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EMCDDA SCIENTIFIC REPORT

**Update and complete the analysis of drug
use, consequences and correlates
amongst minorities**

Volume 1 – Synthesis

EMCDDA / 2002

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Executive summary

We are very conscious that, within the European Union, various terms are used to refer to the many diverse communities living in the member states. We prefer the term Black and minority ethnic (BME) groups / communities. This reflects that our concern is not only with those for whom 'Black' is a political term, denoting those who identify around a basis of skin colour distinction or who may face discrimination because of this or their culture: 'Black and minority ethnic' also acknowledges the diversity that exists within these communities, and includes a wider range of those who may not consider their identity to be 'Black,' but who nevertheless constitute a distinct ethnic group. *Centre for Ethnicity and Health, University of Central Lancashire, Preston, UK.*

Aim

The aim of the study was to examine drug use amongst Black and minority ethnic (BME) communities in the European Union (EU) and Norway in order to give an overview of the situation and its consequences and correlates; to compare the drug use of BME groups with that of the rest of the population; to identify key points relevant to policy-makers; and to suggest further work to fill information gaps.

Methods

Much of knowledge base on the drug use of BME communities is undocumented. To overcome this significant barrier to data collection and to begin to acquire a picture of the situation across 16 countries, the research method used 'key players' as informants. Previous work on drug use amongst BME communities by the Centre for Ethnicity and Health has shown that informants should not be restricted to those working in the drugs field in some capacity (as service providers or as researchers, for example): a diverse range of others involved in aspects of the health and welfare of BME communities - such as BME community organisations, teachers, general health and social services, the police, regional and local government services, youth services, and so on - also have valuable information about drug use amongst these communities.

Key messages were extracted from EMCDDA's previous work on this issue and used to devise a questionnaire for each country. Respondents were asked how accurate they thought a series of statements were and to add any other information they had from, for example, academic journal papers, research reports, the media, websites, and personal experience. Details of pertinent documents and contact details of other potential informants were also requested. The relevant questionnaire was sent to individuals and organisations identified from databases of those working in the drugs field and/or with BME groups, and to new contacts suggested by respondents. To maximise the response rate, each questionnaire was translated into the main language of the country it concerned.

Responses

By the end of the study, questionnaires had been sent to 1,122 potential informants. The overall response rate was at least 28.7% (322) or 1 in 3.5, a high rate for a postal/email survey (in some cases, questionnaires were sent to several members of the same organisation, but there was just one response on behalf of the whole organisation). Three-quarters of respondents (239) completed the questionnaire and/or provided information in another form, and a total of 302 further contact details of organisations or individuals were received. The key player method resulted in 39% (125) of all responses coming from outside the drug service and drug research fields, showing the value of the strategy of asking for information from other disciplines.

Data analysis

The data from informants were collated as profiles for each of the 16 participating countries. A thematic analysis was then performed according to the themes that most consistently arose and that are pertinent to the drug use and related issues of BME groups at local, national, and EU-wide levels. The themes are therefore firmly grounded in the data received from informants during this study, and consisted of:

- the acknowledgement of drug use amongst BME communities and the value of ethnic monitoring
- the prevalence of drug use amongst BME communities, including data from drug services and the criminal justice system
- patterns of drug use amongst BME communities, including cultural variations; factors specifically affecting their drug use; the effects of social exclusion; myths, scapegoats and stereotypes; and barriers to drug service access
- the research agenda, including the need to confront the hidden nature of drug use amongst BME communities; collect comparable data across the EU; consider the most effective methods of expanding the knowledge base; and to disseminate information
- drug service development, including examples of good practice.

The thematic analysis allows the following general statements to be made, although there is much variation between countries, not only in policy and practice surrounding the drug use of, and responses to, BME groups, but also in the knowledge base.

Acknowledgement of drug use in BME communities

It is clear from some of the responses received by this study that, across the EU, drug use amongst BME communities is under-researched, unacknowledged, ignored, unrecognised, or hidden by some policy-makers, drug researchers, drug service planners and commissioners, and by some members of some BME groups themselves. Reasons for this include a fear of accusations of racism by drawing attention to drug use in these communities, and a desire to avoid increasing stigmatisation of them. This stance is misguided. Ignoring or hiding a problem does not make it disappear: it must be confronted in order that appropriate responses can be developed. Many BME groups are already stigmatised as drug users or dealers, yet refusing to accept that this behaviour may occur amongst them does nothing to decrease the stigmatisation, and obstructs consideration of their drug service needs by policy-makers and service planners and commissioners.

Ethnic monitoring

Ethnic monitoring is an extremely sensitive issue, especially when drug use is being monitored, and there was a great deal of variation in the approach to this across the EU member states. However, consistent, co-ordinated ethnic monitoring, based on a common set of classifications, is a reliable instrument to measure drug service use and, importantly, non-use, by drug users. Analysis of results of ethnic monitoring from drug services and drug surveys provide a baseline for improvements to the quality of service provision - including equal access for all drug users and more equitable allocation of resources - and can be used to track changes in drug-using patterns and in the uptake of drug services.

Prevalence

Successive annual reports from EMCDDA on the state of the drugs problem in the EU show that, other than for cannabis, the use of which is relatively common and not highly stigmatised, prevalence data are less reliable for more hidden patterns of drug use such as heroin injecting. It follows that, because drug use by some BME groups is extremely hidden, and because of the lack of research on this issue, the prevalence of drug use amongst these groups is currently even more difficult to assess. BME drug users are under-represented in drug treatment statistics and over-represented in drug law offence statistics. Such data alone therefore give an extremely distorted picture of the prevalence of drug use and of drug-using patterns, yet in some countries, comprise the bulk of the recorded knowledge base.

Drug-using patterns

The link between drug use and social exclusion is well-established, and the evidence collected by this study does not indicate that the drug-using patterns of BME groups are different from those of socially-excluded, white, indigenous populations. However, there are some cultural variations in the types of substances used, and some risk factors specifically affecting drug use amongst BME communities, such as trauma suffered by those coming from countries where there are wars, and the migration experience failing meet expectations.

Myths, stereotypes, and scapegoats surround the drug use of BME groups, but due to the lack of research they can neither be confirmed nor denied. Examples are that religion and the 'strong social bonds' in some BME communities are protective factors against drug use; that BME females do not use drugs; and, fuelled by adverse media reports, an over-representation in criminal statistics, and because they are highly visible to the white population because of their skin colour, that some BME groups are heavily involved in drug distribution.

Barriers to drug service access

BME groups face many barriers to drug treatment, education, and prevention services. These include a lack of cultural sensitivity by the service, a distrust of confidentiality, communication problems because of language, a lack of awareness of drugs and drug services, the stigma surrounding drug use within their community, and the failure of drug services to target BME drug users.

Needs assessments

The usual method of conducting drug needs assessments consists of commissioning researchers who 'parachute' into the relevant local communities, ask about their drug-related needs, raise expectations that there will be some change, but disappear to produce a report that has no long-term impact. Future research should avoid the parachuting model: it is a missed opportunity that the resources employed in traditional needs assessment processes neither involve nor benefit the communities whose needs are being assessed. Fortunately, there are some initiatives within the EU that are successfully engaging BME communities in needs assessments and these can be used as example of good practice.

Development of drug services for Black and minority ethnic groups

Many BME groups are already socially excluded: failure to consider their drug service needs exacerbates this situation. There is considerable variation in the drug services provided for BME groups both within and between member states, but across the EU as a whole, drug policy and practice reflect the needs of the white indigenous population. Although the data collected for this study indicate that the drug-using patterns of BME groups are not different from those of socially-excluded, white, indigenous populations, this does not follow that BME groups can simply 'slot into' existing drug services. Responses may have to be different in order that the barriers to drug service access that these groups face can be overcome.

There is a lack of prevalence estimates of drug use amongst BME communities, they are under-represented in drug services, and there is a lack of recognition that drugs are used by them. This combination means that acknowledgement that there is drug use amongst these communities is an extremely important stage in the development of responses. The lack of evidence of the prevalence of drug use can be used as a justification not to address it, yet it is only through acknowledging it that debate and further investigation can be initiated. The way will then be paved for responses that will support BME communities through drugs and drug service education and awareness-raising activities. Needs assessments can then take place alongside changes within drug services, and, ultimately, evidence of prevalence and drug service uptake and retention can be systematically acquired. This process should be monitored throughout via drug service commissioning systems, to ensure that the needs of the BME population is being identified and appropriate responses are being implemented.

Research and policy-making agendas

The research and policy-making agendas at local, national, and EU-wide levels should prioritise investigations into, and responses to:

- the reasons for the under-representation of BME groups in drug services
- whether or not the commonly-held beliefs about BME groups (such as strong social / family bonds and religion are factors that protect against drug use) are accurate and, if so, how these protective factors operate
- the factors affecting drug-using patterns amongst specific BME groups, such as selling drugs precedes use amongst those who are socially excluded and involved in drug distribution as a method of income generation
- the implementation and analysis of the results of ethnic monitoring.

Given the link between drug use and social exclusion, drug policy development should include connections with other health, social, and regeneration agendas.

Evaluation should be a key component of all drug services for BME groups and an EU-wide database of such initiatives should be constructed to ensure that lessons can be learned from them. Given the gaps in the knowledge base on the drug use of, and related service provision for, BME groups, research results and examples of good practice amongst drug services should be widely disseminated.

The current study was only the very first step in constructing an overview of the drug use of BME groups in the EU. A highly fruitful next step would be to use the Delphi method: to devise just one questionnaire based on a synthesis of the results from this study and repeat the exercise, increasing the range and diversity of informants, and including strategies that encourage the participation of more BME groups in the data collection process.

Acknowledgements

The following 139 individuals or organisations in each participating country are thanked for providing valuable information for this project. We are equally grateful for the information from a further 100 who not indicate that they could be named, or, in a few cases, wished to remain anonymous.

We apologise for any wrongly-spelt names in the following list - hand-written responses were sometimes difficult to read.

