Delivering drug services

to Black and minority ethnic communities

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Acknowledgements

As always in this type of research, we are not able to name the people we owe the most to because of the promises we made to them about confidentiality and anonymity. We are, however, very grateful to all those who gave up their time freely to talk to us. We hope you think it was worth it and that your views and concerns are reflected in the following pages. Thanks also to those who advised us about who we needed to speak to, and those who helped to organise the community consultation exercise.

We are very grateful to the United Kingdom Anti-Drugs Co-ordination Unit and the Drugs Prevention Advisory Service at the Home Office for funding the research. Particular thanks to Tom Bucke for his patience and support and for carrying on some good traditions!

Many thanks to Said Abdi and Vu Long Nguyen for carrying out the Somali and Vietnamese elements of the community consultation exercise in Lewisham. We are also grateful to Jackie Hall for the transcribing and to the Economic & Social Research Council data archive, the London Research Centre and those responsible for managing the Regional Drugs Misuse Databases for providing us with the data and statistics, with a special mention to Paul Eastwood.

Thanks to our colleagues – Tim Newburn, Rod Earle, Tara Young and Mario Matassa (PPRU) and Jane Fountain and Jon Bashford (Ethnicity and Health Unit) – for their support throughout the course of the study. Thanks also to Jane and Jon for their work on the literature review.

We are grateful to the independent assessors for commenting on an earlier draft of this report and for highlighting the things we missed and the things we needed to rethink.

Last – but by no means least – heartfelt thanks to Montez, the ‘hospitality co-ordinator’, for the food, the conversation and the Orange Room. Writing up has never been so much fun!

Deborah Sangster, Michael Shiner, Kamlesh Patel and Noreen Sheikh
November 2001

The Drugs Prevention Advisory Service would like to thank Karim Murji of the Open University, Dima Abdulrahim of the Substance Misuse Advisory Service and Viv Amun of the Federation of Black and Asian Drug and Alcohol Workers for acting as independent assessors for this report.
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Executive summary

Background

This study was commissioned to support the Government’s 10-year drug strategy. It aimed to:

- give a clear overview of the issues surrounding the delivery of drug prevention and drug services to Black and minority ethnic communities; and

- identify specific issues and prioritise areas of work that need more attention.

The research used existing literature and was built around case studies in six Drug Action Team areas. We interviewed 99 professionals involved in commissioning, planning and delivering drug services and carried out a community consultation exercise which involved 13 group discussions with more than 100 people from a range of communities. We also interviewed 14 practitioners and policy makers who were not based in the case study areas, but who were known to be experts in the area of ethnicity and drugs. Analysis of the British Crime Survey and the Regional Drug Misuse Database gave the study an important balance.

Ethnicity and drug use

The idea that levels and patterns of drug use may vary depending on ethnic group has proved to be controversial and this is reflected within the existing literature about racist stereotyping. Although there is obvious illegal drug use in a wide range of Black and minority ethnic communities, statistics show that overall levels of use within these communities are lower than among whites. There are also important differences between Black and minority ethnic communities. Low levels of drug use are particularly evident in south Asian and Black African communities. Although overall levels of drug use were similar among Black Caribbeans and whites this was based largely on the use of cannabis. Use of hallucinant drugs (amphetamines, LSD, ecstasy, magic mushrooms and amyl nitrates) was less evident among Black Caribbeans than among whites.

We found important ethnic differences in patterns of ‘problematic drug use’. (In this report we use the term ‘problematic drug use’ to refer to drug use that is likely to result in serious social, health and legal problems for the user.) This data suggests that problematic drug use among African Caribbean users focuses particularly on crack and that Black and minority ethnic opiate users are less likely than whites to inject. While this appears to apply particularly to south Asian users, there is some evidence of injecting in these communities and among African Caribbeans. Also, problematic drug use among African Caribbean users is more likely than in other groups to focus on cannabis.

There is not much data about ethnic minority communities which have formed as the result of refugees coming into the country. However, our data does show that there is problematic drug use in Vietnamese and Somali communities, although this is mainly limited to men. There was particular concern about the effects of post-traumatic stress disorder, the role of khat within Somali communities, and the availability of drugs which were unknown in Somalia and Vietnam.
Drug services and Black and minority drug users

The problematic nature of relationships between drug agencies and Black and minority ethnic groups was a dominant theme in our research. While this mainly concentrated on racism and social exclusion, it also focused on the institutional failings of existing drug services. These failings were to do with:

- the image of services and their isolation from the community;
- an inability to respond to distinct patterns of drug use shown by Black and minority ethnic communities; and
- a more general inability to respond to different needs.

These failings were seen to be particularly acute in specialist residential services.

Cultural competence and cultural appropriateness

The people we interviewed placed considerable emphasis on cultural ‘competence’ and other related ideas. Here, cultural competence describes an ability to meet the different needs of a community. It should rest on the following.

1. Cultural ownership and leadership (the extent to which race and ethnicity are considered important by a service).
2. Symbols of accessibility (something that shows Black and minority ethnic people that they are welcomed by a service, for example a newspaper).
3. Familiarity with, and ability to meet, the distinct needs of communities.
5. A range of services.
7. Community attachment and ownership and capacity building (the process through which the skills and structures needed to provide drug services are developed).

Although we highlight the role of cultural competence in relation to delivering drug services its importance is not limited to this area, but is just as important in planning and commissioning services.

Models of provision

We highlight the importance of the difference between ‘generic’ services (those which are, in theory, open to users from all communities) and specialist or ‘stand-alone’ services, which target specific communities. Each has particular advantages and disadvantages. But most people we spoke to felt that, while specialist services could have an important role alongside other services, it was important that mainstream providers developed appropriate ways of working with Black and
Executive summary

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.

Levels and patterns of presentation to services

In the case study areas outside London there was strong evidence that people from Black and
minority ethnic groups, particularly south Asians, were under-represented among individuals
presenting to drug services. And there was good reason to suppose that this reflected the nature of
service provision rather than low levels of problematic drug use within these communities.

In the London case study areas there was some difference between Black and minority ethnic
representation. While the largest minority communities (Black Caribbeans and Indians) were
reasonably well represented among people using services in these areas, there was evidence of
under-representation among the smaller groups (Black Africans and Pakistanis and Bangladeshis).
Also there was little evidence of work with recently established Black and minority ethnic
communities and concern about the low number of Turkish people approaching drug services for
help.

Patterns of how people used services confirmed the importance of cultural competence, as Black
and minority ethnic users tended to use a small number of services which showed a particular
commitment to their needs. African Caribbeans mainly used voluntary-sector drug agencies and
this was explained partly by the way in which crack services were concentrated in this sector.
Black and minority ethnic users were less likely than whites to see their GPs about their drug use.
This may be because they want to stay anonymous and it highlights how workers, and the
structure within which they operate, are vital in showing how accessible services are.

Regional strategy

Although there were examples of strategic thought at the regional level, established services
continued to be commissioned and funded whether or not they provided an effective way of
meeting the needs of diverse communities. There was little evidence of organised needs
assessment, and community consultation and monitoring often lacked clear thought. The needs of
Black and minority ethnic communities are often overlooked because most services continue to
focus on users who inject opiates. This was seen to reflect broader problems around cultural
ownership and leadership and Black and minority ethnic representation at a regional level.

Recommendations

We have made a series of detailed recommendations about developing a national strategic
response, working towards cultural competence, tackling institutional racism and improving
systems of data collection. These recommendations are in the conclusion of this report.
1. Introduction

In recent years the links between drug use, ethnicity and drug service provision have emerged as an important, if somewhat contentious, area of social policy. An emphasis on equality is evident in the Government’s 10-Year drug strategy which supports a programme of action to ensure that:

young people from all backgrounds, whatever their culture, gender or race, have access to appropriate programmes...[and] all problem drug misusers – irrespective of age, gender, race and drug with which they have a problem – have proper access to support from appropriate services – including primary care – when needed, providing specific support services for young people, ethnic minorities, women and their babies (Central Drugs Coordination Unit, 1998, 15, 23).

Despite this, critics have argued that drug services continue to be orientated to the needs of white users and that, where it does take place, specific work with Black1 and minority ethnic communities is often poorly thought out and inadequately implemented (Awiah et al, 1990; Perera et al, 1993; Chantler et al, 1998; Cripps, 1997; Sangster, 1997; Khan et al, undated; Khan, 1999).

Although drug services may be responding inadequately to the needs of Black and minority ethnic communities, research in this area lags someway behind practice. A lack of rigorous analysis and a dearth of empirical data have hindered discussion and policy development in this area.

1.1 Research aims and methods

This study was commissioned in order to inform the development of a drugs and ethnicity initiative led by The United Kingdom Anti-Drug Co-ordination Unit (UKADCU). Approximately £1 million from the fund based on the confiscated assets of drug dealers has been allocated to support this initiative and a similar one targeting women (Cabinet Office, 2000). In this study we aim to:

1. Provide a clear overview of the issues surrounding the delivery of drug prevention and drug services to Black and minority ethnic communities.
2. Identify specific issues and prioritise areas of work that require further attention through the development of pilot projects.

The research was made up of four main strands:

1. A literature review;
2. Fieldwork in six Drug Action Team (DAT) areas made up of interviews with key professionals and consultation with community members.
3. Interviews with representatives of appropriate national organisations and local practitioners with relevant experience who were located outside the case study areas;

1 In general we have used a capital ‘B’ for Black as this denotes the political nature of this term (see below, under ‘Political Blackness’). We have made an exception to this general rule when quoting directly from other authors who have used a lower case ‘b’. We have not used a capital ‘W’ for white as this term is generally not used to denote a political location.
4. Analysis of statistical indicators including the Regional Drug Misuse Database (RDMD) for the case study areas and the 1996 British Crime Survey (BCS).

**Literature review**

A literature search was conducted using the Web of Science, PsycInfo, English Nursing Board database, Addiction Abstracts, http://www.QED.org.uk and the DrugScope library. A written request was also sent to all DATs for relevant reports.

**Fieldwork and case studies**

The case studies were conducted in the following DAT areas:

1. The London Boroughs of Lewisham, Southwark and Lambeth (LSL);
2. The London Borough of Ealing;
3. Birmingham;
4. Leicestershire;
5. Bradford; and

These areas reflected the distinctive settlement patterns of Black and minority ethnic communities in Britain (Lakey, 1997; Matheson, and Edwards, 2000), provided a mixture in terms of overall Black and minority ethnic representation and ensured that a variety of groups were well represented. More particularly, they permitted a focus on Black and minority ethnic groups which were recently established in Britain: we considered this to be important as we felt that the needs of such communities may differ in important ways from those ethnic minority communities which have been historically more well established. Somali and Vietnamese communities provided the key focus for our work with recently established communities because they were reasonably well represented in the case study areas and because some projects in these areas were actively seeking to engage with them. The case study areas also provided a good geographical spread and a diversity of community types including inner city districts, a metropolitan borough, shire counties and provincial towns.

A total of 99 interviews were conducted in the case study areas and these were mainly with purchasers, planners and providers of relevant services. Respondents included front-line workers, managers of drug services, drug-education specialists and representatives from DATs, Health Authorities, Social Services and the Drugs Prevention Advisory Service. These interviews were augmented by those conducted with 14 practitioners and policy makers based outside of the case study areas who were considered to be influential in the field: these individuals were identified by the research team and other respondents. Detailed information about respondents is provided in Table 1.1.

---

2 The ethnic composition of the population in these areas was assessed on the basis of the 1991 Census.
The community consultation exercise was made up of 13 group discussions which included 131 participants from a diverse range of communities (see table 1.2). Participants were identified through formal and informal local networks (e.g. Black and minority ethnic workers’ groups) and were included in the group discussions on the basis that their ethnicity, position in the community, professional experience and/or personal experiences meant they could act as key informants about particular communities. Members of the research team facilitated most of the sessions although the Somali and Vietnamese groups in LSL were set-up and facilitated by workers from these communities who were employed specifically for this purpose.

Table 1.1: Respondent profile (number)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>68</td>
</tr>
<tr>
<td>African Caribbean</td>
<td>20</td>
</tr>
<tr>
<td>Indian</td>
<td>15</td>
</tr>
<tr>
<td>Pakistani</td>
<td>4</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>1</td>
</tr>
<tr>
<td>Chinese</td>
<td>–</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>67</td>
</tr>
<tr>
<td>Female</td>
<td>46</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioner/planner</td>
<td>22</td>
</tr>
<tr>
<td>Policy maker</td>
<td>20</td>
</tr>
<tr>
<td>Drug worker</td>
<td>43</td>
</tr>
<tr>
<td>Criminal Justice worker</td>
<td>10</td>
</tr>
<tr>
<td>Youth worker and community workers</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Component of study</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>LSL case study</td>
<td>16</td>
</tr>
<tr>
<td>Ealing case study</td>
<td>17</td>
</tr>
<tr>
<td>Birmingham case study</td>
<td>16</td>
</tr>
<tr>
<td>Leicestershire case study</td>
<td>17</td>
</tr>
<tr>
<td>Bradford case study</td>
<td>13</td>
</tr>
<tr>
<td>Lancashire case study</td>
<td>20</td>
</tr>
<tr>
<td>National experts</td>
<td>14</td>
</tr>
</tbody>
</table>

3 These sessions were conducted in appropriate community languages and the workers provided written, English language, transcripts.

4 Vietnamese has been added to the list of ethnic categories because, in the context of drugs work within LSL, it is an important category.

5 Commissioners included representatives of the DAT, social services and the health authority. Policy makers included academics and those involved in policy development, including representatives from The Federation of Black and Asian Drug and Alcohol Workers, the Drugs Prevention Advisory Service, Drugscope and Local Education Authorities. The category of drug workers includes managers and front line workers.
**Table 1.2: Community consultation groups**

<table>
<thead>
<tr>
<th>Location</th>
<th>Group</th>
<th>Sex</th>
<th>Age</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>African Caribbean group</td>
<td>2 male, 5 female</td>
<td>37-50+</td>
<td>Social welfare professionals e.g. probation officers &amp; mental health professionals.</td>
</tr>
<tr>
<td></td>
<td>Somali Group</td>
<td>2 male, 2 female</td>
<td>30-49</td>
<td>Chairperson of local Somali community, medical doctor, community workers.</td>
</tr>
<tr>
<td></td>
<td>South Asian Group</td>
<td>5 males, 12 female</td>
<td>25-50+</td>
<td>Community members and professionals e.g. youth/community workers, drugs workers &amp; interpreters.</td>
</tr>
<tr>
<td></td>
<td>Vietnamese group</td>
<td>2 male, 2 female</td>
<td>24-41</td>
<td>Community worker, drug users, clients of local drug agency &amp; partner of client.</td>
</tr>
<tr>
<td>Midlands</td>
<td>African Caribbean Group</td>
<td>5 male, 3 female</td>
<td>24-53</td>
<td>Social workers, community workers and representatives of prisoners support project.</td>
</tr>
<tr>
<td></td>
<td>South Asian Group</td>
<td>6 male, 3 female</td>
<td>22-35</td>
<td>Social welfare professionals e.g. community workers, sexual health workers, probation officers.</td>
</tr>
<tr>
<td></td>
<td>Somali Group</td>
<td>9 male, 0 female</td>
<td>29-50</td>
<td>Mix of community members and professionals, e.g. teachers, youth workers, advice workers.</td>
</tr>
<tr>
<td></td>
<td>South Asian Group</td>
<td>5 male, 1 female</td>
<td>23-55</td>
<td>Social welfare professionals e.g. community workers, sexual health workers, probation officers.</td>
</tr>
<tr>
<td>North</td>
<td>African Caribbean Group</td>
<td>6 male, 3 female</td>
<td>22-38</td>
<td>Social welfare professionals e.g. social workers, community workers. Ex prisoners and community centre users.</td>
</tr>
<tr>
<td></td>
<td>Pakistani Group</td>
<td>7 male, 9 female</td>
<td>21-65</td>
<td>Community Members</td>
</tr>
<tr>
<td></td>
<td>South Asian Group</td>
<td>6 male, 4 female</td>
<td>26-55</td>
<td>Social Welfare Professionals e.g. youth/community workers and advice workers.</td>
</tr>
<tr>
<td></td>
<td>South Asian Female Group</td>
<td>17 female</td>
<td>25-45</td>
<td>Community members</td>
</tr>
<tr>
<td></td>
<td>Pakistani Male Group</td>
<td>14 male</td>
<td>16-22</td>
<td>Community members</td>
</tr>
</tbody>
</table>

Interviews and group discussions were based on a semi-structured approach. While interviewers and facilitators had a clear idea of the general areas they wanted to address, respondents were encouraged to raise issues that were important to them. Interviews tended to last for between forty-five minutes and an hour and a half and group discussions lasted for one and a half to two hours. Interviews and group discussions were tape recorded, fully transcribed and analysed according to well-established methods (Agar, 1986).

