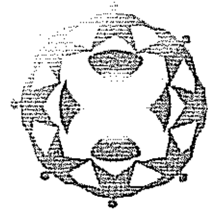

CRER

Coalition for Racial Equality and Rights

My Story with Addictions:

An insight into the road to recovery

South Glasgow minority ethnic community and problematic drug use

Coalition for Racial Equality and Rights, 2012

GLASGOW ADDICTION SERVICES

TREATMENT, CARE AND SUPPORT WHERE IT'S NEEDED

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Contents

Project Summary 4

Key recommendations 6

Introduction 8

Methods 11

A SERVICE USER'S PERSPECTIVE 14

Participant Service Users' Profiles 14

Experiences of Drug Use 15

Causes of Problematic Drug Use 15

Attitudes to Drug Use in the Community 21

Knowledge and Awareness of Drugs in Families 22

Coping Mechanisms 23

Accessing South CAT Services 25

Perceptions of Service Provided 26

Advantages of BME Specific Team 28

Awareness Raising Needs 31

A SERVICE PROVIDER'S PERSPECTIVE 33

The BME Community and Problematic Drug Use 35

Additional Issues Raised by Service Providers 37

BME Communities Seeking Help 41

Attracting BME Clients to the Services 45

Generic or BME Service? 45

Service Improvement 48

FAMILY AND FRIENDS INVOLVEMENT IN RECOVERY 52

Perspectives of Friends and Family Members 53

Support by South CAT Team 57
Service User's Views on the Role of Family and Friends 59
Service Providers views on the Role of Family and Friends 62

Discussion 64
Conclusions 72
Recommendations 74

References 76

Appendix 1: Terminology 80
Appendix 2: Questionnaires and forms used in the study 81
Appendix 3: South CAT services 97

Project Summary

There is a shortage of national data on levels of drug use relating to ethnicity. Data recorded indicates that over 96% of people who contacted addiction services in 2007/2008 described themselves as White Scottish.

However, a study in Glasgow in 2002 reported that of the people surveyed, between 20-25% of individuals from the Pakistani, Indian and Chinese communities had experienced drug use with the majority consuming cannabis (21-23%)[1].

South Community Addictions Team (CAT) is the only addiction service in Scotland that provides BME specific addiction services. This service is however, only available to the Glasgow community. However, recruitment of clients has been very slow and 10 years after initiation, there were 79 registered service users of BME background at South CAT.

There is therefore a need to evaluate the processes in place to encourage members of BME communities affected by drug addiction in accessing necessary services, and investigate the barriers preventing their use.

Mixed qualitative research methods were employed to collect information from service users, their friends and families, as well as service providers at South CAT. Interviews were recorded audio visually (where consented) to produce a DVD resource.

All 9 service users agreeing to take part in this study. One of the service users was female. 4 members of the friends and family circle agreed to take part in the project.

All participants were from the Muslim community. This reflected the composition of the BME community in Glasgow which was predominantly Pakistani, but may have also reflected the fact that both addiction workers in the BME team were from the Pakistani community and had strong links with the community.

Addiction was still taboo in the Muslim community and therefore not openly discussed. Service users still expressed shame and stigma about drug addiction and were reluctant in openly admitting to having a problem.

Service users and their families indicated that they were not aware of problematic drug use and its impact, and did not look into this area until a problem arose. Although they did not feel they were competent to manage

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[1] ISD Scotland 2007/2008

addiction, accessing services was usually as a last resort. This was because they did not know about the services; did not think the services were appropriate for them; and because of past bad experiences with services.

Service users perceived South CAT services to be unapproachable and insensitive at their first encounter which led to apprehension and lack of engagement. Perseverance and continued engagement with the service, particularly with the BME team helped to change opinions.

Satisfaction with the BME specific team was very high. Service users and their family and friends commended the service which they felt was flexible and understanding of their religious and cultural needs as well as resolved issues they had with language barriers.

Resources for the service was considered limited as there was only one full time equivalent case worker for the whole BME community across Glasgow. The work they undertook encompassed building and maintaining relationships with the community, awareness raising, supporting service users as well as supporting family and friends of service users.

Service users had no problems working with the generic team but they felt that the members of the generic team needed to be further trained to understand their perspectives and the personal, familial, community and faith-specific barriers they have to overcome to access services.

The interpretation service was considered problematic. An evaluation of the service needs to be undertaken to assist with overcoming the language barriers. Evaluation standards also need to be revisited to ensure an effective service. Staff need to be trained on how to use the evaluation service.

Awareness raising in the community is essential and working with community based organisations was considered a positive way forward to improving engagement.

Families have a strong influence on individuals in BME communities. Using the family as a resource to support service users was considered important. Educating families can; not only help overcome fears and misconceptions about addiction, but also help families support service users in collaboration with the service provider.

Supporting BME family members with problems related to the addiction of their loved ones was also highlighted. Supporting the families can help prevent psycho-social problems that arise in the family units.

Voluntary self-management groups could be set-up in collaboration with voluntary organisations to help community members support themselves on

areas related to addiction. Community Health Champions could also be used to support engagement with services

Staff training was considered a key area for helping improve services. It was believed that BME and generic team members should have more interaction and sharing of knowledge.

Working in collaboration with the voluntary sector to train staff could be an effective way of improving cultural competence and raise awareness at the same time.

There needs to be a multitude of services at various levels working together to build a culturally competent service which can identify and address the needs of the community it serves.

Many services make the mistake of interpreting cultural needs with providing the right food, literature and illustration but, for a service to be truly culturally competent it, has to recognise the values, beliefs and assumptions of the diverse communities it serves (Fulford 1999). To improve an organisation's cultural competence the organisation has to:

- Gather background information about the communities it serves
- Identify the communities' concerns and priorities
- Develop relationships so it can build trust with the community
- Participate in training to help develop cultural competent skills

Key Recommendations

The image portrayed of the service needs to be improved to make the service more welcoming to BME community members. One of the ways of doing this could be taking the service to the community through community partner agencies. Alternatively, volunteer-led self-management groups could be supported by the South CAT to help engage with the community and build the capacity of community members to identify and resolve issues through South CAT's support.

Community profiles are constantly changing and service provision needs respond to this change. An evaluation of community needs is essential to understand the community being served.

Awareness raising in the community is essential, but in particular working with community based organisations needs to be consolidated to improve engagement.

Methods of engaging with the various subsets of the BME community have to be assessed to identify best methods for each community. Use of Community Champions models or design of self-management groups can support engagement if the community is associates with such methods.

The BME service is necessary to help engage with the community as well as to support the generic Team develop cultural competency. Developmental needs of the BME service have to be further investigated in line with the community it serves and additional resources identified to support the team accordingly.

To improve cultural competency and sensitivity of the service, further training is required for both BME specific and generic team member on how to understand a diverse community's perspectives and provide an appropriate service.

Problems reported with the interpretation services have to be further investigated to assist service providers overcome language barriers. Interpretation standards also need to be revisited to ensure an effective service. Staff identified the need to be trained on how to use the interpretation service effectively.

Families have a strong influence on individuals in BME communities. Using the family as a resource to support service users can be economically beneficial to both services and the families. Educating families will help overcome fears and misconceptions about addiction but also can help support families to support the service user in collaboration with the service provider

The need to support BME family members with problems related to the addiction of their loved ones was also highlighted. At present the BME team has assumed the role of family advisor as family services have not been found to be appropriate. Working in collaboration with organisations and community members, appropriate support groups or self-management groups can be created and supported by South CAT to help BME families prevent or manage some of the psycho-social problems that arise in the family units. This will support South CAT deliver an effective service in the long run.

This study shows that there is a need to clarify the role of the BME service and SMART targets and outcomes assigned to the service, supported with the relevant resources to ensure achievement.

Introduction

In 2001 the Black and Minority Ethnic population of Scotland was 101677 which made up 2% of the Scottish population. This represented a 62.3% growth since 1991 compared to a 1.3% growth for the non-BME population[2].

With migration and changes in UK policy regarding asylum seekers and refugees, the BME population in Scotland has increased significantly since 2001. More recently, the influx of Eastern European migrants has also led to an increase in the minority ethnic population in Scotland. Thus, the ethnic makeup of the BME community is also likely to have changed considerably since 2001.

The largest BME population (31%) resides in Greater Glasgow and makes up 4.5% of the Glasgow population. 70% of the BME population in Scotland is of Asian ethnic background with the largest group being of Pakistani origin[3].

There is a shortage of national data on levels of drug use relating to ethnicity. This is partly due to poor ethnic monitoring in Scotland and partly due to reluctance of disclosing ethnicity when addiction is concerned due to cultural issues. Data recorded indicates that over 96% of people who contacted addiction services in 2007/2008 described themselves as White Scottish[4]. This would suggest that problematic drug use is not common amongst BME community members. However, a study in Glasgow in 2002 reported that of the people surveyed, between 20-25% of individuals from the Pakistani, Indian and Chinese communities had experienced drug use with the majority consuming cannabis (21-23%). A 3-6% use of Crack/Cocaine was also reported (NHS Greater Glasgow, 2002). This study also indicated that the majority of the communities either ignore or hide the problem of drug use. This suggests that drug use is inherent in the BME community but there is a reluctance to involve or contact services when addiction difficulties are experienced. Pearson and Patel (1998) found that despite a big increase in Asian heroin users in Bradford in the1990s, they were under-represented among drug service clientele.

Of the 227 statutory and voluntary services registered as Drug and Alcohol service providers in Scotland only one indicated that they specialised in supporting people from BME communities[5]. In its 2008 policy *The Road to Recovery: A new approach to tackling Scotland's drug problem* the Scottish

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[2] Census 2001
[3] Ibid.
[4] ISD Scotland 2007/2008
[5] Scottish Drugs Services Directory

Government acknowledged that this was inadequate. The Scottish Government also recognised the need to make services more acceptable and accessible to use by BME communities; for more effective ethnic monitoring of the uptake of services; for better publicity of services; and for more support for those from BME communities caring for drug users.

South Community Addictions Team (CAT) provide addiction services under the joint auspices of Glasgow Addiction Services (GAS), Glasgow City Council and South East Community Health Care Partnership (CHCP) NHS services. The service operates in an area where the density of the BME population is relatively the highest in Scotland (Glasgow City Council, 2007). It was reported that approximately 690 asylum seekers live in the area and the proportion of the population from minority ethnic communities (11%) is more than five times the Scottish average (Glasgow Centre for Population Health, 2008).

In collaboration with community organisations, South CAT implemented a number of schemes to raise awareness and promote availability and access to their services in line with national targets and government strategies. However, the uptake of these services by BME communities was significantly low. A small BME specialist team consisting of BME staff offering specialist services was created in 1990s to promote engagement and access to South CAT services by the BME community. However, at the start of this project (2010) there were only 79 registered service users of BME background at South CAT.

The reasons for not using services and means of increasing engagement have been extensively researched (Reid *et al.*, 2001; Bashford *et al.* 2003). In order to accurately advise and support service users from diverse backgrounds, it is essential to consider the cultural meaning of somatic symptoms, and explore the social context of distress.

There is therefore a need to evaluate the processes in place to encourage members of BME communities affected by drug addiction in accessing necessary services, and investigate the barriers preventing their use. It is also very important to investigate how current BME service users have managed to overcome any barriers to access, and to maintain the use of services. In this project a qualitative inquiry of service users, who had been using the services offered by South CAT for at least 3 months, and their families and friends was conducted. The project also studied the perspectives of service providers working at South CAT regarding the barriers faced by BME community members with respect to addressing their addiction problem, and the means of overcoming them. The aim of the project was to evaluate how BME drug users and their families can be encouraged to access and gain support by

mainstream services. A DVD resource was also produced as part of the project with the aim of supporting awareness raising and staff development.

The project objectives were to:

- Explore the barriers to accessing mainstream services and how current service users have managed to overcome them.
- Attempt to learn how to remove any existing barriers
- Identify what has worked and has not with current services and ways to improve them.
- Investigate the role of families/ friends in the road to recovery from problematic drug use.
- Prepare an informative DVD resource that can be used for educational as well as awareness raising purposes.

It is expected that the findings of this project will help to inform the development of a service that is culturally competent and which encourages BME service users to seek help with their addiction.

Methods

Mixed qualitative research methods were employed to collect information from both service users and their friends and families as well as service providers at South Community Addictions Team.

Design

A project advisory committee was organised at the start of the project through which the project was steered. The committee consisted of members from South CAT and Glasgow Addiction Services and GARA researcher and Project Manager. This study utilised qualitative inquiry to evaluate the access to services offered by the South CAT team to BME drug addicts in Glasgow. A mixture of qualitative research methods including in depth one-to-one interviews and focus groups were used in this study.

Recording

Interviews were recorded audio visually (where consented) to produce a DVD resource. Focus groups were recorded using a digital audio recorder.

Ethics

Ethical Approval was obtained for this project by CRER from NHS Greater Glasgow and Clyde Ethics Committee.

Recruitment

All Participants (Service Users and Service Providers) were recruited by South CAT.

Service Users and Friends and Families

All BME service users registered with South CAT who had been using the service for at least 3 months were invited to take part in the project.

Participants included BME services users who:

- Were from black and minority ethnic communities
- Were drug (and alcohol) users
- Had at least 3 months experience and knowledge of the services offered by South CAT
- Were willing to be interviewed
- Were willing to involve their family and friends in the study
- Were not suffering from severe mental health problems
- Had consented to take part in the study

Family and friends were recruited through the participants themselves. Participants were provided with information on the project and given the opportunity to discuss participation with project coordinators.

Service Providers

All service providers who had experience of working with BME clients were invited to take part in the focus groups by South CAT. Participants volunteered to take part through their managers and they were authorized to attend the discussions. Participants were then given the option to contribute to the focus groups relevant to their specialty of service provision.

In Parallel, senior management staff and front line staff directly involved in the provision of care to BME service users were selectively recruited by South CAT for the one-one interviews to represent the variety of services provided by South CAT. These interviews were recorded for the preparation of a DVD resource.

Consent

Informed consent was obtained by service users as well as their friends and family members to take part in the study as well as in the DVD production. Participants were given information sheets about the project and given the opportunity to discuss participation with the project workers as well as their South CAT care provider. Unwillingness to participate was recorded but not pursued. Participants had the option to contribute to the interviews with or without taking part in the video recording. Copies of Consent forms are included in Appendix 2

One-One Interviews

BME service users as well as their friends and families were interviewed using in depth one-one interviews.

One-one interviews were also carried out with senior staff and front line staff directly involved in the provision of care to BME service users.

A semi structured questionnaire consisting of open ended questions was prepared and piloted 'in house' with the staff and non-participating South CAT staff.

Interviews were conducted by a team of researchers who had been trained for the project. All interviews were recorded audio-visually for the preparation of a DVD as well as for data analysis. Interviews lasted 55 minutes on average.

Focus Groups

Members of the South CAT team from both the generic team and the BME specific team who offer services to BME clients were invited to take part in focus groups.

Focus groups were mediated by a project researcher. A Focus group guide was prepared by the research team and piloted with CRER staff members and South CAT team members who did not take part in the interviews. Focus groups lasted between 45 minutes and 1 hour.

The focus groups were organized by teams representing the BME team, generic team, Primary care, Secondary care and Managers team. Data was audio recorded for analysis.

All Focus Group Guides and Interview Questionnaires are attached in Appendix 2.

Analysis

All interviews and focus group discussions were transcribed. Thematic analysis using qualitative content analysis was conducted. Transcripts were manually coded and analysed. Data was also input and coded separately using qualitative data analysis software NVivo 9. Coded data was analysed to identify emerging themes and commonalities. Data of importance but not commonly reported was also examined.

DVD Production

A DVD resource was produced using themes identified through data analysis. A DVD production company (Urbancroft Ltd, Glasgow) was contracted to record and produce the associated project DVD resource.

A SERVICE USER'S PERSPECTIVE

Participant Service Users' Profiles

All 79 service users of BME background registered with South CAT were contacted by the project working group to inform them about the project and seek participation. Participation rate was very low (15/79). Addicts were at various stages of their addictional rehabilitation trajectory and many did not want to be identified. After being fully informed about the project only 9 service users agreed to take part in the project. Six consented to be identified whilst 3 participants preferred to remain anonymous.

Participants were aged between 28 and 45. Eight of the nine participants were male. With the exception of one participant originating from Iran, all participants were of Pakistani origin and all communicated in English. One of the participants was a refugee while the remaining 8 were British-Born.

Five of the 9 participants were married. One participant was divorced, another separated and two were single. Five of the 9 participants indicated that they had parental responsibilities. The majority (7/9) of the participants came from an extended family network.

Only one of the participants was a house owner. One of the participants was homeless and five were housing association tenants. One of the participants lived with their parents. Three of the participants were in employment: two were self-employed and one was employed in a small private business owned by a friend.

