

First Name: Jeff  
Second name: Fernandez  
Phone number: 0207 853 5378  
E-mail: [jfernandez@nhs.net](mailto:jfernandez@nhs.net)  
Country: England

**Presenting author First Name: Jeff**  
**Last Name: Fernandez**  
**Qualifications: RGN, MSc, MPhil.**  
**Organisation: Islington PCT**  
**Insull Wing.**

**Islington PCT**

**110 HAMPSTEAD ROAD, LONDON NW1 2JP.**

**Mailing address: As above**  
**Country: England**  
**Title: The role of the family in a Bengali community in Camden, London with**  
**substance use patterns**

## **Abstract**

### **Route of administration**

### **Polarisation**

### **Bengali**

### **Drug use**

### **Camden & Islington**

This paper explores the relevance of different family structures in Britain upon two distinct ethnic groups to explain different patterns of presentation to substance misuse services in Camden, London.

This paper discusses a qualitative study developed from the information in the ethnicity audit of 2002. The client perspectives on their support structures, and how they are beneficial for them is examined in this research study. Participants were asked to define their family set-up and the data was analysed through the sociological theories surrounding the family. The family perspective was felt to be influential upon choosing treatment modalities from the two distinct emerging ethnic groups.

It explores the themes of ethnicity, polarisation and the perception of the family of drug users in treatment. This is an under-researched area particularly in substance misuse, but hopefully this paper will show the value of considering the family in decision-making for treatment programmes to achieve better outcomes.

The research was conducted as part of an extensive paper that looked at drug using peer groups and route of administration for a cohort of clients entering the South Camden and South Islington drug services.

It is argued that the effects of polarisation and family make-up have had an impact on the Bengali ethnic group and has influenced their clinical presentation between the ethnic groups studied. The lessons are for drug services are to understand the social context, the family and its influences on presenting clients, in order to address ethnic minority issues.

## **Introduction**

There has been an emerging population presenting to drug services nationally from South Asian backgrounds (Bashford, J, Fountain, J, Winters, M, 2003). There has been published research looking at the emerging needs of the 'new' population to health services and some work completed looking at treatments (Patel, K, Sherlock, K, 1997). However, there has been little work looking at the social background and environment and what impact this has in treatment. In a summary document by the National Treatment agency upon drug use and ethnic minority groups, this stated that there are barriers to service provision in substance misuse due a lack of understanding from different communities (Bashford, J, Fountain, J, Winters, M, 2003). This paper is an attempt to highlight the shortcoming and show that by examining the family structures and recognising different socio-economic pressures, that a knowledge of this, can lead to a culturally responsive health service in the area of substance misuse. It is advocating for research in this area where a sociological perspective can be successfully utilised to improve drug service provision in working with ethnic minority groups.

## **Research already completed upon ethnic presentation in Camden**

A detailed case study analysis of South Asian presentation to the local drug service was conducted from January to December 2002. The main finding of this research was the marked difference in the routes of administration used by the local South Asian population, which is mainly Bengali and Muslim. This extensive research showed that the different patterns of use illustrated the level of secularisation and economic polarisation of the Bengali community to the rest of the indigenous population in Camden (Fernandez, 2002).

The South Asians population attending the drug service smoked or chased without switching to injecting. The White/European group interviewed in comparison showed a route of smoking/chasing initially with a move to injecting within two years.

The sustained oral route by the South Asian population in Camden illustrated secular peer groups when using drugs, in mono-cultural groups. The reason they were mono-cultural was due to socio-economic polarisation of the Bengali population from the rest of the community (Fernandez, 2002).

This paper looks in detail at part of this extensive study. Particularly at the section which examined the family, the different family make-up and pressures on their drug using spouses and its relationship to choosing specific treatments. It is argued that there are different needs where the family is far more influential. It is argued that the family structure and social context has to be recognised as it provides essential background information upon which to plan better, more effective health care in substance misuse.

## **The Family in England: a sociological overview.**

There are marked differences in family structure, which is discussed in this paper. This could be the result of cultural difference creating a secular population, with little inter-cultural exchange. The Bengali family structures have remained the same, with an extended network of the family, and not adapted to the structure of the nuclear family in Britain. From sociological theory, this could show the limits of Patterson's (1986) theory of assimilation overtime, and the growing relevance of Gilroy's (1987) analysis of racism practiced upon cultural difference. The result of racism practiced through cultural difference, has arguably produced polarised societies with arguably different family structures. It was noted that the family structures from the ethnicity audit of 2002 marked distinct differences and therefore the structure of the family is discussed next.

