Public Health Specialist BME Workshops – Drug & Alcohol **March/April 2013**

Introduction

For several years, the annual needs assessment conducted by Public Health has shown that there is significant underrepresentation of BME Communities within the local treatment population, although anecdotal reports suggest that drug and/or alcohol problems are prevalent within each community to varying degrees. This would suggest that there are specific cultural barriers which inhibit access to treatment for these communities. Public Health is keen to better understand the nature of these barriers in order to improve access, so that the proportional representation within the local treatment population reflects that within the general population

Hence, throughout March/April 2013, Public Health hosted a series of four specialist BME workshops which focussed on raising awareness about and improving access to drug and alcohol treatment services for local BME Communities. The selection criteria for the communities asked to participate was primarily driven by the depth of the cultural barriers faced by that group, as well as the size of the community. On this occasion, the communities taking part included (1) Bangladeshi males, (2) Bangladeshi females, (3) Polish/Eastern European and (4) Chinese/Asian Communities. However, it is the intention that future workshops will focus on other sections of the local BME Community.

The Purpose and Methodology of the Workshops

The overall purpose of the workshops was to work towards the following three objectives:

- To establish a 'middle ground' by determining how best services can be delivered in a culturally sensitive manner which respects the unique needs of each community that services are attempting to reach.
- To increase the understanding of treatment workers about the specific barriers of access to services for each of the participating BME Communities.
- To increase awareness amongst BME Communities about the range of drug and alcohol treatment services available to them and how they can be accessed.

Each workshop was comprised of ten drug/alcohol treatment workers and ten community members, who were separated into two mixed groups and each group was asked to review separate case studies. It should be noted that the characters within each of the case studies are not real and their stories are purely fictitious, serving only to facilitate discussion but each case study was based on situations and issues commonly reported within participating communities. The case studies used in the workshop events can be viewed below:


Bangladeshi Case Study - Kamal.pdf


Polish Case Study - Adam.pdf


Asian Case Study - Tam.pdf


Bangladeshi Case Study - Dilu.pdf


Polish Case Study - Karolina.pdf


Chinese Case Study - Trung.pdf

The groups were then asked to consider the following questions within the context of the case study:

- *How would your community deal with these issues? Would you always choose to deal with these types of problems in this way or do you think there may be better options?*
- *Putting aside cultural barriers, what support/intervention might each individual (user) need?*
- *How can we then provide this support/intervention in a way which is sensitive to the needs of your community, while protecting the individual's right to confidentiality?*

In addition, where the BME Communities felt comfortable sharing the information, each was asked to describe the types of substances which they consider to be problematic to their specific communities.

Bangladeshi Males Workshop:

How would your community deal with these issues? Would you always choose to deal with these types of problems in this way or do you think there may be better options?

Putting aside cultural barriers, what support/intervention might each individual (user) need?

How can we then provide this support/intervention in a way which is sensitive to the needs of your community, while protecting the individual's right to confidentiality?

The Community Approach:

Both groups in this workshop showed great similarity in their answers to the first question. Cultural and religious drivers meant that both groups would often seek to address such problems in a very contained way, rather than seek support from outside a very close circle. Keeping the issue 'confidential' was particularly important, inferring fears that wider members of the community would find out about the individual's drug/alcohol problem. One community member felt that substance misuse problems are more/less acceptable for different backgrounds, while another approach to 'pray' for the individual to 'change their ways' also underlined the religious factors which may discourage an individual from accessing services. These influences often encourage the individual to lead a 'double life'.

Hence many of the approaches suggested in each group reflect a need to maintain confidentiality. These approaches included getting a close friend, relative or trusted community member to speak with the individual, perhaps over time, to try to make the individual see the error of their ways. Community members' felt that those individuals engaged in substance misuse are unaware of the impact of their behaviour on others around them and they would try to make the individual see this. In one case study, community members felt that Kamal's wife should try to 'look out for him' by calling him regularly. Other advice they would give to the individual included 'not hanging around with the wrong sort of crowd' and not doing anything to 'fit in with the crowd'.