Table 1: Participants Profile - Service Users

	SU1	SU2	SU3	SU4	SU5	SU6	SU7
Gender	Male	Male	Male	Male	Male	Female	Male
Age	35	28	42	45	33	35	40
Relationship Status	Single	Single	Separated	Divorced	Married	Married	Married
Children	No	No	Yes	No	Yes	Yes	Yes
Ethnicity	Iranian	Pakistani	Pakistani	Pakistani	Pakistani	Pakistani	Pakistani

Experiences of Drug Use

66% of the participants indicated that they were introduced to drugs in their teenage years, whilst 33% had started using drugs in their mid-twenties.

At least 5 of the participants indicated that their path to drug addiction began by smoking cigarettes which led onto taking Cannabis also known as Hash (Hashish). All participants progressed to using heroin and two participants also used crack cocaine. Although the main mode of consumption was through inhalation, one participant reported injecting on one occasion.

Causes of Problematic Drug Use

Although the majority of the participants in the study indicated that they were exposed to drugs as a result of 'bad company' and peer pressure, the reasons for their continuous drug use were closely associated with mental health and wellbeing problems.

Peer Pressure

Seven of the nine people interviewed indicated that they were exposed to drugs due to 'bad company'. Some participants commenced drug use due to it being considered 'cool'. Others were influenced through their friends and family members.

"....the first time I ever started using drugs was when I was with and ex, and he started using it, his cousin introduced it to me, and it's just like one person that introduced it to all of us and that's how I initially started.." (SU 6)

"And at first I'd cough, you know, because I would have to inhale, but I liked it because I thought it was cool at the time, because it's smoking Hash, it's Marijuana, it's Ganja. Tupac, you know all that team, they were all about rapping and it was like a trend. Everyone at that time, you've got a joint in your hand, you're the man, you know? So from there on I went on to Cocaine and Ecstasy." (SU 2)

Boredom

Having nothing to do coupled with influence and easy access to drugs can also lead to addiction. Although poverty was not analysed in the study, the majority of the participants in this study were unemployed and lacked a social support network. One of the participants indicated that although they had

used drugs recreationally and were involved in 'dealing' drugs, they did not become addicted until they faced boredom and loneliness in the prison system; ready availability of drugs facilitated their addiction. Another participant experienced loneliness and isolation as an asylum seeker in Scotland. Being single and unemployed with no support network and ready access to drugs led them to engage in drug use which in turn led to addiction.

"....I don't have any hope here, I don't know what to see about tomorrow, I'm hopeless to be honest because I don't have anybody. See when I go home I just watching the wall, glass, TV, get fed-up, but if my family was here, I had somebody to talk to, you know what I mean, I had a hope I would much, much be better than now." (SU 1)

Homelessness

Most participants had experienced homelessness in their lives. This was mainly a result of exclusion from families and relationships. This contributed to substantial stress for a number of the participants but also led some to being further exposed to drugs and addiction. In this study 7 of the 9 participants faced hardships regarding housing issues and 86% managed to secure accommodation in housing associations. One of the participants described how life as a homeless person influenced their addiction.

"I was supported for two years and after that I became homeless, and then I had to live with the people who use drugs and this stuff. Because I had no home and no place to go, I had to live with them, and slowly, slowly I became involved with that, and then I started to use it for about six years now." (SU 1)

Mental Health and Wellbeing

A number of factors can affect the mental health of young adults which can in turn lead to addiction. Although the problems identified by the participants in this study appeared to be universal and shared with the non-BME population, differences due to race, cultural and religious practices added an extra dimension to the problems faced by the study participants and influenced their help seeking strategies. Some of the problems identified by participants that affected their mental well-being included the breakdown of social support mechanisms and problems with immigration issues.

Break down of support mechanisms

Break down of support networks can lead people to experiences of isolation and vulnerability. For those who had already experienced the escapism substance use can offer, substances can, not only act as a source of comfort and mental support, but also lead to a new relationship and support network, substituting the lost one.

Family Issues

All the BME community members taking part in this study have indicated that they have had an extensive family support network. In some cases these networks were no longer available due to family issues or migration.

The majority of participants were first generation married Pakistani Muslim individuals. Most of them described experiencing a culture and identity clash similar to that experienced by first generation migrants. They felt that on the one hand cultures and traditions of one's ethnic background needed to be preserved but on the other, one is growing up in a very different culture which one wants to embrace and engage with. Pre-marital relationships or inter-race relationships, for example, caused considerable tensions in the family. Participants reported that issues such as medical problems, in particular mental ill health and disabilities, were also not openly discussed.

Participants indicated that as the Pakistani Muslim community in Scotland is a relatively small community, many inter/intra-family marriages lead to larger family networks being formed locally. Almost 50% of our participants had married their first or second cousins.

Thus extended families can become a community or vice-versa. Family (and friends) networks played a significant role in supporting participants and their families particularly with respect to migration, business development, employment and housing support for example. These further strengthened the links built between families.

It was felt that it was trickier to break out of difficult relationships. The fear of being judged and criticised and thus excluded from such a small community network has led a number of participant's families to dismiss or hide family issues. This only exacerbated the family's stressful experience but also prevented the potentially useful contribution that families can make to the recovery of the drug user. In some cases, hiding issues contributed to further escalation of issues into serious dilemmas leading to breakdown of family ties and family support, thus increasing vulnerability to drugs.

Two of the participants mentioned the trauma they suffered as a result of family breakdown due to death and splitting of the family unit precipitating the path to addiction.

"I lost my mother, I lost ... my elder sister got married, my father got married again, my brother went to prison, so a lot of very influential people, or people that I care about, they ended up leaving for reasons that I couldn't understand at the time; I was only thirteen or fourteen years of age. It all happened within a period of six months to a year." (SU 7)

"Then my girlfriend got pregnant and it was the same year as my mother died, so I kind of swithered to a bit of depression and I kind of started smoking a little hash, cannabis, and started drinking quite a bit at night just to help me cope with it. And then I found that my life got quite unmanageable, up till then, my work situation, I had some kind of lifestyle and I kind of found it difficult to hold a job down because I was smoking cannabis all day long and was drinking alcohol just about Thursday, Friday, Saturday and Sunday". (SU 3)

The problem of forced marriages is well known in South Asian communities. Two of the participants suffered broken marriages as a result of dissolved forced marriages. One of the participants indicated that their parents thought that the solution to their addiction was marriage and they were forced into marrying someone from Pakistan. But as soon as their spouse became aware of their addiction, the marriage was terminated. Another participant was forced into an arranged marriage after their parents were dissatisfied with their involvement in an interracial / intercultural relationship, but this marriage was also subsequently dissolved. These dimensions added additional pressures on individuals.

"I didn't start using drugs until an age of maybe twenty-six when I was experiencing difficulties at home... I kind of was quite different from my brothers, I'm the youngest of eight, so I got into a lot of trouble due to friends, company I kept, and I also had a girlfriend outside family, and being in a strict Islamic family it kind of caused a lot of aggravation at home.

"Then I thought the answer was in that I should maybe leave my girlfriend and I left her, and then I got married, and my marriage just didn't work out.

"And a lot of my thinking around my wife can be kind of distorted because I am quite angry and probably resentful of a lot of past experience through family and other peoples' agendas when I got married, hidden agendas which I didn't know about." (SU 3)

Rejection from Community and Faith Groups

In our study 50% of the participants who admitted to taking drugs said that they felt ashamed, shunned and isolated by members of their families and communities. Even if an individual underwent rehabilitation, community members still tended to misjudge the person. Participants indicated that if a person was engaged in drug use, they were often labelled as being 'pagal' or mad and linked with crimes such as theft, drug dealing and prostitution.

"I'm actually quite embarrassed that I keep it to myself really. To be honest I avoid family, only because I still carry a lot of shame that I took drugs. If there's any family gatherings and stuff I try to avoid them, sometimes they can't be." (SU 3)

" I felt I was ... a reject, an outcast." (SU2)

The 'culturalisation' of religion is a prominent feature discussed by the participants in this study. All participants were of Muslim background. According to Islam, one should not harm oneself, one's family or one's community. Thus substance use is prohibited in Islam and therefore drugs are considered bad or 'haram' and unlawful in the Muslim culture.

Although faith can be a tremendous source of support for some, participants reported that they were disappointed in the lack of support they received from their religious peers regarding their addiction. One of the participants said their faith helped them to understand that they needed to change but they admitted that their drug use was never discussed with the religious leaders. Two of the participants indicated that they were rejected, isolated and outcast when attending their local Mosque for Friday prayers. Almost all participants have expressed feelings of shame and guilt, and discomfort at being rejected by members of their faith communities.

"I always look at my drug addiction as a kind of a failure in culture, religion or a moral dilemma, there's something wrong with me, you know, I was bad. A person's a bad Muslim, or he hasn't followed his religion or faith and stuff... Personally I would think it's kind of isolated me a bit. I like going to the Mosque on Fridays you know for Friday prayer, and I don't know whether this is a stigma or it's probably something within myself you know, I feel a bit isolated you know more than anything else." (SU 3)

"I went a couple of times but it was like, he takes kit and he's at the Mosque so don't go back." (SU 4)

"I think a lot of people, like if they find out it's a Muslim girl they look at her and think, God, how did she get into it? But I can't say for other religions, but I

can say for mine. Yeah, that they do, they shun you; it's just shunned upon." (SU 6)

Immigration Issues

Immigration issues have been experienced in some way by the majority of the participants in the study. One of the participants was a refugee and 5 of the 9 participants were married to people born outside the UK. The immigration process can be very lengthy and stressful. Issues around isolation and re-adaptation faced by partners, uncertainty about immigration status particularly of spouses, the threat of deportation of spouses, inability to work and contribute to a 'normal' life as an asylum seeker, as well as separation from support mechanisms have been reported as major causes of psychosocial stress and mental health problems which can lead to drug use as a coping strategy.

One of the participants described the refugee and asylum seeking process as debilitating to people who are already vulnerable as a result of violation of human rights issues. They spoke about the trauma they faced before seeking asylum in the UK and the further difficulties they experienced in seeking asylum. This affected their mental health which was made worse by the paucity of support in a foreign country.

"I'm going to bed I'm always thinking what's going to happen tomorrow, what's the Home Office going to do to me, it's going to deport me, it's going to not deport me, but no, now I'm just relaxed I know what tomorrow is saying. Before I had a big problem as when I was homeless, I was homeless four years in this country, longer than four years, not supporting, not allowed to work, everywhere I go I was looking for a job – have you got permission? No support, I couldn't even work, I had a big problem, that's why I'm involved with and my sickness started from those days, and I don't know who make a decision for people like me or, that's very hard, you know. They don't give you a house, they don't give you benefit, they don't give you even permission to work, you know. At least if they don't give you houses, they don't give you benefit, at least they give you permission to work, to work for a couple of days and stay on your legs, but I had nothing, that's why I became sick and I start to do these things in this country, that was the reason." (SU 1)

Attitudes to Drug Use in the Community

A number of stigmas are attached to drug addiction particularly within South Asian communities.

Sin

Drug use is considered a shameful act in many families; it is religiously banned for Muslims. The majority of participants explained that drug and alcohol addiction was regarded as a sin and a moral failure, and not a condition in which individuals could suffer physical effects. This was particularly apparent in this study as all participants were affiliated with the Muslim faith. People were therefore reluctant to admit they had a problem with addiction or seek help from their family, friends, and community or faith groups.

"Once again I think they just look at it as more like a moral failure of somebody you know, rather than what I found that really helped me is looking at addiction as more of an illness, disease." (SU 3)

Embarrassment, Shame

All participants in this research study described themselves as feeling embarrassed to admit to anyone within their family or community that they were using drugs.

The fear of being judged and always classified as an addict was considered equivalent to being put on a criminal register. Once an addict, always an addict.

"If you're a drug user you'll always be classed as a drug user no matter how clean you are and how you've come and you've progressed in your life, they'll always still class you as a drug user." (SU 6)

In some South Asian families, certain topics could not be mentioned in front elders partly due to stigmatisation, but also significantly out of respect for elders. Elders play an important role in the BME family structure and traditionally elders have been respected and their opinions consulted before making major decisions in the household. Topics considered taboo were not brought up in case of offending the sentiments of elders.

"We were born and bred in this country, you know we understand a different way of, but because we've grown up with certain stigmas, it's still going to be whether we would like to admit it, but we will be okay talking amongst ourselves in our own community, but the minute we're in front of elders, the

minute I'm in front of elders and you're in front of elders, we would have a different persona, it's the way it is. And you know it's hard to break certain taboos, do you understand? Certain taboos need to be broken; certain ones don't, you know because they don't count. But this is definitely needs to be." (SU 7)

Failures of the Family

Drug use was viewed as a failure in upbringing and a moral weakness rather than as a condition that required help and treatment. Parents were often blamed for their children's addiction which has wider effects on the family and communities often associated one person's addiction to other siblings being addicted too. Arranged marriages are very common in South Asian families. It was reported that in some cases, addiction problems in a member of the family could affect marriage prospects of other family members.

"I think that from what I've experienced they treat is more as kind of a, like a failing in your upbringing, or your lifestyle or something rather than looking at it in general like maybe somebody who's suffering from an addiction, an illness or something." (SU 3)

Knowledge and Awareness of Drugs in Families

Knowledge and awareness of drugs and addiction was very poor in the South Asian community. This was reported by the majority of participants. Many reported that their families would not know the difference between a Marijuana plant and a normal plant. Some even reported that distinct smell of some drugs was completely unknown to some parents, and that many young people were getting away with using drugs for long periods of time before their addiction was discovered.

Some of the barriers to education regarding this issue are denial and blame by association.

Denial

Drug use and addiction were not topics readily discussed in South Asian families, particularly in Muslim families. The reluctance to seek information or discuss the matter with the family was highlighted by every participant. It was reported that most South Asian families lived in denial: no discussion meant the problem did not exist.

"That is the difference right in the culture, it's hidden under the carpet and because of that there's a lack of education and a lack of understanding especially amongst you know the elders, especially in my parents. I mean my dad; I was smoking hashish for ten years before my dad even understood what hashish was." (SU 7)

Blame by Association

Although denial and other cultural barriers including stigma and shame prevented people from seeking information, these were not the sole reasons for low interest in educational initiatives in the community. Seeking education on the topic was sometimes perceived as one having an association with addiction, rather than wishing to be aware and prepared to recognise any signs. This has been reported as one of the main reason why families were reluctant to become informed about addiction.

"They don't do to listen to the talks...They don't want anybody to think that their son or their daughter may be using drugs. Because it is a shameful thing..." (SU 6)

Coping mechanisms

Swept under the Carpet

The way to deal with addiction has often been to hide the issue from community members but also from close family and friends in some cases. Almost all participants described the community's attitudes towards drug use as 'sweeping the issues under the carpet'.

"... the way I see it is I think it's all hidden, it's all hidden indoors, it's all brushed underneath the carpet, but I think it should be a bit more open." (SU 6)

"It's just brushed under the carpet, you know, this doesn't exist, you know. It's like a scratch isn't it, you know you cut yourself and you wrap it up know, it's going to bleed, you know it's going to bleed, it's going to fester isn't it, you know you cover something up, if it needs addressing, it needs addressing and the Asian community it just does not want to address." (SU 7)

Marriage

Marriage has often been considered as the answer to every prayer by South Asian parents. Some participants were convinced by friends and families that getting married would help provide a sense of responsibility and maturity which would help divert them from addiction. Some were forced into marriage with detrimental consequences.

Extraction to Overseas

Some participants indicated that once drug use was discovered, some families could resort to sending the user abroad to withdraw abruptly (go 'cold turkey'), rather than deal with it within existing health services in the UK. This was partly due to a lack of about services, but also because environmental influences were believed to predispose individuals to addiction and a change of environment would lead to a change in the person's behaviour. However, this was mostly done to minimise 'spreading of the word' and being stigmatised and judged by the family's local community in the UK.

"... it is put down among the Asian community and they don't want anybody to know. They'd rather that nobody knew about it. If they had the choice they would put them on a flight, take them to Pakistan, sort them out there then bring them back here... Meaning like obviously get them cold turkey there or you know get them the help there. I think a lot of parents would rather get the help elsewhere than here in the UK. But they don't realise that the UK and the services UK offer and the facilities that they've got are the best." (SU 6)

Faith

Although in some cases participants have described being excluded from their faith groups, they pursued their religion and found that their belief/faith was a substantial support for them in their recovery.

"Religion is the one thing I turn to, right, that's helped me a lot. My religion has helped me immensely, right, because if I didn't have a strong belief in Allah I don't think I'd be alive now. You know it was the very first time I went to prison that I got reintroduced to my religion, and that was my slow path to recovery. If I look back and think back to a time when I thought... it was actually the one thing that, the one time I can actually pinpoint is a time when an Imam came into my prison cell, and you know gave me a little speech and talked to me about religion, not about drugs, but about Islam. And you know it

made me travel a path to travel my own spiritual path, which I have; I think I've grown immensely because of it. I think I'm so much of a stronger person today, and if I manage to terminate or overcome this, I think religion is the one thing that will be the most all-encompassing power within me that will overcome this, because it just has." (SU 7)

"... I remember Allah every day of the day... you know? No just five times, I remember God every day, you know? And any time when I feel I'm in fear, you know I remember God, you know? And that's it basically." (SU 2)

"My faith has become far more stronger, and if it wasn't for my faith, I don't think I would have come half the way. And I am a strong believer, and I believe that there is God up there watching on us, and he shows you the right path and the wrong path, and sometimes you do falter to the wrong path, but you can come back to the right path as well. You just need to have a bit of faith in you, that's the way I see it. If you've got faith you can conquer anything." (SU 6)

Family Support

Although some family relationships can cause negative influences for the majority of participants, the family played a crucial role in supporting recovery. This is discussed in more detail in the next section.

