proactive policies which embed equality and skills in working with diverse communities throughout the organisation. This process includes:

- **A clear commitment to equality**, valuing diversity and human rights, which is articulated in the aims and objectives of the organisation.
- **Provision of staff training programmes** that meet the needs of a range of personnel, from basic induction through to higher-level learning.
- **A system for engaging and consulting with local communities** and ensuring that services take account of local diversity.
- **Leadership and management** of equality and diversity through performance and monitoring systems.

It should be recognised that individual and organisational cultural competence are inter-dependent: one cannot be effective without the other. No matter how skilled or competent the individual, they require the support of the organisation in order to achieve effective cultural competence. Similarly, however well-developed an organisation's policies and procedures are, it will fail to meet the needs of a culturally diverse population without skilled and competent staff to carry them out.

Taking a maturity approach to cultural competence recognises that there are various levels through which individuals and organisation might pass as they move towards a fully-developed level of competence. This is also in keeping with models of lifelong learning and organisational development.

A culturally competent service operates effectively in different cultural contexts so that the needs of all members of their target population can be met by equitable access, experience, and outcome. The recommendations from the 65 needs assessment reports, some of which documented the experiences of ex-drug service clients, add up to a strong need for increased cultural competence by drug services.

The diversity within a local South Asian population is a crucial consideration when local services are seeking to improve their cultural competence. The studies not only reported on differences according to age, gender and religion but also between those of Bangladeshi, Indian, Pakistani and Sri Lankan heritage. For example:

*Issues affecting a young Bangladeshi woman will differ from a young Bangladeshi man and other South Asians. Young women from the Bangladeshi focus group explained how they are not allowed to socialise in the same way as Bangladeshi young men ... and [must] behave in a manner which is acceptable by the Bangladeshi community as cultural and religious.*

*Second and third generation young Asian Muslims ... are disenfranchised from their cultural identity, where the Asian self is often subordinate to their Britishness. Thus they regard themselves as British Muslims rather than Asian Muslims. In many cases, this is in direct conflict with their parents, who do not suffer from this dichotomy as they arrived in the West with their cultural identities fully formed. They [parents] do not suffer the same ambivalence, nor indeed are they required to exhibit the same flexibilities required of the modern generation who must bridge the gap between two cultures.*

The other elements of South Asian culture that the studies recommended drug services address in order to improve their cultural competence were as follows:

- A major element of South Asian culture, as this report has shown, is that the **family** (particularly mothers and wives) is likely to expect and is expected to be involved in tackling the drug use of a member. Therefore, drug services should not only provide information and advice about drugs and drug services to South Asian families, but also, when a drug user chooses to involve their family in their treatment, support for the family in terms of information, advice and counselling.
- Many studies (especially those concerned with the Muslim population) recommended that drug services take **religious beliefs** into account. One method of achieving this is that religious leaders become more involved in providing information and advice on drugs and drug services, although it was reported that some are currently unwilling to do this (as discussed in Section 4.2.6). Drug services need to understand and proactively address the role that religious beliefs play in drug treatment and rehabilitation, and to encourage and support the involvement of religious leaders to assist them to achieve these aims.
- The **English language** was reported to be unproblematic for the younger generations of South Asians, but some members of the older generations, especially those women who have little contact with English speakers, find speaking and/or

reading English problematic. These members of the population therefore need written, visual and oral information in their own languages and dialects. For those clients whose English is not fluent, it may be appropriate to deliver some services in English with an interpreter. However, to maximise the benefit to the client, this is not an appropriate method for those interventions that depend on in-depth mutual understanding, especially counselling.

- The perceptions and experiences of the studies' samples that drug services will not meet their cultural and religious needs led the majority of their final reports to recommend that drug services employ more **South Asian workers**. Many recommended a recruitment drive to encourage South Asians to see working in drug services as a career option.

However, staffing is a more complex issue than simply employing workers who are from the same ethnic group as potential clients. A South Asian worker should not be expected to be an expert at providing a service to all South Asian drug users, single-handedly, without appropriate and adequate support. All workers, including those who are white, have an explicit role to play in the delivery of culturally competent services. That said, ethnically diverse teams communicate an implicit message that they can respond to the needs of the whole population.

