UKDPC

UK DRUG POLICY COMMISSION

Drugs and Diversity: Ethnic minority groups

Learning from the evidence

Introduction

This review is part of a wider programme of work undertaken by the UKDPC to provide an overview of the differing needs and challenges associated with drug use among diverse minority communities within the UK.

By bringing together a variety of evidence in one place we are seeking to encourage a broader view of the evidence and its implications, as well as prompting debate about how best to respond to the varying patterns of drug use and associated problems within different communities.

The government, local partnerships, commissioners and service providers have sought to address the challenges of a range of diverse groups over the years. This review has not sought to evaluate the impact these have made but rather to describe what is known about the current situation, to stimulate much-needed discussion of the issues, highlight gaps and to identify new areas for action.

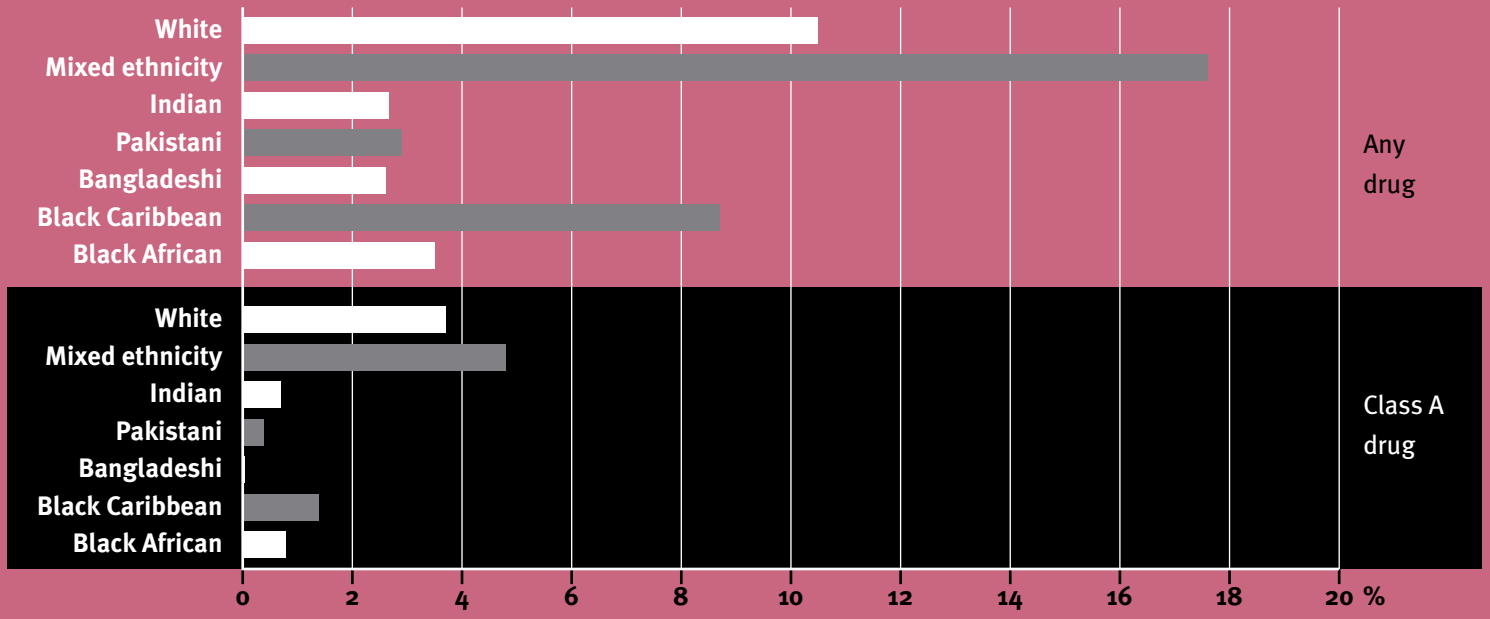
It was a common finding for all the reviews conducted as part of this project that the evidence was limited and often of poor quality using samples that are not necessarily representative of the population. Therefore the findings, although the best available, should be interpreted with caution.