Accessing South CAT services

Referrals

Although two of the participants were referred to the service by GPs or other clinicians, the majority of participants self-referred to the service after hearing about it from friends and family or through community organisations. However, generally users did not know that there was a service to which they could self-refer. Most responses seem to suggest that the service is discovered by almost by chance. The majority of participants reported that they had no idea about how to seek help.

"The first time at that time I didn't know about Twomax and the drug addiction services, it was my GP that prescribed it to me. And then I came off that and the second time when I relapsed I went to the GP and he said – we don't give out methadone you have to go to the addiction services – and that's when I

got in contact with the addiction services myself. I didn't realise it was self-referral; I thought you had to go through the GP." (SU 6)

"I was in Doctor C's clinic in P Road, and from there, I moved from MFI, from that clinic to here, to Twomax, and it's okay here, you know." (SU 5)

"Through a friend, someone told me. I can't remember who it was." (SU 8)

"I think it was my wife that got introduced to a girl called N, who was prominent. I have to give credit to N." (SU 7)

"I had a friend who... So he found out that the Twomax building, first it was prescription, getting Methadone from them and he told me to go there." (SU 1)

Perceptions of Service Provided

Participants were asked about their first impressions about the services offered at South CAT. The feelings they identified were consistent with the stigmas attached to drug addiction.

Fear of Being Recognised

Five of the participants indicated that the location and purpose of the building was an issue for them. Accessing the building was not a problem but some described the service as being located too close to their community within a building well known as being a social work and addictions facility.

Service users were concerned that community members would easily identify them and associate their presence in the building immediately with having social work or addiction issues. This was considered particularly uncomfortable for family members and service users who felt at risk of being stigmatised by association.

"Everyone knows this place, and when they see you coming in they think... I wonder why she/he is going in there... There must be something wrong with her/him" (SU 1)

"The environment's wrong. Right, because see even if the Asian community was aware of that Twomax..." (SU7),

Intimidating Environment

Participants also considered the environment as being very intimidating, particularly for female members of the community. Participants reported feeling alienated and vulnerable when attending a service attended mostly by white males. They felt out of place particularly due to their race and also due to their gender. They felt that the services were not for them.

"...I can see a lot of Asian women going there once, and never going there again. It doesn't cater for our people, it just doesn't. My wife is a pretty thick-skinned woman, right, but I'm reluctant to see her going to that building with me. Right the people there, they're intimidating, right, they're intimidating for most people. I hate to think what they would be like for Asian women, Asian guys, fathers right, who have stayed in an Asian community." (SU 7)

"I was scared, I was really scared, nervous walking in, because when I walked in all I seen was... it was all males, you know. And it was White males... especially me being an Asian female, I think it made me feel, I felt vulnerable when I was walking in." (SU 6)

Lacking Understanding

Some participants initially perceived the service as being unsuitable for them as there were no visible BME staff or clients that they could associate with at their first attendance. They felt that the professionals would not understand their needs and the issues they faced particularly with respect to their culture, community and religion. One participant in particular explained that they experienced the service to be unhelpful when they first approached it for help because the service was about to close and they had not been signposted to alternative help. They perceived the service as unapproachable and insensitive to the barriers they had to overcome in approaching the service particularly being a female Asian from the close-knit community. They were reluctant to return.

"I spoke to a day worker, and I explained my situation to her and told her. And I still remember it was the Christmas period and they were going to close up for Christmas and she says that – we can't really help you or do anything, because we're closing up and we can't give methadone over the Christmas period in case you overdose. And I said to her – so what you're trying to say to me is that I should take drugs up until after Christmas and come and see somebody then – and after that I just left. (SU 6)

BME vs Generic Service Use

Although all participants were offered both generic and BME specific services, only three had initially accessed the generic team but joined the BME specific team within a short time frame. The remainder had joined the BME services directly. Therefore the majority of the participants had little experience with the generic services. None of the participants had negative comments about the generic services, but all participants were very pleased with the services they received from the BME specific team.

"When I found out that there was a choice between going there, yeah, most definitely, I wanted, because I felt a lot more comfortable dealing with a guy who came from the same background as me." (SU 7)

"I feel that the BME team have supported me a lot, and the advice, they're there on hand if I need any advice or I need any help they're there for me. (SU 6)

"No, I never asked (to meet with the generic team), I just was, you know happy with the BME team." (SU 3)

Advantages of the BME specific team

Trust and Confidentiality

Trust was identified as a major predictor for using services. Participants indicated that they were interested in speaking to the BME team because they felt the BME team members were from similar backgrounds to them so could understand their issues better. But they were also worried that details of their history would be shared in the BME community if they spoke to the BME team. Therefore, confidentiality was a major concern and they needed to feel confident that any information they provided would not be going back to their families or communities.

Following reassurance about their professional duty to promote confidentiality, participants felt comfortable to speak to the BME team members. The majority indicated that they maintained engagement mainly because of the support they have received as a result of the trust they have been able to develop with their caseworker.

"....I cannot explain ...but someone from your own community ...it's the trust in it, that you can tell all your thoughts to someone and not get judged and the information will not get back to anyone" (SU 8)

"I was scared... but when I was introduced to U and Z the BME addiction workers, I felt more comfortable. And they made me feel comfortable, they made me feel relaxed, so I wasn't as nervous as what I was." (SU 6)

"They understand my problems and I am very comfortable with them... I am comfortable with Z, I'm comfortable with P as well. I trust them... They have been so helpful to me." (SU 2)

Language

Although all participants were proficient in English and most identified it as their first language, the BME service also appealed to them because of its bilingual case workers. BME families have a very strong influence on the lives of BME individuals and like to be closely involved in their treatment. Many of the service users' close relatives seek reassurance about the rehabilitation process of their loved ones. A BME case worker was considered a major benefit for some the service users, particularly when their family wanted to be actively involved in their treatment. Participants found that having to wait for translators or interpreters was problematic as sometimes they would have to wait for a much longer time to get an appointment and they noticed that sometimes what the interpreters were saying to the family members did not paint an accurate picture of the issues discussed. In some cases despite being proficient in English, some participants indicated having communication problems with the generic team members; they had to make a lot of effort to explain to a white worker something that they would explain to a BME worker in a few minutes.

"The only thing with Z was sometimes my dad used to come with me and my dad could speak Urdu, Punjabi with him, but one thing about South West, they don't have that, it would be helpful if they had one /two Asian people there you know that can speak another language apart from English. It would help, because one day my mum wanted to come, just to see, how am I doing, am I telling the truth, or am I just telling her a load of bull. So I was talking to Lauren, that's my counsellor advisor, and I could see by my mum's expression that she couldn't fully understand her, and there's no one there to translate to her, so obviously she has to take my word against...." (SU 5)

Cultural understanding

Over 75% of participants explained that they preferred the BME service because they felt better understood by the case workers. One of the participants reported that the BME team case workers were easier to relate to because they came from similar cultural backgrounds to them. Other participants explained that the complexities of their personal lives were better understood by the BME team. The complexities of extended families, religious obligations, obligations towards elders, difficulty in making key personal decisions in certain circumstances, significant influences of family, community and religious networks and the fact that everyone knows each other in such a small community were some of the issues raised by participants.

"I was going to the mainstream... some kind of communication problem you have... like I speak perfect English... but with a white worker you just... nothing like personal, I'm just saying the way it is... with someone like Z it's like talking to a friend... like coming from the community... like you understand more kind of thing... I thought I was going to the BME team then go back to the generic team... but I liked it... so I stuck to it..." (SU 3)

"When I found out that I had a choice between the teams you know... yes, definitely, I chose to go with the BME team... with a guy who came from the same background as me... could at least understand that you know... that... I have different issues in how to deal with this thing, than perhaps most Scottish or English do, we definitely do." (SU 7)

Religious Understanding

Over 50% of the participants who used the BME specific service felt that they were better able to relate to a worker who could understand their religious background and were able to support them and their families through the feelings of guilt, blame and sin. This was considered important for service users to continue using the service. The case workers could support them to 'medicalise' their conditions and manage their treatment whist at the same time understanding the important psychosocial aspects of the conditions inducing their (and their families') spiritual and religious concerns.

"I find Z a big benefit, you know what I mean. I find him a major benefit in that area, because I believe he can relate to me and I can relate to him, and he has a co-worker who is a female and can relate to my family." (SU 3)

Home Support

The majority of the participants favoured home visits. Female South Asians as well as parents of service users particularly appreciated the flexibility and discreteness of the service to visit them at home or away from the building where they felt uncomfortable.

"You know I'd rather have the service come to my home because of me being an Asian female and because of people coming into the service. Because I did see a couple of Asian males there as well and I was quite scared going back in again and I did explain my fears to my addiction workers and they understood, and they sympathised with me, and said to me that they can offer the service at home, and I was quite happy at that. You know having the service in my home, rather than me going out my home." (SU 6)

Awareness Raising Needs

Education

Above 70% of the service users believed their community needed to be educated about drugs through awareness raising. Service users also believed that working in collaboration with local community groups was essential to raise awareness.

"...educating them about it, you know? If you educate someone, if you tell them, they know where to come, if you don't tell them, they don't know where to come. If they see something for example, you know, then like some brochures or something like that, you know..." (SU8)

"Sometimes the mum and dad don't know these things in the home for Asian families, you know. It's a big problem, some Asians, their mum and dad don't even know that they take drugs, and later on after two or three years they find out, and then it's a big shock, and they've taken so much drugs and that's something that they've been abusing themselves with drugs, and it turns out that they're already been so mentally messed up, you know, and they've, and then their parents would say to them to get help, you know." (SU5)

Community Leaders

There were views expressed by some of the participants that prominent members of the community should raise awareness of drug addiction especially amongst the young.

"I think like if there's standing members in the community, I think they should be more aware as well, they should know that there is this service and then people can go and get help. They should be told about the service, like I think when you get these speeches and stuff, like one of the BME counsellors I think should attend it, and say to them – look if there is anybody on drugs that needs help, or anybody that needs advice you know we are here. I think they should advertise it a wee bit more." (SU 6)

Women

A number of the participants identified women as a vital aspect in raising awareness. Men have traditionally had working long hours whilst many women were housewives, and perhaps were in a better position to be active in the community.

"The best way, right, to get into any Asian community whether we like to believe it or not is, you know and this is the hard bit, we need to get Asian women involved in this. Right, and see for that, you need to have seminars, and you need to have activities or certain groups where Asian women can frequent, where it becomes, where they make it an issue, you know where they come and they get... And so far there is no infrastructure for that, you know... it's the women that are the ones that teach their kids, the men are always working, the Asian community has got a very strong working ethic... It's the women, if you could get a group or a community where you could get the women to come out, you know, and then to talk to them, you know, that's one way." (SU 7)

Young people

Some of the participants identified the need to engage and educate young people in BME communities. Better ways need to be found of engaging with young people. It was believed that drugs education in schools was not effective and possibly not geared towards the BME community.

"The people that have experienced the drugs, they get off drugs basically and the advice that would be given elsewhere, they would learn from others, you know, that people went through this kind of lifestyle with the drugs and have died over drugs for example, you know? People have taken ecstasy and died in clubs, people that have taken heroin, people that are smoking hash, people have done so much, you know, it's very dangerous, it is so, it's effective in every way, you know? (SU5)

Blame

There was a general feeling that more could be done for BME drug users by the government and public sector.

"It's not just the community I blame, right. I think the authorities should get the blame, because the authorities know that this problem exists. They've got all the statistics, they've got all their data, right, so why is there not enough funding provided so that this can be addressed? You know there is definitely no knowledge, you know I say it the public, but that doesn't mean that there is no individuals in the public like myself, like you, right, that can actually take it to the authorities, right, that can do something about this. Yet, nothing has." (SU 7)

A SERVICE PROVIDER'S PERSPECTIVE

In total 25 service providers were interviewed by focus (discussion) group or one to one interviews. Tables 3 and 4 describe the service providers attending the focus groups and 1-1 interviews respectively. 10 service providers were interviewed individually and 5 discussion groups were conducted with members of the various teams delivering the services at South CAT including the BME Team, generic team, primary care team, secondary care team and Management.

The aim of one to one interviews was to gather information about the services delivered by South CAT to the BME community as well as understanding the perspectives of the service providers on issues related to the BME community they serve. The information gathered by this process was used to develop an awareness raising DVD.

Focus groups were conducted to gather information about the knowledge service providers had of BME service users and their perspectives, as well as to identify areas of successful work conducted with BME communities and areas needing improvement in the opinion of the service providers. The project objective initially was to recruit 6 to 8 people for 3 focus groups. Due to the nature of the teams and the work conducted by each team, it was agreed by the steering group that focus groups by teams would be easier to organise and would generate more discussion. Five mini focus groups were conducted with 4 to 6 participants as indicated.

All 3 BME specific addictions workers providing the BME specific services at South CAT (SP1, SP2 and SP3) and were interviewed through this process. Two

were of Scottish-Pakistani ethnicity and the third was a nurse of Scottish-mixed ethnicity. A senior medical officer (SP14) of South Asian origin was also attached to the team; he also offered services to the generic team.

Three addictions and mental health workers working in collaboration with South CAT but not employed by South CAT were also interviewed (SP4, SP5, SP24). They were all of South Asian origin.

The remaining participants offered generic services to all clients of South CAT. This included a psychiatrist (SP16) who was of South Asian origin.

Languages spoken by the members of the BME team included Urdu, Punjabi, and English.

Table 2: Composition of Focus Groups

Group 1: BME Team	**Group 2: Generic Team**	**Group 3: Primary Care**	**Group 4: Secondary Care**	**Group 5: Managers**
Senior Nurse - Mental Health Substance Misuse (SP1)	Senior Addiction Worker (SP6)	Senior Addiction Worker (SP12)	Clinical Psychologist (SP16)	Nurse Team Leader (SP20)
Addiction Social Care Worker (Adult) (SP2)	Senior Addiction Worker (SP7)	Senior Addiction Worker (SP13)	Psychiatrist (SP17)	Addiction Team Leader (SP21)
Addiction Social Care Worker (Child) (SP3)	Senior Addiction Worker (SP8)	Senior Nurse – Mental Health Substance Addiction (SP14)	Lead Nurse – Addictions (SP18)	Head of Addiction - South East (SP22)
Youth Worker (External) (SP4)	Addiction Social Care Worker (SP9)	Senior Medical Officer BME Team (Generic Team) (SP15)	Clinical Psychologist (SP19)	Programme Manager – Substitute Prescribing (SP23)
Drug and Mental Health Worker (External) (SP5)	Addiction Social Care Worker (SP10)			
	Addiction Social Care Worker (SP11)			

Table 3: Service providers interviewed using one to one interviews

BME Team	Generic Team	Generic/BME Team	Management
Nurse (SP1)	Senior Addiction Worker (SP6)	Psychiatrist (SP14)	Head of Addictions (SP21)
Addiction Social Care Worker (Adult) (SP2)	Senior Addiction Worker (SP23)	Psychiatrist (SP16)	
Addiction Social Care Worker (Child) (SP3)	Psychiatrist (SP25)		
Youth Worker (SP24)			

The BME Community and Problematic Drug Use

Service providers indicated that although they had clients from many subsections of the minority ethnic community, including Sikh, African, Caribbean and Polish communities, the majority of their BME clients were from the Pakistani community. Service providers also indicated that since the setup of the BME team, the number of BME people using South CAT services has steadily increased to approximately 20 new BME clients accessing the services each year. Participants also believed that dropout rates were steadily decreasing, but they believed that there were still many members of the BME community who did not use the services despite being referred.

Knowledge about the BME community

Some of the issues highlighted by the service providers were very similar to the ones raised by the service users.

- There was a lack of awareness about drugs, alcohol and addiction in the BME community
- The BME communities felt that in raising issues of addiction workers were maligning their community
- Respect by the community was considered very important
- Drugs and alcohol were not discussed openly by the community
- The issues were hidden
- Users were often reluctant to seek help within their local community

"They are very scared that their family will find out and very embarrassed at the thought that anybody in the community would even know that they had walked through the doors of the community addiction team." (SP23)

"...they are very close-knit communities, they don't want others to know about it. That is their biggest problem, and that's why they want to hide it as long as they can, and they live in denial." (SP16)

"It's more saving face. It's more the case of, if my child's doing drugs then the rest of the family will basically laugh at them, they'll bring them down. So it's not something which, and this is the reason why people do everything in closed doors." (SP25)

"I suppose there's a lot of shame if a family member has drug and alcohol problems, so it's maybe hidden within the community and maybe people are frightened to outreach and get your service, but even though they know the service is there. Just given the nature I suppose of ethnic background you know that's shameful for the family." (SP19)

The main reasons attributed to the issues raised were stigma and shame associated as being an addict or belonging to a family associated with addiction, and religious barriers.

