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NHS

National Treatment Agency for Substance Misuse

Issues surrounding drug use and drug services among the Black African communities in England

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

This publication collates the findings from 42 reports on issues surrounding drug use and drug services among England's Black African communities. In total, 4,657 members of these communities, who originated from 30 different countries in Africa, provided the data for the reports (Black Caribbeans in England are the subject of the third publication in this series). Thirty-three of the reports were concerned solely with Black Africans, while the remaining nine included a substantial proportion of members of these communities in their samples.

Foreword

This UCLAN series of reports – of which this is the second volume – examines knowledge of and information about drugs and drug services among a range of Black and minority ethnic groups in England.

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

The NTA endorses these reports.

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

An analysis of 2006/07 data from the National Drug Treatment Monitoring System (NDTMS) suggests that generally there is no ethnicity-related differential impact when it comes to drug treatment itself.[1] While different people respond to treatment differently, service user demographic characteristics do not have a major impact on the treatment provided to them – and this applies as much to gender and age as it does to ethnicity. The characteristics of the service provider and the service user's main drug of use are more likely to affect how an individual responds to treatment.

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

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

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

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

[1] This analysis is available on the NTA website at website at http://www.nta.nhs.uk/areas/diversity/docs/differential_impact_assessment_ndtms_0607_%20120309.pdf

What this means for the treatment sector is that we may need to intensify our efforts to ensure that staff and organisational competence is sustained and enhanced to ensure that drug services meet the needs of a range of drug misusers.

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

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

Key messages

Drug service needs

- This report represents the evidence and recommendations for drug service planners, providers and commissioners to address the needs of Black Africans. To be effective, however, this work should take place at a local level, so that the heterogeneity of what have been described here as 'Black African communities' is addressed.

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

- The overall picture painted by the results from the participation of 4,657 Black Africans in 42 studies within the *Department of Health's Black and minority ethnic drug misuse needs assessment project* is that they lack information about illicit drugs and about the existence of drug information, advice and treatment services and the help they can offer. In addition, their trust in the cultural competence of drug services should be built up.

- Engagement between and commitment from local Black African communities and local drug service planners, commissioners and providers is essential for progress towards meeting their drug service needs.

- Adaptation and flexibility are clearly required so that the barriers to drug service access by Black Africans begin to be overcome. However, because trust and confidence in drug services is currently low – and some of the responses to illicit drug and khat use will be challenged – increased access by Black Africans is unlikely to be an immediate outcome of any changes.

Patterns of substance use

- With the exception of cannabis, the perceived and reported prevalence of illicit drug use among England's Black African population would appear to be lower than among the whole population. That said, it is likely that illicit and problematic drug use (especially of heroin and cocaine) was under-reported to the studies because of the stigma surrounding it, the taboo on discussing it and concerns that disclosing drug use would negatively affect immigration status.

- Several risk factors for problematic drug use are present among some Black African communities, including unemployment, separation from the family and, in some cases, the adverse effects on mental health of the migration process and the trauma which led to migration.

- The British Crime Survey (Roe and Man, 2006) covers a representative sample of the whole population in England and Wales and provides details of the illicit drugs used

and the characteristics of users. Although the sample of 4,657 Black Africans from 42 studies was not representative of all Black Africans, the results indicate that:

The illicit drug most used by Black Africans is cannabis, as it is among the general population.

A smaller proportion of Black African females have used illicit drugs when compared with females in the general population.

Khat (use of which is not recorded by the British Crime Survey) is the most commonly used stimulant among Somalis and Ethiopians. Among other Black Africans, as in the general population, cocaine powder is the most commonly used stimulant.

- Overall, Black Africans lack knowledge about illicit drugs (whether they use them or not), although those in communities where khat is used were far more knowledgeable about khat.

- The use of cannabis and of khat was perceived by many Black Africans to be more culturally acceptable than other illicit drugs and alcohol, and considered to be less harmful.

- It appears that most khat users do not also use illicit drugs, and vice versa.

- Patterns of khat use in England are reported to be different and more problematic than those in Africa, and a larger proportion of khat users than illicit drug users reported problems related to their use.

Tackling substance use

- The findings from the 42 community organisations' studies strongly indicate that Black Africans are in need of information and advice on illicit drugs. Compared to the white population, they are also under-represented as recipients of drug treatment services. More sophisticated ethnic monitoring at a local level is required to test this indication.

- There are two main drivers of Black Africans' responses to substance use:

  The stigma that surrounds illicit dug use among Black African communities and the taboo on discussing it. Khat use, however, attracts less stigma and taboo.

  A very limited awareness of the range of drug services that exist and the help they can offer. This impedes access to information and advice for all members of the Black African communities, including non-problematic drug users who would benefit from information about the substances they use and advice on harm reduction strategies. This lack of awareness also hinders access to treatment for problematic drug users, and means that, if it is accessed, there is often an

unrealistic expectation of what can be achieved and the process by which it is achieved.

- Many Black Africans deny that illicit drug use (other than cannabis) occurs in their communities, reject drug users, and most would be reluctant to seek 'outside' help (other than from GPs) if they or someone they knew had a drug problem.

- In the communities where khat is used, there is an ongoing debate on whether use should be addressed in the same way as the use of illicit drugs.

- If community members want advice, information and help on substance-using issues, they are most likely to seek it from their families, followed by friends, religious organisations and GPs.

- Drug users also said they would approach their family, friends and GP for help, and the FRANK website and helpline.

- A reliance on family and friends for support is unlikely to be effective, because these sources' knowledge of illicit drugs and drug services is low.

- As well as a lack of awareness of drug services, a major barrier to their access is the concern that drug services will report illicit drug use to the immigration authorities. It was a commonly held belief among study participants that drug services work with law enforcement and immigration agencies, and that contact with drug services would lead to deportation. Thus, as one study report put it, *'The survey suggests a high level of discomfort at the thought of using statutory services'*.

- Other reported barriers to help-seeking were communication problems because of language, the perceived bureaucracy involved in accessing a service, and services' perceived or experienced cultural incompetence, religious insensitivity and racism.

Information needs

- Raising the awareness of the Black African communities on drug-related issues means that the taboo on discussion on these should be overcome, and this requires sensitivity, persistence, time, and meaningful engagement with the communities in order to discuss, devise and deliver the most effective approaches. Particular challenges are the perceptions of many that drug prevention and abstinence are the only aims of information campaigns and that khat should not be viewed in the same way as illicit drugs.

Cultural competence

- A basic framework for cultural competence is provided in Section 6.

- Only a few of the studies recommended specific drug services for Black Africans. Rather, most wanted mainstream services to demonstrate cultural and religious competence. To achieve this, drug service planners, commissioners and providers

need to understand and address how culture and religion impact on access to, and experience of drug information, advice and treatment services in terms of:

a belief that drug users will be reported to *'the authorities'* and lose the right to stay in the UK;
language;
the ethnicity of drug service staff;
the cultural acceptance of khat use by many Black Africans in those communities where it is used; and
religious beliefs, especially in terms of *'Muslim-friendly'* service provision (such as women-only services and the absence of alcohol) and where it is perceived that drug problems can be solved by religious leaders and by prayer at the church or mosque.

