



UKDPC

UK DRUG POLICY COMMISSION

**The Impact Of Drugs on Different Minority Groups:
A Review Of The UK Literature**

Part 1: Ethnic groups

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Evidence Review
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The UK Drug Policy Commission (UKDPC) is an independent body providing objective analysis of evidence related to UK drug policy. It aims to improve political, media and public understanding of drug policy issues and the options for achieving an effective, evidence-led response to the problems caused by illegal drugs.

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List of Abbreviations

ADIBOP	Asian Drugs Information Befriending Outreach Project
BCS	British Crime Survey
BME	Black and minority ethnic groups
CEBPP	Centre for Evidence-Based Policy and Practice
DES	data extraction sheet
EPPI Centre	Evidence for Policy and Practice Information and Co-ordinating Centre
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
HIV	Human immunodeficiency virus
LSD	Lysergic acid diethylamide
Moj	Ministry of Justice
MSM	Men who have sex with men
NDTMS	National Drug Treatment Monitoring System
NTA	National Treatment Agency for Substance Misuse
OCJS	Offending Crime and Justice Survey
OPM	Office for Public Management
SOCA	Serious Organised Crime Agency
UCLAN	University of Central Lancashire
UKDPC	UK Drug Policy Commission

Executive summary

The Office for Public Management (OPM) was commissioned by the UK Drug Policy Commission (UKDPC) to conduct a review of the literature on factors relating to drug use among black and minority ethnic (BME) communities. This review is part of a wider programme of work being undertaken by the UKDPC, the aim of which is to provide an overview of what is known about the differing needs and challenges associated with drug use among diverse minority communities within the UK. This research is funded by the Home Office.

UKDPC's specific objectives for the review were to provide an overview of the evidence relating to BME groups on the following issues:

1. The extent and nature of drug use within different ethnic minority groups.
2. Drug use prevention and information provision for different ethnic minority groups.
3. The impact of drug markets and drug-related enforcement activity on different ethnic minority groups.

The literature search, review and synthesis were informed by good practice guidelines issued by government agencies and universities (Government Social Research, undated; EPPI-Centre, 2007; Hartley, 2004). These have been developed with the specific aim of facilitating the synthesis of diverse material to inform the evidence-based policy and practice movement within the UK. The search was conducted in partnership with search specialist Alan Gomersall, Deputy Director of the Centre for Evidence-Based Policy and Practice (CEBPP). The review was conducted over a number of stages and literature was identified from a series of database searches and by advisory group members and other experts. After a rigorous sifting process, 56 items were included for review.

The review found that there is significant variability in the robustness of material included for review, which means that it is often difficult or inappropriate to make inferences based on comparisons across studies. Additionally, there are a number of small-scale studies included in this review which aim to provide a snapshot of issues relating to drug use within targeted BME groups, rather than to provide data that is generalisable or representative of wider BME communities. Methodological weaknesses and a lack of detail around certain aspects of the methods used meant

that it was difficult to assess the representativeness and significance of findings. A number of other limitations also make comparisons difficult. For example, the subpopulations studied are wide ranging and there is also inconsistency in the manner in which sample groups are defined. There is also considerable diversity in the drug use variables that are measured, and in most cases there is no distinction made between drug use, drug misuse, drug dependence and problematic drug use. **Caution should therefore be used when interpreting findings.**

MAIN FINDINGS

Objective 1: Extent and nature of drug use

In general, the evidence suggests that prevalence of illicit drug use is highest among respondents described as Mixed race groups. Asian groups (as defined by each study) have significantly lower levels of reported drug use compared to all other ethnic groups. Most recent estimates are provided by the Home Office in its analysis of combined 2006/07, 2007/08 and 2008/09 British Crime Survey (BCS) data (Hoare, 2010) and the findings indicate that those from mixed race groups have the highest level of any drug¹ use in the last year (17.6%), followed by White groups (10.5%), Black groups (5.8%), Chinese/Other groups (5.7%) and finally Asian groups (3%). However, the authors note that the higher level of drug use among people from a mixed race background may be driven by the younger age profile of this population and this is confirmed by the age-standardised data, which indicates a lower prevalence of last year drug use of 12.7%.

Differences between Black and White groups are less clearly defined and vary across subgroups, drug types, gender and age. For example, the results from the 2007 adult psychiatric morbidity report (McManus et al., 2009), using age-standardised data, indicated that Black male respondents were almost twice as likely as their White counterparts to have used any illicit drug in the last year (22% vs. 12%). This appears to be driven by significantly higher levels of cannabis use by Black men (17%) compared with White men (10%). Conversely, Sharp and Budd (2005) report that among young adults (16–25 years), White respondents (35%) were significantly more likely to report having used any drug in the last year compared with Black respondents (22%). The authors perceived this as being driven by lower levels of cocaine and ecstasy use in minority ethnic groups.

A number of studies have explored BME communities' perceptions of why they and those within their communities use drugs. Some reasons appear to be common across BME groups, whereas others are more specific not only to BME

¹ 'Any drug' comprises powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, heroin, methadone, amphetamines, cannabis, tranquilisers, anabolic steroids, ketamine, amyl nitrite, glues, any other pills/powders/drugs smoked.

groups but also to drug types, for example khat. Peer pressure and influence have been identified by a number of BME groups as one of the primary reasons why young people might use drugs. Some communities, for example the South Asian community, have highlighted the growing influence of Western culture and trends on young people, who often try and distance themselves from ‘traditional’ values in order to fit in.

Bashford et al. (2003), in their report on the Department of Health’s needs assessments project, report that the vast majority of community organisations consulted with felt that the use of illicit drugs by BME communities was, among other things, related to the fact that these communities tend to live in economically deprived and poverty stricken areas. The scarcity of housing means that these communities are often settled in the same accommodation where homeless drug users reside and where drug taking and dealing is a conspicuous problem. Additionally, 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 on the part of these communities, which puts them at risk of drug use. In a study with a sample of 94 young Somalis in Sheffield, Nabuzoka and Badhadhe (2000) report that 83 of the respondents reported that Somalis had extra problems that made them more susceptible to using drugs. These included unemployment, lack of knowledge of the British health, social and education systems, frustration as a result of cultural and language barriers and feelings of homesickness and statelessness due to their refugee status.

The evidence reviewed suggested that khat is often regarded as socially acceptable in many BME communities, which means that there are a number of additional reasons for use that have been discussed in the literature, including for socialising, to pass the time and to aid concentration.

The evidence suggests that poly-drug use² is most common among White and mixed race groups compared with other ethnic groups. Additionally, poly-drug use is also reported as common among Romani gypsies, Irish travellers and showmen due to their mobile lifestyle, which exposes them to a variety of drugs. Additionally, cannabis is the most commonly used drug across ethnic groups and age groups. For example, Sharp and Budd’s (2005) analysis of the Offending, Crime and Justice Survey found that use of other drugs by the young age group (10–15 years) was virtually nonexistent. Conversely, the study reported cannabis use levels of 5% for White, Mixed and ‘Black or Black British’³ groups and 1% for ‘Asian or Asian British’ groups. The literature indicates that the high percentages of BME communities

² Use of more than one drug over a period of time, for example: last year, last month.

³ As defined by the study.

reporting having used cannabis is related to attitudes towards cannabis which regard the drug as being more 'acceptable' than other drugs.

As discussed earlier, prevalence data indicates that levels of drug use in Asian groups is very low compared to other ethnic groups. However, there is some evidence to suggest that heroin use may be problematic in some of these communities. For example, in its annual differential impact analysis of drug treatment (2006/07), the National Treatment Agency (NTA) reports that not only was heroin the most commonly reported drug used by all those in treatment (61%), but that its use among Asians in treatment (64%) was much higher than among other ethnic groups in treatment (mixed race: 44%; Black: 31%). These communities also appear to be more likely to use smoking or chasing as their method of administration whereas White communities prefer injecting.

The stigma associated with drug use has been reported across a number of BME communities and explored in a number of reports. Among some BME groups, particularly South Asians and the Chinese, the stigma attached to drug use is not only directed at drug users but also at their families. This can lead to drug users hiding their drug use, which implies that levels of drug use in these communities may be underestimated. Additionally, this stigma also impacts on the way families react to drug use, with denial being the most common reaction. There is a small amount of evidence in the literature that some BME communities perceive some drugs to be less 'acceptable' and more stigmatised than others (Fountain, 2009b,d). For example, among the Black Caribbean community, crack cocaine and heroin were described as such, while 'all' drugs (with the possible exception of cannabis) were described as unacceptable by the Turkish/Turkish Cypriot community. Among Romani gypsies, Irish travellers and showmen, cocaine and amphetamines were regarded as acceptable and heroin as unacceptable (Taylor et al., 2006).

Hoare's (2010) analysis of BCS data indicates that there is more of a gender difference in the prevalence of drug use among some ethnic groups compared to others. Among respondents from a White or Asian background, men were more likely to use any drug compared with women. The authors also note that the gender difference among Asian groups reflects differences in cannabis use, with more men from this group reporting having used the drug in the last year compared with women. The authors also report that no differences between men and women in overall drug use were detected for the other ethnic groups. In the more targeted studies we reviewed, particularly those focused on drug use among young people, gender differences in Class A drug use within particular ethnic groups were difficult to establish, perhaps because of the small numbers of young people that report using Class A drugs compared to the reported use of any illicit drug.

Among khat using communities, the literature suggests that men are more likely to use the substance than women. For example, in their study of khat use among 602 Somali's in London, Birmingham, Bristol and Sheffield, Patel et al. (2005) found that 14% of female respondents reported having used khat recently (16% 'ever' used) compared with 51% of male respondents (58% 'ever' used). However, the literature also suggests that because of the stigma attached to drug use, women are 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.

Records of service users in treatment indicate that the proportion of females is higher in White and mixed race service users compared with Asian and Black service users. Additionally, there is more variation in the percentage of female to male service users across different Asian ethnic subgroups (Indian, Pakistani etc.) than across Black ethnic subgroups (African, Caribbean etc.).

Objective 2: Drug prevention and information provision

In a series of reports on BME communities, Fountain (2009a–e) reports that the majority of community organisations consulted with felt that that BME communities lacked information about drugs and drug services. Where drug-related information had been accessed, a number of sources were identified. Among statutory services, GPs were the most commonly cited source of information. A number of communities identified their family, friends or social and support networks as sources of drug-related information. Religious organisations or leaders as well as community organisations were also commonly mentioned across a range of BME communities.

In the literature reviewed, BME communities have suggested a wide variety of venues for the delivery of drug-related information. The most frequently cited settings were schools and community centres as these settings were seen as familiar, community-based, well visited and 'comfortable and safe'. Since young people were often considered a specific group for whom other settings might be more useful, the communities suggested youth clubs, sports clubs, leisure centres, colleges and universities. Gender-specific venues were also recommended by some communities.

BME communities have suggested using a variety of written, oral and visual media in order to convey drug education successfully. Telephone helplines were popular across all groups because they were felt to offer reliable information and, even more important, anonymity. All communities felt that language was a crucial factor that needed to be taken into account in the delivery of information on drugs and drug services. For example, bilingual leaflets and posters were often suggested by members of Chinese communities (Fountain, 2009c). People from South Asian,

Black African and Kurdish, Turkish Cypriot and Turkish communities saw local newspapers and community newsletters as effective and targeted modes of delivery (Fountain, 2009a,d,e). They were also keen to point out that the delivery of drug-related information should not be limited to written media as substantial numbers of people from ethnic minorities might have poor literacy or be unwilling to read.

With regards to the message of drug education, BME communities all agreed that the information provided should be precise and explicit, particularly with regards to drug services. The Black Caribbean and Black African communities had contrasting attitudes towards the extent to which drug-related information should focus on helping people to make informed choices about illicit drug use and harm-reduction messages. While Black Caribbeans were reported to largely recommend these approaches to drug education, few Black African participants did (Fountain, 2009a,b). Many community members in this latter group argued that the sole message of drug education should be abstinence and that the emphasis of the message should be on the illegality of drugs (Fountain, 2009a). A particular issue emerging from the report on the Black African community was whether or not khat was an illicit drug (Fountain, 2009a). This group recommended that information and advice about khat and treatment for problematic use of the substance needed to acknowledge these opposing viewpoints. Including khat in information about illicit drugs or drug treatment may meet with approval of part of the community, but may not engage khat users.

BME communities have a range of suggestions regarding the most appropriate deliverers of drug education. A number of communities felt that drug education messages from ex-drug users, who were part of those communities, would be helpful. It is interesting to note that this would run counter to the stigmatisation and exclusion of drug users in their communities. Fountain (2009a,b,e) reports that South Asian, Black African and Black Caribbean communities suggested that drug education delivered by peers was potentially effective. Among members of the South Asian community, the most frequently suggested peer educators were parents, women and young people (Fountain, 2009e). Many Black Caribbean community members felt that young people receiving drug education were more likely to consider their peers as credible sources of information than adults. McGrath et al. (2006), in their review of grey literature on drug prevention among vulnerable young people, also report on the success of peer-led projects reviewed by Shiner (2000), which recruited young peer educators from target BME communities and socially excluded areas. However, the authors also report that Shiner's review of the projects demonstrated the need to ensure that peer educators are equipped with the right information and that they are supported in delivering formal sessions and facilitating large groups. South Asian and Black Caribbean community members felt that there was a need for positive role models to get

involved in a ‘mentoring’ or ‘buddy’ capacity’ (Fountain, 2009b,e). Among the Black African community, the most commonly suggested deliverers of drug education were community organisation workers who had received the appropriate training (Fountain, 2009a).

BME communities generally feel that all community members need to receive drug education and information to enable them to support and help drug users and each other. More specifically, these communities agreed that young people, parents and women needed to be targeted as drug education recipients (Fountain, 2009a,b,d,e).

The literature reviewed highlights that BME communities think that drug use can be prevented by the provision of diversionary activities that encourage young people to take part in positive leisure activities. These were felt to make them less vulnerable to drug use. BME groups also recommend addressing the risk factors associated with drug use, particularly unemployment, social exclusion, unstable housing arrangements (including homelessness), difficulties in accessing education and health services and racism and discrimination, all of which have been associated with drug use.

Objective 3: Impact of drug markets and drug-related enforcement activity

Although the prevalence of drug use among BME groups is often reported as lower than that among White ethnic groups (as presented above), a number of sources note that drug-related enforcement activities are disproportionately targeted at BME groups, as discussed in this following section.

In a Ministry of Justice (MOJ) report, Riley et al., (2009) present statistics on the representation in the criminal justice system of members of BME communities in England and Wales. They show that across all ethnic groups, suspected drug crime was the most common reason for conducting a stop and search in England and Wales in 2006/07 and 2007/08. Overall, suspected drug crime accounted for 62% of the recorded stop and searches for Asians compared to 51% of the stop and searches for Black people and 42% of the stop and searches for White people. The disproportionate focus on BME groups for drug crime stop and search becomes apparent when these figures are considered alongside the low levels of prevalence of drug use in the last year among these groups as well as the population size of these communities. For example, whereas Asian groups only make up 4%⁴ of the total UK population and have the lowest prevalence of drug use in the last year (3%) (Hoare, 2010), they are most likely to be stopped and searched because of suspected drug crime rather than for any other offence.

⁴ Based on 2001 census figures.

Additionally, while lower proportions of individuals from BME groups are arrested for drug offences, they are subject to a higher sentencing rate than their White counterparts. Of those arrested for drug offences in 2007/08, 74% were of White origin, 14% were of Black origin and 8% were of Asian origin. However, of those sentenced for drug offences in 2007/08, 28% were of Chinese or other origins, 22% of Black or Black British origin, 18% of Asian or Asian British origin and 11% of White origin.

A number of reports and studies included in this review indicated the importance of kinship and ethnicity within UK drug markets (Fountain et al. (2002), Cragg Ross Dawson (2004), Ruggiero and Khan (2006), Lupton et al. (2002), McSweeney et al. (2008), Roy et al. (2008)). It has been noted that individuals are more likely to associate with members of the same family, ethnic group or background when it comes to obtaining, supplying, dealing or selling drugs, particularly in lower level markets. Such relationships can also be linked to the same country, region, village or tribe that individuals may originate from.

In their study with 123 British South Asian drug dealers, drug users and other key individuals from across England and Wales, Ruggiero and Khan (2006) report that low-level local cannabis markets are held together by some form of cultural homogeneity and a 'common' desire of staying together. They also characterise local-level markets as highly competitive and subject to commercial pressures, which can occasionally lead to violence and arrest. Ruggiero and Khan (2006) also report that middle-level drugs markets run by British South Asian dealers were well organised and managerially effective when compared with markets run by White drug dealers. The researchers also describe violent competition within the British South Asian community; for example, drug disputes leading to shootings and kidnappings. They note that competition within these middle-level drugs markets is based on economic factors rather than ethnic factors. The authors also note that middle-level drugs markets can be intermingled with other illicit activities, notably forged banknotes, guns, stolen cars and loan sharking.

Regarding international drug trafficking, Ruggiero and Khan (2006) report that British South Asian networks are associated with cocaine and heroin markets in Holland, as well as heroin supplies from Turkey (with raw material coming from Afghanistan). British South Asian networks can act as importers, wholesalers and retailers at the same time, supplying to long-term customers. In contrast, McSweeney et al. (2008) identify that Turkish traffickers continue to dominate the supply of heroin to the UK, while Pakistani traffickers are primarily involved in trafficking heroin from Pakistan to the UK using direct transport and trade links. The authors also note that British-born traffickers of West Indian origin are involved in supplying powder cocaine intended for the UK crack cocaine market. Finally, the

researchers mention that the UK synthetic drugs market is dominated by White British, Dutch and Belgian criminals. In *The United Kingdom Threat Assessment of Organised Crime* report produced by the Serious Organised Crime Agency (SOCA) (2009), Turkish, Kurdish and South Asian criminals are again referred to as the major traffickers of heroin in the UK.

With regards to the reasons for involvement in drug markets, the literature suggests that this is rarely undertaken to finance a personal drug habit. In most cases, such involvement is to make money to fund education, repay loans or debts, or afford designer clothes, cars and accessories. Fountain (2009b) also describes how community groups consulted with felt that a lack of educational achievement and unemployment can lead young people of Black Caribbean origin to sell drugs. This can be an attractive option for young people to make a living and to alleviate the boredom of unemployment. Furthermore, Fountain (2009a,b,e) also describes how some of the BME community groups consulted with voiced their concerns regarding the drug dealing and markets in their local areas. These included drug-related crime, family breakdown, public safety, damage to the reputation of the community and local area and the spread of drug use. However, it is important to note that these views are those of particular community groups or members and are not necessarily representative of the wider communities.

McSweeney et al., in their review of literature on drug markets (2008), reported that evidence suggested that disproportionate representation in media coverage can have an impact on certain minority groups. In particular, coverage linking Black boys and men with drugs can have a detrimental effect on the aspirations of members of this group. Concerns about the exaggerated perceptions regarding the involvement of BME groups in drug markets was also reported by Fountain et al. (2007) in their study with members of the Turkish and Jamaican communities in Lambeth and Haringey. Their research shows that these communities perceive that they are being disproportionately affected and harmed by perceptions of them as drug suppliers and the resulting action against them. Because criminal intelligence reveals that members of Jamaican and Turkish communities are involved in the supply of crack cocaine and heroin, activity against drug supply is targeted disproportionately at these communities.

GAPS IDENTIFIED AND CONCLUSIONS

- Where comparisons have been made about drug use across ethnic communities, these communities have tended to be grouped together, which can distort findings and conceal important differences. There is a need for greater diversity in the research. For example, there is limited literature on the differences and similarities in drug use prevalence and patterns within minority ethnic groups.

Kalunta-Crumpton (2003) also argues that insufficient attention has been paid to the heterogeneity of minority White communities.

- More research is needed that explores the different types of drugs used by different ethnic groups and why some groups use particular drugs more frequently. It may also be useful to undertake research that questions whether and where ethnicity is the most important demographic variable (in comparison to class, geography, deprivation etc.) to consider when identifying patterns in drug use.
- There are no reliable/accurate statistics on how many refugees and asylum seekers use drugs. This is because not all institutions involved with drugs and drug treatment record refugee status, and even when it is recorded it is unlikely to be accurate because most refugee and asylum seekers tend to hide any involvement in drugs for fear of the admission impacting on their status in the UK. Further research also needs to be conducted on the prevalence of drug use among these groups.
- Most studies reviewed focus on prevalence of drug use; reporting on patterns of drug use (frequency of use, situational context of use, length of use, methods of administration and changes in patterns of use over time) is limited.
- There is a significant amount of detail in the literature regarding effective drug education and information provision for a range of BME communities, but there is very little with regards to what works in preventing drug use among these communities.
- The drug education and information provision evidence available focuses primarily on South Asian, Black Caribbean and Black African communities. There is also some material that focuses on Kurdish, Turkish and Turkish Cypriot communities and Chinese and Vietnamese communities. Other ethnic minority groups, in particular those from Eastern Europe, do not appear to be covered in the literature.
- There is little evidence available on prevention, education and information provision relating to specific illegal drug types, and also to khat. There is also very little evidence on what is known about khat use among communities that use the substance and how this knowledge relates to patterns of use.
- There is very little coverage of the extent and types of preventative initiatives available to BME communities across the UK.
- There is a lack of large-scale studies about drug market activities among BME groups across the UK. Studies/research focus on very small groups of respondents and informants. Wider studies need to be conducted to enable an informed view of national trends.
- There appears to be more information available on Asian, Black and Turkish ethnic groups' involvement in drug markets compared with other BME groups in the UK. More information needs to be collected on the involvement of other groups in drug markets and in enforcement activities.