Stigma

Stigma attached to drug use was a major contributing problem to the views of the community. Shame and stigma of addiction were important factors in preventing the BME community from seeking help. BME clients were often reluctant to seek help within their local community due to fear of having their family members also labelled as addicts or mental health patients as this could have serious impact this on their family's reputation. It was reported that in some cases such issues affected future prospects of family members including employment and marriage potentials. Affected BME individuals were also weary of the consequences of labelling, particularly for their parents and elders in the community being labelled as 'bad parents'. Service providers indicated that stereotypes needed challenging and the media was not helping to reduce stigma.

"...the stigma of drug and alcohol use is much more in these communities compared to others, in which this is more accepted."(SP16)

"We're still finding there is a big stigma attached to drug and alcohol use in the community. It's not widely accepted, it's still a taboo subject that is not discussed very openly and widely…"(SP3)

Religion/Faith

Participants indicated that the teachings and faiths of a community had a direct effect on how the community was affected, and posed significant challenges. Some service providers understood that in some faiths drug and alcohol use was completely prohibited and use was perceived as sin. However, they were also aware that in other cultures soft drugs were permitted. Religious and cultural issues were a major factor influencing any decision and service providers from the generic team admitted that they did not have the extent of knowledge and understanding to manage some of the issues that have been raised in the past.

"I think religion plays a part in that as well, and if you think of Muslims where they shouldn't be taking alcohol or using drugs or things like that, so I think they would be very isolated, very stigmatised because who could they then go to, who do they turn to, to share that information with?" (Sp8)

Additional Issues raised by Service Providers

Service providers identified issues that were not highlighted by service users or their family and friends.

Living in Denial

Service users described how families lived in denial by brushing the issue under the carpet which was also highlighted by service providers but the other aspect of denial identified by the latter were that some of the drug users themselves did not realise that they had an addiction as some of them, despite realising that they were doing something wrong and not wanting people to know about it, did not realise the severity their addiction. In many cases due to the religious ban were in denial about their problems. Service providers also reported that in general current trends suggest that drug users are injecting less and less and therefore the physical manifestations of the disease such as AIDS and septic infections were not being manifested compared to 20 years back. BME drug users specifically tended to buy 'clean' drugs and as they did not tend to inject, they considered themselves occasional users, not addicts.

"....because they look at drug injectors as junkies, and – I'll never be a junkie, but I only take drugs and I go to the dancing and I take whatever the drugs might be... They don't see themselves in that category, they see themselves as differently and they don't think it's a bad thing to take certain drugs. If you go to the dancing, you take a bit of coke, you take a bit of speed, you take some benzos to come down, you might take a wee bit of heroin, right, and that's the way they would look at it." (SP1)

"Because I'm working with young people so I'm seeing a lot of that is they don't see their problem as an addiction, you know it's just part of them growing up and smoking a few joints is not a big issue for them..."(SP3)

Impact of drugs

A few members of the generic team did not think there were any significant differences in the way in which drugs affect BME community members as compared to non-BME community members. However they acknowledged that the problems could be greatly exacerbated in the BME community due to its close-knit nature. On the other hand, BME service team providers and a few of the generic team members indicated that BME clients were affected differently by drugs as compared to the non-BME clients.

Service providers also indicated that acceptance of drug and alcohol use is more —normalised in the wider community than in BME communities. They associated this mostly with the cultural heritage of the BME clients which included issues such as family make-up, race, religion and traditional beliefs.

"....in these communities acceptance of drugs and alcohol is very, very low which is what we call normalising, it is quite normalised in the rest of the population while in ethnic minorities it is not yet normalised, so that is probably the main reason why there is so much of a stigma." (Sp14)

"I feel the way that BME communities are affected by drug use; it is different. There's things that are similar like the effects of drugs and alcohol is the same on any person, but the differences are socially and culturally, because I think the way people are affected depends on their beliefs, on their belief systems." (SP1)

"To be honest, as I said the severity of stigma is slightly different, but it is there in both the communities. But in the BME community, what they will do is that they will come in to the contact and as soon as it becomes manageable they will try to run away so that others don't come to know about it, and that's the main reason that probably they come in to contact pretty late and they disengage prematurely, that's what my experience has been."(SP16)

Becoming more open

Some of the addiction workers who had been working with BME clients for a considerable period of time indicated that although BME communities have been historically reluctant to discuss the topic, there has been an increasing interest on the in talking about the issue more openly, particularly within the younger members of the community.

Service providers reported that there was more awareness now than 10 years ago, but overall there were still stigmas attached to drug use and addiction.

"Initially it was much harder to get people to come forward to actually state that they had a problem and to accept any kind of service. Over the years it's getting better now, people are coming forward and seeking help. There may be a minority that may say seeking help from a certain group isn't the right thing to do, but on the whole I would say that it is a positive sign, people are coming forward and they do believe it's the right thing to seek help."(SP2)

Some of this has been attributed to generational change. The passage of time has seen second and third generation minority ethnic communities developing Scotland. Newer generations were more aware of drugs and their related issues; and may be more willing to engage in seeking help. Therefore the perception and attitudes towards drug use could be viewed as a generational issue. Previous attempts to discuss the problem of addiction with older men and women were not welcome. There was no acceptance that a problem did exist in BME communities. However, for the workers engaging with younger people, the problem was being raised and young people were speaking more openly it.

"So the generational thing is very much there. I don't know if they're just completely oblivious to what's going on out there, or whether they have the knowledge or the information that they need to be able to deal with it. They probably wouldn't be able to recognise if somebody in their family had a drug or alcohol problem, so there was that, but I think the service users that we work with, and the families we work with, they are very much part of this problem, because it's there, it's either a partner or it's a child that is using drugs or alcohol, or a parent. So, I suppose if they're part of that you know... environment, we would get different feedback from them compared to what the community groups were saying. But it is becoming more and more problematic and it's affecting their lives and it's affecting their families so... The community views are changing constantly..."(SP3)

"I think surely, I would imagine like the generational, you know the Black Minority Ethnic groups that are first generation would be affected differently." (SP7)

Service use as a last resort

Overall many of the service providers expressed views that BME clients accessing their service viewed it as their last resort. The problem tended to be dealt with within the family rather than attending an addiction service. Service providers believed that the problems were usually denied, then hidden from families. When individuals realised that they were no longer able to hide issues, close relatives or friends were informed but they also tried to hide the issues. Participants indicated that after self-management strategies failed, and if parents were prepared to seek help from outside the family, they then tended to turn towards faith organisations and when this did not resolve the issues, they turned towards services. They also believed that most of their clients had been referred on by their GP but some of the clients also self-referred after being signposted by the voluntary sector partners. Most of the clients that they had seen from the BME communities did not know about the existence of either the BME or the generic services prior to needing the services. Service providers in the primary care team have also discussed the issue of families not understanding the nature of addiction and linking the issue to a spiritual issue and try to resolve it in that format. Service providers believed that the key reasons for not approaching the services were partly because of past negative experiences with public services but mostly due to confidentiality issues; approaching services would make their problems public

"They will be more inclined in the first instance to resort to sort of, talking of the Pakistani and Muslim population, more sort of resorting to religious things, or addressing for example, Black Magic, thinking along those lines, before they come to realise maybe it's a physical illness, maybe we need to go to an addiction team." (SP14)

"...And when they do approach us, they're like, keep this between us because I don't want my friends to know, I don't want my family members to know, or if it's the family they're like, keep that between us, don't end up telling other family members they're doing drugs or they're taking alcohol."(SP25)

"And I think part of the reason why they don't seek help; I think part of the reason is because they've had negative experiences in the past using traditional services."(SP1)

" I guess it's not they having difficulty in accessing the service, but it's the social structure which probably hinders them coming to us earlier than what they otherwise would come to us." (SP16)

BME communities seeking help

Although some service providers did not believe that the service provided by South CAT presented any barriers to members of the BME community, they indicated that there was uncertainty within the BME community about where to begin to seek help. BME community members also lacked the knowledge about what resources were available where and by whom.

However, some service providers believed that the community sometimes block themselves in seeking help. Cultural issues were a problem but they also felt that in many cases the community was burying their heads in the sand and pretending there was no problem.

"....They never see it, they've never experienced it, it wasn't something that was an issue for them..." (SP3).

"I don't think it's barriers to the service, I think everything's put in place to allow anybody from any community to access the services. I think it is more maybe a social thing that they're just not accessing it, like you said earlier they're dealing with it in a different way maybe. But I don't think there's any barriers that have been put in place, deliberately put in place, but I don't think there's a barrier from the existing service for people accessing it." (SP18)

Other issues (also identified by the service users) that prevented BME communities in seeking help included language barriers, confidentiality issues, location of the service, perception of potential racism, lack of a culturally competent service.

Language

Service providers highlighted the difficulties language barriers brought up. Medical jargon was confusing for most clients, however, when English was not the client's first language, this made matters more difficult. One of the service providers mentioned for example, that there was no direct translation for 'depression' in Urdu.

The use of interpreters has also been reported as problematic. Interpreters had to be organised in advance and if a service user required help immediately, this was not possible if there were no bilingual workers at the time.

In addition, the interpretation service was not considered useful, particularly as the service was not well evaluated and service providers believed that the information translated was not always accurate. The sessions took much longer. Both clients and service providers had to make twice more effort to explain issues which could have been resolved in minutes if the case worker had spoken the language. Participants also reported interpreters cancelling their appointment at the last minute and clients having to be postponed.

"I know that there's interpreters if required, we've got a number that we can phone and request an interpreter. But I think that that's a barrier as well sometimes, because if somebody's coming to your service, there could be lost information, it could be lack of motivation, because if they feel that they're wanting to access the service, it's no like your every day job that could come in and see somebody that could be giving that service. What you then have to do is organise which takes time." (SP8)

"Definitely, the language is probably the major issue." (SP9)

"I think as well that the interpreting service is really bad. Like I've booked interpreters weeks in advance and they phone up that day and go, oh we're going to have to cancel it, and you've no way of telling the service users, so they're coming in and I've still no got an interpreter..."(SP7)

"...Either that or they (the interpreters) don't turn up at all".(SP6)

Confidentiality

Confidentiality was described as an issue compounded by fear of discovery by family and the local community. Concerns about confidentiality issues were a major factor that influenced the client's decision to continue accessing an addiction service. Service providers acknowledged that people from BME communities were more visible in the service and therefore it was harder to keep their involvement in the service confidential, particularly as the community appeared so small that almost everyone knew each other. Building trust with the client was considered key by the BME service providers. This was described as being a long process which took a lot of discussion, relationship building and hard work. Making sure that the client was comfortable in their environment and with the professionals was paramount before being able to address issues related to their addiction.

"They perceived that if they see individuals from their own community giving them treatment of a problem which has got very high stigma attached to it, they perceive it that whatever one might do but it might leak within the

community and they don't want that. So that is one aspect of the care which we have to keep in mind."(SP16)

"Confidentiality I think would be a biggie for them, which is a biggie for a lot of service users, but I think if you've got small team or a service, then everybody's going to know what people are going to that service for, whereas if you came in to the addiction team you'd maybe be able to, I don't know if hide is the right word, but you'll maybe not be as visible."(SP8)

Location

BME service providers were aware that the close physical location of the building to the community threatened confidentiality and exposed members to the community. The provision by the BME service of house calls and off-site meetings have helped to engage the BME community with the service. One of the service providers also raised the issue of gang warfare in Glasgow. Addiction was closely linked to gangs in Glasgow and the environment at South CAT often meant that people from various gangs were present in the same room and this acted as a deterrent particularly if a BME member of the community had previous encounters with such gangs.

"...So they don't like to use the regular services, plus the services are wide open and everybody can see that you're going into it, an addiction service, so you're openly having to admit that you've got a problem. So, I think it makes it particularly difficult for people to use the services." (SP2)

"...The stigma of coming to the building, being in a waiting area where it's quite busy and quite rowdy, again they don't see themselves as junkies, as having a problem...." (SP11)

"You don't know what to expect and you could potentially expect to find other clients in the waiting room that are maybe harder than you, or have threatened you, or you've had arguments with in the past." (SP13)

Perception of Potential Racism

Although none of the service users have reported experiencing direct racism in services, they had all expressed feelings of apprehension while accessing them sometimes related to an all-white environment. Some service providers suggested that the services may not be portraying the right image to the BME community. One service provider mentioned that historically 'white' people have tried to control the lives of various minority ethnic communities and for a minority ethnic community member who is already in a vulnerable state of

mind approaching a service they perceive to be aimed at white people, the fear of racism can be very intimidating.

"I think racism is a big one as well. I mean you've obviously got, you've got racism across different, it's like A... says, you've maybe got about one hundred and seventy different people from different countries, so you're not talking about one particular population... but historically you've got the running battles between white people and Pakistanis, or white people and Indians, or white people and Black African – Caribbean or whatever it might be, so you've actually got that kind of past hatred if you like, so that when people come in, so if a BME client comes in to a seemingly white service if you like, before they come in the door then they probably would feel apprehensive on using that service, because they don't know what to expect when they get there. So you've automatically got a barrier that you're going in to a place where you're not familiar." (SP13)

Culturally Specific Service

All service providers agreed that clients responded to a culturally specific service. Reasons given for this were that clients felt that there was more understanding of their identity and they would feel more comfortable in opening up to service providers. For example, service providers recognised that religious and cultural events can pose a problem in regard to dispensing of medication. Methadone prescription during Ramadan was cited as a particular problem. Understanding how to deal with such difficulties helped workers in supporting the client better.

When working with BME addicts and their families workers admitted they had serious limitations. There were not many services available, out-with the BME team, that service users and their friends and families could be signposted to that were known to be culturally specific. In many cases BME workers were faced with statements about not having enough numbers to justify a service.

"They need culturally specific services, they need services specific to their culture, because if they don't have services specific to their culture you're starting off at a disadvantage. You're starting off at a place where people don't feel comfortable, they don't feel valued, they feel anxious, they don't have the trust, that's what it's all down to actually, it's down to the trust because it's all down to relationships. Success in treatment is down to, a big part, a major part is down to your relationship, and if you don't have that trust to start with, it takes a whole pile of work to get the trust in before you can start to get the success, and it is, it's down to that." (SP1)

"And it you've got even the services that you've got – the existing services (offering help to clients and relatives out-with South CAT) – we as workers find it difficult to know what services are there because there's lots of services scattered all over the place, and depending on your remit and your resources and what you've got, sometimes it's difficult to find them. And even if you know the services it's difficult to have the time to go and actually check them out and see what's available (relevant to the BME client)..." (SP1)

"So services can't develop because the numbers aren't there, so sometimes it's about what comes first – do the services come first, or do the numbers come first?" (SP2)

Attracting BME clients to the services

Service providers were asked how they had contributed to attracting clients to the services. The BME team members indicated that since they have been created they have been linking with a number of community based organisations to try to promote their services to the community. They have worked closely with

organisations such as the YCSA, REACH community project, Dixon Halls, Amina Muslim Women's group and MECC to raise awareness on addiction issues in the community and they have also pursued engagement activities such as talks and awareness raising campains within the South East Glasgow BME community. Although some of the initiatives have worked, most have been met with resistance from the community. The most successful of these were the engagement with voluntary sector workers who worked with young people. Addiction workers from South CAT built relationships with the voluntary sector workers who understood the work of the South CAT team and could inform their clients about it. Voluntary service workers also indicated that trust was a main predictor for using services. Service providers reported that trust was nurtured by strengthening relationships between voluntary and statutory case workers. These relationships took much longer to build in the BME environment. Referrals from voluntary organisations have been mainly on a 'word of mouth' basis

Generic or BME service?

All service providers (generic and BME teams) indicated that BME specific services provided a culturally sensitive service to the community they served. This allowed clients to feel more comfortable and thus made it possible for all

team members to engage with BME clients. Some generic team members also referred to the BME team service as a 'privileged service' and there was a possibility that this could be misinterpreted as a special favour to the BME community, but others commented that the specialist nature of the service was necessary to help discriminated members of the community access services that they were entitled to, equally.

They felt that BME team members were able to communicate faster with BME clients as there were fewer language and cultural barriers to overcome. They also felt that information given to clients through the BME team appeared to be better received compared to information provided through interpreters and this was demonstrated by higher retention rates of BME clients through the BME team.

Participants also felt that clients' religious and spiritual beliefs were better understood by the BME team and they could therefore manage the addiction problems better by accounting for the spiritual issues whilst delivering the care plan required by the clients and their families.

