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

This publication collates the findings from 34 reports on issues surrounding drug use and drug services among England’s Black Caribbeans and those of mixed Black Caribbean and white heritage (Black Africans are the subject of the second publication in this series). For convenience, this publication refers to the whole sample as ‘Black Caribbean’ unless those of mixed ethnicity are specifically discussed. In total, 1,863 members of these communities provided the data for the 34 reports.
The majority of the other 145 community organisations participating in the project focused on a specific ethnic group, but only five of the 34 studies reported here concentrated solely on Black Caribbeans. The remaining 29 examined drug-related issues among all the Black and minority ethnic populations living in a particular location, although they included a substantial proportion of Black Caribbeans in their samples. Several focussed on a specific issue in their local area, such as:

- the relationship between drug use and offending and antisocial behaviour, including gun crime and gang membership;
- the relationship between drug use and teenage pregnancy;
- the relationship between drug use and mental ill health;
- the influence of urban music culture on drug use;
- cultural attitudes to drug use; and
- drug-related issues affecting women.

The difference between these studies and others in the project may be explained by the fact that, unlike some other Black and minority ethnic communities in England, most Black Caribbeans (especially the younger generations) are not living in an unfamiliar culture and their first language is English. Therefore they do not experience the cultural and language barriers to integration that some other Black and minority ethnic populations do. They may also be more likely than other ethnic groups to feel part of a local community rather than separate from it, and their primary identification may not be Black Caribbean.

This is not, of course, to deny that – as members of England’s Black and minority ethnic population – many Black Caribbeans face the social, educational and economic disadvantages that characterise social exclusion: this was emphasised by a majority of the study reports, particularly those concerned with young males.
Foreword
This UCLAN series of reports – of which this is the third volume – examines knowledge of and information about drugs and drug services among a range of Black and minority ethnic groups in England.

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

The NTA endorses these reports.

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

An analysis of 2006/07 data from the National Drug Treatment Monitoring System (NDTMS) suggests that generally there is no ethnicity-related differential impact when it comes to drug treatment itself. While different people respond to treatment differently, service user demographic characteristics do not have a major impact on the treatment provided to them – and this applies as much to gender and age as it does to ethnicity.

The characteristics of the service provider and the service user’s main drug of use are more likely to affect how an individual responds to treatment.

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

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

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

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

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1 This analysis is available on the NTA website at website at http://www.nta.nhs.uk/areas/diversity/docs/differential_impact_assessment_ndtms_0607_%20120309.pdf
What this means for the treatment sector is that we may need to intensify our efforts to ensure that staff and organisational competence is sustained and enhanced to ensure that drug services meet the needs of a range of drug misusers.

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

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

Drug service needs

- This report represents the evidence and recommendations for drug service planners, providers and commissioners to address the needs of Black Caribbeans.

- The overall picture painted by the results from the participation of 1,863 Black Caribbeans in the Department of Health’s Black and minority ethnic drug misuse needs assessment project is that drug use among young Black Caribbeans (especially males) is one of the consequences of their social exclusion. The majority of the community organisations’ recommendations stressed the complexity of ‘multiple social problems’ within Black Caribbean communities, and that, in order to address drug use, there should be better coordination of health and social services. The study reports frequently described this as a ‘holistic approach’ or a ‘one-stop shop’.

- The drug service needs presented in this report are interrelated: a ‘pick and mix’ approach to meeting them will be ineffective because other barriers to drug service access will remain.

- Meeting these needs relies not only on action by drug service planners, commissioners and providers, but also by the Black Caribbean communities themselves.

- The drug-related needs of Black Caribbeans are, above all, information about drugs and drug services. The study reports stressed that better knowledge of drugs and drug services would increase the capacity of families and communities to support drug users.

- Engagement between the Black Caribbean communities and a whole range of health and social services is essential for progress towards meeting their drug-related service needs.

Patterns of drug use

- A large majority of the Black Caribbeans who participated in this study reported being exposed to illicit drug use and users. As one study participant pointed out, ‘it’s not a shock to find out that people are taking drugs’.

- The British Crime Survey (Murphy and Roe, 2007) covers a representative sample of the general population in England and Wales and provides details of the illicit drugs used and the characteristics of users. Although the sample of 1,863 Black Caribbeans from 34 studies was not representative of all Black Caribbeans, their results indicate that:

  As in the general population, cannabis (including skunk) is the illicit drug most commonly used by Black Caribbeans of all ages.
The use of crack cocaine and, especially, of heroin may have been under-reported by study participants because of the stigma surrounding these substances. It should be stressed here that although the study participants thought that Black Caribbeans are far more likely to use crack cocaine than heroin, the British Crime Survey also reports that a larger proportion of the general population has used crack cocaine than heroin both in their lifetime and in the last year (use in the last month is the same for both drugs).

- The early onset of drug use is a risk factor for problematic drug use (for example, HAS, 2001). This is a cause for concern, as the study participants agreed that drug use among Black Caribbeans began in the early teens.

**Problematic drug use**

- Black Caribbean community members were concerned about the negative effects of drug use and dealing (particularly of crack cocaine) in their localities in terms of crime, public safety and damage to the reputation of their community and of the local area.

- Overall, although community members (including cannabis users) were aware of the health problems that cannabis use may cause, they viewed the drug as harmless, especially when compared to heroin and crack cocaine.

- Crack cocaine users reported physical and mental health problems, the breakdown of family and friend relationships, homelessness, debts and committing crimes to fund their use.

- A few young Black Caribbeans were reported to be selling crack cocaine because their parents are users and want their children to ‘do favours for the crack dealers’ to ensure a continuous supply. Aware of the problems associated with crack cocaine use, these young people do not use the drug and condemn those who do.

**Help-seeking**

- The findings from the 34 community organisations’ studies strongly indicate that, compared to the white population, Black Caribbeans are under-represented as recipients of drug information, advice and treatment services.

- There was no consensus among study participants about where they would go – or would advise someone to go – if they needed information, advice or treatment. However, GPs, friends and a telephone helpline were cited more often than other information sources.

- The major barrier to drug information, advice and treatment services facing Black Caribbeans is a lack of awareness of the range of services that exist and the help they can offer. This impedes access to information and advice for all members of Black Caribbean communities, including non-problematic drug users who would benefit from information about the substances they use and advice on harm.
reduction strategies. The lack of awareness also hinders access to treatment for problematic drug users, and means that there may be unrealistic expectations of what can be achieved by treatment and the process by which recovery is achieved.

• The other reported main barriers to help-seeking were:

  The avoidance of the stigma attached to the use of – and especially dependence on – heroin and crack cocaine.

  The perception that drug services lacked understanding of Black and minority ethnic communities’ cultures because they are staffed mainly by white workers.

  The perception that services do not cater for cannabis and crack cocaine users.

  The perception (confirmed by experience in some cases) that services fail to consider the needs of the families and carers of drug users.

• A minority of those who reported problematic drug use had overcome the above barriers and accessed drug treatment services. Most of them reported positive experiences.

Information needs
• The 34 studies unanimously reported that Black Caribbeans lack information about illicit drugs and drug information, advice and treatment services and their functions.

• A harm reduction approach to drug education was advocated, to allow Black Caribbeans (especially young people) to make informed choices about their drug use.

• Drug services should be advertised widely, making it clear that they are not only for problematic drug users. Confidentiality policies should also be clearly stated, particularly concerning the passing of information about drug service clients on to the police and social services.

• Peers, mentors from the communities’ older generations, youth workers and positive role models are the most credible sources of information for young people.