- **Women-only** services were recommended by several studies, for those women for whom it was culturally unacceptable to mix with men.
- Several studies observed that **treatment modalities** are designed as 'one-size-fits-all' and Eurocentric (that is, they were perceived as responding only to the needs of white Western people) and recommended that to attract South Asians, more complementary and holistic therapies should be offered to clients. That said, it cannot be dismissed that private detoxification treatment was rated highly among those families who had paid for a member to receive it. Counselling services (for individuals and families) were also a popular recommendation, reflecting the South Asian culture of informal, verbal communication via family and community support networks.
- The Race Relations (Amendment) Act 2000 was cited by a few reports to support their recommendation to make greater use of the results of drug services' ethnic monitoring by conducting **differential impact assessments** and adapting services according to the results.
- Given the reported barriers to drug service access faced by South Asians, particularly surrounding keeping drug use and help-seeking confidential, more **low threshold/open access services** were seen as essential by many of the studies. These included satellite services offered in GP surgeries, youth centres, community organisations, places of worship and schools. In this way, the reason for access is not obvious to others, as clients could say, for example, that they were attending an after-school club or seeing their GP for a non-drug related health problem.

- Many reports recommended **cultural competence training** for all drug workers, and that this should not be a discrete exercise that diminished its relevance to day-to-day work. It was clear from those studies that interviewed drug service professionals that this would be welcomed by them. Their knowledge of drug use among local South Asian communities was generally low, especially those who had no (or very little) experience of South Asian clients and/or who were unaware of the results of their agency's ethnic monitoring. In many cases, their sources of information were cited as anecdotal. In addition, many drug service professionals had little knowledge of the local South Asian communities' cultural and spiritual backgrounds, which made them hesitant about approaching the communities:

*I don't know how appropriate it will be to visit temples or mosques and that sort of thing. (Drug service manager)*

- Examples of services that have successfully achieved a culturally and religiously appropriate approach to drug information, advice and treatment should be **widely disseminated**.

## **8 Engagement and commitment**

*See Key messages for a summary of this section*

The *Department of Health's Black and minority ethnic drug misuse needs assessment project* has not only produced 65 local needs assessments from community organisations on the drug-related needs of South Asians, but has also engaged local population groups and local drug service planners, commissioners and providers – in most cases for the first time.

The studies' reports agreed that the engagement the project had initiated should continue and expand. Several reports noted that before the project, *'some local service providers had no idea of how to meet these needs'* and one added that, previously, *'there was a perception by some service providers that the South Asian community were dealing with drug issues themselves.'*

Many of the needs assessment reports highlighted that the community organisations' participation in this project had also helped raise awareness of drugs and drug services in their local communities. This was confirmed by an evaluation of phases two and three (2004-2006), which also reported raised awareness of the participating communities' drug-related needs by local drug service commissioners, planners and providers (Baker, Crompton and Anitha, 2006).

### **8.1 Engagement**

Taken together, the studies' recommendations revealed, as one reported of their specific study:

*A common thread of better and continued consultation, multi-agency engagement, and the use and development of existing skills, individuals and services, running throughout.*

The majority of reports recognised that the South Asian communities have *'a crucial role to play in tackling what is, for many, a difficult and emotive issue which challenges commonly-held beliefs'*, but some also reported that community members may have to be persuaded that their efforts will be worthwhile:

*[The study] participants were sceptical about having the ability to influence any real noticeable change in the way that mainstream agencies delivered services to the community. This view was based on past experiences with the statutory and voluntary sector, where it was felt large amounts of money are spent on the recruitment of consultants who prepare a report, which is followed by a seminar and no noticeable change is seen in service provision.*



Effective engagement between the South Asian communities and drug service planners, commissioners and providers leads both to the communities gaining confidence in drug services and those services establishing better links with the communities. Partnerships were seen as key to this engagement as they can address issues that are outside an individual agency's area of expertise. The most common recommendations concerning the establishment of partnerships were as follows:

