COMMUNITY ENGAGEMENT PROJECT

REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSSING ON WHY BLACK MEN DO NOT ACCESS MAINSTREAM DRUG SERVICES CONDUCTED BY PARTNERS OF PRISONERS AND FAMILY SUPPORT GROUP AMONGST BLACK AND ETHNIC MINORITY PRISONERS BASED IN HMP RISLEY.

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Jamal Anderson – 19 years old. Works for POPS as a Floating Support Worker. This involves working on a prisoner's families helpline and supporting staff based in prison visit centres. No previous experience of carrying out research but has a good understanding of drugs and the effects of drugs from working with families affected by drug use. He assisted in training the peer researchers in drug awareness and helped in administering the questionnaires and focus group.

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Executive Summary

Background

The group undertaking this project is a charity called Partners of Prisoners (POPS). POPS were one of 120 groups who had been selected by the Centre of Ethnicity and Health at the University of Central Lancashire. POPS was set up to provide advice, information and support to prisoner's families. POPS carried out the research project in HMP Risley and looked at the views of BME prisoners. The project aimed to achieve the following:

- To understand why fewer BMEs choose to access mainstream drug services.
- Explore the needs of BMEs in relation to drug support
- Explore the impact of cultural factors when accessing drug support.
- Understanding barriers which are unique to BMEs, which contribute to low service take up.
- Providing BMEs involved in the research with a greater awareness of drugs, drug treatment services and research methods.

Design

POPS recruited and trained a group of 12 prisoners who volunteered to work as peer researchers within the prison. The peer researchers were trained in drug awareness and research methods and played a major part in carrying out the questionnaires and collecting data. All peer researchers were of African, African Caribbean and South Asian descents. Three types of methods were used to explore the above aims and objectives, they were questionnaires, interviews and a focus group. POPS and the peer researchers approached 68 inmates in total. This included questionnaires with 52 inmates and 16 unstructured interviews. 14 inmates did both a questionnaire and interview (these 14 are included in the number who did the questionnaires), so altogether 30 interviews were carried out.

Key findings

Limited BME drug usage

The consensus among most of the respondents was that fewer BMEs are dependent on illicit class A drugs compared to white people, therefore you have fewer BMEs accessing drug services. Although most respondents admit that there are BMEs who are dependent on cannabis, the perception among most was that cannabis was seen as a soft drug and was not considered a big enough problem to merit seeking support or treatment.

Social and community perceptions

The way in which people in your community (including family) will respond to your drug use is a major concern for most BME drug users. Sometimes the shame of being drug dependent may be so great that a user may choose to hide their problem, more so than a white drug user.

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

Most BME communities are small and closely knit, so there is a concern that confidentiality will be broken if a BME drug user seeks help from a BME drug worker who might also be part of the drug user's local community. This worry only further adds to the many reasons why most BME drug users choose to stay anonymous.

An increased understanding of BME culture
A more effective approach for increasing BME drug service uptake could be for drug services to employ general multi ethnic drug workers who have a better understanding of BME culture. This could extend to having some drug workers of South Asian decent who are fluent in Urdu for instance if language is a barrier. At the same time, the presence of white staff who are culturally sensitive and working amongst BME staff may be more comforting for BME drug users who are worried about their problem becoming the talk of their community.

Awareness of drug services
Generally most respondents were not aware of very many drug treatment services. The best known treatment service was the prison CARATs (Counselling, Assessment, Referral, Advice and Throughcare). A few also knew of PASRO and Lifeline. It is difficult to assume whether this lack of awareness of treatment services is a barrier to BMEs in service uptake, as most of the respondents who could name treatment services, did not see treatment services as being effective and so may not have accessed them.

Drug knowledge
Many of the respondents had a good understanding of the effects of certain drugs but not all drugs. For instance more respondents were aware than unaware of the long-term effects of heroin, crack, cocaine and skunk, but fewer knew of the long-term effects of using amphetamines, LSD, ecstasy, solvents, prescribed drugs or steroids. Fewer respondents knew of the long-term effects of using cannabis, but the difference between does that did and did not know was quiet small.

Recommendations

POPS suggested a number of recommendations following on from the outcomes of the project. The recommendations are highlighted below:

Drug awareness and support to families

The way in which people in your community (including family) will respond to your drug use is a major concern for most BME drug users. With most BME communities being small and closely knit, there is a concern that confidentiality will be broken which only further adds to the many reasons why most BME drug users choose to stay anonymous.

A possible future direction could be to offer greater drug awareness to BME families and communities. By increasing families' awareness of drugs, they will hopefully gain a greater understanding of the effects of the drug user's drug/s of choice.

Family support agencies such as POPS, Adfam, PACT (Prison Advice and Care Trust), and Action for Prisoner's families can all inform BME families of the facts surrounding drug use, drug related issues which may effect them and how to deal with these issues effectively without isolating the drug user.

Increasing awareness of treatment services

Most of the respondents were fairly clued-up when it came to general drug knowledge, however most were unaware of any drug treatment services. As well as increasing families general drug knowledge, community and health centres could also play a key role in increasing a BME drug users' awareness of the services available where they can go to get treated.

An increased understanding of BME culture

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INTRODUCTION

Background

In November 2000, the Department of Health awarded a contract to the Ethnicity and Health Unit (now Centre for Ethnicity and Health) at the University of Central Lancashire to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic (BME) community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services

The project was hugely successful. Nearly £1.2 million was invested in the scheme and 49 groups were selected to take part (47 of whom completed) after 500 initial expressions of interest were received. These 47 groups represented more than 30 different ethnic and national groups. 350 people trained in research methods and basic drugs awareness at the University of Central Lancashire, and the 47 groups went on to consult with over 12,000 people (2,000 of whom were drug users) about their needs. The groups produced 51 local reports, which were summarised in two over-arching national reports published in May 2003. The project had a huge impact upon the individuals who took part, the community groups that the groups represented, and the DATs within whose areas they were based.

Also in May 2003 the Department of Health indicated its continuing support for the programme by announcing a further round of Community Engagement Funding for up to 120 additional community groups to become involved during the period to March 2006. Although Black and minority ethnic communities remained a focus for the work, the scheme was also extended to include other disadvantaged groups. The project has four main objectives. These are:

- to ensure that Black and minority ethnic and other disadvantaged and marginalised groups gain a better understanding of the drug misuse issues for their communities;

- to establish information networks across participating projects creating linkages both between different groups and across geographies, in order to encourage information to be shared and gaps in services to be identified;

- to provide capacity building for local Black and minority ethnic communities and other disadvantaged and marginalised groups to ensure not only the completion of the work, but also an enhanced ability to articulate identified needs to service planners and providers;

- to ensure local health and social care planners and providers are involved in the process in order to enable the development of services that are sensitive to and meet identified needs.

Each group undertook a piece of research within their local community. The focus of this research was different for each group depending on local priorities. In the main groups focused on one or more of the following issues:

- the characteristics and extent of the drug misuse problem in their chosen setting (e.g. particular group or location);
- new patterns of drug misuse;
- culturally specific explanations of drug misuse and the terminology employed by local misusers;
- the interventions which have taken place or are needed;
- the availability and adequacy of treatment;
- the nature and effectiveness of drug misuse prevention and education programmes;
- the types of community resources that could be mobilised to develop appropriate interventions;
- the relevance of all of the above to their communities.

The group undertaking this project is a charity called Partners of Prisoners (POPS). POPS were one of the 120 groups who had been selected by the Centre of Ethnicity and Health at the University of Central Lancashire to undertake the research within the prison. POPS was set up to provide advice, information and support to prisoner's families. POPS also run the visitors centres at six prisons across the North West of England. The visitors centre staff provide a service to families, including the provision of general advice on prison regimes, advocacy and support. POPS also manage a Black Prisoners Support Programme that employs two community based mentors for African and African Caribbean men.

Support was provided by the Centre for Ethnicity and Health, which provided the POPS research group with training in understanding, and applying research methods, for instance, learning how to develop a questionnaire, how to collect and analyse data, report writing and so forth. The Centre for Ethnicity and Health also provided a support worker who would visit the project co-ordinator and community researchers on a fortnightly basis to discuss any issues and problems that may have arisen during the research. It also gave the group the opportunity to feedback on how things had been progressing.

It should be noted that the views expressed in the report are of those of the group that undertook the work, and are not necessarily those of either the Centre for Ethnicity and Health at the University of Central Lancashire, or the Department of Health

Demographics
The prison population in custody on the 28th February 2005 was 75,815. The young adult population was 8,364 (Home Office, 2005). In regard to drug offences, on the 28th February 2005, 1,458 male prisoners were on remand, while 9,383 received an immediate custodial sentence for drug offences (Home Office, 2005).

Statistics show that white males accounted for 84% of the prison population in 2003. Black British males accounted for 11% of the overall prison population, Asian males 3% and Chinese and other minority group males made up 2%. Results were also similar for the female prison population. 84% of the female prison population were white, 11% Black, 1% Asian and 3% Chinese or other ethnic minority group. The North West accounted for 11,100 out of a total prison population of 71,000 across England at the time (Home Office, 2003).

The current research was undertaken at HMP Risley which is located in the North West of England (Risley is in Warrington, an area between Manchester and Liverpool). Previously a male/female remand centre, Risley has been a male category C prison since March 2000. The capacity of Risley is 1073 (HM prison service, 2004) and currently holds 1051 inmates.

The table below gives a breakdown of the number of BME and White inmates currently detained in Risley (correct up to March 2005).