Engagement

- Meeting Black Africans' drug service needs relies not only on action by drug service planners, commissioners and providers, but also by members of the Black African communities themselves.

- Partnerships are key to the engagement process. These should involve drug service planners commissioners and providers, community organisations, religious institutions, and Black African community members and a variety of professionals working with them.

- Increased and long-term funding for Black African community organisations is required not only to enhance their participation in partnerships, but also to enable training in drug-related issues and capacity building.

Prevention initiatives

- The focus of some Black Africans on the prevention of illicit drug and khat use may be challenged during their engagement with drug service planners, commissioners and providers. Prevention of substance use was thought to be achievable by:

  the provision of so-called 'diversionary' activities and facilities for young people;
  skill training to address unemployment (especially among the Somali community);
  initiatives to enable Black Africans to *'integrate successfully into UK society'*;
  legislation, stiffer penalties and increased policing to tackle drug use and dealing; and
  the criminalisation of khat.

Further research

- Further research on substance use among Black Africans is required, so as to inform the development of appropriate drug service provision.

Population profile

The 2001 census reported that:

- 0.8% (485,277) of the UK population was Black African.[1]
- Black Africans comprised 10.5% of the UK's Black and minority ethnic population. [1]
- 78% of Black Africans in the UK lived in London, and comprised over 10% of the populations of the London boroughs of Hackney, Lambeth, Newham and Southwark.[2]
- Around two-thirds of Black Africans in Great Britain described their religion as Christian and around one-fifth as Muslim.[3]
- Black Africans were relatively young. For example, in England and Wales:[4]

  10.6% of Black Africans were under five years old, compared to 5.9% of the whole population.

  30.2% of Black Africans were under 16 years old, compared to 20.2% of the whole population.

1 Research methods

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

A variety of quantitative and qualitative data collection methods were utilised, with research instruments and methods that were appropriate to the aims and the target sample of each study, and to the issue they addressed. The majority of the 42 studies incorporated a structured or semi-structured questionnaire (usually via a one-to-one interview but also by self-completion) into the data collection process, but many also conducted focus groups and a few included in-depth case studies.

While some studies targeted any Black Africans in a particular area, over two-thirds concentrated on specific Black African populations. Strategies to recruit samples of community members included the use of the community researchers' and community organisations' networks, but participants were also recruited in the street, from door-to-door and from educational establishments and places of worship. The community researchers also accessed Black Africans at social gatherings in, for example, social clubs, pubs and nightclubs, and from mafrishes (premises specifically used for selling and using khat – mafrish, mafrash or mafraj is an Arabic word meaning 'a refuge from worries').

One study accessed refugees and asylum seekers through their caseworkers and another targeted homeless Black Africans via outreach workers. Several community organisations held drug education workshops followed by sessions to complete their questionnaires. The recruitment process therefore achieved one of the aims of the Centre for Ethnicity and Health's Community Engagement Programme – to raise the awareness of community members of the issue in question.

Several study reports described the stigma surrounding illicit drug use among Black African communities and how discussion on the issue was taboo and seen as an *'invasion of privacy'*: the 42 studies were, in most cases, the first time community members had been asked for their perceptions and experiences of substance use.

This meant that the community researchers encountered some suspicion, reluctance and refusal to participate in the study or to answer some questions. This was particularly marked when their questions related to personal illicit drug use, especially if that use was current, problematic or involved heroin, cocaine powder or crack cocaine. Despite reassurances of confidentiality and anonymity, some respondents were concerned that revealing drug use would jeopardise their immigration status. Others thought that if they acknowledged that there was drug use in their community, the whole community would be stigmatised and the UK would be reluctant to accept future asylum seekers from their country of origin. To illustrate:

One illicit drug user commented that they would not complete a questionnaire on their drug use honestly:

> *I would never put my knowledge of drug use on paper. If I was forced to fill it in, I would not disclose that I use drugs … I don't know where the information would end up. I don't want to be labelled as a druggie. I won't be able to show my face – you know the mentality in our community.*

A study among the Cabindan community reported that potential focus group participants were worried that *'white people'* would attend and report a discussion on the project to *'the authorities'*.

One of the Somali community organisations investigating khat use reported attempts by *'the pro-use lobby' to* discourage community members from participation by *'playing on the fears and traumas of a community that had previously negative experience of government repression and full scale civil strife'.*

It is therefore greatly to the credit of the 42 community organisations that they devised and asked questions, and approached community members with sensitivity in order to maximise participation in the studies. For example, some participants were asked indirectly about personal drug use (*'Have you or anyone you know ever used [a named illicit drug]?'*), while some studies questioned their samples only about their awareness of drugs and drug services, rather than about their own or others' use. The result was the credible snapshots of substance use and the related issues that are collated here.

Note

As the community organisations reported both qualitative and quantitative data, this publication sometimes uses the following terms to give an indication of proportion: small minority (around 5% or less); minority (around 10%-15%); significant minority (around 20%-30%); and majority (more than 50%).

2 The sample

A total of 4,657 community members participated in the 42 studies, of whom 95% reported their ethnicity as Black African, 4% as Black British African, and 1% as mixed Black African and white (for convenience, this report refers to the whole sample as 'Black African'). However, the majority (70%) were categorised and discussed in the community organisations' reports in terms of their 30 countries of origin, as shown in the table below (in total, the continent of Africa and its islands comprises over 50 countries).

African country of origin **(where specified – N=3,284)**	**N**	**% of total sample**
Somalia	820	17.6
Democratic Republic of Congo	556	11.9
Zimbabwe	385	8.3
22 other countries: Angola, Benin, Botswana, Burundi, Equatorial Guinea, Eritrea, Gambia, Ghana, Ivory Coast, Kenya, Liberia, Malawi, Mali, Mauritania, Niger, Nigeria, Rwanda, Senegal, South Africa, Swaziland, Tanzania, Togo	total 369	total 7.9
Uganda	368	7.9
Ethiopia	266	5.7
Igbo (not a country but one of the largest single ethnic groups in Africa, with most Igbo living in SE Nigeria)	160	3.4
Cabinda (Cabinda's status as an exclave and province of Angola or as a republic is currently under dispute)	153	3.3
Sierra Leone	109	2.3
Zambia	98	2.1

- Of those who were asked if they had been born in the UK (2,231 respondents), over three-quarters said they had not.

- Of those who were asked how long they had lived in the UK (1,892 respondents), a third had been in the country for less than five years at the time of the interview.

- Of the 1,533 study participants who reported their citizenship status, 44% (680) were British citizens, 29% (446) were refugees, 23% (347) were asylum seekers and 4% (60) had leave to remain in the UK.

- Many of the studies were conducted in the languages of their target samples – a total of 40, including English (it is estimated that there are 2,000 languages spoken in Africa[5]). In some cases, those from the same African country did not all speak the same language. Many of the study participants spoke several languages, and although a majority spoke English, not all of them were fluent, especially older people. Fewer could read the language(s) they spoke. The variety of languages spoken by Black Africans in the UK meant that the Centre for Ethnicity and Health's Community Engagement Model's use of researchers from the same community as those being researched was crucial to the data collection process.