Cultural competence
• A basic framework for cultural competence is provided in Section 7.

• The cultural competence of drug services was perceived by many study participants as being characterised by ‘friendly staff’ who were ‘understanding’, ‘welcoming’ and ‘non-judgemental’ (especially of drug-using mothers) in a ‘relaxed’ environment.

• Only a few of the studies recommended specific drug services for Black Caribbeans. Rather, most called for increased cultural competence within mainstream services.
• In order to attract Black Caribbean clients, more Black and minority ethnic drug service staff should be recruited. A targeted recruitment strategy is needed and Black Caribbeans need ongoing training and support to be encouraged into the profession. Their value was most commonly expressed as their understanding of the Black Caribbean communities, including the ‘multiple problems’ that young people experience.

**Drug service development**

• Services for crack cocaine users should be better developed. This is particularly relevant to Black Caribbeans if the perception that they are more likely to use crack cocaine than heroin is correct.

• Specific services for cannabis users should also be provided.

• Support for the families and carers of drug users is a major drug service need.

• There should be more consideration by drug information, advice and treatment services of the needs of women and girls, especially of mothers.

• Outreach workers are seen as ‘bridges enhancing communication between drug services and minority ethnic communities’. A considerable increase in outreach work is therefore necessary, particularly among young Black Caribbeans.

• More Black Caribbeans may access drug services if opening hours and appointment systems are more flexible.

• Improved monitoring and evaluation of drug services is necessary, including more sophisticated ethnic monitoring of clients that would confirm or deny the perception of disproportionate crack use by Black Caribbean clients.

**Engagement**

• Reflecting the emphasis that the majority of study reports placed on the range of problems facing members the Black Caribbean communities, of which drug use was just one, their recommendations stressed that partnerships including community members and organisations and a wide range of health and social services are necessary to address this situation.

• Increased and long-term funding for Black Caribbean community organisations will increase and maintain their capacity to assist their communities with a range of needs.
The terms used by the 2001 census to describe the ethnicity of the subjects of this publication are ‘Black or Black British: Black Caribbean’ and ‘Mixed: White and Black Caribbean’. Members of these communities who participated in the project and the community organisations’ reports also used the terms ‘Afro-Caribbean’, ‘African-Caribbean’, ‘West Indian’ and ‘mixed race’ to describe themselves.

The 2001 census reported that:

- 1% (565,876) of the UK population was Black Caribbean.[1]

- A further 0.46% (237,420) of the population of England and Wales was Mixed: White and Black Caribbean.[2] This group comprised 29.6% of those of Black Caribbean background in the UK.[1]

- Black Caribbeans comprised 12.2% of the UK’s Black and minority ethnic population.[1]. Mixed: White and Black Caribbeans accounted for 35.9% of all populations of mixed ethnicity in England and Wales.[2]

- 61% of Black Caribbeans lived in London, and comprised over 10% of the populations of the London boroughs of Brent, Hackney, Lambeth and Lewisham.[3]

- Almost three-quarters of Black Caribbeans and 60% of Mixed: White and Black Caribbeans in England and Wales reported their religion as Christian (almost all the remainder either had no religion or did not answer the census question on religion).[4]

- The proportion of Black Caribbeans in England and Wales aged 15 and under was the same as those of the general population (just over 20%). However, compared to the general population, almost three times the proportion (57.5%) of those of mixed Black Caribbean and white background were aged 15 and under.[2]

- Of the 563,843 Black Caribbeans living in England and Wales, 57.9% (326,194) had been born in the UK and 38.2% (215,412) in the Caribbean and the West Indies (60.7% of these in Jamaica). These proportions were very different for the 237,418 who were categorised as Mixed: White and Black Caribbean: 93.9% (222,901) had been born in the UK and only 3.5% (8,259) in the Caribbean and West Indies (49% of these in Jamaica).[5]

The terms used to describe those of Black Caribbean heritage largely overlook the diversity among them, and one study report deplored the ‘tendency to lump all West Indians together [when] culturally, historically, linguistically they are not homogenous’.
The Caribbean consists of the Caribbean Sea, its islands, and the surrounding Central and South American coasts. Most islands were (and a few still are) colonies of European nations, and those known as the British West Indies consisted of Anguilla, Antigua and Barbuda, Bahamas, Barbados, Bay Islands, Belize, British Virgin Islands, Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, Saint Croix, St Kitts and Nevis, St Lucia, St Vincent and the Grenadines, Trinidad and Tobago, and the Turks and Caicos Islands.

This means, for instance, that one community organisation reported that ‘social networks as well as formal organisations are often island based … especially in the middle-aged and older generations’ and that in their locality there were large groups who identified as Jamaican and Dominican rather than as Black Caribbean. Another study reported that the Black Caribbean population in their local area included two communities who strongly identified as St Vincentian and Montserratian.

Moreover, several reports pointed out that some members of the older generations of Black Caribbeans, particularly Jamaicans, speak patois (a Creole-based dialect) better than English.

On the other hand, immigration from the Caribbean to the UK (mainly from the British West Indies) peaked in the 1950s and 1960s, meaning that, as one report put it:

*We now have third and fourth generations of African-Caribbeans born and bred in Britain, many with no other knowledge of anywhere else but Britain as home.*

This was borne out by some of those participating in two of the studies, which noted that some of those of mixed backgrounds in their samples reported their ethnicity as white. Various explanations were offered for this, including avoiding being negatively stereotyped and stigmatised, because the vast majority of other members of their families are white, and – as one report put it – because ‘they have no distinct culture from that of the White majority.’
1 Research methods

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

A variety of quantitative and qualitative data collection methods were utilised, with research instruments and methods that were appropriate to the aims and the target sample of each study, and to the issue they addressed. All the 34 studies incorporated a structured or semi-structured questionnaire (usually via a one-to-one interview but also by self-completion) into the data collection process, but many also conducted focus groups and a few included in-depth case studies.

A wide variety of strategies were used to recruit Black Caribbeans to the studies. Community researchers’ and community organisations’ networks and relevant local statutory and voluntary agencies, including drug services, were utilised, but study participants were also recruited in a prison and a young offenders institution, youth clubs, educational establishments (including supplementary schools and pupil referral units), places of worship, sports facilities, the street and the local job centre. Some studies were also advertised and participation requested at community festivals and music events, via announcements in the local press, and in shops and on market stalls.

In the study conducted among prison inmates, prisoners worked as community researchers to collect data, and the community researchers of another study comprised current and former crack cocaine and heroin users.

Several community organisations held drug education seminars and one held a drama workshop focusing on drugs. These were followed by sessions in which focus groups were conducted and/or a questionnaire was administered. The recruitment process therefore achieved one of the aims of the Centre for Ethnicity and Health’s Community Engagement Programme – to raise the awareness of community members of the issue in question.

Note

As the community organisations reported both qualitative and quantitative data, this publication sometimes uses the following terms to give an indication of proportion: small minority (around 5% or less); minority (around 10%-15%); significant minority (around 20%-30%); majority (more than 50%); and large majority (more than 75%).
A total of 1,863 community members participated in the 34 studies, of whom 87% reported their ethnicity as Black Caribbean and 13% as mixed Black Caribbean and white.

- Overall, the sample’s age range was wide (from 16 to over 60), although ten of the studies concentrated on those aged 16-25.

- 57% of the study participants were male and 43% were female.

- The studies were conducted across England: London (10 studies), West Midlands (8), North West (5), East Midlands (4), Yorkshire and the Humber (3), the South East (2) and the South West (2). Most of the studies concentrated on a specific area (such as a London borough), although a few covered a whole city or concentrated on a particular neighbourhood.