Table 1. All Ethnic Groups at HMP Risley

Ethnic Group	Number convicted	Percentage
Indian	9	0.9%
Pakistani	22	2.1%
Bangladeshi	1	0.1%
Any other Asian Background	17	1.6%
Black or Black British Caribbean	39	3.7%
Black or Black British African	9	0.9%
Black or Black British Other Background	31	2.9%
Mixed White and Black Caribbean	13	1.2%
Mixed White and Black African	1	0.1%
Mixed White and Asian	5	0.5%
Mixed Any Other Mixed Background	2	0.2%
Other Chinese	1	0.1%
Other Any Other	1	0.1%
White British	848	80.7%
White Irish	11	1.0%
White Any Other White Background	41	3.9%
Not Stated	0	0.0%
TOTAL	1051	100%

As the figures above indicate, altogether there are 151 BME inmates at Risley. However, White British inmates contribute to the majority of Risley's population.

Previous Studies

A number of studies have looked at drug use amongst BME populations. Although the perception has often been that BMEs use fewer illicit drugs than white people, there is evidence to suggest that drug use amongst BMEs is on the increase.

Sheikh et al (2001) found that there is a significant increase in South Asian male heroin users coming for treatment. Likewise, when they looked at the 1997/1998 Thames Regional Drug Misuse Database for Anglia and Oxford, records showed that over 30% of new cases coming for treatment were from BME communities.

Arora and Khatun (1998) found that in Bradford, the level of drug use amongst young South Asians, matched that of the general population.

Studies have shown that the most widely used illicit drug amongst BMEs, as in the white population is cannabis. Sangster et al (2002) in their analysis of the Regional Drug Misuse Database found that problematic drug use in Black Caribbeans is more likely to focus on cannabis than amongst other ethnic groups.

Harrison et al (1997) states that statistics of problematic drug use amongst Black Caribbeans and African males is distorted when they looked at compulsory hospital admissions. They believe that this is due to the controversial use of stop and search tactics aimed at the possession of cannabis by youths from these communities, and to the diagnosis 'cannabis psychosis' which was exclusively given to these groups in England.

Sangster et al (2002) also found that presentation to drug services by Black Caribbeans are more likely to focus on crack cocaine than other ethnic groups including white groups. Chaudry et al (1997) found that Heroin is the drug of choice amongst South Asians in some areas of England, in particular Pakistani and Bangladeshi males. Heroin was also the first ever drug used in some cases.

Stimulants have been reported to be used by Indians at Bhangra events (Patel, et al, 1995), but respondents in studies by Chaudry et al (1997) and Gilman (1993) gave the impression that stimulant use was limited amongst BMEs and were more often used by white people.

Most drug literature suggest that there is low prevalence of BMEs injecting drugs. This is further evidenced by a low uptake of BMEs at needle exchange services. Fernandez (2002) in a study of service users in London, found that 95% of South Asian clients who presented for treatment for heroin use had never injected. However, non of these findings can conclusive prove that uptake of needle exchange services is low amongst BMEs because fewer BMEs inject or because fewer BMEs access needle exchange services.

BMEs and the prison population

It is worth pointing out that Black men appear to be over represented in prison even though very few access drug services. Home Office statistics show that the number of African Caribbean prisoners has leapt 58% since 1997, with young Black males making up over 90% of all Black inmates (Holloway, 2004).

African Caribbean's made up 8% of the total prison population in 1985, but this figure had risen to 12% in 1997. The figure is now 17%. The number of South Asians has also increased recently.

The 'Race Equality in Prisons' report found that for every 100 000 White people in Britain, 188 were in jail. But for Black people the figure was 1,704. That means that Black people are over nine times more likely to be in prison than their White counterparts (Holloway, 2004).

Aims and Objectives
The current project had the following aims and objectives:

Aim
To understand why fewer BMEs choose to access mainstream drug services.

Objectives
Explore the needs of BMEs in relation to drug support

Explore the impact of cultural factors when accessing drug support

Understanding barriers which are unique to BMEs, which contribute to low service take up

Providing BMEs involved in the research with a greater awareness of drugs, drug treatment services and research methods.

METHODS

Instruments

The group used a questionnaire containing 53 items which consisted of both open-ended and closed questions[1]. The questionnaire was broken up into four sections;

- Core Questions (e.g., age, ethnicity, sentence length, etc)
- Drug Use and Knowledge
- Drug Treatment Services
- Social and Community Views

The questionnaires took roughly 20 – 30 minutes to complete. Informal unstructured interviews were also undertaken. The POPS group looked at the inmates' views and opinions in a focus group that was carried out.

Participants

People of African, African – Caribbean and South Asian descents who were detained in HMP Risley. 68 inmates were approached in total. This included questionnaires with 52 inmates and 16 unstructured interviews. 14 inmates did both a questionnaire and interview (these 14 are included in the number who did the questionnaires) so altogether 30 interviews were carried out. POPS also ran one focus group. 12 inmates volunteered to act as peer researchers.

Design

All participants were randomly selected. This was done by going on to each prison wing and approaching any prisoners who recognised themselves as being of BME origin. Those who agreed to take part would fill in the questionnaire. The interviews were undertaken with some inmates on completion of the questionnaire or with prisoners who were in the vicinity where the questionnaires were being carried out.

The focus group was promoted to inmates who showed an interest in talking more about what they had covered in the questionnaire or interview. With the consent of the prison, a morning was set aside for POPS to attend the prison and use a room to run the group on a set day. The name and prison number of each inmate who wanted to do the focus group was taken and they were notified in the post as to when the group would take place.

Volunteers would complete the questionnaires either in small groups or one-to-one whenever the POPS research group attended the prison, but in some cases, the participants had the option of taking the questionnaire away and completing it in their own time before returning it to a member of staff or peer researcher. This may have been the case when a participant was interested in doing the questionnaire but was not available to fill in the questionnaire at the time of the POPS group coming to the prison (for instance if the person was in a workshop). It was also helpful for some participants to take the questionnaire away if they were uncomfortable about filling in the questionnaire in a group setting.

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[1] See Appendix for a copy of the questionnaire.

Procedure
POPS had been granted permission by senior staff at HMP Risley to access BME prisoners for the purpose of a research study, which was being conducted in partnership with the University of Central Lancashire. Risley allocated a member of staff (the Principle Officer) who was able to take the POPS group on to the wings and access the prisoners. The Principe Officer also provided POPS with an appropriate room to undertake the training of the volunteers.

The initial procedure was to recruit a small group (12 inmates) of BME prisoners who agreed to form a prisoners research group. POPS recruited this group by sending letters out to BME prisoners from one wing (the wing in which the Principle Officer was based) which asked if they were interested in taking part in a research study. The letter specified what was required from them and the day and time that the POPS group would come to Risley. The Principle Officer then notified the POPS group of how many volunteers were interested in getting involved and provided POPS with the inmate's names and prison numbers.

The purpose of the prisoners research group was to train the volunteers in drug awareness and basic research methods. The training would provide the volunteers with enough of an understanding to become peer researchers within their own prison. Training was provided by POPS.

The training also gave the volunteers a basic understanding of developing research methods and how these methods can be applied as peer researchers. Before the questionnaire could be used in all the wings, the volunteer group had a hand in piloting the questionnaire. Piloting means to test something out for faults and possible problems before going ahead with the final version. The volunteers were involved in the development of the questionnaire, circulating questionnaires to other prisoners, ensuring that they were properly completed and analysing the finding from the questionnaires. Members of POPS would attend the prison to offer assistance to the peer researchers, collect questionnaires that had been completed and carry out unstructured interviews with prisoners. POPS staff made written notes of the comments made and views expressed by the prisoners who agreed to do the interviews.

Initially, the POPS group planned to run focus groups which would give a small group of prisoners the chance to discuss their feelings regarding drug use and drug services. While the prisoners responses to items on the questionnaire are restricted to what the questions asks (regardless of whether the question is open-ended or closed), the focus group gives prisoners the chance to discuss their views and feelings in more detail and also elaborate on things which they mentioned in the questionnaire. Unfortunately, running regular focus groups within a prison environment that POPS had limited access to, proved to be very difficult and impractical. POPS were only able to run a single focus group session over the period of time that the research was undertaken. What POPS chose to do in addition to the focus group was carry out unstructured interviews with prisoners. The interviews served the same purpose as the focus group (to gather open-ended responses) but were done on a one on one basis rather than in a focus group.

Data was analysed using SPSS (a statistical computer programme). All numerical (quantitative) scores from the questionnaires were input on to a SPSS spreadsheet by the lead researcher of the POPS group. This includes the initial core questions which recorded demographic information such as age, length of sentence, religion and so forth. The open-ended answers from the questionnaires, the comments made during the unstructured interviews and during the one focus group were manually recorded. All of the comments made by the prisoners and the recurring themes from the interviews will be given in the results section of the report.

RESULTS

Questionnaire Results – Closed Questions

Core Questions

Table 2: Q1. Age Last Birthday

	Age range	Frequency	Percent
Valid	19 - 21	3	5.8
	22 - 24	9	17.3
	25 - 29	16	30.8
	30 - 39	18	34.6
	40 - 49	3	5.8
	Missing	3	5.8
Total		52	100.0

Table 3: Q2.Ethnicity

	Ethnicity	Frequency	Percent
Valid	Black or Black British	17	32.7
	Caribbean	13	25.0
	African	2	3.8
	Mixed White and Black Caribbean	9	17.5
	Mixed White and Black African	1	1.9
	Mixed White and Asian	1	1.9
	Indian	2	3.8
	Pakistani	3	5.8
	Bangladeshi	1	1.9
	Asian Other	1	1.9
	Missing	2	3.8
Total		52	100.0

Table 4: Q3.How long have you lived in the UK?