Respondents have been quoted throughout the report. The quotations provided do not constitute the sole – nor necessarily – the main basis for our conclusions but have been given in order to
illustrate the arguments we present. In developing the analysis we have taken account of the range of opinions expressed by respondents. Where appropriate, we have distinguished key themes within respondents’ accounts (that is, those that were a common and central feature of what people said) from those that were more suggestive (those that were less common and/or were less central to respondents’ accounts). The centrality of themes was assessed on the basis of their explanatory value. Those themes that helped to make sense of numerous elements of respondents’ accounts were considered more central than those with less explanatory power (Agar, 1989).

Quantitative analysis

In order to help answer key questions relating to the use of both drugs and drug services the study has drawn on the British Crime Survey (BCS), the Regional Drugs Misuse Database (RDMD) and statistical indicators collected from individual agencies.

The BCS is a national adult survey, based on representative samples of households in England and Wales. Detailed descriptions of the BCS and the methods on which it rests have been provided elsewhere (Ramsay and Percy, 1996, viii; Hales and Stratford, undated & 1999). In the current context it is sufficient to note that the 1994, 1996 and 1998 versions of the BCS included questions about self-reported drug use and that they helped to establish the credibility of this approach ‘beyond doubt’ (Ramsay and Percy, 1996, viii). In the current context, the value of the BCS was heightened by the inclusion of an ethnic ‘booster’ sample as this dramatically increased the number of Black and minority ethnic respondents, thereby improving the reliability of the survey. As the 1998 BCS did not include such a booster sample, the 1996 survey was used for the analysis presented in this report (Ramsay and Spiller, 1997; Ramsay and Partridge, 1999).

The RDMD was established in 1989 by the Department of Health to provide data on problem drug users who present for treatment. It is based on information collected in anonymised form for each person newly presenting to an agency or returning after an absence of six months or more. In the jargon that surrounds the database, a presentation that meets either of these criteria is described as an ‘episode’. Although the database is administered regionally – there are currently eight RDMDs in England – it was designed in such a way that data are comparable over time and between regions. (Hickman et al., 1997; Northern and Yorkshire Substance Misuse Database, 2000). Information from the RDMD was collected for all of the cases study areas and particularly detailed analyses were conducted in relation to LSL and Ealing for reasons which will become clear.

1.2 Concepts and terminology

The study of ethnicity and race raise important conceptual issues. Key questions relate to the nature of ‘difference’ and, more particularly, to the concept of race. The idea that human beings
form distinct racial *types* with identifiable physical characteristics began to take hold in the early 1800s. Although this formulation has been discredited within scientific circles, the idea of race continues to be widely criticised within social science on the grounds that it suggests certain social relationships are natural and inevitable. In rejecting the idea of race, many social scientists have preferred the notion of ethnicity, which they define in terms of social or cultural differences. Although ethnicity may be considered ideologically preferable to race it lacks clarity – it includes notions of colour, country of birth or geographical origin and nationality and boundaries between ethnic groups are unclear (Law, 1996; Khan, 1999a,b,c). Moreover, some commentators have preferred the notion of ‘race’ on sociological grounds:

> A paradox confronts anyone who tries to understand the perplexing and persistent phenomena of ‘race’ and racism in Europe today. On the one hand, in genetic terms, the physical or biological differences between groups defined as ‘races’ have been shown to be trivial. And yet, on the other hand, it is all too clear that racism remains a widespread, and possibly intensifying, fact of many people’s lives. Reiterating that ‘there’s no such thing as “race”’ offers only the frail reassurance that there shouldn’t be a problem. It cannot deal with the problems that do exist, because it fails to see them for what they are (Donald and Rattansi, 1992, 1)7.

To fully understand this position we must consider the notions of political Blackness, anti-racism and multiculturalism. During the 1970s and 1980s the term ‘Black’ provided the basis of a ‘new’ politics of resistance, within which considerable emphasis was placed on the common experiences of racism and marginalisation that were shared by minority groups. This notion of political Blackness was widely criticised during the 1990s and much of this criticism coalesced around concerns about essentialism, that is ‘a notion of ultimate essence that transcends historical cultural boundaries’ (Brah, 1992, 126). Increasing emphasis came to be placed on the subjective nature of individual identity, the diversity of historical and cultural experience of Black subjects and the importance of processes of cultural fusion (Donald and Rattansi, 1992; Back, 1996, 237; Modood et. al., 1997). In time, this emphasis led to what Hall (1992, 254) has described as the ‘end of the innocent notion of the essential black subject’.

Disagreements over the nature of ‘difference’ have been matched by tensions over how best to respond to it. The multiculturalism of the 1970s and 1980s was, for example, strongly criticised by antiracists for focusing on superficial manifestations of culture and for failing to address deeper issues of power and legitimacy. To antiracists, individual beliefs and prejudices were less important than the structures of power, institutions and social practices that produced racial oppression and discrimination (Donald and Rattansi, 1992). The notion of institutional racism was central to this perspective (see text box) below.

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7 The way in which the term ‘race’ is placed in speech marks here is significant as it highlights the socially constructed nature of this concept.
In recent years antiracism has evolved in important ways. Indeed, according to Gilroy (1992, 49) the end of the essential Black subject has been matched by the ‘end of antiracism’. He suggested that the common sense ideology of antiracism had come to reflect racist ideas by drifting towards a belief in the ‘absolute nature of ethnic categories’ and argued that, in order to move forward, we should: accept that Britain’s crisis is centrally and emphatically concerned with notions of ‘race’ and national identity; focus on racism in the mainstream; and reject a notion of ‘race’ that is defined exclusively in terms of culture and identity on the basis that it obscures the inherently political character of the term.

Notions of multiculturalism and antiracism are not the only source of tension in responses to ethnic or ‘racial’ inequality. Indeed, much anti-racist work may be characterised in terms of the ability to maintain contradictory perspectives such as separatism and integration, universalism and particularism, equal treatment and equal outcome, equal opportunity and cultural difference (Law, 1996). Not all of these apparently competing perspectives are irreconcilable, however: according to Malik (1996) the universal and the particular should not be viewed as separate categories; rather they should be seen as existing in a reciprocal relationship which allows us to see human differences as socially constructed, while at the same time reminding us that humans possess a social essence which is the basis of equality.

Our perspective

We have placed considerable emphasis on developing workable recommendations which are sensitive to the recent theoretical developments described above. Although we consider ‘race’ and ethnicity to be analytically useful we accept the problematic nature of these notions. While we recognise the importance of ethnicity to many people’s sense of identity we reject simplistic
1. Introduction

notions of identification. In addition, while we recognise the importance of the related notions of diversity and cultural heritage we have also sought to take account of political dimensions.

Our preferred generic term is ‘Black and minority ethnic’ as this reflects the primary focus of the research. While this term emphasises our concern with groups which may be considered to be ‘Black’ it also acknowledges diversity within these communities and denotes a greater degree of inclusion. Our use of the term ‘minority ethnic’ recognises the position of groups who may not consider their identity to be characterised as ‘Black’ but who nevertheless constitute a distinct minority ethnic group. Minority white communities such as those of Irish descent did not constitute a key focus of the research. We frequently use terms which are more specific than ‘Black and minority ethnic’. In doing so, we have drawn on official classifications\(^8\) although we accept that a number of problems go along with this. For the purpose of analysis we distinguished between the categories of Indian, Pakistani and Bangladeshi although, where appropriate, we have used the generic term ‘south Asian’ to refer to these groups. Similarly, while we have distinguished between the categories of Black Caribbean\(^9\) and Black African when discussing official statistics, elsewhere we have preferred the more generic term of ‘African Caribbean’ as this reflected our interviewees’ terminology.

1.3 Structure and content of the report – what’s new

While we hope that there is much in this report that will be familiar to those working in the field, we believe our analysis builds on existing knowledge in a number of key ways. Our analysis has applied the notion of institutional racism systematically and empirically and has specified how Black and minority ethnic communities’ needs tend to be marginalised in the process by which drugs services are planned, commissioned and delivered. While we have drawn on previous work in the drugs field which has applied the notion of institutional racism (for example, Abdulrahim et al, 1994; Abdulrahim, 1998) we provide fresh insights into the way that this process takes effect:

- Our analysis of the BCS and the RDMD is innovative and highlights important ethnic variations in patterns of illicit drug use.
- Drawing on the experience of a wide range of drugs professionals we have outlined the basis of cultural competence in relation to drugs services.
- In terms of levels of presentation to services we provide evidence of regional variations and of differences between Black and minority ethnic communities.
- As well as looking at levels of presentation we highlight important ethnic differences in the types of services to which users present.

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8 Our fieldwork and analysis predated the revised classification of ethnicity that was introduced for the 2001 Census and our terminology is based on the previous classification.

9 When analysing quantitative data we combined the categories of Black Caribbean and Black other as it has been shown that the category of Black other is used mostly by people of Caribbean family origin who are not white and consider themselves to be British (Ballard and Kalra, 1994).
We provide firm quantitative evidence as to the importance of cultural competence in meeting the needs of Black and minority ethnic communities.

The results of our analysis are presented and discussed in three parts. Part one includes two chapters in which we begin to identify the key issues – chapter 2 focuses on levels and patterns of drug use within Black and minority ethnic communities and chapter 3 examines the relationship between these communities and drug services.

Part two consists of four chapters with a focus on service provision. Cultural competence as it relates to service-delivery provides the basis of chapter 4 and this is followed, in chapter 5, by consideration of different models of provision. In chapter 6 we look at levels and patterns of presentation to drug services and in chapter 7 we discuss the implications of cultural competence for regional strategy.

Part three of the report is made up of a single chapter in which we draw the findings of the study together, focus on their implications for national strategy and policy and make a series of recommendations.
Part one – key issues

2. Ethnicity and patterns of drug use

In this chapter we combine quantitative and qualitative data to examine the ways in which patterns of illicit drug use vary by ethnicity. Our analysis is innovative in a number of ways. In contrast to previous analyses of the BCS we distinguish between the categories of Black Caribbean and Black African with some interesting results. Furthermore our analysis of the RDMD adds a much needed empirical dimension to debates about problematic drug use and ethnicity.

Commentators in the drugs field have been particularly concerned with challenging stereotypes. They have highlighted the way in which drug-images rest on ‘racist constructions of criminality and assumptions of “ethnic welfare”’ (Khan, 1999b, 4.5) and feed into ‘heavy-handed policing of black people’ (Cripps, 1997, 14). Drug related stereotypes vary markedly between ethnic groups. Thus while African Caribbean people have been particularly associated with use of cannabis and crack cocaine (Dale-Perera and Farrent, 1999; Cripps, 1997; Khan, 1999b; Murji, 1999) commentators have been moved to challenge the ‘myth’ that south Asians do not use drugs.

‘Denial’ of south Asian drug use has been identified as an important barrier to the development of appropriate services and one which has not simply been imposed upon these communities from outside. Asian religious and community leaders, it has been noted, have colluded with, and supported, the idea that Asians do not use drugs (Perera, 1998; Patel, 1999).

2.1 Drug use in the general population

Levels of illicit drug use peak amongst young people in their late teens and early 20s (ISDD, 1994; Ramsay and Partridge, 1999). There is, furthermore, fairly strong evidence that levels of use by young people increased during the 1980s and the early 1990s (Clements, 1993; Roberts et. al., 1994) although this trend appears to have leveled off (Ramsay and Partridge, 1999; Druglink, 1998). With increasing levels of use social scientists suggested that illicit drug use had moved away from the margins towards the mainstream of British youth culture as part of a process of normalization (Coffield and Gofton, 1994; Parker et. al., 1995, 1998). This interpretation has, however, been challenged and critics have argued that it exaggerates the extent to which young people use drugs (Shiner and Newburn, 1997; 1999).

Although ethnicity has not been central to debates about normalization, we used the BCS to consider the way in which illicit drug use varies between ethnic groups in the general population (see Table 2.1).
Table 2.1: Illicit drug use in the general population by ethnicity
(percentage of given ethnic groups who had used drugs)\textsuperscript{10}

<table>
<thead>
<tr>
<th>Adults (aged 16–59)</th>
<th>Ever used</th>
<th>Used in last year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Any drug</td>
<td>Cannabis</td>
</tr>
<tr>
<td>White</td>
<td>30</td>
<td>23</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>29</td>
<td>23</td>
</tr>
<tr>
<td>Black African</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Indian</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Pakistani or Bangladeshi</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>22</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Young adults (aged 16–29)</th>
<th>Ever used</th>
<th>Used in last year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Any drug</td>
<td>Cannabis</td>
</tr>
<tr>
<td>White</td>
<td>46</td>
<td>38</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>39</td>
<td>37</td>
</tr>
<tr>
<td>Black African</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Indian</td>
<td>22</td>
<td>18</td>
</tr>
<tr>
<td>Pakistani or Bangladeshi</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>37</td>
<td>31</td>
</tr>
</tbody>
</table>

Source: 1996 BCS

The BCS indicated that illicit drug use is evident within a range of Black and minority ethnic communities and that it involves a similar range of substances to that which is evident among whites. This was also reflected in the community consultation exercise. The south Asian group in Birmingham and the African Caribbean group in LSL reflected upon the way that young people from these communities were using dance drugs (see also Webster, 1996). Nevertheless, the BCS indicates that reported levels of illicit drug use – within both the general adult population and the young adult population – tend to be lower among Black and minority ethnic communities than among whites. Furthermore, although there is considerable evidence of non-use among whites, the suggestion that drug use is becoming normalized appears to be particularly problematic in relation to Black and minority ethnic communities.

\textsuperscript{10} The differences shown in this table were statistically significant at the 0.01 level. The relationships between ethnicity and drug use were assessed separately for each drug or group of drugs shown in the table and levels of ever use and use in the last year were assessed separately. Tests were applied to both 16–59 year olds and to 16–29 year olds.

\textsuperscript{11} The term ‘hallucinant’ was coined by Ramsay and Percy (1996) and incorporates both stimulants and hallucinogens – amphetamine, LSD, magic mushrooms, ecstasy and amyl nitrate.
Although previous analysis of the BCS combined the categories of Black Caribbean and Black African (Ramsay and Percy, 1997; Ramsay and Spiller, 1998) the distinction between these groups is important. While overall levels of use were relatively low among Black Africans and south Asians, the prevalence rate among Black Caribbeans was similar to that which was evident among whites. The relatively high level of drug use among Black Caribbeans, however, was explained largely by their use of cannabis. Use of hallucinants was significantly less widespread among Black Caribbeans than among whites.