1. Introduction

AIMS OF THE REVIEW

The Office for Public Management (OPM) was commissioned by the UK Drug Policy Commission (UKDPC) to conduct a review of the literature on factors relating to drug use among black and minority ethnic (BME) communities. This review is part of a wider programme of work being undertaken by the UKDPC, the aim of which is to provide an overview of what is known about the differing needs and challenges associated with drug use among diverse minority communities within the UK. This research was funded by the Home Office.

UKDPC's specific objectives for the review were to provide an overview of the evidence relating to BME groups on the following issues:

1. The extent and nature of drug use within different ethnic minority groups.
2. Drug prevention and information provision for different ethnic minority groups
3. The impact of drug markets and drug-related enforcement activity on different ethnic minority groups.

UKDPC and OPM recognised from the outset that the breadth of these objectives had a number of implications for the literature review, including the following:

- It was likely that searches were more likely to identify literature relevant to objective 1 than to objectives 2 and 3.
- There might not be adequate coverage of the full range of BME groups that are of interest to this review.
- Findings from studies derived from particular localities and regions might not be applicable on a national level.
- Findings from studies of particular subgroups within ethnic groups (e.g. Bangladeshi) were not necessarily applicable at the wider group level (e.g. South Asian).
- Methods used and quality of data generated were likely to vary considerably.

UKDPC and OPM acknowledged too that there were likely to be numerous gaps in the evidence base. The review has been designed to 'map out the terrain'. We adopted a strategic approach to the available literature, focusing on particular areas

that had the greatest potential to yield valuable insights and learning to inform UKDPC's policy and planning work.

READING THIS REPORT

As explained above, this literature review has been designed to meet the very specific objectives listed above. Although there is a wide range of broadly interesting material related to drug use among the communities involved, not all was directly relevant to the aims and objectives of the review. We do not claim that this piece of research is an exhaustive review of literature relating to drug use and/or BME groups.

The rest of the report reads as follows:

Chapter 2 describes the methods used for searching, securing and reviewing the material. It also provides an overview of the main characteristics of the reviewed literature in terms of methods used, types of literature or study and the quality of the literature. Challenges relating to methodologies, terminology, data analysis and reporting are also discussed.

Chapters 3, 4 and 5 look in turn at each of the three objectives: chapter 3 presents findings on the extent and nature of drug use amongst BME groups; in chapter 4 we look at the need for and access to prevention and treatment programmes and chapter 5 looks at the impact of drug markets and drug related enforcement activities. We should note that the amount and type of evidence available varies across the three objectives. In each chapter, we have presented any gaps in the evidence identified in the course of the review.

Chapter 6 concludes the report by drawing together the key themes.

2. Method and overview of material included

LITERATURE SEARCH AND REVIEW PROCESS

Our approach to the literature search, review and synthesis has been informed by good practice guidelines issued by government agencies and universities (Government Social Research, undated; EPPI-Centre, 2007; Hartley, 2004). These have been developed with the specific aim of synthesising diverse material to inform the evidence-based policy and practice movement within the UK.

In recognition of the importance of qualified search specialists in enhancing the quality of reviews (Wade et al., 2006), we worked with search specialist Alan Gomersall, Deputy Director of the Centre for Evidence-Based Policy and Practice (CEBPP). Alan provided expert advice and support as we developed our search strategies. The stages of the review process were as follows:

1. Initial and revised search of databases

The UKDPC and OPM worked in partnership to develop the approach towards database searches. We agreed that it needed to be underpinned by an iterative process of progressive and informed filtering. Initial searches were broad and allowed us to ascertain the broad contours of the terrain and identify the extent and type of relevant literature available on the different databases. It also helped us to ensure that none of the critical items were missed. Each subsequent search was based on decisions informed by the findings of preceding searches and guided by the overall objectives of the review.

The initial broad search terms were developed in accordance with the aims and objectives of the project and compiled by OPM and our literature search expert at CEBPP with contributions from UKDPC. At the early stages, search terms were focused on objective 1 (the prevalence and patterns of drug use within different ethnic groups). Terms associated with objectives 2 and 3 (prevention and enforcement) were not included as we felt that adding further terms would be too restrictive at this stage. In addition, material that would have been indexed or coded to these search terms would almost certainly have been indexed or coded to one or more of the broader search terms. OPM's and UKDPC's specialist and specific understanding of drug problems among BME groups within the UK added value to this search process. A full list of search terms used can be found in Appendix 1.

Our search expert conducted a total of 15 searches across 15 databases. Three general search strategies were used at this stage:

- **Broad search strategy:** For example, (ethnic minority, minority communities, Asian, African, Polish etc.) + (drug, substance, narcotic) + (use, abuse, misuse).
- **Search strategy with 'NOT' clause:** (ethnic minority, minority communities, Asian, African, Polish etc.) + (drug, substance, narcotic) + (use, abuse, misuse) + NOT (America, China, South Africa, Japan etc.).
- **Search strategy with 'NOT' and 'AND' clause:** (ethnic minority, minority communities, Asian, African, Polish etc.) + (drug, substance, narcotic) + (use, abuse, misuse) + NOT (America, China, South Africa, Japan etc) + AND (England, Wales, Scotland, United Kingdom, Leicester, Bradford etc.).
- **General Simple Search Strategy:** For example, (ethnic minority) + (drug).

We conducted a number of trial searches using the broad search strategy. These yielded an extremely long list of results which included a great deal of international material. A 'NOT' clause was thus added in order to refine the search. This helped to filter the results and make the results list more manageable to sift.

Together with the CEBPP, we developed our search strategy further by adding 'INCLUSION' or 'AND' clauses which specified a range of regions, cities and areas across the UK. This helped to filter the results further. The search strategy was tailored appropriately to the nature of the various databases.

The search systems of a small number of databases (e.g. DrugScope) would only allow very simple searches, using one or two search terms. In these cases, our partner used a number of combinations of terms to ensure that the search process was exhaustive. Additionally, in the case of DrugScope, numerous reading lists published by the organisation were also consulted to identify relevant literature.

We shared all material identified with the UKDPC. As expected, there was significantly more potentially relevant material identified for objective 1 (prevalence and patterns) than for objectives 2 and 3 (prevention and enforcement). There was also better coverage of some minority groups (Asian, Black African, African Caribbean) compared to others (Eastern European groups). Because there have been a number of reviews recently about treatment needs and services available for BME groups, this literature was not included in this review except where it reveals useful information on patterns of use.

At this stage, our partner conducted a handful of further searches that added the term 'enforcement' to the search strategies. Very little potentially relevant material

was identified from these searches. Appendix 2 shows the databases that were searched, the specific search strategies that were used and the results obtained.

The search and reviewing process was designed to be robust, and every effort has been made to ensure that no relevant item has been omitted. At this early stage, we did not filter results on the basis of their quality. We agreed with UKDPC that decisions about the appropriate quality standards to use should come at a later stage of the process, once we had a better understanding of the extent and quality of the material available and following further discussions about the purpose and audience for the review.

2. Input from experts

Consultation with experts can be an effective way of identifying relevant material, including grey literature and very recent material that might not yet be accessible through bibliographic search engines. Experts can also often provide a good indication of the importance of various sources of material and of different individual items. Their input is particularly valuable when their expertise covers a range of areas relevant to the objectives.

Our original proposal was to consult with a number of experts, including practitioners, academics, policymakers and representatives from community groups. However, since a project advisory group was in the process of being set up to comment and advise on the design, progress and outputs of the project, it was agreed that we would draw on the expertise of members of this group. Their knowledge would contribute significantly to the identification of valuable additional materials. The group comprises ten experts from a range of different backgrounds. In addition to these advisory group members, seven other experts were also contacted in order to identify relevant literature. A full list of advisory group members and experts consulted with can be found in Appendix 3.

3. Defining inclusion and exclusion criteria

Following the broader search, we developed a set of inclusion and exclusion criteria against which to generate a shortlist of relevant material to be included in the detailed document review.

We did not feel it was appropriate to set inclusion and exclusion standards prior to carrying out the initial searches. We wished to ensure that the standards we did develop were informed by our initial searches, which yielded helpful clues about the relative distribution of various sources of material and their likely content and quality. In searching and reviewing less well-researched areas, imposing objective inclusion or exclusion standards prior to any search being carried out can mean that

potentially useful material is excluded. It can also mean that too little or too much literature is included in the review (Government Social Research (undated)).

The eventual set of inclusion criteria was agreed in consultation with UKDPC and included:

- Focus on project aims.
- Published between 1999 and 2009.⁵
- About BME communities in the UK.

4. Review of evidence against quality standards

The purpose of this review was to draw together and map the terrain of the available literature on drug use and BME communities. Because of the anticipated gaps in the literature, UKDPC and OPM agreed that using stringent quality standards to exclude literature that met the above broad inclusion criteria was not appropriate at the early stages. We agreed with UKDPC that OPM would review the full shortlist of literature and assess each document against the agreed quality standards. This meant that we could interpret and present the findings alongside appropriate caveats about the quality of the data.

Material that met the inclusion standards was read and reviewed in full. To facilitate a systematic extraction of relevant information, a data extraction sheet (DES) was designed so that identification of relevant evidence was consistent and directed towards answering the review questions. The DES was designed in collaboration with UKDPC. A copy of the blank DES is provided in Appendix 4.

Different quality standards were used to assess the reliability and validity of the different studies. The choice to vary quality standards was made in recognition of the wider debates around appropriateness of standards in relation to different types of studies.⁶

We agreed in consultation with UKDPC that the quantitative studies would be assessed using US Census Bureau standards (13 standards) (US Census Bureau, 2006) on the minimal information to accompany any report of survey or census data. The majority of qualitative studies were small local-level studies, so we agreed with UKDPC that a set of five simple standards recommended by the EPPI-Centre (University of London, Institute of Education) were the most appropriate for this review. The full list of quality standards can be found in Appendix 5.

⁵ This criterion was relaxed after initial searches due to the paucity of material identified.

⁶ However, there can be different preferences across different policy fields, see Nutley et al. (2007), Oakley et al. (2005), Bambra (2005), Attree and Milton (2006), Popay et al. (1998), Spencer et al. (2003)

The quantitative studies reviewed were scored out of 13 and assigned ratings of low, medium or high quality based on comparative scoring. The qualitative studies reviewed were scored out of 5 and also assigned ratings of low, medium and high quality.

These rating categories were defined by considering the relative weight of the quality standards. A number of standards refer to very basic information that tends to accompany all studies and does not in fact shed very much light on the quality of the study. For quantitative studies this basic information includes:

- organisational sponsor of a survey;
- organisation that conducted the survey;
- wording of the questions asked.

For the qualitative studies the basic information includes:

- aims clearly stated;
- context clearly stated.

Standards relating to this basic information in qualitative and quantitative studies were given less weight when defining the rating categories of low, medium and high.

The more significant standards are those that shed light on the quality of the study and are also less likely to be discussed or addressed in study reports. For the quantitative studies these include:

- a discussion of the statistical precision of the results;
- description of estimation procedures;
- discussion of non-sampling errors;
- discussion of methods employed to ensure data quality.

For the qualitative studies the more significant standards include attempts to establish reliability, and sampling and research methods clearly described.

This approach helped to ensure that studies that met only the less significant standards were not assigned an inflated rating and that studies that met the more significant standards received an appropriate rating.

5. Final synthesis

The reviewed material was subjected to broad content analysis, with key themes and associations drawn out.

OVERVIEW OF MATERIAL INCLUDED

The literature included in this review has been identified via a combination of qualitative and quantitative methodologies, including both primary and secondary data. The documents comprise a combination of:

- quantitative studies, including large-scale surveys conducted on the behalf of government departments;
- local-level and small-scale qualitative studies;
- theoretical think pieces, including secondary research; and
- academic articles from journals and books.

A total of 56 documents are discussed in this review, of which 19 were generated through quantitative approaches. These include large-scale surveys such as the British Crime Survey (BCS) and the Offending, Crime and Justice Survey as well as the analysis of recorded statistics on race and crime and a recent analysis of combined 2006/07, 2007/08 and 2008/09 BCS survey data by the Home Office. The quantitative studies also include small-scale surveys conducted with subpopulations, such as particular BME groups or particular age groups (e.g. adolescents). A further 19 documents discuss studies using qualitative approaches for local-level and small-scale research on specific BME groups, in particular cities, neighbourhood or regions and for specific drug types. Finally, 21 documents consist of a combination of secondary and theoretical research. Many of these analysed data held by drug treatment providers.⁷

As discussed above, quantitative studies were assessed against a number of quality standards and assigned a score out of 13 as well as categories of ‘low’, ‘medium’ or ‘high’ quality.

Using this convention, the quantitative studies were spread across the three categories (low: 5; medium: 7; high: 7). Low quality studies were assessed as such primarily due to a lack of information on methods used, sample design, quality of data generated, weighting and estimation procedures, the statistical significance of findings and analysis procedures used. Medium quality studies were primarily weak on providing sufficient information about statistical precision, quality of data generated and weighting and estimation procedures.

Qualitative studies were assessed against a number of quality standards and assigned a score out of 5, and were also assigned categories of ‘low’, ‘medium’ and ‘high’ quality. The majority of these were of low or medium quality (low: 9; medium: 8; high: 2). Lower ratings tended to be assigned because methods and samples

⁷ The number of studies add up to more than 56 as some studies use both quantitative and qualitative methods.

were not clearly described. Finally, the majority of the secondary research included in the review was of medium or high quality (low: 5; medium: 9; high: 7).

The full list of material reviewed to date and quality scores can be found in Appendix 6.

A number of studies were identified as being potentially relevant but could not be included due to the scope and timing of this review. A full list of this material can be found in Appendix 7.

CHALLENGES RELATING TO DATA AND METHODS

Robustness of material generated through quantitative approaches

As is apparent from the discussion above there is significant variability in the robustness of quantitative material included in this review. Larger scale surveys using more rigorous methods, such as the British Crime Survey, the Offending, Crime and Justice Survey and the Arrestee Survey, are of much better quality than smaller scale studies using methodologies that are not clearly defined. This variability means that it is often difficult and inappropriate to make inferences based on comparisons across such studies.

A number of the studies included in this review are small-scale local surveys, for example in East London, greater Glasgow and Sheffield. The aim of these studies is to provide a snapshot of issues relating to drug issues within the targeted BME groups in the areas where they live, rather than to provide data that is generalisable or representative of wider BME communities. A number of these studies also make use of less robust sampling methodologies, such as 'snowball' or 'convenience' sampling. The authors have argued that recruiting participants through gatekeepers is often necessary when trying to access hard-to-reach groups.

A number of other limitations also make comparisons difficult. For example, the subpopulations studied are wide ranging and span regions and cities, age groups and gender. They also include targeted samples, such as arrestees and prison populations. There is also inconsistency in the manner in which sample groups are defined. For example, different age bands are used to define a sample as 'young people' and different ethnic groups are grouped as 'Asian', 'Black' or 'Other'.

There is also considerable diversity in the drug use variables that are measured, which include lifetime use, use in last year and use in last month. In most cases there is no distinction made between 'drug use', 'drug misuse', 'drug dependence' and 'problematic drug use'. A number of different drug types or drug groups are investigated across the studies included in this review, which also makes it difficult to compare across studies. These include:

- specific illegal drugs (heroin, cocaine, cannabis etc.);
- Class A drugs;
- illicit drugs;
- any drugs;
- HCC (heroin, crack and cocaine); and
- opiates.

Robustness of material generated through qualitative approaches

The qualitative material included in this review consists of a combination of secondary research and small-scale local studies with targeted subgroups (women, young people, refugees and asylum seekers) and minority ethnic groups or subgroups (South Asian, Bangladeshi, Turkish, Jamaican, Chinese, Pakistani, Indian). These local studies employed a range of methods, including in-depth interviews, focus groups, seminars and community forums.

A number of the studies focused on asylum seekers and refugees or various Black African communities (Somali, Ethiopian, Yemeni). These communities are generally regarded as ‘hard-to-reach’ and so sampling methodologies primarily involved approaching ‘gatekeepers’ and ‘snowball recruitment’; as a result, findings may be subject to sampling bias.

The aim of these studies was not to generalise findings but to explore in more depth the context of drug use within the populations and the local areas studied. There were thus very few attempts to validate the findings as these were meant to be descriptive rather than inferential. For these reasons we urge caution in the interpretation of the findings and the extent to which they are representative of wider BME communities.

The available evidence base is presented in the following sections of this report and needs to be understood within the context of the caveats highlighted here.

3. Extent and nature of drug use

PREVALENCE OF DRUG USE

There is a wide range of material available on the prevalence of drug use among BME groups, ranging from large-scale surveys of the general population to targeted pieces of research with local communities. Findings on the prevalence of drug use can be analysed and presented in a number of ways. Our approach has been to provide an indication of the breadth of findings by including a high-level snapshot of drug use while also presenting examples of more specific differences within subpopulations.

When interpreting the findings it is important to note that groups such as ‘White’, ‘Black’ and ‘Asian’ are not defined consistently across studies. For example, some studies include Chinese respondents in the ‘Asian’ category and some include them in the ‘Other’ category. When reporting findings we have used the terminology used in the study being discussed. Additionally, some studies refer to ‘ethnic minorities’, others to ‘minority ethnic groups.’

In general, the evidence suggests that prevalence of illicit drug use is highest among respondents described as mixed race groups. Asian groups (variously defined) have significantly lower levels of reported drug use compared to all other ethnic groups. Prevalence among those respondents categorised as White or Black falls between that of those categorised as mixed race or Asian. It is important to note that although a number of the medium and high quality large-scale surveys discussed below (e.g. British Crime Survey) encourage confidential disclosure, there may still be a degree of under-reporting among BME populations.

In their analysis of the 2001/02 British Crime Survey (BCS) – a nationally representative household survey – Aust and Smith (2003) find that 26% of 16–59-year-old respondents from mixed race groups reported using any illicit drug in the last year. This is statistically higher than use reported by White groups (12%), Black groups (12%), Chinese/Other groups (8%) and Asian groups (5%).

More recent estimates are provided report published by the Home Office of analysis of combined 2006/07, 2007/08 and 2008/09 BCS data, which provides nationally

representative and age-standardised data (Hoare, 2010).⁸ In accordance with the 2001/02 estimates, the findings indicate that those from mixed race groups have the highest level of any drug⁹ use in the last year (17.6%) followed by White groups (10.5%), Black groups (5.8%), Chinese/Other groups (5.7%) and finally Asian groups (3%). However, the authors note that the higher level of drug use among people from a mixed race background may be driven by the younger age profile of this population and this is confirmed by the age-standardised data, which indicates a lower prevalence of last year drug use of 12.7%. The authors also note that:

“...the clear driver for the overall prevalence of drug use being higher among Mixed ethnic groups was cannabis use; this group had a higher prevalence (14.8%) than any other group, for example, compared with adults from a White background (8.4%).” (Hoare, 2010: 3)

Similar trends were reported by Sharp and Budd (2005) in their analysis of the 2003 Offending, Crime and Justice Survey (OCJS), a random probability household survey of 10–65-year-olds. Sharp and Budd report prevalence figures for any drug use in the last year of 17% for mixed race groups, 13% for White groups, 11% for Black groups, 9% for Other groups and 4% for Asian groups. The authors also argue that the different levels of reported drug use are driven by the significantly higher level of cannabis use among mixed race groups compared to other groups. This is illustrated by the fact that levels of Class A drug use in the last year for mixed race groups (4%) are either the same as or very similar to levels of use among White (4%), Black (2%) or Asian (1%) groups, compared to levels of ‘any’ illicit drug use.

The evidence presented above suggests that that prevalence of illicit drug use is lowest among Asian groups. This appears to be the case regardless of variables such as age and gender. For example, McManus et al. (2009) in their survey of adult psychiatric morbidity among adults aged 16 and over living in private households in England provide age-standardised data which indicates that approximately 4% of South Asian men compared with 12% of White men and 22% of Black men reported the use of any illicit drug in the last year. Additionally, approximately 1% of South Asian women compared with 7% of White women and 6% of Black women reported doing the same.

Differences in prevalence between White groups and Black groups are less clearly defined, with findings varying across drug types, target populations, age groups and gender. Some of these variations are discussed below.

⁸ Age-standardisation adjusts rates to take into account the differing age profiles of the populations under study.

⁹ ‘Any drug’ comprises powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, heroin, methadone, amphetamines, cannabis, tranquilisers, anabolic steroids, ketamine, amyl nitrite, glues, any other pills/powders/drugs smoked.

The results from the 2007 adult psychiatric morbidity report discussed above, using age-standardised data, indicated that Black male respondents were almost twice as likely as their White counterparts to use any illicit drug (22% vs. 12%). This appears to be driven by significantly higher levels of cannabis use by Black men (17%) compared with White men (10%). White and Black women had similar levels of use of any illicit drug (7% vs. 6%).

Boreham et al. (2007), in their report on the findings from the Arrestee Survey, a nationally representative survey of drugs and crime among individuals arrested in England and Wales, report that whereas White and Black arrestees had similar levels of 'any' drug use in the last month (53% and 52%, respectively), White arrestees were more likely to report using heroin, crack and cocaine (27%) compared with Black arrestees (17%). However, the authors also state that "it should be borne in mind that as 86% [of the sample] described themselves as White, the sample sizes for other ethnic groups are relatively small and thus it is difficult to identify differences" (Boreham et al., 2007: 47).