- Where data on the country of birth and citizenship status of the study participants were available, they showed that almost all had been born in the UK and were British citizens.

- In addition to 1,863 Black Caribbean community members, six of the studies also interviewed a total of 98 individuals involved with these communities in a professional capacity. These were mainly drug service commissioners, providers and workers, but also included representatives of other statutory and voluntary agencies, such as community and youth workers.
3 Patterns of drug use

See Key messages for a summary of this section

It should be stressed that no inferences on the prevalence of illicit drug use among England’s Black Caribbean communities should be made from the data presented in this section. The Department of Health’s Black and minority ethnic drug misuse needs assessment project was not intended to be a prevalence survey, but aimed to provide an overview of drug-using patterns and drug service needs. The data in this section are therefore intended to demonstrate only the relative popularity of each illicit drug among various samples of Black Caribbeans, as reported to the 34 studies.

Over three-quarters (26) of the 34 studies either did not ask their samples about their personal illicit drug use or did not break down the drug use of their multi-ethnic samples according to specific ethnicities. It should also be noted that the samples of the eight studies which documented personal drug use were not intended to be representative of all Black Caribbeans (comprising, for example, prisoners, drug service clients and crack cocaine users). Therefore, in order to give an accurate as possible overview of patterns of drug use among Black Caribbeans in England, this section combines the data on reported drug use with those of the perceptions of the study participants: the data from other publications in this series have shown that these perceptions concur with the reported drug use of the samples.

In this context, it is important to recognise that while a large majority of study participants perceived there to be a ‘drug problem’ in their neighbourhood and that drugs were readily available there, five studies asked whether they thought proportionally more Black Caribbeans used illicit drugs than among the rest of the population. They unanimously responded that this was not the case.

3.1 Cannabis

Twenty-nine of the 34 study reports presented data on the use of cannabis by Black Caribbeans. Several specifically reported the use of skunk, a generic name used to describe a potent form of the cannabis plant that is high in tetrahydrocannabinol (THC)\(^6\), though it is, of course, impossible to determine whether or not all the reported and perceived use was of genuine skunk and – if it was – the drug’s relative strength.

- Those studies that asked their samples about their personal illicit drug use unanimously reported that cannabis was the most commonly used substance.
- A large majority of Black Caribbean community members, whether or not they used illicit drugs, perceived that cannabis was Black Caribbeans’ ‘drug of choice’, with results from the studies showing that cannabis was used by a wide range of Black Caribbeans (both male and female) from people in their teens to pensioners.
- Over 95% of those who had used an illicit drug had used cannabis and in some studies, this proportion reached 100%.
• A significant minority of study respondents thought that cannabis use was ‘accepted’ and ‘normalised’ among Black Caribbeans. For example:

Three reports thought that because cannabis had been used by some Black Caribbeans in the UK since the 1950s, ‘young children have seen their parents smoking it and copied them’ and that ‘people have grown up using it … through the family’.

A study of young people’s attitudes towards drugs reported that cannabis was seen by a large majority as ‘an acceptable recreational drug’ and that the majority ‘talked openly about regular cannabis use’.

• For followers of the Rastafari movement, cannabis use is a spiritual act, although use is not compulsory. Participants of four studies discussed cannabis use among Black Caribbean Rastafarians, saying that ‘it is part of their culture to smoke cannabis’, ‘it comes with the faith’ and ‘if you’re a Rasta, you’re gonna smoke weed’. However, a small minority of other participants in these studies thought that ‘most black people use [the Rastafari] religion as an excuse’ for using cannabis.

• One study examined drug use within south London’s urban music scene and reported that, among young people, skunk was used more frequently than other forms of cannabis, and that a large majority of their sample ‘had been around skunk within the last month’.

• One study reported that over a third of their sample of Black Caribbeans with mental health problems used cannabis to alleviate these.

3.2 Crack cocaine

Crack cocaine use was perceived by study participants to be Black Caribbeans’ preferred Class A drug. However, other than among one sample of drug service clients and another of crack cocaine users, few of those who were asked about their own drug use reported using it. In particular, very few young people said they had used crack cocaine and several service providers commented that few young people of any ethnicity present to services with problematic crack cocaine use.

• Despite the paucity of reports of personal use, a minority of study participants of all ages recognised that crack cocaine is used by Black Caribbeans and a larger proportion reported knowing other Black Caribbeans who used the drug.

• Samples of prisoners and drug service clients who used crack cocaine reported that it was preferred to heroin among Black Caribbeans. This perception was confirmed by several drug service providers.

• Two study reports commented on the ‘surprisingly low levels’ of crack cocaine use reported by their samples. They concluded that use was under-reported because it was ‘unacceptable’ in Black Caribbean communities. One added:
This fits with the information provided by the focus group who discussed the unwillingness of the community to admit to crack cocaine [use] and frowning upon or ridiculing those who were addicted to crack cocaine.

3.3 Cocaine powder, ecstasy and amphetamines

Overall, the studies reported very similar perceptions and patterns of stimulant use, such as cocaine powder, ecstasy and amphetamines. A minority of study participants felt that these were used by Black Caribbeans but only a small proportion of illicit drug users reported having used them.

- There was a difference, however, in study participants’ perceptions of cocaine powder use among Black Caribbeans. While, overall, a minority thought that it was used, in some studies very few people thought this was the case, and young people in two studies ‘argued that cocaine [powder] was a rich man’s drug and as such was out of their reach’.

- Overall, while only a minority of study participants thought that ecstasy was used by Black Caribbeans, some of these (especially young people) cited this as the most commonly used illicit drug after cannabis.

- Amphetamine use among Black Caribbeans was felt to be lower than the use of cocaine powder and ecstasy. Those who reported having used amphetamines were mainly young people.

3.4 Heroin

The overall impression from study participants (including illicit drug users) is that, compared to the white and South Asian populations in their locality, relatively few Black Caribbeans use heroin.

- A small proportion of illicit drug users reported using heroin, but as with crack cocaine, it may be that use was under-reported because of the stigma that Black Caribbean communities attach to heroin use. For example, one study reported that the consensus among a sample of prisoners was that Black Caribbean heroin and crack cocaine users ‘would become ostracised and looked down upon’ by other Black Caribbeans.

3.5 Other drugs

Only a few participants in a small minority of the studies thought that solvents were used by Black Caribbeans, and lifetime use was reported by literally only one or two participants in each of six of the 34 studies. A similar picture emerged in relation to LSD, poppers (amyl or butyl nitrite) and magic mushrooms.
3.6 Injecting drug use

Five studies discussed injecting drug use by Black Caribbeans and the view was that this very rarely occurred. Some drug service clients who were using drugs that could be injected were asked about their mode of administration and confirmed this perception.
# 4 Problematic drug use

See Key messages for a summary of this section

The problems most often reported by community members in relation to drug use in their local areas were that it led them feeling unsafe because of:

- a perceived increase in crime (including street crime, visible drug use and dealing, violent crime, ‘gang culture’ and gun crime);
- the presence of drug-using paraphernalia on the streets; and
- the negative effect on the reputation of an area and of the Black Caribbean communities.

For example:

*It makes the area look bad and rundown.*

*It makes the [Black Caribbean] community be looked down on as bad.*

*Once a community is seen as problematic, it can have a self-fulfilling prophecy to those who live in it.*

*It was felt [the local area] had become economically and socially impoverished as a result of the increasing presence of drugs and the subsequent belief … that certain wards have become ‘no go areas’.*

*There is a fear of drug users and a sense that drug misuse is further isolating the [Black Caribbean] community from wider society.*

Several study reports commented on the link between drug dealing and the lack of educational achievement and employment among young Black Caribbeans. Their samples reported that selling drugs was an attractive income-generating option for some young people and alleviated the boredom of unemployment.