Although lifetime rates of cannabis-use were very similar for whites and Black Caribbeans, differences were evident in relation to use in the last year12. Among 16–59 year olds, Black Caribbeans were significantly more likely than whites to have used cannabis13. This was not the case among 16–29 year olds, however, and this points towards important generational differences. Previous analysis found that while rates of cannabis use among 30–59 year olds were higher for African Caribbeans than for whites, the opposite was evident among 16–29 year olds (Ramsay and Percy, 1996). The notion of generational difference was alluded to by participants in the LSL African Caribbean community group as they spoke of the traditional ‘acceptance’ of cannabis.

Ethnic differences in relation to cannabis were also evident from the RDMD. Presentations to services suggest that cannabis provides a particular focus for problematic drug use among African Caribbean users. Within LSL, cannabis was reported as being the main drug used in 9% of the episodes presented to agencies during the 18 months from the beginning of April 1999 to the end of September 200014. The rate at which it accounted for Black Caribbean and Black African episodes, however, was nearly treble the rate at which it accounted for white episodes (19% and 20% compared with 7%). A much less pronounced difference was evident in relation to Ealing, Hammersmith and Hounslow (EHH) where cannabis accounted for 11% of white episodes and 15% of Black Caribbean episodes.

2.2 Problematic drug use

The extent to which household surveys provide insights into problematic15 drug use is limited because they tend to exclude those who may be considered to be particularly vulnerable to such patterns of use – people in prison, homeless people and those on the ‘fringe’ of society (Ramsay and Percy, 1996, viii). According to the 1996 BCS only 4% of 16–29 year olds had ever used

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12 Specific tests were run to assess the statistical significance of the differences between whites and Black Caribbeans. For an explanation of the notion of statistical significance please refer to the appendix.

13 There is a parallel with the USA here as it has been noted that marijuana use among African Americans appears to be relatively intensive (Xueqin Ma and Shive, 2000).

14 Unless indicated otherwise, all analysis of the RDMD in relation to the London based cases study areas is based on this timeframe. These analyses also excluded episodes where the client was resident in a postal district that was outside of the relevant boroughs. For EHH the number of Black Africans (20) was considered too small to produce reliable findings and thus the figures for this group have not been quoted here.

15 The Advisory Council on the Misuse of Drugs which defined the problem drug user as anyone who experiences social, psychological, physical or legal problems related to intoxication / or regular excessive consumption and /or dependence as a consequence of his / her own use of drugs or other chemical substances, and anyone whose drug use involved, or could lead to, the sharing of injecting equipment (see Lloyd, 1998). While this definition does not limit problematic drug use to heroin and cocaine these substances are considered to be the most harmful illicit drugs (The Police Foundation, 2000).
cocaine and only 1% had ever used crack or heroin/methadone. The number of respondents involved in these forms of drug use is too small for meaningful analysis by ethnicity. The RDMD is particularly important in this context, although it should be approached with care. It does not provide a basis on which overall levels of problem drug use can be estimated reliably as it is based on presentations to services which, arguably, have more to do with the nature of services than with the extent of problem drug use. Where the RDMD is more useful is in considering whether the drugs with which people experience problems vary by ethnicity. Care is required even here, however, as apparent differences between groups may reflect the way in which services are marketed and delivered.

Opiates\(^{16}\) and crack cocaine were the most frequently implicated source of primary drug problems among episodes presented to drug services in LSL and EHH. There were, however, striking differences between ethnic groups (see table 2.2).

### Table 2.2: Primary drug in episodes presented to services by ethnicity\(^{17}\)

(percentage of episodes from given ethnic groups based on specified drugs)

<table>
<thead>
<tr>
<th></th>
<th>Opiates (injected)</th>
<th>Opiates (other)</th>
<th>Crack</th>
<th>Other(^ {18})</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LSL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>47</td>
<td>32</td>
<td>7</td>
<td>14</td>
<td>2396</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>13</td>
<td>24</td>
<td>42</td>
<td>21</td>
<td>666</td>
</tr>
<tr>
<td>Black African</td>
<td>17</td>
<td>29</td>
<td>30</td>
<td>24</td>
<td>77</td>
</tr>
<tr>
<td>Indian, Pakistani and Bangladesh</td>
<td>a</td>
<td>a</td>
<td>a</td>
<td>a</td>
<td>31</td>
</tr>
<tr>
<td>Chinese</td>
<td>4</td>
<td>84</td>
<td>4</td>
<td>8</td>
<td>45</td>
</tr>
<tr>
<td>Other</td>
<td>29</td>
<td>42</td>
<td>16</td>
<td>13</td>
<td>316</td>
</tr>
<tr>
<td>All</td>
<td>37</td>
<td>32</td>
<td>15</td>
<td>16</td>
<td>3531</td>
</tr>
<tr>
<td><strong>EHH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>25</td>
<td>37</td>
<td>11</td>
<td>27</td>
<td>953</td>
</tr>
<tr>
<td>Black African/Caribbean</td>
<td>6</td>
<td>20</td>
<td>52</td>
<td>22</td>
<td>164</td>
</tr>
<tr>
<td>Indian</td>
<td>5</td>
<td>80</td>
<td>5</td>
<td>10</td>
<td>212</td>
</tr>
<tr>
<td>Pakistani or Bangladeshi</td>
<td>7</td>
<td>73</td>
<td>5</td>
<td>15</td>
<td>44</td>
</tr>
<tr>
<td>Other (including Chinese)</td>
<td>10</td>
<td>47</td>
<td>14</td>
<td>29</td>
<td>88</td>
</tr>
<tr>
<td>All</td>
<td>18</td>
<td>43</td>
<td>15</td>
<td>24</td>
<td>1461</td>
</tr>
</tbody>
</table>

Source: RDMD (April 1999–September 2000) \(a = \) insufficient cases

\(^{16}\) Throughout this report this term refers to all opiates including heroin and methadone.

\(^{17}\) Although the ethnic classification used in the RDMD was based on the 1991 Census classification, the small number of cases in some categories mean that adaptations were required for the analysis presented here. In EHH there were very few Black African episodes and thus this category was combined with that of Black Caribbean. Similarly in LSL there were very few Indian, Pakistani or Bangladeshi episodes and so these categories were combined into one, south Asian, category. Although not all episodes included information about injecting, the rate at which this information was missing for primary opiate users showed little variation according to the ethnicity of the client. Measures of statistical significance were not applied to the RDMD because it was, in theory, based on a population not a sample.

\(^{18}\) The extent to which cannabis provided the focus for problematic drug use was discussed earlier under the heading ‘Black Caribbean and Black African: An important distinction?’
African Caribbean episodes presented to drug services in the London case study areas showed a particular concentration on crack. In LSL, presentations from African Caribbean users were more than four times as likely to focus on crack as were those made by whites and in EHH they were more than five times as likely to do so.

Within EHH, south Asian presentations were similar to those of whites in the sense that they focused primarily on opiates (see also Chaudry et al, 1997; Patel, 1988; Patel et. al., 1996; Patel and Sherlock, 1997; Arora and Khatun, 1998; Gooden, 1999). There were, however, striking contrasts in relation to mode of use. While episodes relating to opiate injecting were, by some distance, highest among white clients, those presented by south Asians focused overwhelmingly on non-injectable use.

Although presentations to services are strongly suggestive of important ethnic differences in patterns of problematic drug use, these are not absolute and there is a risk of exaggeration:

- **Opiate injecting and south Asians**: while a preference for smoking opiates among south Asians may reflect traditional modes of use these communities are not immune to injecting (Siddique, 1992; Patel, 1997; Pearson and Patel, 1998). This is evident from table 2.2 which shows that 7% of Pakistani and Bangladeshi episodes and 5% of Indian episodes presented to services in EHH were primarily related to opiate injecting.

- **Opiate use and African Caribbeans**: African Caribbean communities are affected by opiate use. More than a quarter of episodes presented by users from these communities in LSL and EHH focused primarily on opiates. While these episodes tended to focus on non-injecting use they also provided evidence of injecting. African Caribbean drug workers and community members noted that while imprisonment offered respite from crack use it facilitated a shift to opiates.

- **Crack use, whites and south Asians**: while white users accounted for 32% of primary crack episodes in LSL and 48% of such episodes in EHH south Asians accounted for 1% and 5% respectively.

It is evident from the case study areas that patterns and modes of use vary geographically. Opiate injecting was, for example, less evident in episodes presented in EHH than LSL and this was particularly marked in relation to African Caribbean users. Nevertheless, the ethnic differences shown in Table 2.2 are striking and reasonably consistent and it is unlikely that they are limited to LSL and EHH.

This analysis of the RDMD was supported by our qualitative data. The idea that crack provided a particular focus for problematic drug use among African Caribbean users was an explicit part of the accounts given by drug workers from these communities. It also formed a key theme in their

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19 For discussion of crack and African Caribbean communities in the UK see Gilman (1993), Perera et al, (1993), Gripps (1997) and Chantler et al., (1998). It should also be noted that there is a parallel with the American literature here. While ‘blacks’ (African Americans) have generally been found to show lower levels of illicit drug use than whites there is some evidence that they have higher levels of crack use (Friedman and Ali, 1997; Xueqin Ma and Shive, 2000).
discussions of appropriate services (see chapter 4). Furthermore, this emphasis was not limited to the London case study areas or to drugs professionals and the accounts given by the African Caribbean community groups indicated that the patterns of presentation described above were not simply the result of the way that services were marketed and delivered:

_The problem [drug use in the ‘Black’ community] hasn’t been discussed too much, it’s quite a hidden problem. Lots of the indigenous white people of Liverpool who are drug users are opiate users whereas the black community drug users are stimulant users…The stimulants they use tend to be crack cocaine and from there they are going on to opiate use just to bring them down from the cocaine (drug worker, African Caribbean, North)._  

_Crack is tearing our community apart, it’s destroying the community (African Caribbean community group, LSL)._  

While the focus on opiate smoking among south Asian presentations in EHH is part of a broader trend across North and South Thames (Sondhi et. al., 1999) our qualitative data indicated that this pattern is evident in other parts of the country:

_Our referrals are all south Asian males between 25 to 30 years old. Mainly heroin smokers and one cocaine user…The heroin users started at a very early age, about 16/17 (drug worker, Pakistani, North)._  

### 2.3 Drug use in recently established Black and minority ethnic communities

The recently established Black and minority ethnic communities based, largely, on refugee migrations are largely invisible in quantitative records (Bloch, 1999). The qualitative component of this study indicated, however, that:

1. Drug use, including problematic forms, is evident in these communities. Crack use is evident in Vietnamese and Somali communities and while opiate use was seen to be a big problem in relation to Vietnamese (see also Whittington, 1999) it was thought to be less evident among Somalis. While the Somali group considered that drug use in this community was largely limited to men, drug workers reported that khat and crack episodes had been presented by Somali women and that opiate episodes had been presented by young Somali men.

2. Drug use within these communities reflects collective cultural experiences which preceded settlement in Britain. Thus, for Somali men the khat house was described as being the equivalent to ‘the pub’ for the British (see also, Griffiths, 1998; Nabuzoka and Badhadhe, 1998).
2. Ethnicity and patterns of drug use

Among Vietnamese, an ‘older’ group of users were described as having started to inject opiates while they were in refugee camps in Hong Kong. In relation to Somalis and Vietnamese particular concern was expressed about links between drug use and Post-Traumatic Stress Disorder:

*It [drug use] is a big problem in men who are not working, those who stayed in the camps and were in the army. They take drugs, they want to forget who they are* (Vietnamese community group, LSL).

3. Settlement in Britain has presented these communities with new challenges in relation to drugs. It was felt that levels of khat use had increased among Somali men as a response to, and a reinforcement of, high levels of unemployment. Vietnamese and Somali respondents expressed concern about the availability of drugs which were unknown in their countries of origin. Drug use among young Vietnamese people was described as being ‘more or less the same as among whites’. Particular concern was expressed about how the criminal justice system facilitated contact with problematic forms of drug use and the way that young Somali men were moving into wider forms of drug use and dealing through supplying khat:

*Khat is a huge problem, Somali women complain about the men in their families taking it. Somali youths are getting mixed up in the drugs trade because of it and get into selling crack and heroin (drug worker, African Caribbean, North).*
3. **Relationships between services and Black and minority ethnic communities**

Within the literature, drug services have been roundly criticised for failing to meet the needs of Black and minority ethnic communities (Awiah et al, 1990; Perera et al, 1993; Chantler et al, 1998; and Khan et al, undated; Khan, 1999; Dale-Perera and Farrant, 1999; Nefertari and Ahmun, 1999). In part this failure has been grounded in the historical process by which services developed. Many services emerged out of the heroin epidemics of the mid-1980s and were crucially concerned with the way in which injecting use provided a potential route for HIV-transmission. In effect, it has been argued, this meant they were configured largely around the needs of white males as they tend to dominate this category of drug use (Sangster, 1997). While cultural barriers to service use by Black and minority ethnic users have been identified, commentators have warned against approaches which treat cultures as fixed and immutable. While certain barriers may be particularly significant for Black and minority ethnic users, barriers have been identified by all drug users regardless of culture or ethnicity (Abdulrahim, 1998).

The problematic nature of relationships between drug agencies and Black and minority ethnic groups dominated the accounts given by drug workers included in our study. While these respondents discussed a range of specific issues they were located within a broader context of racism and social exclusion:

*The community views those traditional services in the same way they view the whole world system, ‘you are anti me, you want my information, my data so you can expose me, I don’t trust you’... There’s one thing that’s been marketed and published widely in the black community is the fact that the institutions are racist. Everybody, five to six year olds knows that, it’s straightforward and it’s reiterated in the language, in the music, and in the individual chit-chat on the street corner (drug worker, African Caribbean, London).*

Within this context, however, the problematic nature of relationships between Black and minority ethnic groups and drug services were attributed primarily to failings within existing provision. These apparent failings were not simply grounded in the prejudice of individuals but were considered to reflect wider issues and, as such, amounted to a form of institutional racism. Key factors were:

1. The image of services and their isolation from ‘the community’;
2. An inability to respond to distinct patterns of drug use by Black and minority ethnic communities; and
3. A more general inability to respond to diverse needs.
3. Relationships between services and communities

3.1 The image of drug services and isolation from ‘the community’

Drug services were not seen to be culturally neutral and it was frequently suggested that they presented a ‘white’ image. This was seen to be reflected in the people they employed, the clients they served and the décor of the organisation. A lack of positive cultural symbols was identified as a particular barrier to potential users from Black and minority ethnic communities:

*It’s very important to have black workers, it’s a way people identify with somebody. They [black workers] said to me ‘when you enter a room you’re conscious all the time whether you’re going to have a good or a bad experience, especially when you go to some sort of like authoritarian structure…so you’re looking around for key signals to let you know if this place is okay. If you see a picture of something related to black culture, it makes you feel a little easier. But if you’re going to a place that has no signals whatsoever it makes you put your guard up’ (drug worker, white, London).*

The suggestion that existing services tend to present a ‘white image’ was tied up with the idea that they have an authoritarian approach and are distant from the community and this was summed up by the negative description of them as ‘institutions’.