	Years	Frequency	Percent
Valid	1- 5 years	11	21.2
	6 - 10 years	3	5.8
	11 years +	20	38.5
	Born in UK	16	30.8
	Missing	2	3.8
Total		52	100.0

Table 5: Q4. Citizenhip: Are you a?

	Citizenship	Frequency	Percent
Valid	British Citizen	36	69.2
	Asylum Seeker	1	1.9
	Other	13	25.0
	Missing	2	3.8
Total		52	100.0

Table 6: Q5. How long have you been in prison?

	Length	Frequency	Percent
Valid	0 - 6 months	5	9.6
	7 - 12 months	2	3.8
	13 - 18 months	3	5.8
	19 months - 2 years	3	5.8
	2- 3 years	8	15.4
	3 - 4 years	7	13.5
	Over 4 years	23	44.2
	Missing	1	1.9
Total		52	100.0

Table 7:Q7. What is your religion?

	Religion	Frequency	Percent
Valid	None	11	21.2
	Christian	15	28.8
	Muslim	14	26.9
	Sikh	1	1.9
	Other	8	15.4
	Missing	3	5.8
Total		52	100.0

Table 8: Q8. Sexuality

	Sexuality	Frequency	Percent
Valid	Heterosexual	48	92.3
	Missing	4	7.7
Total		52	100.0

Table 9: Q9. Do you have a disability?

		Frequency	Percent
Valid	Yes	6	11.5
	No	44	84.6
	Missing	2	3.8
Total		52	100.0

Drug Use and Knowledge

Table 10: Q10 (a). Have you ever tried or taken any of the following illegal drugs - Heroin?

		Frequency	Percent
Valid	Yes	6	11.5
	No	41	78.8
	Missing	5	9.6
Total		52	100.0

Table 11: Q10 (b). Have you ever tried or taken any of the following illegal drugs - Crack?

		Frequency	Percent
Valid	Yes	9	17.3
	No	37	71.2
	Missing	6	11.5
Total		52	100.0

Table 12: Q10(c). Have you ever tried or taken any of the following illegal drugs - Cocaine?

		Frequency	Percent
Valid	Yes	14	26.9
	No	32	61.5
	Missing	6	11.5
Total		52	100.0

Table 13: Q10 (d). Have you ever tried or taken any of the following illegal drugs - Amphetamine?

		Frequency	Percent
Valid	Yes	9	17.3
	No	37	71.2
	Missing	6	11.5
Total		52	100.0

Table 14: Q10 (e). Have you ever tried or taken any of the following illegal drugs - Cannabis Resin?

		Frequency	Percent
Valid	Yes	29	55.8
	No	16	30.8
	Missing	7	13.5
Total		52	100.0

Table 15: Q10 (f). Have you ever tried or taken any of the following illegal drugs - Skunk?

		Frequency	Percent
Valid	Yes	35	67.3
	No	11	21.2
	Missing	6	11.5
Total		52	100.0

Table 16: Q10 (g). Have you ever tried or taken any of the following illegal drugs - LSD?

		Frequency	Percent
Valid	Yes	10	19.2
	No	36	69.2
	Missing	6	11.5
Total		52	100.0

Table 17: Q10 (h). Have you ever tried or taken any of the following illegal drugs - Ecstasy?

		Frequency	Percent
Valid	Yes	19	36.5
	No	27	51.9
	Missing	6	11.5
Total		52	100.0

Table 18: Q10(i). Have you ever tried or taken any of the following illegal drugs - Solvents?

		Frequency	Percent
Valid	Yes	3	5.8
	No	42	80.8
	Missing	7	13.5
Total		52	100.0

Table 19: Q10(j). Have you ever tried or taken any of the following illegal drugs - Misuse of prescribed drugs?

		Frequency	Percent
Valid	Yes	4	7.7
	No	42	80.8
	Missing	6	11.5
Total		52	100.0

Table 20: Q10(k). Have you ever tried or taken any of the following illegal drugs - Misuse of Steroids?

		Frequency	Percent
Valid	No	46	88.5
	Missing	6	11.5
Total		52	100.0

Table 21: Q10 (l).Have you ever tried or taken any of the following illegal drugs - Other?

		Frequency	Percent
Valid	Yes	3	5.8
	No	42	80.8
	Missing	7	13.5
Total		52	100.0

Table 22: Q11(a). Do you still use any of the following illegal drugs - Heroin?

		Frequency	Percent
Valid	Yes	2	3.8
	No	29	55.8
	Missing	21	40.4
Total		52	100.0

Table 23: Q11(b). Do you still use any of the following illegal drugs - Crack?

		Frequency	Percent
Valid	Yes	1	1.9
	No	30	57.7
	Missing	21	40.4
Total		52	100.0

Table 24:Q11(c). Do you still use any of the following illegal drugs - Cocaine?

		Frequency	Percent
Valid	No	31	59.6
	Missing	21	40.4
Total		52	100.0

Table 25:Q11(d). Do you still use any of the following illegal drugs - Amphetamine?

		Frequency	Percent
Valid	No	31	59.6
	Missing	21	40.4
Total		52	100.0

Table 26:Q11(e). Do you still use any of the following illegal drugs - Cannabis Resin?

		Frequency	Percent
Valid	Yes	18	34.6
	No	13	25.0
	Missing	21	40.4
Total		52	100.0

Table 27:Q11(f). Do you still use any of the following illegal drugs - Skunk?

		Frequency	Percent
Valid	Yes	15	28.8
	No	17	32.7
	Missing	20	38.5
Total		52	100.0

Table 28:Q11(g). Do you still use any of the following illegal drugs - LSD?

		Frequency	Percent
Valid	Yes	1	1.9
	No	30	57.7
	Missing	21	40.4
Total		52	100.0

Table 29:Q11(h). Do you still use any of the following illegal drugs - Ecstasy?

		Frequency	Percent
Valid	No	31	59.6
	Missing	21	40.4
Total		52	100.0

Table 30: Q11(i) Do you still use any of the following illegal drugs - Solvents?

		Frequency	Percent
Valid	No	31	59.6
	Missing	21	40.4
Total		52	100.0

Table 31: Q11(j). Do you still use any of the following illegal drugs - Misuse of prescribed drugs?

		Frequency	Percent
Valid	No	31	59.6
	Missing	21	40.4
Total		52	100.0

Table 32: Q11(k). Do you still use any of the following illegal drugs - Misuse of steroids?

		Frequency	Percent
Valid	No	31	59.6
	Missing	21	40.4
Total		52	100.0

Table 33: Q11(l). Do you still use any of the following illegal drugs - Other?

		Frequency	Percent
Valid	No	31	59.6
	Missing	21	40.4
Total		52	100.0

Table 34: Q12. If you have used these drugs, has it ever caused you a problem?

		Frequency	Percent
Valid	Yes	9	17.3
	No	27	51.9
	Not applicable	2	3.8
	Missing	14	26.9
Total		52	100.0

Table 35: Q13. Do you worry of the effect your drug use has on others?

		Frequency	Percent
Valid	Yes	14	26.9
	No	20	38.5
	Not applicable	2	3.8
	Missing	16	30.8
Total		52	100.0

Table 36: Q14(a). Do you know anyone who has a problem when it comes to using Heroin?

		Frequency	Percent
Valid	Yes	17	32.7
	No	15	28.8
	Missing	20	38.5
Total		52	100.0

Table 37: Q14(b). Do you know anyone who has a problem when it comes to using Crack?

		Frequency	Percent
Valid	Yes	15	28.8
	No	14	26.9
	Missing	23	44.2
Total		52	100.0

Table 38: Q14(c). Do you know anyone who has a problem when it comes to using Cocaine?

		Frequency	Percent
Valid	Yes	13	25.0
	No	16	30.8
	Missing	23	44.2
Total		52	100.0

Table 39: Q14(d). Do you know anyone who has a problem when it comes to using Amphetamine?

		Frequency	Percent
Valid	Yes	8	15.4
	No	21	40.4
	Missing	23	44.2
Total		52	100.0

Table 40: Q14(e). Do you know anyone who has a problem when it comes to using Cannabis Resin?

		Frequency	Percent
Valid	Yes	11	21.2
	No	18	34.6
	Missing	23	44.2
Total		52	100.0

Table 41: Q14(f). Do you know anyone who has a problem when it comes to using Skunk?

		Frequency	Percent
Valid	Yes	11	21.2
	No	18	34.6
	Missing	23	44.2
Total		52	100.0

Table 42: Q14(g). Do you know anyone who has a problem when it comes to using LSD?

		Frequency	Percent
Valid	Yes	4	7.7
	No	25	48.1
	Missing	23	44.2
Total		52	100.0

Table 43: Q14(h). Do you know anyone who has a problem when it comes to using Ecstasy?

		Frequency	Percent
Valid	Yes	7	13.5
	No	22	42.3
	Missing	23	44.2
Total		52	100.0

Table 44: Q14(i). Do you know anyone who has a problem when it comes to using Solvents?

		Frequency	Percent
Valid	Yes	2	3.8
	No	27	51.9
	Missing	23	44.2
Total		52	100.0

Table 45: Q14(j). Do you know anyone who has a problem when it comes to using Misuse of prescribed drugs?

		Frequency	Percent
Valid	Yes	1	1.9
	No	28	53.8
	Missing	23	44.2
Total		52	100.0

Table 46: Q14(k). Do you know anyone who has a problem when it comes to using Misuse of Steroids?

		Frequency	Percent
Valid	Yes	4	7.7
	No	25	48.1
	Missing	23	44.2
Total		52	100.0

Table 47: Q14(l). Do you know anyone who has a problem when it comes to using Other drugs?

		Frequency	Percent
Valid	Yes	1	1.9
	No	29	55.8
	Missing	22	42.3
Total		52	100.0

Table 48: Q15. Do you see any problems linked to using cannabis?