The problems surrounding the use of illicit drugs were perceived by the majority of those who were asked as dependent on the drug in question. As one report put it, their sample:

*split drugs into two distinct categories – destructive and recreational … They pitched drugs on a scale of the harmful effects they could cause to yourself, families and communities … Crack cocaine and heroin were seen as degenerative drugs linked to crime and violence and a negative stigma was attached to anyone using these drugs.*

As discussed in the following two sections, the overall focus of the 34 studies in terms of problematic drug use was on cannabis and crack cocaine: the perceived and/or reported use of drugs other than these were relatively low.
4.1 Problems associated with cannabis use

A significant minority of study participants believed that cannabis use was not problematic, especially when compared to the use of alcohol, heroin and crack cocaine. Cannabis was variously perceived by these Black Caribbeans to be non-addictive and not a drug but rather to be a ‘natural herb’ with medicinal (i.e. relaxing) properties and therefore ‘good for you’. For example:

I don’t see cannabis as a drug because it has many positive attributes.

Ganja – relaxes me, helps me cope with the day.

It doesn’t seem to do any harm.

I would never touch any of that hard stuff [heroin and cocaine] but I love smoking my ganja.

This was evidenced in some cases by reports of elderly relations in the Caribbean using it ‘to keep calm’. That said, a majority of the sample – including cannabis users – were aware of the problems cannabis (particularly skunk) may cause, including dependence, the cost (skunk is relatively expensive compared to other forms of cannabis), fatigue, depression, short-term memory loss and paranoia.

However, the overall message from the study reports is that, despite recognition of these problems, few cannabis users reported that they had personally experienced any such difficulties. Thus, adverse effects of skunk (such as hallucinations) were explained away by some young users in one study as a result of crack cocaine being mixed with it, while ‘getting desperate’ when cannabis was not available was denied by some of the young users in another study to be indicative of dependence.

4.2 Problems associated with crack cocaine use

Black Caribbean community members felt that crack cocaine primarily impacted on their communities through crime, violence and community safety concerns. For example:

Drug dealers set up crack houses around here which in turn attract addicts and those of us who do not take them [drugs] have to live with these dealings going on on our doorstep, causing a rise in crime.

Violence has increased and brought fear to the estate. People from outside come in to buy [crack cocaine].
One study was conducted in an area in which many crack cocaine-related problems were reported in detail by community members, including:

- feeling unsafe when outdoors because of street crime, violence, ‘gang culture’ and gun crime;
- an increase in prostitution to pay for the drug;
- domestic violence perpetrated by crack cocaine users;
- ‘bad people are attracted to the area’; and
- the breakdown of family relationships.

These study participants welcomed an increased police presence in their neighbourhood to tackle crack cocaine dealing, but had doubts over the effectiveness of this strategy and were concerned that there was ‘inappropriate’ targeting of Black Caribbeans as suspects for dealing and other crimes.

Some young people reported that their own or their friends’ parents used crack cocaine and thought that this contributed to family breakdown:

*Crack makes you stupid – your kids want food, your girl wants ya and all you can think about is crack.*

*I know people my age [17] and younger who are living with their grans or aunty or someone else … Before, it was [because] the father gone to jail … but now crack take over. On this estate I can name ya five who don’t live nowhere really, ’cause their dads go off and their mums are cracked out [use crack cocaine]. The only people they got is their grans.*

These young people also reported that some crack cocaine-using parents encouraged their children to become involved in distributing the drug:

*In situations where parents were crack cocaine users, young people feared they would get sucked into supplying and running [delivering] crack cocaine despite their best intentions, Indeed three of the respondent cohort noted that their parents would make them … befriend and do favours for the crack dealers so as to ensure the continuation of their parents’ supply.*

Crack cocaine users felt that the most common problems associated with use were:

- physical health problems (weight loss, lung problems and stomach pains);
- mental health problems (depression, paranoia, anxiety and mood swings);
- the breakdown of family and friend relationships;
- homelessness;
- debts; and
- committing crimes to fund use.
A study that interviewed several young people who sold crack cocaine reported that they were aware of these problems and avoided them by not using the drug themselves:

[They] adhered to the motto ‘simply to supply and avoid getting high from what they supply’ … [and used their profits for] the purchasing of expensive jewellery, cars, designer clothes, music and … the latest technology equipment.

Me and my friends, we don’t use it, we just sell it for a man sometimes. We can buy trainers and stuff – you’re stupid if you use it ‘cause then you ain’t got no money left.
5 Help-seeking
See Key messages for a summary of this section

This section reports on the perceived and reported sources of drug information, advice and treatment, and on the barriers to accessing drug services.

5.1 Sources of help

A majority of the study participants were asked where they would go – or would advise someone to go – if they needed information, advice or help with a drug problem. There was no consensus on this issue, although GPs, friends and a telephone helpline (FRANK was most often mentioned) were cited slightly more often than other sources.

Other reported sources of advice were family members, the internet, religious leaders, Yellow Pages, libraries, Citizens Advice Bureaux, magazines, hospitals, Connexions, community centres, youth clubs/workers and named or unspecified drug services.

- No young study participant reported that they would ask for help from school: some young people believed the response would be to exclude them.

- Young drug users were more likely to approach a service if it had been recommended by someone they trusted, such as a friend or a youth worker.

- Those who said they would ask friends for help (particularly those who had used drugs themselves) said that this was because friends could be trusted to keep the request confidential. That said, some drug service clients who had revealed their drug problems to friends reported that the response was condemnation rather than the help and understanding they had expected. Those whose friends had been supportive said this had made them more comfortable about subsequently approaching drug services.

5.1.1 Drug education

Around half of the studies asked their participants if they had received any formal drug education. The majority had, mostly from school and/or a youth club, and most agreed this had been useful. Nevertheless, as a community organisation that delivered drug education sessions at schools noted:

> During formal drugs education sessions there was often more bravado than learning – no-one wanted to admit to being affected by drugs and conversely, no-one wanted to acknowledge that there was anything they could learn from visiting drugs education specialists.

Two studies of young people examined the issue of drug education at school in some depth and reported that only when it was delivered by ex-drug users and peers were pupils enthusiastic about the experience. Drug education sessions at youth clubs were more positively received, as ‘the atmosphere was more relaxed’.
In addition to schools and youth clubs, study participants gave their sources of information about drugs as the internet and leaflets at GP surgeries and health clinics. Many also gave, as one report put it, ‘many unofficial sources of information’ about drugs, including their own experiences, ‘observation on the street’, friends and television.

5.1.2 Drug treatment services
Although only a minority of those who reported problematic drug use had accessed drug treatment services, nine studies talked to drug users who had done so. A large majority of them reported positive experiences. The exception was a sample of those who had a dual diagnosis of drug dependence and mental health problems and who preferred to rely on friends, family and cannabis to cope.

5.2 Barriers to drug service access
People are not able to seek help if they do not know about or feel that they cannot access drug services. This section therefore reports on the barriers to drug services facing Black Caribbeans, as perceived and reported by the study participants. The barriers cited most often were:

- a lack of awareness of drug services and the help they could provide;
- a low level of need for the services on offer;
- a perceived lack of services’ cultural understanding;
- a lack of consideration on the part of services for the needs of families and carers; and
- pride and the avoidance of stigma and stereotyping.