The issue of trust and developing relationships was also highlighted by service providers. All generic and BME team members indicated that building relationship and trust took much longer with the BME clients than with non-BME clients as trust and confidentiality were paramount for the BME client. This was reported as the main reason for BME community members being fearful to engage with service providers. The majority of BME clients have opted for the BME team support. Clients from the BME communities who were apprehensive of speaking to BME team members for fear of breach of confidentiality sometimes opted to join the generic team. Service providers also indicated that some of the BME clients who chose to use the generic team services did not generally identify themselves as BME members of the community and wanted to be treated as Scottish. Service providers indicated that those with language and communication barriers in particular, eventually joined the BME team.

All service providers described the importance of including the family and friends as part of the care plan delivered to the clients and this was more difficult for the generic team who could not communicate easily with the non-English speaking members of the community. Through the BME teams, the clients as well as families and friends received a personal, culturally and spiritually sensitive service that generic teams were not confident they could deliver without further training. Many of the generic team members reported liaising closely with BME team members when providing services to BME clients to ensure better service delivery for the client.

Both generic and BME specific team members recognised that there were limitations to the BME team service provision. The BME team was staffed with only 1 FTE case worker and a nurse at the start of the project but by the end of the project the nurse had left their post and the post had not yet been filled. Thus resources were limited. Furthermore, the BME team was only able to offer medical and social support but the clients as well as their relatives and friends had a number of other biopsychosocial needs that needed to be addressed which could not be offered by the BME team. Some specialist services such as psychiatric support had to be accessed through generic teams. Signposting to support services out-with South CAT was considered problematic as there were no approved lists of culturally competent quality assured services to support BME clients. Service providers reported that many families and friends have tried to access generic family support groups but these were mainly run in English and interpreter services have been problematic. Clients have also reported that the discussions in those groups were seldom relevant to their lifestyles or needs.

Thus although participants considered a BME service necessary to engage with service users, it was recognised that BME specific services were limited and lacked resources to fulfil the needs of the BME community members. Thus the generic team was also vital in the provision of services to the BME community and they needed to be further supported in that role. However, some of the generic team members have indicated that since they do not see BME clients regularly, they feel they are less skilled at helping them manage their particular issues.

"I would say it's a specialist service as opposed to a privileged service, I think that's what S's trying to say. Specialist in the sense of, if somebody comes through the door and chooses, because it's a choice, if somebody comes through the door at baseline and they're asked do you want a BME service and it's explained, if they say yes, and bearing mind, most of our clients are from the Asian community."(SP13)

"You know they might be Asian, but they see themselves as Scottish, and they've maybe spent quite a long period of time trying to prove to everybody round about them that they are Scottish, therefore, they don't want to go to a separate service that is seen as different, they want to come to a generic service... Could also be they might prefer to come to a generic service, where there is predominantly white service users, therefore less chance of them being identified by other BME clients." (SP9)

"I think we're less skilled because of the allocation process, because in the Gorbals we've got BME workers, so a lot of the cases tend to get allocated to

the BME workers, so that can be seen as deskilling us in a sense because ...we're maybe picking up on a BME service user occasionally." (Sp10)

Service Improvement

Although all service providers agreed that staff need to be more culturally informed and additional resources were required to support for BME client needs, there was a difference in opinion about what was needed in terms of resource between the generic and BME team.

The generic team highlighted the need to know more about the various BME communities they serve. For example, participants highlighted that in some cases generic team staff have been known to assume that drug and alcohol addiction was not a problem within the BME community. They also indicated the need for additional training to better understand the needs of BME clients and this included experience of working with BME clients. Service users indicated that they wanted to be better acquainted with cultural norms and practices of the various community member groups so that they could be confident of the cultural sensitivity of service they offered clients. Need for training on how to better use interpretation services was also identified. generic team members expressed an interest in shadowing BME team members to improve their understanding.

The BME team also recognised that issues identified by the generic team were very important but they also believed that additional resources were needed for their team in order to continue the work they have been doing with BME communities. Some BME clients were not yet ready to work with non-BME workers and generic services were not always appropriate for BME clients. BME team members reported having limited access to resources but their work included awareness raising, identifying community organisations to work with, gaining trust and building relationships with various subsets of the community, supporting friends and families through the identification of relevant literature and support services as well as providing personal support. They indicated that they have had to spend a considerable amount of time promoting South CAT services to the community members and this was not an effective use of their limited resources. They indicated that additional resources were required to expand on this work to other subsets of the community including the growing population of asylum seekers and refugees as well as the rapidly increasing population of recent migrants from Eastern Europe. The need for further research to identify how to better resource the team to serve communities and support the generic team was also raised.

"If we can improve the understanding of cultural issues to a basic level to every service provider we should be able to break maximum number of barriers. I would be really worried if we start talking that because an individual is from a particular community, that's why that particular community's patient should be able to access the service very easily. No, every individual should be able to access the service very easily whichever community they belong to, and every service provider should be given a basic understanding of, not every culture within the country, but a basic understanding. I mean it's not a, they don't have to spend months or years, I mean giving basic understanding – this is what Islam is, this is what Hinduism is, this is what Sikhism is, and these are their beliefs about addiction and mental health issues, and that should be able to break the barrier." (SP16)

"Every practitioner has responsibility. Because I'm coming from a nursing background, and obviously the main theme that runs through nursing is about non-judgemental and respect individuals and then if you have those inherent beliefs and skills when you're practising, it's then a responsibility of the practitioner and the team, if a new issue came their way and had to work and offer services and design services to suit that need then you need to go and research that topic." (SP17)

"I would quite like an awareness session, you know, I don't know who would provide this, but of, you know maybe somebody looking at what type of BME clients are in this area, what are the differences in the cultures? You know if somebody was to present here, you know what is the background of that culture, you know depending on whether if they're born in this country, then what type of things will they experience. If they're not born in this country, the country that they're coming from what type of trauma has happened prior to that, so that when they come in here, you've got an understanding of some of the difficulties that individual countries would have that has an impact on them." (SP9)

Areas requiring improvement

Development

Development of a more flexible, better equipped BME service that is able to go out to satellite bases.

Developing better relationships and building partnerships with voluntary organisations.

Care

Development of better aftercare and relapse management services.

Identification or development of services appropriate to support clients, friends and families out-with South CAT

Interpreting Services

Development or resourcing of a more effective interpretation service which could be more regulated and staffed with interpreters who were knowledgeable about the terminology frequently used by addiction and mental health services

Training

- Training on culture and religious needs
- Training on lifestyles
- Training on engagement strategies (liaising and developing relationships) with BME communities
- Training on how to use interpretation services
- Training for the interpreters on the work carried out by South CAT
- Training on the work done by BME voluntary organisations in attracting clients of BME backgrounds
- Training from the BME team about the work they have been conducting
- Training on BME support available out-with South CAT
- Shadowing of the BME team
- Hands-on experience with BME clients

Resources

- Research on of community needs
- Resources to facilitate engagement with community organisations
- Evaluation of engagement methods that would work for different BME groups
- Resources for community awareness raising programmes
- Additional staff /time dedicated to the BME team to support the various activities they engage in.

- Management support and resources for work with family members of the service users

"And it's quite exhausting because the BME work in itself is more difficult, believe me, than the generic work because you're doing exactly the same thing, but you've got all the added then there are added language barriers, so every time you see a client, it's maybe taking two, three times the amount of time, you've got interpretations and by the time you actually try and build up a relationship it's much more difficult, because you don't have family members it's much more difficult, because you don't have the same amount of services it's much more difficult, because you've only got, in reality you've only really got a nurse and an addiction worker for the whole of the BME community for the whole of Glasgow if you like, although we're focussed in the southeast" (SP1)

"I would quite like an awareness session, you know, I don't know who would provide this, but of, you know maybe somebody looking at what type of BME clients are in this area, what are the differences in the cultures? You know if somebody was to present here, you know what is the background of that culture, you know depending on whether if they're born in this country, then what type of things will they experience. If they're not born in this country, the country that they're coming from what type of trauma has happened prior to that, so that when they come in here, you've got an understanding of some of the difficulties that individual countries would have that has an impact on them." (SP7)

"I think maybe African-Caribbean stuff; I think a lot of Asian stuff I know. It's no - like witchcraft and black magic and voodoo and beliefs and things like that in their cultures that I've got no understanding whatsoever, but I believe it's a big part, or it can be a big part of the BME service users" lives. (SP9)

"I think the BME service within South (CAT) could inform us, and I think you know, just sitting listening to what we're talking about just now I'm thinking that, you know we have in-house training days, or awareness days, whatever suits best, is that BME could maybe help us." (SP7)

"I would actually like to shadow, I would maybe like to be given the opportunity to shadow with the BME team, because I think as F is saying, how are you going to gain these skills if you're just kind of, well obviously that's the service that's been decided and identified for them, but me personally, I would like to shadow if I had the opportunity in doing that for my own personal experience."(SP8)

"I think we've put quite a lot of emphasis and training around prostitution or around various things, but just exactly what F's saying there, we haven't done any training at all or in accessing an interpreter or how that would feel for the addiction worker in that setting. This is kind of stuff that we have done in other areas, like prostitution, and we haven't done anything like that for the BME." (SP8)

"Also I think for the BME clients coming in, you know we might do some work in organising an interpreter or whatever, but any other service that we use or refer on to, you know that service wouldn't be available." (SP7)

"I was on duty just the other week and there was the eleven o'clock appointment that was booked in was for an interpreter and it was a Slovakian, and I felt uncomfortable, because I hadn't used the interpreting service before and I was a bit apprehensive. Now it was getting nearer the appointment time, the person never arrived anyway and it wasn't needed, but my feeling of being uncomfortable wouldn't have augured well in my dealings with the service user." (SP9)

FAMILY AND FRIENDS INVOLVEMENT IN RECOVERY

Recruitment of family and friends was limited to voluntary involvement by the service users. All service users were invited to nominate at least 3 members from their family and friends circle who had been influential in their recovery.

Minority Ethnic communities tend to live within extended families and this was reflected in the participants in the project. Some of the participants chose to inform their friends and family circles from the start about their addiction but others chose to guard this information from them.

The majority of the service users declined involving their family and friends in the project. For the majority, the main reason was to protect their families who had been through 'enough'. In some cases the service user's relatives were not comfortable in talking about drug issues and in others they did not want to risk being identified and associated with addiction. In some cases friends and families were not aware of their treatment or had not been closely involved in their recovery. In one case, the service user's family was overseas and they did not have any friends associated with their recovery. However, the parents of one service user (who had been contacted but refused to

participate in the study) found out about the study and were keen to participate.

In this study, all the people who agreed to be interviewed were family members of service users and therefore the term 'family and friends' will be replaced with 'family members' or 'relatives'.

Three of the family members were wives of service users and one was the mother of a service user. Two of the wives had husbands with long standing addiction problems (almost 20 years). One of the wives was newly married and had only she had only recently arrived in the UK from Pakistan. The mother of a service user had only recently found out about her son's addiction (3 months); however she had actively contacted South CAT BME team and was seeking support through them. All but one of the family members could not communicate well in English. Although most of them understood limited English, they could not speak the language fluently. They were therefore interviewed by the bilingual researchers and their responses were interpreted into English following each question. Most of the participants were able to verify the accuracy of the translation and clarify meaning.

Table 4 Participants Profile: Family Members of Service Users

	FF1	FF2	FF3	FF4
Gender	Female	Female	Female	Female
Marital Status	Married	Married	Married	Married
No. of Children	5	3	1	0
Housing	Mortgage	Housing Assoc.	Housing Assoc.	Family Home
Ethnicity	Pakistani	Pakistani	Pakistani	Pakistani
Education	High School	None	None	None
Extended Family	No	Yes	No	Yes
Family Support Group	No	Yes	No	Yes
Citizenship	British	Pakistani	British	Pakistani
Language	English, Punjabi	Punjabi, Urdu	Punjabi, Urdu	Urdu

Perspectives of Family Members

In this section, the role family and friends had in the recovery of the service users is examined from the point of view of service users, their family members as well as service providers

Knowledge of Drug Use

All family members interviewed demonstrated a lack of knowledge and understanding about drug use. All four participants described not being aware of what types of drugs their family member was using and the impact of those substances. One participant described not having heard about anything related to addiction before meeting her husband. Another participant explained that she still had very little knowledge about her husband's drug use and now best to help him. As described by service users, relatives also commented that drug use was often hidden and not discussed openly. One of the identified reasons for this was denial. Relatives reported thinking out of sight, out of mind, but realised that the issues did not get resolved, in fact they got worse. Relatives also indicated that they found it difficult to find out about addiction and treatment options when they sought this information. This was mostly due to lack of awareness about where to find such information in confidence, and also as appropriate information was not readily accessible in their language. They reported feeling sacred of picking up a leaflet in case their family was linked to addiction due to the stigmas attached to it.

"...from the background that I come from I didn't know nothing about drugs. His life was slightly different to mine, and with his mother passing away, he had quite a lot of issues in the background. But at the time when he was taking drugs, I didn't actually realise what he was doing. I knew he was doing something that he shouldn't have been doing, but I didn't realise the impact of these things that he was doing... But he made it look so normal that it wasn't like it was anything odd or strange that he was doing. And I thought maybe it was just me that's not doing something that he was doing." (FF1)

"...I knew there was a problem quite early on and managed to kind of tap on to it, but I didn't know a lot about drugs, and there was a hesitation to go out and find out about it, or tell anybody about it." (FF3, response translated into English by interviewer)

Community Views

All the relatives indicated that drug use was viewed very negatively by their communities. Family members detailed how they were marginalised or even ostracised from their community due to their relative's addiction. Faith communities also did not offer any substantial support to them on addiction issues. Some reported being criticised by faith groups and communities and sometimes made to feel they were to blame for their predicament.

"...it's quite a talking point... (people) tell me – Oh, I saw your husband doing this and that, he was – so I feel it's very, I suppose stigmatising for the family as well and we have to bear the brunt of the problems... I stay in a heavily populated Asian community and your neighbours will criticise, nobody will actually say anything to your face, but you'll know... drugs are not discussed in any of the Mosques or any of the religious establishments.... It's not discussed full stop, it's not a topic there.." (FF1)

"...my husband does go to the Mosque... to try and reconnect with religion and try and get some spiritual help; when he goes there, even the Imams, which are like the religious leaders can kind of be heard saying things about him... so my husband will come back home saying – I'm not going there, I don't want to go there." (FF2, response translated into English by interviewer)

Support from Family Members

All family members reported that they had tried or were trying to help their relative through their problematic drug use. Some of them had been struggling with addiction and its effects on the family for 17 years.

Self-Management

Family members have supported the drug user in many ways. Management strategies have included putting up with the drug use; trying out self-management techniques such as talking, encouragement and using faith; withdrawing and gaining independence by either distancing themselves physically or emotionally, or changing the way they relate to each other, or the rules that governed their relationship. Family members found self-management techniques ineffective. In some cases, relatives reported discussion fatigue and increased tensions in the household.

All relatives described experiencing considerable stress from their predicament and eventually had to resort to seeking help. Three of the four relatives attempted to access services on behalf of their drug using relative. Some consulted GPs and some consulted South CAT directly, however, they reported that until their relative was not ready to access the services themselves, service providers could not provide any support.

"My son is still very much in denial that he's got a problem and he doesn't want to engage with services ...I tried various tactics with my son, trying to be strict with him, trying to be kind of gentle with him; nothing worked and things kind of progressed." (FF3, response translated into English by interviewer)

"The impact of him on my household has been far too much, and you could say it's like a trauma, it affects your life and it changes you for the rest of your life... we've parted ways, we've been through all sorts you know these drugs do cause a lot of animosity in the house, and at the moment we're at a stage where I prefer not to even discuss drugs in the house. You know it turns you into quite a cold person as the years go on... I'm very cold towards drugs at the moment and I have been for a good long while." (FF1)

"It really sabotages your life." (FF2, response translated into English by interviewer)

Although some of the family members indicated that they had received very good support from their family and friends in dealing with their relative's addiction, they realised that sometimes their family felt they had exhausted their effort in this cause.

"...you need positive support and you know what... friends and family have heard all of this time and time again, it seems like a broken record." (FF1)

Extended Family Support

Family members indicated that the extended family structure was a very useful support mechanism, particularly with regards to financial difficulty. The level of unemployment was high for the participants in this study and thus many families relied heavily on the family financial support. However, they also indicated that emotionally, being part of a large family structure was sometimes disadvantageous. Despite being surrounded they could feel completely isolated and withdrawn. Family members reported feeling anxious, worried, depressed and helpless. In some cases the wives were made to feel at blame for the condition in which their husbands or children were in.

"...I've got very good in-laws, and they, along with my husband's brother and sister supported my husband quite a lot; (they gave) advice and support to try and help him come off drugs, so I felt that if that wasn't there then maybe I would have been in a different situation, and possibly would have even left my husband, but they supported him and myself..." (FF2, response translated into English by interviewer)

"With my husband's family, they don't actually approach him any more with regards to drugs. It's not even a topic that's discussed anymore, so if he's looking for support at the moment, the family after so many years, wouldn't be an option." (FF1)

Spiritual Healing

Family members reported that they could not understand or interpret the changes in behaviour and mental health of their relatives who had developed an addiction. Since this was not a physical problem that they recognised, at times they or members of their circle of family and friends had considered the possibility of spirit ('jinn') possession. This was reported as a common means of interpreting mental health issues when a plausible explanation was not available.