A study by Borrill et al. (2003) on illicit drug use among a sample of women from White ($N = 190$) and Black/mixed ethnic backgrounds ($N = 111$) drawn from both remand and sentenced population in ten prisons across England found that drug use in the year before prison was significantly higher for White women (77%) than for those from a Black/mixed ethnic background (63%). Specifically, White women were significantly more likely to use amphetamines (25%), heroin (59%) and tranquilisers (43%) compared to those from Black/mixed race backgrounds (5%, 19%, 14%, respectively). It should be noted that this study combines the drug use figures for Black and mixed race respondents, which is in contrast to most of the other studies discussed in this section, where figures for Black and mixed race respondents are reported separately. Additionally, given the small sample sizes and the fact that quota sampling was used to select this sample, the findings from this study need to be interpreted with caution.

Sharp and Budd (2005), in their report on the OCJS, find that among young adults (16–25 years), White respondents (35%) were significantly more likely to report having used any drug in the last year compared with Black (22%) respondents. The analysis proposed is that this is driven by lower levels of cocaine and ecstasy use in minority ethnic groups. However, they report that drug use over the last year among a younger age group (10–15 years) was similar for Black and White respondents (5% and 6%, respectively). It is important to note here a large difference in sample sizes: 59 respondents within this younger age group were Black, while 1,800 respondents were White.

Rodham et al. (2005), in their survey of drug use among a school-based sample ($N = 6,020$) of 15–16-year-olds from 41 schools across England, report that Black males and females (7% and 2.1%, respectively) were more likely to report using opiates than their White counterparts (2.3% and 1.2%, respectively).

The recent analysis of BCS data Hoare (2010) also includes an evaluation of whether drug use behaviour has changed among BME groups over time by comparing combined 2003/04, 2004/05, 2005/06 data with 2006/07, 2007/08, 2008/09 data. The findings indicate that use of any drug in the last year fell among White (from 11.9% to 10.5%), Asian (from 4.3% to 3%) and Black groups (from 9% to 5.8%), driven primarily by a fall in cannabis use. In contrast, there was no change in the use of any drug in the last year by mixed race groups and Chinese/Other groups.

Summary: Prevalence of drug use across ethnic groups

- In general, reported drug use prevalence is highest among the mixed race minority ethnic group and lowest among the Asian group. However, as noted in the Home Office analysis (Hoare, 2010) of 2006/07, 2007/08 and 2008/09 BCS data, the higher level of drug use among people from a mixed race background may be driven by the younger age profile of this population.
- Differences between Black and White groups are less clearly defined and vary across subgroups, drug types, gender and age.

REASONS AND RISK FACTORS FOR DRUG USE

A number of studies, both quantitative and qualitative, explore BME communities' perceptions of why they use drugs. Some of reasons given appear to be common across BME groups, whereas others are more specific not only to BME groups, but also to drug types, for example khat. Unlike other drugs discussed in this report, khat is not currently classified as illegal in the UK.

Much of the literature included in this section does not assert that the reasons or risk factors for use discussed – such as peer pressure and social exclusion – are unique to BME groups. Rather, it simply presents BME communities' perceptions of why drug use occurs. It is also worth highlighting that the findings discussed in the section below are not intended to be representative views of BME communities. Instead, the authors hope to shed some light on patterns of drug use among the samples consulted with. Finally, the quality of the evidence discussed in this section varies widely, from the high quality reports on the findings from the Department of Health BME drug misuse needs assessment projects (Bashford et al., 2003; Fountain, 2009a–e) to smaller scale quantitative and qualitative studies with

specific BME groups, which tend to be of low to medium quality. Methodological limitations have been discussed as and where appropriate.

Peer pressure and influence

A number of reports cite peer influence as one of the primary reasons given by BME communities for drug use among young people. Bashford et al. (2003) in their analysis of the findings of the Department of Health BME drug misuse needs assessment project report that, of 1,465 respondents asked by a range of BME community groups ($N = 47$) why they thought people used drugs, 36% said that it was a result of peer influence. Ross et al. (2004) carried out a study on drug issues among young people from Pakistani, Chinese and Indian backgrounds living in greater Glasgow. The survey element of this study ($N = 174$, 16–24-year-olds) found that a significant predictor of drug use was having drug-using friends from the same background.

The quality of this study is limited by the fact that approximately 56% of the sample was recruited by ‘snowball’ sampling (although the authors report continuously monitoring the data collection in order to ensure stratification by age, gender and geographic areas). In her reports on South Asian and Chinese communities, as part of the Department of Health BME drug misuse needs assessment project, Fountain (2009c,e) reports that respondents consulted with by community groups from across both communities felt that peer influence was one of the major factors influencing drug use in their communities.

Among the South Asian community, the issue of peer pressure seems to be closely related to their perception of the growing influence of ‘Western’ trends and culture on young people:

“[Young people] have adopted much more western standards and values and terms of references and are much more exposed to a ‘drug culture ... the use of cannabis is widespread amongst this age group. This we believe is similar to the usage of cannabis amongst other communities.” (Fountain, 2009e: 13)

A similar issue was highlighted in the study by Ross et al. (2004), where some of the respondents who took part in the qualitative element of this study (ten focus groups with young people and key informants) were keen to distance themselves from ‘traditional’ attitudes towards drugs and alcohol:

“I was born and brought up here ... so it’s, it’s within my own community, Pakistani as well as the rest of my social circles that I see, it’s not an issue. It’s a part of life,

you know. Going to clubs, taking drugs, having a drink, it's a part of life. (Pakistani male key informant)" (Ross et al., 2004: 55)

This kind of 'cultural' influence was also reported by Bashford et al. (2003) in their report on the Department of Health's needs assessments project. The authors note that some Greek/Greek Cypriot community groups reported young people from their communities often taking drugs to "look hard" and to try to "act black...to portray the image of the Black man in the American ghetto" (Bashford et al., 2003: 18). The authors argue that a desire to be part of the wider cultural scene and to resist the imposition by older generations of traditional values and beliefs can increase the effects of peer pressure.

Peer pressure was also identified by a sample of refugees and asylum seekers ($N = 67$) as a reason for using drugs, in a qualitative study by the Centre for Ethnicity and Health at UCLAN (2004). Respondents felt that they could not resist the pressure, because not only was it the 'in' thing to do but because of fear of being ganged up on or beaten: "They said 'If you don't take it, I'll slap you,' or something. I was scared. Anyway, it was good for me, I was relaxed" (Centre for Ethnicity and Health, 2004: 171).

The presence of drug users and markets in deprived areas

Bashford et al. (2003) in their report on the Department of Health's needs assessments project, report that the vast majority of community organisations consulted with felt that the use of illicit drugs by BME communities was, among other things, related to the fact that these communities tend to be concentrated in economically deprived and poverty stricken areas. The authors state that: "This is not surprising considering that 45 out of 47 of the needs assessment projects are located amongst the 88 most disadvantaged local authority areas in England" (Bashford et al., 2003: 22).

In addition to being poor quality and cramped, housing in these areas was thought to attract drug users and drug suppliers, which in turn led to local areas getting a 'bad name'. This presence of drugs in the local areas often resulted in businesses closing, families moving out and greater economic and social impoverishment. Respondents felt that such conditions "generate a breeding ground" for drug misuse.

Similar findings are reported by Cragg Ross Dawson (2004) in a small-scale scoping study, which consisted of interviews with people involved in working with asylum seeker and refugee communities ($N = 10$). The authors report that drug misuse was often regarded by interviewees as a problem that these communities 'face' when they enter the UK, rather than a problem they 'generate'. The scarcity of housing means

that these communities are often settled in the same accommodation where homeless drug users reside and where drug taking and dealing is a conspicuous problem:

“I don’ t think primarily people are coming over here with drug habits. I think the bigger risk is that you end up with a lot of people being resettled into areas of urban poverty where substances are widely available.” (Drugs worker and educator) (Cragg Ross Dawson, 2004: 15)

The stated purpose of this study is simply to provide a snapshot of what interviewees thought about asylum seekers’ and refugees’ involvement in drugs and thus an exploratory rather than systematic methodology was used – with leads being followed up as and when they appeared. These findings should thus be treated with caution.

The role of unemployment, isolation and exclusion

The Centre for Ethnicity and Health at UCLAN (2004) carried out a study on problematic drug use among refugees and asylum seekers. Among the issues explored was the difficulties these groups face in accessing employment opportunities. The authors argue that historically, limited employment opportunities lead to frustration, boredom and anxiety in these communities and that these factors have contributed to drug use. Refugees and asylum seekers are also likely to experience considerable isolation and loneliness, as they are often separated from their families and living in an unfamiliar culture.¹⁰ Difficulties in accessing services such as housing, health and education were also regarded as increasing isolation and frustration. The small sample (67 respondents) of refugees and asylum seekers (from Nepal, Afghanistan, Africa, Zimbabwe, Iraq and Turkey) consulted with as part of this study provided further evidence of the role of these confounding factors in drug use:

“I can say that our people’ s main problems are housing, visa, no job, or they have problems with their family who are in Afghanistan or Pakistan. They can’ t help them, or they have no documents allowing them to travel there and visit them. That’ s why they use drugs, because they are suffering emotionally.”

“... you have come to a new world, you feel depressed, you need to concentrate on something else, but then you just get more depressed.” (Centre for Ethnicity and Health, 2004: 170–171)

¹⁰ It is worth noting that the review on drug use among disabled people, which is part 3 of the programme of reviews undertaken for the UKDPC, highlighted isolation as one of the factors contributing to drug use among this group.

Similar views were expressed by a sample of 94 11–26-year-old Somalis who reported using Khat in Sheffield in a study by Nabuzoka and Badhadhe (2000). Eighty three respondents reported that Somalis had extra problems that made them more susceptible to using drugs. These included unemployment, lack of knowledge of the British health, social and education systems, frustration as a result of cultural and language barriers and feelings of homesickness and statelessness due to their refugee status.

Fountain (2009a) reports similar results in her report on drug use in Black African communities (many of whom were refugees), which was part of the Department of Health's needs assessments project. Here, drug use was considered a means "to forget about problems" caused by the range of factors discussed above. These factors were also mentioned by a minority of respondents consulted with by community groups in Fountain's (2009d) report on drug use in Turkish/Turkish Cypriot communities.

A study by Kalunta-Crumpton (2003) on drug use among Portuguese and Italian drug users presenting to a treatment service provider ($N = 86$) found by analysing case files and talking to staff at the service that social exclusion and a lack of support structures was high among these groups, when compared with majority White groups presenting at these service ($N = 81$). The author argues that both groups traditionally come from strong extended family systems in their home countries. In the absence of such support they can become quite dislocated and isolated. This can result in these communities associating and socialising with fellow drug users or only within their own ethnic group, which can result in further isolation from mainstream culture. The author argues that linguistic difficulties and unstable accommodation also contribute to these communities being at risk of drug use. A large number (29 out of 86) were in fact listed as having 'no fixed abode', with street homelessness and squatting common. Finally, a needs assessment study of Romani gypsies, Irish travellers and showmen¹¹ by Taylor et al. (2006) found that out of 100 people interviewed, eight used drugs to cope with the stress of earning a living and nine used them to cope with the stress of finding accommodation.

Reasons for khat use

The evidence suggests that the reasons for khat use among Black African communities, overlap to some extent with the reasons given for their use of other drugs. However, khat is often regarded by these communities as more socially acceptable and less harmful than other drugs, and in some cases as 'part of our culture'. This means that there is a range of additional and different reasons for khat use (Fountain, 2009a).

¹¹ Members of a group that organises fairs, circuses and shows.

Patel et al. (2005) in their study on khat use among a sample of 602 Somalis recruited using purposive sampling in London, Birmingham, Bristol and Sheffield report that socialising was the most commonly identified reason for using khat; 40% of respondents indicated that this was the case. 'For fun and enjoyment' was the second most popular reason identified by the sample (17%). Another study on khat use consisting of 45 interviews and eleven focus groups with Somali, Yemeni and Ethiopian community members from across five areas in England (Havell, 2005) cited khat as providing a reason for friends to come together and discuss their communities, both in the UK and in their home countries:

"I like it when you have got everything in place, e.g. job, money etc., and I am sitting with my friends talking about our old good and bad days." Somali man (Havell, 2005: 32)

Stress relief was another reason for use identified in the study by Patel et al. (2005) of Somali communities across four cities (given by 11% of respondents). These respondents tended to feel that chewing khat was an effective distraction from the range of problems they faced:

"I enjoy it, I like the feeling I get after I chew. [It] takes away all my problems and I dream of what it is like to be at home and all is well with family and friends." (Patel et al., 2005: 17)

Other reasons that have been reported in the literature include aiding concentration, passing the time and addiction (Patel et al., 2005; Havell, 2005; Fountain, 2009a).

Patel et al. (2005) asked respondents to consider the extent to which they felt that their use of khat had increased since arriving in the UK. The proportion of those reporting increased use, decreased use or similar amounts of use since being in the UK were broadly the same (approximately 30%). Among those who felt that their use of khat had increased (62 respondents), the most commonly provided reasons were as follows:

- changes in family life – 11 respondents;
- depression or feeling stressed in the UK – 10 respondents;
- alienation from culture – 10 respondents;
- unemployment – 8 respondents

The reasons given for increased khat use in the UK are similar to the reasons given for the use of other drugs by these communities that are discussed earlier; these are: isolation, exclusion and unemployment.

Summary: Reasons and risk factors for drug use

- Peer pressure and influence have been identified by a number of BME groups as among the primary reasons why young people use drugs. Some communities, for example the South Asian community, highlighted the growing influence of Western culture and trends on young people, who often try and distance themselves from 'traditional' values in order to fit in.
- BME communities are at risk of drug use because they often live in disadvantaged and deprived areas where housing is cramped and where drug users and sellers reside.
- 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 on the part of these communities, which put them at risk of drug use.
- In some BME communities, khat is regarded as socially acceptable, which means that there are a number of additional reasons for use that have been discussed in the literature. These reasons include: for socialising, to pass the time and to aid concentration.

POLY-DRUG USE VS. 'DRUGS OF CHOICE'

The prevalence among different ethnic groups of poly-drug use¹² versus a single/main drug of choice has been explored in a number of studies, particularly in the context of the greater likelihood of White communities indulging in poly-drug use, the normalisation of cannabis use across BME communities and the rising use of heroin in the Bangladeshi community. The literature included in this section includes a combination of medium and high quality large-scale surveys as well as some local or small-scale low quality surveys. The methodological limitations of low quality studies are highlighted throughout the following sections. The literature included in this section also includes reviews of data on presentation of BME groups at drug treatment services (across the UK and at specific treatment centres) and reports on the Department of Health's needs assessment project.

In their analysis of the 2001/02 BCS, a nationally representative household survey of 16–59-year-olds, Aust and Smith (2003) report on the number of drugs used in the last year by drug users from different ethnic groups. The majority of drug users across all ethnic groups in the sample surveyed reported using only one drug, which in most cases was cannabis. People from White (33%) or mixed race (37%) backgrounds were most likely to report using two or more drugs over the last year compared with people from Black, Asian and Chinese/Other ethnic groups (16%, 26% and 17%, respectively). Table 1 illustrates these findings:

¹² Use of more than one drug over a period of time, for example: last year, last month.

Table 1: Percentage of drug users (16–59-year-olds) reporting having used multiple drugs in the last year.

Number of drugs used	White	Black	Asian	Mixed	Chinese/ Other
1	67	84	74	63	83
2	15	9	17	22	8
3	8	4	2	8	6
4	4	-	4	6	-
5	2	-	2	-	-
6+	3	3	1	1	3

Source: Aust and Smith, 2003: Table 7. (Following Aust and Smith, ‘-’ in this table = 0.)

A number of more targeted studies mirror these findings. For example, a study by Borrill et al. (2003) on illicit drug use used a sample of women from White ($N = 190$) and Black/mixed ethnic backgrounds ($N = 111$) drawn from both remand and sentenced populations in ten prisons across England. The study found that almost half (46%) of the White drug-dependent women ($N = 115$) were dependent on two or more drugs in the 12 months before prison compared with just over a quarter (28%) of Black/mixed race drug-dependent women ($N = 32$). However, given the small sample size of Black/mixed race drug-dependent women these results should be treated with caution.

Holloway and Bennett (2008) in their survey of arrestees ($N = 4,645$) processed through the New English and Welsh Arrestee Drug Abuse Monitoring programme (1999–2002) across 13 police areas report that, using urinalysis, prevalence of multiple drug use was significantly higher among White arrestees (38%) compared with Black arrestees (27%) and Asian arrestees (23%).

Taylor et al. (2006) report that among a sample of 100 Romani gypsies, Irish travellers and showmen, 64 said that they mixed their drugs, 12 did not mix drugs and 24 did not use drugs. The authors report that poly-drug use was most common among young people, who reported mixing drugs weekly for social and party use. The authors also report that the mobility of these communities gives them ‘unique’ access to a variety of drugs and encourages experimentation with new drugs when others are not available. However, given the small sample sizes these results should be interpreted cautiously.

The ‘normalisation’ of cannabis use

A number of studies indicate that cannabis is viewed differently to other drugs. Table 2, showing prevalence of use in the last year reported in the BCS 2001/02, shows that cannabis is the most commonly used drug across ethnic groups regardless of age group.

Table 2: Prevalence of last year drug use across age groups

Percentage used	16 – 24					25 – 34					35 – 59				
	White	Black	Asian	Mixed	Chinese /Other	White	Black	Asian	Mixed	Chinese /Other	White	Black	Asian	Mixed	Chinese /Other
Amphetamines	6	0	1	2	-	2	2	0	5	2	0	0	0	1	-
Cannabis	29	17	8	32	13	14	10	3	26	4	4	7	1	8	2
Cocaine	5	1	2	4	2	4	1	0	11	-	1	1	0	-	-
Crack	1	-	-	-	1	0	-	-	-	-	0	-	-	-	-
Ecstasy	7	1	1	5	2	3	1	0	8	2	0	1	0	1	-
Heroin	0	-	-	0	-	0	-	-	-	-	0	-	-	-	-
LSD	1	-	-	-	1	1	-	-	1	-	0	-	-	-	-
Magic mushrooms	2	1	-	0	1	1	-	0	4	-	0	-	-	-	-

Source: Aust and Smith, 2003: Table 6. Following Aust and Smith, ‘o’ = less than 0.5%, but not zero, ‘-’ = zero. All figures are rounded to the nearest whole number, therefore columns may not always sum to 100%.

Sharp and Budd’s (2005) analysis of the OCJS, a random probability household survey of 10–65-year-olds, found that the use of other drugs in the last year by the young age group (10–15 years) was virtually nonexistent. The study reported last year cannabis use levels of 5% for White, mixed and ‘Black or Black British’¹³ groups and 1% for ‘Asian or Asian British’ groups. In its report on service users in treatment, the National Treatment Agency (NTA) reports (2007) that among service users in treatment in 2006/07, cannabis was the second most used primary drug (13%) after heroin (61%) and that Black and mixed race service users were twice as likely as White service users to use cannabis (24% each vs. 13% overall).

¹³ As defined by the study

Fountain (2009a–e) reports that across BME groups there were high levels of lifetime cannabis use among those respondents who reported having ever used illicit drugs.¹⁴ Between 60% and 100% of respondents across the South Asian, Black Caribbean, Black African, Chinese and Vietnamese and Turkish/Turkish Cypriot ethnic groups that had ever used illicit drugs reported having used cannabis. In their report on the Department of Health’s needs assessment project, Bashford et al. (2003) report that 51% of 1,571 respondents (who reported using illicit drugs) had used cannabis. These rates were highest among Black African and Black Caribbean communities (86% combined).

The literature suggests that these high proportions of BME communities reporting having used cannabis is related to attitudes towards cannabis, which regard the drug as being more ‘acceptable’ than other drugs. Bashford et al. (2003) also report that many respondents, across BME groups were in favour of the legalisation of cannabis and Fountain (2009a–e) states that a number of groups (Black Caribbean, Black African) reported that cannabis use was regarded as ‘normal’ or not particularly harmful in their communities.

For the Black Caribbean community, Fountain reports that the community organisations who participated in the research reported unanimously that cannabis was the most common substance used. A number of community organisations also reported that cannabis was seen as an acceptable recreational drug and its use was talked about openly in the Black Caribbean community. Among the Black African community, cannabis was also regarded as a very different category of drug compared to other more ‘harmful’ drugs, such as cocaine and heroin, for example one young male cannabis user commented: *“I don’t do dangerous drugs like heroin or cocaine. My weed [cannabis] keeps me mellow, so I don’t need them”* whilst a community organisation consulted with reported that *“using cannabis is seen as something that ‘everybody’ does and not harmful.”* (Fountain, 2009a: 15)

Another factor that was mentioned by the Black African community in contributing to the normalization of cannabis use was the perceived history of use within families with one young female cannabis user commenting that *“cannabis has been in the family as long as I can remember. It has never harmed anyone..”* (Fountain, 2009a: 15)

This factor was further elaborated on by the Black Caribbean community, who felt that *“young children have seen their parents smoking it and copied them”* and that *“...people have grown up using it ... through the family.”* (Fountain, 2009b: 14)

¹⁴ As emphasised by the author it is important to note that findings reported from this project are not intended to infer prevalence data, but rather to provide an overview of drug-using patterns and drug service needs.

Respondents from the Black Caribbean community felt that, for the followers of the Rastafari movement, cannabis use was in fact a spiritual act and part of the 'culture' of the movement.