5.2.1 Lack of awareness of drug services
This was by far the most commonly-cited barrier to drug information, advice and treatment services, reported by 29 of the 34 studies. For example:

_I haven’t got a clue where these places are and it’s sad to say, because if we knew where they were, we could put things in the [community centre] windows saying ‘Look, these are places where you can go if you have problems’._

_I don’t know about them – if drug services are available, they are not very well advertised._

A study of drug-using prisoners reported that their sample had heard of the prison’s CARATS (Counselling, Assessment, Referral, Advice and Throughcare Services), but did not know what know what they entailed.

As two of the studies summed up:

_[There is a] large communications/information deficit about where to go for help, support or rehab._
Participants were in no position to comment on the relevance or effectiveness of service provision, as they had no knowledge of what was ‘out there’.

The lack of awareness about the nature of drug services meant that some study participants held perceptions such as:

- Drug services are staffed by ‘unforgiving Christians’.
- There is no point in treatment because there is no guarantee it will be effective.
- Drug treatment means enduring ‘intolerable cold turkey’.
- There are no services for crack cocaine users and existing drug services ‘don’t know enough’ about crack cocaine and its users. Some crack cocaine users thought that, if they wanted to stop using the drug, prison would be a better alternative to a drug service, because access to the drug would be severely curtailed.
- There are no services for cannabis users.
- Problematic drug use (including dependence) can be tackled by the user simply stopping use, reducing use, not going into environments where drugs are used, and/or by the user changing their friends to non-drug users.

5.2.2 ‘No need’ for services
A large majority of the drug users who participated in this project reported that they did not need drug information, advice and treatment services. Not surprisingly, help-seeking from drug services was not considered necessary by those who used a drug only occasionally (usually cannabis), and had not experienced any problems.

However, some of those drug users who said they did not need drug services also listed the negative effects of their use, including depression and committing crimes to finance it. The major reasons they gave for not needing help were:

- Cannabis (including skunk) use is ‘acceptable’ and they therefore did not need to access drug services, especially treatment. As one study report put it, ‘cannabis was seen as a soft drug and was not considered a big enough problem to merit seeking support or treatment’.
- They did not want to stop using drugs, despite problems: ‘we all die sometime’.

5.2.3 Perceived lack of services’ cultural understanding
Ten studies reported that a majority of their participants believed that drug services would not meet the cultural needs of Black Caribbeans – nor those of any Black and minority ethnic population.

As one report put it, it was thought that staff there ‘would have no insight into what their lives entailed’, while another noted that ‘Many respondents believed service providers believed Black [and minority ethnic] communities were monocultural’.
One study felt that drug users thought that if they accessed a drug service, the workers there would react negatively to them, seeing them as stereotypical Black Caribbeans, who not only use drugs but who are also ‘dealers who cause the problem’.

However, in another study, although six of 39 drug treatment service clients felt the service had discriminated against them, they believed that this was because they were crack cocaine users attending a service that they saw as set up to deal with heroin users, not because they were Black Caribbeans. Indeed, reported or perceived racism by drug services was very rarely articulated by study participants. As one study report put it:

*Racism was not seen as a factor in low service uptake. Few of the respondents seemed to feel Black drug users were treated differently from white drug users.*

5.2.4 Ethnicity of staff
Nine of the 34 studies discussed the ethnicity of drug service staff and agreed that the lack of Black and minority ethnic workers was a barrier to access by Black Caribbeans, especially young people, because it suggested that only the white culture would be understood. One study reported that this perception was exacerbated because all the publicity about a local service featured only white people.

The effect of all-white staff was lucidly described by one drug service client:

*I used to walk past this drug service every day and everyone in there – they were all white. And they were all smiling and happy. I used to look at this service … and I was afraid to go in there. I was afraid. Until one day and there was a Black worker in there.*

5.2.5 Lack of consideration for the needs of families and carers
Several studies interviewed the families and carers of drug users, and drug users who were caring for their own children. Carers included young people whose parent was a drug user and grandparents, who, it was reported, were traditionally called upon to help out in family crises such as when a family member was experiencing problems surrounding drug use.

Overall, carers were more aware than other study participants of local drug services and their functions, but perceived that these services did not cater for their needs. For example, one study focused on the experiences of the families and carers of crack cocaine users and reported a ‘cycle of disappointment’ that began when family members discovered use and was followed by attempts to support the user (including the provision of sympathy and money), anger and frustration, and finally, rejection of the drug user.

This cycle could be interrupted by the involvement of professional agencies (such as mental health, criminal justice and drug services), but many carers felt ‘abandoned and unsupported by existing systems of care’ and ultimately the cycle ended in the abandonment of care:

*It was either him or me … he just had to go. I couldn’t handle him anymore.*
Some of those with childcare responsibilities, including drug-using mothers, reported that they had accessed drug services, but had found it difficult to attend because the appointment system did not take childcare responsibilities into account (such as being available for children outside school hours) and because the service had no childcare facilities. Another barrier to drug service access for drug-using mothers was a concern that the service would report them as drug users to a social services agency and their children would be put into care.

5.2.6 Pride, stigma and stereotyping
A majority of study participants discussed the stigma Black Caribbeans attach to heroin and crack cocaine use (especially dependence) and to seeking help from a drug service.

For example, whether or not they had accessed drug services, the majority of male crack cocaine users in one study explained how they ‘felt themselves to be weak’ and ‘not a man’ because crack cocaine had ‘conquered’ them. The study concluded that ‘Sometimes, the shame of being drug dependent may be so great that a user may choose to hide their problem more than a white drug user’.

Many crack cocaine users had accessed treatment only as ‘a last resort’ when they had ‘reached the point of despair’ and, as one of them put it, were ‘ready to accept my addiction’. A fear of ‘failing’ to tackle their drug use was also given by a few crack cocaine users in treatment as a reason for delaying to seek help.

Several drug users who had received treatment in the past said that their embarrassment about relapsing was a barrier to seeking help again, and a number of drug-using mothers reported that they were ashamed to seek treatment because drug use was contrary to their role in the family as carers.

5.2.7 Other barriers
Barriers to drug service access less often cited than those above were:

- the lack of immediate help because of waiting lists and a strict appointment system;
- services’ use of patronising language and jargon, and lack of consideration of poor reading skills; and
- a lack of confidentiality because drug services were situated in conspicuous public places, and, in one case, because gaining entry meant announcing the reason for the visit via an intercom on the pavement.
The remaining sections report on the drug service needs of Black Caribbean communities as identified by the 34 community organisations on the basis of their findings. These strongly indicate that Black Caribbeans are in need of information and advice on illicit drugs and on drug services, and, compared to the white population, are under-represented as recipients of drug treatment services. These communities’ drug service needs are categorised as **information** on drugs and drug services, services’ **cultural competence**, **drug service development** and **engagement**.

Of course, not all these needs apply exclusively to Black Caribbeans, nor indeed only to members of Black and minority ethnic communities. Unlike some other Black and minority ethnic communities, the vast majority of Black Caribbeans in England (especially the younger generations) are not living in an unfamiliar culture, do not have difficulties with the English language, and, as British citizens, have no concerns that their problematic drug use will result in deportation. Nevertheless, it does not follow that they can simply ‘slot into’ existing drug services. Responses may have to be different if the barriers to drug service access that they face can be overcome.

Drug use among young Black Caribbeans (especially males) as a consequence of social exclusion was a recurrent theme in most of the community organisations’ reports. Their recommendations to address this stressed the complexity of Black Caribbean communities’ ‘**multiple social problems**’.