Austria

CARITAS HIOB	Gabriele Druneckny
Karin Goger	Christine Gruber
Martin Hefel	Thomas Legl
Bernard Lindenbauer	Karin Schulze
Alfred Uhl	Verein Wiener Sozialprojekte
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Belgium

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Denmark

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Finland

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France

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Germany

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Janet Hucker
Gerry McAleenan
Martin Murphy
Maura Seabrook

Italy

Francesco Auriemma
Monaci Paola
Stefania Rota
Stefania Totaro
Ludovico Verde

Roberto Chiarelli
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Polomo Valerixio

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Portugal

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Fundación Secretariado General Gitano (FSGG)

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Fiaz Khan
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Luke Mitcheson
Geeta Pankhania
Malcolm Rae
Matthew Southwell
Aziz Ahmed Toki
Ferhan Wetisal

Getachew Alemu
Evelyn Asante-Mensah
Tracy Beswick
Paul Cathal
Sook Mun Chow
Vasco Fernandes
Mahmood Hussain
Michael Kelleher
Neville Leroy
Jim McCambridge
B.I.G. Mukhayer
Azra Puri
Jac Ross
Sarah Swash
R Velleman
Maahmood Yaqoob

The research team are also grateful to Carol Haworth and Samantha Duncan at the Centre for Ethnicity and Health, University of Central Lancashire, UK for their work on this project.

Lifeline Language Services, Preston, UK are thanked for their care and efficiency in translating the questionnaires and accompanying letters into each of the main European Union languages, and we are also grateful to friends and colleagues who helped us to translate responses.

We are very conscious that, within the European Union, various terms are used to refer to the many diverse communities living in the member states. We prefer the term Black and minority ethnic (BME) groups / communities. This reflects that our concern is not only with those for whom 'Black' is a political term, denoting those who identify around a basis of skin colour distinction or who may face discrimination because of this or their culture: 'Black and minority ethnic' also acknowledges the diversity that exists within these communities, and includes a wider range of those who may not consider their identity to be 'Black,' but who nevertheless constitute a distinct ethnic group.

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1 Background to the project

An EMCDDA project to map available information on the relationship between drugs and social exclusion was conducted from September 1999 - November 2000 (*Mapping available information on social exclusion and drugs, focusing on 'minorities' across 15 EU member states*, Khan et al, 2000). That project collected data mainly through the available literature and a network of 14 partners throughout the European Union (EU), and provided information on definitions of Black and minority ethnic (BME) groups; socio-demographic and economic conditions of BME groups; the situation of these groups in terms of social exclusion and drug use; national policies on drugs and BME groups; and selected examples of relevant practice interventions.

As a mapping exercise, the previous project did not allow a descriptive overview of drug use amongst BME groups in the EU, the consequences of this, nor an analysis of the hypotheses that might explain the differences observed between their drug use and that of the rest of the population. Consequently, the current project was commissioned by EMCDDA to focus on patterns of drug use and their consequences and correlates amongst all BME groups in the EU. The objective was to collect more comprehensive data to assist in answering the following questions:

What is the situation regarding drug use amongst minorities (levels, trends, patterns, health, social and legal consequences, and correlates) and how does it compare to the general population?

What information exists that might help account for any differences observed (eg cultural traditions, including 'protective' ones, reporting differences, social exclusion, discrimination, etc)?

This was an ambitious undertaking in the time (eight months) and financial resources allowed for the project, so the Centre for Ethnicity and Health aimed to fulfil the objectives by employing creative data collection methods. Much of the drug use of BME communities is undocumented and ethnic monitoring is inconsistent and inadequate both within and between countries. To overcome these significant barriers to data collection, the sources of information utilised by the previous project were considerably expanded, in order to provide a more comprehensive picture of drug use and related issues amongst BME communities in the EU. In total, 1,122 individuals or organisations throughout the EU were contacted for information.

Section 2 of this report describes and discusses the methods used to collect data for this study: the identification of potential informants, the research instrument, the data collection process, the responses and response rate, and how the data were analysed.

Section 3 presents a thematic synthesis of the data according to the broad themes of:

the acknowledgement of drug use amongst BME communities and the value of ethnic monitoring

prevalence of drug use amongst BME communities, including data from drug services and the criminal justice system

patterns of drug use amongst BME communities, including cultural variations; factors specifically affecting their drug use; the effects of social exclusion; myths, scapegoats and stereotypes; and barriers to drug service access

the research agenda, including the need to confront the hidden nature of drug use amongst BME communities; to collect comparable data across the EU; to consider the researchers and informants who can best expand the knowledge base; and to disseminate information

drug service development, including example of good practice

a summary of the findings and recommendations in the form of key points for consideration by policy-makers.

The wide variety of publications, government reports, websites, etc. that informed the current project have been added to the relevant country profiles in Volume 2 and also appear in alphabetical order in Section 4 of Volume 1.

Detailed profiles of the situation regarding the drug use of BME groups in each EU country and Norway are presented in Volume 2.

This study did not reproduce the work conducted on EMCDDA's previous investigations into BME groups in the EU (Khan et al, 2000), but concentrated on drug use amongst them. Although the relevant information from Khan et al was incorporated into the current study, comprehensive details of the socio-demographic and economic conditions of these groups, national drug policies, and some examples of practice interventions can be found in the report on the previous project.

This report is a synthesis of the findings that are presented in the detailed country profiles in Volume 2. Although it is not intended that any country profile is used as a 'stand-alone' report of drug use amongst Black and minority ethnic communities, they contain a wealth of local and national information on drug use amongst BME groups.

2 Methods

This section reports on the methods used to collect data on the drug use of BME groups in the EU. It describes how potential informants were identified, how the research instrument was constructed, the process of collecting data, issues arising from the responses and the response rate, and the data analysis process.

In order to obtain a descriptive overview of drug use amongst BME groups to fulfil the aims of this study, the research methods consisted of three major elements. For each country:

a list of potential informants was compiled from databases of individuals and organisations working in the drugs field and/or with Black and minority ethnic groups

key messages were extracted from EMCDDA's previous work on this issue (Khan et al, 2000) and used to devise a questionnaire to ask respondents how accurate they thought they were, to add any other information they had (such as that from academic journal papers, research reports, the media, relevant websites, and from personal experience or rumours), and to provide contact details of other potential informants

questionnaires were sent to any new informants suggested by respondents.

2.1 Identification of potential informants

The experience of the Centre for Ethnicity and Health from our work in the UK, and from information from the previous project (Khan et al, 2000), is that much of the drug use of BME communities is undocumented and that ethnic monitoring is unlikely to be consistent and adequate both within and between EU countries. To overcome these significant barriers to data collection, the 'one partner per country' method used by the previous project was considerably expanded, in order to provide a more comprehensive picture of drug use and related issues amongst BME communities in the EU. The Centre's work in the UK has established that the identification of 'key players,' from a range of disciplines, is an extremely productive method of obtaining a descriptive overview in the absence of statistical information (it was clear from the previous project that it is not possible to obtain prevalence rates of the drug use of BME communities).

Potential informants were identified and contacted on an on-going basis throughout the project, from the following sources:

the Centre for Ethnicity and Health's database of contacts that includes a wide variety of BME forums and the Centre's international and European contacts

contacts from EMCDDA's previous work on the drug use of BME groups in the EU (Khan et al, 2000)

QED (network of qualitative drugs researchers in the EU -
<http://www.qed.emcdda.org>)

UNDCP Directory of non-governmental organizations working in drug demand reduction, 2001

EMCDDA's Annual Report 2001

the REITOX National Focal Points' 2001 annual reports to EMCDDA

via the project manager at EMCDDA, 15 REITOX National Focal Points (NFPs) in the EU were asked to participate in the project as a voluntary task

relevant conference participant lists

a flyer inserted in the conference bag at the International Conference on the Reduction of Drug Related Harm, Ljubljana, Slovenia, in March 2002

requests for contacts on several relevant electronic discussion lists, in the UK's DrugScope Members' Briefing and EMCDDA's Drugnet Europe, on EMCDDA's QED website, and by email to all the qualitative drug researchers listed in QED's Directory of Researchers

EMCDDA staff, via the project manager at EMCDDA

relevant websites and databases concerned with drug use and/or BME groups as follows:

A-Clinic Foundation	AC Company - European Project for the Target Group of Mobile Drug Users
ARCHIDO	Council of Europe, Pompidou Group
DrugScope (UK)	Exchange on Drug Demand Reduction Action (EDDRA)
EURIDICE	European Addiction Training Institute (EATI)
European Association of Libraries and Information Services on Alcohol and Other Drugs (ELISAD)	European Group for Exchange Rhine-Meuse-Moselle (GEERM)
European Cities on Drug Policy (ECDP)	European Commission
European Household Survey Panel	Euro-methwork
European Network for Practical Approaches in Addiction Prevention (EURONET)	European Network for Prevention of Drug Abuse - Drugs and Images Network
Hamburgische Landesstelle gegen die Suchtgefaren - Three Cities Project	European Network of Drug and HIV/AIDS Services in Prison
European Network of Telephone Drug Helplines (FESAT)	European Network on Drug Abuse Prevention among Children and Young People (DAP)
European NGO Council on Drugs and Development (ENCOD)	European Society for Social Drug Research (ESSD)

European Society of Professionals Working with Drug Dependencies (ITACA)	Federation of European Professionals Working in the Field of Drug Abuse (ERIT)
Forum Européen Pour la Sécurité Urbaine	Fundación Secretariado General Gitano / European Network for Drug Abuse and HIV/AIDS Prevention in the Romany Community (FSGG / SASTIPEN)
Gruppo Abele	Hassela Nordic Network
International Council on Alcohol and Addictions (ICAA)	INSUFO
International Parenthood - Drug Abuse Network (RIPUDD)	IREFREA (promotion and research of prevention of drug and other child and adolescent problems)
Les Étrangers en France (INSEE)	Le Système Français de Prévention et de Soins en Toxicomanie (ANIT)
Medecins Sans Frontieres	National Acupuncture Detoxification Association (NADA)
OCRIS	Odense Kommune (ROPLNZ)
TMC c/o PRAXIS (working with drug users in prison)	Toxicomanies - Europe - Echanges - Etudes (T3E)
Trimbos Institute - Trimbos Peer Support Project	United Nations International Drug Control Programme (UNDCP)
United Nations High Commission for Refugees (UNHCR)	

In addition to all of the above, the list of potential informants grew as more were provided in completed questionnaires.

2.2 Research instrument

The research instrument designed for this project was a series of questionnaires - different for each country - compiled from relevant key data from EMCDDA's previous investigations into the drug use of BME groups in the EU. For each country, the information from Khan et al (2000) was collated in the form of statements about each BME group, with which respondents were asked to indicate their level of agreement. For example, Khan et al report that in Spain, Gypsies who use drugs do not access drug services. The questionnaire for Spain therefore included a statement 'Gypsies who use drugs do not access drug services' and asked respondents to indicate their level of agreement using a 5-point scale (strongly disagree - strongly agree).