Also, it is important to note that considerable diversity within Black and minority ethnic (BME) communities is often concealed by the use of generic terminology covering a wide range of geographic origins (ie 'South Asian' may describe populations from Pakistan, India, Bangladesh, etc.). Indeed, even within groups with the same ethnic background there may be differences associated with other factors such as place of residence within the UK, generational and social differences.

This briefing is based on the following reviews:

- *The Impact of Drugs on Different Minority Groups: A Review of the UK Literature Part 1:Ethnic Minority Groups*
- *The Impact of Drugs on Different Minority Groups: Ethnicity and Drug Treatment*
- Available at: www.ukdpc.org.uk/reports.shtml

Proportion of 16 to 59 year olds reporting use of drugs in the past year by ethnicity (combined dataset 2006/07, 2007/08 & 2008/09 BCS)



The extent and nature of drug use and associated problems

- In general, overall drug use is lower among minority ethnic groups than among the White population.
- Reported drug use prevalence is highest among those from mixed ethnic background in a number of studies, largely as a result of high levels of cannabis use. However, when the younger average age of this group is taken into account, their drug use levels are similar to those in the White population.
- Lowest overall levels of drug use are reported by people from Asian backgrounds (Indian, Pakistani or Bangladeshi).
- Cannabis is the most commonly used drug across all ethnic groups and age groups.
- Rates of Class A drug use are higher among people from White or mixed ethnic background than among other ethnic groups.
- Poly drug use is most common among White groups, compared with other ethnic groups.
- Men are more likely than women to use any illicit drugs in many ethnic groups, particularly among Asian, White and Chinese/other groups. Black and mixed race men and women have similar levels of use.
- National and local records of treatment services, and some small scale studies, indicate that the types of drugs that cause individuals to seek help vary between different communities:
  - Among the Asian community the most common reason for seeking treatment is problematic use of heroin;
  - Asian drug users also appear to be more likely to use smoking or chasing as their method of administration; those in White communities are more likely to inject;
  - Drug users from Black groups are most likely to seek treatment for crack cocaine and cannabis use;
  - Women make up a bigger proportion of White people in treatment than they do of Black people; the proportion of women among Asian ethnic subgroups (Indian, Pakistani, etc.) is lower still;
  - Almost half of people from White, Mixed and Black ethnic groups report alcohol use prior to entering treatment compared with only about a third of those of Asian background.
- In some ethnic communities, khat use may be a cultural or social recreation. Although khat use is legal, concerns have been raised regarding its potential negative health impacts.
- Among khat using communities, men are more likely to be users than women. This may be due to:
  - the stigma attached to drug use being greater for women;
  - Women being more likely to deny their khat use and use it alone rather than in social settings;
  - Women also appear more likely to regard their khat use as problematic.
- Information on reasons for use mainly comes from qualitative studies and discussions with users and community members; it may not be completely representative, and should be interpreted with caution.

- Peer pressure and influence are seen as important reasons why young people use drugs. Young people growing up under the influence of western culture and trends may seek to distance themselves from 'traditional' cultural values in order to 'fit in'.
- BME communities may be at risk of drug use because they often live in disadvantaged and deprived areas, where drug markets thrive.
- A number of minority ethnic groups, particularly refugees and asylum seekers, face high levels of unemployment, isolation and social exclusion. Limited opportunities can lead to frustration, boredom and anxiety increasing the likelihood of drug use.
- Factors suggested as linked to high levels of cannabis use within Black communities include:
  - a perception that it is safe and less harmful than other drugs;
  - a history of cannabis use within families;
  - for Rastafarians, cannabis use is a spiritual act and part of the 'culture' of the movement.
- Among some BME groups, particularly South Asians and the Chinese, high levels of stigma are attached to drug use and directed at both drug users and their families. This can lead drug users to hide the extent of their use, and levels of drug problems being underestimated.