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

See Key messages for a summary of this section

The overall impression from the 34 reports is that a large majority of the Black Caribbean participants – especially the younger generations – could name illicit drugs (including their street names); were aware of drug use among Black Caribbeans in their local area; personally knew drug users; and knew where to obtain drugs. Several study reports commented that this awareness was greater than had been anticipated and that participants were confident about their basic knowledge of drugs and the related issues.

That said, the 34 studies unanimously reported that Black Caribbeans lack information about illicit drugs and drug services. Several studies probed their participants’ knowledge of drugs in some depth and concluded that it may not as comprehensive as it might first appear. As one report of a study of young people stressed:

> A key learning point … is the danger of assuming that young people have detailed knowledge of a drug’s effects simply because they are able to state the name.

One example of this lack of knowledge came from a sample of skunk users, few of whom had used other illicit drugs, and among whom ‘there seemed to be no expectation that drugs would lead to addictions and poor health’. Another example is that a large majority of participants in a number of studies felt that only the use of heroin and crack cocaine could cause harm.

A large majority of the reports agreed that Black Caribbeans also lacked awareness of drug services and their functions:

> Most of the respondents were fairly clued-up when it came to general drug knowledge. However, most were unaware of any drug services.

Three study reports added that if Black Caribbeans’ knowledge of drugs was greater, their capacity for increasing family and community support for drug users would increase. They would be less likely to stigmatise crack cocaine and heroin users, and be able to contribute to a change in attitudes and opinions of drug use and drug services.

6.1 The message

The study reports raised a variety of issues in terms of drug education priorities, most commonly:

- how to recognise the signs of problematic drug use;
- the long-term effects of cannabis use;
- the relative harm caused by different drugs; and
- crack cocaine.
Overall, the majority of studies recommended a harm reduction approach to drug education, to allow Black Caribbeans (especially young people) to make informed choices about drug use: just two of the 34 study reports wanted a ‘just say no’ approach, ‘no matter what the temptations’. One study recommended that Black Caribbeans’ ‘acceptance of the use of cannabis’ was challenged by drug education initiatives, although another advocated flexibility to accommodate what they described as the ‘normal and acceptable’ attitude to cannabis use.

A study that examined mental health issues among drug users stressed that these should be included in drug education sessions.

The most common recommendation for raising awareness of drug information, advice and treatment services was widely advertising exactly what services were provided, their location and their opening hours, and making it clear that not all drug services were for only ‘heavy drug users’.

Several reports recommended that the information on drug services should include a clear confidentiality policy, particularly concerning passing on information about drug service clients to the police and social services.

6.2 Recipients

Between them, the study reports recommended that information about drugs and drug services should be available to all members of the Black Caribbean communities – although young people were particular targets, especially those thought vulnerable to drug use because they were (or were at risk of being) excluded from school or unemployed.

A majority of studies specifically recommended that parents and carers (including grandparents and other family members) needed advice and information on drugs and drug services in order to help family members who used drugs and because:

They were frustrated by the disempowering nature of being close to someone who is misusing drugs. They are unable to change the behaviour of the users and experience all the negative consequences of their actions.

Several studies added that drug education for parents who use drugs should highlight that this may encourage their children to copy them.

A majority of the study reports recommended drug education for all workers from agencies that came into contact with members of the Black Caribbean communities (such as GPs, teachers, police and probation officers, youth workers, community workers, housing officers and community centre workers). It was argued that this would enable these workers to support drug users and those trying to deal with the drug use of friends and/or family members.
6.3 Media

Several study reports pointed out that poor literacy and/or an unwillingness to read should be considered when developing drug education materials for Black Caribbean communities, one stressing that:

*People would rather attend an hour-long session than read a piece of literature on drugs.*

For this reason, several of the studies that were concerned with young people emphasised that current drug education literature should be updated, made ‘fun’ to read, and presented in a format that was related to recipients’ day-to-day experiences of drugs and the related issues.

Creative and informal education sessions on drugs and drug services were also suggested for Black Caribbeans of all ages. These included drama, music, sport and carnival floats with drug-related themes, and drug education videos featuring Black Caribbeans’ experiences of drugs and drug services.

6.4 Settings

The study reports had a variety of suggestions about the settings in which drug education could be delivered. The most common was that drug education for young people (and in some cases, their parents) should be conducted in schools, but the other main recommendations were that information should be available:

- Via a telephone helpline (including Christian helplines) and, less frequently, the internet, because those seeking information could remain anonymous.
- In the settings in which particular drugs are used. For example:

  *Ecstasy, specifically was used solely in clubs and solvents in the streets … [there is a] need to undertake club-based and street-based educational work.*

- In public places where people (particularly young people) congregate, such as bus stops, street corners and shops.
- In ‘comfortable and safe’ environments such as youth clubs, community centres and homes.

6.5 Educators

It was commonly felt that young people’s peers should be involved in educating them about drugs and drug services. It was believed that peers would be seen by young people as a more credible source of information than adults.
Several study reports did not envisage drug education for young people as a one-off event, but as an ongoing process involving mentors and positive role models:

- The value of the older generations of Black Caribbeans (after training) in drug education and as mentors was stressed by several of the community organisations. Older generations were seen as key to providing support to families in crisis, including caring for grandchildren whose parents were problematic drug users (Section 4.2).

- Youth workers were also suggested as mentors and role models for young people: several studies reported positive relationships between young people and youth workers.

Two study reports recommended that initiatives be set up to encourage parents with drug-using children to share their experiences with other parents in the same situation.

Finally, drug education delivered by ex-drug users and drug users in treatment was also recommended by many of the study reports. As one study participant put it:

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

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

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

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

**Individual competence**

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

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

**Organisational competence**

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

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

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

Taking a maturity approach to cultural competence recognises that there are various levels through which individuals and organisation might pass as they move towards a fully-developed level of competence. This is also in keeping with models of lifelong learning and organisational development.
A culturally competent service operates effectively in different cultural contexts so that the needs of all members of their target population can be met by equitable access, experience, and outcome.

The majority of the study reports recommended increased cultural competence by drug services. There was, however, a discrepancy between study participants’ perceptions and experiences of drug services’ current cultural competence. While the principal perception was of cultural incompetence and, in a minority of cases, racism, the studies that documented the experiences of current and ex-drug treatment service clients reported largely positive experiences (Section 5.1.2), except by those with a dual diagnosis and by carers (Section 5.2.5) and that Black Caribbean clients had not experienced racism by drug services (Section 5.2.3). It was clear from several studies that cultural competence was perceived by participants to be characterised by ‘friendly staff’ who were ‘understanding’, ‘welcoming’ and ‘non-judgemental’ (especially of drug-using mothers) in a ‘relaxed’ environment.

7.1 Generic or specific service provision

A small minority of study participants thought that drug services could achieve cultural competence only by providing specific services for Black Caribbeans. The majority of those who discussed this issue did not agree, however:

Many respondents felt that there is a stigma attached to attending a drug service. Having a Black treatment service would only heighten this stigma, especially if the Black treatment service is located in a BME [Black and minority ethnic] community, as it would simply make the community more aware of who is using drugs if they are seen entering or leaving the service.

Concern was expressed at the need not to segregate people or services. Instead, a cultural understanding was needed alongside proactive working approaches that enable barriers to be broken down.

7.2 Ethnicity of drug workers

The lack of Black and minority ethnic drug workers was seen as a major barrier to drug service access by the nine studies that discussed the ethnicity of drug service staff in some depth (Section 5.2.4). The majority of the 34 study reports recommended that, in order to attract Black Caribbean clients, more Black and minority ethnic staff – especially Black Caribbeans – should be recruited.