There were some references made to seeking external support for the individual, such as contacting the individual's GP or the local Sports Centre. Drug and alcohol treatment services were mentioned but there was an admission that the Bangladeshi Community knew little about the range of available services locally that are designed to address such problems. Other sources of external support which were referenced by both groups

included advertisements, leaflets, seminars, group work and even Community TV. More commonly, the community would send the individual back to Bangladesh to 'sort themselves out' or go to rehab.

It was unclear how prevalent drug and alcohol use is within the Bangladeshi Community, probably due to the closed nature in which the community addresses these problems. The types of substances used within the community seemed to vary across different generations of the community. Alcohol and heroin use were cited but use of cannabis, ecstasy and more recently 'legal' highs, such as MCat, have become more popular.

The Treatment Approach:

Discussions about the range of available services were extremely broad. The community were informed about the efforts of treatment services to work preventatively, providing information and education in various forms, such as youth work, through schools or via brief interventions.

Where more specific support is required, treatment workers indicated that the individual would be assessed to determine the type of substance misuse, the size and scale of the problem and the impact this was having on the individual and others around them. It was emphasised that involvement of the individual within their care plan is crucial to success. Discussions followed about how the individual can be referred or signposted into other services and how these services can be delivered in group and one-to-one settings.

The community were then informed about harm reduction interventions and a full range of treatment interventions, such as opiate substitution therapies, alcohol detox and rehab. Ongoing support with relapse prevention was discussed, such as aftercare, support groups and counselling, in addition to support for the family members affected by the problem.

The Middle Ground:

A particular focus for each of the groups in this workshop was the issue of a language barrier. The community emphasised the importance of having somebody speaking to them at a level they understand while treatment services indicated the availability of interpreter services, although it was unclear how best these could be sympathetically deployed. It was suggested that a single, trusted Bangladeshi community member could potentially act as the liaison between the individual and treatment services, improving access to treatment as a result. This theme was explored further by suggesting the lack of BME treatment workers inhibited engagement and perhaps more BME treatment workers could be recruited so treatment services could be delivered without any need for a liaison. Additionally, the community members indicated that the prevailing dialect used amongst Wirral's Bangladeshi Community is Sylheti which is a living language from a particular district in Bangladesh, a consideration for the commissioning of interpreter services for this community.

Information about services and how it is delivered was also important to both groups. Grammar and terminology needs to be understandable while the suggestion was made that information about drug and alcohol services should be disseminated under a generic umbrella of health and wellbeing. The community placed great emphasis that any literature should heavily emphasise the confidential nature of services and the individual's right to confidentiality.

The community suggested that treatment services need to provide a greater level of outreach services, disseminating information in the appropriate locations, such as the mosque, community centres, playgroups, schools/colleges and the community press. Other methods of engaging with the Bangladeshi Community included the recruitment of peer mentors/community volunteers to promote services and the provision of a

helpline. The community suggested that engagement activities could be arranged to coincide with key Bengali or other cultural festivals.

Finally, the issue of appropriate location recurred in the provision of the services themselves. The community maintained that services need to be delivered in generic locations which offer anonymity to prospective service users and that the services need to offer more flexible opening hours, to suit the needs of the community, many of whom work during traditional opening hours.

Bangladeshi Females Workshop:

How would your community deal with these issues? Would you always choose to deal with these types of problems in this way or do you think there may be better options?

Putting aside cultural barriers, what support/intervention might each individual (user) need?

How can we then provide this support/intervention in a way which is sensitive to the needs of your community, while protecting the individual's right to confidentiality?

The Community Approach:

Bangladeshi females reiterated many of the approaches given by male community members but also gave their own unique perspectives on how the Bangladeshi Community would deal with issues of substance misuse. One group noted that the outcome or approach taken would vary from family to family while any attempts to deal with such problems would be a very straightforward (i.e. do this or do that). Another aspect raised was the importance of gender, in that the person experiencing drug and alcohol problems would be approached by a family member of the same gender.

Unsurprisingly, confidentiality was greatly emphasised and one group suggested that in the 'Dilu' case study, a family conference would be arranged with elders only from the immediate family. Great lengths would be taken to ensure that extended family members or the wider community remained unaware of such problems. The group studying this case study also felt that a typical response to Dilu's situation would be to either pull him out of university or disown him.