		Frequency	Percent
Valid	Yes	17	32.7
	No	25	48.1
	Missing	10	19.2
Total		52	100.0

Table 49: Q19(a). Which of the following drugs are you aware of being used often in the Black community - Heroin?

		Frequency	Percent
Valid	Yes	18	34.6
	No	29	55.8
	Missing	5	9.6
Total		52	100.0

Table 50: Q19(b). Which of the following drugs are you aware of being used often in the Black community - Crack?

		Frequency	Percent
Valid	Yes	32	61.5
	No	15	28.8
	Missing	5	9.6
Total		52	100.0

Table 51: Q19(c). Which of the following drugs are you aware of being used often in the Black community - Cocaine?

		Frequency	Percent
Valid	Yes	23	44.2
	No	24	46.2
	Missing	5	9.6
Total		52	100.0

Table 52: Q19(d). Which of the following drugs are you aware of being used often in the Black community - Amphetamine?

		Frequency	Percent
Valid	Yes	9	17.3
	No	37	71.2
	Missing	6	11.5
Total		52	100.0

Table 53: Q19(e). Which of the following drugs are you aware of being used often in the Black community - Cannabis Resin?

		Frequency	Percent
Valid	Yes	36	69.2
	No	11	21.2
	Missing	5	9.6
Total		52	100.0

Table 54: Q19(f). Which of the following drugs are you aware of being used often in the Black community - Skunk?

		Frequency	Percent
Valid	Yes	40	76.9
	No	7	13.5
	Missing	5	9.6
Total		52	100.0

Table 55: Q19(g). Which of the following drugs are you aware of being used often in the Black community - LSD?

		Frequency	Percent
Valid	Yes	4	7.7
	No	42	80.8
	Missing	6	11.5
Total		52	100.0

Table 56: Q19(h).Which of the following drugs are you aware of being used often in the Black community - Ecstasy?

		Frequency	Percent
Valid	Yes	19	36.5
	No	27	51.9
	Missing	6	11.5
Total		52	100.0

Table 57: Q19(i). Which of the following drugs are you aware of being used often in the Black community - Solvents?

		Frequency	Percent
Valid	Yes	1	1.9
	No	45	86.5
	Missing	6	11.5
Total		52	100.0

Table 58: Q19(j).Which of the following drugs are you aware of being used often in the Black community - Misuse of prescribed drugs?

		Frequency	Percent
Valid	Yes	3	5.8
	No	43	82.7
	Missing	6	11.5
Total		52	100.0

Table 59: Q19(k). Which of the following drugs are you aware of being used often in the Black community - Misuse of steroids?

		Frequency	Percent
Valid	Yes	6	11.5
	No	40	76.9
	Missing	6	11.5
Total		52	100.0

Table 60: Q19(l). Which of the following drugs are you aware of being used often in the Black community - Other?

		Frequency	Percent
Valid	Yes	3	5.8
	No	42	80.8
	Missing	7	13.5
Total		52	100.0

Table 61: Q20. Do you think fewer Black people use class A drugs compared to White people?

		Frequency	Percent
Valid	Yes	34	65.4
	No	8	15.4
	Not Sure	8	15.4
	Missing	2	3.8
Total		52	100.0

Table 62: Q22(a). Do you know what the long-term effects are of misusing the following drugs - Heroin?

		Frequency	Percent
Valid	Yes	19	36.5
	No	18	34.6
	Missing	15	28.8
Total		52	100.0

Table 63: Q22(b). Do you know what the long-term effects are of misusing the following drugs - Crack?

		Frequency	Percent
Valid	Yes	21	40.4
	No	15	28.8
	Missing	16	30.8
Total		52	100.0

Table 64: Q22(c). Do you know what the long-term effects are of misusing the following drugs - Cocaine?

		Frequency	Percent
Valid	Yes	18	34.6
	No	16	30.8
	Missing	18	34.6
Total		52	100.0

Table 65: Q22(d). Do you know what the long-term effects are of misusing the following drugs - Amphetamine?

		Frequency	Percent
Valid	Yes	9	17.3
	No	26	50.0
	Missing	17	32.7
Total		52	100.0

Table 66: Q22(e). Do you know what the long-term effects are of misusing the following drugs - Cannabis Resin?

		Frequency	Percent
Valid	Yes	17	32.7
	No	20	38.5
	Missing	15	28.8
Total		52	100.0

Table 67: Q22(f). Do you know what the long-term effects are of misusing the following drugs - Skunk?

		Frequency	Percent
Valid	Yes	20	38.5
	No	15	28.8
	Missing	17	32.7
Total		52	100.0

Table 68: Q22(g). Do you know what the long-term effects are of misusing the following drugs - LSD?

		Frequency	Percent
Valid	Yes	9	17.3
	No	25	48.1
	Missing	18	34.6
Total		52	100.0

Table 69: Q22(h). Do you know what the long-term effects are of misusing the following drugs - Ecstasy?

		Frequency	Percent
Valid	Yes	12	23.1
	No	23	44.2
	Missing	17	32.7
Total		52	100.0

Table 70: Q22(i). Do you know what the long-term effects are of misusing the following drugs - Solvents?

		Frequency	Percent
Valid	Yes	6	11.5
	No	29	55.8
	Missing	17	32.7
Total		52	100.0

Table 71: Q22(j). Do you know what the long-term effects are of misusing the following drugs - Misuse of prescribed drugs?

		Frequency	Percent
Valid	Yes	6	11.5
	No	29	55.8
	Missing	17	32.7
Total		52	100.0

Table 72: Q22(k). Do you know what the long-term effects are of misusing the following drugs - Misuse of steroids?

		Frequency	Percent
Valid	Yes	11	21.2
	No	24	46.2
	Missing	17	32.7
Total		52	100.0

Table 73: Q22(l). Do you know what the long-term effects are of misusing the following drugs - Other?

		Frequency	Percent
Valid	Yes	3	5.8
	No	29	55.8
	Missing	20	38.5
Total		52	100.0

Drug Treatment Services

Table 74: Q23. Do you know of any drug treatment services?

		Frequency	Percent
Valid	Yes	13	25.0
	No	26	50.0
	Missing	13	25.0
Total		52	100.0

Table 75: Q25. Would you use or have you used any drug treatment services?

		Frequency	Percent
Valid	Yes	4	7.7
	No	16	30.8
	Not Applicable	12	23.1
	Missing	20	38.5
Total		52	100.0

Table 76: Q27. Did the service meet your cultural/religious needs?

		Frequency	Percent
Valid	Don't know	1	1.9
	Yes	2	3.8
	No	3	5.8
	Not applicable	30	57.7
	Missing	16	30.8
Total		52	100.0

Table 77: Q28. Whether you have used drug services or not, do you think these services are specific to Black people?

		Frequency	Percent
Valid	Don't know	2	3.8
	Yes	6	11.5
	No	20	38.5
	Missing	24	46.2
Total		52	100.0

Table 78: Q31.Using the following scale, if you had a problem, would you be more or less likely to use a Black specific drug treatment service?

		Frequency	Percent
Valid	Very Likely	23	44.2
	Likely	8	15.4
	Unsure	11	21.2
	Unlikely	3	5.8
	Very Unlikely	2	3.8
	Missing	5	9.6
Total		52	100.0

Table 79: Q33. Do you think a Black treatment service would have a positive effect for Black drug users?

		Frequency	Percent
Valid	Yes	41	78.8
	No	6	11.5
	Missing	5	9.6
Total		52	100.0

Table 80: Q35.Have you ever used the prison CARAT team?

		Frequency	Percent
Valid	Yes	13	25.0
	No	32	61.5
	Missing	7	13.5
Total		52	100.0

Table 81: Q36.If yes, on the following scale, how helpful would you rate the CARAT team?

		Frequency	Percent
Valid	Very helpful	3	5.8
	Helpful	5	9.6
	Neither helpful nor unhelpful	4	7.7
	Very unhelpful	3	5.8
	Not applicable	25	48.1
	Missing	12	23.1
Total		52	100.0

Table 82: Q38.Is prison the right environment for drug rehabilitation?

		Frequency	Percent
Valid	Don't know	2	3.8
	Yes	11	21.2
	No	30	57.7
	Missing	9	17.3
Total		52	100.0

Table 83: Q40. Do you think drug treatment services treat Black class A drug users differently from White class A users?

		Frequency	Percent
Valid	Yes	2	3.8
	No	11	21.2
	Don't know	32	61.5
	Missing	7	13.5
Total		52	100.0

Table 84: Q42. If you use cannabis and it became a problem, would you get in contact with a drug treatment service for help and support?

		Frequency	Percent
Valid	Yes	18	34.6
	No	16	30.8
	Don't know	13	25.0
	Missing	5	9.6
Total		52	100.0

Table 85: Q43. If you use a Class A drug like heroin or crack and it became a problem, would you get in contact with a drug treatment service for help and support?

		Frequency	Percent
Valid	Yes	29	55.8
	No	5	9.6
	Don't know	6	11.5
	Missing	12	23.1
Total		52	100.0

Table 86: Q44. Would you use a drugs helpline for guidance or advice?

		Frequency	Percent
Valid	Yes	20	38.5
	No	12	23.1
	Don't know	11	21.2
	Missing	9	17.3
Total		52	100.0

Social and Community Views

Table 87: Q47.Do you feel you are a victim of the society you live in?

		Frequency	Percent
Valid	Yes	19	36.5
	No	22	42.3
	Don't know	5	9.6
	Missing	6	11.5
Total		52	100.0

Table 88: Q50.Do you think a Black class A drug user will be treated in their community in the same way as a White class A drug user?