3.2 Responding to distinct patterns of drug use

The historic focus of many services on opiate-injecting has been accompanied by a reluctance, if not outright opposition, to the development of cannabis services and an underdevelopment of stimulant services (Bottomley, 1999; Cripps, 1997). Although stimulant services were evident in the case study areas there were few of them and they tended to be of fairly recent origin.

That the underdevelopment of stimulant services across the country has particularly marginalised the needs of African Caribbean communities is strongly suggested by the patterns of problematic drug use described in the previous chapter. Further support for this interpretation was provided by the community consultation exercise. The African Caribbean groups in Leicester and Bradford described how prison offered respite from crack use, but that this was not subsequently followed up by treatment agencies in the community. Ethnic differences in patterns of drug use also suggest that the needs of African Caribbean users are marginalised by the paucity of treatment responses to cannabis. The extent to which problematic drug use among south Asian users appears to focus on opiates smoking also suggests that their needs tend to be marginalised by services which focus on injecting:

*Because they [south Asian users] are not injecting, their access to treatment is much slower (Criminal Justice Worker, white, South).*

The focus of many drug treatment services on harm minimisation approaches has further implications for south Asian users. Within such approaches injecting is particularly discouraged and non-injecting use is seen to offer a way of reducing harm (Gossop and Strang, 1990). There is considerable doubt as to the capacity of such approaches to respond effectively to the needs of non-injectors.
Finally, there was little evidence that services are engaging with the needs of Somali and Yemeni communities around khat and this gap in provision was generally acknowledged by commissioners and providers. Members of one of the Somali community groups were critical of research (Griffiths, 1998) which they felt reflected the widely held view among Somalis that khat is not a problematic drug, but did not reflect the opposition to this drug which is evident among women and religious leaders.

The implications associated with existing patterns of service provision are likely to become more far-reaching because of the growing emphasis on diverting drug users away from the criminal justice system into treatment. While services are likely to see more Black and minority ethnic drug users as a result of these initiatives there is considerable doubt about their ability to meet the needs of such users. Respondents raised particular concerns about the use of legal sanctions against users who break contact with services.

### 3.3 An inability to meet diverse needs

Drug services were not simply criticised for the drugs with which they worked but also for the way in which they worked. This included a suggestion that services were failing to deal adequately with the practicalities of working with Black and minority ethnic users and raised wider cultural and religious issues:

- **Language**: respondents emphasised the role of language as a barrier to service use, particularly in relation to recently established Black and minority ethnic communities. Service providers and commissioners often felt that such barriers are less relevant to south Asians because most young people within these communities speak English. This view may be questioned on the basis of the high numbers of marriages involving a partner from the sub-continent of India and because of the importance of intergenerational working:

  *A lot of Asian parents don’t speak English and can’t read Urdu (Pakistani, Community consultation exercise, North).*

  Workers and community members from these groups highlighted the need for translated materials, bi-lingual workers and translators.

- **Other functional needs**: the distinct nature of Black and minority ethnic communities’ needs were not limited to language but also embraced issues such as food and physical appearance:

  *I attended a day service…which was an absolute nightmare, little things which really matter. I remember asking to go to the hairdressers, I said ‘it must be Black hairdressers’ because of hair types, ‘they need to have experience and expertise in cutting it’. They convinced me the individual had experience, they were European, and they cut my hair terribly. In the end I more or less had to be scalped… and I was really angry about it, and they couldn’t understand why I was so angry (Policy maker, African Caribbean, London).*
3. Relationships between services and communities

- **Family interventions:** an inability of services to work appropriately with family members was identified as an important issue by south Asian drug workers and community members (see also Abdulrahim et al, 1994; Abdulrahim, 1998). Drugs workers cited the need for family work as a key difference between south Asian and white clients and in Lancashire they noted that south Asian clients were accompanied by family members more often than their white counterparts.

- **Stigma and shame:** it was often suggested that distinct norms and values within Black and minority ethnic communities discouraged drug users from accessing services. Respondents – including those from Black and minority ethnic communities – commonly reported that drug use is heavily stigmatised within such communities and is identified as a particular source of shame. These influences were identified as an important barrier to use of services and were seen to be grounded in a range of religious and cultural influences (see also Abdulrahim et al, 1994; Abdulrahim, 1998; Gooden, 1999):

  > If you come from somewhere foreign to do better and it’s actually gone worse it’s a disgrace. If your child turns out to be a criminal who takes drugs…it’s a burden sharing your disgrace so you’d rather shut the door on it and keep it to yourself (Drug worker, African Caribbean, London).

The Somali community group in LSL felt that it was difficult for Somali drug users to seek help because of the particularly stigmatised nature of drug use in this community which was seen to reflect the influence of Islam and a general cultural emphasis on discipline and responsibility. An emphasis on shame was also reflected in the suggestion that Vietnamese clients reacted poorly to group counselling because it reminded them of the way in which drug users were publicly humiliated in Vietnam.

Although stigma and shame may be considered to be barriers to service use which are internally generated by communities, services have been criticised for having failed to develop practices which take account of this dynamic. Such criticism has focused on issues of trust and confidentiality which, are seen to be particularly, although not exclusively, important in relation to Black and minority ethnic communities (Abdulrahim et al, 1994; Abdulrahim, 1998). According to a drug worker in a specialist ‘Black’ service:

  > One of the classics…is people get asked to present as a drug user…whereas what they are saying is ‘we will get to that, I know I am here to deal with that, but actually at the point where I present I am not able to deal with that. It’s been a big enough battle to get here never mind having to sit through 1 or 2 hours screening’. When they get asked that, they walk in and walk out and the whole thing fails (Drug worker, African Caribbean, London).

### 3.4 Specialist residential services

The institutional failings described above were seen to be particularly acute in relation to specialist
residential services, including in-patient detoxification and rehabilitation facilities. Reflecting broader concerns about image, such services were associated negatively with psychiatry and the criminal justice system. Respondents suggested misdiagnosis of problematic cannabis and crack use as mental illness had contributed to a general mistrust of mainstream services within Black and minority ethnic communities, especially those of African Caribbean heritage. Nonetheless, this association was considered particularly acute in relation to specialist residential services:

One of the things people don’t understand is we’re very struck by symbolism and for me residential rehabs are a non-barred version of a prison cell, particularly because most of them have medical support, clinical support. If you merge the two together what does it equate to? A mental institution straightaway. Most Black people in this country have had a family member who’s had a brush or skirmish with the mental health system...there’s a real fear that you will get institutionalised, medicated (drug worker, African Caribbean, London).

Further difficulties associated with specialist residential services were the degree to which they were dominated by a focus on opiates, by practices which were seen to be culturally inappropriate and by an explicit Christian ethos. This is evident in a lack of provision in community languages (see also Dale-Perera and Farrent, 1999) and in the inappropriate nature of the assumptions that underpin practice in such services:

Say I need to refer a Vietnamese client to in-patient detox, it’s nearly impossible…it’s there for white people and they’re not looking for ethnic minority users...because of language and other things as well. Say we go to a big country house, you have to sit down in a group, talk about your problems...back home in Vietnam, under the Communist policies you have to confess yourself, they breakdown your personality...Years ago I referred about two or three clients but eventually they say ‘no’, because they say ‘look, I don’t need this, I come here, ask you for help, I don’t have to go over there to do army works, or punishment’. In-patient detox is like a labour camp (Drug worker, Vietnamese, London).

Workers also expressed concern about the geographical location of residential facilities. They felt that such services were rarely located in areas of high Black and minority ethnic concentration and that this increased users’ sense of isolation. Specialist residential services were considered poor at retaining Black and minority ethnic users and workers highlighted problems in securing appropriate aftercare.
Part two – Working with Black and minority ethnic communities

4. Cultural competence and service delivery

Many respondents often rejected ‘colour-blind’ approaches to service-delivery and emphasised the importance of cultural ‘competence’, ‘appropriateness’, ‘sensitivity’ and ‘specificity’. It was not always clear what was meant by such terms, however, and there is a need for greater clarity. Although these terms are inter-related, we believe that they describe different things. Cultural competence is most appropriately viewed as an umbrella term which describes an ability to meet the needs of diverse communities; cultural appropriateness provides the mechanism through which cultural competence is achieved; and cultural sensitivity and cultural specificity form the building blocks for culturally appropriate ways of working.

The notion of cultural competence is particularly associated with health care, both in the United States of America (see for example, Lavizzo-Mouey and Mackenzie, 1996, The Institute on Aging, 2001) and in Britain (see for example Chandra, 1996, Salimbene, 1999; O’Hagen, 2001). According to Lavizzo-Mouey and Mackenzie (1996, 920) cultural competence refers to:

The demonstrated awareness and integration of three population-specific issues: health related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy.

They went on to suggest that the most significant aspect of this concept is the inclusion and integration of these three areas which are usually considered separately if they are considered at all. In its early formulations the notion of cultural competence was used to describe individual providers. More recently, however, it has been applied to systems of care:

The concept of cultural sensitivity seems inadequate to define both what purchasers and providers should be aiming for and what users have a right to expect. This toolkit therefore coins the term ‘cultural competence’ to denote services perceived by Black and minority ethnic users as being in harmony with their cultural and religious beliefs and not just provided by people who are, or are assumed to be, ‘culturally sensitive’ (Chandra, 1996, 1; see also, The Institute on Aging, 2001).

The application of cultural competence to systems of care rather than to individual providers is a significant development. It provides the basis for moving beyond individually-focused anti-racism training and brings into play the culture of organisations, their aims and core competencies, their management structures and their use of monitoring (Chandra, 1996).
The implications of cultural competence for drugs services have yet to be clearly identified (but see Ellis, 1999). On the basis of our analysis, we suggest that cultural competence – as it relates to the delivery of drug services – requires the following elements:

1. Cultural ownership and leadership;
2. Symbols of accessibility;
3. Familiarity with, and ability to meet, the distinct needs of communities;
4. Holistic, therapeutic and social interventions;
5. Diversification of services;
6. Black and minority ethnic workers; and
7. Community attachment/ownership and capacity building.

These dimensions should not be seen as existing in isolation but as being interdependent. Put simply, it is likely that symbols of accessibility and Black and minority ethnic workers will have limited impact unless they are accompanied by other elements on which cultural competence relies. Moreover, cultural competence should not be considered to work in mechanistic ways. We are not, for a moment, suggesting that the elements we describe below are universally applicable to work with Black and minority ethnic clients. What we are suggesting, however, is that for services to be culturally competent they must develop a repertoire of responses which they can apply as, and when, they are appropriate to the needs of individuals.

4.1 Cultural ownership and leadership

An important aspect of a culturally sensitive service was seen to relate to ownership and leadership. This translated into an emphasis on the importance of ethnicity within organisational strategy (see also Khan, 1999b and 1999c) and a concern about ‘tokenism’. Work with Black and minority ethnic communities was frequently criticised for being short term and superficial. Strategic ownership, in contrast, was seen to involve an emphasis on the importance of ethnicity at all levels of an organisation and was characterised by a willingness to reflect on the nature of the service. Important aspects of such an approach include: an ethnically mixed team with dedicated Black and minority ethnic posts, Black and minority ethnic representation within the management structure of the organisation and use of monitoring data to promote anti-discriminatory practice (see also, Fraser, 1999).

4.2 Symbols of accessibility

Within a culturally sensitive framework, symbols of accessibility were considered to have an important role in the way that a service is marketed. They were thought to provide the basis for an image of accessibility and for communicating the message that an agency is there to meet the needs of a diverse community. Important cultural symbols were identified as including posters, leaflets, culturally-specific newspapers and magazines:
I mean other things can help, it’s about what sort of materials you have lying about, what sort of publicity you have, what sort of things are left in a public way... if you have got copies of things like The Voice or the Irish Post in your waiting room it might only be saying something very small but it’s saying something... it’s saying that ‘at least we recognise that there are other cultures’ and it’s saying ‘we welcome people’ (Drug worker, white, London).

Although this symbolic dimension was considered to be important, it was only considered to be a small part of what was required. In isolation it was considered to be tokenistic and to reflect the drawbacks of the ‘saris, samosas and steel-bands syndrome’ that has been associated with the multiculturalism of the 1970s and 1980s (Donald and Rattansi, 1992, 2). This concern was summed up by one respondent in the following way: ‘sticking up a Bob Marley poster will not suffice’ (Policy maker, African Caribbean, London).

4.3 Familiarity with, and ability to meet, the distinct needs of communities

Cultural competence was seen to rest on familiarity with the distinct norms, history, codes of conduct, experiences, expectations and beliefs that exist within communities and was linked by some respondents to the notion of authentic understanding:

For Black clients to walk in, they feel really alienated anyway and they start telling the man all kinds of things about the streets, and the man is looking at them like ‘what on earth are you talking about’, your face is saying it and your body language is saying it... They may come once, they may come twice, and after the second time you may not see them again. In order to capture them, you have to reflect a culturally diverse community... and you have to make sure you’re abreast of some of the issues that are happening (African Caribbean community consultation exercise, LSL).

An emphasis on cultural competence may be reflected in an ability to meet the functional needs of clients from Black and minority ethnic communities such as those relating to language, food and physical experience. Thus, for example, the Making Things Equal Project in Lancashire and the Southall Community Drugs Education Project used educational videos in Urdu and Bengali to raise drug awareness among parents. In part this reflected high levels of illiteracy among older south Asians and parents (see also Patel, 1999).

The implications associated with cultural competence were not limited to aspects of need which related straightforwardly to functional matters, but extended to the nature of the service being provided. Key dimensions in this regard were:

- **Distinctive cultural and religious perspectives**: distinctive cultural and religious perspectives were considered important in relation to a range of Black and minority

20 Although the notion of authenticity has been applied elsewhere in the literature on drugs prevention (Shiner, 2000), it has been considered problematic in relation to ‘race’ and ethnicity (see Gilroy, 1993). While the notion of authenticity may be problematic, we consider it to be real in effect if people consider it be real (Cuff et al., 1992).
ethnic communities. One of the Somali community groups discussed the need for ‘religious and cultural counselling’ which explored issues of faith and aimed to enhance ‘self control’ and ‘stress reduction’ and a similar emphasis was evident in relation to Bengali communities:

Somewhere like Tower Hamlets have a large Bengali community... The young person is talking about the issues he or she may have with their religion, vis a vis their drug use, and what they want to bear is a re-enforcement of the need for them to remain in step with their cultural dimension. But instead what they get is language that suggests they don’t need to worry about that … ‘I don’t want you telling me it’s cool to not practice, to not pray five times a day. That’s not what I want to hear’ and that’s what they feel they’re getting (Drug worker, African Caribbean, London).

The assumptions on which interventions are based and the implicit messages that they communicate were identified as a potential source of conflict with communities which have distinctive cultural and religious beliefs:

When you’re talking about drugs prevention it’s important to understand what sort of messages are congruent with that community. So, when you go and deliver drugs prevention messages to parents for example, it has to be worded in a certain way that they’ll respect and accept. It’s about understanding their cultures, their religious beliefs, and the context that they’re living in (Drug worker, Bangladeshi, London).

Particular issues were identified around harm-reduction philosophies which have proved to be controversial with community and parents’ groups (Black/minority ethnic and white) who consider that they ‘condone’ drug misuse (Pearson et al., 1985). Some of our young south Asian respondents reported that their parents had reacted very badly to drugs education literature which they had taken home. While this raises the issue of involving the wider community in the development of interventions, workers felt that this was likely to take much longer with south Asian communities than with white groups because of the particular sensitivity of cultural and religious issues involved.