The family structure in England has changed over time from the extended family, which consisted of Grandparents, Father and Mother and spouses, to a structure in post-war Britain, which is termed as the nuclear family. The nuclear structure has made the family more mobile for work, and they (The family) could theoretically move from to any area were there was work and economic opportunity to better oneself. These structures were very defined, but over time as society in Britain changed, it can be argued, the family has moved towards a more post-modern society defined by nuclear families with new structures that have challenged the former ones. Currently, in Britain there are various structures to the nuclear family, which make it hard to define within a singular term. Many men and women now marry twice and bring with them children from a former relationship. Therefore introducing stepdaughters and sons, as well as children from their current relationship. This

particularly for academics makes it hard to define a family structure, which would have contemporary relevance. Another factor is the number of same-sex relationships, that have been acknowledged, which historically in previous censuses in Britain was not a category. Families in most of these cases or relationship structures tend not to have children. There is also the growing number of single parent families, which are often matriarchal and have children, with no male support, particularly in the cases of the working class and lower working classes (Taylor et al, 2000).

The focus of this research is in the Muslim ethnic community, which is based in Camden. Work conducted in 1982, and recently in 1995 showed that while the households of Muslims tend to be nuclear, the extended family networks are nearby. In the area of Somertown, the family networks are strong and the extended families often live in the same house, or close by on the estate (Bilton et al 1982, Fleming, 1995). Asian households tend to be larger than 'White' or 'West Indian' households. Seventy-three of the Asian household have children which is a higher percentage than the 'White' and Afro-Caribbean families whose percentages are 31% and 57% respectively.

The recent changes, from the extended family structures to nuclear has not affected the importance of family ties which still remain strong in South Asian communities particularly for the Bengali population. Economic assistance as well as emotional support is still provided by these close-knit structures, while for 'White' and Afro-Caribbean families have been adversely affected by the movement from extended to nuclear structures. This has often resulted in a fragmentation of communication and contact within these family structures (S Westwood, P Bhachu, 1988).

In terms of sociological theory a relevant one for this study, is the interpretative approach of the family. The family is seen as a social construct and the roles of the

husband and wife are to interpret their world around them. Roles are often negotiated in the family structure, in terms of working and the rearing of children, for example. It is an approach, which can be called descriptive, as it describes family structures as they are experienced, emphasizing the importance of the family being a collection of individuals who are free to choose through negotiation the role they can play in this structure.

These perspectives will have relevance to this project as the role of the family is important in the presentation, and needs of clients who attend the Margerete Centre. Anecdotal evidence indicates that the role of the family is highly influential on the Bangladeshi community accessing treatment and the qualitative interviews asked about the role of the family, which is analysed in the next section.

The most common families structures, for the Asian clients interviewed for the study showed the nuclear with the extended family nearby was the most applicable. In the questionnaire many referred to their family structure as extended but when pushed described their immediate family structure as nuclear with family members close either in the housing estate or near geographically. In the questionnaire the nuclear family was described as being either make up of a Wife, Partner, children or parents. The extended family was made up of Grandparents, relatives such as aunts and uncles as well as cousins.

### **BME Families and substance misuse**

It has to be stated while there is a problem of a lack of basic awareness of substance use from Black and ethnic minority populations, there are also gaps in knowledge from these communities across a range health problems, both physical and mental (Stein, S, Christie, D, Shah, R, Dabney, J, Wolpert, M, 2003/ Kegler, M, McCormick, M, Allen, P, Spigner, C, Ureeda, J, 2002).

However, it has been recognised that there has been a limited understanding from the older members of Black and minority ethnic communities upon substance use. (Arora and Khatun, 1998). Infact in the Asian communities young Asian drug users have reported that it is relatively easy to conceal their drug use from their parents, as in many cases parents would not feel that their children would be under the influence of drugs. Infact while it is acknowledged that drugs are available in society, many parents from South Asian communities would not see that their children would make a choice, on their own, to use drugs (Bola and Walpole, 1997).

The research around BME groups showing there is a gap in levels of awareness for substance use between parents and their children has been well documented by localised research studies (Bola and Walpole, 1997, Khan and Ditton, 1999, Patel et al, 1996). The poor knowledge of substance misuse from BME families and its implications for their children is important for services to acknowledge.