One of the mothers in the study said that she suspected that her son had been 'possessed by a jinn'. The way to deal with such issues traditionally had been to seek spiritual help through the faith groups or spiritual healers. She reported that she became unwell and this was all associated with the 'jinn'. However she later found that it was his drug use that was causing his erratic behaviour and she was suffering due to stress (through her doctor). She mentioned that spirit possession was more acceptable by the faith groups than drug use and she found it more difficult to seek help on addiction problems through them. As she came to understand the concepts of mental health and addiction, she sought alternative support from services.

"...they(healers) were trying to be gentle with him, they were doing the prayers with him, and it got to a point where I myself became really unwell with what had been happening, and then I eventually went to Twomax." (FF 4; Translated into English)

Support by South CAT team

Support regarding addiction

Family members were very pleased with the services their relatives had received through the BME team. Some felt that they were pleased that their relatives had finally found a professional they could talk to when they were in need but they wished the service was available 24 hours as they felt support could be needed any time.

They also mentioned that there were only 3 BME addiction workers and they only worked part time; this made it difficult to get support when required. Family members were pleased that there was a helpline where they could leave a message and someone would get back to them the next day, but often this was not sufficient. They felt their relatives (and themselves) could feel

really low at any time and it would help to have a 24 hour service even, in the form of someone at the end of a telephone line.

"I think they're a great help for him, you know to come on a weekly basis and speak to his counsellor, I think it keeps him going. It keeps him going for the simple reason that he can't speak to me, and because I'm glad he's got a counsellor and he's got somebody where he can go and let off steam or whatever it is that's going on in his head. I'm glad he's got somebody there to support him. I just don't feel like I can be that person, when I'm his mother and his wife and his business partner... It does work for him, but it's just a nine-to-five thing and drugs is just not nine-to-five. Sometimes you just want to talk and it's not a nine-to-five." (FF1)

Relatives of the service users also indicated that they were pleased to be part of the recovery process of their family member. They felt included and able to ask any of the case workers in the BME team a question freely.

They were particularly pleased to have access to a BME team due to language issues, as three of the women had poor fluency in English. A bilingual case worker was therefore very welcome as they felt they could communicate confidentially and faster with a bilingual worker who could not only understand what they were asking directly in their maternal language, but were also able to explain the issues back to them. They indicated that this helped with minimising misunderstandings and increase their trust in the system. They felt that they could also contribute more effectively in the recovery process and that gave them more hope.

"So I was just saying, so initially when my husband went to the service, Z used to come at home, and it was through talking, I felt that talking really helped a lot, for Z, but also for myself, I felt that there was support, I was able to go out and actually get a life, sort of make a life for myself outside of work, which was really helpful for me, but I was also given advice from the team about how they could manage my husband at home, and just what to look out for, you know in terms of medication and things. And things really have improved quite a bit and we are actually quite happy now, just been quite a big difference from before." (FF1, translated in English)

"I feel that I don't have a communication problem with U, I can speak freely, I feel that she can understand me better based on the same sort of cultural background, she can just say a little and U can understand the situation quite well from that, so she doesn't need to kind of go to lengths to try and explain things." (FF2, response translated into English by interviewer)

"We've had a lot of help from U and Z from the South CAT, and particularly, U has been a source of support for me as well, so I've been able to kind of speak to her about my problems, and have been able to get advice and support from there. And I know U is not going to go and tell anyone else, so I feel safe."(FF1,response translated into English by interviewer)

Support to Family and Friends of Service Users

Relatives recognised that the support family networks could offer was very limited as the knowledge about addiction and its treatment mechanisms was very poor in the community. They therefore turned to the BME services for support.

All participants favoured being visited at home by BME service providers as this 'did not raise many eyebrows' in the community. The family members including English speaking members also indicated that they found it easier to relate to someone from her own ethnic and cultural backgrounds.

Three of the four relatives had received counselling and support for themselves from the BME addiction service at South CAT. They also commended the help that they were provided by the team on not only addiction and mental health but on basic information about their rights and benefits as well as signposting towards other sources of help in their own language. They could not find any other generic family support mechanisms that were so responsive to their needs.

"I just felt that the Ethnic project would be a lot more appropriate to me because of the way I was brought up and the way I live. And you know about discretion, you know about the stigma attached to it, you know using these services. Because it's one of the things that puts a lot of people off... actually approaching anybody, who else is going to find out? Everybody knows everybody. The last thing you want is your personal life discussed." (FF1)

"U was so nice, she was so helpful. She helped me fill in forms and get benefits... I would not have known anything about that... she also told me about English classes etc..." (Translated into English FF2)

Service User's Views on the Role of Family and Friends in Recovery

Almost all service user participants had sought family support at some point in their life. Family and especially spouses were an important motivational factor for seeking help with problematic drug use.

Extended families provided financial and emotional support in some cases and participants indicated that without this they would have struggled to continue with their battle against addiction.

Wives of service users, in particular, demonstrated striking resilience in this study. Their support was described as crucial in the service user's decision to address their problematic drug use. Despite violence and abuse, some of the wives had supported husbands for over 17 years in some cases.

"...we got married and four weeks after marriage I got a two year sentence... and I said to her if you want to call it a day, I can't blame you. I think she slapped me or something, and she was – don't ever say anything, I've made my choice – and that was it." (SU 1)

"You know, to know that that woman, no matter what happened she always thought that there was so much more about me, and I couldn't see it, I couldn't........." (SU7)

Some service users explained that their family had sometimes been a hindering factor to their treatment and that they didn't/wouldn't want them involved. At times, they preferred to distance relatives from treatment to protect them from the negative effects of addiction including misjudgement from the community. In some cases, this also helped them focus on their problem and motivate themselves to 'get clean' faster as they wanted to return to their family free of drugs. In other cases, families were reported to be unsupportive due to their lack of understanding about addiction and rigid moral values which created barriers to providing support.

"I finally told my dad that I was taking drugs, which wasn't very nice, and he wasn't very happy. But I told him but not until I'd got myself cleaned up, I wouldn't see him, see the family again, because I seen the pain that it caused my family." (SU 6)

Some service users indicated that their family were reluctant seek help for fear of stigmatisation. However, for those who did engage in the process, on behalf of the service users, the latter found it extremely useful. Seeking help was considered daunting and the fact that there was someone there supporting them through that and could sometimes take the initiative, was most welcome. Some admitted that at the time they were apprehensive and doubtful that they could ever be helped but with family support they realised that it was possible.

"My wife has supported me unflinchingly; you know she's done so much for me. You know she has suffered so much because of me, right that I would have to have no heart to have not gone out and tried to do something. You know

nobody deserves that much affection from another person, and you know, to have not given anything back. You know that's a question for her, why she did it, what was the reason? But you can only run away from somebody's feelings, you know, somebody that you love for so long. If they don't give up, then sooner or later I suppose, you know if you try, try, and she just didn't stop trying." (SU7)

"My wife, she's like a great support for me. She's quite good, if she was someone else, another Asian, she would have left me by now. She didn't leave me, she's like willing 'cause she loves me, like support me, like be there for me. She helps me as well; with willpower, whatever, weak, she encourages me. Like when I become ill, like before with withdrawal, she used to help me quite a lot as well. Just for her as well, I didn't want to lose her, and that's what made me go, like, on the Suboxone as well. 'Cause Methadone is no like a way to come off it, it's just a substitute, like still a drug, but like because of her, I really wanted to come of it, so I went to Suboxone, like I'm on it successfully for a good few months now. Hopefully, Inshallah, I'll come off it soon." (SU 8)

"They support me, like whenever, like support, verbally, like physically, like say when I'm ill, she would like help me. Like when you get off drugs whatever, you start getting withdrawals, you start feeling sick, this, that, you don't know anybody else, start feeling sick, clean up after me. And that made me feel low as well, my wife, doing what she's doing, this kind of stuff and that. And that's why, made me want to come off it more. "Cos I felt quite low, her seeing me in that state kind of thing."

"She helped me physically, like when I was sick, like cleaned after me, like take care of me, and like verbally she like help me, like with support, you know? Like willpower, need some, like drive from somebody sometimes when you feel weak to say like – you no want me, you want me to leave – like that. She'll not leave me, but just to make me stop, I don't want to lose my wife as well." (SU8)

"Okay, every husband and wife has their quarrels, but it has been quite a few times that she was ready to pack everything up and said – I don't want nothing to do with this, what should I do take my children away...These thoughts we were discussing between me, her and the family, that's how serious it was getting because of heroin and so far so good. It's not happened that way. Okay we still have our wee stupid quarrels, but it's nothing major, major that would happen before. And I can actually see my daughter now, she's eight and she says – Dad, you look more nice when you happy and smiling, but when you when you have the grumpy face you look more scary to approach, to ask a

question, you know, to do something, but again, that's because of the heroin." (SU5)

Service Providers' views on the role of friends and family in recovery

The majority of the generic and BME service providers identified family as a valuable asset in recovery. They recognised that due to the nature of addiction it can be very important to involve them in the care plan received by the service user. Service providers understand that they may be seeing their clients once a week but family and friends see them all the time. Service providers also reported that the majority of BME clients prefer to have family involvement wherever possible. It was observed that families themselves wanted to be involved and were very much an integral part of their management plan. However there were cases where confidentiality was a major issue for the client and consent to involve families was not obtained, and therefore family and friends could not be involved.

"I think it affects families greatly. I think in my experience with Black and Minority Ethnic community, very often parents, particularly the mother will be very much more involved and often accompany a client to consultation, and wish to try and support and direct that client within the therapeutic situation." (SP24)

"..my experience with BME patients has been that family involvement is much, much more than what I see in other group of patients, and to be frank, we just don't take any decisions without involving the family, we just don't take any decision with patient alone." (SP16)

Service providers have also described incidences where family involvement has been obstructive to the care of the client. Irrespective of whether the services were being delivered by the BME specific team or the generic team, similar problems have been experienced by BME family involvement. Some of the reasons described by service providers were common to those described by service users and these included:

- Denial of the problem.
- Lack of knowledge and understanding of drug use.
- Expectation of a quick fix.
- Being more forceful and demanding with the drug user.
- Attempting to take over the control of the care plan.

"...if the family don't acknowledge that there is an addiction problem... and the client is then looking for some sort of support and help, and rather than getting support and help they're actually shunned away from the family..." (SP1)

"Obstructive, yes you're absolutely right. In not many a times, more than many a times, they have their own perception of the whole issue, they have got a perception of stigma within the community as well, and they don't them self are to certain degree are in denial about the whole the gravity of the problem and they just keep telling us that is not the case, that is not the main issue, we just do little bit here and there, and he'll be alright and we'll take him home. They don't seem to understand the amount of work required for individuals." (SP16)

Lack of Understanding about Drug Addiction in BME Families

Service providers indicated that a lack of understanding about drug addiction was a major constraint in the recovery of BME clients. Service providers indicated that there was a lack of understanding about the nature of addiction and the factors leading to addiction. They were at times unaware of the potential serious health consequences of addiction. Family and friends also lacked understanding about the treatment process and expected to see rapid improvements as in physical conditions. The length of the treatment process and potential of relapse were not comprehensible to some. In some cases families expected service users to just accept that this was a wrong and change their behaviour overnight.

"Family members who've got an unrealistic expectation of where a service user should be at any given time (level of treatment), especially maybe with methadone treatment – how come that person's been on that dose for so long and how's things no changing and families not understanding the nature of methadone treatment." (SP9) -

BME Families taking Control (or ownership) of the Treatment

Service providers also indicated that the slow process of recovery and relapses led a number of BME families to attempt taking over control of the treatment plan. Lack of knowledge and family pressures led to a number of BME families to becoming more forceful with the service users. In some cases, drug users were taken out of the country to go through a period of abstinence by immediate withdrawal (cold turkey). Service providers indicated that in many

cases, when the client returned to the service, their problem was worse than before they were made to leave. Service providers also reported clients and their families talking about spirit possession and exorcism as the required approach 'was not having an effect' on the client.

"I know one family they actually intend to send this kid back to India because he was on methadone, to get him off methadone in India. I've heard of service users as well wanting to go back to India or Pakistan and just take a detox of methadone and try and detox themselves while they're there and come back drug free." (SP6)

"But, I feel as though some of the BME families can be more forceful, they're almost driving the service user from behind, and expectations – you shouldn't be doing this, you shouldn't be doing that, and you should be at this level and no the level that you're currently at – I've witnessed that with BME service users...

I've got examples as well of service users wanting me to speak to their partner, now actually passing the phone and saying now can you explain this to my partner, specifically about methadone, how they're still at that dose and level of methadone and how there's no decreasing.." (SP9)

Education

The need to educate the families to prepare them for the lengthy recovery process to help them identify and manage problems with the treatment process as well as seeking support for themselves and others in relation to the treatment has been highlighted by all service providers.

"So part of the education is educating the friends and family on how they can provide ongoing support, how they can highlight any potential difficulties, or any kind of possible relapse, how they can actually get on the phone to us." (SP1)

Discussion

All clients in this study were Muslim residing mostly in the South Side of Glasgow in a close knit Pakistani community. They had all been using the services offered by the BME team at South CAT for more than 6 months. The majority of the service users had been exposed to drugs as young adults. Despite being at times surrounded by friends and members of extended

families, all expressed feelings of solitude and emotional isolation which were strongly associated with the religious, cultural and social structures which supported them. Being migrants to the country also isolated some from family and friends' support. The added trauma associated with seeking refuge was also highlighted in this study. Family members of the service users reported their lack of knowledge on addiction as well as the systems available for treatment and support in this regard, as well as non-addiction related issues. They argued that it was difficult for everyone (BME and non-BME persons) to find out about which services were available, but when issues such as language problems and cultural influences were added, this becomes even more difficult. Service users and family members perceived that generic addiction services were geared towards supporting the drug user and not their families and friends. Service providers appeared to be generally aware of the problems faced by BME service users but generic team members felt they lacked the knowledge and confidence to serve the BME community effectively. Some did not agree there were differences in the treatment required by BME and non-BME clients.

The stigma and shame attached to addiction, as well as the religious prohibition of substance use on drugs deterred BME community members and their close relatives from openly speaking about drugs or seeking help, for fear of being stigmatised and excluded. This was particularly the case for the older generation. As described above, despite observing behavioural changes in their drug using relatives, members of BME families were ill-informed about recognition of addiction symptoms and possible treatment options. This not only contributed to and exacerbated the family's stress, but also prevented/delayed the potentially useful contribution that families could make to the early intervention and treatment of drug use. As families became aware of physical, psychological and behavioural changes, several management strategies were employed by them, but the use of addiction services were perceived to be a last resort. These strategies were heavily focused around seeking faith based support and a strong relational network which they believed were the two key means of addressing the addiction problem.

Addiction and Faith

Faith and strong beliefs have been shown to be tremendous sources of support (Sheikh & Gastrad, 2000). In many cultures, unexplained changes in behaviour are understood as being associated with spiritual influences. Practices such as praying have been used as religious and cultural coping mechanisms, developed traditionally to deal with a number of unexplained phenomena.

The role that religious leaders can play in supporting patients with various ailments including mental health issues has been highlighted. A number of projects have also suggested a positive link between better mental health and practices such as attending mosque where people can obtain informal psychological support (Bhui et al., 2008). The concept of spirit possession by the 'jinn' for example is religiously associated with Islam and widespread across the Muslim community (Khalifa and Hardie, 2005). Similar concepts exist in Indian (Bhutpret; Pakaslahti (2009)) or African (Voodoo; Fishman et al., 1993) beliefs as well as in some pockets of westernised cultures. Faith groups have often used spiritual healing techniques and intervention to support people with health issues, particularly mental health. However, the stigma associated with drug addiction means that accessing support from community and faith organisations can be very challenging.

Addiction and Relationships

The presence of a stable relationship that provided support was considered crucial by all participants. In this study participants indicated that marriage was considered the ideal solution to many problems by the parents of young unwed adults; this also applied to addiction in many cases. Parents believed that young adults would find stability, comfort and a sense of responsibility that would deter them from addiction. Francis, Williams and Village (2011) have recently identified clear and complex associations between faith traditions and marital status; of the faith groups they analysed, the proportion of married Muslims was second highest (72%). Unfortunately forced involuntary marriages are not uncommon in South Asian communities (Samad and Eade, 2002). This was experienced by one male service user in this study. This is not to be confused with arranged voluntary marriages. Well-intending parents often cause more damage than expected through forced marriages. Relationship issues had both positive and negative influences on addiction. Relationship loss and breakdown was linked with initiation of drug use and difficulties in managing rehabilitation, whilst strong relationships supported recovery.