Respondents were also asked for any other information about each BME group, for general information about all BME groups, whether any groups were missing from the list in the questionnaire, for details of relevant publications and other documents, and for the contact details of others who may be able to provide information for the study. An example of a questionnaire appears in Appendix 1.

A letter (Appendix 2) accompanied the questionnaire, and explained the background to the project. Letters were personally addressed to potential respondents (ie *Dear name*). The questionnaires and accompanying letters were translated by a professional translating service into the main language for each country (two languages in the case of Belgium).

In order that potential informants were not discouraged from responding because they thought they had too little information, both the questionnaire and the accompanying letter stressed that:

We don't expect anyone to be able to answer all the questions! However, even if you only have one small piece of information, please take a few moments to add it to the questionnaire. Not much is known about this issue, so anything you can tell us will be valuable.

This study was already underway when the Centre for Ethnicity and Health began to develop links with the Norwegian Temperance Alliance around BME community engagement issues, and the Alliance volunteered to participate, providing the contact details of others who could also help. Norway is not a member of the EU and was therefore not included in the study by Khan et al (2000). Unlike other EU countries, a questionnaire on the drug use of BME groups in Norway asking for levels of agreement with series of statements could therefore not be compiled. Instead, contacts were given a list of general questions on this issue.

2.3 Data collection

The questionnaire and accompanying letter were sent to 1,122 potential informants in both English and their native language, with a request to answer in English if possible. The strategy of providing the questionnaire and letter in potential respondents' own language proved to be successful, and is doubtless responsible for the overall high response rate (see Section 2.4): the large proportion of responses that were not in English indicates that these would not have been forthcoming if the questionnaire had been sent in English only.

The strategy to identify informants had produced a somewhat bewildering array of European organisations concerned with drugs and/or BME groups, and revealed that some are connected to each other, the same individuals are involved in several different organisations, and, unfortunately, that many contact details (particularly email addresses) on databases are out-of-date. Time-consuming aspects of the data collection period included trying to locate specific individuals and organisations who it was thought could provide valuable information to the study, but for whom the available contact details were incorrect.

Another resource-consuming aspect of the project was dealing with the volume of information that was received in addition to responses on the questionnaire. Whilst this was extremely welcome, resources did not allow for a verbatim translation of the large amount of material that was in a language other than English. Using the research team's colleagues and friends who understood the relevant languages, and the internet translation website <http://www.babelfish.altavista.com>, the information was summarised, checked for relevancy to this study, and, if appropriate, added to the relevant sections of the questionnaire to facilitate a coherent analysis of all the data collected for this study.

Data collection continued for four months, from the end of February to the end of June, 2002. All contacts and responses were recorded on a specially-designed contact monitoring form, and reminders sent to those who had not responded after four - six weeks. Wherever possible, informants were contacted by email, although if they did not respond to this, reminders were sent as hard copies by ordinary mail.

2.4 Responses

Table 1 shows that the questionnaire and accompanying letter were sent to 1,122 potential informants, and that the overall response rate was 28.7% or 1 in 3.5, an extremely high rate for a postal / email survey. The response rate varied considerably however, from 12.5% (Netherlands) to 71.1% (Finland): each country's response rate is discussed in the Country Profiles in Volume 2.

The reasons some of those contacted to participate in this study did not respond at all, even to decline the invitation, can only be speculated. It could be that in some countries, a response to say 'I have no information' or 'I do not want to participate because ...' is thought unnecessary. No such responses were received from Greece, Norway, and Portugal. In Sweden, on the other hand, responses of this nature outnumbered those with information. Nonetheless, overall, almost three-quarters of responses - a total of 239 - contained information.

2.4.1 Responses with no information

Responses stating that the sender had no information were an aspect of this study that merits consideration alongside the findings and when further work on the issue of drug use amongst BME groups is conducted. Responses with no information fell mainly into one of three categories:

- Those who simply said they had no information - the largest proportion. In the case of France, this was frequently followed by the comment that under French legislation, ethnic monitoring cannot be conducted.
- Those who misunderstood the aim of the project and the origin of the statements in the questionnaire, despite the explanation in the accompanying letter. For example, it came to the attention of the research team that some of the drug professionals contacted in Austria feared that the results of this study would further stigmatise BME groups there by increasing racism and nationalism; and that some Belgian drugs researchers who had received the questionnaire had circulated an email urging others not to respond because they saw the survey as a tool to stigmatise BME drug users, and were concerned about implications of the results in terms of immigration policy. In Austria, complaints became so vehement that, after discussions with EMCDDA and the Austrian REITOX National Focal Point, data collection was prematurely halted in that country. In Belgium, a respected drugs researcher intervened on behalf of the research team and contacted complainants in their own language to attempt to allay their fears.

This reaction is surprising in the sense that it was thought (albeit by a small minority of those contacted) that EMCDDA and the Centre for Ethnicity and Health may use the results of the study in a way that would impact negatively on BME groups in the EU. On the other hand, the reaction was not entirely unexpected, as the Centre's experiences in the UK have revealed that it is difficult for many individuals and organisations (including policy-makers, drug researchers, drug service planners and

commissioners, and BME groups themselves) to acknowledge that there is problematic drug use amongst BME groups, because they fear accusations of racism and want to avoid increasing stigmatisation of these communities. This issue is further discussed in Section 3.1.

Other comments questioning the validity and ethicality of the method of data collection and declining to give an opinion not based on 'objective facts' were made directly to the research team by recipients of the questionnaire from Belgium (by 2 respondents), Denmark (4), Spain (2), Sweden (4) and the UK (2).

- The third group of those who did not provide information were those who gave another reason for not doing so. For instance, two youth workers from Austria said that they could not provide any information because they did not have any drug users amongst their clients, and a respondent from France because they no longer work in the drugs field. However, it is believed that such respondents had misunderstood that information was not only required from 'drug experts,' but from a wide range of those who come into contact with BME groups.

2.4.2 Terminology

As discussed earlier, the Centre for Ethnicity and Health prefers to use the term 'Black and minority ethnic groups,' although in the questionnaire for this project, we felt that 'minority ethnic' or 'ethnic minority' would be most easily understood by potential informants. In the previous project, Khan et al (2000) devoted considerable effort to categorising the different BME groups in each EU country. However, given that the questionnaire for the current study had separate sections, each headed with the name of the group in question (Pakistani, Iranian, Central and Eastern European, Black African, Gypsy / Roma, etc), it was felt that it was clear about which groups questions were being asked, whether or not they were regarded as a BME group by a particular country and/or respondent. The terminology did not appear to affect responses, despite being unfamiliar to some respondents.

Nevertheless, a few respondents - from Denmark, Finland, France, Germany, and Greece - commented on the term 'minority ethnic groups.' For example, it was pointed out that, in Greece, the only officially-recognised ethnic minority is the 'Muslim minority' and it is clear from Khan et al (2000) that some BME groups - such as Gypsies in Portugal and Spain - are officially categorised as Portuguese and Spanish citizens.

Table 1: Contacts and response rate

	CONTACTED N	RESPONSES N	RESPONSE RATE	RESPONSES WITH INFORMATION	
				N	OF ALL RESPONSES
AUSTRIA	78	20	25.6%	14	70.0%
BELGIUM	72	22	30.6%	14	63.6%
DENMARK	40	13	32.5%	9	69.2%
FINLAND	45	32	71.1%	28	87.5%
FRANCE	99	24	24.2%	19	79.2%
GERMANY	104	21	20.2%	15	71.4%
GREECE	35	7	20.0%	7	100%
IRELAND	77	15	19.5%	11	73.3%
ITALY	58	14	24.1%	11	78.6%
LUXEMBOURG	19	8	42.1%	6	75.0%
NETHERLANDS	80	10	12.5%	5	50%
NORWAY	8	5	62.5%	5	100%
PORTUGAL	47	12	25.5%	12	100%
SPAIN	125	32	25.6%	25	78.1%
SWEDEN	50	20	40.0%	9	45.0%
UK	185	67	36.2%	49	73.1%
TOTAL QUESTIONNAIRES SENT			1,122		
TOTAL RESPONSES			322*		
OVERALL RESPONSE RATE			at least* 28.7% / 1 in 3.5 range 12.5% - 71.1%		
RESPONSES WITH INFORMATION			239		
OVERALL PROPORTION OF RESPONSES WITH INFORMATION			74.2% / 1 in 1.3 range 45% - 100%		
<p>*In some cases, questionnaires were sent to several members of the same organisation, but there was just one response on behalf of the whole organisation.</p>					

2.4.3 Response to the request for further contacts

Informants to this study gave a total of 302 contact details of individuals and organisations they thought could provide further information. All those who were not already on the project's database were sent a questionnaire. Informants from Spain, Italy and Portugal gave the largest number of further contacts (56, 53 and 40 respectively). The least number of new contacts were from Denmark (3), Norway (4), Belgium (7), Luxembourg (8 - although this is a relatively small country), the Netherlands (8), and Sweden (8).

As discussed in Section 2.1, the method used to collect data for this project moved far beyond the traditional interpretation of 'research partners.' For the 'key player' method to be most productive, however, informants should not be restricted to those working in the drugs field and academics, as the Centre's previous work has shown that those involved in other aspects in the health and welfare of BME communities are also likely to have information about drug use amongst these communities: as diverse a range of informants as possible was crucial to the compilation of a valid overview of the drug use of BME groups in the EU. This was clearly explained in the questionnaire as follows:

Please give the names and contact details (address, telephone, fax, email, website) of any person or organisation you think could give us more information. We will then send this questionnaire to them, or, if you prefer, you can copy it and the accompanying letter and send it to them yourself. Note that contacts need not be working in the drugs field as, for example, researchers or drug service providers. Valuable information can also be provided by ethnic minority community organisations, general health and social services, social workers, the police, regional and local government services, youth services, etc.

Table 2 shows the occupations of respondents to this study, revealing that one-third (104/32%) were from drug research organisations or universities, and 29% (93) were from drug services. The first phase of the identification of potential informants detailed in Section 2.1 was concentrated heavily on drug researchers and drug services, but it was hoped that information on completed questionnaires would lead to contacts from other disciplines. Although this aim was achieved, and this study has laid the foundations for future work using the key player method in the EU, few drug researchers and drug service workers gave contacts outside their own professional network. In particular, few gave contacts of BME organisations other than large, national organisations such as Fundación Secretariado General Gitano in Spain. Although 29 responses to this study were received from BME organisations, 20 were from the UK, from the Centre for Ethnicity and Health's own database. Nevertheless, 39% (125) of all respondents were neither from drug services nor research organisations / universities, showing the value of the strategy of asking for information from outside these disciplines.