Family and inter-generational work: while an inability to work appropriately with family members was identified as a failing of many services (see chapter 3), the importance of this gap was highlighted by the inter-generational nature of interventions targeted at south Asian and Vietnamese communities:

Young Vietnamese people speak very little Vietnamese and their parents speak very little English, so there is complication inside the family... The kids do not know what the parents think... because they are educated over here, brought up over here and went to school over here they think completely different to the
4. Cultural competence and service delivery

parent...This is dynamic, if you don’t talk with the parents then it will never work with the young group (Drug worker, Vietnamese, London).

- Working around issues of shame: flexibility about the way in which services present themselves to clients and the way in which clients present themselves to services were seen to offer ways of working around particular issues of shame and dishonor. One of the Somali community groups suggested that agencies should not be readily identifiable as drug services because of the particular stigma and taboos attached to drug use within this community. More generally, screening and assessment procedures were seen to offer a way of easing the process by which users were expected to present to services:

When you walk through the door you don’t want to answer all those questions that you appear to get asked in mainstream services...‘do your parents know?’ ‘Do your family know?’ ‘Hell no’, always ‘hell no’, because culturally you can’t tell them. That isn’t a question we’d ask, because we know what it’s like...All the rest of the services are completely hung up on people having to present as a user...what we’re saying is ‘well no, we actually don’t insist on people presenting and confessing at the point of entry’. We know that will materialise at some point (Drugs worker, African Caribbean, London).

Achieving such flexibility may be difficult for services that define themselves narrowly in terms of treatment. It may be more easily facilitated where services act as a broader community resource through, for example, the development of drug education and prevention initiatives (see, for example Sangster with Mistry, 1999).

4.4 Holistic, therapeutic and social interventions

Rejection of narrow medical approaches to drug treatment constituted an important theme in the way some drug workers talk about cultural appropriateness. While, for some, this rested on rejection of ‘Eurocentric’ perspectives (Nefertari and Ahmun, 1999) it also reflected emphasis on social and emotional dimensions and a view that problematic drug use may be seen as a way of escaping painful experiences associated with disadvantage and marginalisation. Thus culturally appropriate practice was characterised as focusing on the realities of racism and social exclusion. This translated into emphasis on therapeutic interventions – including talk therapies and holistic therapies (e.g. acupuncture) – and development of support and advocacy in relation to employment, education, training, housing, social security benefits and health. In the context of recently established Black and minority ethnic communities, it also produced a focus on social participation. For example, the work of Orexis – which is based in the London borough of Lewisham – with Vietnamese clients included visits to theatres and football matches and a preference for English language teaching over translation services on the basis that it reduces dependence.
Discussion of ‘talk therapies’ included an emphasis on approaches that are based explicitly on notions of culture and cultural difference: examples include intercultural therapy and transcultural therapy. (Kareem and Littlewood, 1992; Krause, 1998). Interest in such approaches has increased in reaction to established psychiatric and psychological interventions and the misdiagnoses of problematic drug use in Black and minority ethnic communities as mental illness. While culturally focussed therapies may be particularly appropriate in relation to dual diagnosis they should not be limited to this context.

The social and therapeutic basis of cultural competence was evident in the focus of several interventions on identity-formation. The RAW service was developed by Involve (formerly known as NDAP) for young ‘Afrikan, Asian and Afrikan Caribbean’ people to explore issues of identity and was underpinned by a historical focus on slavery and colonialisation. An emphasis on identity was also evident in the way that certain services sought to bring together apparently disparate cultural identities. The work of Orexis with the Vietnamese community and the work of Nafas with the Bangladeshi community in the London borough of Tower Hamlets shared a distinctly intergenerational flavour and sought to engage young people and their parents. Similarly, Somali community members expressed concerns about the way that young Somalis were drifting away from ‘traditional’ ways of life.

Although holistic, therapeutic and social interventions were considered to be a central part of cultural appropriateness it is important to note the following:

- **Positive responses to medical interventions:** some drugs professionals suggested that south Asian communities tend to favour medical approaches which concentrate on symptom relief and they noted that this was reflected in high rates of take-up of private hospital detoxification services. Alternative interpretations were offered, however, and it may be that this pattern of service use reflects a desire for quick treatment and/or particular issues around shame and honour within these communities.

- **A lack of traditions based on counselling:** drug workers suggested that some Black and minority ethnic communities do not have a tradition of counselling or therapy outside of family structures and friendship networks (see also, Awiah, undated; Mistry, undated).

In response to these issues, advocates of holistic, therapeutic and social approaches emphasised that holistic, therapeutic and social approaches and medical approaches should not, necessarily, be seen as competing alternatives. They also noted that preference for medical approaches may reflect a lack of understanding and awareness about other options. According to a drug worker in a non-prescribing service which specifically targeted Bangladeshi communities:

> *In the Bangladeshi community, there is a lack of knowledge and understanding about the whole situation. That’s because they see it as a medical problem… they don’t always understand the complexity of it, having to go to a rehab after the detox, they think send them to detox and that’s it* (Drug worker, Bangladeshi, London).
Furthermore, where there was no tradition of counselling advocates of therapeutic approaches emphasised the importance of approaches which centered on notions of culture and cultural difference and focused on identity, intergenerational working and religion. Although this required some degree of adaptation, both on the part of the worker and the client, positive responses were reported.

4.5 Diversification of services

Holistic, therapeutic and social interventions are central to cultural competence, in part at least, because of differences in the type of drug problems that ethnic groups present to services. Crucially related to this point, respondents emphasised how opiate-led, addiction focused, services are poorly placed to meet the needs of crack cocaine users:

> You can’t treat crack in a residential rehab...there’s no clinical response. Therefore you go there and you get this completely inappropriate service which is basically opiate led...
> It’s not a pharmaceutical issue...the whole programme is not designed to deal with that individual... Treatment it’s such a stupid word, when people say treatment it evokes the idea that you treat their body. I’m treating your whole social life or lack of it, it’s not about giving you some kind of pharmaceutical response to a situation that’s social.

(Drug worker, African Caribbean, London)

We have already seen how presentations to services by African Caribbean users showed a particular focus on crack and, to a lesser extent, cannabis (see chapter 2). It follows from this that diversification away from opiate-led models of provision is a key element of cultural competence. Further analysis of the RDMD confirmed the importance of crack services in meeting the needs of African Caribbean communities. Figure 6.1 shows, for each agency\(^{21}\) in LSI and EHH, the percentage of episodes presented by Black Caribbean and Black African users and the percentage of all episodes (regardless of ethnicity) primarily related to crack. There is a clear trend whereby the percentage of episodes presented by Black Caribbean and Black African users increased with the percentage of primarily crack related episodes\(^{22}\). This clearly suggests that services with a focus on crack were more successful at accessing African Caribbean users than were those which lacked such a focus. Those services represented by the numbers 1, 2, 3, 5, 12, 14 and 15 either included a specialist stimulant service or were generic services which worked actively with stimulant users. Most of these services were based in high street agencies although one of them was a hospital-based service which included a stimulant clinic. The remaining services included community drug and alcohol NHS services, General Practitioners and opiate-focused high street agencies. The directness of the link between crack services and accessing Black and minority ethnic communities was highlighted by African Caribbean workers who noted that the development of such services had been central to their attempts to meet the needs of African Caribbean communities.

\(^{21}\) For the purposes of analysis, in each area GPs were grouped together to form a single service.

\(^{22}\) The spearman’s rank correlation co-efficient between these two variables was 0.73.
The way in which opiate episodes among Black and minority ethnic users, particularly south Asians, focus on non-injecting use (see chapter 2) also has important implications for cultural competence. It follows from these patterns of presentation that interventions which focus on preventing transitions to injecting are more relevant to these communities than are needle exchange schemes and interventions targeted at drug overdoses (see Gossop, et al, 2000). There is, however, evidence of injecting by Black and minority ethnic users, including south Asians, and thus it is crucial that:

1. Interventions which focus on transitions into injecting do not take place at the expense, or to the exclusion, of those based on injecting and harm minimisation.
2. Services which focus on injecting should seek to ensure access to Black and minority ethnic users.
3. The extent to which Black and minority ethnic opiate users move into injecting should be carefully monitored. The age at which users presented to services suggests this may be particularly important in relation to south Asians. The average age associated with opiate episodes in EHH was 22 years for Indians, 27 for those classified as other, 29 for Pakistanis and Bangladeshis, 32 for Black Africans/Caribbeans and 33 years for whites. In LSL it was 26 years for south Asians and 30–32 for Black Caribbeans, Black Africans, whites and those classified as other.
4.6 Black and minority ethnic workers

While Black and minority ethnic drug workers were a core feature of many people’s visions of cultural appropriateness, important questions were raised about the purpose and nature of their involvement. Black and minority ethnic workers were particularly concerned about the dangers of tokenism and this was reflected in frustration about the way in which initiatives for Black and minority ethnic users were often defined solely in terms of employing staff from these communities. Recruitment of Black and minority ethnic workers was considered most appropriate when it was part of a process – rather than an end in itself – and was grounded in the broader issues relating to cultural competence:

> It feels to me that this project is a token gesture because money was suddenly available...and though managers and colleagues see us as a specialist project they still expect us to work in the same way they do...all the Black workers had been complaining for quite some time that we felt supervision was inefficient with the existing managers because they didn’t understand our work. I mean when I go to my manager and say ‘the family of my Asian client is making demands on me’, she just tells me to explain about boundaries and that I'm there for the client not them – If you’re working with an Asian client my experience tells me that you must also work with the family (Drug worker, Pakistani, North).

Concern was also expressed that Black and minority ethnic workers’ roles should take account of diversity:

> This is the difficulty with sticking us all under one label, and even Asian all under one label, because, you know, they’re fake communities, and there’s been long intrinsic battles, so to sort of clump everybody together and assume that this one big melting pot is going to be a successful conduit I think is naive to say the least (Policy maker, African Caribbean, London).

There was, however, little evidence of distinctions between Black Caribbean and Black African workers and ‘Asian’ workers were often employed in a way which paid little apparent attention to religious, regional and linguistic distinctions within this category.

White workers were generally considered to have an important role in the delivery of culturally competent services. Although ethnic matching was generally considered appropriate where it was identified as important either by the client or the worker none of the generic agencies represented in the study followed a policy of strict ethnic matching. Such a policy was construed as racist and stereotypical by white and Black and minority ethnic drug workers who – along with participants in the community consultation exercise – emphasised that it should not be assumed that clients will want to see a worker from their own ethnic background (for a similar point in relation to drug education see Shiner, 2000).

The willingness of clients to see workers from different ethnic backgrounds was seen to reflect broader processes of cultural synthesis. It was also grounded in the influence of characteristics such
as age, sex and, less concretely, credibility. It may, however, also reflect cultural inhibitors which discourage some Black and minority ethnic users from accessing workers from similar ethnic backgrounds. Feelings of shame may be sharply felt when confronted by a worker with shared cultural understandings. While concerns about confidentiality and a desire to remain anonymous may discourage clients’ from seeing workers from their own ethnic background (Edmunds, et al, forthcoming), Black and minority ethnic workers felt this was less of an issue than was often supposed and that it could be dealt with adequately by established codes of conduct:

*The issue of confidentiality, I don’t think is a major one in that respect, if the person is professionally trained and can provide a service. Confidentiality shouldn’t be an issue, I know trust is a big issue, Black people tend not to trust white services because of previous experience (Policy maker, African Caribbean, Midlands).*

It was also suggested that clients’ reluctance to see workers from a similar ethnic background should provide the basis for a therapeutic intervention as it might reflect something important about their relationship with the wider community.

Despite the caveats described above, Black and minority ethnic workers were widely considered to be axiomatic to cultural competence. While such workers were seen to have considerable value as symbols of accessibility and trust, their value was seen to extend well beyond the symbolic. Black and minority ethnic workers were seen to have ready access to Black and minority ethnic social networks and were identified as an important source of authentic knowledge and experience. The manager of one project described how the retention rate among ‘Black’ clients had increased dramatically with the employment of ‘Black’ staff. It was also suggested that Black and minority ethnic workers could help to enhance the cultural competence of their white colleagues:

*We have a dedicated Black post, most workers have got a dedicated post, and the idea was that, as well as the general work, there would be somebody within the staff team that would have a greater knowledge on certain subjects, and would be able to share that knowledge and help improve some of the policies within the project…You need to have some sort of cultural sensitivity for when people come in – you first try to get them through the door and second you make them feel comfortable…Maybe the easiest way of doing it is to have culturally specific workers but that doesn’t mean the Black worker sees all the Black clients. But there’s an idea that maybe because there are workers coming from the same background, that they feel more comfortable (Drug worker, white, London)*.
4. Cultural competence and service delivery

4.7 Community attachment/ownership and capacity building

For some respondents cultural competence was seen to require that services were in, and of, the community. The term ‘community’ was, however, used to describe particular ethnic groups (the ‘Black community’) and specific geographical locations (the ‘local community’) and two distinct themes were identified in this discourse:

1. **Community attachment**: this notion was evident in an emphasis on services building relationships with, and delivering work through, the community. In this context, community was thought of in terms of formal organisations: the role of ‘church’ was, for example, noted by African Caribbean respondents. The theme of community attachment was also reflected in an emphasis on outreach work, satellite services and the role of community volunteers.

2. **Community ownership**: community ‘ownership’ was crucially concerned with ways in which Black and minority ethnic communities could become ‘stakeholders’ in services. While representation on management teams and steering groups was identified as a key issue it is important that attempts to ensure such representation reflect the complexity of communities. Community is an ambiguous and problematic notion and divisions within communities mean ensuring genuine representativeness is difficult (Crawford, 1999). There is, furthermore, a degree of tension between the notion of Black and minority ethnic community ownership and the suggestion that drug use is particularly stigmatised within such communities (see section 5.2). Although this tension is not irreconcilable, it raises important issues about accountability and the importance of recognising the way in which certain groups (women, homeless people and drug users for example) may be marginalised in the structures that communities develop (Crawford, 1999).

Within social policy, appeals to ‘community’ frequently translate into ‘the community must mobilize its own resources’ (Crawford, 1999, 166). This assumes that communities have capacity, in the form of knowledge, skills, ‘goodwill’ and infrastructures, to fulfill such a role. Questions relating to the readiness of some Black and minority ethnic communities to work with drug users were raised by respondents (see section 7.2). Moreover, several respondents highlighted the way in which agencies within the Black and minority ethnic voluntary sector had been subject to short term funding and were particularly vulnerable to closure.

Community attachment and ownership (and the employment of Black and minority ethnic workers) raise important issues about capacity building in the form of education, training, drug awareness and organisational funding. Examples of capacity building were provided by the Making Things Equal Project in Lancashire and the Southall Community Drugs Education Project, both of which sought to build capacity in their local communities through an ‘inter-actors’ model involving education, training and skills development among local community volunteers.

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23 Inter-actors are individuals whose position in the community gives them unique access to target groups although they would not necessarily be perceived to be community leaders.
4.8 The inclusive nature of cultural competence

Cultural competence provides the basis for working with a diverse range of people, including those from white communities. While the needs of Black and minority ethnic communities were seen to be distinct, they were not necessarily considered to be separate from, or opposed to, those of white communities. A focus on identity and exclusion was considered appropriate for work with white working class communities and diversification of services and a shift away from narrow medical models was considered to be ‘good practice’ generally. Furthermore, although minority ethnic status is often equated with Black people, white communities contain minorities which may require culturally specific approaches. This was reflected in the work of the Stockwell Project with Irish and Portuguese clients in LSL. Although cultural competence is an inclusive notion it is especially important in relation to Black and minority ethnic communities because of their particular, rather than exclusive, needs. Thus, for example, it has been illustrated how different patterns of presentation to services means that the diversification of services is particularly important to Black and minority ethnic users. More generally, a social orientation was seen as being particularly relevant to Black and minority ethnic communities as it provided a basis for working with the realities of racism.
5. Models of drug service provision

The distinction between generic and specialist or ‘stand alone’ services was commonly made by respondents. It was, furthermore, defined primarily in relation to the communities with which services sought to work although it was also applied to the range of drugs on which agencies focused. Generic services rest on the notion of universalism in the sense that they are, in theory at least, open to all communities. Specialist services adopt a more particularist approach and target specific communities. Although the distinction between generic and specialist services is important it is not always clear cut as there were several examples of specialist interventions within generic projects.