- Overall, the sample's age range was wide (16 to over 60), although the majority were aged 40 and under. 56% were male and 44% were female.

- Most of the studies (31 in total) were conducted in London, where 78% of Black Africans in the UK live[2]. The remainder were carried out in the South East (3), West Midlands (3), North West (2), South West (1), East Midlands (1) and the East of England (1). Overall, most of the studies were conducted in a specific area (such as a London borough), although a few covered a whole city or concentrated on a particular neighbourhood.

- In addition to 4,657 Black African community members, nine of the studies also interviewed a total of 120 individuals involved with these communities in a professional capacity. These were mainly drug service providers and commissioners, representatives of community organisations, and health and social service community/outreach workers.

3 Patterns of substance use

See *Key messages* for a summary of this section

It should be stressed that no inferences on the prevalence of illicit drug use among England's Black African communities should be made from the data presented in this section. The *Department of Health's Black and minority ethnic drug misuse needs assessment project* was not intended to be a prevalence survey, but aimed to provide an overview of drug-using patterns and drug service needs. Some studies did not intend to document the personal drug use of their samples, while others targeted current drug users.

The proportion of Black Africans who have used each of the substances discussed below is therefore intended to demonstrate only their relative popularity among those who reported this use to the 42 studies.

Throughout this section, illicit drugs and khat – which is not an illegal substance in the UK – are discussed separately. This reflects the community organisations' approaches: only two of the ten studies that focused on khat users asked them about their use of illicit drugs and many of the others did not ask illicit drug users if they had also used khat. The separation also reflects the studies' results, as where use of both illicit drugs and khat were investigated, only a small minority of study participants had used both (in most cases, the illicit drug used was cannabis).

3.1 Lifetime substance use

3,568 Black Africans were asked what substances they had ever used, and 1,420 (40%) had used an illicit drug and/or khat at least once. Of these, 1,249 specified the substances they had used.

- **Illicit drugs** had been used by 721 (58%) of the lifetime substance users, and the vast majority of these illicit drug users (70%) reported having used **cannabis**.

- 29% of the 721 illicit drug users had used **cocaine powder**.

- A quarter (25%) of the illicit drug users had used **heroin**.

- Almost one in seven (14%) had used **crack cocaine**.

- One in eight (12%) had used **ecstasy**.

- Smaller proportions of the 721 illicit drug users had used **amphetamines** (7.2%), **hallucinogenic mushrooms** (5.7%) and **LSD** (3.5%).

- **Khat** had been used by 572 of the lifetime substance users (46%). Most of the project's studies of khat use focused on Somalis, but use was also reported by Ethiopians and Eritreans (Somalia, Ethiopia and Eritrea border each other in Africa), although very rarely by members of other Black African communities.

Those who had ever used an illicit drug were not asked if use had started in their home country or in the UK, but some drug use prior to immigration was reported:

> *In the focus groups, marijuana was reported as growing wild in the Congo … Marijuana (and its derivatives) were used by the community 'back home' and did not seem to be considered a dangerous drug.*

In addition, a study of the Sierra Leonean and Ugandan communities reported that various warring factions used cocaine as a form of control over young people they kidnap to fight for them:

> *When the rebels captured me in Sierra Leone, they cut a wound on the back of my hand and pushed cocaine into the wound. Every morning from there on, they deliberately open the wound every day and put cocaine into it. I became an addict in next to no time.* (Male drug user)

3.2 Current substance use

As discussed in Section 1, the sensitivity, stigma surrounding illicit drug use (especially of heroin and cocaine) and the taboo on discussing it meant that not all the studies asked their samples if they were currently using illicit drugs. Nevertheless, 899 of those who had ever used an illicit drug and/or khat were asked if they were still doing so, and 732 (81%) were currently using at least one. As noted earlier, most khat users did not also use illicit drugs, and vice versa.

- The reported pattern of current **illicit drug use** among Black Africans was the same as lifetime use, described above. Cannabis was by far the most commonly used illicit drug, followed by cocaine powder, heroin, crack cocaine, ecstasy and amphetamines.

- The majority (two-thirds) of the lifetime **khat** users were currently using the substance.

- Very little **injecting drug use** was reported, although few studies asked drug users about their mode of administration.

- The **gender** ratio of the current substance users was around four or five males to one female.

- The **age range** of the current illicit drug users was wide, although most were under the age of 40. The majority of khat users were over 30 years old, but some younger people also used khat.

3.3 Perceptions of substance use

Most of the 42 studies asked participants for their perceptions of substance use among members of their communities. A significant minority said they knew nothing about this issue, and many did not distinguish between illicit and licit substances (such as khat, alcohol, tobacco and over-the-counter or prescribed medication). While some study reports pointed out that their respondents may have professed a lack of knowledge because they were uncomfortable discussing illicit drug use, a few thought that this was genuine:

> *Because they have not yet fully integrated into mainstream society, the target community have tended to be insular, and as such, may not be fully exposed to the level of drug misuse as is currently the case in certain mainstream or sections of the Black ethnic minority communities.*

Among those who had some knowledge, however, perceptions largely concurred with the patterns of substance use reported above.

- It was generally thought that that **illicit drug use** among Black Africans was lower than in the general population. Nevertheless, a majority of participants knew people who were using at least one drug and/or khat and that the easy availability of illicit drugs in the UK encouraged experimentation that had not occurred in Africa.

- Overall, the sample specified **cocaine and heroin** as the most harmful illicit drugs, and **cannabis** as the least. For example:

  > *I don't do dangerous drugs like heroin or cocaine. My weed [cannabis] keeps me mellow, so I don't need them.* (Young male cannabis user)

  > *Using cannabis is seen as something that 'everybody' does and not harmful.* (Community organisation's final report)

  > *Cannabis has been in the family as long as I can remember. It has never harmed anyone.* (Young female cannabis user)

- Although most community members thought that younger people (particularly males) were more likely to be using illicit drugs than the older generations, it should be noted that some Black African communities refer to those in their thirties as 'young' if they are unmarried and/or living with their parents.

- Among the Somali community, it was thought that **khat** was used predominantly by older males, but several studies reported a perceived increase of khat use among women and younger males, including secondary school pupils. It was also reported that khat was used by some students to stay alert while studying and by those who worked long hours or in more than one job.

- Several so-called **'traditional substances'** other than khat were reported to be used among some Black African communities in the UK. For example, the Igbo

participants said that members of their community used many of these, including kola (or cola) nut, kpateshi, onugbu and alligator pepper. However, the nature and extent of use, including whether or not it was problematic, was not explored by the studies.

- Although two drug service providers had Black African clients who used heroin, most could not comment on substance use among local Black African communities, as they had few or no clients from these populations.