Although a few informants provided lists of BME community organisations in their countries, these contained many outdated or incomplete contact details. For example, many questionnaires sent to those on a database of 351 BME organisations given to the study by an informant in Finland were returned to the research team marked 'moved premises' or 'address not recognised,' and the list was received too late in the data collection period to investigate the whereabouts of those whose contact details were incorrect. Another example is a list of BME organisations received from a Greek informant: in some cases, no postal nor email address was given, meaning that a questionnaire could not be sent to them.

Table 2: Occupations of respondents

Occupation	total	Aus	Bel	Den	Fin	Fra	Ger	Gre	Ire	It	Lux	Neth	Nor	Por	Sp	Swe	UK
Research / university	104	4	12	9	7	11	3	1	5	4	3	4	2	1	12	10	16
Drug service	93	5	3	2	15	5	14	2	5	6	3		3	4	10	3	13
BME organisation	29*				2*				2					1	4		20
Government department / drug policy	21	4	1	1	1				1	3		2			3	1	4
European / international organisation	17		3			2	1			1		2			1	6	1
Social worker / community worker	11	3			1				2	1				3			1
Health service	10						2					1					7
Youth worker / teacher	5	3							1		1						
Journalist / media	3				1	2											
Librarian	3					2									1		
Prisons	2		2														
Police	2				2												
Immigration	1				1												
Cultural planning officer	1				1												
REITOX National Focal Point	7	1		1		1		1	1			1	1	Not applicable	1		
Unknown	13		1		1	1	1	1						3			5
TOTAL	322	20	22	13	32	24	21	7	15	14	8	10	5	12	32	20	67

*This statistic excludes responses to a mailshot to 351 BME community organisations on a database provided by an informant: these questionnaires were sent at the very end of the data collection period, and, at the time of writing, have attracted only 5 responses, 3 of which had no information. The database may be outdated, as many questionnaires were returned marked 'moved premises' or 'address not recognised.'

2.5 Data analysis

As shown in table 3, of the total of 239 individuals and organisations who sent information to this study, 157 completed the questionnaire. Many of these respondents not only gave additional information where requested on the questionnaire, but also sent it in other forms, such as research reports, journal papers, statistics on drug treatment clients and drug law offences, and the results of literature and other database searches. Over one-third (82/34.3%) of informants did not complete the questionnaire, but provided information in another form.

Table 3: Questionnaires and other information received

	Completed questionnaire	Other information	Total
AUSTRIA	10	4	14
BELGIUM	8	6	14
DENMARK	5	4	9
FINLAND	18	10	28
FRANCE	3	16	19
GERMANY	9	6	15
GREECE	4	3	7
IRELAND	7	4	11
ITALY	8	3	11
LUXEMBOURG	4	2	6
NETHERLANDS	4	1	5
NORWAY	4	1	5
PORTUGAL	10	2	12
SPAIN	17	8	25
SWEDEN	2	7	9
UK	44	5	49
TOTALS	157	82	239

Factors influencing the data analysis methods employed by this project were:

- The statements on the drug use of BME groups in each country were based on EMCDDA's previous work on this issue (Khan et al, 2000). As the information provided by Khan et al was different for each country, the statements in each country's questionnaire were also different and could not therefore be collated and compared across the EU.
- The sources of data varied between countries. For example, much of the information on the drug use of BME groups in Sweden was from research that was conducted between 1991 and 1995, whilst that from Norway was based on current research; drug treatment and/or drug law offence statistics figured largely in the information from Austria, Denmark, Ireland, Italy, and Luxembourg, whilst information received from Finland indicated a strong qualitative knowledge base. Ethnic monitoring cannot legally be conducted in France and appears not to be conducted in Belgium, Greece, Portugal, and Spain, so the information from these countries was largely of a qualitative nature.

The data from informants were collated as profiles for each of the 16 participating countries (Volume 2). Clearly, the variety of forms in which information was received meant that a statistical analysis was highly unsuitable. Consequently, a thematic analysis was then performed on the data, according to themes that most consistently arose and that are pertinent to the drug use and related issues of BME groups on local, national and EU-wide levels. These themes are therefore firmly grounded in the data received from informants during this study.

The results of this analysis appear in the following section.

3 Overview of the drug situation amongst Black and minority ethnic groups in the European Union

The information on specific BME groups and countries reported in this section are derived from that collected for the study and do not necessarily represent the views of the authors of this report. Further details of all the illustrations given below can be found in the relevant country profiles in Volume 2.

The variations in this information, discussed at the beginning of this section, should be firmly borne in mind throughout.

This section presents a thematic synthesis of the data according to the broad themes identified by this study. As shown in detail in Section 2, the amount of data collected varied tremendously between countries. There were also variations in the aspects of the drug use of BME groups in the information received for each country, not least because each questionnaire was compiled from information provided by EMCDDA's previous work on this issue (Khan et al, 2000): it is to be expected that, given the gaps in the knowledge base, the type of information reported in Khan et al was not consistent across all countries. Because of these variations, no attempt has been made to collate and compare the data to provide a picture of the drug use of a specific BME group across the whole of the EU, nor to compare drug use between specific BME groups. Such an exercise would indicate, for example, that in all the countries in which a particular BME population are living, there is use of a particular drug amongst them, but this would generate an extremely distorted picture of the situation.

Examples of variations in the information received include the following:

Whilst 29 (66%) of the 44 respondents who completed the UK questionnaire agreed that there is heroin use amongst people from India, only one informant from Germany had any information on the drug use of this group.

The information from France and Norway was largely based on qualitative research investigations amongst drug users not in treatment, whilst informants from Austria, Denmark, Ireland, Italy, and Luxembourg tended to report drug treatment and/or drug law offence statistics.

In some countries, although valuable information was obtained about the drug use of a particular BME group, it was sometimes restricted to a particular locality, and may or may not be representative of the situation in the whole country, or of drug use amongst the whole BME population in question. Examples of this are reports on the drug use amongst Maghrebians in Provence Alpes Côte d'Azur in France, and amongst BME groups who frequent the drug-using street scene in Oslo, Norway.

In some cases, there was a lack of consensus on a particular issue amongst informants from the same country, such as whether or not there are drug services in Greece that target BME drug users; if North Africans in Italy are more involved in drug law offences than other BME groups; and if Gypsies in Portugal are under-represented in drug services.

The BME communities in each country also vary according to past and current migration patterns (fully described in Khan et al, 2000): for example, whilst the largest BME group is the UK is from South Asia (Bangladesh, India and Pakistan), South Asians do not appear to live in Greece; Gypsies are the largest BME group in Spain but were not reported from Sweden; and whilst Moroccans are the largest BME group in Italy, there do not appear to be any of these North Africans in Denmark.

Given the above variations, in order to provide an overview of the drug situation amongst BME groups in the EU, a thematic analysis was performed according to issues which most consistently arose via the information collected by this study. The themes are therefore firmly grounded in this information, and throughout this analysis, examples extracted and used as illustrations.

The themes discussed in this section are:

the acknowledgement of drug use amongst BME communities and the value of ethnic monitoring

the prevalence of drug use amongst BME communities, including data from drug services and the criminal justice system

patterns of drug use amongst BME communities, including cultural variations; factors specifically affecting drug use amongst BME groups; the effects of social exclusion; myths, scapegoats and stereotypes; and barriers to drug service access

the research agenda, including the need to confront the hidden nature of drug use amongst BME communities; to collect comparable data across the EU; to consider the researchers and informants who can best expand the knowledge base; and to disseminate information

drug service development, including examples of good practice.

Finally, a summary of the findings and recommendations is provided in the form of key points for consideration by policy-makers.

3.1 Acknowledgement of drug use amongst Black and minority ethnic communities

This section discusses the effects on the knowledge base of the failure to acknowledge drug use amongst BME groups and the lack of ethnic monitoring.

It is clear from some of the responses received by this study that, in several EU countries, drug use amongst BME communities is unacknowledged, ignored, unrecognised, or hidden by some policy-makers, drug researchers, drug service planners and commissioners, and by some members of some BME groups themselves. The study revealed many examples to illustrate this. For instance:

Policy-makers in Germany, the Netherlands, Spain, and Sweden are failing to address drug use amongst BME groups.

As discussed in Section 2.4.1, some of those involved in the drugs field in Austria and Belgium refused to participate in this study because of fears of increasing racism, nationalism, and stigmatisation of BME groups.

With a few exceptions, such as research amongst Gypsies in Spain and South Asians in the UK, this study was characterised by a lack of investigation into drug use amongst BME communities and the surrounding issues. There are a variety of reasons for this, including the avoidance of further stigmatisation of these groups, fears of accusations of racism by exposing drug use amongst them, lack of access to the communities in question, and language barriers. The UK probably has the widest knowledge base, but even so, large gaps in it remain.

Some BME communities and families hide drug use within them for a variety of reasons, including to avoid the stigma associated with drug use by their community and a fear of being ostracised. Therefore, many BME families and/or communities reject drug users completely, such as the Turkish community in Austria, Finland, and the Netherlands; the Gypsy / Roma community in Finland and Spain; and some BME groups in the UK, especially South Asians. In the UK, another method of hiding drug use within the South Asian communities is for the drug user's family to either attempt an enforced 'home detoxification' or to send the drug user 'home' to Bangladesh, India, or Pakistan in the hope that they will 'recover.' However, due to the availability and cheapness of drugs in these countries, some return with a greater dependence.

The reluctance to acknowledge drug use amongst BME groups in order to avoid further stigmatisation is misguided. Ignoring or hiding a problem does not make it disappear: it must be confronted in order that appropriate responses can be developed. Many BME groups are already stigmatised as drug users or dealers, yet refusing to accept that this behaviour may occur amongst them does nothing to decrease the stigmatisation, and obstructs consideration of their drug service needs by policy-makers and service planners and commissioners.