### **Materials and methods**

The study was ethically approved through the Camden & Islington Mental Health Trust committee, and confidentially and forms detailing the research were considered to meet standard research protocols of the Trust.

The research was a comparative study, using The Margerete Centre. This approach is looking at the beliefs and perceptions of client support, it is in essence trying to interpret client's thoughts on how the family influences the approach and modality of treatment and what support structures there are. Therefore, to capture this type of data, the approach of this study was qualitative, and looked at generating data from the client's perspective.

A semi-structured interview was designed, with space for clients to talk freely, with open and closed questions. These questionnaires have been used in the past at the

Margerete Centre and have generated rich descriptive data, important to qualitative research aims (Fernandez, 2000). All the interviews were taped and confidentiality of the clients was protected through a formal signed document that all willing participants signed.

### **Sample**

This comparative qualitative study took the first twenty British Asians to attend as new referrals to the Margarete Centre in the year 2001 to 2002, and compared this to the first twenty new referrals of White/European clients to attend the same service modality, within the same time period. This was to ensure that there was no room for a bias sample being generated for the study.

### **Approach of the questionnaire**

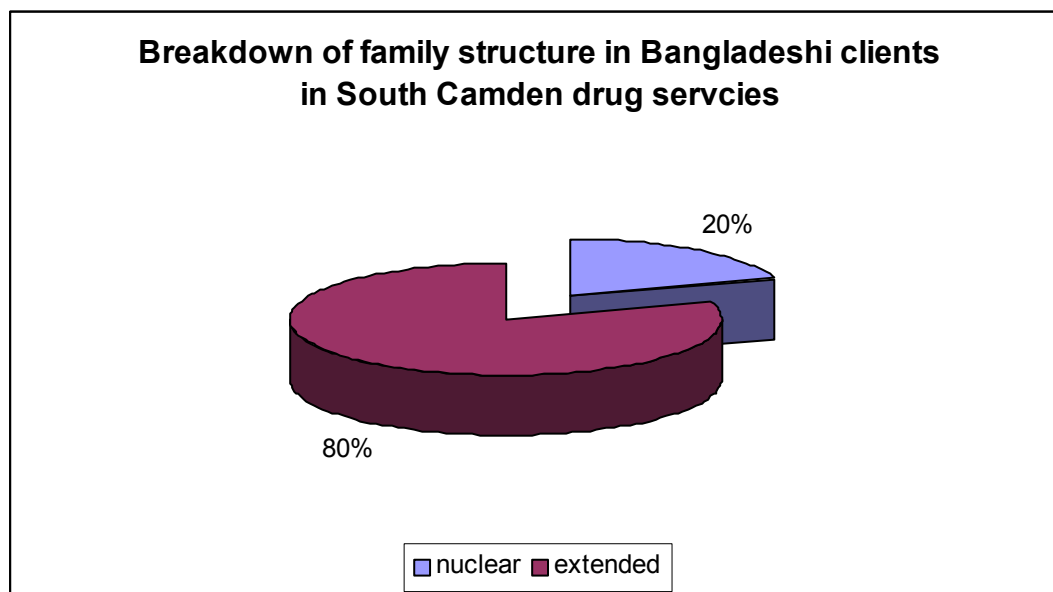
Questions were asked upon the make-up of the family structure, whether it was nuclear, extended or otherwise. Also there was space for the clients interviewed to expand upon the role of the family for them, and its influence on treatment and support if any. There emerged some interesting data, which was transcribed onto paper during the interview and expanded upon post interview.

The qualitative data was collected was then analysed through the process of key words and coding upon themes which emerged. Solely the researcher who designed the study conducted the qualitative analysis. The key themes are reflected in the results through statements, which illustrate the typicality of the themes, which emerged from the data.

The qualitative questions are shown below in the appendix.

## Results

Of the Bengali clients in the study, the average age was 20 (S.D +/- 3). All were male with no females from this community interviewed for the study. The length of drug history was short with a median of fourteen months. The total number of clients interviewed was twenty and the results are shown below.



From the questionnaires the influence of the family is very important in the young British Asians attending the Margerete Centre.

From the qualitative questionnaires the following statements illustrate the importance of the family upon entering a detoxification programme.

“ I get pressure to detox constantly from my family, they want the son they knew and loved back.”

This person always presented for an outpatients detoxification programme and relapsed within three weeks of the regime finishing. He also stated that detox instead of methadone maintenance is the preferred option for the elders in the Bengali families.