In the 'Kamal' case study, it was suggested that his wife should seek out a trusted person to talk to/advise her husband and that she would not approach him directly. It was feared that to do so would cause them to argue and another alternative given was that Kamal and wife simply would not talk about these problems. The groups advised that Kamal's wife would feel helpless in this situation and it was also mentioned that there is a degree of illiteracy among Bangladeshi females who require translation support and this alone would perpetuate any feelings of helplessness.

Both groups agreed that community members would be unlikely to access any 'drug' and 'alcohol' services, labelled as a user of these services. Most would instead prefer to present to their GP or at hospital. One group suggested that most community members would be more 'comfortable/confident' dealing with a white, non-muslim practioner, as they would feel that this wouldn't get back to the community. However, the drawback to this is that the practioner may not be able to appreciate the sensitivity of the cultural/religious issues particular to drug/alcohol misuse.

Other comments made reflected the male workshops in the suggestion that the individual could be sent to a rehab in Bangladesh, while the community suggested that although contacting treatment services was an option, it was a fairly low priority option.

The Treatment Approach:

The discussions about treatment approaches followed similar lines to the male workshops. Client confidentiality was again strongly emphasised and the broad range of treatment services and interventions were described. The treatment workers spoke about more specific information relating to the case studies such as prescribing a Librium alcohol detox. Most interestingly, treatment workers also referenced a drop-in alcohol service which the community had earlier suggested that they would be disinclined to use. This is the clearest indication of the failure of the service delivery to account for the particular needs of this community.

The Middle Ground:

Bangladeshi females shared many similar suggestions to the males within the community. Information and awareness-raising about drugs and alcohol (leaflets, events, etc.) should be delivered under the generic guise of health and wellbeing. A greater use of outreach services could be employed. A variety of different venues should be targeted, such as the mosque, schools, crèches, 'One Stop' shops, Halal food shops, etc. These activities, as well as service delivery, need to offer flexible opening hours to accommodate for individuals who work, for daily prayer and religious festivals e.g. Ramadan.

All treatment services should be delivered appropriately with respect to age and gender. In the case of the latter, males and females should be targeted separately and one group suggested that the females need to know about drugs and alcohol in order to keep their families safe. Community members also stated that most females will have issues with transport and will walk everywhere and treatment services need to take this into account when planning any activities or service delivery with the Bangladeshi Community.

Other points of discussion included the importance of confidentiality, the development of peer support within the community and the provision of appropriate pharmacy services (i.e. a non-muslim pharmacist).

Polish and Eastern European Workshop:

How would your community deal with these issues? Would you always choose to deal with these types of problems in this way or do you think there may be better options?

Putting aside cultural barriers, what support/intervention might each individual (user) need?

How can we then provide this support/intervention in a way which is sensitive to the needs of your community, while protecting the individual's right to confidentiality?

The Community Approach:

In the Polish/Lithuanian Communities, drug use was described as varied dependent upon age group but alcohol was cited as particularly problematic and one example was given of a worst case scenario where the parents spent their money on alcohol instead of food for the children. In the 'Adam' case study, the group suggested that the wife would have to leave the town/village while the husband would probably carry on

drinking. Poland was described as a patriarchal society where there would be little or no support for the wife. While there may be some support from close family and friends, there would be no interference from the wider community with respect to individual life choices. One group also suggested that Eastern European cultures are very self-reliant and less likely to source external support with their problems.

Both groups felt that confidentiality was a big issue, with many people fearing deportation if they were to admit to their drug or alcohol problem. It was suggested that there are language difficulties for many wishing to engage with services, in particular for older people, as well as a lack of information about services in Polish. For this reason, both groups felt that this contributed to a general lack of awareness about the range of services which are available in the UK. One group also believed that local GPs are currently unable to provide interpreter services or there was a lack of appropriately qualified Level 3 interpreters.

In Poland/Lithuania, there is less trust in the Police and in services which may indicate why Polish people are less inclined to access services in the UK. However, while some community members would approach the GP, they would not necessarily trust their advice, as it differs considerably from that offered by doctors in Poland. In the 'Karolina' case study, the group felt that there was less help and preventative interventions in the Polish school system than in the UK. It was felt that the outcome of their case study would be a confrontation between Karolina's parents and teacher.