		Frequency	Percent
Valid	Yes	14	26.9
	No	17	32.7
	Don't know	14	26.9
	Missing	7	13.5
Total		52	100.0

Table 89: Q52.Do you think more support needs to be offered to the families dealing with Black class A drug users?

		Frequency	Percent
Valid	Yes	31	59.6
	No	2	3.8
	Don't know	13	25.0
	Missing	6	11.5
Total		52	100.0

Questionnaire Results - Open Ended Questions

Core Questions

Q6) ***Which languages are you fluent in?***

All 52 respondents were fluent in English both written and spoken. Some respondents were multi-lingual with one being fluent in Spanish and Swahili, one fluent in Urdu and one fluent in French, German and Portuguese.

Drug Use and Knowledge

Q12) ***If you have used any illegal drugs, has it ever caused you a problem?***

Only 9 of the respondents admitted that they currently use any illegal drugs and that it has caused them a problem. Problems stated were, memory loss, weight loss, paranoia, mental health problems, offending behaviour, family breakdown, hormonal damage and financial problems.

Q14a) ***If yes for any drugs, what kind of problems have anyone who you know experienced?***

10 inmates gave a response to this question. Some of the social problems listed where paranoia, financial problems, anti-social behaviour, losing friends, and becoming ostracised in the community. Health problems mentioned were weight loss and mental health issues. Family problems, being kicked out of family home, losing respect and stealing from family members. Law problems, imprisonment and being arrested for drug possession. Health problems, mental health. Other problems, death.

Q16) ***What kind of problems do you associate with using cannabis?***

17 respondents saw a problem using cannabis. The problems mentioned included, short-term memory loss, financial cost, health problems, offending to fund cannabis use, paranoia, anti-social behaviour, problems when mixed with alcohol, hallucinations, urges for food, depression, aggression and fatigue.

Q17) ***Has cannabis use created any problems for you, if so what problem?***

Just two respondents answered this question. Answers given were anger, memory loss, headaches and fatigue.

Q18) ***Has cannabis led to you using other drugs, if so which drug/s?***

Two inmates admitted that using cannabis had led on to using ecstasy, amphetamines, cocaine and heroin.

Drug Treatment Services

Q21) ***Why do you think fewer Black people use drugs compared to White people?***

18 people answered this question. Responses were as follows. “Race is not an issue”.

“I live in Manchester…the amount of Black people who use class A drugs is the same as the number of White people”.

Four inmates said that “Class A drugs is a White issue not a Black issue”.
Two said that, “It’s most of the Black community that sells drugs not use drugs”.
6 people felt that “there are more White communities than Black so you will get more White users”.
“According to the ratio of the population, I would say that more Black people use Class A drugs”.
“Because of family”.
“Black communities are small and everybody will find out that you are using drugs”.
“Black people have more to lose”.
“Maybe just as many Blacks use drugs but they keep it under wraps”
“Because of the way Blacks are raised”.

Q24) ***Can you name any drug treatment services and state what service they offer?***
12 inmates answered this question. 7 people were aware of the prison CARATS, 2 of Lifeline, 1 of Turning Point, 1 named Manchester Drug Team, 2 named P-ASRO (Prison – addressing substance related offending programme), 1 named Goal 8 and 1 respondent named Alcoholics Anonymous.

Q26) ***If you have used a treatment service, why did/would you get in contact with the drug service?***
6 inmates had been in contact with a treatment service. 3 said that they simply needed the help. 2 said that they got in contact to come off the habit. The other respondent stated that it was part of his sentence plan to attend CARATS.

Q29) ***Please state why you think drug services may or may not be specific to Black people?***
17 respondents gave an answer to this question. They were as follows:
Four thought that drug services are not specific because it is about “addiction not colour”.
3 said that “they never needed to use a service”.
“No, many Black people who take class A drugs are ashamed for it to become common knowledge so they tend to avoid agencies that can help”.
“Yes, it depends on the individual”.
“I can beat the problem alone”.
“No, most drug services are run by White people”.
“No, there isn’t anyone from the same background, race or religion as myself who can relate”.
“No, they lack knowledge of Black culture”.
“No, because there aren’t that many Black areas with that much of a problem”.
“No, I’ve not heard anything telling me what they can offer”.

Q30) ***How do you think drug treatment services could be more Black specific?***
19 inmates suggested the following ways in which drug services could be more Black specific.
Nine respondents felt that a service could be more Black specific by “Having more Black staff involved”.
“By having users from the Black community”.

"Being based in Black areas"
"To be able to better understand the person".
"By advertising and letting people know that Black people do have drug issues".
"By having more staff who understand our (Black) culture".
"Focus more on problems to do with using weed as most Black people use weed not Class A drugs".
"Having a service which targets just Black addicts".

Q32) ***Why would you be more likely or less likely to use a Black drug service?***
22 respondents gave the following responses to this question.
6 of the inmates said, "Likely, your defences would come down and you can identify with one of your own".
5 people stated, "Very likely, they (the drug workers) would be more aware of Black culture and I prefer that".
3 people said that they would be "Very likely" because they would "feel more comfortable" and "confident about opening up".
"Unsure, I would use the service closest to me".
"Very likely, I think it is down to the person to get help from any service and not look at colour or race".
2 respondents said, "Very likely because there would be no bias".
"Unsure, I want to keep my problems to myself".
"Unlikely, I would feel shame using a service".
"Likely, I would go if it helps me".
"Unsure, it depends on the counsellor".
"Very likely, I think I'd get better advice and help".

Q34) ***Why do you think a Black treatment service would have a positive effect for Black drug users?***
25 respondents gave reasons as to why a Black drug service would be a good thing.
8 of the respondents said that they would feel more comfortable in that kind of environment.
6 people said that it would be positive because you can "relate to your own kind better".
3 people said that the service would "have a better understanding of your culture"
"No, race isn't an issue".
3 people said that "Black people need more help".
"It would be appreciated if it was available".
"No, I would worry about friends and family finding out about my problem".
"The user and service provider face the same issues and think alike".
"I would gain a better understanding of drug issues in a Black treatment service".
"They may help a lot more than a White service".
"Many Black people know about cannabis and nothing else but a Black drug service would let Black people know more about other drugs".

Q37) ***What did you think of the service offered to you? (CARAT service)***

9 gave an answer to this question.
"I didn't need that much service because I just use cannabis".
3 inmates said that they "could speak to someone when they needed it".
"Helpful, I learnt more about drug problems".
2 people said, "Very unhelpful, they offered very little".
"Very helpful, offered a good one to one service".
"Neither helpful or unhelpful, it's very hard to see CARATS".

Q39) ***Why do you think prison is/is not the right environment for drug rehabilitation?***

This was one of the most frequently answered questions with 33 people answering the question in total. The prisoners gave the following answers:
9 said, No, "drugs are everywhere, they are just as abundant in prison as they are outside".
8 said, No, "you still have access to a lot of drugs in prison".
3 stated, Yes, "drugs are limited in prison"
Yes, "You have time to reflect in prison"
"No, a high percentage of prisoners only get treated because they know they would not get parole".
"We (the prisoners) are forced into it".
2 respondents said, "Yes, fewer drugs would come in and you can use your time constructively".
"Don't know, it depends on the person in need of rehab".
"Yes, It could be the only time to get help".
No, "the stress of being in prison will make you more likely to use drugs"
"Yes, they can offer you support".
"No, staff are not supportive and not enough Black staff work in the prison".
"They try too hard to focus on people who use cannabis so they go on to harder drugs".
"No, mandatory drug testing in prison means that people are going on to harder drugs".

Q41) ***Why do you think drug treatment services treat Black class A drug users differently from White class A drug users?***

13 people responded to this question.
2 people said that they "Don't know, I've never used a treatment service to know".
7 people felt that they would not treat you differently based on race.
"Yes, most drug services only cater for their own (white people)".
"Don't know, I don't think that they understand my background".
2 said, "Yes, as society tend to look down on us and we are stereotyped which also happens in drug services".

Social and Community Views

Q45) ***What do you think are the key issues for the Black community in relation to drug use?***

24 inmates answered this question.
6 people suggested that “denial”, “not admitting that there are drug problems” in the Black community and “ignorance” are all issues
3 people suggested “a lack of family support”
2 suggested “a lack of education”.
“Racism, stereotypes and prejudice”.
“Stricter control of kids”.
“Seeking help more often”.
“Lack of self-esteem”.
“Feelings of uselessness”.
“Pressures to provide for family”
“Less police harassment”.
“More Black professionals working with drug users”.
“More Black counsellors for Black people”.
“Shame”.
“Feeling that they can deal with these issues their own way”.
“Keeping their use to themselves”.
“Respect”.
“Providing more jobs”.
“Single parent families”.
2 mentioned, “living in deprived areas”.
“Believing stigmas”
“The easy availability of drugs in Black areas”

Q46) ***What do you think are the main issues for the Black community in relation to drug dealing?***

22 respondents answered this question.
9 said “not finding work” was a key issue
5 mentioned “a fast way to make money” as an issue
4 suggested “education”
“The community could help the police to stop known drug dealers”.
“The government could also help the community by stopping drugs coming into the country”.
“Racism”.
“Family breakdowns”.
“Negative role models”.
“To be the big man (peer pressure)”.
2 mentioned, “gang rivalries”.
2 people referred to, “negative social perceptions”
“People think that Blacks sell all the drugs but that is a myth”

Q48) ***How do you think people in the Black community would act if they knew that you smoked cannabis heavily?***

29 inmates answered this.
The most common answer given by 18 of those that answered was "they would not be concerned".
4 said that "they wouldn't say anything"
3 mentioned that "it depends on beliefs".
3 suggested that "the older generation will be against it".
3 also said "youths wouldn't think anything of it".
2 people said that "it should become legal".
"Would lose respect".
"Would have concerns about the social implications and stigma".