“ My parents just believe in detoxing off drugs and not in maintenance.”

This was another statement from another interviewee, which show the family may have a one-dimensional way of looking at solutions to these problems. This is stereotyping the detox regime to an inadequate and simplistic form. From the clinical perspective of those who successfully detoxed shows that in many cases it masks complex problems, which are not addressed often and not acknowledged by the family which results in a relapse fairly quickly.

One interviewee of Bengali origin stated:

“ My family really want me to detox and do not understand the implications. Maybe the family would need help in understanding drugs.”

The last statement shows this maybe an area where drug service provision can be improved in ethnic groups to try and educate the families of drug users. This may have positive implications for the clients who are attending the centre. In this case the Bengalis’ and this would arguably reduce the levels of stress the client has which is influential on relapse.

“ My family do not understand the levels of withdrawals which are associated with detoxing and there is education needed around this. It would make life easier for me.”

This statement shows that work would be perceived as being beneficial to this group currently accessing services.

However, these examples do show the level of influence the family has on mode of treatment, in many cases at The Margerete Centre being an outpatient’s detox. This may lead to many clients from the Bengali community requesting one mode of treatment, which is enforced and not appropriate for the individual. However, this cannot be quantified from this research but may need to be in the future.

What can be said is that the parents of the families interviewed play a very prominent role in the choice of modality i.e. detox regime when young Bangladeshi males present to the service. The literature from the sociology of the family, as mentioned, has highlighted that the structure of families in Muslim cultures in Britain are patriarchal. The structure is a functional one, which is not easily adopted by the growing interpretative structures developing elsewhere in Britain.

However, it does have some positive benefits in controlling the level of drug use and for Bangladeshi users, it arguably focuses the user to look at treatment, but not fully at the options available to him. The role of the family and the importance it has upon the individual can be an explanation of their spouses looking for detoxification packages and that they unaware they are unsuitable for them in many cases, and result in a high relapse rate. If a Bengali user presented when he felt ready for treatment, without family pressure, may be he/she would choose a mode of treatment that was more appropriate for him/her, instead of being psychologically pushed into a detox programme. This has been illustrated by the qualitative responses to the research work in this area.

What this can mean for treatment services such as ours is that there is a need for working with the families in increasing their knowledge upon substance misuse and the available treatments, which we provide. To achieve this would need managerial input and consensus. For, it may be important to see the client and their immediate families and go through the assessment process and suitable treatments that is available. Of course this would only occur if the client consents to this. If not, may be there needs to be more of a contact for services with youth and cultural centres in the area to promote drug awareness. Also to hold forums and days were access to treatment services can be discussed informally with clinical staff. These options need

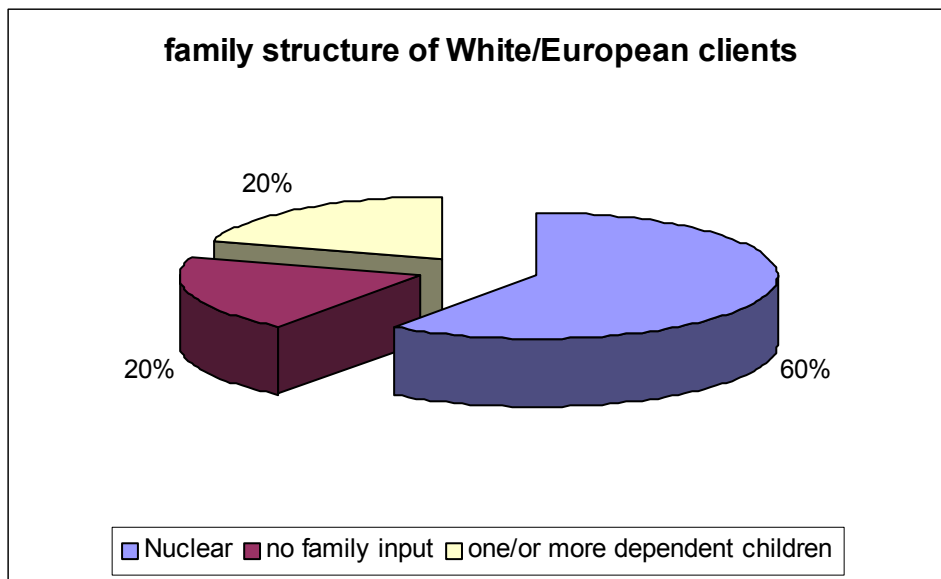
to be explored as they could have a valuable part to play in addressing clients from the ethnic community to appropriate treatments.