Additionally, Polish/ Lithuanian people would be reluctant to access a service which 'labels' them but would instead approach their GP for help. Despite this, one group suggested a lack of trust in UK doctors because 'they offer different advice than Polish doctors'.

In terms of the substance used, the groups stated that alcohol use was associated more with the older generation where drug use was more common in younger people. The Polish Community members reported that cocaine, cannabis and steroids are most commonly used while Lithuanian Community members reported that cannabis, MDMA and Crystal Methamphetamine

The Treatment Approach:

Treatment workers emphasised the importance of client confidentiality as part of the therapeutic relationship. They described the range of services on offer for alcohol and a range of drugs, including heroin, cocaine, cannabis, MCat, etc. This discussion elaborated on particular interventions such as detox and rehab, similar to other workshops. One group also mentioned that there are more specialist services for young people and families.

One area of uncertainty for treatment staff related to interpreter services. In one group, services were clear about their legal obligation to provide interpreter services while the other group, one of the services advised that they did not offer this support. This highlights a need for greater clarity regarding the provision of additional support needs for BME clients.

Treatment staff also highlighted the importance of service users being involved in the development of service provision to ensure that the services provided meet the needs of those using the service.

The Middle Ground:

A key observation made within both groups was that many individuals within the Polish/Lithuanian and Eastern European communities work hard and 'play' hard too. Many individuals are sourcing work through

recruitment agencies and both groups agreed that this was a good area to target with information about services, as well as local factories. Universities and schools/colleges who offer English language courses would be another area to target, along with the Wirral Change, the church and Polish shops.

Both groups suggested that most of the community members have access to the internet, particularly via their phones. Services could make better use of social media to communicate health messages and one group stated that Facebook even has a Polish 'page' which a lot of the community are signed up to.

The discussions touched upon the need for interpreter services and the availability of information in other language formats. One group even suggested using volunteers as translators.

Community members spoke about the inflexibility of opening hours of service provision. Many community members who might need help are often in jobs working long hours and are not able to attend within traditional opening hours. Additionally, the groups felt that the delivery of drug and alcohol services would be better taking place within a 'One Stop Shop', along with other support services (information/advice on Housing Benefit, debt, etc.) where the individual would feel more anonymous.

Chinese/Asian Workshop

How would your community deal with these issues? Would you always choose to deal with these types of problems in this way or do you think there may be better options?

Putting aside cultural barriers, what support/intervention might each individual (user) need?

How can we then provide this support/intervention in a way which is sensitive to the needs of your community, while protecting the individual's right to confidentiality?

The Community Approach:

In both workshops, the groups conveyed a sense of shame felt by those with drug and/or alcohol problems and the taboo nature associated with it. As a result, both groups felt that community members are unlikely to approach others within their community for support. Individuals are likely to want to keep such issues very private. In the 'Trung' case study, a Chinese community member stated that Trung would not speak to his parents out of hierarchical respect and also due to their expectations about Trung's educational achievements.

It was stated that most families would try to deal with any problems within the family where possible and both groups suggested that they would be more comfortable about speaking about their problems with somebody from outside their community. Gender issues were also mentioned, in that it is more acceptable for males to have drug and alcohol problems than it is for women.

One group suggested that the communities do not feel that services are private and confidential enough, intimating that consultations should take place in a private room on a 1-2-1 basis. This highlighted the community's perceived view of how treatment is delivered. Once again, the communities expressed their preference for treatment services to be delivered at a venue which has no affiliation with drug and alcohol treatment in order to offer a degree of anonymity.

This workshop also raised similar points about the lack of awareness and information about services, particularly in other languages. This then relies on community members relaying information about service provision back to others. The groups felt that more education is needed about drug and alcohol misuse and the services which provide treatment and support. While the groups felt it was beneficial for them to find out more about treatment provision, they also expressed difficulties visualising the range of services on offer.

The Treatment Approach:

As in other workshops, treatment staff gave community members a comprehensive description of local service provision in great detail. In addition to many of the aspects covered in previous workshops, treatment staff also informed community members about criminal justice treatment services and how they are linked into the courts.

Other interventions discussed included testing for blood borne viruses, hostel and homeless provision (including the YMCA night shelter), shared care provision via GP surgeries and the role of mental health services. Otherwise much of the rest of the discussions duplicated previous workshops.