Implications for policy and practice

- Drug use is generally proportionally greater amongst white communities than BME groups; this may change as young people become more absorbed into predominant national culture with the potential for increasing drug problems in these communities.
- The high rates of use among mixed race individuals may be of concern, as they are likely to be an increasing group in the future.
- A more sophisticated understanding of ethnic differences in drug use that recognises the differences within broad ethnic categories is required; at present considerable variability is concealed within broad categorisation which may lead to inappropriate responses.
- The extreme social stigma associated with drug use in some ethnic groups may lead to under-estimation of problems and inhibit service provision.

Evidence needs

Further information is needed about:

- the variation in drug use within specific ethnic communities to identify the role and relative importance of other factors – personal, social, economic, cultural, geographical – that may increase risk of or provide protection against drug use;
- the different patterns of drug use (types of drugs, mode of administration, length of use) between different ethnic groups and the contexts in which drug use occurs;
- the extent of drug use among refugees and asylum seekers;
- the variation in drug use within the White ethnic group, for example among the new communities from Eastern European countries.

Drug treatment and prevention programmes

- There is some evidence about perceived good practice in drug education and information provision for a range of BME communities, but no robust evaluations of the effectiveness of such programmes.
- It appears there is limited awareness among BME communities of the range and value of existing drugs services. Sources of information on services that may be used include:
  - GPs;
  - family, friends or social networks;
  - religious organisations or leaders;
  - community organisations.
- BME communities suggested a wide variety of venues for delivery of drug-related information, including:
  - schools and community centres (familiar, community-based, well-visited, 'comfortable and safe');
  - youth clubs, colleges and universities;
  - gender-specific venues may be important for some groups.
- A variety of written, oral and visual media in appropriate languages will be needed to provide drug education successfully, such as telephone helplines – the anonymity is helpful where stigma is an issue – and information in non-written formats for groups with a tradition of oral communication or poor literacy levels.
- BME communities were agreed that information needs to be precise and explicit, particularly regarding drug services, but were split as to whether drug related information should focus on harm reduction messages or emphasise abstinence / illegality.
- BME communities have a range of suggestions regarding the most appropriate people to deliver drug education including:
  - ex-drug users or drug users in treatment (from within communities);
  - young peer educators (may be perceived as more credible than adults);
  - the need for positive role models to get involved in a 'mentoring' or 'buddy' capacity;
  - community organisation workers with appropriate training.
- While all community members need to receive drug education and information it was felt that there should be a particular focus on young people, parents and women.

Implications for policy and practice

- There is a need to identify ways of supporting and maintaining cultural resilience against drugs among successive generations in a way that does not stigmatise users and families and inhibit help-seeking.
- Action is needed to reduce the stigma associated with drug use in some BME communities to make it easier for people affected to obtain help and achieve and maintain recovery.
- Evidence-based harm reduction services and messages need to be accessible to all drug users whatever their cultural and religious background even though.
- Lack of information about drugs and services inhibits treatment access among BME groups. GPs, faith-based bodies and religious leaders could be utilized more to communicate and engage with young people and families from these groups.
- Peer educators and positive role models can be important. Social and cultural media and networks can be used to reinforce or cultivate positive pro-social behaviours rather than just to inform about harms and risks.
- Specialist drug services for specific ethnic groups will be unsustainable in many areas. Local partnerships and commissioners need to assess local needs and stimulate innovative solutions to meet the needs of a growing ethnic population, some of whom will inevitably develop substance misuse problems.
- Mainstream drug services should review how they are meeting the needs of ethnic communities. Organisational and workforce planning and development programmes should specifically address issues of diversity including meeting the needs of different ethnic groups.