- A major aim of partnerships should be to create channels of communication that reach every member of a local community, *'not just make plans to establish yet another BME [Black and minority ethnic] advisory group'* that neither represents a whole community nor has effective influence on local drug services.
- Partnerships should not rely on community nor religious leaders to represent and access the South Asian communities: because of the stigma of drug use, their lead can be a barrier to others' participation.
- That said, partnerships should be sensitive to the communities' religious and cultural influences on tackling drug use. This aspect of their work will be challenging if it is to avoid sending mixed messages to the communities. For example, the older generations of South Asians may not accept that younger generations may think that drug use is *'not necessarily the end of the world'*, and those promoting a 'just say no approach' (especially if this is part of their religious belief) may object to harm reduction approaches.
- Partnerships should be initiated with those South Asian community members and organisations most willing to acknowledge drug use in their communities and to discuss this issue. Community organisations should be fully utilised in this process: this project has shown that they can act as a bridge between local drug services and the local communities, and could encourage other community members and organisations to participate in the partnership.
- Suggested members of partnerships were wide-ranging and included:
  - local representatives of all generations of a community;
  - all drug information, advice and treatment services;
  - different faith groups;
  - statutory and voluntary service users;
  - schools and youth clubs;
  - organisations and individuals that have credibility with young people;
  - women's organisations;
  - projects that have already worked on drug-related issues with the South Asian communities;
  - community organisations;
  - GPs (because, as shown in Section 4.2.6, they are most likely to be approached by South Asians seeking help with drug use, and for many older women are their link with the 'outside world'); and
  - the police (in order to explain what they are doing about drug use and, particularly, dealing).

## 8.2 Commitment

One report warned that *'any inaction now will compound problems for the future'*, and many others emphasised that drug service planners, commissioners and providers **and** the South Asian communities must be committed to developing effective methods of engagement, in order to understand issues surrounding drug use and drug services and to develop appropriate responses.

It was emphasised that such responses should be seen as a long-term process of the continual improvement and responsiveness of drug services to the South Asian communities, and given local strategic consideration rather than being treated as an 'add-on' to services' core activities. In this way, the current situation, where drug services are *'reactive rather than proactive in their approach when dealing with issues affecting the community'*, will be addressed.

The reports' recommendations on this issue were that the partnerships described in Section 8.1 should be committed to:

- involvement by the South Asian communities in planning, managing and delivering drug information, advice and treatment services;
- enhancing trust, transparency and accountability by setting up processes providing ongoing feedback to the communities not only about their activities, but also about, for example, the results of relevant research (such as the local needs assessments used to compile this report), the establishment and evaluation of pilot initiatives, and examples of good practice;
- continually reviewing and monitoring the representation of the local South Asian communities within the partnership, taking into account any changes in local population trends; and
- ensuring that the actions necessary to meet the requirements of the Race Relations (Amendment) Act 2000 are carried out by all relevant local services (detailed by CRE, 2000).

In order that that available resources and expertise are maximised, and the partnerships' work is not left to under-funded community organisations and volunteers, many of the reports highlighted the need for long-term, sustainable funding.

Funding was also recommended for further research to fill gaps in local knowledge, and, especially, for so-called 'diversionary' activities and facilities for young people to be provided as an alternative to experimentation with drugs.

## Notes

[1] <<http://www.statistics.gov.uk/cci/nugget.asp?id=273>> (accessed June 2007)

[2] <<http://www.cre.gov.uk/diversity/ethnicity/othersian.html>> (accessed July 2007)

[3] <<http://www.statistics.gov.uk/CCI/nugget.asp?ID=457&Pos=4&ColRank=2&Rank=224>> (accessed May 2007)

[4] <<http://www.statistics.gov.uk/CCI/nugget.asp?ID=460&Pos=1&ColRank=1&Rank=326>> (accessed July 2007)

[5] Calculated from Census 2001, Table S101 (sex and age by ethnic group).  
<<http://www.statistics.gov.uk/StatBase/Expodata/Spreadsheets?D7547.xls>> (accessed May 2007)

## References

Baker, B. Crompton, N. Anitha, S. (2006) *An evaluation of the Community Engagement Programme for the Centre for Ethnicity and Health*. Preston, Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire.

Bhui, K. Warfa, N. Edonya, P. McKenzie, K. Bhugra, D. (2007) Cultural competence in mental health care: a review of model evaluations. *BMC Health Services Research*, 7(1).

CRE (Commission for Racial Equality) (2000) *Strengthening the Race Relations Act*. London, CRE.