In her study, Fountain (2009d) notes that some Kurdish, Turkish and Turkish Cypriot organisations reported that, while the majority of their respondents reported that illicit drug use (and users) were often stigmatised and ostracised, a minority of respondents also felt that cannabis use was 'acceptable'. This view was echoed by Chinese community organisations, which reported that the use of cannabis was perceived by all age groups as "a normal activity" for young people on a night out. This was also regarded as the case for the use of ecstasy among this group.

The Asian community and heroin use

As discussed earlier, prevalence data indicates that levels of drug use in Asian groups is very low compared to other ethnic groups. However, there is some evidence to suggest that heroin use may be problematic in some of these communities. For example, in its annual differential impact analysis of drug treatment (2006/07), the NTA (2007) reports that not only was heroin the most commonly reported problem drug by all those in treatment (61%), but that its use among Asians in treatment (64%) was much higher than among other ethnic groups in treatment (mixed race: 44%; Black: 31%). Similarly, statistics published for the West Midlands (Sondhi, 2009) indicate that 80% of Asians presenting for treatment in 2007/08 recorded problematic heroin use, compared with 59% of Black service users and 72% of mixed race service users. Bashford et al. (2003) in their report on the Department of Health's needs assessment project report that of the 158 respondents who reported ever having used heroin, 68 (43%) were South Asian.

A small number of targeted studies have explored the use of heroin in Asian communities (Bangladeshi in particular). Two such studies focus on drug users presenting themselves for treatment to substance misuse services. One small-scale study by Fernandez (2002) examines the drug use habits of drug users who had accessed two substance misuse treatment centres in London: The Junction Project, in the borough of Brent (between 1998 and 1999) and the Margarete Centre, in the borough of Camden and Islington (between February 2000 and February 2001).

Fernandez (2002) reports that 12% of people using the Junction Project treatment centre were Asian and 88% were White. Of this 12% who identified themselves as Asian, almost all (95%) reported smoking heroin, and there was almost no history of poly-drug use. Crack was the only other drug that some people reported using occasionally. The majority of White users reported using heroin, crack cocaine, benzodiazepines and alcohol. The situation was similar among those using the

Margarete Centre, although the level of presentation to the service by Asian clients here was lower. Only 4% (ten people) of clients identified themselves as Asian, of which all identified themselves as chasing and smoking heroin, and there was little reported use of other drugs. The author reports that levels of presentation at the Margarete Centre were much lower than those at services in the North Thames region, as recorded by the Thames Regional Drug Misuse Database (13% on 1997 figures). The author argues that this might suggest a 'hidden' population that is in need of help and hard to reach. Of the drug users using the Margarete Centre who identified themselves as White/European, 90% reported using heroin, crack cocaine and benzodiazepines routinely. Across both treatment centres, more than nine out of ten White users reported that injecting was their preferred route of administration, whereas a similar sized majority of Asian users identified smoking and chasing as preferred routes. The small-scale nature of this study and the lack of detail provided about exact sample sizes, particularly in the case of the Junction Project treatment centre, means that these findings should be interpreted with caution.

In his review of Bangladeshi drug users presenting themselves to five sets of treatment agencies in the London boroughs of Camden and Islington, Newham and Tower Hamlets, White (2001) presents similar results. He reports that although there were only 301 Bangladeshi's presenting for treatment (out of a total of 23,000), 88% of these did so for heroin use, compared to 63% in the White sample. The author also reports a marked gender difference in presentations for heroin use among Bangladeshis, with 96% of all reports being for male users. Presentations for heroin use in the Bangladeshi sample were highest among younger age groups (mean age: 21.1 years). In comparison, presentations for heroin use in the White sample occurred across a wider range of age groups. The author argues that this spread across age groups for the White sample was due to a combination of repeat treatment presentations, delayed help-seeking and a slightly later age of first use. The author also notes that "given that heroin use by Bangladeshis is a new phenomenon, delayed help-seeking to this degree will not yet have manifested" (White, 2001: 1819).

The author also argues that the ratio of Bangladeshi heroin users to White users (in the under 25 age group) is much higher than the ratio of Bangladeshis to Whites in the general population in the three boroughs. For example, in Camden and Islington, 27% of reports were from Bangladeshi users although Bangladeshi's only account for 2% of the borough population for this age group. Finally, analysis of this younger subsample also revealed that whereas 72% of White users reported using a second drug, only 53% of Bangladeshis reported using a second drug.

Summary: Poly-drug use vs. 'drugs of choice'

- Poly-drug use is most common among White groups compared with other ethnic groups.
- Cannabis is the most commonly used drug across ethnic groups and age groups. The literature suggests that this high level of use may be related to attitudes towards cannabis which regard the drug as 'acceptable' and not as harmful as other drugs. Additionally, in Black African communities, a factor that contributes to the acceptability of cannabis use was the perceived history of its use within families. Black Caribbean communities felt that for the followers of the Rastafari movement, cannabis use was in fact a spiritual act and part of the 'culture' of the movement.
- National and local records of treatment service users as well as some small-scale targeted studies indicate that there may be some problematic use of heroin among the Asian community. Drug users within these communities also appear to be more likely to use smoking or chasing as their method of administration, whereas those in White communities are more likely to use injecting.

DRUG USE AND STIGMA

The issue of stigma is explored in a number of reports and the evidence shows that stigma associated with drug use affects a number of BME communities. Many studies highlight the impact on families of this stigmatisation, and others note the unacceptability of certain drug types and resulting ostracism. The evidence discussed in this section includes reports from the Department of Health's needs assessment project (Bashford et al., 2003; Fountain, 2009a–e) as well as some small-scale low quality local studies (Glasgow, East London) with specific ethnic groups (Bangladeshi, Pakistani).

Stigma and families

A number of qualitative reports on BME communities have elaborated on the manner in which the stigma attached to drug use is directed not only at drug users themselves, but also at their families and extended families. A local small-scale qualitative study with eight Bangladeshi women in East London by Cottew and Oyefeso (2005) reported that the majority of the women interviewed felt that exposure of their drug use would result in shame for themselves as well as for their families: "For a Muslim girl to be taking heroin is such a big deal. They'll neglect you, they'll neglect your family." (Cottew and Oyefeso, 2005: 182) As a result of this, the women felt that drug use among their peers was likely to be 'undercover' or 'hidden'. The authors argue that this implies the true extent of Bengali women's

drug use is unknown. However, given the small size of the sample these findings should be interpreted with caution as they are not necessarily representative of the wider Bangladeshi community.

Fountain argues that drug use among more traditional communities, for example South Asian communities, “must be understood in the context of the centrality of the family and of respect in the traditional cultures of South Asian communities” (Fountain, 2009e: 16). Participating community organisations reported that concerns centred around being alienated from the rest of the community, which would have a negative impact on all family members, for example by hindering the marriage prospects of not only the drug user but of his or her siblings as well.

“It brings so much shame to the family within the community, people just look down on you, they think the whole family is bad. The drug user won’t get a marriage proposal, and neither will the sisters if their brother is a drug user.” (Drug user’s sister) (Fountain, 2009e: 56)

Similar views were also expressed by the Chinese community where “face and reputation” were considered very important and adversely affected by drug use within the family (Fountain, 2009c). Both communities reported that fear and avoidance of this stigma had an impact on the way families reacted to drug use, with denial being the most common reaction. Ross et al. (2004), in their study of drug issues among Pakistani, Indian and Chinese communities in Greater Glasgow, report that the survey element of this study ($N = 174$, 16–24-year-olds) found that Pakistani respondents were more likely (56%, $n = 41$) than Indian or Chinese respondents (38%, $n = 18$ and 26%, $n = 14$, respectively) to suggest that their community ignores or hides drug use. The majority of Indian or Chinese respondents felt that their community would deal with a drug problem in the same way as the general population.

However, these findings need to be interpreted with caution given that snowball sampling was used to recruit approximately half of the sample and no indication of the statistical significance of these findings is provided. The Pakistani young people in this study said that this denial often resulted in parents sending the drug user away from the geographical area where use was occurring. The authors note that this ‘DIY Detox’ was recognised by workers in the area:

“I’ll say for every client I have, there has ... been a story about young people getting sent back home to Pakistan as an alternative to approaching service provision.” (Ross et al, 2004: 56)

Fountain (2009e) reports similar practices among South Asian communities, whose members hoped that a change of environment – for example sending the using family member to a parent’s country of origin – would distract them from drug use. Community members reported as well that in some cases these family members were ‘married off’ in the hope that increased responsibilities would discourage drug use. However, community members who reported having adopted these practices also felt that abstinence from drug use tended only to last until the family member returned to the UK.

The denial of drug problems in families in response to fears about stigma was also felt to be common in the Black African community, and was seen as a result of a desire to avoid ostracism by the wider community (Fountain, 2009a).

The ‘acceptability’ and ‘unacceptability’ of certain drug types

There is a small amount of evidence in the literature to suggest that some BME communities perceive some drugs to be less ‘acceptable’ and more stigmatised than others (Fountain, 2009b,d). For example, Fountain, in her reports for the Department of Health’s needs assessment project, reports that among the Black Caribbean community, crack cocaine and heroin were viewed as particularly unacceptable, with community members reporting that this often led to users of these drugs hiding their drug use in fear that they “would become ostracised or looked down upon” (Fountain, 2009b: 15). Community members also felt that this inevitably resulted in the under-reporting of the use of these drugs within this community. For members of the Turkish/Turkish Cypriot community involved in the study **all** drugs (possibly with the exception of cannabis) were considered unacceptable and a sample of drug users agreed that they were considered “useless” and “filth” by the wider community. One participant said: “Anyone who admits to taking drugs is automatically excluded from the community” (Fountain, 2009d: 15).

In contrast, Taylor et al. (2006) in their needs assessment study on Romani gypsies, Irish travellers and showmen, report that cocaine was regarded as a culturally acceptable drug, with 64 out of 100 people interviewed reporting having used it. Cocaine was thought to be a ‘designer’ drug in that its relatively high cost indicated that its users were affluent and thus to be ‘looked up’ to. Additionally, amphetamines were regarded as a necessary aid to working, with 63 out of 100 people reporting having used the drug. For older users, they were thought to help with driving long distances to work and to keep up with their younger counterparts during work. In fact, when asked why they used drugs, 24 out of the 100 people interviewed said they did so for work.

Whereas cocaine and amphetamines were regarded as acceptable, heroin was regarded as unacceptable and was described by respondents as a '*mochardi*' (dirty) drug. Although respondents did not want to talk about the drug, they did agree that its use was quite widespread and that the drug-related deaths they knew of were mostly related to heroin use. Of the 100 people interviewed, 17 reported having used heroin.

Summary: Drug use and stigma

- Among some BME groups, particularly South Asians and the Chinese, the stigma attached to drug use is not only directed at drug users, but also at their families. This can lead drug users to hide their drug use. This suggests that levels of drug use in these communities may be underestimated. Fear of this stigma impacts on the way families respond to drug use by their members, with denial being a common reaction.
- Some drugs are considered more 'unacceptable' than others in specific BME groups. For example, among the Black Caribbean community, crack cocaine and heroin were described as such, whereas 'all' drugs (with the possible exception of cannabis) were described as unacceptable by the Turkish/Turkish Cypriot community. Among Romani gypsies, Irish travellers and showmen, cocaine and amphetamines were regarded as acceptable and heroin as unacceptable. However, it is important to note that these findings are based only on a small number of studies and are thus not necessarily representative of all members of these communities.

GENDER AND DRUG USE WITHIN ETHNIC GROUPS

Gender differences in the prevalence and patterns of drug use has been explored in the literature in the context of differences in 'any' drug use, Class A drug use, khat use and presentation at treatment service providers. The evidence discussed in this section includes medium and high quality large-scale surveys as well as smaller scale qualitative and quantitative studies of low and medium quality with specific populations (Somali, Yemeni) in specific geographical regions (London, Birmingham). Reviews of data on presentation by BME groups at drug treatment services are also included.

'Any' drug use

The majority of studies included in this review indicate that within minority ethnic groups, males are more likely than females to use illicit drugs. The same is true of White groups. For example, Aust and Smith's analysis of the BCS (2003) reflects these findings (Table 3).

Table 3: Prevalence of drug use over the last year/last month among males and females (16–59-year-olds)

	Male					Female				
	White	Black	Asian	Mixed	Chinese/Other	White	Black	Asian	Mixed	Chinese/Other
Percentage used any illicit drug										
Last year	16	17	6	29	8	9	7	5	23	7
Last month	10	12	4	22	4	5	5	2	11	4

Source: Aust and Smith, 2003: Table 6

The more recent analysis of BCS data (Hoare, 2010) presents a slightly different picture. The authors state that among adults from a White or Asian background, men (White: 14%; Asian: 4%) were more likely to use any drug compared with women (White: 7%; Asian: 1.8%). The authors also note that the gender difference among Asian groups reflects differences in cannabis use, with 3.2% of men from this group reporting having used the drug in the last year compared with 1.2% of women. The authors also report that no differences between men and women in overall drug use were detected for the other ethnic groups, although there was a gender difference among Black groups for cannabis use, with 6.5% of men reporting having used the drug in the last year compared with 3.8% of women.

The analysis discussed above (Hoare, 2010) unfortunately does not include an analysis of drug use over the last year by gender and age groups. However, there is some evidence in the literature reviewed that there are may be some gender differences in age groups. For example, a self-reported school-based survey of drug use among a sample of 6,020 young people (15–16-year-olds) from 41 schools across England by Rodham et al. (2005) found that males were more likely than females to have taken any drug in the previous year:

- 25% of Asian males reported having used drugs in the last year compared with 9% of Asian females;
- 55% of Black males reported having used drugs in the last year compared with 33% of Black females;

- 52% of 'other' minority ethnic males reported having used drugs in the last year compared with 32% of 'other' minority ethnic females.

Sharp and Budd (2005), in their analysis of the OCJS, report that this difference also holds for an older age group (26–65-year-olds) within mixed race and Black groups (Asian males and females demonstrate similar levels of use):

- 29% of males from mixed race backgrounds ($N = 81$) reported using any drug in the last year compared with 4% of females from the same background ($N = 110$);
- 15% of 'Black or Black British'¹⁵ males ($N = 232$) reported using any drug in the last year compared with 5% of Black or Black British females ($N = 288$).

It should be noted that there is no indication as to whether these differences are statistically significant.

Fountain (2009a,d,e) has also reported on gender differences in drug use in a series of ethnic minority group focused reports that form part of the Department of Health's Black and minority ethnic drug misuse needs assessment project. The ratios of male to female respondents who reported currently using any illicit drugs were:

- South Asian: 3 males: 1 female;
- Kurdish, Turkish, Turkish Cypriot: 6 males: 1 female;
- Black African: 4–5 males: 1 female.

Class A drug use

The recent analysis of BCS data (Hoare, 2010) also provides data on gender differences in Class A drug use across BME groups. However, the low prevalence of class A use means these differences may not be statistically significant so caution is needed if extrapolating from these findings. The proportional difference between prevalence figures for reported Class A drug use in the last year for males and females suggests that differences in prevalence may be most clearly defined for Asian,¹⁶ and White groups, with Black and mixed race males and females exhibiting similar levels of use:

- 0.9% of Asian males reported having used Class A drugs in the last year compared with 0.3% of Asian females reported (ratio 3:1);

¹⁵ As used by authors.

¹⁶ It should be noted, however, that the overall percentage of Asian people reporting having used Class A drugs is very low (0.6%).

- 5.2% of White males reported having used Class A drugs in the last year compared with 2.1% of White females (ratio 2.5:1); whereas.
- 1.7% of Chinese/Other males reported having used Class A drugs in the last year compared with 1% of females from this group (ratio: 1.7:1);
- 5% of males from a mixed race background reported having used Class A drugs in the last year compared with 4.6% of females from the same background (ratio 1.1:1); and
- 1% of Black males reported having used Class A drugs in the last year compared with 1.3% of Black females (ratio 0.8:1).

In the more narrowly focused studies we reviewed, particularly those focused on drug use among young people, gender differences in Class A drug use within particular ethnic groups were more difficult to establish. For example, a school-based study with 6,020 15–16-year-olds by Rodham et al. (2005) found that boys from Asian and Black ethnic groups are significantly more likely than girls to report having used stimulants or hallucinogens in the last year. However this finding is based on only a small number of young people (5.7%) reporting stimulant or hallucinogen use. Jayakody et al. (2006) found more mixed results in their study of drug use among a sample of 2,789 young people from a representative sample of 28 secondary schools in East London. They reported that use of Class A drugs and amphetamines was higher among boys from some ethnic minority subgroups compared to other ethnic subgroups, where prevalence was higher among girls:

- Bangladeshi males: 2.8%, Bangladeshi females: 0.9%
- Pakistani males: 0%, Pakistani females: 2.8%

Findings such as these indicate that gender differences in Class A drug use among young people may be more difficult to detect with certainty, particularly because of the small numbers of young people who report using Class A drugs compared to the reported use of any illicit drug.

Khat use

Several studies into khat use by Black African groups have found that men are more likely than women to report using khat. For example, in their study of khat use among a sample of 602 Somali's recruited using purposive sampling in London, Birmingham, Bristol and Sheffield, Patel et al. (2005) found that 14% of female respondents reported having used khat recently (16% 'ever' used) compared with half (51%) of male respondents (58% 'ever' used). The authors report that "this greater prevalence of khat use among male respondents is in accordance with the greater cultural acceptance of men rather than women using it" (Patel et al., 2005: 14).

The 'acceptability' of drug use relative to gender is also explored by Havell (2005) in her study on khat use, consisting of 45 structured interviews and 11 focus groups

with Somali, Yemeni and Ethiopian community members from across five areas in England. The author reports that although nearly half the female respondents interviewed reported chewing khat at the present, three out of five women's focus groups reported that nobody chewed khat. Both studies also indicate that women were more likely to chew khat in small groups or on their own, which may indicate a desire on their part to keep their khat use relatively hidden. This view was echoed in a report by Buffin et al. (2009) on community engagement forums across the UK which were attended by approximately 100 people. Participants reported that although khat use was primarily seen as a male issue, women are also using it alone and in non-social settings, often when the children are in bed and their husbands are out. Bashford et al. (2003) in their report for the Department of Health's needs assessment project note that various community organisations consulted with reported that perceived gender differences in khat use could be attributable to the different ways in which men and women used khat, with male use regarded almost as a 'rite of passage' and female use staying hidden.

In their study on khat use among young Somalis in Sheffield, Nabuzoka and Badhadhe (2000) report that 54 out of 154 individuals contacted to take part in the study refused to take part because they did not want to talk about khat, and of these 54 individuals, 40 were women. In their study on khat use in London, Birmingham, Bristol and Sheffield, Patel et al. (2005) say that a smaller number of female than male respondents reported that their family members knew about their khat use. Half of female recent khat users (50%) reported that older family members were aware of their khat use, compared with three-quarters (75%) of male recent khat users. The same study also reports that women were almost twice as likely to want to stop using khat (50%) when compared with men (27%). This may indicate that they are more likely to regard their khat use as 'problematic'. There were also gender differences in attitudes towards prohibiting khat, with men twice as likely (50%) as women (25%) to be against banning khat. Bashford et al. (2003) in their report for the Department of Health's needs assessment project also report that women are more likely to consider their khat use problematic compared with men.

The extent to which gender differences are a factor in the frequency of khat use is less clear. Havell (2005), in her study on khat use, which included 45 structured interviews with Somali, Yemeni and Ethiopian community members, reports that women were less likely to use khat than males, with most women reporting using it either 'occasionally' or 'more than once a week' and men reporting use on 'most days' or 'more than once a week'. Conversely, Patel et al. (2005) report little difference, with female respondents reporting using khat twice a week and male respondents reporting using khat three days a week. However, it is important to bear in mind that Havell's (2005) sample includes Yemeni and Ethiopians, who may have different patterns of use when compared with Somalis.

Drug treatment service users

In its annual differential impact analysis of drug treatment (2006/07), the NTA (2007) reports that there were more male service users in treatment, across BME groups, than females. The proportion of women was higher in White and mixed race service users compared with Asian and Black service users. For example, 29% of White British and 32% of 'White and Black Caribbean' service users were female, compared with 15% of Indian service users and 22% of African service users.

There are also differences in the proportion of female to male service users within ethnic subgroups. For example, there is little variation in the percentage of female to male service users across different Black ethnic subgroups: African: 22% female; Caribbean: 21% female; other Black: 23%. Conversely, there is variation across the Asian and mixed race subgroups. For example, only 9% of Bangladeshi service users were female compared with 15% of Indian female service users. Similarly, within the mixed race subgroup, 32% of 'White and Black Caribbean' service users were female, compared with 25% of 'White and Asian' service users.

Summary: Gender and the prevalence of drug use within ethnic groups

- The literature suggests that males are more likely than females to use any illicit drugs in many ethnic groups. This trend tends to hold across age groups.
- Gendered differences in Class A drug use appear to be most clearly defined among Asian, White and Chinese/Other groups, while Black and mixed race males and females have similar levels of use. Gender differences in Class A drug use among young people from BME groups are difficult to establish, perhaps because of the small numbers of young people who report using Class A drugs, compared to the reported use of any illicit drug.
- Among khat using communities, the literature suggests that men appear to be more likely than women to use the substance. However, the literature also suggests that this may be because of the stigma attached to drug use. Women are 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.
- Records of service users in treatment indicate that the proportion of females is higher in White and mixed race service users compared with Asian and Black service users. Additionally, there is more variation in the ratio of female to male service users across different Asian ethnic subgroups (Indian, Pakistani etc.) than across Black ethnic subgroups (African, Caribbean etc.).