3.4 Risk factors for substance use and problematic use among Black Africans

The prevalence of substance use among Black African communities – and their responses to it (as discussed in Section 4) – should be seen in the context of the risk factors that make refugees and asylum seekers vulnerable to use and problematic use (Patel *et al*., 2004). A significant minority were aware of these and particularly discussed that illicit drugs and/or khat are used by some Black Africans *'to forget about problems'* caused by:

- the trauma that led to migration, of leaving the home country and the migration process (some respondents reported long and arduous journeys to the UK);
- living in an unfamiliar culture;
- uncertainty about immigration status;
- unemployment and the ensuing boredom and poverty;
- separation from the family;
- a lack of contact with others from the home country because of the asylum seeker dispersal policy or, in the case of minors who arrived in the UK unaccompanied, being placed in care;
- a wait of several months before newly arrived children are allocated a
- school place; and
- racism.

Elements of the vulnerability to problematic substance use are encapsulated in the following account from a study participant:

> *I watch the rebels kill my sister with her baby on her back. She was trying to run to save her baby. We could not even pick up the body. When I arrive in the UK, I suffered hostility, racism, homelessness and serious financial problems. Applying for asylum was the most humiliating experience. I was treated like a criminal. I started going out with a guy just to get somewhere to live and food to eat. He smoked [heroin] – I just got into the habit.*

The extent to which some of the sample were vulnerable to problematic substance can also be seen from the data in Section 2. For example, many were (or had been) asylum seekers, who are not allowed to earn a living in the UK, while those who had been in the UK for only a few years and whose English was not fluent were still grappling with an unfamiliar culture, including the use of substances which may not have occurred in their home country.

3.5 Problems surrounding illicit drug use

3.5.1 Community members' concerns

Community members' biggest concern in relation to illicit drugs was crime (including antisocial behaviour and involvement in drug distribution as dealers or 'mules'), followed by addiction and other effects on physical and mental health, family breakdown (including domestic violence) and financial problems because of the money spent on drugs.

3.5.2 Problematic drug use

Not all the illicit drug users were asked if they had experienced problems relating to their use, but the study reports yielded sufficient data to be able to conclude that although a small minority reported current daily illicit drug use and drug-related problems, the overall picture from the studies was that:

> *Most of the respondents' illicit drug use is casual and recreational and does not appear to have led to dependence or to conspicuous harm.* (Community organisation's final report)

Nonetheless, around half of the current illicit drug users had either thought about stopping, wanted to stop or had tried to stop.

Although several studies attempted to obtain information from local drug services about problematic substance-using clients from a specific Black African community, their efforts were largely unsuccessful because data on clients' ethnicity were either unavailable or imprecise: the relevant data could not be extracted from drug service statistics because all Black Africans are recorded as such, rather than by their countries of origin.

3.6 Problems surrounding khat use

3.6.1 Community members' concerns

Study participants had sharply divided opinions about khat use. Many of the Somalis who did not use khat pointed out that use was more prevalent among their community in the UK than in Somalia, where it is chewed by males during a session lasting for an hour or two with friends after work and at celebrations.

They reported a *'vast difference'* in patterns of use in the UK, where many use it every day – a significant minority of them while on their own – and where a session may last for half a day or longer. In addition, they noted the difference between a majlis in Somalia (the house of one of a group of friends who meet there to chew khat) and a mafrish in the UK (premises specifically used for selling and using khat). A small minority disagreed with these views, however, and reported that khat-using patterns are no different in the UK than in Somalia.

Khat use caused a great deal of concern among many of the participants in the studies that focused on it. These concerns centred around the effect on users' physical and mental health, domestic violence and the breakdown of family relationships because men chew khat for many hours every day rather than spend time with their families and work to provide for them (which in turn leads to financial difficulties for the family). As one study report put it, in the eyes of those Somalis who do not use khat:

> *Removed from its cultural context … far from being perceived as an affirmation of Somali cultural identity, khat usage is perceived as problematic.*

3.6.2 Problematic khat use

The majority of Somali male khat users emphasised that khat should not be viewed in the same way as illicit drugs, because its use is an element of male socialising behaviour that *'brings us together'* and stimulates discussions, and is *'part of our culture'*. Overall, these study participants rated khat as the least harmful of a list of substances including illicit drugs, alcohol and tobacco, believed use to be culturally and socially acceptable in their communities (although far less so for females than males), and a small minority argued that khat use prevented the use of illicit drugs.

However, despite these viewpoints, khat users *did* report family, financial and health problems related to their use and tended to stress the health consequences, particularly insomnia, mood swings, impotence, and mouth, gum and throat problems.

Two studies asked khat users how much they worried about their use. Around four in five users in one and almost two in three in the other responded that they *'always'* or *'often'* worried. In both studies, perhaps reflecting the fact that khat use by females was reported to be less culturally acceptable than by males, a larger proportion of female than male khat users reported being worried about their use, and more females than males used khat when they were alone. There were also some indications of dependence on khat:

- Overall, around a third of current khat users used the substance daily. This proportion almost doubled when those reporting use on five or six days a week were included.

- Although not all the khat users were asked if they wanted to stop using, overall, around half of those who were asked had either thought about stopping, wanted to stop or had tried to stop. In one study, 75 out of 107 khat users (70%) said that they wished they could stop using.

- One study reported that 80% of khat users agreed that they *'always strongly need khat'*.

- In another study, 62% agreed that their khat use was *'out of control'*.

4 Tackling substance use

See *Key messages* for a summary of this section

This section examines the responses of families, communities and substance users to illicit drug and khat use. It was clear from the study reports that, overall, Black Africans lack knowledge about drugs and drug services, and that seeking information, advice and treatment from these services was uncommon.

Relatively new arrivals to the UK were reported to face particular problems coming to terms with a new culture which included illicit drug use. For example:

> *The Congolese people are very new to facing the dilemmas and contradictions of wanting to fully integrate in to UK society, but at the same time seeing the new dangers and realising how ill-equipped they are to cope with some of these, such as UK drug culture.* (Community organisation's final report)

4.1 Family and community responses to substance use

A few of the studies reported on Black Africans' methods of dealing with illicit drug use in their community or by a family member. The reactions reported most often were denial, punishment and rejection, against a background of the stigma of illicit drug use and the taboo on public discussion of it. As discussed in Section 3.6, however, many Black Africans did not attach the same stigma and taboo to khat use.

4.1.1 Denial

Although a majority of study participants accepted that some illicit drug use (especially of cannabis) occurred within their communities, a minority adopted an 'it-couldn't-happen-to-us' approach. For example a study of Zimbabweans reported that some of their sample believed that:

> *An ambitious, educated Zimbabwe resident in London could not possibly be vulnerable to such distractions as 'drug addiction' … [This perception] can be attributed to a belief which regards the problem of drug misuse as exclusively affecting [the] uneducated working class … Adults perceive drug users as 'bad people' or as people with 'social problems'.*

Several studies reported that religious institutions and leaders would not accept that followers of their faiths used illicit drugs and that they were *'absent in the current debates'* around illicit drug and khat use. Muslims were more likely to report this than those of other faiths – several reports noted that *'the mosque doesn't discuss any social problems, including drugs'*.

It is also clear from the study reports that the denial of illicit drug use within a community may also have been due to concerns that all community members – not just the drug users – would be stigmatised and *'betrayed to the Home Office'*, resulting in a negative effect on the immigration status of all those from a particular African country.

At the family level, the stigma of illicit drug use and the taboo on discussions of it meant that families deny the drug use of a member in order to avoid ostracism and *'play "happy families" in public to maintain social standing'*.