Beyond the family structure

Traditionally South Asian families have been stereotyped as one big extended family where members look out for and support one another. Thus it could be assumed that South Asian communities do not need the support of external services or institutions, and would rather manage issues independently. While

the extended family structure still holds a strong presence, it has to be recognised that problems do exist. Marital and family pressures as well as issues such as housing, employment, low economic status and racism have been shown to affect marginalised BME communities leading to mental health and addiction problems. This was evidenced by the majority of participants in this study who were unemployed, living on benefits and highly dependent on family support. As part of a close-knit extended family and community structure, individuals had fewer options including the independence to seek help openly. Despite these barriers, some of those affected by addiction and their families overcame personal and familial barriers to access services.

Perception of the services

Although all service users and friends and family commended the services they received from the BME team at South CAT, they all indicated apprehension at their first encounter with the service. Difficulties in access due to location and confidentiality issues were highlighted, but many initially perceived the service to be unapproachable. This was felt to be a major determinant in their continued use of the services. Lack of understanding about their culture and way of living, potentials of racial prejudice, and significant barriers they had to overcome to approach the services were reported as main concerns. This has been reported in many studies on drug use and service access including work conducted in Glasgow in 2000 (Rassool, 1997; 2006; Khan *et al.* 2000). Although South CAT services could be culturally sensitive, this was not visible to BME communities walking through the doors for the first time.

Developing a 'bio-psycho-socio-spiritual' model of healthcare.

Health professionals are likely to regularly encounter patients with strong religious beliefs. Although historically mental health professionals have regarded religion as irrational and as a 'universal obsessional neurosis' Freud (1907: p. 25), recent research demonstrates largely positive associations between religiosity and well- being (Dein *et al.*, 2010). When considering mental health and cultural implications, two interpretation models have been suggested: the Biomedical (Eurocentric) model and the Ethnomedical (Ethnocentric) model (Marsella and White, 1982). The question therefore arises: whose values are important? Interpretation of research on spirituality and mental health is complex and controversial, so it is not surprising that this matter is still difficult for many to accept. However, some mental health professionals are acknowledging the need to recognise patients' religious

beliefs in designing explanatory models for better treatment pathways (Dein 2004; Powell, 2005; 2009). Powell (2009) argues that:

"In mental healthcare, treatment is largely pragmatic, based on the prevailing bio-psycho-social model of our times. It is a good working model yet spirituality, the highest function of the imaginal mind, has got left out. This is something of an irony since psyche means spirit or soul, and it is a lack that urgently needs putting right. Apart from the importance of encouraging patients to feel able fully to confide in their psychiatrists, research over the last fifteen years has shown that spirituality is good for both mental and physical health. So we need to develop a 'bio-psycho-socio-spiritual' model of healthcare."

Tapping into the family and friends resource

Historically, it has been perceived that addiction could be a consequence of family dysfunction and female partners were often put to blame (Orford *et al.*, 2005). This meant that families were mostly excluded from recovery processes except to encourage service users to attend the service. Traditionally, although policies have supported the need for involvement and support of family members

(The Scottish Government, 2008), with the exception of services for children, the needs of family members, particularly BME family members, have been largely overlooked. Research indicates that previous interactions with families have been to encourage them to sort out their marital relationships (Orford *et al.*, 2010). However, more recently, the importance of involving family members in the recovery process has been highlighted. Families have been recognised as a 'largely untapped treatment resource'and a strong ally in the management of addiction (Copello *et al.*, 2002; 2006; 2009; Orford *et al.* 2005, 2008; Templeton *et al.* 2001, 2007). Annual cost estimates a total cost for Scotland of £229 Million and resource savings to the NHS and local authorities from the care that family members provide to drug using relatives of £95 Million (2008 prices; Copello, Templeton and Powell, 2009). Enabling BME family members to support the service users can bring not only monetary benefits to services by enhancing service user en engagement with their treatment and rehabilitation but also increase engagement by services with the community and promote drug use awareness.

Supporting the needs of BME family members

As described in this study, close family members of people affected by problematic drug use often need support from services for themselves. Stigma around drug use can lead families to hide not only issues in relation to drugs from society and services but a number of other issues associated with addiction. Some of these described in this study included financial difficulties, psychological distress an family breakdown, impact of drug use on children, employment prospects for parents, homelessness, drug dealing, imprisonment and in some cases issues with immigration. As identified in many studies (reviewed by Orford *et al.* 2010), families in this study also experienced familial relationship conflicts, marital discord resulting at times in aggression and abuse, conflicts over money and possessions, worries about relatives, threat to home and family life. As recognised by policy, needs of families also have to be addressed to enable them to better support the service user and the service providers.

On the whole, addiction services, including South CAT, mainly focus on the needs of the drug user whilst the needs of family members are often seen as not central to the treatment process. Families tend to be referred to external support mechanisms which do not necessarily meet the need of BME families. This has also been reported by others who have been studying the impact of addiction on families of drug users from various cultures (Orford *et al.*, 2001; Copello and Orford, 2002; Copello *et al.* 2005; Orford *et al.* 2010). Families report not only language barriers but also as sense of being disconnected to the issues discussed at sessions which were not relevant to their lifestyles and the particular problems they were experiencing. They felt service providers did not understand their culture and traditions. In 2002, a study on interventions for families reported that "There are specific issues around access to services for Ethnic minority families which include the thin spread of specialist services, and language and cultural issues." (Macdonald *et al.,* 2002). In 2011, the situation seems to be still the same for BME communities. In this study, South CAT BME team service providers took on the role of family adviser as well as client adviser; this was performed mainly on a one to one basis which was not necessarily the most effective use of their resources. This needs to be further evaluated to identify better ways of supporting relatives.

A number of models have been developed to support families. One of the most recent models describing support to BME family members is the '5 Step-method' which is a brief psychosocial intervention to support family members who have a close relative with an alcohol or drug problem based on a stress-strain-coping-support (SSCS) model (Orford et al., 2007a; 2007b; Copello et al., 2009; 2010a; 2010b).

Attracting more clients to the service

Although drug use and addiction was considered a taboo subject for many subsets of the BME community, willingness to learn more about the subject was recognised particularly within the younger generation. Communities' traditional stigmatisation of drugs and addiction was believed to be partly responsible for creating barriers to accessing help. However, it was also observed that the poverty of knowledge and awareness was not due to community factors alone but also due to poor government may investment in this area. The term 'hard to reach' was contested by both service users and providers. It was observed that communities were not hard to reach, but government initiatives did not target the community appropriately. Lack of engagement with community members in targeting interventions was identified as one of the possible reasons for failure.

Participants suggested that one of the ways to address this issue was to target awareness raising campaigns and initiatives to community leaders including faith group leaders. Others have indicated that women and young vulnerable BME people need to be engaged with. As described earlier, working in collaboration with voluntary sector organisations to engage with community members also resulted in increased referrals to South CAT and therefore, a need to strengthen such relationships was highlighted. Community Health Champions have also been used by other health organisations to help engage with BME communities. These champions can lead figures in the community who can be trained to support community members and mediate their transition to services. Any solution devised without engaging with the community is likely to be met with resistance. By nature people do not like being told what to do and this is no different in the BME communities.

The majority of BME clients at South CAT were from the Pakistani community. This partly reflected the makeup of BME community in Glasgow but could also be due to the fact that both of the key workers in the South CAT BME team were from the same community and had strong links with organisations providing services to the Pakistani community. Thus the needs of the Pakistani community were well identified and the services provided were very satisfactory to the service users, friends and family. Similar links need to be established with other subsets of the BME community including the asylum seeker and refugee community, traveller community and recent migrants to identify better ways of engaging and service provision to community members.

Four broad suggestions were made for improving engagement. These were:

- Making services more visible to the community(Better communication about what is available)
- Providing more services (more BME team service providers and wider variety of support, particularly for families)
- Increasing flexibility around individual needs; (understanding client needs and adapting services to better support clients)
- Improved training for staff (Increased understanding of differences in cultural issues and engagement processes).

The way clients enter, leave and remain in mental health and addiction services have been shown to vary between ethnic groups (Bhui *et al.,* 2003). Perception of barriers can determine if clients are likely to be retained by services. There has been a low rate in referral of BME clients by general practitioners for reasons described above including stigma and reluctance to confide in services. In many cases referrals take place through the non-statutory sector services. In order to improve access to services, and to develop appropriate and effective interventions, many innovations have been described by statutory services but much of this work is not formally published. Bhui *et al.* (2009) attempted a review of grey literature in this area and suggested ways forward to working in collaboration with the voluntary sector and associated partners for the benefit of the client. The study identified that services that support collaboration, referral between services, and improve access seem effective, but warrant further evaluation. Further studies on enhancing pathways into care have been developed with BME communities in England (Hackett *et al.,* 2009)

Conclusions

Assuming that someone has a particular set of characteristics because they come from a particular cultural group is inappropriate. Culture is dynamic and changes with time and exposure. However, there are certain core beliefs and assumptions that reside in the depths of each culture that underpin the values and norms in each cultural group. These values steer certain behaviours in people. To be able to actively engage with clients, it is important to understand and respect the values that underpin their behaviour.

Many services make the mistake of interpreting cultural needs with providing the right food, literature and illustration but, for a service to be truly culturally competent it, has to recognise the values, beliefs and assumptions of the diverse communities it serves (Fulford 1999). To improve an organisation's cultural competence the organisation has to:

- gather background information about the communities it serves
- identify the communities' concerns and priorities
- develop relationships so it can build trust with the community
- participate in training to help develop cultural competent skills

From this study it can be concluded that the BME team service has been a significant step forward in improving cultural sensitivity of the mainstream service provision to the BME community in Glasgow. However, many of the problems identified in Glasgow a decade ago are still relevant today. Thus further improvements in the service are still required to make the service a culturally competent one. BME specific services are required to increase engagement with the service while generic team members need to be given the competency to work in parallel with the BME team.

Needs of the various ethnic minority communities across Glasgow have to be evaluated and further ways of engagement with these communities designed. Working with family and friends appears to be a successful route in tapping on this resource to support services provided to community members. Not only does this help educate the community but it also helps to promote support for the service users through the families. This can also help to address close family and friends' needs.

Appropriate training of all staff appears to be a crucial element which needs to be addressed at South CAT. To be able to work with the various community members they represent, generic and BME team members need to be further trained to gain the competence and confidence of dealing with people from various cultures. Elements of training should contain both formal and informal (practical) training and this could be delivered in conjunction with voluntary

organisations working with potential service users. This does not mean that service providers need to be experts on all ethnic groups and their cultural backgrounds. Instead they need to be culturally flexible and understanding and treat the client as an individual. Thus to address the complex issue of problematic drug use a multi-sectorial approach is required; from government bodies, policy makers, service providers, service users, carers and BME community organisations.

Recommendations

- The image portrayed of the service needs to be improved to make the service more welcoming to BME community members. One of the ways of doing this could be taking the service to the community through community partner agencies. Alternatively, volunteer-led self-management groups could be supported by the South CAT to help engage with the community and build the capacity of community members to identify and resolve issues through South CAT's support.
- Community profiles are constantly changing and service provision needs respond to this change. An evaluation of community needs is essential to understand the community being served.
- Awareness raising in the community is essential, but in particular working with community based organisations needs to be consolidated to improve engagement.
- Methods of engaging with the various subsets of the BME community have to be assessed to identify best methods for each community. Use of Community Champions models or design of self-management groups can support engagement if the community is associates with such methods.
- The BME service is necessary to help engage with the community as well as to support the generic Team develop cultural competency. Developmental needs of the BME service have to be further investigated in line with the community it serves and additional resources identified to support the team accordingly.
- To improve cultural competency and sensitivity of the service, further training is required for both BME specific and generic team member on how to understand a diverse community's perspectives and provide an appropriate service.
- Problems reported with the interpretation services have to be further investigated to assist service providers overcome language barriers. Interpretation standards also need to be revisited to ensure an effective service. Staff identified the need to be trained on how to use the interpretation service effectively.
- Families have a strong influence on individuals in BME communities. Using the family as a resource to support service users can be economically beneficial to both services and the families. Educating families will help overcome fears and misconceptions about addiction but also can help support families to support the service user in collaboration with the service provider

- The need to support BME family members with problems related to the addiction of their loved ones was also highlighted. At present the BME team has assumed the role of family advisor as family services have not been found to be appropriate. Working in collaboration with organisations and community members, appropriate support groups or self-management groups can be created and supported by South CAT to help BME families prevent or manage some of the psycho-social problems that arise in the family units. This will support South CAT deliver an effective service in the long run.

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Appendix 1: Terminology

BME: In this report BME refers to Black and Minority Ethnic Communities however, in the associated DVD resource, users of the South CAT services tend to refer to the BME specific team as BME or BME workers.

Service Users: This term is used to refer to individuals accessing the services offered by the South CAT team

Clients: Addiction Service Users

Service Providers: This term refers to the Social Work and Health service provision team who offer addiction support services at South CAT

South CAT : South Community Addictions Team

CHCP: Community Health Care Partnerships

BME Specific team: Service providers providing addiction support services to BME clients only

Generic Team: Service providers providing addiction support services for the local population, including indigenous and BME clients

Appendix 2: Questionnaires and forms used in the study

Interview Questions/ Themes for service users

BACKGROUND ON DRUG USE

- **Experiences**
- **Started, Current status**
- **FF help/support. How?**
- **Seeking of help?**
- **Quitting/stabilisation. Examples from BME communities?**

INVOLVEMENT OF FAMILY, FRIENDS AND COMMUNITY

- **Community aware re drug use?**
- **Community views re drug use?**
- **Religion**
- **How does that make you feel? Impacts?**
- **FF help seeking. How?**
- **How can tackle stigma**

SEEKING HELP

- **What do you know about drugs in Glasgow? – Knowledge re drug services in Glasgow**
- **Ever seen any adverts for drug services.**
- **Involvement with current service**
- **Can you tell me how you got here? Service chosen? Why?**
- **Difficulties accessing**
- **Overcoming difficulties**

SERVICES

- **Transferred?**
- **Attraction**
- **Expectations**
- **Helpful?**
- **Service delivery**
- **Staff**
- **Knowledge**
- **Problems**
- **Have you ever faced any racism?**
- **Signposting/other things that may help**

SERVICE IMPROVEMENT

- **What's worked well?**
- **How difficulties, if any, tackled?**
- **Improving services. Anything else that can be done to meet your needs?**
- **Help needed. What kind?**
- **Resolving drug addiction in BME? What do you think could/should be done?**

Anything else you would like to discuss?

Interview Questions/ Themes for service providers

BACKGROUND KNOWLEDGE

- **Community views**
- **How are BME affected by drugs?**
- **Community opinion re help seeking?**

ACCESSING SERVICES

- **Aware of types of help for BME?**
- **Aware of process of accessing services?**
- **Service BME would prefer. Why?**
- **Why might they prefer generic or BME service?**

EXPERIENCE OF SERVICE

- **Difficulties for BME accessing help? BME and generic?**
- **How would any difficulties be overcome?**
- **Worked well? Not worked?**
- **How service can improve?**

FAMILY INVOLVEMENT

- **F&F – do they have a role?**
- **Help? Hinder process?**
- ***Should* F&F be involved – what would their specific role be?**

STIGMA

- **How can the stigma of drug use in BME communities be removed?**
- **Are you aware of any anti-stigma initiatives that are active in the BME community?**

RECOVERY

- **What is your experience of recovery in BME communities?**
- **Aware of additional help for BME's in their communities?**
- **Do BME's need different/ additional help?**

Anything else you would like to discuss?

Interview Questions/ Themes for Family and Friends

BACKGROUND ON DRUG USE

- **Experiences of DA? In your Community?**
- **How does your community view DU?**
- **Have you been Involved in helping/supporting for DA. How?**
- **Are you aware of help for BME?**
- **Have seek help on behalf of DA?**

SEEKING HELP

- **Did you know where to seek help for the DA and what to do?**
- **Did you help DA access a service?**
- **Was anyone else involved in helping you with this? If so, who?**
- **Are services available specifically for the BME community in your area?**
- **Tell me about the services you're aware of?**

INVOLVEMENT OF FAMILY AND FRIENDS AND COMMUNITY

- **Are you involved with South CAT? In which way? How did you get involved?**
- **How did the DA feel about your involvement?**
- **How did the SP feel about your involvement?**
- **Did your involvement help the DA? If so yes or no, describe how?**
- **Did your involvement affect you and your immediate family? How?**
- **How do your community's views affect DA recovery process? How?**
- **Were there any other issues you personally faced in helping the service users**

SERVICES

- **Are you involved in accessing a service for you or the DA?**
- **If yes did you choose the GS or BME? What led you to do so?**
- **Transferred between services, what led you to do so?**
- **What do you think of the BME service?**

- **What were the service delivery and the staff like?**
- **Usefulness of advice**
- **What made you come back?**
- **Have there been difficulties in accessing GSor BME services?**
- **How have the difficulties been overcome?**

SERVICE IMPROVEMENT

- **Do you think FF should be involved in services?**
- **Thinking about the services you've used is there any way this be improved?**
- **Tell me about what you think worked well in the service?**
- **Is there anything that did not work in the treatment you and/or the DA received? Difficulties, missing?**
- **Difficulties can be tackled?**
- **Do you feel that you require additional support as FF of a DA?**
- **Need for any additional or different forms of help/support for DA?**
- **If yes, please specify what this may be and why you think it would help?**
- **Anything else you want to discuss?**

If no involvement with the services please describe how they have helped in other ways.