3.1.1 Ethnic monitoring

EMCDDA's previous work on the drug use of BME groups (Khan et al, 2000) discusses the issue of ethnic monitoring in some detail, particularly in relation to how categories are devised, how ethnic monitoring is implemented, and how the results are subsequently used. That discussion will not be reproduced here, other than to emphasise that consistent, co-ordinated ethnic monitoring, based on a common set of classifications, is a reliable instrument to measure drug service use and, importantly, non-use, by drug users. Analysis of results of ethnic monitoring from drug services and drug surveys provide a baseline for improvements to the quality of service provision - including equal access for all drug users and more equitable allocation of resources - and can be used to track changes in drug-using patterns and in the uptake of drug services.

Ethnic monitoring is an extremely sensitive issue, especially when drug use is being monitored, and there was a great deal of variation in the approach to this from the countries participating in this study. Although this study's questionnaire did not specifically ask about this topic, it was raised by some informants from every country:

In Austria and Portugal, ethnic monitoring is not conducted except, it appears, by the criminal justice system. However, in Austria, crime statistics do not show ethnicity, but nationality, and some BME groups, such as Roma / Sinti therefore appear as 'Austrians' or another nationality. Nationality is also used to categorise populations in Belgium, Ireland (although Travellers are recorded as such), and Sweden.

In Greece, the only officially-recognised BME group is the 'Muslim minority' comprising largely of Turkish people, but also Pomaki and Gypsies.

Under French legislation, ethnic monitoring cannot be conducted in France.

Ethnic monitoring does not appear to be conducted in Belgium and Germany.

Some ethnic monitoring of drug service users is conducted in Denmark, Finland, Italy, Luxembourg, the Netherlands, and Norway and is widespread in the UK.

Ethnic monitoring of drug service clients, hospital admissions relating to drug use, and drug overdose deaths will begin in Spain in 2003.

However, although there is some form of ethnic monitoring of drug service clients and drug survey participants in the majority of EU countries, vast improvements are required to ensure more consistent data collection and analysis. From the UK, where ethnic monitoring is conducted more comprehensively than in other EU countries, Sangster et al (2002:59) recommend improvements be facilitated by the following actions:

'Funding the production of clear guidelines to ensure ethnic monitoring is consistent, co-ordinated and based on official classifications'

Ensuring that the benefits of monitoring are clearly felt by those involved in data collection. This may involve training for frontline workers which focuses on the way in which monitoring can help to improve services. It may also require improved systems by which results of monitoring are fed back to agencies.'

Increasing the capacity of DATs [Drug Action Teams in England that co-ordinate the delivery of the national drugs strategy and act as a focus for joint planning by local agencies], to make use of statistical data and other research in planning and commissioning services.'

Monitoring referral and treatment outcomes for Black and minority ethnic drug offenders.'

Systems for improved data collection should include a particular focus on drug use among Black and minority ethnic women and girls.'

3.2 Patterns of drug use amongst Black and minority ethnic groups

This section discusses what was reported to the study on the prevalence and patterns of drug use amongst BME communities, including cultural variations; factors specifically affecting drug use amongst BME groups; the effects of social exclusion; myths, scapegoats and stereotypes; and barriers to drug service access.

3.2.1 Prevalence of drug use amongst Black and minority ethnic groups

Successive annual reports from EMCDDA on the state of the drugs problem in the European Union show that, other than for cannabis, the use of which is relatively common and not highly stigmatised, '*prevalence data are less reliable for more hidden patterns of use, such as heroin injection*' (EMCDDA, 2000:11). It follows that, as will be shown throughout this section, because drug use by some BME groups is extremely hidden, and because of the lack of research on this issue, the prevalence of drug use amongst these groups is even more difficult to assess. It was clear from EMCDDA's previous work on this issue (Khan et al, 2000) that it is not possible to obtain prevalence rates of the drug use of BME communities, and the current project confirms the reasons for this.

3.2.2 Data from drug services and the criminal justice system

Much of the information on the drug use of BME groups received by this study from Denmark, Ireland, Italy, Luxembourg, and Sweden consisted of data from drug treatment statistics, and in Austria, Denmark and Spain drug law offence statistics were a major source of informants' knowledge. Such data alone can therefore give an extremely distorted picture of the prevalence of drug use and of drug-using patterns, as they do not take into account those drug users who do not use drug services nor come to the attention of the criminal justice system. Examples of how statistics exaggerate or understate the involvement of BME groups in drug use and/or distribution include:

Black Africans in Austria, who are highly visible because of their skin colour, are associated with drugs by both the police and general public, fuelled by adverse media reports (Eisenbach-Stangl, 2002). The consequence is that this group are over-represented in reports of drug crimes to the police, in statistics on recorded drug offences, and in charges for drugs offences. In addition, after coming to the attention of the police, Black Africans are proportionally more likely than the rest of the population to be charged for drug distribution than for possession of drugs. In Austria, although ethnic monitoring is not conducted by agencies other than the criminal justice system, it is recognised that BME groups are under-represented in clients of drug services.

BME groups are under-represented in drug treatment client statistics in Norway, but over-represented in the drug law offence statistics. There are indications that those described by one informant as '*non-Western immigrants*' are targeted by the Norwegian police as suspected drug law offenders.

Very few drug users from BME groups use drug services in Finland, despite evidence that there is drug use amongst these populations.

BME groups in Luxembourg are under-represented as drug treatment clients, apart from those from some other European Union countries especially from Portugal.

The National Drugmonitor in the Netherlands shows that BME groups are under-represented in both drug inpatient and outpatient treatment services.

In the UK, BME groups are under-represented in drug services and over-represented in drug law offence statistics.

3.2.3 Patterns of drug use

The evidence collected by this study indicates that, although there are some cultural variations in the types of substances used and some risk factors specifically affecting drug use amongst BME groups, their drug-using patterns are not different from those of socially-excluded, white, indigenous populations. However, to be successful, responses may have to be different, as discussed in detail in Section 3.4.

As discussed in Section 3.1.1, ethnic monitoring of drug service clients would provide one indicator of patterns of problematic drug use amongst BME populations, but it is not conducted in all EU countries, and where it is, requires many improvements for this aim to be achieved. A further illustration of the need for improvement comes from an informant of this study who is involved in the European Addiction Severity Index (EuropASI) project, which measures the dependency of clients in drug treatment from participating European countries. This project could, theoretically, provide valuable data about BME drug users in treatment in the EU. However, the informant reported that, although EuropASI screening includes detailed questions regarding land of birth, parents' land of birth, etc, these questions are not asked as often of BME groups as they are of the rest of the population because of '*language problems*'. The informant concluded that are therefore too few relevant EuropASI data to detect drug-using patterns for BME groups in general, or amongst specific populations.

Cultural variations in the substances used by Black and minority ethnic drug users

The cultural variations in the substances used by some BME drug users reported to this study include:

The use of qat (or khat), appears to be restricted to members of the Somali community in Denmark, Finland, Italy, Norway, and Sweden. Some people from the Middle East, Somalia and Ethiopia use this drug in the UK and it is used amongst Black Africans in the Netherlands.

'Marasotu' (literally grass from Maras, a town in south-west Turkey) is a powder that is held or chewed in the mouth for many hours, like qat, and used by some Greek and Turkish Cypriots in the UK.

Amongst older Russians newly-arrived in Spain, pharmaceutical morphine and homemade opium preparations such as 'kompot' are used.

Opium is used amongst Iranians in Germany and people from the Middle East in the Netherlands.

Factors specifically affecting drug use amongst Black and minority ethnic groups

There are several factors exclusive to BME groups that may make them vulnerable to drug use:

Some migrants have suffered trauma because of wars in their home countries. This was noted amongst drug users amongst Central and Eastern Europeans in Austria and Denmark; in Denmark amongst Pakistanis and people from the Middle East; in the Netherlands amongst some BME groups; and in Sweden (although the research on this issue was conducted a decade ago) amongst Iranians, Lebanese, Africans, and South Americans.

The immigration experience may not have lived up to expectations, which was noted amongst drug users from the former Yugoslavia in Denmark and North Africans in Spain.

Some members of some BME groups were using drugs before they emigrated to an EU country and continued to do so once they arrived, although the substances used may change. Examples include:

Russians in Germany who used heroin in Russia and continued to do so after they left.

Iranians who used opium in Iran but have changed to injecting heroin in Germany.

Maghrebians who used cannabis only in North Africa, but changed to heroin in Italy.

North African drug users in Spain, some of whom smoked cannabis in their home countries, but who began to smoke heroin and snort cocaine in Spain.

An unwitting change of drug is reported amongst Turkish and Greek Cypriots in the UK, who used cannabis in Cyprus and were sold heroin as 'powdered cannabis' in the UK.

That said, although some refugees and asylum seekers arrived in the UK with an established drug problem, drug use amongst some others did not start until they arrived in the country. In the UK, this is particularly the case amongst the younger generations of South Asians, who have adopted the drug-using patterns of the white indigenous population.

Drug use and social exclusion

The focus of EMCDDA's previous work on BME groups (Khan et al, 2000) was social exclusion. That project explored the relationship between BME groups, social exclusion, and drug use in depth, concluding (p9) that;

'Although the use and abuse of drugs is not restricted to any one sector of society, its high prevalence and associated social problems are particularly marked in areas and localities marked by social exclusion. Minority [BME] drug users could therefore be said to be facing a position of double jeopardy: they carry the stigma of racial exclusion and of drug use.'

BME groups are vulnerable to problematic drug use in the same way as the socially-excluded, white indigenous populations are, and this applies particularly to the younger generations of some groups. It was pointed out by informants from most of the countries that participated in this study that drug use was more prevalent amongst the younger generations of BME groups than amongst the older generations, and many informants linked this with social exclusion. This phenomenon was noted amongst:

Turkish people and Central and Eastern Europeans in Austria
people from Morocco, Greece, Italy, Portugal, Turkey and Spain in Belgium
people from the former Yugoslavia and Turkey in Denmark
Ingrians in Finland
Tzigane / Gypses / Roma in France
Turkish people in Germany
Travellers in Ireland
Moroccans and Antillians in the Netherlands
BME groups who hang around the drug-using street scene in the Centre of Oslo, Norway
Black Africans in Portugal, especially those from Cap Verde.
Gypsies and some Africans in Spain.
Pakistanis, Bangladeshis and African Caribbeans in the UK.

This study did not aim to address drug distribution by members of BME groups in any detail, and the information available on this issue is reported in each country profile in Volume 2. However, an aspect of social exclusion raised by this study was economic survival via involvement in the distribution of drugs. This was noted amongst, for example, Black Africans in Austria, Antillians in the Netherlands, Cap Verdeans in Portugal, and Pakistanis and Bangladeshis in the UK. Those employing this method of income generation are vulnerable to drug use, and their conspicuous wealth in impoverished communities makes selling drugs an attractive proposition to others.