Q49) ***How do you think people in the Black community would act if they knew you used a Class A drug like cocaine or heroin?***

This was also a frequently answered question. 33 inmates gave a valid answer to this question.
15 people said that they "would become isolated and ostracized"
12 said that they would "look down on you and dislike you"
"Would be very concerned"
3 said that "they would not say anything to you"
3 mentioned that they "would not trust you"
3 people mentioned "losing respect"
"Help me get off the drug"
"If I was working and they find out, I would lose my job"
"Concerns about the social implications"
"Would not be bothered"
Interestingly, one of the respondents said that although a Black class A drug user might become ostracized, "they would maybe not be isolated for using coke".

Q51) ***Why do you think a Black class A drug user and a White class A drug user will be treated differently in their communities?***

7 people gave an answer to this.
"The way in which you are raised and what is said to you as you grow up in life is enough to deter you from using drugs"
"The drug destroys all races"
"To them (the White community) it is just money"
"Drug use is more common in White communities so White communities will be more supportive of a drug user"
"Relating to others who have a common unity"
"Black families are very different to Whites. We are church and god fearing people".
"I don't think they will be treated differently because the drug affects us all in the same way"

Q53) ***What do you think can be done to break down the barriers for Black drug users using heroin, crack or cocaine in receiving support from their community/families?***

24 inmates suggested what could be done to break down any barriers to BME communities and families.
7 people suggested, "Make them more aware of how to spot someone who is using drugs and offer information about how to help and support them"
2 people said, "to make people have a better understanding of drugs and why people take them".
"Try and get communities to unite more"
2 said, "to have more Black people involved who have used drugs before and can offer support because they have been there before".
2 people mentioned "more honesty"
"Some sort of facility that can make the user and family help each other"
2 inmates said to "put messages in notices and billboards in the community"
2 suggested "targeting the youth and focus on their needs"
"Reduce denial"
3 suggested, "having treatment facilities in deprived Black communities"
"Offer discrete support"
"Have more Black drug workers"
"Set up a support phoneline in the heart of the Black community offering help"

Interview and focus group feedback
POPS were unable to run regular focus groups (the reasons for this are explained in the methods section) so many of the comments and responses given are from the unstructured interviewed that were carried out with 30 of the inmates. Listed below are some of the main themes that came out of the interviews.

A Black specific service.
Arguments for a Black specific drug service seemed to be both in favour of a service and against.

- "I ain't sure if having Black people working in drug services would make me use it (drugs) any more or less"

- "I would feel shame going to a Black drug service in my neighbourhood and other people seeing me go there"

- "It's a small world. I could go to this Black service for help and the next thing you know I see one of my friend's family working in there. If that happened I'd just get off and not bother going back"

- "I reckon more people would find out about me doing it (using drugs) if I went to an all Black drug service"

- "I would be more likely to get help if I went to a Black drug service. Most of these (White) drug workers haven't go a clue what we've (BMEs) been through"

- "Me personally I think it would be a good idea, because you can relate more to the staff if they are Black"

- "I would feel more comfortable around a group of Black drug workers"

- "Colour isn't the issue, if you don't want to get help with your problem then it doesn't matter if the workers are Black, White, Asian or purple, you just won't go"

- "To tell the truth, I think a Black drug worker might come down on me harder than a white drug worker"

Cannabis is not a problem
Views on cannabis seemed to reinforce the views already expressed about the drug in the questionnaires.

- "I would never touch any of that hard stuff (Class A drugs) but I love smoking my ganja"

- "Cannabis isn't a problem for me and it isn't a problem for most of the people I know"

- "You don't get addicted to weed like you do with drugs like coke and brown"

- No one would make a fuss about me smoking weed"
- "They (drug services) don't treat people for problems with cannabis, they only treat the hard stuff"

Drugs use is a white problem

Most of the interviewees did not consider class A drug use to be frequent amongst BMEs. Instead, drug use was seen as more common amongst White people. The view seemed to be that Black people are more likely to sell drugs to make money rather than waste money purchasing drugs.

- "It's more of a White problem than a Black problem"
- "There are more White people than Black people in this country so you will get more White people using drugs"
- " I don't know any Black man who uses drugs apart from weed"
- "Black people sell drugs, they don't use drugs"
- "I don't know anybody that uses Class A drugs and if they did I don't know what I could do to help them because if you can't help them, who can?"

Accessing Treatment

"I wouldn't know where to get help anyway"

"I used CARATS and they aren't really saying much so I don't think I would go anywhere in the community"

"I probably wouldn't get treated because I don't want my family to know I had such a problem as I would be ashamed and my family would not understand me"

DISCUSSION

Key outcomes

The main aim of this piece of work is to understand why fewer BMEs choose to access mainstream drug services. In attempt to answer this question, the research focused on 1) the needs of BMEs in relation to drug support, 2) the impact of cultural factors in accessing drug support, 3) the barriers which are unique to BMEs, which contribute to low service take up, and 4) providing BMEs involved in the research with a greater awareness of drugs, drug treatment services and research methods.

Limited BME drug usage

The consensus among most of the respondents was that simply fewer BMEs are dependent on illicit class A drugs compared to white people, therefore you have fewer BMEs accessing drug services. Question 20 in the questionnaire asked if you think fewer Black people use class A drugs compared to White people. 34 out of 52 respondents said yes and only 8 said no. Although most respondents admit that there are BMEs who are dependent on cannabis, the perception among most was that cannabis was seen as a soft drug and was not considered a big enough problem to merit seeking support or treatment.

The respondents were encouraged to think more widely however. They did acknowledge that there are fewer BMEs using Class A drugs compared to white people, but they were asked to consider what barriers may stop BMEs with a genuine drug problem, not to seek treatment or help.

Black specific drug services

Results showed that more respondents were likely than unlikely to use a Black specific drug service. The scores from Question 31 (If you had a problem would you be more likely or less likely to use a Black specific drug service?) found that 23 respondents would be ‘very likely’ to use the service, 8 would be ‘likely’, 3 were ‘unlikely’ and 3 were ‘very unlikely’. However, the responses from the interviews seemed to contradict the findings from the questionnaires. Unlike the questionnaire responses, the interviewees appeared to show a more cautious view of the effectiveness of a Black treatment service. One of the reasons for this was that, regardless of the race of the drug worker, if the person with the drug problems is not willing to seek support on their own accord, then they are no more likely to go into treatment. The reluctance to seek treatment is rooted in the individual’s level of motivation not the race of the drug workers.

Some respondents also pointed out that most BME community are small and closely knit. The opinion is that by having more black drug workers, you are increasing the chances of people (albeit drug professionals) in BME communities becoming aware of your drug problem. A professional hearing this may argue that all agencies that work with drug users have confidentiality guidelines which they would be in breach of if they made information about their clients community gossip. Despite this, most BME drug users would not feel reassured or comfortable about the possibility of parents, neighbours or friends of the family being aware of their drug problem. The shame of being a known BME drug user in a BME community would be unbearable. A further concern was that a drug worker from the same ethnic group as a drug user might not be as sympathetic because of their own beliefs and values.

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

Drug awareness and drug use

The most common drug of choice was cannabis and skunk (a variation of cannabis). 18 people admit to still using cannabis (see table 26) when they can get it in prison and 15 said that they use Skunk (table 27). Only a small proportion of the respondents currently use Class A drugs. Two inmates still use heroin, one uses crack and one uses LSD. Non of the respondents currently use cocaine, amphetamines, ecstasy, solvents, any prescribed drugs (such as subutex) or steroids. The findings appear to reinforce the perception that cannabis is frequently used and is accepted within BME communities but Class A drugs are rarely used.

The inmates had a good understanding of the effects of certain drugs but not all drugs. For instance in Question 22, more respondents were aware than unaware of the long-term effects of heroin, crack, cocaine and skunk, but fewer knew of the long-term effects of using amphetamines, LSD, ecstasy, solvents, prescribed drugs or steroids. Fewer knew of the long-term effects of using cannabis, but the difference between does that did and did not know was quiet small (17 said that they knew what cannabis did in the long-terms and 20 did not know).

Nearly all respondents admitted that drugs are readily available in prison despite the prison environment. Therefore prison was not seen as the ideal place for drug rehabilitation. 30 of the inmates felt that prison was not the correct environment for rehabilitation, while 11 felt that it was. Even though someone's level of drug use may decrease in prison, the results from the questionnaire would appear to suggest that just by being in prison is not enough to avoid coming into contact with illegal drugs.

Awareness of drug services

Generally most were not aware of very many drug treatment services. Most respondents when asked the question 'Do you know of any drug treatment services', answered no (26 said they knew no drug treatment services and 13 said that they were aware of some). Most who answered yes to this question were able to name the prison CARATs. A few also knew of PASRO and Lifeline. It is difficult to assume whether this lack of awareness of treatment services is a barrier to BMEs in service uptake, as most of the respondents who could name treatment services, did not see treatment services as being effective and so may not have accessed them.

Community views

The respondents were in agreement that more support needs to be provided to the families of BME drug users. In Question 52, in total, 31 respondents said that more family support needs to be offered and only 2 people thought that no support was needed. In terms of overcoming barriers, most talked about making communities more aware of drug problems rather than people burying their heads in the sand.

Racism was not seen as a factor in low service uptake. Very few of the respondents seemed to feel that Black drug users were treated differently from white drug users (2 people felt that BMEs were treated differently by drug services and 11 people did not think they were treated differently).

Almost all of the respondents thought that it would not be an issue or a concern in the Black community if people knew that they smoked cannabis, except perhaps in the older generations. However, the consensus was that a Class A drug user in the Black community would become ostracised and looked down upon by others. There was also a great fear that they did not want other family members finding out about their problems which would greatly reduce uptake.