Is there anything that would want to make them involved want to be involved in the services.

Anything else you would like to discuss?

My Story Project

Participant Information Sheet (Service User)

22 January 2010

Introduction

Glasgow Anti Racist Alliance (GARA) is a multi-agency social inclusion partnership established to tackle the social exclusion of people. GARA aims ensure that BME people enjoy equal opportunities in getting access to jobs, education, health, housing and public services[6].

Our broad research aims are to investigate issues that affect BME communities. This particular research is interested in black and minority ethnic (BME) drug users and their friends and family experiences of accessing services. In addition to this, we are interested in the experience of service providers for BME drug users and their role in providing rehabilitation services.

What is the study about?

GARA is working together with South Community Addiction Team (CAT) to conduct research on the experience of people from BME communities with drug addiction including the effect this has on friends and family members of drug users. We are also studying how mainstream services (NHS based drug services) are equipped to meet needs of BME community members facing this problem and how these can be improved.

What is the purpose of the research/what will happen if I agree to take part?

The research will:

- Explore the experience of BME drug users in accessing mainstream services and how they have managed to overcome any difficulties.
- Learn what has worked and has not with services accessed by BME drug users and ways to improve them.
- Learn and understand the role of families/ friends in the road to recovery from drug use.
- Investigate the experience of mainstream and BME specific drug service providers in delivering services to BME drug users.

In order to do this the research will involve interviews with BME drug users and their friends and family members who may have been involved in their recovery processes. The interviews will be conducted by peer researchers (researchers from the BME community) who have been working in this field with GARA. The interviews will be recorded digitally

[6] GARA is the former name for CRER, the Coalition for Racial Equality and Rights

using audio-visual equipment (camera/video recording) and analysed by a researcher. The footage from the camera recordings will be used to produce a training DVD for the NHS staff members and the BME community in general. We will anonymise participants in cases where they prefer to do so. Focus groups will also be conducted to interview NHS staff members and this will be carried out by GARA researchers.

If you choose to take part in this project you will be interviewed for a maximum of 1 hour by an independent researcher. The interview will be recorded audio-visually, anonymised and analysed before a report is drafted.

You will also be asked to nominate a maximum of 4 friends and family members who may have contributed to your recovery process. They will then be approached by our team and interviewed separately to find out about their experience in helping you.

You will also have the chance to contribute to the findings as we will send you a summary report before the final report is drafted. You will also be invited to take part in a discussion session on the findings.

Will my taking part in the study be kept private?

Yes. Information provided by you will be anonymised and coded and analysed by the researchers at GARA. Only anonymised research findings will be shared with other parties. If you choose to remain anonymous during your interviews this can also be facilitated. You will not be identified against your wishes.

Do I have to take part?

No. This research is completely voluntary and if you decide to stop participation you are free to do so and all data gathered up to the point of withdrawing with either be kept with your consent or destroyed if that is what you want.

Will I receive payment or expenses?

You will not be paid for taking part in the research. However you travel expenses will be reimbursed — please note, travel should be made on public transport wherever possible. Researchers will aim to arrange for support such as interpretation, childcare etc upon demand.

Are there risks or benefits to taking part?

This research does not anticipate any risks to you taking part. The potential benefits for you taking part are gaining new experiences and knowledge. Sharing your experiences, helping future training and contributing to the community.

How do I complain?

If you have any queries and complaints with regards to this research please go through the standard NHS complaints procedure. Information is available from the NHS website.www.nhsggc.org.uk.

You can also contact the Glasgow Addiction Services through the Glasgow City Council website http://www.glasgow.gov.uk/ or call them on 0141 287 0900.

We do advice all participants that in the first instance please contact a member of staff who is aware of your participation in this research project. Kelly Smith can be contacted on 0141 420 8100.

What will happen to the results of the study?

The results of this research will be presented in a final report which will be accessible to you and all participants. This research also aims to produce a training DVD to facilitate future drug service provision to BME service users.

This DVD will also aim at encouraging BME communities to access drug rehabilitation services.

Who is funding the Research?

This research is funded by the Scottish Government and supported by Glasgow Community Addictions Services.

What do I do now?

Please fill in and sign the provided consent form and send it to the address provided or hand it to a member of the BME drugs and alcohol addictions team at South CAT.

Can I find out more?

If you require any further information please contact Ms Sidra Shirjeel, Researcher, on 0141 418 6530 or email research@gara.org.uk

Thank you for reading this – please ask any questions if you need to.

My Story Project

Participant Information Sheet (Service Provider)

22 January 2010

Introduction

Glasgow Anti Racist Alliance (GARA) is a multi-agency social inclusion partnership established to tackle the social exclusion of people. GARA aims ensure that BME people enjoy equal opportunities in getting access to jobs, education, health, housing and public services.

Our broad research aims are to investigate issues that affect BME communities. This particular research is interested in black and minority ethnic (BME) drug users and their friends and family experiences of accessing rehabilitation services. In addition to this, we are interested in the experience of service providers for BME drug users and their role in providing range of drug addiction services.

What is the study about?

GARA is working together with South Community Addiction Team (CAT) to conduct research on the experience of people from BME communities with drug addiction including the effect this has on friends and family members of service users. We are also studying how mainstream services (NHS based drug services) are equipped to meet needs of BME community members facing this problem and how these can be improved.

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- Learn and understand the role of families/ friends in the road to recovery from drug use.
- Investigate the experience of mainstream and BME specific drug service providers in delivering services to BME drug users.

In order to do this the research will involve interviews with BME drug users and their friends and family members who may have been involved in their recovery processes. The interviews will be conducted by peer researchers (researchers from the BME community) who have been working in this field with GARA. The interviews will be recorded digitally using audio-visual equipment (camera/video recording) and analysed by a researcher. The

footage from the camera recordings will be used to produce a training DVD for the NHS staff members and the BME community in general. We will anonymise participants in cases where they prefer to do so. Focus groups will also be conducted to interview NHS staff members and this will be carried out by GARA researchers.

If you choose to take part in this project you will be interviewed most probably through focus groups for a maximum of 1 hour by an independent researcher. Most interviews will be taken through focus groups. The interview will be recorded audio-visually, anonymised and analysed before a report is drafted.

You will also have the chance to contribute to the findings as we will send you a summary of the report before a final report is drafted. You will also be invited to take part in a discussion session on the findings.

Will my taking part in the study be kept private?

Yes. Information provided by you will be anonymised and coded and analysed by the researchers at GARA. Only anonymised research findings will be shared with other parties. If you choose to remain anonymous during your interviews this can also be facilitated. You will not be identified against your wishes.

Do I have to take part?

No. This research is completely voluntary and if you decide to stop your participation you are free to do so and all data gathered up to the point of withdrawing will either be kept with your consent or destroyed if that is what you want.

Will I receive payment or expenses?

You will not be paid for taking part in the research. However your travel expenses will be reimbursed — please note, travel should be made on public transport wherever possible. Researchers will aim to arrange for support such as translation, childcare etc upon demand.

Are there risks or benefits to taking part?

This research does not anticipate any risks to you when taking part. The potential benefits for you taking part are gaining new experiences and knowledge. Sharing your experiences, helping future training and contribute to the community.

How do I complain?

If you have any queries and complaints with regards to this research please go through the standard NHS complaints procedure. Information is available from the NHS website.www.nhsggc.org.uk

You can also contact the Glasgow Addiction Services through the Glasgow City Council website http://www.glasgow.gov.uk/ or call them on 0141 287 0900.

We do advice all participants that in the first instance please contact a member of staff who is aware of your participation in this research project. Kelly Smith can be contacted on 0141 420 8100.

What will happen to the results of the study?

The results of this research will be presented in a final report which will be accessible to you and all participants. This research also aims to produce a training DVD to facilitate future drug rehabilitation service provision to BME service users.

This DVD will also aim at encouraging BME communities to access drug services.

Who is funding the Research?

This research is funded by the Scottish Government and supported by Glasgow Community Addictions Services.

What do I do now?

Please fill in and sign the provided consent form and send it to the address provided or hand it to a member of the BME drugs and alcohol addictions team at South CAT.

Can I find out more?

If you require any further information please contact Ms Sidra Shirjeel, Researcher, on 0141 418 6530 or email research@gara.org.uk .

Thank you for reading this – please ask any questions if you need to by contacting us as above

My Story Project

Participant Information Sheet (Service User Friend/Family Member)

22 Jan 2010

Introduction

Glasgow Anti Racist Alliance (GARA) is a multi-agency social inclusion partnership established to tackle the social exclusion of people. GARA aims ensure that BME people enjoy equal opportunities in getting access to jobs, education, health, housing and public services.

Our broad research aims are to investigate issues that affect BME communities. This particular research is interested in black and minority ethnic (BME) drug users and their friends and family experiences of accessing rehabilitation services. In addition to this, we are interested in the experience of service providers for BME drug users and their role in providing rehabilitation services.

What is the study about?

GARA is working together with South Community Addiction Team (CAT) to conduct research on the experience of people from BME communities with drug addiction including the effect this has on friends and family members of drug users. We are also studying how mainstream services (NHS based drug services) are equipped to meet needs of BME community members facing this problem and how these can be improved.

What is the purpose of the research/what will happen if I agree to take part?

The research will:

- Explore the experience of BME drug users in accessing mainstream services and how they have managed to overcome any difficulties.
- Learn what has worked and has not with services accessed by BME drug users and ways to improve them.
- Learn and understand the role of families/ friends in the road to recovery from drug addiction.
- Investigate the experience of mainstream and BME specific drug service providers in delivering services to BME drug users.

In order to do this the research will involve interviews with BME drug users and their friends and family members who may have been involved in their recovery processes. The interviews will be conducted by peer researchers (researchers from the BME community) who have been working in this field with GARA. The interviews will be recorded digitally using audio-visual equipment (camera/video recording) and analysed by a researcher. The

footage from the camera recordings will be used to produce a training DVD for the NHS staff members and the BME community in general. We will anonymise participants in cases where they prefer to do so. Focus groups will also be conducted to interview NHS staff members and this will be carried out by GARA researchers.

If you choose to take part in this project you will be interviewed for a maximum of 1 hour by an independent researcher. The interview will be recorded audio-visually, anonymised and analysed before a report is drafted.

You will also have the chance to contribute to the findings as we will send you a summary before a report is drafted. You will also be invited to take part in a discussion session on the findings.

Will my taking part in the study be kept private?

Yes. Information provided by you will be anonymised and coded and analysed by the researchers at GARA. Only anonymised research findings will be shared with other parties. If you choose to remain anonymous during your interviews this can also be facilitated. You will not be identified against your wishes.

Do I have to take part?

No. This research is completely voluntary and if you decide to stop your participation you are free to doso and all data gathered up to the point of withdrawing will either be kept with your consent or destroyed if that is what you want.

Will I receive payment or expenses?

You will not be paid for taking part in the research. However your travel expenses will be reimbursed — please note, travel should be made on public transport wherever possible. Researchers will aim to arrange for support such as translation, childcare etc upon demand.

Are there risks or benefits to taking part?

This research does not anticipate any risks to you when taking part. The potential benefits for you taking part are gaining new experiences and knowledge. Sharing your experiences, helping future training and contribute to the community.

How do I complain?

If you have any queries and complaints with regards to this research please go through the standard NHS complaints procedure. Information is available from the NHS website. www.nhsggc.org.uk

You can also contact the Glasgow Addiction Services through the Glasgow City Council website http://www.glasgow.gov.uk/ or call them on 0141 287 0900.

We do advise all participants that in the first instance please contact a member of staff who is aware of your participation in this research project. Kelly Smith can be contacted on 0141 420 8100.

What will happen to the results of the study?

The results of this research will be presented in a final report which will be accessible to you and all participants. This research also aims to produce a training DVD to facilitate future drug rehabilitation service provision to BME service users.

This DVD will also aim at encouraging BME communities to access drug services.

Who is funding the Research?

This research is funded by the Scottish Government and supported by Glasgow Community Addictions Services.

What do I do now?

Please fill in and sign the provided consent form and send it to the address provided or hand it to a member of the BME drugs and alcohol addictions team at South CAT.

Can I find out more?

If you require any further information please contact Ms Sidra Shirjeel, Researcher, on 0141 418 6530 or email research@gara.org.uk .

Thank you for reading this – please ask any questions if you need to by contacting us as above

Study Number:

Patient Identification Number for this trial:

CONSENT FORM FOR SERVICE USERS

Title of Project: **BME My Story Drug Project**

Name of Researchers: **Dr Nundita Reetoo and Sidra Shirjeel**

Please tick box

Initial box

1. I confirm that I have read and understood the information sheet dated 22nd of January 2010 for the above study explained in the information sheet .

I have had the opportunity to consider the, information, ask questions and have had these answered satisfactorily.

Initial box

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

Initial box

3. I give consent to have my interviews recorded using an audio tape recorder.

Initial box

4. I give consent to have my interviews recorded using a camera

Initial box

5. I **agree/do not agree* to** be identified in my interviews.

6. I agree to take part in the study as above. **Initial box**

7. I give consent for GARA to contact my friends and family for the purpose of this research.

Initial box

*** delete accordingly**

________________ ______________ ____________________

Name of Participant Date Signature

________________ ______________ ____________________

Name of Person taking consent

Date Signature

Study Number:

Patient Identification Number for this trial:

CONSENT FORM FOR SERVICE PROVIDER

Title of Project: **BME My Story Drug Project**

Name of Researchers: **Dr Nundita Reetoo and Ms Sidra Shirjeel**

Please tick box

Initial box

1. I confirm that I have read and understood the information sheet

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4. I give consent to have my interviews recorded using a camera

Initial box

5. **I agree/do not agree* to** be identified in my interviews.

6. I agree to take part in the study as above. **Initial box**

7. I give consent for GARA to contact my friends and family for the purpose of this research.

Initial box

*** delete accordingly**

____________________ _______________ ________________________

Name of Participant Date Signature

____________________ _______________ ________________________

Name of Person taking consent

Date Signature

Study Number:

Patient Identification Number for this trial:

CONSENT FORM FOR SERVICE USER'S FAMILY/FRIEND

Title of Project: **BME My Story Drug Project**

Name of Researchers: **Dr Nundita Reetoo and Sidra Shirjeel**

Please tick box

Initial box

1. I confirm that I have read and understood the information sheet dated 22nd of January 2010 for the above study explained in the information sheet .

I have had the opportunity to consider the, information, ask questions and have had these answered satisfactorily.

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7. I give consent for GARA to contact my friends and family for the purpose of this research.

Initial box

*** delete accordingly**

____________________ _______________ _________________________

Name of Participant Date Signature

____________________ _______________ _________________________

Name of Person taking consent

Date Signature

Appendix 3: South CAT services

Glasgow addiction services were based on a tier system, so that tier four is the Social Work based services, tier three is GP based services, tier two are community addiction and top are the consultants. Patients have access all four services on individually or through their GP. In addition to this South East of Glasgow has a small team called Black Minority Ethnic (BME team). The BME team work across the board, so in addition to all the other services which are available to the rest of the population this is an additional service for BME patients.

The BME service was initially established because South CAT was receiving information and feedback from BME patients that they were finding it difficult to engage with the Generic service because of the predominantly white male make-up. Staff also observed that a number of BME patients were approaching the services but were not being retained.

The BME service established by South CAT aimed at targeting —hard to reach groups within the BME community to promote the services of South CAT and encourage those who were in doubt to approach and use the services. The BME services offered by South CAT were initially aimed at the South East Glasgow CHCP population, but Glasgow and Clyde NHS Health Board and Glasgow City Council as well as Glasgow Addiction Services viewed that there was a need to provide as wide an access service as possible across the city. It was agreed that this service should still be located within the South- East of Glasgow because of the relatively high BME population certainly within Govanhill, Pollokshields area of the city. The BME team recently inherited the management of BME clients on drugs and alcohol addiction for the Greater Glasgow area.

South CAT received referrals from individuals through self-referral or through their friends and family members or through organisations, charities, and health services, for example their GPs. BME patients had access to both BME specific and Generic services. Where appropriate interpreters were organised through an interpretation service. After a decision was made by the client, an appropriate a drug and alcohol case worker was allocated to them to identify their basic needs. This was usually done within one to two weeks of referral. Needs of clients family and friends were also assessed by the case worker and appropriate referrals made.

The BME specific team consisted of 2 case workers working part time who had specific remits in either adult (0.5 FTE) or child (0.5 FTE) addiction and psychiatry. They also had a BME specific mental health nurse and medical doctor attached part time to the team. By the end of the project, the BME nursing support was decreased as the designated nurse left the service. A 24 hour phone line in multiple languages was set up and used by the BME team to respond to BME client needs. Other than the usual services offered by South CAT, BME case workers also offered support to families and friends dealing with the addiction problems of their relatives. This ranged from education, advice, coping strategies, mediation, and signposting to appropriate support mechanisms and information. These varied from providing information related to poverty, to mental health support.