4.1.2 Punishment and rejection

Overall, the study participants reported that illicit drug users would be ostracised by other Black Africans, although there was more tolerance of khat users among the communities in which the substance is used (Section 3.6).

Several studies reported that parents' reaction to illicit drug use by their children would be punishment, including rejection, beating, confinement in the home and threats to send the drug user back to the country of origin (although there were no reports that this had occurred). A few reports noted that these reactions to drug use may be because it destroys parents' high expectations for their children when they settle in the UK.

4.1.3 Help-seeking

Most of the studies asked their samples where they would go for help if they or someone they knew had a substance use problem. From the responses, it was clear that most community members lacked an understanding of how to support illicit drug and khat users, and were unaware of the existence of drug information, advice and treatment services and of the help they can provide. When discussing drug services, for instance, many appeared to believe that 'counselling' was the only treatment option available: very few appeared to be aware of detoxification or of ameliorative and substitute prescribing.

It was also clear from the study reports that there was a reluctance among members of many communities to seek 'outside' help for any problem and that many Black Africans do not fully understand the system of statutory health care in the UK, other than that provided by GPs.

- The **family** was most often cited as a potential source of help. It was believed that *'Family members can help better because of family bond'*. Parents thought they had a duty to discuss drugs with their children, although some young people said they would not be comfortable discussing drugs with their parents. The studies also reported that most parents lacked the knowledge to advise their children about drug use and drug services.

- The next most popular sources of help were equally friends, religious institutions and/or leaders, and GPs.

  As well as saying they would approach **friends** for help, many study participants also imagined that they would be the first port of call for a friend with a substance use problem. However, the studies revealed that most members of the Black African community are unlikely to have sufficient information about drugs and drug services to be able to assist a friend.

Overall, a smaller proportion of Muslims than Christians said they would seek help from a **religious institution/leader**, because of their unwillingness to acknowledge and discuss substance use, Islam's perceived zero tolerance of substance use and because they imagined that help would consist only of an instruction to follow Islamic teachings. Christians were more likely to report that *'Church has all solutions, both spiritual and material'* and that *'the church would understand my problem more than any other institution'*.

GPs were seen as the access point to getting help for a variety of health problems, including substance use.

- A number of other perceived sources of help were cited less often:

  Community organisations: these were thought to be best able to understand the cultural context of a specific Black African population. It should be noted, however, that in some cases, community organisations may have been cited as a source of help because they were undertaking the needs assessment and asking this question. For instance, some of the participating Somali organisations provided advice and information about khat and were involved in campaigns to raise awareness of the health and social problems of khat use.

  That said, community organisations (other than those participating in this project) may not have the expertise to assist, because, as one study report put it:

  > *The community leaders and some of the project workers only realised the existence of drug service organisations at the [project's steering group] meetings.*

  Drug services: responses such as *'treatment centre', 'drug agency',* and *'counselling'* were given by some community members when asked where they would go for help if they or someone they knew had a drug problem. In some cases, this was qualified by the caveat that they would not approach a service in their local area because of the stigma surrounding drug use in their community.

  It was also clear that many had little idea what these services entailed and where and how they could be accessed: for example, many named the police, Childline or a local youth club as 'drug services'.

  Telephone helplines/internet: in one study, the FRANK website and helpline was quoted as a source of help by more study participants than any other drug service.

4.2 Help-seeking by substance users

When those who used drugs and/or khat were asked who they would go to if they needed help, responses largely followed the pattern of those of community members: their family, friends, GP and the FRANK website and helpline. However, unlike community members, few substance users said they would approach a community organisation or a religious leader/institution for help.

4.2.1 Experiences and perceptions of drug services

Only a very small proportion of the illicit drug or khat users who were asked if they had sought information, advice or treatment from a drug service had done so, reflecting reports from the drug service providers in the areas where the studies were conducted that they had few or no Black African clients.

Around half of those who had used drug services said their experience of these services was positive and their needs had been met. The remainder were dissatisfied, particularly because of a perceived lack of cultural competence among staff, their *'unfriendliness'*, their *'lack of compassion'* and communication problems because of language.

When substance users who had not sought help from drug services were asked why they had not, their main responses were that:

- They were **unaware of any service**.

- They **did not need services** because they did not use 'hard' drugs, did not want to stop using, used drugs only occasionally, enjoyed using them and/or their use was *'not harming anyone else'*.

- They did not need help because they **could handle any problems themselves** by stopping use, cutting down, or keeping away from substance-using friends.

- They **lacked confidence in the confidentiality** of drug services. Although some young people worried that, if they approached a drug service, their parents would be told and punish them, illicit drug users' major concern was that they would be reported to other *'authorities'* and their immigration status would be affected.

Other reasons why substance users had not accessed drug services were:

- **Communication difficulties** because of language differences and a lack of a lack of non-written information for those whose main method of communication is oral.

- A perception that the **bureaucracy** of drug services would be overwhelming: some study participants had experienced this when they were seeking asylum and had tried to register with a GP.

- The **stigma** not only of drug use, but in the case of some communities, of help-seeking. For example, it was reported from a study of the Busoga community that they *'are used to solving their own problems'* and several study reports pointed out that problematic substance users would find it embarrassing and humiliating to be considered a *'junkie'* in need of help.

- A perception that drug services would not understand **cultural and religious needs**, fuelled by the absence of Black African workers.

Barriers to drug services less often reported were worries about the cost and a conviction that there are no services for khat users nor for families of substance users.

The remaining sections report on the drug service needs of the Black African communities in England as identified by the 42 community organisations on the basis of their findings. Their recommendations are categorised here as:

- **information needs**;
- **cultural competence** within drug services;
- **prevention initiatives** by the provision of alternatives to substance use, increased penalties for drug use and dealing (including making khat use and supply illegal);
- **engagement** via partnerships between drug service planners commissioners and providers, community organisations, religious institutions, and community members and a variety of professionals working with them; and
- **further research.**

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

However, despite this, the overall indication from the seven-year period of the project is that – when compared to the white population – Black Africans are under-represented as clients of drug information, advice and treatment services.

One explanation for this, as discussed in Section 3, is that illicit drug use (other than cannabis) and problematic use among these communities may be relatively low. However, prevalence rates may rise due to the fact that some of the risk factors for problematic illicit drug use are evident among some Black African communities (Section 3.4).

There are also proportionally more young people in the Black African communities than in the general population (see 'Population profile'). As these young Black Africans grow up in the UK and adopt aspects of British culture, they may become increasingly exposed to illicit drugs. As one study report put it:

> *Young girls, unlike their parents' generation, are more adventurous and ready to experiment with peer groups. They are more willing and able to live outside their communities.*

Therefore, drug service planners, providers and commissioners and the communities themselves were urged by the study reports to take proactive measures to ensure that the Black African communities have information about drugs, harm reduction and drug services.

Of course, not all the drug information, advice and treatment service needs identified in this publication apply exclusively to Black Africans, nor indeed only to members of Black and minority ethnic communities. However, although the data collected during this project indicate that the drug-using patterns among Black African communities are similar to those among the general population, it does not follow that Black Africans can simply 'slot into' existing drug services. Responses may have to be different so that the barriers to drug service access that they face can be overcome.

