

BME Drug & Alcohol Use

Are Substance Misuse Services Equipped to Respond to it?

Harrinder Singh Dhillon – Drug & Alcohol Service for London (DASL)

How can generic services access BME users given the priorities of the treatment system?

- DASL's generic credentials – a 27 year old London based charity and voluntary sector provider offering 75% alcohol and 25% drug services across 5 London boroughs.
- The services provided include the following community based services (non-residential);
 - 3 community alcohol teams (home & ambulatory detox, reduction, harm minimisation and reduction work)
 - 3 group programmes (2 alcohol & 1 drug – drug/alcohol free & controlled)
 - a wrap-around service, a substance misuse counselling service (drug & alcohol) & 3 alcohol counselling services

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- a DRR programme
- a drug and alcohol education and training service (Spark)
- a number of specific community lead projects (tiers 1-2), Bengali Alcohol Project, DV projects that work with women, men & children (including perpetrator work), Girl's Talk, Lesbian Youth Project & a Young Gay Men's Substance Misuse Project
- a brief intervention project targeted at primary care (GP practices) around alcohol.
- DASL = the community end of substance misuse service provision.

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- The BME populations in the boroughs DASL works;
 - Newham over 50% (over 41% < age of 24 years)
 - Tower Hamlets approaching 40% (largest Bengali population in the UK)
 - Redbridge (over 35% with one of the largest Jewish populations in London)
 - Greenwich – (over 25%)
 - Bexley – (8%)
- Overall with just Greenwich & Bexley below the average BME population for a London borough.

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- What are the priorities of the treatment system?

- important here not to merge the priorities of the drug treatment system with that of the alcohol treatment system

- for the drug treatment system the overriding priority is that of reducing crime as linked to drug use by chanting the mantra “drug treatment works” so aiming to increase the number entering and remaining within the system long enough for it to have a positive impact (the crime Home Office paradigm)

- for the alcohol treatment system the overwhelming priority is about convincing the non-believers that alcohol poses a serious public health concern and that policy and resources better need to match the seriousness of the problem (the public health Department of Health paradigm).

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- Can we make use of each others priorities (drug and alcohol and vice versa)?
 - we probably already have done so as we all exist within an economic and political climate that has since 1998 aimed to change the landscape of how drug treatment is delivered, measured and accounted for in accordance to an emerging policy and strategic agenda
 - DASL was a community alcohol team that developed into a community drug and alcohol service and then decided to provide services in neighbouring boroughs (we were never going to go to Preston to deliver a service and I am not sure what the motivation would be to do that)!
- DASL remains at heart a local community drug and alcohol provider = BME friendly

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- What can a drug and alcohol service do to deliver services to growing BME communities whilst managing the mainly top down priorities? (waiting times, retention, treatment outcomes profiles, numbers in treatment, DANOS, Quads, Models of Care, unit costs, service user consultation...)
- DASL's main resource are it's staff – over 50% are BME with over 60% women (despite the mobility of today's workforce they are or have local connections). DASL's staff are of the communities they serve.
- With a diverse well inducted, trained and experienced staff team comes skills in being able to speak a number of mother tongues. To be able to talk to your communities and clients.
- DASL ordinarily would provide service information in the main community languages spoken locally, for example, in Tower Hamlets Bengali and in Redbridge Punjabi.

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- DASL has in place an EOP policy and where appropriate work plans cite specific activities that services, teams and staff will undertake with BME communities.
- Making and working with partners within the BME communities is crucial. It opens the door to building trust, it can give you opportunity to find out the temperature of the community around the issues and their potential needs.
- Work with BME communities and groups is a two-way reciprocal process – avoid being a pick pocket. Short-term results Vs long-term gains. Bengali Alcohol Project in Tower Hamlets initially worked by supporting significant others (partners), we now see the drinkers themselves (2-3 year process).
- Join the BME communities with the issues and concerns that they may have, not always compatible or in tune with drugs or alcohol. For example, Girl's Talk works around self-harm and mental health issues for young Asian women.

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- Be prepared to invest in and to develop your staff in the direction of BME work as rewarding, meaningful, respected and valued activity. Not ghettoisation, these are portable skills.
- Take risks but not without thought – Somali research conducted by COF on behalf of DASL funded by a contribution we made to an AERC publication. The DAAT then convened a Somali Drug and Alcohol Conference for the community in Tower Hamlets.
- Be prepared to work either up or down the food chain – tiers 1-4. BME work may be more likely to be found at tiers 1-2 rather than tiers 3-4. This would then require a re-think of the more appropriate interventions (education, training, community health projects, development projects, media projects, peer lead projects, harm reduction work, tie-ins with other mutual issues such as coronary heart, smoking, paan chewing, obesity, primary care screening, brief interventions, mental health and domestic violence).

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- Stop feeling guilty and just act! If you work in a London borough approximately 30% of your population are BME. They are your clients and to embrace being client and user lead will necessitate meeting their needs.
- Work with your commissioners and your DAAT, you should not have to shoulder the responsibility alone it is a partnership challenge.