Issues and Problems
Undertaking research within a prison environment will differ greatly from community research. For instance, keeping prisoners involved in a research project may be more straightforward as a prisoner will have fewer responsibilities and commitments than someone doing the research in the community who may have to worry about travel arrangements, work, education commitments, child care and so forth. Nevertheless, the POPS group did encounter a number of obstacles and difficulties when doing the research in Risley.

Volunteer Dropout
As with any form of research, when participants are recruited, there is a chance that a number of people will eventually dropout of the research, especially if they have lost interest. However, with the prisoners, dropout was not necessarily down to just losing interest. The original group of volunteers began as a group of 12 BMEs at the drug awareness and research methods training stage of the project, but this number fell to just 5 members by the time the questionnaire was being piloted and due to role out. One of the reasons for this was that some of the volunteers had been released from prison since the research commenced. So they could not apply their skills as peer researchers despite being trained as peer researchers because they physically were not available to carry this out.

Many volunteers were unable to attend the research group sessions because they had mandatory requirements within the prison. For instance, some prisoners must attend behaviour programmes such as Enhanced Thinking Skills (ETS) and PASRO (since it is a requirement of their prison sentence). So even though a volunteer is keen to be involved in the research and makes himself available for the research, if the volunteer has to attend ETS, then this will take priority over the research training. As a result, some volunteers where lost for key parts of the volunteer training.

Communication between staff
Although the POPS group had gained the consent of senior staff at Risley to attend the prison, having permission to attend the prison and actually getting in to the prison where two different things. Firstly, even though most senior staff at the prison were informed of the POPS research, many of the wing officers were uninformed. Generally, most wing officers did not know who POPS were, what they did, the purpose of the research or even how many POPS staff were due to attend the prison on a given day which had been prearranged days in advance. Overall there seemed to be a lack of communication between the senior staff and wing officers at Risley. As a result, the wing officers (who played a key part in taking POPS around the prison) were often not sure of what was required of them. This would often slow down POPS progress around the wings, as time was wasted explaining what the POPS group are doing to uninformed wing staff.

Furthermore, since the wing staff did not know what POPS were doing, it was not regarded as a priority by some staff. This meant that POPS were made to wait for long periods of time before being greeted by a wing officer and gaining entry into the prison to do the research. Again this lack of urgency, which may have been a result of a lack of communication between staff, restricted the amount of available time to the POPS group.

Gaining Access
POPS were also reliant upon the Principle Officer when it came to use of a room for running the training sessions and focus groups. Use of this room (the prison Chaplin) was restricted for a number of reasons. For instance, the room was frequently used by the prison to run specific groups for the inmates. Therefore the volunteer training and focus groups could only run whenever the Chapel was available, regardless of the availability of POPS.

Even on occasions when both POPS and the chapel were available, there was still no guarantee that POPS could attend Risley as POPS needed to get permission from the Principle Officer before coming down. If the Principle Officer – who POPS rely upon - was unable to take POPS on the wing, provide another staff member who could take the POPS group on the wing, or failed to return a call to arrange when POPS could come down, the opportunity was lost to go back in the prison until another day. Restricted access and depending on staff who were not always available, meant that it was very difficult to run focus groups. These circumstances meant that POPS chose to carry out informal interviews with inmates alongside the one focus group.

Time constraints
The regime at Risley meant that inmates would leave their cells at 8.30am and would return to their cells at 11.30am before having lunch, going through role-call (a prisoners count) and returning to their cells. They could then leave their cells again at 2.00pm before returning to them again at 4.30 pm. This basically meant that any activity POPS did with the inmates whether it is training, interviewing or doing questionnaires, could only be done between 8.30am and 11.30am and between 2.00pm and 4.30pm. Usually POPS were restricted to visiting for just half a day each time as opposed to a full day (8.30am – 4.30pm) because of limited staff availability and the chapel not being free. Coupled with the other problems mentioned above, such as long waiting times at the main gate, it often meant that the potential to do 3 hours of work in the morning (8.30am – 11.30am) was lost. Realistically, the time spent in Risley in the morning was more likely to be two or two and a half hours rather than the full three hours.

Using Questionnaires
All of the questionnaires were self completed by the inmates. Self-completed questionnaires are very efficient as you can get through a large number in a relatively short space of time unlike interviews which are much more time-consuming. However, even though questionnaires may generate a large number of answers, the quality of the answers is not reliable. There is little or no check on the honesty, seriousness or level of depth of each response in a self-completed questionnaire. Take for instance the subject of a Black specific drug service. The questionnaire respondents seemed strongly in favour of such a service (see tables 78 and 79). Yet the responses, which came out of the interviews and focus group seemed more cautious about a Black drug service, with some expressing slight concerns about using the service. It seems here that when given the chance to talk in more detail, the responses to this topic in the questionnaire differed from the responses given in interviews and the focus group.

Furthermore with a questionnaire you do not have the chance to elaborate upon your answers as you are only restricted to ticking boxes or writing short statements to get your point across. If someone has reading and literacy problems, this in itself will create an additional barrier for someone trying to complete a questionnaire and might affect the quality of the answers given. This may explain why some respondents only filled in the tick box responses but missed out open-ended questions. The interviews and focus group served to overcome the problems associated with using questionnaires but fewer inmates were interviewed or attended the focus group compared to those that did questionnaires.

Capacity Building

Being involved in the research gave an excellent opportunity for the POPS group to develop their own understanding of drugs, drug services and research methods. Sometimes, learning can be more effective by actively taking part in a task rather than just passively listening to someone discuss the task or learning objective. This active participation proved very useful for the POPS group in terms of increased general drug awareness as well as developing skills which POPS staff can apply in their roles as workers at POPS. For instance, the drug knowledge that would have been acquired by doing the research means that POPS staff will be better informed of the effects of drugs, the different types of drugs and the drug treatments service out there when working with families or prisoners. It also provided the POPS group with an insight into some of the issues facing BME prisoners and drugs and how much these issues differ from BMEs in the community.

Attending the steering groups was useful as it was interesting to get the perspective of other groups involved in similar research. The current research differed from that of other groups undertaking community engagement research as it was based in a prison rather than a community environment. However, it was interesting to hear about the outcomes of the other group's work and also look at whether the barriers that the other groups encountered in relation to BME service uptake differed greatly from the barriers identified in the current research.

The research was also beneficial to the volunteers. They were very keen to participate, and but for prisoners being released or not being able to attend sessions due to sentence requirements, the number of volunteers involved and the number of questionnaires and interviews carried out may have been greater.

The volunteers also appreciated the responsibility of being peer researchers as it gave them the chance to learn as well as do something in prison which differs from their usual weekly routine. Likewise most of the prisoners who did the interviews and the questionnaires welcomed the opportunity to express their views about BMEs and drugs and that somebody (POPS) was willing to listen to them and do something about it. Most of the inmates felt that their opinions tend to go ignored in prison so the research allowed them to express views that had previously fell on deaf ears.

Conclusion

Despite the problems encountered while undertaking the project, the research was successful in achieving its aims and objectives. Using peer researchers proved especially useful as they were able to access inmates who may have had no intention of taking part in the research had they been approached by POPS workers or somebody from outside the prison. The reason for this may have been due to the inmates feeling more comfortable answering questions around their peers rather than around someone who they do not know or regard as an authority figure. Overall, the peer researchers made a major contribution to the healthy number of inmates who completed a questionnaire.

The findings clearly show that there are unique factors and barriers which prevent BMEs from accessing mainstream drug services, whether it is fear of being ostracized by the family and the community, or just denying or ignoring the fact that some BMEs do have serious drug problems beyond cannabis. Certainly some of these barriers could be applied to White drug users, but they seemed to be magnified amongst the BME population.

The POPS group believe that the inmates who participated in this research gained a greater awareness of some of the problems facing BMEs using drugs and the help that they can receive. Whether this increased drugs knowledge will increase the likelihood of a BME accessing treatment remains to be seen, as concerns do still persist about confidentiality and small knit BME communities. As well as making those with a potential problem more aware of the effects of drugs and the services out there, there may also be a need to inform BME communities of the same. A more knowledgeable and supportive community could be significant when it comes to improving BME drug service uptake in future.

RECOMMENDATIONS

The POPS group suggested the following recommendations following on from the findings of the research

- **Drug awareness and support to families**

  The way in which people in your community (including family) will respond to your drug use is a major concern for most BME drug users. Sometimes the shame of being drug dependent may be so great that a user may choose to hide their problem, more so than a white drug user. With most BME communities being small and closely knit, there is a concern that confidentiality will be broken which only further adds to the many reasons why most BME drug users choose to stay anonymous. In short, how the BME community will react to a BME drug user is one of the most significant factors in explaining why fewer BMEs access mainstream drug services.

  A possible future direction could be to offer greater drug awareness to BME families and communities. By increasing families' awareness of drugs, they will hopefully gain a greater understanding of the effects of the drug user's drug/s of choice. Consequently, families and communities may be less likely to conform to the myths that surround usage of certain drugs and may be less likely to stigmatise someone who uses Class A drugs.

  Clearly achieving this will not be easy, but possible ways forward could be for information to be put across to families at say community or health centres, especially centres where BME families are likely to attend. Conveying this information through community and health centres may be more effective than having the same information conveyed by a drug treatment service which might be seen as a more clinical and unapproachable environment. Being in contact with a drug treatment service alone may be enough to make some families/individuals feel uncomfortable or avoid seeking information altogether. On the other hand, if the drug information is from a community centre (which is used by a wide range of people), then the drug stigma is lessened. Key people in the community could also play a role in putting across important drug information to BME communities.