It is noticeable that the recommendations in most of the study reports barely discussed drug treatment and harm reduction measures. This reflects the fact that:

- there was a lack of knowledge of drug treatment services and modalities among the majority of study participants and community organisations;
- this project was the first time many of the community organisations had systematically investigated substance use and drug service needs; and
- for many Black Africans, the solution to tackling substance use was to prevent it from happening.

5 Information needs

See *Key messages* for a summary of this section

The conclusions and recommendations from the 42 studies represent a strong plea for information about illicit drugs (and khat in those communities where it is used) and drug services. Many reports emphasised that an aim of increasing awareness is to ensure that members of Black African communities talk openly about drugs, so that the taboo on such discussions can be broken.

5.1 The message

While the community members who participated in this project agreed that the stigma, taboo and denial attached to illicit drug use should be challenged, they were divided over the messages about illicit drugs and khat that should be transmitted to their communities.

Some thought that the sole message should be abstinence and that drug education should stress the illegality of some substances, that khat was a drug, and the dangers and negative consequences of substance use. In the extreme, their suggestions were based on the opinion that *'if our children are taking to drugs … then that will be the doom of the society'*.

Far fewer wanted the information to enable recipients to make informed choices about illicit drug use and even fewer wanted it to include harm reduction messages for drug users.

In terms of drug services, it was recommended that the communities received precise details of how they operate, the process by which they are accessed, and where linguistically, culturally and religiously appropriate support can be found. The aim was not only to inform the communities that services exist and what they do, but also to address the situation where it is *'a matter of luck whether or not a person has access to the correct services.'*

5.2 Venues

A very wide variety of preferred venues for the delivery of information and advice about illicit drugs, khat and drug services was recommended by the participants in this project.

The most common recommendation was that information and advice should be delivered in community-based, familiar venues such as community centres and places of worship, and at these organisations' festivals and other social events. Other suggested venues were the cinema, parties, pubs, nightclubs, community meetings and conferences, African restaurants and shops, and in the street and all public places via billboards and posters.

Several reports recommended gender-specific venues for the delivery of information. For those women for whom it is culturally unacceptable to mix with men, women-only venues or their homes were thought most appropriate, while the studies dealing with khat use in the Somali community recommended that information was given to men in the mafrishes.

Young people's need for information was particularly stressed, and it was recommended that it was delivered to them not only at the venues suggested above, but also in youth clubs, schools (including Saturday/supplementary schools and religious schools), colleges, universities, and in sports and leisure centres.

5.3 Media

A wide range of written, oral and visual media were suggested for transmitting information about illicit drugs, khat and drug services, with the emphasis on cultural appropriateness (especially language) and a format that would most attract the target groups. It was felt that Black Africans should feature prominently in any media used to transmit information.

Recommended media included leaflets, community and religious newsletters, videos/DVDs, television, radio (including phone-in shows where listeners could share their experiences anonymously), telephone helplines, community theatre events and the internet (although one study noted that new arrivals to the UK may not have had experience of using the internet).

Reflecting the desire to raise the awareness of all members of a community, one study report suggested having a drugs awareness week in their area, during which banners would be prominently displayed and a mobile information service would drive around with loudspeakers.

5.4 Educators

Community organisations were the study reports' most popular choice for delivering education about drugs and drug services to the Black African communities – once they had been trained to do this. As many reports noted, currently *'few people possess the skills and/or strategies for educating other members of the community about drug use.'*

It was thought that community organisations' workers and volunteers could play an effective role in drug education and signpost those who need help to drug services, because:

- community centres and events were well-attended by local Black Africans;
- staff *'speak the language and understand the cultural background of community members'*; and
- community organisation staff are *'approachable and willing to talk'* and this would help overcome the stigma and taboo surrounding drug use.

A variety of other educators were also suggested by the studies, particularly peers, outreach workers who were members of the target community and ex-drug users.

5.5 Recipients

All members of a community were thought to need information about drug services and illicit drugs (and khat in the case of the communities in which it is used), so that they can all offer help and support to users and those affected by use.

Overall, however, it was thought that young people and their parents were in particular need. Some study reports recommended that the information was delivered to parents and children *'sitting together'* in order to promote *'a lively exchange of ideas'* and encourage families to discuss drugs, while others thought that separate sessions should be held. As one report put it:

> *Community members … were very much concerned about the strained relationship between parents and children when it comes to topics like drugs … [Parents] find it very hard to discuss such topics with their children … [and] need to be given enough information about drugs so that they gain the confidence and courage to be brave and discuss issues on drugs with their children.*

It was also recommended that drug education initiatives should target newly-arrived asylum seekers, the families of problematic substance and young people vulnerable to substance use and problematic use (such as unaccompanied minors in care).

6 Cultural competence

See *Key messages* for a summary of this section

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

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

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

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

Individual competence

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

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

Organisational competence

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

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

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

Taking a maturity approach to cultural competence recognises that there are various levels through which individuals and organisation might pass as they move towards a fully-developed level of competence. This is also in keeping with models of lifelong learning and organisational development.

A culturally competent service operates effectively in different cultural contexts, in order that the needs of all members of their target population can be met by equitable access, experience, and outcome. The majority of the needs assessment reports stressed a need for increased cultural competence among drug services, and it was thought that recent arrivals to the UK and those who could not speak English were particularly affected by its absence because they remain *'heavily influenced by their tradition and culture'*.

Several study reports noted that progress towards cultural competence was slow:

> *The implementation of the call for culturally competent perspectives to inform service design … appear to remain largely an abstraction or an empty slogan that is at best implemented as a ritual necessity.*

A few study reports stressed that local communities had a role to play in this issue and suggested that local drug service staff should be invited to attend the local Black African communities' festivals, cultural events and religious gatherings in order to develop links and mutual cultural understanding.

The main topics that the studies raised in relation to drug services' cultural competency concerned the **diversity among Black Africans**, **language**, whether **generic or specific services** should be provided, **the ethnicity of staff**, the **stigma and taboo** surrounding drug use, and the **cultural acceptance of khat use** by some Black Africans.

6.1 Recognition of diversity

As discussed in Section 3.5.2, Black Africans are recorded by drug services as such, rather than according to their countries of origin. As this project (with study participants from 30 different African countries of origin) has shown, this cannot be ignored when services seek to improve their cultural competence: initiatives and interventions that are successful with one Black African community may not be appropriate for another. It was clear from the study reports that drug services' responses to substance use among Black African communities should therefore be devised on a local basis.

It is not being suggested here that more precise ethnic monitoring automatically ensures cultural competence, but – as several reports noted – this would ensure that any under-representation as drug service clients of particular Black African communities is identified at a local level and that service providers *'will be in a position to know where their resources should be focused'.*

6.2 Language

As discussed in Section 2, the participants in this study spoke a total 40 languages. Although a majority spoke English, not all of them were fluent, especially older people, and fewer could read the language(s) they spoke. A drug service may therefore encounter several different languages among the Black Africans in their catchment area.