Fountain, J. Patel, K. Buffin, J. (2007) Community engagement: The Centre for Ethnicity and Health model. In Domenig, D. Fountain, J. Schatz, E. Bröring, G. (eds.) *Overcoming barriers: migration, marginalisation and access to health services*. Amsterdam, Amsterdam Oecumenisch Centrum (AMOC)/Correlation network for social inclusion and health.

HAS (Health Advisory Service) (2001) *The substance of young needs. Review 2001*. London, Health Advisory Service.

Roe, S. Man, L. (2006) *Drug misuse declared: findings from the 2005/06 British Crime Survey England and Wales*. Home Office Statistical Bulletin 15/06. London, Home Office.

Tamkin, J. Ashton, J. Cummings, J. Hokker, H. Pollard, E. Rick, J. Sheppard, E. Tackey ND (2002) *A review of training in racism awareness and valuing cultural diversity*. RDS on-line report 09/02. London, Home Office.  
<<http://www.homeoffice.gov.uk/rds/pdfs2/rdsolr0902.pdf>> (accessed February 2008)

Winters, M. Patel, K. (2003) *The Department of Health's Black and minority ethnic drug misuse needs assessment project. Report 1: the process*. Preston, Centre for Ethnicity and Health, University of Central Lancashire.

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## Acknowledgements

The author thanks Jez Buffin and Jon Bashford (International School for Communities, Rights and Inclusion, University of Central Lancashire) and Annette Dale-Perera and Oswin Baker (National Treatment Agency for Substance Misuse) for their assistance with the preparation of this publication. The 65 community organisations whose needs assessment reports provided the data for it are also gratefully acknowledged.

Aaina Asian Women's Group, Walsall	AMANI, Warwickshire
Amber Group, Bedworth	Asha Women's Centre, Worcester
Asian Anti-Drugs Initiative, Calderdale	Asian Community Forum, Hyndburn
Asian Drug Advisory Group, Coventry	Asian Youth Association, Leeds
Aware, Woking	Awaaz, Wolverhampton
Awaz Utaoh, Bristol	Bangladesh Youth League, Luton
Black and Minority Ethnic Housing Consortium, Wolverhampton	Bradford Youth Development Partnership
Chester Asian Council	Community Action on Health and Norcare, Newcastle upon Tyne
Community Development Team, Buckinghamshire	Corner House Youth Project, Stockton-on-Tees
Derby Millennium Network	EACH, Hounslow
East Birmingham Community Forum	Ethnic Minorities Development Association, Blackburn with Darwen
Ethnic Minority Health and Social Care Forum, Blackburn	Gymnation, Gloucester
Hillingdon Service User Forum	Holy Trinity Community Network Forum, Tameside
Humaara Research Project, Dudley	Hyde Bangladeshi Association, Cheshire
Indian Muslim Welfare Society, Batley	Integrated Asian Advice Service, Greenwich
KIKIT, Birmingham	Kirklees Racial Equality Council – Youth Forum
League of British Muslims, Redbridge	Leeds Health Focus Research Group
Making Things Equal, Kirklees	Marylebone Bangladesh Society and Hungerford Drug Project, London
Medway Racial Equality Council	Mushkil Aasaan, London
Navjyot Organisation for Asians, London	North East Hindu Cultural Trust
Options, Southampton	Oxfordshire Bangladeshi Association
Pakistan Kashmir Welfare Association, Kirklees	Pakistan Centre, Nottingham
Project 6, Keighley	Qualb Mental Health Centre, Waltham Forest
Rais Academy and Age Concern, Rochdale	Saaf Dil, Rotherham
Sahāili Project of Gibbet Street Association, Calderdale	Sandwell Sikh Community and Youth Forum
Savile Town Community Association, Dewsbury	Smethwick Bangladeshi Youth Forum
Smethwick Youth and Community Centre	Southall Community Drugs Education Project
Three Faiths-One Issue Partnership Group, Leicester	Turning Point – Worcester Druglink
Turning Point, Southall	Union of Muslim Organisations, Walsall
Wakefield Drugs Misuse Project	Walsall ACIDS
Wellingborough Black Consortium	Werneth and Freehold Community Development Project, Coppice Community Centre, and Substance Misuse Project, Oldham
Wolverhampton Sikh Council of Gurdwaras in Wolverhampton	Youth Awareness Programme, Leeds
Youth Federation/Islamic Youth Connection, Warrington	