5.1 Generic services

Generic services tended to be equated with ‘mainstream’ provision and had implications of longevity and of being funded by statutory commissioners as part of their core provision. The potential for tokenism was seen to be particularly high in relation to such services as they were often considered to lack cultural ownership and leadership. Black and minority ethnic workers in generic services were concerned about management and the capacity of agencies to provide Black and minority ethnic workers with appropriate direction, guidance and support. According to an Indian drug worker in the north of England it was crucial that generic organisations ‘acknowledge the experiences of being a Black worker in a white organisation’. It was argued that management failings within generic services mean that Black and minority ethnic workers are, in effect, often ‘set up to fail’. More specifically, it was suggested that:

1. because of a need to be seen to be doing something, generic agencies have appointed Black and minority ethnic workers who lack appropriate qualifications, training and experience;

2. that Black and minority ethnic workers are often isolated, overburdened with responsibility for entire communities, insufficiently supported, inadequately managed, poorly trained and expected to accord to ‘white’ practice; and

3. the need for, and value of, development work with Black and minority ethnic communities is not always recognised by service managers and when results are not evident quickly Black and minority ethnic workers are sacked.

Even when some of these issues were absent the potential for tokenism and isolation within generic services remained:

*Note my post can be considered as tokenistic, no two ways about it. It’s commissioned from money that was available, it wasn’t mainstream provision…We have to really push for the service to do things for Black communities…well, not push it, but sell it to the*

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24 Henceforth the term specialist services has been preferred to the term ‘stand alone’ services. It was suggested to us that while the term ‘stand alone’ describes the negative climate that specialist services working with Black and minority ethnic communities have had to endure it does not reflect the purpose or role of such services.
manager who thankfully is supportive…There is elements of isolation…it’s about having an affinity, it’s around having things in common, it’s about sharing language, sharing modes of behaviour and that kind of stuff. And that’s very difficult to find sometimes, so yes it’s around the isolation and ensuring that support is there…I suppose the way it impacts on me is that you go through peaks and troughs…sometimes I’m encouraged sometimes I’m discouraged. Sometimes I think what the f*** am I doing here (Drug worker, African Caribbean, London).

5.2 Specialist/‘stand alone’ services

The rationale that was put forward for specialist services was very similar to that which surrounded Black and minority ethnic workers. Such services were seen to have cultural ownership and leadership built into their structures. They were considered to have an authentic understanding of distinct cultural needs. Issues relating to isolation of Black and minority ethnic workers were seen to be less applicable. On the other hand, the disadvantages of specialist services were seen to be that they minimised opportunities for sharing expertise and that they were expensive, impractical and inefficient. Respondents frequently noted that such services could not be established for every community.

Further difficulties were associated with specialist approaches which reflected the problematic nature of community. Within such a model, the boundaries of inclusion and exclusion need to be defined so that it is established for whom, and from whom, a service ‘stands alone’. The specialist services included in the study embraced notions of diversity and avoided some of the difficulties associated with essentialism. Recognition that not all Black and minority ethnic clients would, necessarily, want to access a Black and minority ethnic service was matched by a readiness among some specialist providers to work with white clients. Although specialist services tended to focus on fairly specific communities – hence Nafas targeted Bangladeshis – a broader focus was also evident which embraced groups that did not identify straightforwardly as a community. Thus a worker in a specialist service which targeted older African Caribbean communities and more recently established Somali communities described how young Somali’s definitions of themselves varied from being ‘Black’ to being ‘Somali’ and that this was, in some ways, reflective of tension between Somali and African Caribbean young people.

Similarly, groups which may be regarded as a ‘community’ from the outside may actually include important divisions: tensions between people from north and south Vietnam were, for example, highlighted by Vietnamese workers and community members. Equally, recognition was given to the way in which other sources of identity such as religion and gender cut across ethnicity (see Edmunds et al, forthcoming). Moreover while tensions between Pakistani Muslims and Punjabi Sikhs in the London borough of Ealing have a long history, more recent difficulties were noted between Indian Hindus and Pakistani Muslims in Bradford.

Specialist services share many of the assumptions on which the role of Black and minority ethnic workers and an emphasis on community attachment and ownership are based. The problematic
5. Models of drug service provision

nature of some of these assumptions was highlighted in relation to specialist services. It was suggested that, in recruiting staff, such services draw on a relatively small proportion of the population and may have difficulty securing the required range of skills. Somali community members expressed a preference for the establishment of a ‘health centre’ run by Somalis, and while they felt that Somali communities had particular experience of khat they felt that they lacked knowledge of other drugs. These respondents identified the need for a partnership approach whereby established drug services trained Somali workers who would adapt and integrate ‘western’ approaches into a more traditional Somali framework.

Further questions about the role of specialist services (and community ownership) are raised by the suggestion that drug use is considered to be particularly taboo within Black and minority ethnic communities. Drug workers emphasised the need to protect drug users from the community and while this was discussed in relation to white communities there was a suggestion that it may be particularly pressing in relation to some Black and minority ethnic communities. Although Vietnamese workers were considered crucial to meeting the needs of Vietnamese clients this was matched by an emphasis on wider community tensions:

*When I started working in this field a lot of Vietnamese professionals gave me very negative feedback about what I was doing…they said what I’m doing is wrong, completely wrong…they say that you shouldn’t help heroin users, they should cut off themselves…I’ve got a very different view, I’ve been to school here, plus I’ve got a different attitude (Drug worker, Vietnamese, London).*

*Many of my friends take drugs, it helps us to meet each other, otherwise who would we talk to? No one in the community wants to know us…I’ve never been to Vietnamese community services, my friends have told me they do not welcome us…The community does not like to deal with us, they are ashamed and make us feel shame because of their shame (Vietnamese community group, London).*

These concerns were reported as matching those of some South Asian communities ten years ago and were linked to particular migration and settlement patterns and inter-generational differences.

5.3 Getting the mainstream right

While some respondents were highly critical of generic approaches, ideological objections to specialist services were evident in suggestions that they reflect an unrealistic division and reinforce ‘dangerous’ notions of segregation. Most respondents, however, took a pragmatic view and felt that services should do whatever works and that the precise configuration of services should reflect the local context. It was also suggested that generic and specialist services should not be in competition with one another but should work in partnership, with specialist providers often being viewed as having key role as referral agents. By providing a ‘gateway’ into mainstream provision it was noted that specialist services may change community attitudes to services which traditionally have been viewed as inappropriate for Black and minority ethnic users. Alternatively, it was
suggested that, having ‘bought time’ for other services to develop culturally competent ways of working specialist services may be integrated into mainstream provision.

The focus on partnership working, reflected a broader emphasis on the importance of having a mixed economy of provision:

*It has to be a twin approach, the approach is how do we get mainstream organisations to deliver culturally competent services...but at the same time how do we build capacity within organisations in communities for community based delivery* (Policy maker, Indian, Midlands).

From the perspective of commissioners, however, this emphasis had to be balanced by the realities of limited funding and competing needs. The practical limitations of specialist services were also recognised by advocates of such approaches:

*I don’t want to see a women’s service not necessarily having thought about how you would co-operate ethnic women into it but what would be absurd is to have a woman’s service and an ethnic woman’s service* (Drug worker, African Caribbean, London).

Overall, the balance of opinion among respondents rested on the notion that while specialist services may have an important role in facilitating choice their role should be essentially complimentary. This reflected a widely held belief that mainstream providers should develop appropriate ways of working with Black and minority ethnic communities:

*I think there should be two camps and people should be able to have a choice, whether they want to work in an integrated system, or whether they want to work in a specialist system...choice is good but where it’s an integrated service awareness and knowledge should be in the system and a lot of the time it’s not* (African Caribbean Community group, London).

*I don’t always think that setting up a specific service for that particular client group is always the most beneficial. From a strategic and economical sense it’s important that we look at all services and what can they deliver, we need them to deliver...to a greater range of people* (Service commissioner/planner, white, London).

In this context it should be noted that there were examples of generic services which incorporated many of the dimensions of cultural competence discussed earlier. These agencies were described as being ‘multicultural’ and sought to integrate the advantages of a specialist approach with a generic framework. Involve provided one example. This multi-site project focused on a broad range of drugs, had an ethnically mixed staff team and included Black and minority ethnic representation among its managers. Furthermore, although it had a generic focus it included an ethnically specific service known as RAW. A second example was provided by Orexis. This project included a specific focus on crack, had an ethnically mixed management committee which included African Caribbean and Vietnamese representation and had a staff team which was made up of four white workers, seven African Caribbean workers, two Vietnamese workers and a Chinese worker. While Black and minority ethnic staff were employed in dedicated posts they
were also represented in generic posts and the entire staff team was considered to be responsible for meeting the needs of an ethnically diverse community:

_The main positive aspect [of having ‘Black’ workers] is in terms of building trust with a client group, it’s a lot easier to have someone who is Black, but at the same time who has got a certain aptitude for working with the clients…I think that goes through all the different aspects of the service and that’s why I would see a Black worker as a bridge to the community. The community travels over here to the service but once they’re in the service they interact with white, Vietnamese, Chinese, everybody (Drug worker, white, London)._  

_Because you’ve got Vietnamese and English working together…we’ll share the work so the English person learns Vietnamese culture. Now it’s very interesting that at the same time we’re passing the English culture onto the Vietnamese I’m passing my knowledge about Vietnamese culture on to English workers (Drug worker, Vietnamese, London)._
6. Presentations to services

The extent to which drug Black and minority ethnic communities access drug services has been a cause for concern and in this chapter we examine evidence from the six case study areas. In doing so we look beyond levels of presentation and consider the types of services to which Black and minority ethnic users tend to present.

6.1 Levels of presentation

Much of the literature in this area is predicated on the notion that Black and minority ethnic groups are under-represented among users of drug services (see, for example, Awiah et al, 1990, 1992; Johnson and Carroll, 1995; Chantler et al, 1998; Khan, 1999a, b & c). This view has not, however, gone uncontested in relation to London-based services (see Mirza et al, 1991; Sondhi, 1999) and it may be that this reflects important regional differences in the nature of services being provided (see Druglink, 1997). While our analysis offered some support to the suggested distinctiveness of London-based services it also pointed to important differences between Black and minority ethnic communities.

Assessing levels of presentation

Presentations to services were assessed on the basis of the RDMD. Figures were taken from annual reports, collected from database administrators and taken directly from the RDMD. Those for Birmingham and Leicester related to the administrative year 1999–2000, those for Lancashire related to the year 2000, those for Bradford related to the period April–September 2000 and those for LSL and EHH related to the period April 1999–September 2000.

The ethnic composition of presentations to services was compared with that of the youthful population. For the London case study areas comparisons were made with the estimated population aged 15–39 years for the year 2000\(^{25}\). For the other case study areas comparisons were made with 1991 Census figures for 5–29 year olds. This reflected the way in which this information was made available and the passage of time – those aged 5 to 29 years in 1991 were 14–38 years old by 2000. The youthful population provided the basis for comparison because clients of drug-services tend to be young – more than 80% of episodes in both London case study areas were presented by 15–39 year olds and because Black and minority ethnic communities have relatively youthful population structures (Modood et al, 1997).

Although comparisons with the general youthful population are informative, apparently low levels of Black and minority ethnic presentation do not necessarily reflect unequal service delivery. They may, for example, also reflect different levels of problematic drug use across communities.

\(^{25}\) Estimates were provided by the London Research Centre.
Outside London there was strong evidence that Black and minority ethnic communities were under-represented among those presenting to drug services (see Table 6.1). In Birmingham, for example, while these communities accounted for 30% of the youthful population they accounted for 23% of episodes presented to services. While this pattern was broadly replicated in each of the case study areas outside of London, under-representation was particularly marked in relation to south Asian communities. In Bradford, for example, south Asians accounted for 19% of the youthful population but only 7% of presentations to services. There are good reasons to suppose that under-representation of south Asians in these areas reflected the nature of service provision rather than low levels of problematic drug use:

- Evidence of problematic drug use in south Asian communities has been produced by national, regional and local studies (Ramsay and Percy, 1996; Ramsay and Spiller, 1997; Sondhi, et. al, 1999; Chaudry et. al, 1997; Perera, 1998; Sherlock et. al, 1997). Moreover, respondents in these case study areas pointed to research evidence of problematic drug use within such communities.

- Presentations in EHH (see Table 6.2) indicate that where specialist provision is made, south Asians in general, and Indians in particular, will access services in reasonable numbers.

- Specific services in these case study areas accessed south Asian users in good numbers. In Bradford, for example, a drug dependency clinic saw 179 south Asian clients in the year 1997–8 which accounted for 17% of the clients seen by that service26.

While levels of presentation from south Asians outside of London showed a clear trend, the situation regarding African Caribbeans was more complex. Evidence of African Caribbean under-representation was limited to Birmingham. The levels of representation that were evident in Leicestershire and Bradford, however, were based on very few presentations (19 and 13 respectively) which does little to sustain the idea these communities were being accessed effectively, particular given the overwhelming focus of provision on opiate injecting.

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26 We are very grateful to Dr Michael Ross for providing this data.
Table 6.1: Ethnic breakdown of presentations to drug services – outside London (percentage of episodes presented by specified ethnic groups)27

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Birmingham Presentations to services</th>
<th>Youthful Population</th>
<th>Leicestershire Presentations to services</th>
<th>Youthful Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>77</td>
<td>70</td>
<td>92</td>
<td>86</td>
</tr>
<tr>
<td>African Caribbean</td>
<td>6</td>
<td>8</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Indian</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Pakistani or Bangladeshi</td>
<td>9</td>
<td>12</td>
<td>*</td>
<td>1</td>
</tr>
<tr>
<td>Chinese</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>*</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>*n</td>
<td>946</td>
<td>354,388</td>
<td>531</td>
<td>302,720</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bradford Presentations to services</th>
<th>Youthful Population</th>
<th>Lancashire Presentations to services</th>
<th>Youthful Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>87</td>
<td>77</td>
<td>96</td>
</tr>
<tr>
<td>African Caribbean28</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Indian</td>
<td>2</td>
<td>3</td>
<td>*</td>
</tr>
<tr>
<td>Pakistani or Bangladeshi</td>
<td>5</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>Chinese</td>
<td>0</td>
<td>*</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>*n</td>
<td>534</td>
<td>168,202</td>
<td>2,686</td>
</tr>
</tbody>
</table>

* < 0.5%

In the London case study areas white communities were slightly over-represented although a degree of diversity was evident in relation to Black and minority ethnic groups (see Table 6.2). While the largest Black and minority ethnic communities were well represented in these areas there was evidence of under-representation among the smaller groups. Thus, while Black Caribbeans were slightly over-represented in LSL and EHH, Black Africans were consistently under-represented. Similarly, while Indians were well represented in EHH there was evidence of under-representation among south Asians in LSL and, more specifically, among Pakistanis and Bangladeshis in EHH. These patterns may reflect the ethnic profile of Black and minority ethnic workers in these areas. As already noted, the extent to which issues of diversity were reflected in the employment of such staff was limited. Most African Caribbean workers included in the

27 This analysis must be treated with some degree of caution because of the doubt that surrounds the efficacy of the ethnicity data recorded on the RDMD. This was particularly evident in relation to Birmingham as ethnic information was missing for 28% of all recorded episodes. The situation in Birmingham was further clouded by the high proportion of cases in the RDMD which were recorded as having an ‘other’ ethnicity. These issues were less evident in relation to the other areas. Ethnicity data was, for example, missing in 10% of recorded episodes for Bradford, 9% for Leicestershire and 13% for Lancashire. The use of the other category was also less marked in these areas.