Staffing is a more complex issue than simply employing workers who are from the same ethnic group as potential clients. Black Caribbean workers should not be expected to be an expert at providing a service to all Black Caribbean drug users, single-handedly, without appropriate and adequate support. All workers, including those who are white, have an explicit role to play in the delivery of culturally competent services.
That said, ethnically diverse teams communicate an implicit message that they can respond to the needs of the whole population. The study reports that discussed this issue recognised this, and none of them recommended drug services staffed solely by Black Caribbeans, but rather:

*Better representation [of Black and minority ethnic populations] in the development of generic services so that the provision for BME [drug] users is mainstreamed and that services further develop cultural competency.*

It was stressed that in order to achieve this, a targeted recruitment strategy is needed and Black Caribbeans need ongoing training (including paid placements) and support to be encouraged into the profession:

*Concern was expressed that whilst Black people would have the capacity to perform the function of a drug worker, they may not have the educational background required to apply for relevant posts. There was, therefore, an expressed need to address training issues for Black staff.*

The value of Black Caribbean drug workers was most commonly expressed as their understanding of the Black Caribbean communities, including the ‘*multiple problems*’ that young people (particularly males) experience:

*During my work [as a detached youth worker], I have known many crack users and dealers approach me and ask for my assistance. They said they would come on a programme with me because I seem to have an understanding. They need to be addressed without any prejudicial views. No-one asks them why they got into that state, they just seem to condemn them from afar. They need to have someone who is sensitive and knowledgeable as an outreach advisor … unless you know the community and even if you are from the community, you need to have some sort of street credibility in order to get those people’s attention.*

*[We recommend] mentoring and counselling which are specific to the psycho-social and developmental needs of Black males … in order to address the multiple social problems highlighted within the report on numerous occasions. Black males need someone to talk to to help address ways of dealing with their problems … access to professional assistance which is designed and administered by Black individuals within the community.*
7.3 Training and support for existing drug service staff

The majority of the study reports recommended improved cultural competence training for existing staff, whatever their ethnicity. The main recommendations concerning training were that Black Caribbean workers and ‘appropriately supported white staff’ should be included in training teams, that training should be mandatory, and that it should include:

- workshops with drug service providers and Black Caribbean community members to ‘break down barriers’ and so that they could ‘understand each other’;
- sessions addressing the barriers to drug service access, particularly stigma and the lack of trust in confidentiality; and
- sessions utilising the positive experiences of those Black Caribbeans who had accessed drug services.

Two study reports added that drug services should regularly collect feedback on their staff’s perceptions (especially those of Black and minority ethnic staff) of the services’ cultural competence, in order to identify and address areas for development.
8 Drug service development

See Key messages for a summary of this section

This section reports on study recommendations for the development of drug services so that they can be more responsive to the needs of Black Caribbean service users and their families. These include:

- a considerable increase in outreach work;
- support for the families and carers of drug users;
- the development of drug services for Black Caribbean females, crack cocaine users and cannabis users;
- flexible access to drug services;
- the coordination of health and social services; and
- better monitoring and evaluation of services.

8.1 Outreach

The most common recommendation for drug service development – put forward by a majority of the study reports – was for outreach work, particularly among young Black Caribbeans. It was thought that outreach workers were, as one study report put it, ‘bridges enhancing communication between drug services and minority ethnic communities’.

Twelve of the study reports discussed outreach work in detail, variously seeing it as valuable to:

- raise awareness of drugs and drug services;
- provide ‘a visual street presence’ and ‘instant access to a qualified drug worker’;
- attract community members to activities that may divert them from using drugs, such as sport, training and employment (Section 9.2);
- ‘reach those considered hard to reach and who would not approach the existing [drug service] provision’, including drug-using mothers. It was emphasised that outreach work should cover an entire town or city to ensure that no population was neglected;
- intervene before a drug user and/or their family reaches crisis point;
- encourage the use of drug services; and
- provide reassurances of the confidentiality of drug services.

8.2 Support for the families and carers of drug users

This was another popular recommendation. Two major needs were identified by the study reports in this respect:

- Support to lessen the tensions in families with a drug-using member by working on their relationships and to help them deal with the drug user.
• Counselling for drug users’ children ‘to address the possible problems raised by their parent’s drug use’.

8.3 Drug services for Black Caribbean females

Several reports recommended that drug services for Black Caribbean women and girls should be developed to include:

• childcare provision at drug services;
• more ‘talking therapies’ for female drug users; and
• training for staff on the issues that Black Caribbean females were particularly thought to face, such as single parenthood and young women’s ‘attraction to young men with the “bad boy” image’.

8.4 Services for crack cocaine users

Several reports pointed out that services for crack cocaine users should be better developed, one adding that this was particularly relevant to Black Caribbeans if the perception that they are more likely to use crack cocaine than heroin is correct. As discussed in Section 5.2.3, there were some reports that drug treatment service clients had experienced discrimination as crack cocaine users attending a service that they saw as set up to deal with heroin users.

8.5 Services for cannabis users

Four studies examined cannabis use among Black Caribbean communities and strongly recommended that specific services for cannabis users be provided. As shown in Section 5.2.2, the ‘acceptable’, ‘soft drug’ image of cannabis (including skunk) meant that even those who were having problems with its did not consider seeking support from a drug service.

8.6 Flexible access

Drug services’ opening hours as a barrier to their access were discussed by a few study reports, which emphasised that the current opening hours added to the ‘unwelcoming image’. These reports recommended that these should be extended to include early morning, late night and weekends, with a more flexible appointment system and confidential drop-in sessions where visitors discuss their own and others’ problems. It was suggested that the effect on access by Black Caribbeans was then evaluated.
8.7 Coordination of services

Around half of the study reports stressed that, in order to address drug use among Black Caribbeans, there should be better coordination of health and social services. The reports frequently described this as a ‘holistic approach’ or a ‘one-stop shop’. Recommendations included:

- A service for young people that addresses their drug use as part of ‘interventions to motivate and educate young people around the many and complex issues that affect their lives’ and addresses issues other than drugs ‘that children might want to discuss with someone they can trust to help them to achieve their full potential’.

- A combined service for those with drug and mental health problems.

- A combined service for those with drug and alcohol problems.

- A service directory distributed to all GPs, housing offices, estates, community services, and the police.

8.8 Monitoring and evaluation

Six study reports called for improved monitoring and evaluation of drug services. The main recommendations concerning these were that drug services should:

- conduct more sophisticated ethnic monitoring of drug treatment services’ clients, to test the indication from their research that Black Caribbeans are under-represented;
- analyse clients’ drug use by postcode to see if trends are developing in a particular area, regularly review the results and translate into action;
- use the Census 2001 format to record ethnicity, to facilitate comparisons and assess if the perception of disproportionate crack use by Black Caribbeans is accurate (Section 3.2); and
- conduct race equality impact assessments in consultation with Black Caribbean communities, and address differential impacts through remedial action.
9 Engagement

See Key messages for a summary of this section

The Department of Health’s Black and minority ethnic drug misuse needs assessment project has not only produced 34 local needs assessments from community organisations on the drug-related needs of Black Caribbeans, but has also engaged local population groups and local drug service planners, commissioners and providers – in most cases for the first time on this issue. The study reports agreed that the engagement which had been initiated by the project should continue and expand. For example:

Because of this project, the voices and need of our community (African Caribbean) are being heard … we believe in this project and community engagement is the way forward.

[The project] was a valuable and profound experience which increased the ability of the [community] organisation and its service users to collectively participate in the beginnings of change and development within service delivery with/to our community.