It was also suggested that involvement in drug distribution precedes drug use amongst, for example, Black Africans in Austria; Antillians, Central and Eastern Europeans and Russians in the Netherlands; and Gypsies in Spain.

That said, it was believed that some BME groups were selling drugs but that drug use amongst them was low. These groups were Black Africans in Austria and Belgium, Asians in Belgium, people from the Middle East in Denmark, and Turkish people in the Netherlands.

Another example of the link between poverty and drug distribution is that some Black Africans living in poverty in Africa have been recruited in their home countries to sell drugs in Austria and to smuggle drugs into Ireland.

3.2.4 Myths, scapegoats and stereotypes

In a discussion of using qualitative research to examine the nature of drug use amongst BME communities in the UK, Patel (2000:127) lists a series of statements collected from a range of Asian communities, including from religious 'leaders' and workers in statutory and non-governmental organisations in the drugs field. These include:

'Asian people don't use drugs.'

'Religion prohibits drug taking - therefore it is not a problem.'

'It [drug use] is a white western disease.'

'Our strong religious and cultural values stop us from this behaviour.'

Patel continues that *'These statements clearly highlight the dilemma facing agencies, researchers and drug workers in the UK, operating as a series of myths that have acted as barriers to the development and delivery of drug services for Asian minority ethnic groups.'*

The results of this study reveal that myths about the drug use of BME groups are not exclusive to the UK: along with scapegoating and stereotyping, they are also apparent in other countries. For example:

The knowledge base on the involvement of members of BME groups in drug distribution is largely influenced by, and dependent upon, statistics from the criminal justice system, which can reflect a bias against BME groups (Section 3.2.2); media reports (which are often extremely biased, as noted in Austria and in Norway for example); and impressions gained from the visibility of drug sellers on the street because of their skin colour, noted in Austria and Italy in relation to Black Africans. However, Eisenbach-Stangl (2002) usefully unpacks the criminal statistics in Austria to show that there is little support for the *'Black skin, black market'* stereotype of Black Africans as heroin dealers.

Other examples of what may be stereotypical assumptions that are based on crime statistics include Albanians in Greece, who are blamed for the increase in the rise of heroin and cannabis use, especially by adolescents, because they sell these drugs cheaply; and Antillians in the Netherlands who are thought to be 'heavily involved' in transporting drugs as 'drug mules' or 'bodypackers.'

Some BME groups in the EU are described as 'close-knit' and that it is therefore 'difficult' for drug services to work with them because they 'do not allow interference from outside.' This was applied to the Turkish population in Belgium and to Moluccans in the Netherlands, for instance. However, as noted in relation to the Turkish community in Belgium, these difficulties can be equally translated as non-Turkish-speaking drug workers being unable to communicate with the Turkish community and drug services' lack of culturally-appropriate responses.

It is believed that 'strong social bonds' in some way protect BME groups from drug use. This was reported in relation to BME groups in general in Austria, and to Turkish people in Germany.

It is also believed that religion 'protects' some BME groups from drug use. This was suggested in relation to Iraqis in Finland, and as shown in the quotations from Patel (2000) earlier, to South Asians in the UK.

The lack of research into the drug use of BME groups in the EU is reflected in the lack of consensus about their drug-using patterns compared to the rest of the population. The results from this study suggest that, in some countries, the 'whiter' or more assimilated into the host country the BME group is, the more likely it is thought that their drug use would be the same as that of the white indigenous population. This was noted about, for example, northern European Union nationals in Belgium; the Swedish-Finnish population in Finland, whose drug use is thought to be 'recreational' rather than problematic; in Sweden, about the 'fully-integrated' South Americans and also the South Asians who were adopted by Swedish families in the 1970s and 1980s; and about other European Union nationals in Germany, Italy, Spain and Sweden. On the other hand, it was suggested that drug use would increase amongst younger members of BME groups in Ireland as they became more assimilated, as has occurred amongst some BME groups in the UK; and that 'giving up their Turkish traditions' has led to drug use amongst young Turkish people in Austria. However, lack of integration into Dutch society was suggested as a risk factor for drug use by, for example, young Moroccan and Antillian males in the Netherlands.

The lack of research into the drug use of BME groups throughout the EU also means that, currently, many myths, scapegoats and stereotypes can neither be confirmed nor demolished. Even where research has demolished a particular myth, such as female Gypsies in Spain and South Asians in the UK do not use drugs, it persists.

3.2.5 Barriers to drug service access by Black and minority ethnic groups

The barriers to health and other services are a significant element of social exclusion, and in this study, these were explicitly or implicitly discussed by informants from almost every country in relation to the under-representation of BME groups as drug service clients. The result of lack of access to drug services contributes to the hidden nature of drug use amongst some BME communities, and to the employment of alternative strategies to 'keep the drug use within the family / community' (Section 3.1).

The issue of barriers to drug services are thoroughly discussed in studies from the UK (Fountain et al, 2002; Sangster et al, 2002) and the Netherlands Broers and Eland, 2000; Van Wamel and Eland, 2001), and can be categorised as follows:

Lack of cultural sensitivity

This was specifically noted as a reason for the lack of uptake of drug services by various BME groups in Belgium, Denmark, Germany, Greece, Ireland, the Netherlands, Norway, Portugal, Spain, Sweden and the UK. An example is a lack of consideration of the significance of the family amongst some BME communities, and how drug users' families could be incorporated into drug treatment. In the Netherlands, for instance, drug workers thought that the lack of including BME drug users' families in treatment programmes was one of the reasons for the high drop-out rate of BME clients; and in Portugal, it has been discovered that Gypsy drug users are much more receptive to family, rather than individual, therapy. Other examples of differing cultural sensitivities are that BME groups in Sweden attach stigma to seeking any help from social services, but especially for drug use; and in the Netherlands, male drug users from BME some groups are ashamed to accept help from a female therapist.

Ethnicity of drug service staff

One of the components of a lack of cultural sensitivity is the ethnicity of drug service staff, and this was noted in the Netherlands, Norway and the UK. However, in the UK, the ethnicity of drug workers has been shown to be a more complex issue than simply employing those who are from the same ethnic group as the clients the service is trying to attract (Fountain et al, 2002; Sangster et al, 2002). The complexities include that it should not be assumed that clients want to see a worker from their own ethnic background, as feelings of shame may thus be amplified; and that one BME worker may be expected to be culturally-sensitive to the needs of every non-white client.

Distrust of confidentiality

A distrust of the confidentiality of drug services was given as reason for the under-representation of BME drug users in drug services from Finland, the Netherlands and the UK. This is a special problem for illegal immigrants who, obviously, do not want to come to the attention of 'official' institutions, as pointed out from Belgium, the Netherlands, and Spain.

Language

Language as a barrier to drug service access was noted in relation to the Turkish community in Belgium, Russians in Finland, Chinese people in Italy, and BME groups generally in the Netherlands and in the UK.

Lack of knowledge about drugs

The lack of knowledge about drugs - including a recognition of problematic drug use - was noted as a barrier to drug service access amongst some BME groups in the Netherlands, Spain, and the UK. In the UK, a difference was noted between generations in some BME groups, with younger people having a far greater knowledge about drugs than the older generations.

Lack of awareness of drug services

A lack of knowledge of the process of accessing drug services and what the services involve, was noted amongst BME groups generally in the Netherlands and the UK, and amongst Black Africans in Spain. This lack of knowledge is not only a barrier to drug service access, but also leads to unrealistic expectations by those who do access services, and, as suggested from the Netherlands and Norway, a high drop-out rate amongst BME clients.

Stigma

The failure of BME drug users and their families to admit to a drugs problem because of the associated shame was noted amongst the Roma / Sinti in Austria and Germany; Moroccans and especially Turkish people in the Netherlands; BME groups in Norway; Gypsies in Portugal and (especially when the drug user is female) in Spain; Iranian males in Sweden; and amongst several BME groups in the UK.

The failure of services to target BME drug users

A solution to break down the barriers preventing BME communities accessing drug services (including not only treatment, but also education and prevention services) is to target them at specific BME groups. In some countries, however, this is either constitutionally forbidden - for example, in France and in Portugal, or the issue of cultural diversity appears not to be addressed in relation to drug services - in Germany, the Netherlands, Spain, and Sweden, for example. Nevertheless, as shown in Section 3.4.1 and in some of the country profiles in Volume 2, there are examples of good practice, including in those countries where targeted drug services are officially either not allowed or not encouraged.

3.3 The research agenda

This section discusses the considerations that should inform the research that is necessary to fill the gaps in the knowledge base about the drug use of BME groups at local, national and EU-wide levels. The discussion covers the need to confront the hidden nature of drug use amongst BME communities; to collect comparable data across the EU; to consider the researchers and informants who can best expand the knowledge base; and to disseminate information.

3.3.1 Confronting denial

As discussed in Section 3.1, denial that drug use is taking place amongst BME groups may have to be confronted, including amongst BME communities themselves. In a discussion of research of drug use amongst South Asian communities in the UK, Patel (2000:130) stresses that:

'Researchers should be aware that they will encounter official bodies and professionals who will simply deny that Asian young people are as much at risk as the 'white' population; researchers must be prepared to challenge those who dogmatically repeat these assumptions.'

It is necessary to repeat here that drug use amongst BME communities must be confronted in order that appropriate responses can be developed. Many BME groups are already stigmatised as drug users or dealers, yet refusing to accept that this behaviour may occur amongst them does nothing to decrease the stigmatisation, and obstructs consideration of their drug service needs by policy-makers and service planners and commissioners.

3.3.2 Comparable data

Research in specific localities amongst specific BME groups can and does provide the valuable data that are necessary to inform the development of local drug services, and should be encouraged and expanded. To begin to obtain a comprehensive picture across the EU requires comparable data, however. This would clearly be a difficult undertaking given that:

BME communities are not an homogenous group: there is a large variety of these communities in the EU, cultural variations between them, and, within each group, differences between those who were born in another country and those born after migration

there is overall lack of ethnic monitoring (as discussed in Section 3.1.1)

drug use amongst many BME groups is hidden and ignored (Sections 3.1 and 3.2.5)

some risk factors for drug use are specific to some BME groups (Section 3.2.3)

some researchers and policy-makers in some countries are unwilling to address the issue of drug use amongst BME groups (Sections 2.4.1 and 3.1), and funding for research may not be forthcoming.