  Family support agencies such as POPS, Adfam, PACT (Prison Advice and Care Trust), and Action for Prisoner's families can all inform BME families of the facts surrounding drug use, drug related issues which may effect them and how to deal with these issues effectively without isolating the drug user. If families, especially BME families are encouraged to use these agencies, then they may be more willing to support and accommodate the drug user.

- **Increasing awareness of treatment services**

  Most of the respondents were fairly clued-up when it came to general drug knowledge, however most were unaware of any drug treatment services. As well as increasing families general drug knowledge, community and health centres could also play a key role in increasing a BME drug users' awareness of the services available where they can go to get treated.

More can be done to increase drug service awareness for those using drugs in prison. Prison CARAT teams may be able to increase an inmates awareness of the available drug services in their local area. Therefore, if someone feels that they need continued support for their drug usage after release, at least they will be aware of what is out there within their area. This increased awareness may also reduce the chances of someone relapsing once coming out of prison since they will know where to get treated if they seek that option.

- **An increased understanding of BME culture**
  The concerns relating to a Black specific drug treatment service have already been documented. A more effective approach for increasing BME drug service uptake could be for drug services to employ general multi ethnic drug workers who have a better understanding of BME culture. This could extend to having some drug workers of South Asian decent who are fluent in Urdu for instance if language is a barrier. At the same time, the presence of white staff who are culturally sensitive and working amongst BME staff may be more comforting for BME drug users who are worried about their problem becoming the talk of their community. Advocating a confidential drugs helpline that allows drug users to speak to someone about their problems without needing to leave a name or contact number may well lessen these concerns.

Appendix 1

Sample Questionnaire

Black Prisoners Research Group

To investigate:

- ***If Black men access mainstream drug services.***
- ***If they do not access mainstream drug services, then why not?***

Please note, Questions 1 – 9 are optional so you do not have to answer these questions if you do not want too.

Main Questions (Please tick appropriate box)

1) Age last Birthday

15 or under	
16 – 18	
19 – 21	
22 – 24	
25 – 29	
30 – 39	
40 – 49	
50+	

2) Ethnicity

Black or Black British	
Caribbean	
African	
Other (write in)	
Mixed White and Black Caribbean	
Mixed White and Black African	
Mixed White and Asian	
Other (write in)	
Asian and Asian British	
Indian	
Pakistani	
Bangladeshi	
Other (write in)	

3) **Were you born in the UK? If no, how long have you lived in the UK?**

Less than 1 year	
1- 5 years	
6- 10 years	
11 years or more	

4) **Citizenship: Are you a**

British Citizen	
Refugee	
Asylum Seeker	
Other	

5) **How long are you in prison for?**

0-6 months	
7-12 months	
13-18 months	
19 – months – 2 years	
2-3 years	
3-4 years	
Over 4 years	

6) **Which languages are you fluent in?**

Spoken	
Written	
None	

7) What is your religion?

None	
Christian	
Buddhist	
Hindu	
Jewish	
Muslim	
Sikh	
Other (write in)	

8) Sexuality

Heterosexual or straight	
Homosexual or gay	
Bisexual	

9) Do you have a disability?

Yes	
If yes, please state	
No	

Drug Use and Knowledge

10) Have you ever tried or taken any of the following illegal drugs?

Drugs	*Yes*	*No*
Heroin		
Crack		
Cocaine		
Amphetamine		
Cannabis Resin		
Skunk		
LSD		
Ecstasy		
Solvents		
Misuse of Prescribed Drugs		
Misuse of Steroids		
Other (Please state)		

11) Do you still use any of the following drugs?
If yes, how often do you use?
If No, go to question 14.

Drugs	*Please tick*	*How often do you use this drug?*
Heroin		
Crack		
Cocaine		
Amphetamine		
Cannabis Resin		
Skunk		
LSD		
Ecstasy		
Solvents		
Misuse of		
Prescribed Drugs		
Steroids		
Other (Please state)		

12) If you have used any of these drugs, has it ever caused you a problem?

Yes, If yes, what problems?	
No	

13) Do you worry of the effect your drug use has on others (e.g. family and friends?

Yes	
No	

14) Do you know of anyone who has a problem when it comes to using the following drugs? Please tick, If no go to question 15

Drugs	*Friend*	*Family*	*Acquaintance/other*
Heroin			
Crack			
Cocaine			
Amphetamine			
Cannabis Resin			
Skunk			
LSD			
Ecstasy			
Solvents			
Misuse of Prescribed Drugs			
Misuse of Steroids			
Other (Please state)			

14a) If yes for any drugs, what kind of problems have they experienced? Please list:

Problems	*Please state:*
Social problems	
Health problems	
Family breakdown	
Law problems	
Other:	

15) Do you see any problems linked to using cannabis? If yes go to question 16, if no go to question 17.

Yes	
No	

16) If yes, what kind of problems do you associate with using cannabis? Please state:

17) Has cannabis use created any problems for you, if so what problem? (e.g. affecting people close to you, depression)

Your use ***Go to question 18***	
Other peoples use ***Go to question 19***	

18) Has cannabis led to you using other drugs, if so which drug/s? Please list:

19) Which of the following drugs are you aware of being used often in the Black community?

Drugs	*Yes*	*No*
Heroin		
Crack		
Cocaine		
Amphetamine		
Cannabis Resin		
Skunk		
LSD		
Ecstasy		
Solvents		
Misuse of Prescribed Drugs		
Misuse of Steroids		
Other (Please state)		

20) Do you think fewer Black people use class A drugs compared to White people?

Yes	
No	
Not sure	

21) Why do you think Yes or No? Please state:

22) Do you know what the long-term effects are of misusing the following drugs? (Please give a brief answer if you can).

Drugs	*Yes*	*No*	*If yes, what:*
Heroin			
Crack			
Cocaine			
Amphetamine			
Cannabis Resin			
Skunk			
LSD			
Ecstasy			
Solvents			
Misuse of Prescribed Drugs			
Misuse of Steroids			
Other (Please state)			

Drug Treatment Services

23) Do you know of any drug treatment services? If no go to question 29.

Yes	
No	

24) If yes, can you name any of these services? And state what service they offer:

Name of drug service	*Services offered:*

25) Would you use or have you used any of these services? If No, go to question 28:

Yes	
No	

26) If yes, why did/would you get in contact with the drug service?

27) Did the service meet your cultural/religious needs?

Yes	
No	

28) Whether you have used a drug service or not, do you think these services are specific to Black people?

Yes	
No	

29) Please state why you have said yes or no:

30) How do you think drug treatment services could be more Black specific?

31) Using the following scale, if you had a problem, would you be more likely or less likely to use a Black specific drug treatment service?

Very likely	
Likely	
Unsure	
Unlikely	
Very Unlikely	

32) Why would you be more likely or less likely to use a Black drug service?

33) Do you think a Black treatment service would have a positive effect for Black drug users?

Yes	
No	

34) If so, why?

35) Have you ever used the prison CARAT team?

Yes	
No	
If no, why not? *Then go to question 38*	

36) If Yes, on the following scale, how helpful would you rate the CARAT team?

Very helpful	
Helpful	
Neither helpful or unhelpful	
Unhelpful	
Very Unhelpful	

37) What did you think of the service offered to you?

38) Is prison the right environment for drug rehabilitation?

Yes	
No	

39) Why do you think so?

40) Do you think drug treatment services treat Black class A drug users differently from white class A drug users?

Yes	
No	
Don't know	

41) Why do you think so?

42) If you use cannabis and it became a problem, would you get in contact with a drug treatment service for help and support?

Yes	
No	
If no, why not?	
Don't know	

43) If you use a Class A drug like heroin or crack and it became a problem, would you get in contact with a drug treatment service for help and support?

Yes	
No	
If no, why not?	
Don't know	

44) Would you use a drugs helpline for guidance or advice?

Yes	
No	
Don't know	

Social and Community Views

45) What do you think are the key issues for the Black community in relation to drug use?

46) What do you think are the main issues for the Black community in relation to drug dealing?

47) Do you feel you are a victim of the society you live in?

Yes	
No	
Don't know	

48) How do you think people in the Black community would act if they knew you smoked cannabis heavily?

49) How do you think people in the Black community would act if they knew you used a class A drug like cocaine or heroin?

50) Do you think a Black class A drug user will be treated in their community in the same way as a White class A drug user?

Yes	
No	
Don't know	

51) If yes, why do you think they would be treated differently in their communities?

52) Do you think more support needs to be offered to the families dealing with Black class A drug users?

Yes	
No	
Don't know	

53) What do you think can be done to break down the barriers for Black drug users using heroin, crack or cocaine in receiving support from their community/families?

Thank You for taking the time to complete the questionnaire.
Your answers will be kept confidential.

Appendix 2

Consent Form

Please tick the boxes if you agree with the following

I have been told what the information will be used for ☐

I understand the aim of the research and what it is being used for ☐

The data collected in the questionnaire is anonymous and confidential and is strictly being used for research purposes ☐

Answering these questions will not affect my prison sentence ☐

Since some of the things I might mention are illegal and sensitive, I **DO NOT** need to say anything that could identify me or anyone else ☐

I do not need to answer any questions I do not want to answer ☐

I understand that I can agree to stop at any time ☐

I have given my consent to take part in the questionnaire and for the information to be used for research purposes ☐

If you would like to:

- Complain about any aspect of this research.
- Withdraw any information you have provided.
- Withdraw your consent.

Then you may either do this now by telling the researcher, or in the future by calling this number, and telling us the questionnaire number printed on the top of this form.

Partners of Prisoners and Families Support Group (POPS):
0161 702 1000

Thank you for your time.

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