For example, one study reported five mother tongues among a sample of only 102 Black Africans living in the south London boroughs of Lambeth, Southwark and Lewisham: English, French, Portuguese, Swahili and Yaruba. Therefore, the studies variously recommended that drug services take into account that:

- it should be *'standard practice'* to translate all written media on drugs and drug services into the language(s) read by local African communities;
- even those who speak English as an additional language may have difficulty understanding UK concepts, systems and processes surrounding drug services and may need an interpreter; and
- in some Black African communities, the preferred means of communication is oral, and they are *'more likely to value word of mouth'* sources of information and advice than other forms.

6.3 Generic and specific service provision

Some study participants could see drug services becoming culturally competent only if they provided specific services for specific Black African communities, staffed by workers from those communities. However, the majority of those who discussed this issue recommended increasing cultural competency within existing service provision.

Several reports called for services to be more *'Muslim-friendly'* by, for example, holding drug information sessions in alcohol-free environments and providing services for women in women-only venues, staffed by women. A drug telephone helpline specifically for Muslims was also suggested.

6.4 Ethnicity of drug service staff

Over half of the study reports noted the lack of Black African drug service workers and recommended that members of the local Black African communities were trained and employed to conduct this work. For example, a study of a Muslim community stressed only Muslim workers could overcome *'the cultural and religious barriers'* to drug services facing Black African Muslims, and another study recommended that an outreach worker *'has to be somebody from within the local community who understands the secrets of the community'*.

However, staffing is a more complex issue than simply employing workers who are from the same ethnic group as potential clients. A Black African worker should not be expected to be an expert at providing a service to all Black African drug users, single-handedly, without appropriate and adequate support. All workers, including those who are white, have an explicit role to play in the delivery of culturally competent services. That said, ethnically diverse teams communicate an implicit message that they can respond to the needs of the whole population.

6.5 Stigma and taboo

As this report has shown, many Black Africans believe that illicit drug use, discussions about it and attendance at a drug service will be reported to the government and result in drug users being denied the right to stay in the UK. It was clear from many of the study reports that this concern contributes substantially to the stigma and taboo surrounding illicit drug use among Black African communities.

This means that not only do drug services need to reassure clients and potential clients of their confidentiality, but also, as many study reports noted, the majority of Black Africans would not visit premises that were advertised and well-known as offering drug services.

Thus, rather than dedicated drug premises, outreach was a popular recommendation for the delivery of drug education and advice, and for referral to drug treatment services. The study reports recommended that outreach work should be conducted in community centres, places of worship, schools and colleges, youth clubs and through home visits.

6.6 Khat use

As discussed in Section 3.6, many members of communities where khat is used (and the users in particular) consider khat use to be part of their culture. Others, however, argue that the pattern of use in the UK is very different to that in Africa – and more harmful. Nevertheless, it appears from the studies that focused on this issue that UK khat-using patterns have become part of the cultural identity of many Somalis, Eritreans and Ethiopians who live in the UK.

Some of the study participants from these communities (both khat users and non-users) did not consider that khat should be viewed in the same way as an illicit drug, despite the problems that use caused, while others disagreed and recommended that drug services addressed its use.

Information and advice about khat and treatment for problematic use needs to recognise these opposing viewpoints. For example, including khat in an information leaflet about illicit drugs or drug treatment may meet with approval of some members of the community, but may not engage khat users.

7 Prevention initiatives

See *Key messages* for a summary of this section

For many Black Africans, the main solution to substance use was to prevent it from happening. The study reports had several recommendations concerning this in addition to the abstinence message of illicit drug and khat education initiatives discussed in Section 5.1.

Fourteen reports recommended that so-called 'diversionary' activities and facilities for young people should be provided as an alternative to experimentation with illicit drugs and khat, in order to build their self-esteem and *'keep them off the streets and lead a healthy lifestyle':*

> *There are not enough activities for young children – e.g. sports clubs. There need to be more activities that can deter young people from drug taking.*

Muslim study participants stressed that facilities such as sports centres should be alcohol-free, or at least have times when alcohol was not being consumed, so that young Muslims could attend.

Several study reports (especially those concerned with the Somali community) pointed to unemployment as a risk factor both for substance use and problematic use. They recommended skills training to counteract this and the vulnerability to selling drugs as a means of generating an income.

Several studies reported that substance use was related to a lack of integration into the UK among some Black African communities. They therefore recommended social and practical support for families, including workshops and seminars so that they could *'learn about good citizenship'* and *'integrate successfully into UK society'.*

A minority of study reports recommended that illicit drug and khat use should be prevented by more punitive measures:

- Six of the ten studies that focussed on khat discussed whether use and supply should be made illegal. Of these, only one recommended that khat should keep its legal status, while the other five made a strong plea for change. One of the five pointed out, however, that 54% of their sample of khat users said they would continue to use the substance if it was made illegal, and 32% said they would use illicit drugs or alcohol if khat became unavailable.

- A sample of young people in one study supported drug testing in schools and exclusion for those testing positive.

- Several studies recommended that illicit drug use could be prevented by more legislation, stiffer penalties and increased policing to tackle drug use and dealing.

8 Engagement

See *Key messages* for a summary of this section

The *Department of Health's Black and minority ethnic drug misuse needs assessment project* has not only produced 42 local needs assessments from community organisations on the drug-related needs of Black Africans, but has also engaged local population groups and local drug service planners, commissioners and providers – in most cases for the first time. Community organisations' positive experiences of the project meant that they were enthusiastic about further engagement. For example:

> *This is the first time we have worked with others on such an important issue of concern. It has already built bridges that did not exist before and broken down barriers of distrust. The team would very much like to train further and gain formal qualifications so they can work with and alongside statutory service providers … people have actually developed a belief that they can influence a change for the better.* (Community organisation's final report)

Thus, the study reports' recommendations stressed that partnerships were key to addressing drug use among Black African communities, and that these should involve drug service planners, commissioners and providers alongside community organisations, religious institutions, community members and a variety of professionals working with them.

8.1 Community organisations

The most common recommendation concerning partnerships was to establish them between community organisations and local drug service planners, commissioners and providers. As one study report put it:

> *Perhaps one of the most outstanding gaps evident in mainstream service provision is the missing rapport between the frontline community groups and the mainstream providers.*

The Black African community organisations participating in this project were concerned about illicit drug or khat use among their communities, and their needs assessments gave them the opportunity to voice these concerns and make suggestions to address it. Many were eager to gain the skills and resources to work with local drug services and with drug and alcohol action teams (DAATs).

Although, as discussed in Section 4.1.3, community organisations are not currently the study participants' most popular perceived source of help with substance use problems, community organisations nevertheless believed that they were an *'untapped resource'* in this respect, because, in a culturally competent manner, they could (after training) provide drug services with a gateway into their communities and refer drug users to the appropriate service.

Community organisations wanted to be involved in every aspect of drug service provision:

> *Involve the voluntary sector right from the onset, at the design stage through to implementation of new initiatives/projects and in the decision making process to ensure effective involvement and ownership.*

8.2 Religious institutions

It was clear from the study reports that religion plays a significant role in the lives of many Black Africans in the UK, including active membership of a congregation. Many Christians thought the church had all the solutions to all their problems, and in the samples of two studies of Muslim communities, two-thirds believed that their religion prevents substance use.