The current study was only the very first step in obtaining comparable data. A highly fruitful next step would be to use the Delphi method: to devise just one questionnaire based on this section's synthesis of the information received for this study, and, using the methods described in Section 2, repeat the exercise. The constraints imposed on the current study make it essential that any follow-up is adequately funded and has a realistic timeframe in order that, for example, the range and diversity of informants can be increased and, where necessary, the questionnaire can be translated into BME languages.

Investigations of trends at local, or country, or EU level, or across particular ethnic groups are also necessary. Themes that should be prioritised for future investigations should incorporate both quantitative and qualitative research methods, and include:

the reasons for the under-representation of BME groups as drug service clients, as discussed in Section 3.2.5

whether or not commonly-held beliefs about BME groups - such as strong social / family bonds and religion are factors that protect against drug use - are accurate (Section 3.2.4) and, if so, how these protective factors operate

factors affecting drug-using patterns amongst specific BME groups (Section 3.2.3), such as selling drugs precedes use amongst those who are socially excluded and who are involved in drug distribution as a method of income generation

implementation and analysis of the results of ethnic monitoring (Section 3.1.1)

collating examples of good practice in methods of researching drug use and the related service needs amongst BME groups, including those obtaining information from a wide variety of sources, such as this study (Section 3.3.3)

collating examples of good practice of planning and delivering drug services to BME communities, especially those that effectively engage with the communities involved (Section 3.4.1).

Such investigations should not neglect those BME groups newly-arrived in the EU; those groups that are dispersed throughout a particular country (a characteristic that, in the UK, has been found to apply particularly to the Chinese population); nor those BME groups that are not officially regarded as such in the countries where they live (such as all groups except the 'Muslim minority' in Greece and Gypsies in Spain).

Qualitative research

As noted by Hartnoll (2000:13), "*Qualitative research focuses on the meanings, perceptions, processes and contexts of the 'world of drugs' and offers ways of understanding drug use patterns and related responses.*" In this study, the knowledge base on the drug use of BME groups and related issues in some countries - particularly those in which ethnic monitoring cannot or is not conducted - has been especially enhanced by the results of qualitative research studies. In the discussion of future directions necessary for progress to be made in the development of drug services for BME groups in most of the countries covered by this study (Volume 2), it is stressed that the necessary research should include (or continue to use) qualitative research to, for example, examine the drug use of BME groups in relation to the link between drug use and social exclusion, and to barriers to drug service access and uptake.

Before any such research is undertaken, however, the characteristics of both those who conduct the investigations and those who are asked for information are crucial considerations.

3.3.3 Researchers and informants

Several disadvantages to the usual methods of conducting research on drug use and the related service needs amongst BME communities have been revealed by this study:

Although this report represents the very first stage of a needs assessment concerning the drug use of BME groups throughout the EU, it is significant that almost two-thirds of respondents were from drug services or drug research organisations / universities. As discussed in Section 2.4.3, valuable though information from these sources is, the relevant knowledge is not exclusive to them. The method used to collect data for this study

extended well beyond these fields to include those involved in other aspects in the health and welfare of BME communities, such as BME community organisations, general health and social services, social workers, the police, regional and local government services, youth services, and so on. However, it appears that few drug researchers and drug services have contacts outside their own professional field.

As pointed out by Patel (2000), in the UK, the usual method of conducting drug needs assessments amongst BME groups consists of commissioning researchers who 'parachute' into the relevant local communities, ask about their drug-related needs, raise expectations that there will be some change, but disappear to produce a needs assessment that has no long-term impact.

In the UK, there is a history of failure to include potential clients in the planning and delivery of drug services, especially those from BME communities. It has been shown that many BME community organisations / groups do not feel able to form effective partnerships with statutory bodies (Sangster et al, 2002) and many of the methods of 'consulting' BME communities (such as talking to religious leaders and those who were established as traditional leaders during the first waves of immigration) often leave more isolated individuals, families, and communities unrepresented: this is particularly the case in relation to consultation with BME drug users.

A solution to these problems is illustrated by a project from the UK, *The Black and minority ethnic community drugs misuse needs assessment project* (Buffin et al, 2002), an initiative from the Department of Health (DH) and the Centre for Ethnicity and Health, University of Central Lancashire. This radical and highly successful project used BME community groups (ie local groups that provide some sort of service for their community - social welfare rights advice, refugee groups, religious groups, groups that provide education in addition to school, language classes, social events, child care, lunches for elderly people, and so on) as researchers.

In order to avoid the 'parachuting' model discussed above, the DH wanted local BME community groups to undertake drugs needs assessments themselves: it was seen as a missed opportunity that the resources employed in traditional needs assessment processes neither involve nor benefit the communities whose needs are being assessed. It was recognised that these groups were probably not familiar with drug use and the related service issues, and that they were unlikely to have any experience of conducting a needs assessment. However, as community groups, they had access to their local communities, the potential to be supported and trained, and could work in a culturally-sensitive manner. In addition, members of the groups were familiar with the language and the culture of their communities. Therefore, even where drug use was a taboo subject and hidden to avoid stigmatisation, the groups were far less threatening to potential informants and more likely to obtain information than an investigator who was a stranger, white, and a professional researcher.

The project recruited, trained (in drugs awareness and research methods) and supported 47 BME community groups - representing 25 different ethnicities - to conduct drug needs assessments in their communities in order to inform an effective strategic approach by drug policy-makers, service commissioners, planners and providers. The **process** by which these needs assessments were produced was as important as the final output.

Partnerships with local service planners and commissioners were an essential criteria for participation. A Project Support Team, consisting of a total of 13 members of staff from the Centre for Ethnicity and Health was established, and was a vital component of the project. Project support workers were required to offer a significant level of support to the community groups, but to stop well short of doing the work that the communities were learning to do themselves.

By participating in the project, the community groups benefited by learning about drug-related issues and about managing and undertaking a needs assessment. In this way, at the end of the project, a number of individuals who gained from undertaking this work remained in the community, having learned about drugs and the related needs of their communities, and able to continue to articulate those needs to their local service planners, commissioners and providers. In some cases, the involvement of local individuals in the project resulted in the recruitment of more people from BME communities into local drug services and into other related statutory and voluntary sector roles where BME communities are under-represented.

As a result of this project, the Community Engagement Agency (CEA) has been established to act as a continuing focus to develop and support capacity building in BME communities in England, and the Centre for Ethnicity and Health are currently developing a model of community engagement.

3.3.4 Dissemination of information

This study has revealed the many gaps in the knowledge base concerning the drug use of BME groups in the EU and the related drug service issues. This situation is not helped by the lack of dissemination of the information that **is** available. The study heard about several apparently major relevant research projects, but details proved difficult locate and they were not all reported by informants from the relevant countries. Comprehensive dissemination of information should not be restricted to drug research organisations and academics in the drug field, but include policy-makers, social workers, youth workers, national and European agencies, BME community organisations, and drug service planners, commissioners and providers. A database of those contacted for this study has been established, and this should be kept up-to-date, expanded, and utilised for this purpose.

3.4 Drug service development

This section discusses how drug services can be developed to meet the needs of BME communities in the EU, providing examples of good practice to illustrate the way forward.

Many BME groups are already socially excluded: failure to consider their drug service needs exacerbates this situation. Although there is considerable variation in the drug services provided for BME groups both within and between member states, across the EU as a whole, drug policy and practice reflect the needs of the white indigenous population. For progress to be made in the development of drug services for BME groups, in each of the 16 countries covered by this study there is a need for the implementation (or improvement) of ethnic monitoring (Section 3.1.1) and

targeted needs assessments that engage BME communities (as described in *The Black and minority ethnic community drugs misuse needs assessment project* in Section 3.3.3).

The lack of uptake of drug services by BME groups is reflected in the drug service client statistics (Section 3.2.2) which reveal that, with very few exceptions, every BME group in the EU is under-represented. Nevertheless, the information gathered for this study has shown that the potential for members of BME groups to develop drug problems is the same as it is for the rest of the population (Section 3.2.3). However, to be successful, responses may have to be different. Two major reasons for this are the barriers to service access faced by BME groups (Section 3.2.5) and the factors specifically affecting drug use amongst them (Section 3.2.3). Therefore, ethnic monitoring and targeted needs assessments must address these issues and suggest appropriate responses.

These initiatives can be best illustrated by examples of good practice that were reported to this study.

3.4.1 Drug services for Black and minority ethnic communities: examples of good practice

It is highly appropriate that this section begins with details of the Race Relations (Amendment) Act 2000, that came into force in the UK in April 2001, and places a general duty on public authorities to promote race equality. The Act creates a clear expectation that these authorities will review their functions and identify steps to be taken to comply with the new provisions, and can be used as a template for the development of services for BME groups in other countries.

The Act challenges all public services to eradicate discrimination and disadvantage and it requires public organisations to have clear race equality action plans. This provides the impetus for drug services to address the shortfalls in the provision of appropriate and accessible services for BME groups. The Act specifically seeks to address institutional racism, defined by Macpherson (1999:9) as:

'The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.'

In relation to drug services, this provides a benchmark from which to examine the current situation: an understanding of the social, political, and economic structures within which racism is constructed and experienced is crucial when planning service delivery and the Commission for Racial Equality (CRE, 2000) has provided guidelines to assist public authorities in implementing the Race Relations (Amendment) Act 2000. Briefly, these are:

Definition

Define all your functions - what you must do, and what you can do. Then identify - by ethnicity and other relevant criteria - the people for whom you should be providing various services.

Consultation

Talk to your employees and to the people affected by your policies and practices, including people from ethnic minorities. Listen to their concerns and pay attention to their perceptions of your organisation's stand on racism and racial equality.

Monitoring

Set up systems to monitor your workforce and the outcomes of your policies and practices.

Assessment

Examine the impact of your policies and ask whether all ethnic groups are being treated fairly. Do they have equal opportunities and equal access to benefits, facilities and services? If not, why not?

Change

Where the evidence from monitoring shows unequal outcomes between different ethnic groups, consider what changes are needed, and take action to prevent direct or indirect discrimination and to promote greater equality.

Implementation

Where your organisation already has good policies on racial equality, make sure they are understood and put into practice at every level within the organisation. The policies should also be reinforced through staff performance appraisals and disciplinary procedures.