The Middle Ground:

The community members suggested that drug and alcohol education should begin within the schools, (with one suggestion that the school should provide a consultation room) and that education should continue within the local community. The methods to achieve this should include outreach services, community events and more workshop events such as this one. Another good suggestion is to organise an 'Open Day' Tour of all local services for all BME community members.

Greater effort needs to be made to overcome any language barriers, with service information translated into other languages and a further suggestion that community volunteers could offer to translate to keep costs down.

Outreach services should be visible and approachable within the localities where BME community members frequent. Places such as Chinese/Asian shops, cultural community centres and GP surgeries.

Recommendations:

The participants within each of the workshop events felt that the sessions were very productive with respect to shared learning. The suggestions they made informed the recommendations below, many of which are practical, affordable and can be implemented with minimal effort. However, while the focus of the workshops was upon the provision of drug and alcohol services, many of the suggestions are equally applicable to wider healthcare services and on this basis, it is suggested that the learning from these events is circulated as widely as possible.

Getting services closer to local BME Communities

- Increase the level of assertive outreach targeting specific venues where local BME community members frequent, such as:
  - Mosque, churches and temples.
  - Organisations working with local BME Communities.
  - Playgroups, nurseries and crèches.
  - Recruitment/Work Agencies i.e. Polish, Lithuanian and other Eastern European.
  - Cultural food shops i.e. Chinese, Polish, Thai, etc.
- Ensure Engagement Events are arranged to coincide with key religious/cultural festivals/dates.
- Any information used to target BME Communities should always deliver messages about drug and alcohol misuse under the general umbrella of health and wellbeing, so the individual carrying the leaflet is offered some anonymity with regard to the type of service they may be interested in accessing.
- Literature should ***strongly emphasise the confidential nature*** of any relationship between the individual and the treatment provider.
- For some BME communities (e.g. Bangladeshi), it is suggested that activities to raise local awareness about drug and alcohol issues should be conducted separately with males and females, as the needs of and the role played by each gender may differ greatly.
- Explore opportunities to recruit community-based peer mentors to raise awareness about substance misuse, whilst actively promoting treatment services and supporting engagement.
- Local drug and alcohol treatment providers should facilitate a series of Open Days, one for each of the BME Communities who they are seeking to target, to assist the invited elders to 'visualise' local treatment services for themselves.
- Consideration should be given as to how the use of social media can be used to communicate health messages to specific BME Communities and improve engagement and retention with treatment services.

Increasing the flexibility of service delivery and access to substance misuse treatment

- Reconfigure substance treatment provision to meet the specific needs of local BME population by:
  - Creating greater flexibility of opening times to allow for individuals who work unsociable hours but may need to access services.
  - Facilitating outreach clinics at generic locations (e.g. One Stop Shops) offering a wide range of services, thereby offering a greater level of anonymity for BME individuals wishing to engage with treatment services.

- Support local treatment providers to encourage more applications from BME individuals for treatment worker posts.

Overcoming the language barrier

- Undertake an analysis of the most commonly spoken languages/dialects among local BME populations.
- Continue to develop information about drugs, alcohol and local treatment provision in a range of relevant language formats.
- Work with local BME agencies to build local capacity to deliver interpreter/translation services while reducing current costs for these services.
- Ensure service providers that are commissioned by Public Health are aware of what their legal obligations are with respect to the Equality Act (2010) and also clarify local protocols for arranging interpreter (or signing) services.

Next Steps:

The following steps will be undertaken in order to disseminate any learning as widely as possible:

- The final version of this report will be hosted on the Joint Strategic Needs Assessment (JSNA) website in the BME chapters, Public Voice and other areas to increase awareness among other commissioners and service planners in general.

- It will be presented to key stakeholders involved in improving healthcare services to the local BME Community and also present at Wirral Ethnic Health Advisory Group (WEHAG).

- Actions taken in light of the recommendations outlined above will be reviewed on a regular basis.

- Updates regarding progress made with any actions will be provided to key stakeholders on a regular basis.

For further information please contact Steve Gavin on 0151 606 2000 or email to stevengavin@wirral.gov.uk