GAPS IDENTIFIED

The literature reviewed highlighted a number of gaps in research, some of which are more general and apply to all BME groups and some of which are more specific to ethnic groups, subpopulations and drug types. Where comparisons have been made about drug use across ethnic communities, these communities have tended to be grouped together, which can distort findings and conceal important differences (Jayakody et al., 2006; Rodham et al., 2005). Jayakody et al. (2006) also argue that:

“There is thus a need for a more sophisticated understanding and treatment of ethnicity, or at least a greater number of ethnic groups identified for research/survey.” (p. 330)

Similarly, Kalunta-Crumpton (2003) states that:

“... there has been insignificant attention paid to the heterogeneity and diversity of Britain’s White population, particularly minority White communities.” (p. 170)

Wider literature on the heterogeneity within populations, which was not included in this review, also states that heterogeneity within ethnic groups (including BME groups) can be as great or even greater than those between groups (Modood, 2007).

More specifically, Fernandez (2002) argues that there is a need for more research that explores the different types of drugs used by different ethnic groups, why some groups use particular drugs more frequently and why they administer them differently. Additionally, Holloway and Bennett (2008) argue that research into types of drugs used, the rate of use and methods of administration need to be complemented by research into any associated problem behaviours.

With regards to refugees and asylum seekers, the Centre for Ethnicity and Health at UCLAN (2004) has argued for more dedicated research to be conducted:

“Although very few of the young refugees and asylum seekers interviewed for this project were problematic drug users, the presence of the known risk factors, documented throughout this report, indicates that they are highly vulnerable to future problematic drug use and a systematic needs assessment should be conducted amongst this population” (p. 224)

Similarly, McCormack and Walker (2005) argue that there are no accurate and reliable statistics available on how many young refugee and asylum seekers misuse drugs. This is because not all institutions involved with drugs and drug treatment record refugee status, and that even when it is recorded it is unlikely to be accurate

because most refugee and asylum seekers tend to hide any involvement in drugs for fear of the admission impacting on their status in the UK.

Fountain, in her ethnic minority focused reports for the Department of Health’s needs assessment project, reports that a number of community organisations serving Black African communities and Kurdish, Turkish and Turkish Cypriot communities identified topics in need of further research (Fountain, 2009a,d). These are summarised in Table 4.

Table 4: BME communities’ suggestions for future research

Communities	Suggested topics for future research
Black African	<ul style="list-style-type: none"> • Existing and emerging patterns of substance use (including longitudinal studies) among specific Black African communities and/or specific vulnerable groups within them • The impact of migration and immigration policies on substance use • The effects of substance use on families • The impact of social exclusion on substance use • Gender differences in substance use • The impact of khat use on mental health • Substance use and domestic violence • The use of so-called ‘traditional’ substances
Kurdish, Turkish and Turkish Cypriot	<ul style="list-style-type: none"> • Drug use among school pupils • Determining – by improved ethnic monitoring – how many Kurdish, Turkish Cypriot and Turkish people are living in the UK and are clients of drug services

With regards to khat use, a number of studies suggested that there is a need for further research to determine the ‘*prevalence of khat use amongst Somalis in general and other ethnic communities, as well as characteristics of those who use, context and associated problems*’ (Nabuzoka and Badhadhe, 2000: 32). Finally, with regards to Muslims, Rodham et al. (2005) report that there has been insufficient research conducted on the impact of faith on drug use.

Other gaps in literature evident from this review are:

- It is apparent from the literature reviewed that there is much greater coverage of BME groups such as South Asians and Black Caribbeans, compared with other minority ethnic groups such as the Chinese, Vietnamese and Eastern Europeans.

- Since diverse ethnic groups are often grouped together as 'Asian' or 'Black', there is limited literature on the differences and similarities in drug use prevalence and patterns within minority ethnic groups. There is also limited literature on the differences and similarities in drug use in specific BME groups across different geographical areas.
- Most studies reviewed focus on prevalence of drug use; reporting on patterns of drug use (frequency of use, situational context of use, length of use, methods of administration and changes in patterns of use over time) is limited.
- There is a small amount of information on prescription drug abuse among certain groups (Asians, Romani gypsies), as well as about the association between drug use and prostitution among Eastern European and South East Asian women. However, this was not enough to be identified as a key theme in the report.
- Where methods of administration of drugs are explored in the literature, there is quite a narrow focus on specific ethnic subgroups (e.g. Bangladeshis).

4. Drug prevention and information provision

The evidence presented in this section is drawn primarily from Fountain's BME focused reports (2009a–e) for the Department of Health's needs assessment project. It discusses BME communities' perceptions of and opinions about what represents good practice in terms of information provision and drug use prevention, rather than evidence about what has worked in terms of drug use prevention and information provision for different BME groups. The findings should thus be interpreted with caution.

AWARENESS OF AND ACCESS TO DRUG-RELATED INFORMATION

In her series of reports on BME communities, Fountain (2009a–e) reports that the majority of community organisations consulted felt that that BME communities lacked information about drugs and drug services. This lack of awareness was said to “impede access to information and advice for all members of the communities, including non-problematic drug users who would benefit from information about the substances they use and advice on harm reduction strategies” (Fountain, 2009e: 5). Where drug-related information had been accessed, a number of sources were identified.

Among statutory services, GPs were the most commonly cited source of information on drugs and drug services among the following communities: South Asian, Black Caribbean, Chinese and Vietnamese, and Kurdish, Turkish Cypriot and Turkish communities (Fountain, 2009b–e). Some members of the Turkish community were cited to have more trust in private doctors than in GPs, particularly with regard to confidentiality. Members of the Black Caribbean and Chinese communities identified schools, health centres and health clinics as other statutory sources of information (Fountain, 2009b,c).

A number of communities identified their family, friends or social and support networks as sources of drug-related information. Black Africans were most likely to approach their families for advice, information or help on issues relating to substance using, and they were the only minority group who tended to put family, friends and religious organisations before GPs as sources of information (Fountain, 2009a). This was in contrast to the Kurdish, Cypriot Turkish and Turkish community, only a minority of which would ask their family or friends for help with a drug problem (Fountain, 2009d).

Religious organisations or leaders were commonly mentioned by Black African community members, as well as occasionally by South Asian and Kurdish, Turkish Cypriot and Turkish community members (Fountain, 2009d,e). Community organisations were also common sources of information across the ethnic groups, although they were rarely reported as a source for Black Caribbean and Kurdish, Turkish Cypriot and Turkish people.

Many BME groups made use of a number of informal sources of information, including telephone helplines and websites. These were relatively popular among a majority of BME groups, with the exception of the Chinese and the Vietnamese. Black African and Black Caribbean community members mentioned the FRANK website particularly often (Fountain, 2009a,b). Black Caribbean community members also reported “many unofficial sources of information” about drugs, including their own experiences, “observation on the street” and television (Fountain, 2009b).

SETTINGS FOR DELIVERY OF DRUG INFORMATION/EDUCATION

Fountain (2009a–e), in her needs assessments of BME communities, notes that participants recommended a wide variety of venues for the delivery of drug-related information. Schools and community centres were the most frequently cited settings. These were seen as familiar, community based, well visited, ‘comfortable and safe’, and as places where social events could be held (Fountain, 2009a–e). Other supportive and safe settings included places of worship, mentioned by the South Asian and Black African communities (Fountain, 2009a,e).

Health centres were reported as recommended by both South Asian and Chinese community members, with South Asians making this recommendation most strongly (Fountain, 2009b,e). The desire for confidentiality and anonymity meant that South Asian participants often proposed drop-in facilities that advertised themselves as providing advice on a number of issues, in addition to drug-related ones. This was so that visitors would not be identified as seeking information on drugs (Fountain, 2009e).

Kurdish, Turkish Cypriot and Turkish, Chinese and Vietnamese, and Black Caribbean communities recommended a number of other settings where people tend to congregate and where information provision could be delivered through outreach.. These were often public outdoor spaces, including parks, bus stops, street corners and Chinatowns. Other venues, such as local shops, pubs, cafés, hairdressers and libraries were also mentioned occasionally (Fountain, 2009b–d).

The participants often considered young people as a specific group for whom other settings might be more useful as a potential platform for information delivery. Apart from schools, youth clubs were often cited by South Asian, Black African and Black Caribbean community members (Fountain, 2009a,b,e). South Asian, Black African and Kurdish, Turkish Cypriot and Turkish participants indicated colleges and universities (Fountain, 2009a,d,e). The two former groups additionally mentioned sports and leisure centres (Fountain, 2009a,e). Members of the Black Caribbean community – the minority ethnic group demonstrating the greatest awareness of drugs – identified night clubs as venues where particular kinds of drugs tend to be taken by the youth and thus as potential venue for information provision. (Fountain, 2009b).

Black Africans who took part in the project highlighted additional factors that ought to be taken into account when providing drug education to women in their community. The community members recommended gender-specific venues for the delivery of information on drugs and drugs services, as it is often considered unacceptable for women of Black African descent to mix with men in public places (Fountain, 2009a). Women-only venues and women's homes were regarded as most appropriate. Another recommendation by this community was that drug information sessions could be held in alcohol-free environments. Finally, the studies investigating khat use in the Somali community recommended that information was given to men in the *mafrishes*¹⁷ This suggestion was also made by Somali, Yemeni and Ethiopian participants in a study conducted by Havell (2005). The participants also recommended that since women tend not to visit *mafrishes*, it would be helpful to have information available at GPs surgeries and perhaps through Parent Staff Association links.

¹⁷ Premises specifically used for selling and using khat.

Summary: Settings for delivery of drug information/education

- The literature suggests that there is limited awareness among BME communities about the range and value of existing drugs services. Where drug-related information had been accessed a number of sources were identified. Among statutory services, GPs were the most commonly cited source of information. A number of communities identified their family, friends or social and support networks as sources of drug-related information. Religious organisations or leaders as well as community organisations were commonly mentioned by a range of BME communities.
- In the literature reviewed, BME communities suggested a wide variety of venues for the delivery of drug-related information. The most frequently cited settings were schools and community centres as these settings were seen as familiar, community based, well visited, comfortable and safe. Since young people were often considered a specific group for whom other settings might be more useful, the communities suggested youth clubs, colleges and universities. Gender-specific venues were also recommended by some communities.

MODES FOR DELIVERY OF DRUG INFORMATION/EDUCATION

The literature suggests that BME communities would like drug-related information to be conveyed through a range of channels, including written, oral and visual media (Fountain, 2009a–e), with different factors contributing to the effectiveness of each medium.

Telephone helplines were popular across all groups for a number of reasons. They were felt to offer reliable information (Fountain, 2009e), could be provided in a range of languages and dialects and, even more important, offered anonymity to the caller (Fountain, 2009b,c,d). The FRANK telephone helpline (as well as the website) was mentioned specifically by three different communities: South Asian, Black African and Black Caribbean (Fountain, 2009a,b,e).

The evidence suggests that language is a crucial factor in the successful delivery of information on drugs and drug services for all BME communities apart from Black Caribbean communities, whose first language is English (Fountain, 2009b). For example, bilingual leaflets and posters were often suggested by members of Chinese communities (Fountain, 2009c). People from South Asian, Black African and Kurdish, Turkish Cypriot and Turkish communities saw local newspapers and community newsletters as effective and targeted modes of delivery (Fountain, 2009a,d,e).

Members of South Asian and Black Caribbean communities were keen to point out that the delivery of drug-related information should not be limited to written media, as substantial numbers of people from ethnic minorities might have poor literacy or be unwilling to read (Fountain, 2009b,e). Some groups suggested developing more informal and creative drugs education, using community theatre events involving music and drama, for example (South Asian, Black African and Black Caribbean communities; Fountain, 2009a,b,e). Concerns about literacy were also raised in a needs assessment study of Romani gypsies, Irish travellers and showmen by Taylor et al. (2006). Of 100 people interviewed, 86 were unable to read and 89 were unable to write. It is thus not surprising that when asked what format information relating to drugs should be delivered in, 32 suggested pictorial paper format, 48 suggested DVD or video format and 13 said by audio tape.

Other visual media cited included videos and DVDs, with a suggestion by the Black Caribbean community that these should feature individuals from the ethnic group concerned, showing their own experiences of drugs and drug services (Fountain, 2009b). Workshops were seen as another targeted mode of delivery. These were seen as one of the best ways to convey information on drugs and drug services to Black Caribbean, Kurdish, Turkish Cypriot and Turkish, and Chinese and Vietnamese community members (Fountain, 2009b,c,d).

The internet was recommended occasionally by the Kurdish, Turkish Cypriot and Turkish communities. Finally, radio and television programmes were often seen as powerful media with potential for drug education and were mentioned by all communities except for the Black Caribbean.

THE 'MESSAGE' OF DRUG EDUCATION – INFORMATION CONTENT

Fountain (2009a–e) reports differences in the views of BME communities on the appropriate content and message of drug education. A common recommendation was for information provided to be precise and explicit, particularly when it regards drug services. Community groups consulted with highlighted that awareness-raising initiatives should advertise exactly what services were offered to community members and give precise details of how these operate and, in particular, how they are accessed. The precision and explicitness of drug information emerged as a theme in the reports concerning South Asian, Black African and Black Caribbean communities (Fountain, 2009a,b,c). These communities felt it important to state clearly that drug services are not only for 'heavy drug users' (Fountain, 2009b). They felt too that it was also important to be honest if it is "a matter of luck whether or not a person has access to the correct services" (Fountain, 2009a: 25). The latter information was regarded by many communities as crucial for developing realistic expectations among community members since many, particularly South Asians,

were often cited to have false conceptions of what particular services can be provided for them (Fountain, 2009e).

The Black Caribbean and Black African communities had contrasting attitudes towards the extent to which drug-related information should focus on helping people to make informed choices about illicit drug use and harm-reduction messages. While Black Caribbean people were largely reported to recommend these approaches to drug education, few Black African participants did (Fountain, 2009a,b). Many community members in this latter group argued that the sole message of drug education should be abstinence and that the message should emphasise the illegality of drugs (Fountain, 2009a). Fountain (2009e) reported too that some older South Asian community members had attitudes towards drug education similar to the majority of Black Africans, objecting to harm-reduction approaches.

Another important factor that was common across a number of communities was the issue of stigma. The most prevalent issue emerging from the responses of the Kurdish, Turkish Cypriot and Turkish community was a recommendation for drug education to encourage communities “to acknowledge drug use within them, addressing the stigma and lifting the taboo on discussing drug-related issues” (Fountain, 2009d). Members of Black African communities also emphasised the need to challenge the stigma, taboo and denial attached to illicit drug use (Fountain, 2009a).

Chinese and Vietnamese participants occasionally mentioned the importance of addressing the stigma around drug use too, but were more concerned about the importance of information about illicit drugs, for example accurate information about the harm associated with different drug types (Fountain, 2009c). A number of these participants recommended that drug education should also give advice to parents on how to spot drug use among their children and how to deal with this problem. In addition, a significant minority of Chinese and Vietnamese participants expected drug information to include education on the risk factors associated with drug use. Some young people from this community suggested that information on sexual health could be included along with that on illicit drugs. Similar issues were mentioned by the Black Caribbean community, for which the most common drug education priorities identified were: (a) how to recognise the signs of problematic use; (b) the long-term effects of cannabis use; (c) the relative harm caused by different drugs; and (d) crack cocaine (Fountain, 2009b).

A particular issue emerging from the report on the Black African community was whether or not khat should be treated as an illicit drug (Fountain, 2009a). This group recommended that information and advice about khat, and treatment

for problematic use of the substance, needed to acknowledge these opposing viewpoints. Including khat in information about illicit drugs or drug treatment may meet with approval from part of the community, but may not engage khat users. Conversely, Buffin et al. (2009) report that Somali community members consulted with suggested that given the rising levels of cannabis use among young people, messages about khat could be combined with those about cannabis.

Confidentiality was stressed across BME communities as a crucial feature of drugs services. This issue was also mentioned in relation to drug information by the South Asian and Black Caribbean communities (Fountain, 2009b,e). This group recommended that information on drug services ought to include a clear confidentiality policy with unambiguous statements. For example, 'we operate a strict confidentiality policy' was seen as a potentially ambiguous statement, with 'we will not tell your parents, any member of your family, the police, or anyone else that you had contacted us' being suggested as a better example (Fountain, 2009e: 27).

Summary: The 'message' of drug education – information content

- In the literature reviewed, BME communities suggested using a variety of written, oral and visual media to convey drug education successfully. Telephone helplines were popular across all groups because they were felt to offer reliable information and, even more important, anonymity. All communities felt that language was a crucial factor to take into account in the delivery of information on drugs and drug services. They were also keen to point out that the delivery of drug-related information should not be limited to written media as substantial numbers of people from ethnic minorities might have poor literacy or be unwilling to read.
- With regards to the message of drug education, BME communities all agreed that the information provided should be precise and explicit, particularly with regards to drug services. BME communities were split on the extent to which drug-related information should focus on harm-reduction messages or whether it should emphasise abstinence and the illegality of drugs.

DRUG EDUCATION

Suggested deliverers

Ex-drug users

Fountain (2009a,b,e) reports on a range of suggestions made by South Asian, Black African and Black Caribbean communities regarding the most appropriate deliverers of drug education. All three communities felt that members of their own communities who were ex-drug users or in treatment would be effective channels

of information. Many South Asian community members saw ex-drug users as the real ‘experts’ and felt that their involvement in the delivery of drug education could help address the issue of the stigma associated with drug users. Members of the Black Caribbean community felt that hearing from ex-drug users could be helpful in inspiring hope among current drug users:

“I need to know some of the success stories of those who were once drug addicts. All we’ve heard is addiction and imprisonment. The story so far has been onesided.” (Fountain 2009b: 30)

The value of involving ex-drug users in delivering education and information was also emphasised by young people from the Black Caribbean community. They had experience of drug education in a school setting and reported that this had been most powerful when delivered by ex-drug users.

Small-scale qualitative research conducted with the Asian Drugs Information Befriending Outreach Project (ADIBOP) in Luton (Bauld et al., 2004) also found that having ex-drug users on the team was valuable. The value lay not only in the unique perspective they were able to provide, but also in the increased credibility their experience brought to the messages being conveyed. This research also highlighted the need for gender-matched drug education deliverers in the Asian community. Male project workers reported the difficulties they had faced in engaging with females in the absence of a female project worker.

Peers and community organisation workers

Fountain (2009a,b,e) reports that South Asian, Black African and Black Caribbean communities felt that peer-delivered drug education could be effective. Among members of the South Asian community, the most frequently suggested peer educators were parents, women and young people (Fountain, 2009e). Many Black Caribbean community members felt that young people receiving drug education saw their peers as more credible than adults as sources of information (Fountain, 2009e).

Among the Black African community, the most commonly suggested deliverers of drug education were community organisation workers who had received the appropriate training (Fountain, 2009a). Members of this community felt that community centres were well attended and that organisation workers were “approachable and willing to talk” (Fountain, 2009a: 26) as well able to communicate in the language of the community and to understand their cultural background. South Asian community members also suggested community

organisation workers as potentially effective deliverers of drug education (Fountain, 2009e).¹⁸

McGrath et al. (2006), in their review of grey literature on drug prevention among vulnerable young people, also report on the success of peer-led projects reviewed by Shiner (2000), which recruited young peer educators from target BME communities and socially excluded areas. They identified a number of benefits. First, in addition to providing formal education sessions, these peer educators often used their informal social networks to distribute drug prevention messages. Second, peer educators were effective in raising awareness about the drug prevention project within target BME communities. Finally, young peer educators were regarded as more credible than adult educators.

The authors remark as well on a number of factors identified by Shiner's review (2000) that were important to realising these benefits. These included the need to provide peer educators with the right information and also to ensure that the support was in place to enable them to deliver formal sessions and facilitate large groups. The development of policies on confidentiality and personal disclosure about drug use and a procedure on when and how to intervene were also recommended.

Outreach workers

South Asian and Black African communities identified the involvement of active outreach workers as potentially helpful (Fountain, 2009a,e). South Asian community members felt that outreach needed to be conducted at early stages and to target young people most vulnerable to drug use. Active outreach work with those 'at risk' of drug use was also reported as an important part of drug prevention work in qualitative research conducted with ADIBOP (Bauld et al., 2004). The project workers reported actively seeking locations where these young people may be 'hanging out', and at the time the research was being conducted a proposal was being developed for targeted work with truants.

Positive role models

South Asian and Black Caribbean community members identified the need for positive role models to get involved in a 'mentoring' or 'buddy' capacity (Fountain, 2009b,e). Some Black Caribbean community members emphasised that the involvement of role models in the delivery of drug education needed to be an

¹⁸ Roy, A. (2009) *An Evaluation of Manchester Drugs and Race Unit's 'Reaching Out' Programme*, which has been included as item 13 on the list of potentially relevant literature in Appendix 7, includes a small evaluation of a programme in which BME community members were trained to deliver awareness raising about drugs and drug services.

ongoing process and not limited to one-off events. Youth workers were suggested as role models and mentors for young people. Black Caribbean participants felt as well that older generation community members had value as mentors and could play a supportive role in times of crisis. South Asian community members felt that the involvement of role models was particularly important for reaching those drug users who had become estranged from their family and friends.

Religious leaders and statutory services

Some South Asian community members, particularly those who felt that abstinence was the only message that drug education should deliver, felt that religious leaders and establishments needed to play a role in tackling drug use. However, the extent to which they were felt to have a role to play in drug education was less clear. Some members of the community felt that religious leaders would not understand the issues involved as they were not regularly involved in community life.

Some community members felt that local drug or health service staff, GPs and police officers could be potentially effective deliverers of drug education (Fountain, 2009e).