Issues such as the Bengali group of clients being more suitable for maintenance programmes rather than an outpatients detoxification are hopefully issues which can clinically create discussion and improved approaches through this work, with an evaluation process to monitor effective change. This would in the long-term influence services to change their operational structures to be more cultural responsive.

It is clear that this section shows that the family structures for the Bengali clients is a functional one which is still based on parents influencing their spouses to a large extent. This influence needs to be considered in the holistic treatment of this ethnic group, when they present for services. A thorough evaluation of this concept with families being researched across ethnic groups and their influence would be useful to achieve, as future research.

### **The white/European family**

The average age of this client group was 36 (S.D +/- 7). The group was mixed with 6 females taking part in the study and fourteen males. The group was older with a longer history of drug use (Median= 2.5 years) when compared to the Bengali group. Also the gender was more mixed



In comparison, the white/European population interviewed didn't have an extended family structure. Sixty percent had a nuclear family structure, and twenty percent had no family input whatsoever. This is very different to the Bangladeshi clients attending the service. There is also a new category where the client had one or more dependent children and classed themselves as a 'lone' parent. These were predominately female, and there were no females attending for treatment from the Bangladeshi group. This gender difference does seem to affect the lack of pattern of family input.

The main reasons for the fragmented family picture when compared to the Bengali group was that there were many from first generation immigrants from Ireland or the

European continent. Also, that through having a longer pattern around drug use, this tended to test the families patience and in effect, from the clients perspective, the family would eventually give up on them.

“...Through my drug use over the years and my failure to get off them has resulted in my family not wanting to know me. It is sad but I don't blame them.”

This clearly illustrates the pressure the family has and when breaking point is approached, it results in the drug user being left without support. This can be seen as a factor, which makes this client group more prone to relapse, as outside support is lacking.

Having children and not being able to come off drugs is also a factor given by one former client who participated in the study:

“It was fine before I had my first son, but my parents and grandparents didn't support me after they found out I couldn't give drugs up. They never saw me until social services got in touch with them....”

It seems ironic that social services in this case, is seen as bringing people together, but the role of social services, particularly in child protection look to include the family, as a process of keeping the child from care. However, this example does show that a mother can seem to exhaust her avenues of support from the family relying upon social services to formulate the support process.

In some cases the family is supportive when a client attends for treatment with a detoxification programme. They seem very supportive in the view that their daughter or son will be 'clean' (Off drugs) and welcome this image as the next extract illustrates:

“ My family were at the end of their ‘tether’ with me. But once they knew I was coming here, and looking to get off drugs, they have been behind me. It is good and I want to do it.”

This would seem to indicate that the family influence is similar to the Bengali group. However, support is arguably less influential on their children seeking treatment and trying to detox from drugs. It seems drug use has strained the relationships thus far. As a result and from the above statement in very few cases (n=3) but not all, detox can bring positive benefits and better relationships between families and their drug using spouses when a detoxification programme is requested.

“ My family want me to detox, and I want to for them as they are ‘made up’ at the moment. But I am worried that I will struggle to stay clean after the programme has finished.”

This clearly shows that by entering treatment through a detoxification programme can add unwanted pressure upon an individual. This can make work difficult for the client and the drug worker involved in planning a practical way to achieve ‘clean-time’.

## **Discussion**

What this clearly shows is there is a different family structure between the two ethnic groups. This leads to different pressures upon the individual in some cases leading to choose unsuitable programmes from treatment services. This is common across both ethnic groups but more frequent upon the Bengali group whose family are arguably looking for a quick solution. In our clinical experience this can lead to a detoxification programme being completed but relapse occurs within a week. Therefore little is achieved in having 'clean-time' and a break from drugs to increase insight and develop coping strategies worked upon in key-working sessions.

The family structure of the Bengali families is in many ways an extended one, more akin to the functionalist theory (Taylor et al, 2000) in that nuclear families are geographically, very close by. This has more of an impact upon the Bengali drug users, as culturally the family is central to many leisure activities linked through religion (Fleming, 1995). This is not the case for the White/European group.

The Bengali families also have a very patriarchal family structure where there is little development of negotiated roles. The patriarchal structure and lack of knowledge around drug use encourages the males to inappropriately seek a detoxification programme.