Although this project has now ended, the real work has not yet begun … effective, relevant and workable strategies for future initiatives will best arise if relevant agencies and individuals capitalise and work on the issues raised by local people during the review.

However, a minority of study reports expressed concern that their recommendations would not be implemented. In particular, there was a view that if the engagement between Black Caribbean community members and drug service planners, commissioners and providers were to cease when the project ended, the under-representation of Black Caribbeans as drug service clients would continue:

Although these recommendations may seem quite simplistic, it is the lack of their implementation that has led to a significant under-representation of African Caribbean people accessing drug services … [and] to the community being unable to engage and participate in tackling drugs and crime within their community.

Local communities need to see local service providers and statutory agencies taking a more proactive approach to their neighbourhoods, otherwise apathy and disengagement will escalate.
9.1 Partnership members

Reflecting the emphasis that the majority of study reports placed on the range of problems facing members of Black Caribbean communities, their recommendations stressed that partnerships between community members and organisations and a wide range of health and social services are necessary for change. The services most commonly recommended as partnership members were:

- employment services;
- GPs;
- mental health services;
- housing services (especially those connected to local authority estates);
- family support agencies;
- the police;
- drug and alcohol service planners, commissioners and providers;
- recreation and leisure services;
- social service agencies; and
- youth services.

Only one study report recommended that representatives of the Christian church were involved in partnerships and another that partnerships included those in the music industry whose work ‘promotes drug use and gang culture’.

Several study reports linked partnerships to regeneration initiatives:

Learning from this research is not new – local people have been asking for local facilities and improved resources for a long time. There is now real opportunity, with the planned regeneration of the area, for the communities and local agencies to really have a meaningful dialogue.

As detailed below, the involvement in partnerships of community members (especially young people), community and voluntary organisations, and the police service was discussed by many reports in detail.

- Community members were seen as key to partnerships, with the aim (after relevant training) of involving them in planning and delivering drug services, especially drug education:

  Communities are the ones, at the end of the day, where the problems are directly. They see and live with them every day so they have to be part of the solution/strategy … We should engage and empower black people.

Many of the study reports stressed that if services want young people to know about and use them, they should involve young people in discussions about these services. It was also thought that the involvement of young people in, for example, a youth forum to advise drug and other services would encourage others to participate:
Young people are very well-placed to motivate other young people to attend and to be vocal in focus groups and ongoing youth forums, which have been successful in other boroughs in improving youth representation in policy making.

- The role of **community organisations** as the link between Black Caribbean communities and the members of other partnerships was highlighted by many of the study reports. They stressed that, by working more closely with Black Caribbean communities and voluntary organisations, all statutory services could improve the quality of their services to Black Caribbeans:

  > There is a huge human resource that is untapped by mainstream organisations … the team members [from a participating community organisation] have gained a locally grounded community development background and have gained a significant advantage in securing the confidence of local groups and therefore are in a position to bring valuable information resources to [drug-related] initiatives.

  > **Build and generate sincere and effective relationships between residents and mainstream drug agencies** … The community organisation would be very keen to facilitate this.

Many community organisations wanted appropriate support and resources so that they could plan and deliver drug services (especially information and advice).

- The role of the **police service** in partnerships was discussed in some detail by eight study reports. One of these reports pointed out that, as many Black Caribbeans (particularly young men and boys) ‘have first hand experience of oppressive treatment from the police, it will be a lengthy process to build trust and respect’.

  It was recommended that the police work more closely with Black Caribbean communities to help inspire the trust and confidence of those living in neighbourhoods affected by drug use. Currently, it was argued, there was apathy among local people because of the perceived failure of the police to tackle drug dealing, crack houses and crime and because they ‘had been slow to respond to informants who have reported crack houses and drug dealing in their neighbourhood’.

  A few study reports stressed that progress on the improvement of the relationship between the police and the Black Caribbean communities should be facilitated by training in cultural competence for police officers.
9.2 Funding issues

The majority of the study reports recommended better funding for community organisations in order to increase and maintain their capacity to assist their communities with a range of needs:

*It is evident from the recommendations that the emphasis rests on the capital investment and development of the Black voluntary sector and community organisations.*

However, it was stressed that the potential role of community organisations in the provision of services was not always recognised and that funding (especially long-term) was difficult to obtain:

*The big agencies need to trust the small players … there is a role to be played by small groups. There are a number of groups with contacts and they are important, but people don’t take them seriously when they approach them for money.*

*Services should develop a relationship marketing strategy, which recognises the importance of each stakeholder and the benefit of long-term investment in relationships with the community, in contrast to short-term projects with short-term funding.*

Eleven study reports recommended funding was provided for so-called ‘diversionary’ activities and facilities. The most common target group for these was young people, and included the provision of leisure activities and better funding for youth services ‘to distract them from drug use’ and education and training opportunities to combat unemployment and the temptation to earn money by selling drugs. Several study reports suggested that young people were consulted ‘to see what they want’ in this respect, and that outreach workers were employed to attract them into the activities.

In addition, several studies recommended funding for leisure, education and training activities for adults, including for those with a dual diagnosis of drug dependence and mental health problems, and for those who had successfully completed treatment.

Nine studies recommended funding for further research on a variety of issues, especially ‘what works’ for Black Caribbeans in terms of drug services and issues affecting young people vulnerable to problematic drug use.
Notes

[2] Calculated from Census 2001, Table S101 (sex and age by ethnic group).


[5] Calculated from Census 2001, Table S102 (sex and country of birth by ethnic group).


References


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<table>
<thead>
<tr>
<th>Organisation</th>
<th>Location</th>
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<tbody>
<tr>
<td>ACHIS (African Caribbean Health Improvement Service), West Bromwich</td>
<td>African Schools Association, London</td>
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<tr>
<td>AWAAZ, Wolverhampton</td>
<td>Bath and North East Somerset Racial Equality Council</td>
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<tr>
<td>Black Country Holistic Approach, Walsall</td>
<td>Bradford Youth Development Partnership</td>
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<tr>
<td>BRO-SIS, Birmingham</td>
<td>Community Action Development, Oxford</td>
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<tr>
<td>Community Development Team, Buckinghamshire</td>
<td>Community Drugs Participatory Assessment Programme (CDPAP), Liverpool</td>
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<tr>
<td>Derby Millennium Network</td>
<td>Gloucestershire Drugs and Alcohol Service and Gymnation Health and Fitness Club</td>
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<tr>
<td>Hideaway Youth Project, Manchester</td>
<td>Hyson Green Youth Club, Nottingham</td>
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<tr>
<td>In-volve, Lambeth</td>
<td>In-volve, Newham</td>
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<tr>
<td>In-volve, Southwark</td>
<td>Kirklees Racial Equality Council – Youth Forum</td>
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<tr>
<td>Mentek Foundation, Liverpool</td>
<td>NACRO and Prison Link, Wolverhampton</td>
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<td>Nguzo Saba Centre, Preston</td>
<td>Olmec, London</td>
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<td>Outside Edge, London</td>
<td>Partners of Prisoners and Family Support Group, HMP Risley</td>
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<td>Sheffield Black Drugs Service</td>
<td>St Peter’s Elders’ Group, Sweatbox Youth Group and African-Caribbean Community Initiative (ACCI), Wolverhampton</td>
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<tr>
<td>Turning Point – Worcester Druglink</td>
<td>Walsall ACIDS (Addressing Cultural Inequalities in Drug Services)</td>
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<tr>
<td>Waltham Forest BME Alliance</td>
<td>Wellingborough Black Consortium</td>
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