Target groups

While drugs education was seen as useful for all, the literature suggests that there are some groups for whom it is felt to be particularly valuable. These include children and young people, parents and women.

Fountain (2009a,b,d,e) reports that the Black African, Black Caribbean, Kurdish, Turkish and Turkish Cypriot and South Asian communities felt that all community members needed to receive drug education and information as this would enable them to support and help drug users and each other. More specifically, these communities agreed that drug education needed to target young people. South Asian communities suggested that drug education should begin at the age of 10 or 11, and Black Caribbean communities felt that young people most vulnerable to drug use – for example, those excluded from school – should be targeted.

South Asian, Black African and Black Caribbean communities agreed that there was also a need for targeted work with parents. ‘Family sessions’ for young people and their parents were also seen as having a role in creating a healthy cross-generational dialogue about drugs. Evidence of targeted work with parents is reported in case study research with ADIBOP (Bauld et al., 2004). The project workers reported that they delivered basic drug education and awareness to parents attending weekly luncheon clubs. At first they faced resistance from parents, who questioned the personal relevance of the information. However, as parents got to

know the project workers, they began as well to take interest in the information they were providing.

Fountain (2009d,e) reports that South Asian and Kurdish, Turkish and Turkish Cypriot communities stressed the importance of drug education for women in their communities, as it is often women who have to deal with the impact of drug use on the family. South Asian community members stressed that women who are particularly 'sheltered' are most in need of drug education. This community felt too that religious leaders and community elders needed education about drugs so that they could advise community members and act as sources of support. Finally, the Black African community (Fountain, 2009a) felt that newly arrived migrants needed to be targeted as recipients of drug education.

REDUCING VULNERABILITY TO DRUG USE

Any approach to reducing vulnerability to drug use needs to take into account the particular group at which activities or initiatives are directed. Many of the approaches discussed in the literature take into account the risk factors pertinent to different groups – for example, limited employment opportunities or a lack of local facilities for young people – and build their suggestions around these factors.

Fountain (2009a,b,d,e) reports that South Asian, Black African, Black Caribbean and Kurdish, Turkish and Turkish Cypriot communities felt that young people's vulnerability to drug use could be reduced by providing diversionary activities that encouraged them to take part in positive leisure pursuits. Suggestions included sports centres and youth clubs. Black Caribbean community members reported that better funding for youth services was needed "to distract them [young people] from drug use" (Fountain, 2009b: 41) and that outreach workers could be employed to attract young people to these activities. Members of the Black African community felt that this kind of activity would help build young people's self esteem and "keep them off the streets and lead[ing] a healthy lifestyle" (Fountain, 2009a: 32).

Two other studies focused on the value of providing activities for young people that would give them positive options to drug use. In a study by the Centre for Ethnicity and Health at UCLAN (2004), young refugees and asylum seekers suggested that community centres were places where young people could be engaged, noting that "there is not much to do, that's why many young people turn to alcohol and drugs (Centre for Ethnicity and Health, 2004: 219). The qualitative research conducted with ADIBOP, a drug prevention and education project in Luton (Bauld et al., 2004), reported using sport and other diversionary activities widely. These were seen as providing a good 'backdrop' for the delivery of drug-prevention messages and as providing young people with new interests.

A number of reports are more explicit in their focus on the risks factors associated with drug use – unemployment and education and training in particular – and include recommendations from BME groups about how these might be addressed. Fountain (2009a,b,d) reports that Black African, Black Caribbean and Kurdish, Turkish and Turkish Cypriot communities felt that unemployment needed to be tackled in order to reduce these communities’ vulnerability to drug use. The Black African and Black Caribbean communities felt that education and training opportunities could help to counteract poor employment opportunities as well reduce young people’s temptation to earn an income by selling drugs. The Kurdish, Turkish and Turkish Cypriot communities felt that more employment opportunities could help prevent drug use because this would mean that young people had “less spare time and more aim in life” (Fountain, 2009d: 27).

Refugees and asylum seekers have identified a range of additional risk factors that they feel, if addressed, would help reduce drug use. These include social exclusion, unstable housing arrangements (including homelessness), difficulties in accessing education and health services and racism and discrimination, all of which have been associated with drug use (McCormack and Walker, 2005; Centre for Ethnicity and Health, 2004).

Summary: Drug education and reducing vulnerability to drug use

- BME communities have a range of suggestions regarding the most appropriate deliverers of drug education. A number of communities felt that drug education messages from ex-drug users or drug users in treatment who were part of those communities would be helpful. Others felt that drug education delivered by peers was potentially effective as young peer educators are regarded as more credible than adult educators. South Asian and Black Caribbean community members felt that there was a need for positive role models to get involved in a 'mentoring' or 'buddy' capacity'. Among the Black African community, the most commonly suggested deliverers of drug education were community organisation workers who had received the appropriate training.
- BME communities generally feel that all community members need to receive drug education and information to enable them to support and help drug users and each other. More specifically, these communities agreed that young people, parents and women need to be targeted as drug education recipients.
- The literature reviewed highlights that BME communities think that drug use can be prevented by the provision of diversionary activities that encourage young people to take part in positive leisure activities. These were felt to make them less vulnerable to drug use. BME groups also recommend addressing the risk factors associated with drug use, particularly unemployment, social exclusion, unstable housing arrangements (including homelessness), difficulties in accessing education and health services and racism and discrimination, all of which have been associated with drug use.

GAPS IDENTIFIED

The following knowledge gaps have been identified:

- There is a significant amount of detail in the literature regarding effective drug education and information provision for a range of BME communities, but there is very little on what works in preventing drug use among these communities.
- The drug education and information provision evidence available focuses primarily on South Asian, Black Caribbean and Black African communities. There is also some material that focuses on Kurdish, Turkish and Turkish Cypriot communities and Chinese and Vietnamese communities. Other ethnic minority groups, in particular those from Eastern Europe, do not appear to be covered in the literature.
- There is little evidence available on prevention, education and information provision relating to specific illegal drug types, and also to khat. There is also very little evidence on what the communities that use khat know about the substance and how this knowledge relates to patterns of use (Nabuzoka and Badhadhe, 2000).
- There is coverage in the literature of the extent of BME groups' knowledge and awareness about drugs, but little on how this knowledge relates to patterns of drug use.
- There is very little coverage of the extent and types of preventative initiatives available to BME communities across the UK. Most of the evidence in this field relates to perceptions of what might work; there is little evaluation of programmes instituted in order to see what has and hasn't worked and why.

5. Impact of drug markets and drug-related enforcement activity

DISPROPORTIONATE POLICING OF BME GROUPS

Although the prevalence of drug use among BME groups is often reported as lower than that among White ethnic groups (as presented above), a number of sources note that drug-related enforcement activities are disproportionately targeted at BME groups, as discussed in this following section.

Ruggiero and Khan (2006) report that disproportionate law enforcement activities directed at certain minority groups may have the unintended effect of creating opportunities for the upward mobility of other groups. For example, attention on West Indian criminal groups may have created ‘vacancies’ which are being filled by British South Asian groups. In the same way, the disproportionate concentration of law enforcement efforts on British Pakistanis may create ‘vacancies’ for other groups. The following section presents statistics on a variety of drug-related enforcement activities.

Drug-related stop and search

In a Ministry of Justice (MOJ) report, Riley et al. (2009) present statistics on the representation in the criminal justice system of members of BME communities in England and Wales (See Table 5). The authors show that across all ethnic groups, suspected drug crime was the most common reason for conducting a stop and search in England and Wales in 2006/07 and 2007/08. Overall, suspected drug crime accounted for 62% of the recorded stop and searches for Asians compared to 51% of the stop and searches for Black people and 42% of the stop and searches for White people.

Asian groups make up 4% of the total England & Wales population and have the lowest prevalence of drug use in the last year (3%). However, they are more likely to be stopped and searched because of suspected drug crime rather than for any other offence (62%). The MOJ analysis provides further detail about which particular groups, in which areas are most targeted by stop and searches carried out on suspicion of drug crime. For example, within the Asian category, suspected drug crime accounted for 70% of the recorded stop and searches for people of Bangladeshi origin, compared to 64% for those of Indian origin and 62% for those of Pakistani origin. This is illustrated in Table 5.

Table 5: Disproportionate drug-related stop and search

Ethnic group	Percentage of stop and searches that are for drug crime*	Percentage of total England & Wales population**	Percentage that report drug use in the last year***
White	42	91.3	10.5
Black	51	2.2	5.8
Asian	62	4.4	3.0
Indian	64	2.0	2.7
Bangladeshi	70	0.5	2.6
Pakistani	62	1.4	2.9

* Source Riley et al., 2009.

** Percentage of total population of England & Wales based on 2001 census figures, available at: <http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=14629>

*** From 2006/07-2008/09 BCS (Hoare, 2010).

There is some regional variation in the percentage of each ethnic minority group stopped and searched. For instance, in the Thames Valley the highest proportion of people to be stopped and searched are of Pakistani origin (74%). The highest proportion of Black Caribbeans (62%) and Black Africans (64%) stopped and searched occurred in Nottinghamshire.

Drug-related arrests

Riley et al. (2009) further present statistics relating to arrests for drugs offences. Overall, such arrests were comparatively less disproportionate towards BME groups than stop and search tactics, which may imply that these acts are not based on good intelligence. Of those arrested for drug offences in 2007/08, 74% were of White origin, 14% were of Black origin and 8% were of Asian origin. Further breakdown of ethnic groups is provided in Table 6, as is comparison with prevalence of drug use and population size.

Table 6: Drug-related arrests 2007/08

Ethnic group	Percentage of total number of people arrested for drug crime*	Percentage of total England & Wales population**	Percentage that have used drugs in the last year***
White	74.4	91.3	10.5
Pakistani	2.8	1.4	2.9
Indian	1.7	2.0	2.7
Bangladeshi	1.4	0.5	2.6
Black Caribbean	6.0	1.0	8.7
Black African	3.3	0.9	3.5

* Source Riley et al., 2009.

** Percentage of total UK population based on 2001 census figures, available at: <http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=14629>

*** From 2006/07-2008/09 BCS (Hoare, 2010).

Exceptions to this picture occur in some regions. For example, in West Yorkshire, West Midlands and Greater Manchester the proportion of arrests of people of Pakistani origin is considerably higher than in the other regions mentioned (14%, 12%, 8%, respectively). The West Midlands has a lower proportion of White British arrests than other regions (51%) and a higher proportion of Black Caribbean arrests than any other region (13%) (Riley et al, 2009: 80–90). However, it should be noted that these variations may relate to differing regional make-ups of ethnic populations.

In their drugs, alcohol and substance misuse needs assessment study of Romani gypsies, Irish travellers and showmen, Taylor et al. (2006) report on the disproportionate number of problems experienced by gypsy travellers after individual arrests on sites. Out of 100 people interviewed about their experiences after an individual's arrest, 78% had further problems including (Taylor et al., 2006: 62):

- being moved on from a stopping place (21%);
- having uninformed members of the group arrested (19%);
- having all caravans in the group searched (14%);
- having a police raid (10%);
- having a social services investigation (7%); and
- having children taken into care (7%).

Past drugs enforcement activities have also included whole group or site raids by the police when one member of a travelling group has been found in possession of drugs. To illustrate the disproportionality of such searches, one informant reported to the researchers: “The gavvers [police] wouldn’t search every house in a road if one man was caught with drugs” (Taylor et al., 2006: 63).

Drug-related sentencing to prison

The MOJ report (Riley et al. 2009) presents findings indicating that BME groups are more likely than White groups to be sentenced to prison for drugs offences. In 2007/08, drug offences accounted for 32% of the recorded prison sentences for people of Chinese and Other origins, 16% for those from Black and Black British origins, 13% for those of Asian and Asian British origins and only 6% for those of White origin.

McSweeney et al. (2008) indicate that research has shown that there are a great deal of negative consequences of conviction, including loss of earnings, damage to relationships and family break-up. They also note that due to this the disproportionality of imprisonment rates for drugs offences among young ethnic minority men raises important questions about the enforcement of drugs laws against particular groups and communities.

Cannabis and policing

In his article considering the reclassification of cannabis, Turnbull (2009) gives several suggestions as to why BME groups tend to be over-represented in the British criminal justice system. These include:

- the over-representation of BME groups in high-crime areas, where stop and search tactics are used more widely;
- the over-representation of BME groups as cannabis users; and
- police targeting of BME suspects in high-crime areas.

The author notes that others have found that following the reclassification of cannabis to Class C, BME offenders were over-represented in cannabis offences. In some areas over half of all contacts with the police and arrests for cannabis were among BME groups. Other research found that the London Metropolitan Police Service appears to find a disproportionately high rate of young Black men in possession of cannabis. This rate is ten times higher than that of their White counterparts, with Black adults being more likely to be arrested and prosecuted than to receive a cannabis warning.

Summary: Disproportionate policing of BME groups

- A disproportionately high level of stop and searches are targeted at BME groups compared with White groups, with those from Asian communities most likely to be affected.
- While lower proportions of individuals from BME groups are arrested for drug offences, they are subject to a higher sentencing rate than their White counterparts.
- Over-representation of BME groups in policing of cannabis and other drugs may stem from the high proportion of BME groups present in high-crime stop and search areas.

DRUG MARKETS AND RELATED ISSUES

Extent of involvement in drug markets (selling drugs)

There is very little high-quality recorded evidence on the extent of BME communities' involvement in drug markets. The OCJS (Sharp and Budd, 2005) asks respondents to indicate whether they have committed a range of offences, including the selling of drugs. It should be noted that this is not an official record of drug selling offences but instead a self-completion survey, which often means that there may be significant under-reporting. The findings should thus be treated with caution. In their analysis of the survey, Sharp and Budd (2005) present their findings on the prevalence of reported drug selling offences ever committed as well as committed over the last year. The authors report that 4% of both White and mixed race respondents reported ever having committed a drug selling offence. In comparison, 1% of 'Asian or Asian British' respondents and 2% of 'Black or Black British' origin reported doing the same, with the difference between the Asian and White groups reported as statistically significant.

The authors also report that there were no significant differences between ethnic groups in prevalence of drug selling offences committed over the last year, with 1% of both White and 'Black or Black British' groups, 2% of mixed race groups and less than 0.5% of 'Asian or Asian British' groups reporting having done so.

As Table 7 illustrates, the findings also indicate that across the ethnic groups men are more likely than women to have sold drugs in the last year. However, there is no indication as to whether these differences are statistically significant.

Table 7: Percentage of males and females who have sold drugs in the last year

	White	Mixed	Asian/Asian British	Black/Black British	Other
Male	2	3	<0.5	1	2
Female	1	1	-	<0.5	1

Source: Sharp and Budd (2005) Table A2.5, p34.

Following Sharp and Budd, <0.5 per cent indicates percentages less than 0.5 per cent but above zero; '-' in tables indicates zero.

Sharp and Budd also report that age standardisation was applied to last year offending, including selling drugs, and that the rate for White respondents was found to be higher than the average, while that for 'Asian or Asian British' respondents was lower than the average. In a recent literature review on strategies to tackle illicit drug markets and distribution networks in the UK, McSweeney et al. (2008) mention the role of ethnicity in domestic drugs market, which is discussed in more detail below. The authors make a passing reference to Vietnamese criminal groups that are an established source of cannabis production on a commercial scale and which often use illegal immigrants 'gardeners', including children, to work on 'factories' or 'farms'. This finding is based on intelligence rather than evidence and should thus be treated with caution.

The role of kinship and ethnicity in drug markets

A number of reports and studies indicate the importance of kinship and ethnicity within UK drug markets (Fountain et al., 2002; Cragg Ross Dawson, 2004; Ruggiero and Khan, 2006; Lupton et al., 2002; McSweeney et al., 2008; Roy et al., 2008). These reports were of low and medium quality and were a combination of small-scale qualitative/quantitative studies and secondary reviews of evidence. It has been noted in the literature reviewed that individuals are more likely to associate with members of the same family, ethnic group or background when it comes to obtaining, supplying, dealing or selling drugs, particularly in lower level local markets. Such relationships can also be linked to the same country, region, village or tribe that individuals may originate from.

Fountain et al. (2002) conducted a detailed study analysing drug use, consequences and correlates among minority groups in different countries, published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). In the UK, participants were drawn from a range of BME community organisations and other individuals with knowledge of drug use issues among BME groups. The authors report that of 43 responses received, 20 respondents agreed that "in some BME communities links between the country of origin and the UK have been used to build

up drug supply networks”, 10 disagreed and 13 did not know (Fountain et al., 2002 :271). An example was given by one informant, who mentioned links in Turkish and Greek Cypriot communities between drug supply networks and political groupings.

Cragg Ross Dawson (2004), in a small-scale scoping study which consisted of interviews with people involved in working with asylum seeker and refugee communities ($N = 10$), report that these communities may become involved in the drugs trade because of their vulnerable situation. They may feel more comfortable making contact with individuals and communities who speak the same language in order to obtain some form of income. In some cases, the newly arrived refugees and asylum seekers may unknowingly undertake drug market activities and be unaware of what they are transporting:

“It may be that when they come here as a new immigrant, they might have a family member or a friend, or they might mix with somebody who is in a gang. Then they could be recruited very easily.” (Community worker from Turkish/Kurdish community)” (Cragg Ross Dawson, 2004: 28)

In other cases, drugs service providers and community workers indicate that children of refugees and asylum seekers are more likely than refugees and asylum seekers themselves to become involved in drugs markets. In particular, lack of English language skills, education or employment and parental presence at home might lead UK-born young people of Turkish, Kurdish, Albanian or Kosovan origins to become part of gangs, as the following quote suggest:

“Our experience shows it is the second generation ... It is those that we are losing (to crime and drug dealing), not the newcomers, because the newcomers have had a lot of problems to prove to the state that they are good citizens, to get the status I have never seen a newcomer being involved in crime or drugs. It's the other generation, the young generation born here, or who came as very small children and are now 16 or 17. This is the problem.” (Community worker from Turkish/Kurdish community) (Cragg Ross Dawson, 2004: 29)

However, it should be noted that this is a very small-scale targeted study, which discusses the opinions and perceptions of those that work with these communities, rather than of these communities themselves. Similar patterns might have been found, had one conducted this same study in a White community.

Local and middle-level drug markets

In their qualitative study with 123 British South Asian drug dealers, drug users and other key individuals from across England and Wales, Ruggiero and Khan (2006)

report that low-level local cannabis markets are held together by some form of cultural homogeneity and a 'common' desire to stay together. They also characterise local-level markets as highly competitive and subject to commercial pressures, which can occasionally lead to violence and arrest: "There is ethnic competition in the market, but only at a low level" (Ruggiero and Khan, 2006: 477). The authors find that with British South Asian groups branching out into other supply markets, such as crack cocaine and heroin, ethnic links in drug markets are loosening and more cross-racial groups being formed.

Cultural homogeneity in local markets has also been described in a report on retail drug markets in eight deprived neighbourhoods in the UK by Lupton et al. (2002). The authors provide evidence, obtained from 32 interviews with the police, drug users and residents, about African-Caribbean street dealers who control the distribution of crack cocaine in a particular neighbourhood. The crack cocaine market is described as an open, static street market, with the selling scene being highly organised and 'business-like'. In the same area, the research indicates that the heroin market is dominated by Asian sellers. In contrast to the crack-cocaine market, the heroin market operated as a closed, highly mobile selling structure, in which all drug sales were arranged by mobile phone and runners were sent to prearranged locations where money and drugs were exchanged. The report found, however, that both crack cocaine and heroin sellers were beginning to diversify and sell other drugs. According to the police, this has led to problems, such as tension and friction between the two selling networks and power struggles, particularly between Asian males and African-Caribbean males.

Ruggiero and Khan (2006) also report that middle-level drugs markets run by British South Asian dealers were well organised and managerially effective when compared with those run by White drug dealers. The researchers also describe violent competition within the British South Asian community, for example drug disputes leading to shootings and kidnappings. They note too that competition within these middle-level drugs markets is based on economic, rather than ethnic, factors. Indeed, when competition prevents a particular dealer from gaining ascendancy, then partnerships with other ethnic groups can be formed. For instance, British South Asian middle-level market dealers develop associations with Turkish networks. The authors also note that middle-level drugs markets can be intermingled with other illicit activities, notably forged banknotes, guns, stolen cars and loan sharking. In addition, some dealers are involved in one-off operations or set up legitimate businesses after accumulating finances through drugs, such as restaurants, music shops, security firms, and painting and decorating companies.

McSweeney et al. (2008), in their review of recent literature on drug markets, summarise the UK market as having two types of distribution systems, a structured,

pyramidal one and a more fragmented, non-hierarchical and entrepreneurial free market. They indicate that ethnic groups involved in the UK drugs market appear to be shifting more towards the second type of distribution market. In this model, historical affiliations and ties with hierarchical structures seem to be less important for some ethnic groups, and more open and entrepreneurial distribution networks are composed of individuals who lack any formal connections with traditional syndicates. The authors also refer to earlier work by Ruggiero and South (1995) (not viewed), which suggested that roles within the UK drugs market may be divided along racial lines, with the more precarious and poorly paid work being undertaken by young Black males.