28 The categories of Black Caribbean and Black African have been combined because of the very small numbers of Black Africans living in these areas.
6. Presentations to services

research were of Caribbean heritage, for example, and this may help to explain the particular under-representation of Black Africans among individuals accessing services.

Table 6.2: Ethnic breakdown of presentations to drug services – London
(percentage of people presenting from specified ethnic groups)\(^{29}\)

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>LSL People presenting to drug services</th>
<th>LSL Estimated population (aged 15–39)</th>
<th>EHH People presenting to drug services</th>
<th>EHH Estimated population (aged 15–39)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>68</td>
<td>63</td>
<td>65</td>
<td>63</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>20</td>
<td>16</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Black African</td>
<td>2</td>
<td>10</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Indian, Pakistani or Bangladeshi</td>
<td>1</td>
<td>3</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
<td>1</td>
<td>*</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>6</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>(n)</td>
<td>2,926</td>
<td>318,904</td>
<td>1,289</td>
<td>280,267</td>
</tr>
</tbody>
</table>

Source: RDMD and London Research Centre projections

\(^{29}\) Figures relating to drug services were taken from the RDMD for the period from the beginning of April 1999 to the end of September 2000 and were based on people presenting to services for the first time or doing so after a break of six months or more. It is important to distinguish people from episodes. Where a person presents to more than one agency or presents to the same agency twice with gap of six months or more between presentations then multiple episodes are recorded by the RDMD. For the analysis presented in this table, multiple presentations have been ignored and thus the figures relate to people not episodes. While the LRC projections included a category ‘Asian other’ no such category was included in the RDMD. Thus, for the LRC figures quoted in this table, Asian other was combined with the other category.

Although levels of presentation to services by Black and minority ethnic users in LSL and EHH were reasonable, it is important that they are set in context:

- While figures from the RDMD measured initial contact they indicated nothing about the development or quality of the contact. This is important given the suggestion from drug workers that retention rates were particularly poor for Black and minority ethnic clients.

- The RDMD is based largely on direct access services and figures presented above do not offer any grounds for questioning respondents’ concerns about residential services (see chapter 3).
Certain Black and minority ethnic communities are hidden within the RDMD classification. In this context it is important to note respondents’ concerns, particularly in London, about low levels of presentation from Vietnamese, Somali and Turkish communities.

Important questions arise about the types of service that Black and minority ethnic users access and, as will be seen below, important ethnic differences are evident in patterns of help seeking behaviour which may, in part, be explained by the notions of cultural competence and institutional racism.

6.2 Patterns of presentation

Sufficient numbers of Black and minority ethnic users accessed services in the London case study areas to support detailed analysis of their patterns of presentation. Analysis focused on recent trends, differences between Black and minority ethnic groups, the role of cultural competence and culturally specific projects and the distinction between statutory and voluntary sectors.

Specialist or ‘stand alone’ services

Doubts were expressed by some respondents about the ability of specialist services to increase levels of presentation from Black and minority ethnic communities. While the initiatives on which these views were based tended to be fairly new or were short term, the role of culturally specific projects was assessed more formally on the basis of RDMD data for LSL.

Brixton Drug Project (BDP) opened early in 1995 as a culturally-specific service targeting African Caribbean communities. Initially funded by regeneration money, BDP closed after LSL’s stimulant-service-contract was awarded to another, generic, project in the area. The award of this contract coincided with a growing emphasis within this project on work with Black and minority ethnic communities which was reflected in the establishment of two dedicated ‘Black’ posts and the subsequent involvement in Black History Month. While the closure of BDP was widely criticised (Druglink, 1999; Nefertari and Ahmun, 1999), LSL’s service commissioners emphasised that access of Black and minority ethnic communities to all local drug services was a key priority (McGhee and Jobbins, 1999). Reflecting this claim, service contracts included targets for the proportion of clients who should be from Black and minority ethnic communities.

The proportion of episodes presented to services in LSL from Black and minority ethnic communities increased fairly dramatically during the late 1990s. This upward trend was largely associated with Black Caribbeans as presentations from south Asians and Black Africans remained consistently low (see Table 6.3). BDP clearly contributed to the upturn in Black Caribbean presentations: in 1998/9, 20% of all presentations from these communities were made to BDP. Nevertheless, this project was not wholly responsible for the increased levels of Black Caribbean
6. Presentations to services

Table 6.3: Ethnic breakdown of people presenting to drug services in LSL
(percentage of people from given ethnic groups drugs)

<table>
<thead>
<tr>
<th></th>
<th>1997/8</th>
<th>1998/9</th>
<th>1999/00</th>
<th>2000/01*</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>82</td>
<td>72</td>
<td>66</td>
<td>66</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>11</td>
<td>19</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>Black African</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Indian, Pakistani and Bangladeshi</td>
<td>*</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>4</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>.n</td>
<td>953</td>
<td>1466</td>
<td>1446</td>
<td>803</td>
</tr>
</tbody>
</table>


Presentations which were, at the very least, maintained after the closure of BDP (following the commissioning process for the financial year 1999/2000). There is, however, no way of knowing whether levels of Black Caribbean presentations would have risen further had BDP remained open.

Implications for cultural competence

Patterns of help seeking behaviour varied between ethnic groups in a way that confirmed the importance of cultural competence (see also Finn 1994; Ellis, 1999). The ethnic profile of clients varied markedly between services and presentations from Black and minority ethnic users were clustered in a narrow range of services.

In LSL during the period April 1999 – September 2000 there were services which had had an overwhelmingly white client-base. At its most extreme, 83% of the episodes presented to two agencies were from white clients. Other services reflected a far greater degree of diversity. Three services saw almost equal numbers of Black/minority ethnic and white episodes. Moreover, while they accounted for nearly two-fifths (38%) of all Black and minority ethnic episodes presented in LSL this compared with a fifth (21%) of white episodes. Although this concentration of Black and minority ethnic episodes could not be explained simply in terms of geographical proximity, these services were distinctive because of the particular commitment they showed to cultural competence. This was reflected in the nature, focus and marketing of the service as well as in the ethnic composition of the staff.

Compared with LSL, an even sharper degree of polarisation was evident in EHH during this period. Two-fifths (40%) of Black Caribbean/Black African episodes were presented to a single agency which included a crack service, employed African Caribbean staff and had specifically marketed the service to African Caribbean communities. Two-thirds (65%) of south Asian presentations went to two partnership agencies – one in the voluntary sector and one in the NHS – which employed Asian staff and provided a designated, funded, Asian service. This adds to

*50 Figures for this year were based on the period from the start of April 2000 to the end of September 2000.
the literature which suggests that Asian workers facilitate service-use by Asian clients (Patel and Sherlock, 1997).

**Statutory provision, GPs and voluntary sector services**

Striking differences were evident in the rate at which users from different ethnic groups presented episodes to statutory services, voluntary sector agencies and GPs (see Table 6.4). Within LSL, 55% of white episodes were presented to non-statutory services, 40% were presented to statutory services and 5% were presented to GPs.

While Black Caribbean and Black African episodes in LSL and EHH were concentrated in voluntary sector services this could partly be explained by the particular opiate focus of statutory providers: in LSL 72% of crack presentations were made to non-statutory services, compared with 90% in EHH. Within EHH, south Asians were well represented in statutory services and, in part, this reflected their patterns of drug use. Other dimensions of cultural competence also came into play, however, and this was evident in the way that south Asian episodes were concentrated in a single service (see previous section).

**Table 6.4: Type of service approached by ethnicity (percentage of episodes from given ethnic groups presented to specified type of service)**

<table>
<thead>
<tr>
<th></th>
<th>Non-statutory</th>
<th>Statutory</th>
<th>GP</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LSL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>55</td>
<td>40</td>
<td>5</td>
<td>2403</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>73</td>
<td>25</td>
<td>1</td>
<td>666</td>
</tr>
<tr>
<td>Black African</td>
<td>68</td>
<td>27</td>
<td>5</td>
<td>77</td>
</tr>
<tr>
<td>Chinese</td>
<td>78</td>
<td>22</td>
<td>0</td>
<td>46</td>
</tr>
<tr>
<td>Indian, Pakistani and Bangladeshi</td>
<td>66</td>
<td>29</td>
<td>3</td>
<td>31</td>
</tr>
<tr>
<td>Other</td>
<td>66</td>
<td>31</td>
<td>4</td>
<td>316</td>
</tr>
<tr>
<td>All</td>
<td>60</td>
<td>36</td>
<td>4</td>
<td>3539</td>
</tr>
<tr>
<td><strong>EHH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>64</td>
<td>20</td>
<td>16</td>
<td>958</td>
</tr>
<tr>
<td>Black African/Caribbean</td>
<td>82</td>
<td>15</td>
<td>3</td>
<td>166</td>
</tr>
<tr>
<td>Indian</td>
<td>45</td>
<td>55</td>
<td>1</td>
<td>213</td>
</tr>
<tr>
<td>Pakistani or Bangladeshi</td>
<td>50</td>
<td>48</td>
<td>2</td>
<td>44</td>
</tr>
<tr>
<td>Other – including Chinese</td>
<td>67</td>
<td>26</td>
<td>7</td>
<td>89</td>
</tr>
<tr>
<td>All</td>
<td>63</td>
<td>26</td>
<td>11</td>
<td>1470</td>
</tr>
</tbody>
</table>

Source: RDMD (April 1999–September 2000)

Although the number of cases presented by Indian, Pakistan and Bangladeshi users was very small in LSL figures have been included as they were broadly in line with those for other minority ethnic groups.
Many commentators have identified GPs as an important source of help for Black and minority ethnic drug users and have recommended the development of GP-based drugs services (Awiah, undated; Johnson and Carroll, 1995; Chaudry et al, 1997; NWLHPU/GMLCA, 1997). The patterns of presentation that were evident in the London case study areas, however, raise serious doubts about the extent to which GPs provide an appropriate basis for delivering drugs services to Black and minority ethnic communities. This was particularly striking in EHH where white episodes were more than five times as likely as south Asian or Black African/Caribbean episodes to be presented to GPs. A similar, albeit notably less striking, pattern was evident in LSL, although rates of white presentation to GPs were matched by those shown by Black Africans.

Respondents in EHH suggested that low levels of south Asian presentation to GPs might reflect concerns about anonymity and confidentiality because a large number of GPs in this area are, themselves, south Asian. However, we have already seen that large numbers of south Asian drug users presented to services which employed south Asian workers. This suggests that the role of workers and the structure within which they operate is crucial in defining the extent to which drug users consider services to be accessible. GPs tend to have personal knowledge of their patients and their families and they keep written records, all of which may contribute to a sense of unease about the extent to which they provide an anonymous, confidential service. It was also suggested that low levels of presentation to GPs among African Caribbean users might reflect a concern about being diverted into mental health services. Regardless of how they are explained, low rates of presentation to GPs by Black and minority ethnic drug users have important implications for the development of culturally competent services, particularly given the growing emphasis on GPs as providers of drugs services (Ford and Ryrie, 1999).
7. **Cultural competence and regional strategy**

Cultural competence was seen by respondents to have relevance which extended beyond the delivery of drug services and embraced issues of strategy, planning and commissioning (see also Chandra, 1996):

> Unless you change the framework in which services get planned, developed and delivered, you can have a whole project run by Black people but if the frame when its delivered is the same, it’s not going to make any difference (Policy maker, Indian, Midlands).

The importance of cultural competence to strategic planning and commissioning was highlighted by the suggestion that resources could be re-allocated in such a way as to make the overall configuration of services more responsive to the needs of diverse communities:

> They don’t actually need to spend money, what they actually need to do is to sort out the NHS Trusts and what they’re doing with all the money that’s gone into drug treatment services. The vast bulk of money goes to those set ups…and they’re probably the worse services in relation to reflecting the local population in terms of users…I think there’s a very important principal that seems not to have been recognised in the whole treatment debate about how to expand…and that is the inflexibility of those traditional community drug dependency units…[There’s a need] to look at where people have been really successful in providing services to ethnically diverse communities (Policy maker, white, London).

Examples of strategic approaches were evident in the areas on which the research focused. In LSL specific targets had been written into service providers’ contracts regarding the representation of Black and minority ethnic users. In Greater Manchester the Drug Action Partnership had funded the Manchester Drugs and Race Unit to work with the DAT and service providers to improve accessibility for Black and minority communities. Such examples were not typical, however, and many respondents felt there was a lack of strategy in the commissioning process and that services were commissioned largely on the basis of historical precedent:

> What I’ve noticed generally is that there’s a strategic vacuum for drugs misuse, that services are, based on historical development for community drug teams and voluntary sector agencies and that the DAT and the Alcohol Advisory Service are not linking up strategically over issues of gender or ethnicity (Commissioner, white, Midlands).
7. Cultural competence and regional strategy

7.1 Determining the needs of Black and minority ethnic communities

The process by which services were commissioned raised important issues about needs assessment, community consultation, monitoring and the role of workers employed to engage with Black and minority ethnic communities:

- **Needs assessment:** there was little, if any, evidence of assessment at the regional level which sought to establish a comprehensive and integrated picture of need. In so far as needs assessment was evident it was conducted by individual agencies to highlight to commissioners new patterns of presentation that were being made to the service.

- **Community consultation:** there was little evidence of community consultation in the process by which services were planned and commissioned. Moreover, where community consultation was discussed it tended to be rooted in a largely discredited approach based on religious and community leaders:

  *The senior staff in the Trusts in the city said to me ‘the way to identify need is to call in the so-called community leaders’. They want to call themselves ‘community leaders’. They then tell them what their needs are and then they deliver a service accordingly. Now if that is the level of sophistication of your model of service development then quite frankly I’m amazed. You know, you wouldn’t go and ask a white middle class person what are some of your health needs, they wouldn’t even contemplate it so why do it with our community (Policy maker, Indian, Midlands).*

This approach may be considered particularly problematic in relation to south Asian communities because of the ‘denial syndrome’ discussed earlier (see chapter 2) and because of the way in which people in these communities, particularly women and young people, are challenging the assumptions and stereotypical responses of community and religious leaders.

- **Monitoring:** ethnic monitoring was widespread although it often lacked a clear sense of purpose and there was little suggestion that it was used to promote anti-discriminatory practice (Khan, 1999b). While some commissioners did refer to patterns of drug use that were evident from monitoring, others did not appear to recognise the value of such information and this was reflected in the way that they dismissed the RMD as being unreliable.