Drug treatment and prevention programmes continued

- Diversionary activities (encouraging positive leisure activities) for young people may make them less vulnerable to drug use.
- BME groups also recommend addressing known risk factors associated with drug use: unemployment, social exclusion, unstable housing arrangements/ homelessness, difficulties in accessing education and health services and racism and discrimination.
- The lack of knowledge about services and a reluctance to seek help due to stigma may mean BME groups are underrepresented in services. A perceived lack of understanding of their culture and, occasionally, racism within services were also reported as barriers to treatment.
- However, for those in treatment the experiences among different groups appear similar. Data from the National Drug Treatment Monitoring System (NDTMS) shows no significant variation by ethnic group for a range of measures. For example:
  - Waiting times for the first intervention among clients commencing a new treatment journey does not vary much by ethnic group; between 93% and 95% of clients waited less than 3 weeks;
  - The proportion of individuals who were retained in treatment for 12 weeks or completed treatment within 12 weeks was similar across ethnic groups ranging from 81% of those of Mixed ethnic background to 85% of those in the "Other" ethnicity grouping.
- The 2007 user satisfaction survey showed generally good levels of satisfaction with services. Asian service users reported lower levels of overall satisfaction and, although not statistically significant, were less positive about the impact of treatment, the extent to which they were treated with respect and the level of support received.

Evidence needs

Further information is needed about:

- the extent and nature of drug information, education and other prevention interventions available to different BME communities;
- which programmes are effective in preventing drug use among these communities;
- models of good practice relating to prevention, education and information provision relating to specific illegal drug types and khat;
- how knowledge and awareness about drugs relates to patterns of drug use within BME communities.

Interaction with the police and criminal justice system (CJS)

- BME groups experience disproportionate levels of 'stop & search' and a higher percentage of these are for drug offences compared to White groups, despite their lower levels of drug use. Tensions around disproportionate policing of Romani gypsies, Irish travellers and showmen have also been reported.
- Over-representation of BME groups in policing of cannabis and other drugs may stem partly from the high proportion of BME groups living in areas of social disadvantage and high crime.
- The over-representation of BME groups is less marked when arrests for drug offences are considered. However, people from BME groups are more likely to be sentenced to prison than people from the white ethnic group and higher proportions of people in prison from BME groups are there for drug offences.
- Ethnic links, cultural homogeneity and family ties are important to some street-level and middle-level drugs markets and may be associated with other illicit, profit-making activities.
- Links with the country or area of origin may be used by BME groups for the trafficking of drugs sold in the UK:
  - heroin is mostly obtained from Afghanistan, Pakistan and Turkey, by South Asian and Turkish groups;
  - synthetic drugs are obtained by White suppliers of British, Dutch and Belgian origins.
- The media has been criticised for its disproportionate representation and sensationalising of BME involvement in drug markets.
- Involvement in drug markets by people from BME communities appears to be rarely undertaken to finance a personal drug habit, but more often to fund education, repay loans or debts, or afford designer clothes, cars and accessories.
- Drug markets and the involvement of some individuals in dealing can affect BME communities in many ways; through drug-related crime, family breakdown, public safety, damage to the reputation of the community, and the spread of drug use within the community.

Implications for policy and practice

- The potential damage to community relations from the disproportionate experience of 'stop & search' is well-established; given the sensitivity of the issue, a robust evaluated trial, to compare the impacts of ceasing to use it in certain localities, should be considered.
- The introduction of police and crime commissioners could afford the opportunity to put the use of stop and search tactics in certain areas under the local microscope in order to judge their efficacy and value.
- Where there is concern about local drug markets with a BME dimension, innovative approaches to get low-level and non-violent dealers into 'dealer exit programmes' should be tested and evaluated, as has been done in the United States.
- The importance of providing treatment programmes as backup when local drug market enforcement operations occur is now well established; for ethnic minority groups the provision of broader 'diversionary' activities and educational inputs may be more relevant, especially for young people.
- There are growing calls to control khat. However, banning the plant may lead users to switch to more harmful substances.

Evidence needs

There is a need for information on:

- the effectiveness and value for money of stop and search for drugs compared with alternative policing methods such as intelligence-led and neighbourhood policing;
- what works for diverting low-level dealers from ethnic minority groups from drug crime;
- how to build resilience against drugs among different ethnic communities;
- national studies to provide a clearer picture of drug market activities across all ethnic groups, including the majority White population.

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The full version of this briefing, and the accomanying full reports, are available at www.ukdpc.org.uk/reports/shtml