The white/European family structures seem more fragmented through their members drug use, and have longer drug histories in many cases. Their family structures are more akin to the negotiated roles, with drug users often testing the process of negotiation for their respective families.

To summarise, for the Bengali clients the pressure for their children to access detoxification seems to be a very medical model way of viewing this issue. It maybe

that they do not understand the psychological factors, which are arguably important in trying to attain some 'clean time'.

To address the issue, maybe what services need to have, is a way of incorporating the families in their spouses care provision. This would not only enable the family to explore useful patterns of support with the drug worker, but help in raising drug awareness.

This can be valuable, but the family as a support structure needs to be recognised. In order to holistically deal with drug use there should be in some capacity involve the family in a constructive way to aid their spouse (Billips, K, Marini, I, Stenbnicki, MA, Slate, JR, 1997).

This approach was also advocated in a recent literature review conducted by the University of Lancashire from its research on ethnic minorities ( Bashford,J, Fountain,J, Kamlesh P, Winters M, 2003). This review showed that families could play a valuable part in treatment. However, the fact that drug use is not talked about due to the stigma attached to this in families has resulted in an unsupportive environment for Asian drug users. Therefore, this ethnic group, in this particular study being Muslim, are isolated from their immediate support structures. Also, the level of knowledge upon drugs was an issue where drug education from services could be valuable to informing families about drugs and how they can support a person with substance misuse problems (Bashford J, Buffin J, Patel K, 2003).

Therefore through increasing drug awareness of the family members, particularly the Bengali group, would hopefully be beneficial to the client accessing treatment. This area is often under utilised and can be clinically fruitful and would need a commitment to explore its inclusion in care packages, for as this paper indicates, while relevatively unexplored, it can be of relevance.

Indeed, some argue that the role of the family is still in this post-modern world (Taylor et al, 1995), is still highly influential upon its children. Therefore the question is how to harness this asset constructively. For, if achieved the family can be incorporated in health care packages and used to benefit clients who attend for drug treatment.

### **Polarisation ?**

Arguably, polarisation has implications on the different presentations, which come forward to the service. However, in terms of the results of cultural difference, such as, losing out economically in work and housing has led to secularised communities. It can be argued that for Bengali families, their poor understanding of drug use is due through polarisation with little contact to its wider community. Through this the Bengali population has experienced poor knowledge in not being aware of the services that are available to them. This is due current health information channels not being effective in reaching this marginalised ethnic group. As stated in the paper they are the poorest and most marginalised population in Britain. This would have to be recognised if health services through health promotion are to address the problems of substance misuse effectively.

It is hoped that this paper highlights the need to understand the social context, the role of racism and cultural isolation of the societies they are addressing. This would help in planning good accessible, practical health care in this area. Some recommendations from the extensive study have already been implemented.

The recommendations are argued as being transferable and adaptable to any drug service working in cities with a multi-cultural population. It is important to cater for cultural differences in British society. Research can provide some answers to this, as illustrated in this paper.

**Recommendations to practice to meet an emerging cultural groups' needs:**

- 1) To have a more tailored assessment that includes a social dimension at first contact so that care programmes can be planned effectively. Action: This has been completed by the introduction of the Common Assessment Tool that has a family and social/housing evaluation on assessment.
- 2) To repeat the audit annually on emerging ethnic groups to review a new assessment form and its effectiveness. Action: This will be completed through a working party on ethnicity.
- 3) Teaching practitioners among the key features that emerging ethnic groups presenting to drug services so that the social dimension of exclusion is understood and worked with which could improve outcomes. Action: Teaching across all venues on Camden to primary care and hospitals completed 2003.
- 4) If the main route of use for the Bengali community is to chase/smoke to ensure that health education around hepatitis and HIV is given so that the risks of injecting drug use are understood by this cohort. (On-going)
- 5) To look at a more active engagement of OT services to look at literacy and training for skills to improve employability in the labour market. (On-going)
- 6) To look at including the families at assessment in order to educate and hopefully facilitate better support for the individual particularly when an out-patient detoxification is chosen.

Appendix.

The Semi-structured interview plan

What is your drug of choice?

.....  
.....

Do you use any other drugs?

.....  
.....

How long have you used illicit drugs e.g. heroin?

.....  
.....

How do you take your drugs i.e. route?

Describe your family structure?

.....

What are their thoughts on your drug use?

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.....

How do they support you in treatment?

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Does the main support come from the family or from elsewhere?

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Is family support important for detoxification?

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Any other relevant data?

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