In a qualitative study involving 130 participants (including drug users, drug dealers, professionals and community workers and others) about BME communities and drug supply, Roy et al. (2008) present an overview of the main groups involved in street-level drug supply in Bolton. Such groups include South Asian and Jamaican street-level suppliers. Members of South Asian communities form cooperatives, small close-knit groups formed through kinship ties, who supply one or more drugs on the street. Those involved in the cooperatives do not appear to be problematic drug users themselves and are predominantly young people, often first-time offenders, who still live at home. Involvement of other older family members is rare, and only seems to be for investment purposes. Generally, it seems that young people of South Asian origin involved in street-level drug supply in Bolton have had bad experiences within the education system. In contrast, Jamaican street-level suppliers tend to be London-based, travelling to Bolton as and when necessary, and rotate those that are involved in street-level supply. In this way, Jamaican groups supplying drugs in the Bolton area do so in a more discreet and cautious manner.

Drug trafficking

Regarding international drug trafficking, Ruggiero and Khan (2006) report that British South Asian networks are associated with cocaine and heroin markets in Holland, as well as heroin supplies from Turkey (with raw material coming from Afghanistan). British South Asian networks can act as importers, wholesalers and retailers at the same time, supplying to long-term customers. The authors suggest that traffickers from this group tend to avoid the overcrowded markets of Holland and buy substances directly from Turkey, where prices are even cheaper.

McSweeney et al. (2008) identify that Turkish traffickers continue to dominate the supply of heroin to the UK, while Pakistani traffickers are primarily involved in trafficking heroin from Pakistan to the UK using direct transport and trade links. Other observations include those traffickers of White British origin who source their supplies of cocaine powder from Spain and Holland. The authors also note

that British-born traffickers of West Indian origin are involved in supplying powder cocaine intended for the UK crack cocaine market. They have also become active in selling heroin alongside crack cocaine. Finally, the researchers mention that the UK synthetic drugs market is dominated by White British, Dutch and Belgian criminals.

In *The United Kingdom Threat Assessment of Organised Crime* report produced by the Serious Organised Crime Agency (SOCA) (2009), Turkish, Kurdish and South Asian criminals are again referred to as the major traffickers of heroin in the UK. More specifically, criminals from Pakistan and South Asia control heroin supply and distribution in North England and the Midlands, exploiting family and ethnic ties in order to “enter at higher levels of the trade” and obtain the commodities required for trafficking and distribution (SOCA, 2009: 38).

Summary: The role of kinship and ethnicity in drug markets

- It has been noted in the literature reviewed that individuals are more likely to associate with members of the same family, ethnic group or background when it comes to obtaining, supplying, dealing or selling drugs, particularly in lower level local markets. Such relationships can also be linked to the same country, region, village or tribe that individuals may originate from.
- Ethnic links and cultural homogeneity are important in the running of low-level, street-level and middle-level markets. These types of market are run mostly by members of South Asian or African-Caribbean communities, who supply cannabis, cocaine, heroin and crack cocaine. The markets run in a business-like manner, with buying and selling of drugs often taking place via mobile phone and with the use of runners to distribute the goods. In some cases, drug markets are associated with other profit-making illicit activities.
- Links with the country or area of origin are used by BME groups for the trafficking of drugs to be sold in the UK. As such, 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.

Reasons for involvement in drug markets

In a qualitative study with 123 British South Asian drug dealers, drug users and other key individuals from across England and Wales, Ruggiero and Khan (2006) present evidence demonstrating that only a small number of British South Asian individuals are involved in drug markets to finance a drug habit. According to their findings, the majority of those who get involved do so to make a living, for profit, or to repay loans, and tend not to use the drugs that they sell or deal.

Roy et al. (2008) report on the motivations of young South Asian individuals seeking to get involved in small tight knit 'cooperatives' that sell drugs in Bolton. They identify the following motives: to make money in a short length of time to pay off debts, or to pay their way through college; to achieve a particular lifestyle; and to gain status in the community/society.

Fountain (2009b) reports that community groups consulted with as part of the Department of Health's needs assessment project reported that Black Caribbean communities rarely partake in drug dealing and selling to finance their habit. They state that some young people of Black Caribbean origin are encouraged by their parents, who are users, to sell crack cocaine or "do favours for the crack dealers", to ensure a continuous supply for the parents. However, the young people are aware of the problems associated with crack cocaine and so do not use the drug themselves. Drug dealers from Black Caribbean origin profit from the selling of drugs to buy items such as expensive jewellery, cars, designer clothes, and music.

Fountain (2009b) also describes how community groups consulted with felt that a lack of educational achievement and unemployment can lead young people of Black Caribbean origin to sell drugs. This can be an attractive option for young people to make a living, as mentioned above, and to alleviate the boredom of unemployment. Similar results were reported by Ruggiero and Khan (2006) in their study of British South Asian drug dealers. The authors report that the majority of dealers with whom they had spoken had experienced instability, low wages and unrewarding or menial occupations and had first encountered drug dealing while engaged in other semi-legitimate income raising activity.

Impact of drug markets on communities

Impact of involvement

Fountain (2009a,b,e), in the series of reports produced for the Department of Health's needs assessment project, describes how some of the BME community groups consulted with voiced their concerns regarding the drug dealing and markets in their local areas. These included drug-related crime, family breakdown, public safety, damage to the reputation of the community and local area and the spread of drug use. However, it is important to note that these views are those of particular community groups or members and are not necessarily representative of the wider communities.

A separate study conducted by Fountain et al. (2002), which consulted with a range of BME community organisations and other individuals with knowledge of drug use issues among BME groups ($N = 43$) as part of a wider European project, shows 'strong involvement' of Bangladeshis in the importation of heroin, which

has led to its use spreading among this community and to a growth in concern about its effects. The authors mentioned that drug dealing by Bangladeshis has an 'unhealthy influence' within some impoverished communities, because drug dealers' conspicuous wealth makes selling drugs an attractive economic proposition for others.

Impact of 'exaggerated' perceptions of BME involvement in drug markets

McSweeney et al., in their review of literature on drug markets (2008), reported that evidence suggested that disproportionate representation in media coverage can have an impact on certain minority groups. In particular, coverage linking Black boys and men with drugs can have a detrimental effect on the aspirations of members of this group.

In her series of reports for the Department of Health's needs assessment project, Fountain (2009d) reports that some community groups consulted with felt that the media 'sensationalise' drug-related crime involving Kurdish, Turkish Cypriot and Turkish communities. This in turn can result in exaggerated perceptions of the extent of drug-related crime within these communities, particularly if the information is transmitted by gossip.

In a separate report, evidence provided by Fountain et al. (2002) indicates that more than half the respondents involved in work with BME groups (community organisations, researchers etc.) feel that they are over-represented in the statistics on drug-related arrests (58%, 25/44 agreed). The same trend was found concerning Black Caribbean groups, with 56% (20/36) of respondents agreeing that they are over-represented in drug-related statistics. However, only a third (33%, 13/39) of respondents agreed that this is the case for Black Africans.

Concern regarding exaggerated perceptions about the involvement of BME groups in drug markets was also reported by Fountain et al. (2007) in their qualitative study consisting of eight focus groups and 12 interviews with members of Turkish and Jamaican communities and professionals who work with them in the London boroughs of Lambeth and Haringey. Their research shows that these communities perceive that they are being disproportionately affected and harmed by perceptions of them as drug suppliers and by action against drug suppliers. Because criminal intelligence reveals that members of Jamaican and Turkish communities are involved in the supply of crack cocaine and heroin, activity against drug supply is targeted disproportionately at these communities. In addition, the stop and search strategy is seen to unfairly target members of these communities due to racism and stereotyping.

Summary: Reasons for involvement in drug markets and impact on communities

- Several studies report that BME involvement in drug markets is rarely undertaken to finance a personal drug habit. In most cases, such involvement is to make money to fund education, repay loans or debts, or to afford designer clothes, cars and accessories.
- The impacts of involvement in drug markets on communities include drug-related crime, family breakdown, public safety, damage to the reputation of the community and the spread of drug use among the community.
- The media is criticised for its disproportionate representation and sensationalisation of BME involvement in drug markets.

GAPS IDENTIFIED

The following knowledge gaps have been identified through this review:

- There appears to be more information available on Asian, Black and Turkish ethnic groups than on any other minority ethnic groups present in the UK. More information needs to be collected on the involvement of other groups in drug markets and as the focus of enforcement activities.
- There is a lack of information on prevalence and the impact of drug enforcement activity relating to different types of drugs and types of offences committed.
- There is a lack of large-scale studies about drug market activities among BME groups across the UK. Studies and research focus on very small groups of respondents and informants, and there is a lack of comparison with White communities. Wider studies need to be conducted to enable an informed view of national trends.
- Another area to be researched, which could add to the evidence on drug use among BME groups, is the cultivation of drugs for personal use. For example, the Cragg Ross Dawson scoping study (2004) mentions that migrants from Iran, Afghanistan and Pakistan extract opium from poppies on railway embankments in London.
- Fountain (2009a) reports that Black African communities consulted with suggested that there is a need for more research that focuses on Black African women acting as 'mules' to bring illicit drugs into the UK.

6. Conclusions

This review has highlighted a number of areas where further research into the use of drugs, including alcohol, by black and minority ethnic (BME) people would be valuable. One of the most basic is gaining a more accurate picture of the size, profile and needs of this population. There is significant variability in the robustness of both the quantitative and qualitative material included in this review. Differences such as the definition of particular groups studied and who is included within a group and in the timescales over which drug use is measured make it difficult and inappropriate to make inferences based on comparisons across studies. Despite these limitations, the review does indicate that prevalence of use is highest among people of mixed race – although to a certain extent this is due to its younger age profile – and is lowest among Asians.

Some of the reasons for drug use among BME groups appear common across different communities, while others are more specific – not only to particular BME groups, but also to drug types. Reasons for use that are more specific to particular groups include cultural attitudes and practices, such as khat chewing among Somali communities, smoking cannabis among Black Caribbean Rastafari, and cocaine use by Romani Gypsies, Irish Travellers and showmen. Cultural differences between particular communities and more mainstream Western youth culture are also important. These are seen by some South Asian communities as a factor in drug use among young people, who are seeking to assimilate and may be resistant to ‘traditional’ values.

In addition to these cultural factors, economic and social issues appear to play an important role. In the study by Bashford et al. (2003) for the Department of Health, community organisations suggest that economic deprivation, poor housing, limited employment and leisure opportunities might all be influential in use, particularly as availability is likely to be higher in these areas.

The combination of the factors influencing patterns and prevalence of drug use among BME groups is complex and research investigating the interaction of these different factors might be valuable. This kind of research might provide useful information about the types of intervention or services that would best address the needs of particular communities.

Use of many mainstream drug treatment services is often lower among BME communities than among the wider general population, but it is not clear to what extent this is due to lower levels of drug use. Drugs services might learn from some of the existing knowledge about how to engage with particular groups. This might be particularly important when seeking to address hidden use – for example, khat use among South Asian women, which is often done in isolation, in the home. Identifying local community groups that already have a relationship with these women – particularly when these are health-focused – would help to ensure that discussions about drug use can take place with minimal risk to the women themselves of being stigmatised as users.¹⁹

Accessible information is crucial – but at present it seems we know little about how knowledge about drugs relates to levels and patterns of use among BME communities. Low levels of literacy or limited use of English among some populations mean that methods such as group sessions and visual media are more likely to be effective than written materials. Involving members of the community in question – particularly ex-drug users – to deliver messages appears to be particularly important. This can help both in validating the messages themselves and perhaps help reduce the reluctance among these communities to admit to drug problems and seek advice and support. The stigma associated with drug use appears very strong among a number of BME communities, so messages about drugs that come from within the community, encouraging more open discussion and providing information on services, appear to be important. The nature of the messages that communities perceive would be effective – for example, harm reduction or abstinence – appears to vary across groups.

A number of the studies reviewed report that the prevalence of drug use among BME groups is lower than that among White ethnic groups. However, it seems that drug-related enforcement activities are disproportionately targeted at certain BME groups. The statistics published by the MOJ (Riley et al., 2009), shows that, across all ethnic groups, suspected drug crime was the most common reason for carrying out a stop and search in England and Wales in 2006/07 and 2007/08. And although levels of arrest for drug-related crime are less disproportionate, BME groups are subject to a higher sentencing rate than White arrestees.

Greater insight into the reasons for the disproportionate number of stop and search activities and arrests involving people from BME communities, and the relative importance of different reasons, would be valuable. This applies to stop and search and arrests and also to the impact on a wider community of the arrest of one of

¹⁹ For example, the Women's Health and Family Services in Tower Hamlets works to address the unmet health education and welfare needs of ethnic minority women and their families who are resident in Tower Hamlets and the surrounding boroughs. <http://www.whfs.org.uk/>.

its members. This is highlighted in the study of Romani Gypsies, Irish Travellers and showmen by Taylor et al. (2006), which lists whole-site raids, being moved on and social services interventions as some of the consequences of the arrest of one person. Given what is known about some of the factors that make young people, in particular, vulnerable to drug use, these tactics might not be helpful in reducing use over the longer term.

The study by Ruggiero and Khan (2006) suggests that disproportionate law enforcement activities directed at particular minority groups might create gaps in the market that are exploited by other groups. The literature reviewed suggests that ties based on ethnic or family background are important factors influencing the dynamics of low-level, street-level and middle-level markets. This can mean that the entry of a small number of people from a particular background into a new market is likely to have implications for the wider community from which they come as well. As Roy et al. (2008) show in their study, income from drug markets might be used to fund education or repay loans or debts. These could be seen as positive benefits not just for the individual, but possibly for the wider community as well. Understanding the geography of drugs markets better – for example, whether people live near to the low-level and street-level markets in which they operate – might be useful in helping us to understand whether the perception of involvement in the drugs market and its impact on a particular community are affected in anyway by trade being carried at a distance, with customers from a different community. How are what might be seen as positive benefits weighed against such things as damage to reputation and wellbeing of the community and the local area?

The literature reviewed suggests that policing alone cannot address drug use and involvement in drug markets. A more comprehensive approach appears necessary, one that is informed by rigorous research and takes into account the wider social and economic factors that studies suggest are implicated in drug-related activities. Understanding more about how stigma works in relation to drugs might also be useful. For example, does the stigma attached to using drugs apply with equal strength to selling them? To what extent is it mitigated, if at all, by income generated through drugs markets that might have benefits for the wider community? A greater understanding of this might have strategic value for citizen-focused policing, for example, which seeks to embed policing within communities.

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Appendix 1. Search terms used

BROAD SEARCH TERMS

<p>Group 1: Drug (s) Substance Narcotic (s)</p>	<p>Group 3: <i>(This group of terms is likely to be picked up by searching for Group 1 and Group 2 terms)</i> Preval (ent, ence) Pattern (s) Behaviour (s)</p>
<p>Group 2: Use (abuse, misuse) Problem (s) Addict (s, ion, ed) Depend (ence) Habit</p>	<p>Group 4: Ethnic (ity) Race Minorit (y, ies) Asian Afr (ican, o) Carribbean Europe (an)</p>

Appendix 2. Database search results

	Databases searched	Search date	Search terms	Search date range	Items identified	Items exported by searcher	Comments
1	SPP	13/10/09	((ethnic minorit* or minority communit* or Asia* or afric* or afro* or polish or rumani* or alban* or eastern europe*) and ((drug or substance or narcotic*) and (abuse or misuse))) not (America* or china or south Africa or far east).	1999 – 2009	142	142	80% on Reviews 1 & 2 (trends, prevalence, treatments needs, service provision, dug education / information provision, community / peer approaches, guidance and good practice interventions– good coverage of BME groups 20% on Review 3 (markets and enforcement) – good coverage of BME groups BME groups: South Asian; African Caribbean; Black African Sources: Journal articles; books; Home Office; DSD, NACRO, NTA Areas: London, Yorkshire, Leeds, Manchester, Birmingham
2	HMIC – 1	14/10/09	(((((ethnic adj minorit*) or minority) adj communit*) or Asia* or afric* or afro* or polish or rumani* or alban* or eastern europe*) and ((drug or substance or narcotic*) and (abuse or misuse))) not (America* or china or australi* or south Africa or far east))	1999 – 2009	30	23	100% on reviews 1 & 2 (prevalence, trends, local prevention programmes) Significant duplication of relevant results (from SPP search) 25% new relevant material: London, Lancashire, Nottingham, European schools survey project

	Databases searched	Search date	Search terms	Search date range	Items identified	Items exported by searcher	Comments
3	HMIC – 2	14/10/09	((black and ((drug or substance or narcotic*) and (abuse or misuse))) not (America* or china or australi* or south Africa or far east))	1999 – 2009	23	22	60% duplication from previous searches 10% new relevant material (Review 1 and 2 – prevalence and service/ treatment needs) BME groups: South Asian; ‘BME’; ‘ethnic differences’
4	CommunityWise –1	14/10/09	Ethnic minorit* and (drug* or substance*)	All	11	11	80% pre-1999 Ethnic group differences in drug use and needs (1) Bexley crime and disorder audit (1) A handful of international documents
5	CommunityWise – 2	14/10/09	Ethnic minorit* and (drug* or substance*) not America* or china or australi* or south Africa or far east))	All	30	22	90% pre-1999 material Local homelessness and CYP strategies

	Databases searched	Search date	Search terms	Search date range	Items identified	Items exported by searcher	Comments
6	CJA	15/10/09	ethnic adj minorit* or minority adj communit* or afro* or pol* or rumani* or alban*) and ((drug or substance or narcotic*) and (abuse or misuse)) and (england or wales or scotland or united kingdom or London or liverpool or birmingham)) not (America* or china or United adj states or south adj Africa or japan* or usa or far adj east)	1999 – 2009	141	108	50% – arrest referral schemes, DTOs, enforcement, probation, reoffending, criminal justice interventions, drugs in prison – very little overlap with BME groups 35% – Drugs and rape/crime / homelessness/driving/sex workers etc – no overlap with BME groups 5% – Recreational drug use – no overlap with BME groups 5% – Drug policy 5% – Drug markets – very little overlap with BME groups Geographical focus is Scotland
7	ERIC, Social Services Abstracts, Sociological Abstracts	15/10/09	((ethnic adj minorit* or minority adj communit* or afro* or asia* or polish or rumani* or alban*) and ((drug or substance or narcotic*) and (abuse or misuse)) and (england or wales or scotland or united kingdom or London or liverpool or birmingham)) not (America* or china or United adj states or south adj Africa or japan* or usa or far adj east)	1999 – 2009	62	18	A number of irrelevant studies on self harm 2 relevant studies on Bangladeshi communities 1 relevant study on Black drug use and trafficking A few duplications

Databases searched	Search date	Search terms	Search date range	Items identified	Items exported by searcher	Comments
8 NCJRS	15/10/09	((ethnic adj minorit* or minority adj communit* or afro* or asia* or polish or rumani* or alban*) and ((drug or substance or narcotic*) and (abuse or misuse)) and (england or wales or scotland or united kingdom or London or liverpool or birmingham))	1999 – 2009	22	11	Some duplicates 1 relevant article on ethnic differences in drug use in London 1 relevant article on heroin market and Asian community in London 1 relevant article on ethnic group drug needs in Glasgow
9 Web of Knowledge	16/10/09	((ethnic adj minorit* or minority adj communit* or afro* or asia* or polish or rumani* or alban*) and ((drug or substance or narcotic*) and (abuse or misuse)) and (england or wales or scotland or united kingdom or London or liverpool or birmingham)) not (America* or china or United adj states or south adj Africa or japan* or usa or far adj east)	1999 – 2009	17	14	A number of irrelevant articles on psychosis services and psychiatric patients A few general articles on drug prevention and treatment – no overlap with BME groups A few articles on ethnic differences in drug use prevalence (some duplicates)
10 Embase & Medline	16/10/09	(((((ethnic adj minorit*) or minority) adj communit*) or afro* or asia* or polish or rumani* or alban*) and ((drug or substance or narcotic*) and (abuse or misuse)) and (england or wales or scotland or united kingdom or Leicester or Bradford or London or liverpool or birmingham)) not (((((America* or china or United) adj states) or south) adj Africa) or japan* or usa or far) adj east))	1999 – 2009	35	26	Considerable duplication A few new articles on prevalence and ethnic differences 1 article on access to services by Asian community 1 article on drug markets

	Databases searched	Search date	Search terms	Search date range	Items identified	Items exported by searcher	Comments
11	PsychInfo	16/10/09	(((((ethnic adj minorit*) or minority) adj communit*) or afro* or asia* or polish or rumani* or alban*) and ((drug or substance or narcotic*) and (abuse or misuse)) and (england or wales or scotland or united kingdom or Leicester or Bradford or London or liverpool or birmingham)) not (((((America* or china or United) adj states) or south) adj Africa) or japan* or usa or fat) adj east))	1999 – 2009	7	5	Some duplication 1 relevant article on counselling for South Asian and African and Caribbean groups
12	ASSIA	16/10/09	(ethnic minorit* or ethnic communit*) and (drug abuse or substance abuse)	1999 – 2009	29	17	75% International material 25% duplicates
13	Scopus	19/10/09		1999 – 2009	350	55	85% of material is irrelevant and focuses on a broad range of literature including: HIV & drugs, drug related deaths in Scotland, drug use methods, hepatitis c etc Relevant material duplicates material already identified
14	Drugscope 1 + 2	19/10/09	Ethnic, Black, United Kingdom	1999 – 2009			Considerable amount of relevant material Communities: Greek, Bangladeshi, Somali, Asian, Vietnamese, Turkish Focused on local prevention services/ programmes and people in: Birmingham, Tower Hamlets, Hackney, Sheffield, Islington, Bradford Areca nut use, khat use A number of reports from UCLAN Some material on drug markets but nothing on enforcement

