Debate Reigns Over Complexities of Improving Access

What does a Tamil torture survivor, Lithuanian sex worker and black teenage gang member have in common ? They may well all be members of a very diverse and marginalised group in London - black and minority ethnic drug and alcohol users, and they are all probably having more difficulties accessing treatment than their white British peers, but for different reasons.

The subject of BME drug and alcohol use is complex and controversial but for some time there has been agreement that minority ethnic groups are misusing substances and in need of help, but face considerable barriers to treatment. Notwithstanding race relations legislation, which obliges publicly funded agencies including DATs and PCTs to treat all groups equally, drug and alcohol treatment has had, in short, a white Eurocentric bias.

Models of Care for Drugs itself admitted as much when it stated there were "institutional failings" in meeting black and minority ethnic drug users needs "especially true for residential rehabilitation facilities, but also of the whole treatment system", while in 2002 an Alcohol Concern commission said BME alcohol users were not being catered for adequately either.

Barriers to Treatment

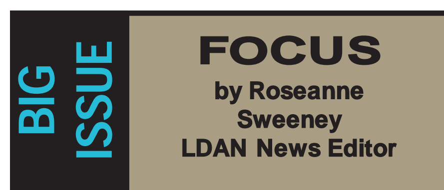
There was however considerable consensus about what the main barriers to treatment were: opiate focused services; Eurocentric treatment approaches including a focus on the individual; an inability on the part of staff to understand and respond to the needs of BME users; too few BME workers; language barriers; poor awareness among BME groups about services available; concerns around confidentiality; and anxiety among refugees and asylum seekers about being reported to the authorities.

The chief remedies prescribed were better ethnic monitoring; more outreach work, community engagement and working with families; targeted literature; and the substantive implementation of equal opportunities policies. It was also recognised that more minority ethnic workers needed to be recruited in diverse areas like London. Mainstream services though staffed with culturally competent workers were to drive forward improvements on BME access.

So are things getting any better?

Flawed Treatment System

Practitioners working with BME groups say there is a growing need in minority ethnic communities for drug and alcohol services but the treatment system makes it difficult to cater for it, as there is so much pressure to meet centrally imposed targets around numbers and retention times. This does little to promote the time consuming relationship building and awareness raising work necessary to access users in diverse communities, while the focus on Class A drugs makes it difficult to work with those using other substances like khat problematically.



Most also contend that there is a need for specialist services, as mainstream services are not as accessible to diverse groups. Though these may have workers from minority ethnic backgrounds, BME practitioners say the working practices and culture of mainstream services are still very much geared towards the majority population - something that does not pass minority ethnic users by.

They also say that many clients prefer a specialist service as people are naturally more comfortable among who those they regard their peers - particularly when they are feeling vulnerable.

The lack of resources for alcohol treatment is another problem as alcohol is being used and misused by all communities. But the treatment system too has been criticised as inappropriate for BME groups. Writing in *Drink and Drugs News* last year, Don Shenker from Alcohol Concern said the then just published Models of Care for Alcohol, regarded treatment as "a strict mono-cultural, individualistic and bureaucratic top down model, passing only scant reference to the needs of Black, Asian and other ethnic groups… No examples, suggestions or guidelines are given on how to engage with diverse community groups."

Progress Being Made?

A recent NTA report suggests progress is being made in drug treatment. Based on National Drug Treatment Monitoring System data for 2005-2006, it says many minority ethnic users in London are accessing and being retained in treatment. While Asian drug users are under represented, the report states the black population has been "successfully engaged by treatment providers." In fact, it says that based on a comparison between the treatment population and overall population, black users are over represented in some London boroughs. Blacks and Asians are also more likely to be retained in treatment than other ethnic groups, something it ascribes to "ethnic-specific services, effective assertive outreach and local prioritisation".