In the country profiles in Volume 2, there are examples of large and small initiatives that are attempting to engage with BME groups. As an illustration, some of these are presented in this section. As informants to this study were not specifically questioned on this issue, there are many other examples (see, for example, EMCDDA's previous work on this issue – Khan et al, 2000; AC Company, 1999 and 2001; the EDDRA database - http://www.emcdda.org/responses/methods_tools/eddra.shtml) and doubtless many more are continuously being planned and implemented. In some cases, few details of the service noted below were provided. However, it is noticeable that an essential element of many of the examples for which details were available is the involvement of the targeted BME community in the planning and delivery of the service in question.

Finland

There has been a recent focus of targeting services at Russian-speaking groups, although these activities are in their early stages.

France

Espoir Goutte d'Or

In France, the strict legislation surrounding BME-targeted services appears to have been overcome by Espoir Goutte d'Or (EGO). This drug service is based in the Goutte d'Or district of Paris, a well-known drug-using and dealing area and also home to a large population of Maghrebians, other Black Africans and Dom-Tom.

Thus, the majority of EGO's clients are from these communities. The project operates by involving all members of the community in all its activities, and is a focal point and mutual aid network around drug use and HIV / AIDS. EGO offers a range of social and health services - including a needle exchange - and training in community work, AIDS and hepatitis prevention, and the reduction of drug-related harm.

Greece

Drug advice services have been set up for Russians via the INTEGRA / KETHEA programme in the Psychiatric Hospital of Thessaloniki.

Netherlands

The Arrazi Prevention Project

The Arrazi Prevention Project was initiated as a response to the concern over drug use and criminality amongst adolescent Moroccan boys in the Netherlands and because it is commonly assumed that their parents lack knowledge about drugs and about drug services. Though a decrease of drug-related problems amongst these boys is a long-term target, the first step was the development and implementation of a series of education course initiated in co-operation with Moroccan interest groups. The courses aimed to enhance discussions about drugs and crime amongst Moroccan families in specific Amsterdam neighbourhoods, and to inform parents about drug services.

An evaluation of the project revealed that its importance was stressed by almost all the parents, especially because it was initiated by Moroccan interest groups and targeted parents. More than 80% of those who attended the courses thought that there should be more discussion about drugs and crime in their community, whereas only 47% of non-participants agreed. Participants strongly expressed that the courses should continue, but that organising these in co-operation with Moroccan interest groups had to be a prerequisite.

Experimental project for North-African drug users in Rotterdam

In Rotterdam, 12 - 15% of 'street junkies' are of North African origin, and most of them are illegal immigrants. This group were considered to be at very high risk of sexually-transmitted diseases, as they are characterised by injecting heroin use and prostitution; regarded as very hard for drug services to reach; and drug use and sexual activity is not discussed amongst members of their families and community. Preventive activities amongst this population are sparse, but an experimental peer support project was conducted amongst them. An evaluation shows that, of thirty-five potential peer supporters (all male), eight were chosen to be trained and, between them, contacted 595 male drug users, three-quarters of whom had never had contact with drug services in Rotterdam. The peer support offered included information about drugs and drug services, and the distribution of sterile injecting equipment.

The Tjandu Foundation: 'Ethnic Minority Youngsters and Creative Forms in Addiction Prevention'

The Tjandu Foundation is the national Moluccan foundation, and has expanded its activities from the original Moluccan target group to other BME groups. The project '*Ethnic minority youngsters and creative forms in addiction prevention*' is based on the self-help approach, and has produced manuals for creative and educational activities for the Moluccan, Antillian, Turkish, and Moroccan communities. A film about Moluccan drug users has also been produced. An interim report (Tjandu Foundation, 1999) shows a substantial reduction in the number of Moluccans dependent on 'hard' drugs.

Other examples of good practice from the Netherlands include:

Some drug treatment centres in Amsterdam have established contact via the imams (religious leaders in mosques) to the parents of young North Africans males who are at risk of drug use. This strategy aims at facilitating access to help and information from drug services.

Illegal immigrants are offered drug services at St Paul's Church and the Boumanhouse in Rotterdam, and by AMOC in Amsterdam.

As discussed in Section 3.2.3, some BME drug users are from countries where there are wars, and drug treatment is complicated by the trauma they have undergone. Some drug services in the Netherlands have addressed this issue via co-operation with mental health services for asylum seekers.

Norway

In Oslo, Uteseksjonen's outreach work includes targeting young members of BME groups who are involved in selling and using cannabis in an area of the city also frequented by older injecting heroin users. These young people have problems including those related to drugs, and are at risk of problematic drug use. A report is currently being prepared on this, and focuses on young people (mainly Somalis) and the process of marginalisation (Kuvoame and Dugstad, forthcoming).

Rusmiddeletaten (Agency for the Prevention and Treatment of Drug and Alcohol Problems) is concerned about the drug use of the second generation of BME groups and is funding a drug prevention project targeting this group.

Portugal

The importance of the family in the Gypsy community in Portugal led to the belief that Gypsy drug users would be more receptive to family, rather than individual, therapy. A successful family therapy programme has therefore been established in a drug service in the country.

Spain

There is evidence that few Gypsies in Spain attend abstinence-based treatment programmes, preferring treatment with methadone. Recently, some drug services in Spain have been lessening the regulations on treatment with methadone in an effort to attract more Gypsy clients.

UK

Packages to support drug treatment services organisational reviews on diversity

In the UK, the National Treatment Agency (NTA) acknowledges that a number of groups are currently under-represented in drug treatment, and is committed to addressing this and to ensuring that drug treatment services are more inclusive. The NTA has, within its corporate plan, objectives to increase the numbers of currently under-represented groups accessing and remaining in treatment, and to improving the quality of treatment for these groups. As part of this commitment, the NTA is leading a series of major initiatives to improve the quality and quantity of treatment, including an initiative on diversity.

The scope of the project is to provide a package of support to drug treatment services to enable them to improve the quality of services to currently under-represented groups. Over 2002 - 2003, eight selected services are acting as pilots and pathfinders for developing this package of support. The project is designed to work on a partnership basis and the practical commitment of each selected drug treatment service is crucial: this varies according to each organisation, its size, remit and experience in addressing diversity issues. Thus, the initiative is not being 'done to' the services. The project is a collaborative process in which the project managers work with and alongside the pilot treatment services, providing expert guidance and support over a sustained period. This co-operative approach is especially needed during the process of organisational review and the development of a template for change. Based on lessons learned, the NTA intends subsequently to roll out models of best practice, guidance and support to drug treatment services nationally.

The Southall Community Drugs Education Project

The Southall Community Drugs Education Project (SCDEP) (Winters and Dhillon, 2002) is an on-going project based in an area of London that has a large South Asian population, and is also home to other BME communities. The need for such a project had become apparent following national and local research into drug prevention issues that highlighted the inaccessibility of drug prevention information, particularly to parents in South Asian communities. The project began with three main themes: to access BME communities in a sensitive manner; to engage young people; and to raise awareness within a wide range of voluntary, community and religious organisations, as well as amongst families.

The SCDEP project's aims were achieved via high-profile publicisation of the project; a young person's panel; through volunteers who were trained to deliver drugs awareness education to families; and work with professionals, business leaders, voluntary organisations, and religious groups. This approach provided the community with ownership of the project, ensured that the voice of young people was heard, and laid the foundations for future sustainability via a local management

group. Thus, the whole community was involved in both a needs assessment and the response to those needs: drugs education and awareness were delivered **at the same time as** needs were being discovered, and stigmatisation was thus avoided.

Many other successful initiatives in the UK are detailed in Fountain et al (2002) and Sangster et al (2002).

3.4.2 Evaluation and dissemination

Evaluation should be a key component of all drug services for BME groups, and an EU-wide database of such initiatives would ensure that lessons can be learned from their successes and failures.

In the same way that information about drug use amongst BME communities should be widely disseminated (Section 3.3.4), so should examples of relevant good practice amongst drug services.

3.5 Key points for policy-makers

The key points arising from the results of this study for policy-makers at local, national and EU-wide levels are:

- Drug use amongst Black and minority ethnic (BME) groups is under-researched, and the knowledge base is distorted by an under-representation of many of these groups in the statistics on drug service uptake, and their over-representation in drug law offence statistics.
- There is a lack of prevalence estimates of drug use amongst BME communities, they are under-represented in drug services, and there is a lack of recognition that drugs are used by them. This combination means that acknowledgement that there is drug use amongst these communities is an extremely important stage in the development of responses. The lack of evidence of the prevalence of drug use can be used as a justification not to address it, yet it is only through acknowledging it that debate and further investigation can be initiated. The way will then be paved for responses that will support BME communities through drugs and drug service education and awareness-raising activities. Needs assessments can then take place alongside changes within drug services, and, ultimately, evidence of prevalence and drug service uptake and retention can be systematically acquired. This process should be monitored throughout via drug service commissioning systems, to ensure that the needs of the BME population is being identified and appropriate responses are being implemented.
- Consistent, co-ordinated ethnic monitoring by drug researchers and drug service providers, based on a common set of classifications, is a reliable instrument to measure drug service use and, importantly, non-use, by drug users. Analysis of results provide a baseline for improvements to the quality of service provision - including equal access for all drug users and more equitable allocation of resources - and can be used to track changes in drug-using patterns and in the uptake of drug services.

- Although there are some cultural variations and some risk factors specifically affecting drug use amongst BME groups, their drug-using patterns do not appear to be different from those of other socially-excluded groups. However, this does not mean that BME groups can simply 'slot into' existing drug services. Responses may have to be different in order that the barriers to drug service access faced by BME communities are overcome. Examples of alternative drug treatment approaches include, for example, the use of ethnic healing systems and using healers within the community as primary care service deliverers.
- Comparable data should be collected on the following issues by both quantitative and qualitative research methods, and the results used to inform the development of appropriate drug service provision:

the reasons for the under-representation of BME groups as drug service clients

whether or not commonly-held beliefs about BME groups - such as strong social / family bonds and religion are factors that protect against drug use - are accurate

factors affecting drug-using patterns amongst specific BME groups

implementation and analysis of the results of ethnic monitoring

examples of good practice in methods of researching drug use and the related service needs amongst BME groups, including those obtaining information from a wide variety of sources

examples of good practice of planning and delivering drug services to BME communities, especially those that effectively engage with the communities involved.

- Given the link between drug use and social exclusion, drug policy development should include making wider linkages to other health, social and regeneration agendas, especially those programmes tackling sexual health and poverty.
- Given the gaps in the knowledge base on the drug use of, and related service provision for, BME groups, research results and examples of good practice amongst drug services should be widely disseminated.

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