	Databases searched	Search date	Search terms	Search date range	Items identified	Items exported by searcher	Comments
15	Drugscope 3	27/10/09	Ethnic, enforcement, UK	1999 – 2009	20	15	Some international material A number of relevant studies that are duplicates New study: threat assessment from NCIS
16	CJA	27/10/09	ethnic and (drug* or substance*) and enforce*	1999 – 2009	36	15	80% international material A few relevant duplicates
17	NPIA website	27/10/09	Drug enforcement and ethnic minorities	1999 – 2009	18	9	Some irrelevant material Some duplication 2 new articles on enforcement

Appendix 3. Advisory group members/experts consulted with

Advisory group members

Haleh Afshar (chair), UKDPC Commissioner
Paul Turnbull, Institute for Criminal Policy Research, Kings College London
Karim Murji , Faculty of Social Sciences, The Open University
Annette Dale Pereira, UKDPC Commissioner
Kate Davies, Assistant Director Strategy, Equality and Diversity – NCTPCT / UCLAN
Kath Browne, University of Brighton
Lawrence Taggart, School of Nursing, University of Ulster
Harry Sumnall, Centre for Public Health, Liverpool John Moores University
Howard Meltzer, University of Leicester
Sara Skodbo, Principal Researcher, CDAR, Home Office

Other experts consulted with:

Gordon Hay, Senior Research Fellow, Centre for Drug Misuse Research, University of Glasgow
Mike Ashton, Drug and Alcohol Findings, London
Monty Moncrieff, Hungerford Drug Project, Turning Point, London
Jane Fountain, Professor of Substance Use Research, International School for Communities, Rights and Inclusion (ISCRI), University of Central Lancashire
Gareth Hewitt, Head of Substance Misuse, Strategy Implementation & Finance Team, Welsh Assembly Government
Sandie Saunders, Strategy and Commissioning Manager, Drugs and Alcohol, Bolton Home Office Equalities Forum

Appendix 4. Data extraction sheet

Note page numbers in brackets when referencing

Record findings by group

Title	
Author(s)	
Date published	
ID Number (from spreadsheet)	
Date document analysed by OPM	
Content Overview (from abstract)	
Methodology – consider the research questions/ hypotheses posed; the research design; the sampling strategy (including sample size and response rates in quantitative research); the nature and quality of the fieldwork; the process of analysis; and the nature and robustness of findings.	
Quality Assessment (TBD)	
Sector background of published document – (e.g. academic discipline, health, policy guidance, think tank, research centre, charity etc)	
Sample group(s) discussed , e.g. ethnic group age gender sexuality faith disability nationality or national background	

Geographical focus	
Evidence/information relating to Review 1: Prevalence and patterns of drug use within different ethnic groups	
<p>Prevalence – Quantitative (or qualitative) evidence about: the number/percentage of people with drug misuse problems across different minority ethnic groups change over time comparisons across groups <i>(Record findings by ethnic group)</i></p>	
<p>Patterns: Quantitative or qualitative evidence about BME groups' drug use across: e.g., drug types drug use methods regions gender deprivation/socio-economic class frequency of use length of time of use reasons for use etc Also note change over time and comparison across groups <i>(Record findings by ethnic group)</i></p>	
Evidence/information relating to Review 2: Drug prevention and information provision for different ethnic communities	
<p>Extent and types of preventative work specifically with BME groups, including: drug prevention drug education and information provision work <i>(for example, school based, community based, public campaigns, sole preventative focus or combined with other interventions etc)</i> <i>(Record findings by ethnic group)</i></p>	

<p>What works, in drug prevention, education and information provision for BME groups? Can include: Evaluations/reviews of effectiveness of specific BME prevention/information provision work, or general prevention work that is working well with BME groups 'Good practice' identified 'Needs' identified <i>(Record findings by ethnic group)</i></p>	
<p>Evidence/information relating to Review 3: The interaction and impact of drug markets and drug-related enforcement activity on different ethnic minority groups</p>	
<p>BME groups involvement in drug markets (trafficking and supply) Note different levels of involvement: Traffickers, wholesalers, street dealers, middle market etc <i>(Record findings by ethnic group)</i></p>	
<p>Prevalence/Impact of drug enforcement activity on BME groups: stop and search arrest sentencing other enforcement activities <i>(Record findings by ethnic group)</i></p>	
<p>Research gaps identified</p>	
<p>Policy implications identified</p>	
<p>Key conclusions of study</p>	
<p>Additional references to obtain <i>(add to spreadsheet)</i></p>	

Appendix 5. Quality standards for review

1. Census Bureau Standard: Minimal Information to Accompany any Report of Survey or Census Data

1. The organizational sponsor(s) of a survey;
2. The organization(s) that conducted it;
3. The wording of questions asked and description of derived measures that are the subject of the report;
4. A definition of the population under study, and a description of the sampling frame used to identify this population;
5. A description of the sample design;
6. The size of sample, and disposition of sample cases (e.g., numbers of interviewed cases, ineligible cases, and nonresponding cases);
7. If applicable, information on eligibility criteria and screening procedures;
8. A discussion of the statistical precision of the results, at least for the major estimates. This could include estimates of sampling variances, standard errors, or coefficients of variation, or presentation of confidence intervals;
9. Description of estimation procedures, including weighting, editing, and imputation methods;
10. If applicable, clear indication of which results are based on parts of the sample, rather than on the total sample;
11. Method and dates of data collection;
12. Discussion of nonsampling errors that may (or are known to) affect the data; and
13. Discussion of methods employed to ensure data quality.

2. EPPI Centre – Qualitative research quality standards

1. Aims clearly stated
2. Context of study clearly described
3. Sample clearly described
4. Methods clearly described
5. Attempts to establish reliability and/or validity of data analysis

Appendix 6. Material reviewed

Author	Title	Published by	Date	Sample information	Quality assessment score
Adfam	Becoming visible: The Somali community and substance use in London	Adfam	2009	5 focus groups with Somali community in London (N=46)	Qual: 3,5; Medium
Aust, Rebecca and Smith, Nicola	Ethnicity and drug use: key findings from the 2001/2002 British Crime Survey	Home Office	2003	N=22,742 BME= 341 mixed, 1,832 Asian, 1,18 4lack and 448 Chinese/other	Quant: 10.5; Medium
Bashford et al	The Department of Health's Black and Minority Ethnic drug misuse needs assessment project: community engagement. Report 2: The findings.	University of Central Lancashire. Centre for Ethnicity and Health	2003	47 BME community groups consulted with	Sec: 4.5; High
Bauld et al.	Drug Prevention for Vulnerable Young People in England: Final Report	Report submitted to the Department of Health	2004	Case study of ADIBOP – Prevention programme in Luton 14 interviews 7 focus groups	Qual: 5; High
Boreham et al.,	The Arrestee Survey 2003 – 2006	Home Office	2007	72 custody suites, N=8027 BME=14%	Quant: 10.5; Medium

Author	Title	Published by	Date	Sample information	Quality assessment score
Borrill et al	Differential substance misuse treatment needs of women, ethnic minorities and young offenders in prison: prevalence of substance misuse and treatment needs.	Home Office	2003	N=301 women White:190 Black/mixed:111	Quant: 8; Low
Buffin et al	Khat: current views from the community around the UK: Findings from Community Engagement Forums	National Drugs & Race Equality Coalition	2009	5 forums with Somalis, Yemenis, Ethiopians in West London, Northampton, Manchester, Birmingham, Bristol N=~100	Qual: 3; Low
Centre for Ethnicity and Health, Faculty of Health, UCLAN	Young Refugees and Asylum seekers in Greater London: Vulnerability to problematic drug use	Greater London Authority, City Hall, The Queens Walk, London SE1 2AA	2004	N=67 refugees and asylum seekers	Qual: 4.5; High
Cottew, Gillian and Oyefeso, Adenekan	Illicit Drug Use among Bangladeshi Women Living in the United Kingdom: An Exploratory Qualitative Study of a Hidden Population in East	Drugs: Education, Prevention and Policy, vol. 12, no. 3, pp. 171-188	2005	N=8 Bangladeshi women Age: 20-32	Qual: 3; Low
Cragg Ross Dawson	Drugs Scoping Study: Asylum seekers and refugee communities report	London: Home Office.	2004	N=10 interviews with people who work with asylum seekers and refugees	Qual: 2.5; Low
Croucher R and Islam S.	Socio-economic aspects of areca nut use.	Addiction Biology, 7(1) (pp 139-146),	2002	NA	Sec: 4; Medium

Author	Title	Published by	Date	Sample information	Quality assessment score
Ewetuga et al	Cracking it: report of the community-led research project focusing on black and minority ethnic parents, carers and young people's experience and exposure to illegal drugs and access to local drug agencies in the Vassal Ward in the London Borough of Lambeth.	[London]: Olmec, 2005. 68p.	2005	N=218 African, Caribbean and White young people Age:10-25 years	Quant: 6; Low
Fernandez J	Patterns in use: a study on routes of administration of Asian drug users.	Journal of Substance Use. 7(2), June 2002, pp.100-104. 2002	2002	NA	Sec: 3; Low
Fountain et al	EMCDDA Scientific Report Update and complete the analysis of drug use, consequences and correlates amongst minorities – Volume 2 – Country profiles	EMCDDA	2002	N=43 responses from BME community organisations and other individuals with knowledge of drug use issues	Quant: 8.5; Medium
Fountain et al.	Black and minority ethnic communities in England: a review of the literature on drug use and related service provision	National Treatment Agency for Substance Misuse	2003	NA	Sec: 4.5; High
Fountain et al	Sources of support for members of communities identified with the supply of illicit drugs: a pilot study of Jamaican and Turkish communities in London	UCLAN, Centre for ethnicity and health	2004	8 focus group; 12 interviews with members of Turkish and Jamaican communities and professionals who work with them in Lambeth and Haringey	Qual: 4; Medium

Author	Title	Published by	Date	Sample information	Quality assessment score
Fountain, et al	Stop and search or stop and engage? Factors influencing community-police engagement around drug supply issues.	Drugs and Alcohol Today, Vol. 7 no. 3, 2007, p.37-45. 10p.	2007	8 focus group; 12 interviews with members of Turkish and Jamaican communities and professionals who work with them in Lambeth and Haringey	Qual: 3; Low
Fountain, Jane	Issues surrounding drug use and drug services among the Black African communities in England	NTA	2009a	NA	Sec: 4; Medium
Fountain, Jane	Issues surrounding drug use and drug services among the Black Caribbean communities in England	NTA	2009b	NA	Sec: 4; Medium
Fountain, Jane	Issues surrounding drug use and drug services among the Chinese and Vietnamese communities in England	NTA	2009c	NA	Sec: 4; Medium
Fountain, Jane	Issues surrounding drug use and drug services among the Kurdish, Turkish Cypriot and Turkish communities in England	NTA	2009d	NA	Sec: 4; Medium
Fountain, Jane	Issues surrounding drug use and drug services among the South Asian communities in England	NTA	2009e	NA	Sec: 4; Medium
Harocopos, et al	On the rocks: Follow-up study of crack users in London	London: South Bank University. Criminal Policy Research Unit	2003	N=100 White:53 Black:36 Mixed race: 9 Asian: 2	Qual: 4; Medium

Author	Title	Published by	Date	Sample information	Quality assessment score
Havell, Cathy	Khat use in Somali, Ethiopian and Yemeni communities in England: issues and solutions	Drugs Strategy Directorate, Home Office, 2 Marsham Street, London SW1P	2005	45 interviews and 11 focus groups with Somali, Yemeni and Ethiopian community members	Qual: 3.5; Medium
Holloway, Katy R. and Bennett, Trevor H.	Ethnic Group Differences in Drug Misuse Among Arrestees in the United Kingdom	Journal of Ethnicity in Substance Abuse vol.7 no.2 p.214 -236	2008	N=4645 White:80% BME:20%	Quant: 9; Medium
Hoare, J.	Nationally representative estimates of illicit drug use by ethnicity, 2006/07-2008/09 BCS	Home Office	2010	N=85,383 White: 885 Mixed: 1% Asian or Asian British: 6% Black or Black British: 3% Chinese/Other: 2%	Quant: 11.5; High
Jayakody et al	Illicit and traditional drug use among ethnic minority adolescents in East London	Public Health, vol 120, no 4, April 2006 p 329-338 ISSN	2006	N=2789 11-14 year olds from 28 schools 25% Bangladeshi, 21% White British, 10% Black African, 9% Asian Indian, 7% Pakistani, 7% Mixed ethnicity, 6% Black Caribbean, 6% White other, 4% Black British and 4% other ethnic groups	Quant: 12.5; High
Kalunta-Crumpton Anita	Problematic drug use among 'invisible' ethnic minorities.	Journal of Substance Use. 8(3), September 2003, pp.170-175.	2003	N=86 members of Portuguese and Italian communities	Qual: 1.5; Low

Author	Title	Published by	Date	Sample information	Quality assessment score
Lupton et al	A rock and a hard place: Drug markets in deprived neighbourhoods.	London: Research Development and Statistics Directorate, 82 pp.	2002	32 interviews with the police, drug users and residents	Qual: 4; Medium
McCormack M., Walker R	Drug prevention for young asylum seekers and refugees: a review of current knowledge.	London: Mentor, 2005. 26p	2005	NA	Sec: 3; Low
McGrath et al.	Review of grey literature on drug prevention among young people	NHS, National Institute for Health and Clinical Excellence	2006	NA	Sec: 5; High
McManus et al	Adult psychiatric morbidity in England, 2007	The NHS Information Centre for health and social care	2009	N=7461	Quant: 13; High
McSweeney et al	Tackling Drug Markets and Distribution Networks in the UK	UKDPC	2008	NA	Sec: 3; Low
Murji, K	Hierarchies, markets and networks: ethnicity/race and drug distribution	Journal of Drug Issues	2007	NA	NA
Nabuzoka D and Badhadhe F.A.	Use and perceptions of Khat among young Somalis in a UK city.	Addiction Research: 8 (1), 2000, p.5-26	2000	N=94 Age:11-26 years M=89 F=5	Quant: 8.5; Medium Qual:3.5; Medium
NatCen	Smoking, drinking and drug use among young people in England in 2008	NHS Information Centre for Health and Social Care	2009	N=7798 11-15 year olds from 264 schools	Quant: 13; High
NTA	Annual differential impact analysis of drug treatment 2006-07	NHS	2007	NA	Sec: 4.5; High

Author	Title	Published by	Date	Sample information	Quality assessment score
Patel et al	Khat use among Somalis in four English cities.	London: Home Office, 2005. 50p.	2005	N=602	Quant: 9; Medium
Rassool, GH	Substance abuse in black and minority ethnic communities in the United Kingdom: A neglected problem?	Journal Of Addictions Nursing 2006, Vol. 17, No. 2, Pages 127-132	2006	NA	Sec: 2.5; Low
Riley, J, Cassidy, D and Becker, J	Statistics on race and the criminal justice system – 2007/08	MOJ	2009	NA	Sec: 3.5; Medium
Rodham et al	Ethnic and gender differences in drinking, smoking and drug taking among adolescents in England: a self-report school-based survey of 15 and 16 year olds.	Journal of Adolescence. 28(1), February 2005, pp.63-73. 2005	2005	N=6020 from 41 schools White (82.3%), Black (2.8%), Asian (11.1%) or Other (2.6%)	Quant: 11.5; High
Ross et al	Drug Issues Affecting Chinese, Indian and Pakistani People Living in Greater Glasgow	Drugs: Education, Prevention and Policy, vol. 11, no. 1, pp. 49 – 65, February 2004	2004	Pakistani=73 Indian=47 Chinese=54	Quant: 7.5; Low
Roy et al	Black and minority ethnic communities, drug supply and drug and alcohol use in Bolton.	Bolton Community Safety Partnership	2008	N=130 participants (including drug users, drug dealers, professionals and community workers and others	Qual: 4; Medium
Ruggiero V. Khan K.	British South Asian communities and drug supply networks in the UK: A qualitative study.	International Journal of Drug Policy. 17(6) (pp 473-483), 2006.	2006	N=123 British South Asian drug dealers, drug users and other key individuals from across England and Wales	Qual: 3; Low

Author	Title	Published by	Date	Sample information	Quality assessment score
Sangster et al	Delivering drug services to black and minority ethnic communities.	Home Office. Drugs Prevention Advisory Service.	2002	99 interviews with professionals in commissioning, planning and delivering drug services 13 community group discussions with more than 100 people	Qual: 3-5; Medium
Sharp, Clare and Budd, Tracey	Minority ethnic groups and crime: findings from the Offending, Crime and Justice Survey 2003	Home Office	2005	N=10,079 White (9,285 respondents in OJCS); Mixed: 429 Asian or Asian British: 1,116 Black or Black British: 743 Chinese/other: 350	Quant: 12.5; High
Shaw et al	Indications of Public Health in the English Regions, 10: Drug Use	Association of Public Health Observatories	2009	NA	Sec: 3-5; Medium
Shiner, M	Doing it for Themselves: an evaluation of peer approaches to drug prevention	Home Office	2000	NA	NA
SOCA	The United Kingdom threat assessment of organised crime – 2009/10	London: NCIS, 2009	2009	NA	NA
Sondhi, A	National Drug Treatment Monitoring System West Midlands Diversity Report	West Midlands Public Health Observatory	2009	NA	Sec: 4-5; High

Author	Title	Published by	Date	Sample information	Quality assessment score
Strang et al	Heroin chasers and heroin injectors: differences observed in a community sample in London, UK.	American Journal on Addictions. 8(2):148-60, 1999.	1999	N=400 17-53 years White: 89% Black Caribbean: 7% Asian: 2% Mixed/other: 3%	Quant: 8.5; Medium
Taylor et al	Needs Assessment of Romani Gypsies, Irish Travellers and Showmen Regarding Drug, Alcohol & Substance misuse awareness, treatment and education	Nonpublished	2006	N=100	Quant: 7.5; Low
Turnbull, P.J.	The great cannabis classification debate: what are the likely consequences for policing cannabis possession offences in England and Wales?	Drug and alcohol review, 28 (2), pp. 202-209.	2009	NA	NA
Warnakulasuriya S.	Areca nut use following migration and its consequences.	Addiction Biology. 7(1):127-32, 2002 Jan.	2002	NA	Sec: 2; Low
White, Rupert	Heroin Use, Ethnicity and the Environment: The Case of the London Bangladeshi Community	Addiction, vol. 96, no. 12, pp. 1815-1824, Dec 2001	2001	N=21 Bangladeshi drug users in Camden and Islington	Quant: 7.5; Low Sec:4.5; High
Williams et al	Sociocultural aspects of areca nut use.	Addiction Biology. 7(1)(pp 147-154),	2002	Focus groups with Bangladeshi, Pakistani and Gujrati women	Qual: 2; Low

Appendix 7. Potentially relevant material not included in review

	Author	Title	Published by	Date
1	Akhtar, Shakeel; South, Nigel	Hidden From Heroin's History: Heroin Use and Dealing Within an English Asian Community, A Case Study	Chapter in: Illegal Drug Markets: From Research to Prevention Policy, P 153-177, 2000, Mangai Natarajan and Mike Hough, eds.	2000
2	Tran V.	Problem drug use among Vietnamese refugees in Hackney and the East London area. – emailed	London: An Viet Foundation, 2000. 24p.	2000
3	Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire	Drug information needs of diverse communities in Hertfordshire	Hertfordshire Drug Action Team and Hertfordshire Health Authority	2002
4	Patel, K; Wibberley, C	Young Asians and drug use	Journal of child healthcare	2002
5	Kalunta-Crumpton, Anita	“Race and problem drug use in an English city.”	International Journal of Offender Therapy and Comparative Criminology, vol. 47, no. 6, pp. 677-697, 2003	2003
6	Patel, Kamlesh and Pearson, Geoffrey	Outreach Among Asian Drug Injectors In Bradford	Home Office and the Mental Health Foundation	2003
7	Fountain, J. McQuade, C. Peters, E. Anitha, S. Crompton, N. Roy, A. Patel, K.	Drug-related interventions for refugees and asylum seekers: a pilot study amongst Somali and Turkish Kurdish communities in London	Government Office for London Drugs Team.	2004
8	Budd, Tracey, Collier, Patrick, Mhlanga, Bonny, Sharp, Clare Weir, Guy	Levels of self-report offending and drug use among offenders: findings from the Criminology Surveys	Home Office	2005

	Author	Title	Published by	Date
9	McCambridge, Jim; Strang, John	Can It Really be this Black and White?: An Analysis of the Relative Importance of Ethnic Group and Other Sociodemographic Factors to Patterns of Drug Use and Related Risk Among Young Londoners	Drugs: Education, Prevention and Policy, vol. 12, no. 2, pp. 149 – 159, April 2005	2005
10	Roy, Alastair, Christopher Wibberley, Christopher and Lamb. Jon	The usual suspects: Alcohol, tobacco and other drug use in 15- to 16- year old school pupils – prevalence, feelings and perceived health risks	Drugs: education, prevention and policy, Vol 12, No 4, August 2005: 305-315	2005
11	Anitha, S.	A cultural approach to understanding the stigma of drug use: the experiences of prisoners in England and Wales.	Chapter in Fountain, J. Korf, D.J. (eds.) Drugs in society: European perspectives. Oxford: Radcliffe Press, pp.76-86.	2007
12	Roy, Alastair with Buffin, Jez and Bassa, Ebrahim	South Asian communities, drug supply and substance use in Blackburn: what is the potential role for the Drug Advisory Group?	The International School for Communities Rights and Inclusion, UCLan	2008
13	Roy, A.	An Evaluation of Manchester Drugs and Race Unit's 'Reaching Out' Programme.	The Black Health Agency, Manchester	2009