Trevor McCarthy, NTA best practice manager, says that while there is clearly room for improvement - the improvement review this year is looking at diversity - many mainstream services are effectively catering for BME communities. "Many people are happy with mainstream services and just go and use them," he says, adding that those using specialist services may be disproportionately critical of mainstream services because of a bad

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Unwitting Focus on "White UK" Means Crack Users Lose Out

Crack specialists COCA say not enough priority is attached to treating crack users. Despite the publication of several reports in recent years criticising the opiate focused nature of drug services, and a national crack plan, COCA's Tony D'agostino says there are still not enough specialist services while mainstream services are not being reconfigured to engage crack users.

D'agostino says the problem is services do not have the resources to reconfigure and train their workers to deal with crack users - of which a significant proportion are black Caribbean - while the treatment system does little to promote it.

"The 12 week retention target was thought up with opiate users in mind. Why aren't there targets around cognitive behavioural therapy, motivational interviewing and alternative therapies to encourage work with stimulant users?" he asks.

"Stimulant users are much more difficult to work with, need more intensive help and do not have the incentive of a script to come back for," he continues. "But because there is not one target around crack or cocaine use, agencies with a full caseload quickly get the message that they don't have to work with stimulant users."

D'agostino is critical of the Department of Health's and NTA's harm reduction strategy published earlier this year, for focusing heavily on opiate users

"despite the fact that crack use is attributed to higher risk behaviour and linked to the increased prevalence of Hepatitis C." He says there is a need for more information around safer smoking and pipe exchanges should be introduced.

His criticism comes despite mounting concern in recent years about the extent to which crack users are catered for. One Home Office report described the focus on opiate injecting as an "important source of institutional racism".

D'agostino thinks the institutionally racist label inappropriate, but says that by focusing on injecting users, services are unwittingly focusing on "white UK". If services want to widen their reach they need to adapt to cater for smokers and snorters, he says. "The South Asian community smoke heroin. African Caribbeans are more likely to snort or smoke. If you provide services that cater for a wide range of drugs, you will see more people from BME communities coming through the door."

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experience they have had in one. "They may not have liked staff or how they were treated there," he said.

But Abd Al-Rahman from the Federation thinks the problem is more systemic and much more priority needs to be given at strategic level to the needs of BME users, as at service level workers have a poor understanding of diversity issues and their role in increasing accessibility. He wants the Government to undertake a thorough review of the progress made on black and minority ethnic issues in recent years so it can identify problem areas. He also thinks more stringent performance monitoring should be introduced for drug action teams.

Complex Issue

Jane Fountain from the University of Central Lancashire's Centre for Ethnicity and Health has spent much of the past seven years immersed in issues surrounding drug use and service provision for BME communities. She has been working on the Department of Health's Black and Minority Ethnic Drugs Needs Assessment Project that was conducted throughout England in 2000-2006. This huge and ambitious project employed a community engagement model to train and support 179 community organisations to conduct needs assessments, and Professor Fountain is now in the process of writing up the project's results to inform drug service planning and provision.

Part of the reason why progress on service provision is difficult is because it is very complex area, she says. "There are a lot of barriers to access other than the obvious ones like language. Black Africans often don't want to come out as a drug user in case they will be reported to the Home Office. The idea of services being confidential is completely alien to them. Some will have come from less than democratic countries and will have spent several years getting to the UK. The last thing they want is to be sent back. For South Asians on the other hand, the issue is often about gossip in the community and not wanting to let the family down."

Fountain says it is difficult to accurately measure whether BME groups are adequately represented in treatment, but straightforward statistical comparisons between the treatment population and overall ethnic minority population in a given area do not give the full picture. Many black users are in treatment because they are over represented in the criminal justice system due in part to discriminatory stop and search procedures, she says. Other communities like the Bangladeshis have a very young population so would have more people at risk of drug use than the older white population, another factor that should be taken into account.

Overall, she says cultural competence is key to improving access. One of many complicated definitions defines this as, ensuring the "knowledge, information and data about individuals and groups is integrated and transformed into clinical standards, skills, service approaches, techniques and marketing programmes to match the individuals culture and increase both quality and appropriateness of health and health outcomes."

So not easily achieved, especially when as Fountain points out diversity training is more often than not a "one-off" exercise.