- **Insights of Black and minority ethnic workers:** in some of the case study areas commissioners dismissed the insights of Black and minority ethnic workers as ‘anecdotal’. This is noteworthy given the lack of strategic information in these areas and because of the way in which commissioning on the basis of historical precedent reinforces the focus of service on opiate injecting. Most Black and minority ethnic drug workers were clear about the distinctive nature of problematic drug use within their communities. In contrast, service commissioners (most of whom were white) were often uneasy with the suggestion...
that patterns of drug use may vary between ethnic groups and frequently talked of the need to avoid stereotypes. While some commissioners were unclear about patterns of drug use within south Asian communities, it was suggested in four of the case study areas that white drug-professionals had been blinded to a genuine need because of concern about stereotyping African Caribbean people as crack users:

> When I first started working in the drugs field services were for white opiate users and there had to be a shift in that...there has quite rightly been a swing in the drugs field against stereotyping people in minority ethnic groups...but I think it can reach a point whereby it becomes counter productive...if workers reach somebody who actually fits that stereotype they're loathe to acknowledge it...and I think it becomes a barrier to certain services...the services aren't appropriately developed to meet the need. I think that some things become a heresy within the drugs field, things have almost reached a point of paralysis...whereby people are reluctant to verbalise issues or think off the top of their head for fear of being accused of racist. You know, so it's been almost a heresy to say in the forum meetings, DAT meetings, DRG meetings – but may be not quite so much now but may be five years ago – that what we need are services for Black crack users (Drugs worker, white, London).

In the absence of firm evidence, it was suggested that the safest starting point is provided by the assumption that different communities have equal levels of need for a drugs service:

> I think that if you are working in this area...you must proactively make an assumption that everybody's going to have problems. I went back to Amsterdam, after three years to visit some services and I said 'what's changed?'. They said 'well we've noted that 200 Dominicans had moved into the area and we...assumed that there would be 5% prevalence amongst them, because that's what was happening locally'. Having made that decision you can tune up or down, and also I think that assumption also stops you from apologising to any particular group (Policy maker, Indian, London).

### 7.2 Cultural ownership and leadership

Many respondents, including some commissioners, felt that not enough was being done to meet the needs of Black and minority ethnic drug users. Developments in this area were considered to be piecemeal and ad-hoc and this was reflected in complaints about the lack of specific budgets for work with Black and minority ethnic communities and the short-term nature of most funding for dedicated Black and minority ethnic posts. While this was seen to reflect a general absence of cultural ownership and leadership, particular criticisms were made of the DATs for lacking coherent strategies, for poor structures, for low levels of awareness and for acting as 'little more than talking shops'.
Although DATs are developing an increased commissioning role (Shapiro, 1999) it is unlikely that this will provide the basis for improved cultural leadership and ownership unless the national strategy is reviewed. The current strategy does not offer any guidance about how services may seek to ensure cultural competence and none of the performance indicators or targets set by the strategy specifically mention ethnicity. This severely limits the extent to which such issues are prioritised by commissioners:

You’ve got to bear in mind we’ve got a national strategy with four key strategic aims against which we are acutely measured and those are going to be our priority areas…The Somali population are not accessing services particularly well but there is a recognised problem within that population. We’ve done an initial piece of needs assessment work and will be keeping our eyes open for any opportunities to follow-up work in that area. But we have another problem and this must not be underestimated in any way. We’ve got national targets to rapidly increase treatment drastically (Service commissioner/planner, white, London).

The trouble is, and this isn’t just the drugs field, but we get all these directives about how to do things from the Department of Health, the Home Office and Social Services Inspectorate and we spend the whole time at DAT and DRG meetings sitting around talking about them…We’re having to respond to an agenda that isn’t ours and we don’t have time to sit back and look at what we’re doing…It’s the agenda of central government, UKADCU, and ethnicity is struggling to get on that agenda although locally it’s seen as important (Service commissioner/planner, white, London).

7.3 Black and minority ethnic representation

While the lack of strategic development in this area was seen to reflect an absence of cultural leadership and ownership this was, in turn, linked to low levels of Black and minority ethnic representation within DATs, DRGs and at management, commissioning and planning levels:

There is value in having someone around the table representing different groups… I think a lot of the decisions to set up or to possibly close specific projects, have been taken for pure financial reasons…and they [minority groups] are not represented on the decision making table on who makes the cuts. When the cuts have got to be made who is represented in the positions of power? (Drug worker, white, London).

If you’ve got a set of services commissioned by the white suburban middle classes or who are newcomers to London…that causes you a huge problem because people that are commissioning services have no relationship with the people, particularly culturally, that they are actually commissioning the services for (Drug worker, African Caribbean, London).

Implicit in these views was the suggestion that Black and minority ethnic representation at management, planning and commissioning level is an important route through which cultural leadership and ownership can be ensured. The importance of this type of representation has been identified in the policing literature as one of the key ways in which institutional racism may be challenged (Lea, 2000).
Part three – Summary and recommendations

8.1 Overview

This study was funded on the basis that it would inform the development of a drugs and ethnicity initiative led by The United Kingdom Anti-Drug Co-ordination Unit (UKADCU). An early possibility discussed with UKADCU officials was that they might fund services for specific work with Black and minority ethnic communities. We conclude that money would not best be spent on short term pilot or ‘demonstration’ projects as this would fail to address key institutional issues and would reinforce the ad-hoc, peripheral, nature of initiatives targeted at Black and minority ethnic communities:

I assume it’s 2 or 3 year money, unless it’s revenue funding my first statement would be really that you need to be very careful about how you use that money…because if that money was used to set up particular interventions they wouldn’t be around for very long…and then you would be back to where you started. Where that money could more usefully be used is around those more one off costs really, which could be around setting in place those sort of strategies (Service commissioner/planner, other, London).

The key findings of the report indicate the need for far reaching changes within drug service provision in order to meet the needs of Black and minority ethnic communities. Furthermore, these changes are unlikely to take place or be effective unless they are clearly set within a context of addressing institutional racism and are located within the framework provided by the national drugs strategy.

We have borne this in mind when making our recommendations. We have considered what needs to be done nationally, regionally and locally and have placed considerable emphasis on the role of central government and the recently established National Treatment Agency (NTA). Our recommendations are grounded in the analysis we have presented in this report and reflect the concerns raised by respondents. We focus on three key areas:

1. A national strategic response;
2. Moving towards cultural competence and tackling institutional racism; and
3. Improvement of data collection systems.

Our recommendations may be considered to be consistent with existing government policy in a number of key areas although they also seek to ensure that issues of ‘race’ and ethnicity become more firmly located within the mainstream of national, regional and local policy. The extract from the national strategy quoted at the beginning of this report indicates that an emphasis on cultural competence and diversification of services is consistent with government thinking. There is, however, currently no official guidance for commissioners and service providers about how to ensure cultural competence and none of the performance indicators or targets set by the strategy specifically mentions ethnicity. While this severely limits the extent to which commissioners
 prioritise these issues, our recommendations seek to ensure that these gaps are filled. The recommendations that we have made regarding the development of a national executive and regional structure to represent the interests of Black and minority ethnic communities should also be set in context. Government funding has recently been made available for the Federation of Black and Asian Drug and Alcohol Workers to carry out development work and the UKADCU’s ‘Race Issues Group’ recently convened a working group of academics, policy makers and practitioners to inform the government’s strategic planning in this area.

8. Summary and recommendations

In this report we have demonstrated that drug use is an important issue within Black and minority ethnic communities; that ethnic groups have distinct patterns of drug use; and that the way in which services are provided unwittingly discriminates against Black and minority ethnic drug users.

We found that the extent to which drug services took account of issues of ‘race’ and ethnicity was hindered by a general lack of strategy at the regional level:

- There was a feeling among Black and minority ethnic communities, practitioners in the field and, to some extent, commissioners themselves that not enough was being done to meet the needs of Black and minority ethnic drug users and that developments in this area were piecemeal and ad-hoc. Particular complaints were voiced about the way in which Black and minority ethnic specific initiatives were often funded on a short-term basis.

- Information that exists about Black and minority ethnic drug use is under used, monitoring often lacks clear sense of purpose and there is little evidence of strategic needs assessment. In the absence of firm evidence it was suggested that assumptions of parity in levels of problematic drug use provide the safest starting point for service development.

- DATs and their related structures were considered to function poorly in relation to commissioning services for Black and minority ethnic communities.

- A lack of Black and minority ethnic representation within DATs, DRGs and at management, planning and commissioning levels was identified as an important source of bias. Implicit in these views was the suggestion that such representation is an important route through which cultural leadership and ownership can be ensured.

In relation to service delivery:

- Important regional differences were evident in levels of presentation to drug services. Black and minority ethnic groups were reasonably well represented among those presenting to services in the London case study areas. Outside of the capital, evidence of under-representation was particularly marked among south Asian communities and it was concluded that this had more to do with the nature of services being provided than with low levels of problematic drug use in these communities.
If drug services are to meet the needs of Black and minority ethnic communities they must diversify in terms of the substances/modes of use on which they focus and the models of intervention on which they rest. A shift away from opiate injecting and the development of services with a holistic, therapeutic and social focus are particularly – although not exclusively – important to meeting the needs of Black and minority ethnic communities.

Overall levels of illicit drug use within Black and minority ethnic communities are generally lower than those that are evident for whites. This is particularly so among south Asian and Black African communities. While Black Caribbeans showed levels of drug use, which were comparable to those of whites, this was primarily driven by cannabis.

Patterns of problematic drug use vary between ethnic groups and the continued focus of services on opiate-injecting is an important source of institutional racism. The failure of drug services to engage adequately with crack, opiate smoking, cannabis and khat has particularly marginalised the needs of African Caribbean, south Asian and Somali users. At the same time there is evidence of opiate injecting by Black and minority ethnic drug users and it is crucial that services actively engage with injectors from these communities.

The failure of services to diversify was considered particularly important in view of recent developments in criminal justice policy: because of a lack of appropriate treatment options Black and minority ethnic drug users on Drug Treatment and Testing Orders were considered to be particularly vulnerable to being breached.

There is a lack of targeted provision for recently established Black and minority ethnic communities (e.g. Somalis and Vietnamese) and issues associated with particular patterns of drug use within these communities appear to be poorly understood.

We have highlighted the importance of cultural competence – and related notions – in meeting the needs of Black and minority ethnic communities:

- We suggest that cultural competence is an umbrella term which describes the ability to meet the needs of diverse communities; cultural appropriateness is the mechanism through which cultural competence is ensured; and cultural sensitivity and cultural specificity form the building blocks for culturally appropriate ways of working.

- Cultural competence rests on the ability to distinguish, and respond to, distinct cultural needs which may include different patterns of drug use; diverse functional needs; the importance of family and intergenerational factors; distinct cultural and religious perspectives; and particular experiences of shame.

- Cultural competence involves working with the realities of racism and social exclusion and this translates into a holistic, therapeutic and social focus. Rather than being defined in terms of narrow medical interventions, culturally competent practice emphasises the role of
8. Summary and recommendations

talk therapy, holistic therapy (e.g. acupuncture), support and advocacy and – in the context of work with recently established Black and minority ethnic communities – social participation. Approaches to talk therapy which focus on notions of culture and cultural difference have a key role, particularly in the context of dual diagnosis.

- While Black and minority ethnic workers have considerable value in relation to work with Black and minority ethnic communities, fulfillment of this potential depends on other dimensions of cultural competence – particularly cultural ownership and leadership. In the absence of these dimensions there is a danger of isolation and tokenism.

- Cultural competence includes an emphasis on community attachment and ownership. While recognition should be given to the problematic nature of community, the notions of community attachment and ownership are tied crucially to the notion of capacity building, particularly in the context of recently established Black and minority ethnic communities.

- Evidence from the London case study areas indicated that presentations by Black and minority ethnic users tend to cluster in services which show a commitment to the notion of cultural competence.

We have identified various types of service and discussed their role in meeting the needs of Black and minority ethnic communities:

- It is crucial that mainstream services are geared towards meeting the needs of diverse communities. While this does not preclude the role of Black and minority ethnic specialist services, our findings indicate that generic services can meet the needs of Black and minority ethnic communities if they address issues of institutional racism and take seriously the notion of cultural competence.

- Our analysis of the London case study areas raise significant doubts about the ability of GPs to meet the needs of diverse communities. Black and minority ethnic users were less likely to present to GPs than were whites and in some instances the differences were striking.

- We have identified particular concerns about specialist residential services. While these services were seen to be the least capable of meeting the needs of diverse communities particular problems were identified in relation to retention and delays in follow-up care.
8.3 Recommendations

1. A National Strategic Response

We recommend that the relevant government departments and the National Treatment Agency should co-ordinate and finance the development of a strategic response to the needs of Black and minority ethnic communities in relation to drug treatment and prevention services. Specific recommendations to facilitate this process include the following:

- An emphasis on ethnic equality should be included throughout all aspects of the national drugs strategy. Specific indicators relating to take-up of services by Black and minority ethnic users should be written into the strategy. Targets for rates of client retention within these communities should also be included in the process by which DAT performance is reviewed.
- An ‘experts panel’ should be established in the development of this strategy.
- Relevant government departments and the NTA should: fund the production of practical guidelines on how services may seek to ensure cultural competence; and work directly with the Commission for Racial Equality on the creation of guidelines for service provision and funding in light of the Race Relations Act (Amendment) Act 2000.

2. Working towards cultural competence and tackling institutional racism

We recommend that funding should be used to address issues such as Black and minority ethnic representation, community attachment and ownership, capacity building and cultural sensitivity:

- Relevant government departments should invest in a national executive and regional structure which represents the interests of Black and minority ethnic communities, including those that are recently established in the UK. This body should be integrated into the structures and processes by which central government, NTA and DATs formulate policy and should have a key role in monitoring the development of services for Black and minority ethnic communities. The representativeness of this body and the channels through which it ensures accountability should be clear.
- Resources should be used to improve levels of Black and minority ethnic representation within agencies, at management, commissioning and purchasing levels and within DATs and DRGs. Financial support for appropriate training (scholarships and study leave) and secondments offer ways of preparing existing Black and minority ethnic staff for management, commissioning and planning roles. Development of trainee positions and mentoring schemes offer ways of attracting more Black and minority ethnic workers into drug services although this should be balanced by a focus on career development for existing staff.
- If the needs of Black and minority ethnic communities are to be met, it is essential that services diversify in terms of the drugs and modes of use on which they focus and in relation to the models of intervention on which they rest. An increased capacity to work effectively with non-injecting heroin users, crack users and cannabis users is a key element of this recommendation. Relevant government departments and the NTA should put structures in place to ensure that such diversification takes place. It is important, however, that this focus does not detract from the importance of ensuring equality in those services that focus on heroin injecting.
- Investment should be used to support the development of holistic, therapeutic and social interventions. Workers (Black/minority ethnic and white) should be trained in counselling and therapeutic techniques – including those which focus on issues of culture and cultural difference – in advocacy and in holistic medical therapies.
- Capacity building should be encouraged through the development of partnership services with community groups, the establishment of satellite services, community volunteer schemes, training and mentoring schemes and secondments from community organisations. Education and awareness raising initiatives should be promoted with recently established Black and minority ethnic communities.
8. Summary and recommendations

3. Improvement of data collection systems

This report has clearly demonstrated the potential value of the RDMD, although improvements are required to ensure more consistent data collection and analysis. We recommend that this be facilitated by the following actions:

- Funding the production of clear guidelines to ensure ethnic monitoring is consistent, co-ordinated and based on official classifications.
- Ensuring that the benefits of monitoring are clearly felt by those involved in data collection. This may involve training for front line workers which focuses on the way in which monitoring can help to improve services. It may also require improved systems by which results of monitoring are fed back to agencies.
- Increasing the capacity of DATs to make use of statistical data and other research in planning and commissioning services.
- Monitoring referral and treatment outcomes for Black and minority ethnic drug offenders.
- Systems for improved data collection should include a particular focus on drug use among Black and minority ethnic women and girls.
References


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