Another study reported that their sample of Sierra Leoneans and Ugandans believed that they would be helped with all their problems – including drug-related issues – by prayer at the church or mosque. In addition, many study participants stressed that drug users need spiritual support. Thus, as one study report put it:

> *Service providers cannot afford to ignore the influence of religious institutions in addressing problems related to drug misuse.*

The study reports' recommendation on this issue was that religious leaders and institutions should be involved in partnerships that address drug use among Black African communities:

> *We should get the faith groups involved in educating people [about drug use] through using their premises for drug awareness workshops and education … thus working hand in hand with the leaders of the faith groups to bring about change.*
>
> *Church and religious leaders should be made to play a key role in drug services publicity.*
>
> *Local mosques' management committees and imams should be empowered and skilled to address these social problems in partnerships with local service providers.*

However, this strategy is likely to meet with resistance from those religious leaders who do not acknowledge that illicit drug use occurs among their congregations (as discussed in Section 4.1.1) or recommend prayer and adherence to religious teachings as a solution (Section 4.1.3).

8.3 Black African community members and those working with them

In addition to community organisations and religious leaders and institutions, a variety of other Black African community members and those who work with them were suggested as members of partnerships with local drug planners, commissioners and providers:

- **young people**, so that their voices are heard by adults, through – for example – youth forums and student groups to advise DAATs;
- **community leaders**, who, it was felt, should openly support drug education campaigns and launches of drug services;
- **GPs**, because although many Black Africans do not fully understand the system of statutory health care in the UK, they are familiar with GPs and see them as the access point to other health services;
- the **police and probation services**, to explain how they are tackling drug dealing in order to reassure the communities that they take this seriously;
- **health service staff** and **schoolteachers**, so that they can support drug users they encounter and refer them to drug services;
- **drug and khat users and ex-users**, so that users' needs are considered; and
- **drug and khat users' families and carers**, to ensure consideration of their needs.

The study reports stressed that the proposed partnerships would build the confidence of clients, potential clients and community members in drug services, and, along with an increased knowledge of substance use and drug services:

> *will build the community's confidence to tackle local drug problems and in the long run increase the community's resistance to drug misuse.*

8.4 Funding

It was clear from some of the study reports that there was some dissatisfaction over funding issues. Some attempts at partnerships between statutory drug services and the Black African voluntary sector were reported, but were deemed to have failed because of insufficient funding. For example:

> *The Black and Minority Ethnic Strategy Group … is an arrangement meant to be an interface between statutory and community/voluntary sector organisations working in the drugs awareness and education areas. This arrangement was not working properly … because it brought together fully funded government agencies to work with the unfunded and under resourced community sector whose presence on strategy group depended on … funds and dedicated staff to deal with drugs education and awareness issues on a regular and long-term basis.*

Funding was also an issue when a few community organisations discussed their findings with their local DAATs and were told that funds for the next year had already been allocated, so nothing could be done to implement their recommendations immediately. While this may have been the case, it did not inspire confidence in the DAATs' willingness to work in partnership.

Funding was recommended by some of the study reports to train community organisations in drug and drug service awareness so that they could educate members of their communities. This was thought particularly necessary to build capacity within newly formed community organisations catering for new arrivals to the UK.

Several community organisations reported that they needed educating about relevant funding sources and application processes so that they could raise funds themselves, and one said that local Black African communities themselves should contribute funds to their drug-related initiatives.

The reported lack of cross-borough funding was an issue for some of the London-based community organisations, whose members did not necessarily live solely in one particular borough.

8.5 Sharing good practice

Some study reports recommended that one of the aims of partnerships should be to collect and disseminate examples of good practice of:

- working with Black African communities around substance use and the related issues;
- culturally appropriate service provision, including that in the communities' countries of origin; and
- relevant research, including the needs assessment reports from this project.

In this way, it was stressed that the communities would have access to accurate, up-to-date information to help them respond to substance use.

9 Further research

See *Key messages* for a summary of this section

As many of the community organisations discovered when they attempted to search for relevant data on their specific community, little research has been conducted on substance use and the related issues among the Black African communities in the UK. Many of the studies reported enthusiastically about their new experiences as researchers and made suggestions for further research to inform the development of appropriate service provision:

- existing and emerging patterns of substance use (including longitudinal studies) among specific Black African communities and/or specific vulnerable groups within them;
- the impact of migration and immigration policies on substance use;
- the effects of substance use on families;
- the impact of social exclusion on substance use;
- gender differences in substance use;
- the impact of khat use on mental health;
- Black African women acting as 'mules' to bring illicit drugs into the UK;
- substance use and domestic violence; and
- the use of so-called 'traditional' substances.

Notes

[1] <http://www.statistics.gov.uk/cci/nugget.asp?id=273> (accessed June 2007)

[2] <http://www.statistics.gov.uk/CCI/nugget.asp?ID=457&Pos=4&ColRank=2&Rank=224> (accessed May 2007)

[3] <http://www.statistics.gov.uk/CCI/nugget.asp?ID=460&Pos=1&ColRank=1&Rank=326> (accessed July 2007)

[4] Calculated from Census 2001, Table S101 (sex and age by ethnic group). <http://www.statistics.gov.uk/StatBase/Expodata/Spreadsheets?D7547.xls> (accessed May 2007)

[5] <http://en.wikipedia.org/wiki/African_languages> (accessed July 2007)

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African Community Involvement Association (ACIA), Mitcham, Surrey	African Community Link Project, London
African Health for Empowerment and Development (AHEAD), London	African People's Link, London
Afya Health International, London	Agenda for Community Development, London
Appropriate Support and Training (ASAT), London	Black Orchid/Nilaari, Bristol
Busoga Association UK, London	Cabinda Community Association, London
Congolese Refugee Women's Association, London	Congolese Youth Association (CYA), London
Croydon Somali Community Association, London	Eritrean Community in Greenwich and Lewisham, London
Ethiopian Community in Lambeth, London	French African Welfare Association, London
Harrow Council for Racial Equality (HCRE)/Harrow Association of Somali Voluntary Organisations (HASVO), London	Hawa Women and Family Capacity Building Project, Liverpool
Igbo and Tutorial School, London	KIKIT, Birmingham
League of British Muslims, London	The Light Outreach, London
Minorities of Europe, Coventry	Northamptonshire Somali Community Association
Options, Southampton	Organisation of Positive African Men (OPAM), London
Peninsular Community Development Foundation (PCDF), London	Refugee Enterprise and Employment Connect, London
Sahel Refugee Association, London	Simba Community Alliance, London
Somali Development Trust, Manchester	Somali Health and Mental Health Link, London
South London African Women's Organisation (SLAWO)	Supporting African Youth Development (SAYD), Surbiton, Surrey
Sizanani Africa, London	Transocean Development Agency (TDA), Barking, Essex
Turning Point – Worcester Druglink	Ugandan AIDS Action Fund (UAAF), London
Way Forward Organisation/Voices of African Women, London	Worldwide House of Hope Anti-Drugs Initiative, London