ALL WALES
DRUGS AND CULTURAL DIVERSITY CONFERENCE

1ST APRIL 2004

REPORT & RECOMMENDATIONS

ENGAGING BLACK & MINORITY ETHNIC COMMUNITIES IN WELSH SUBSTANCE MISUSE STRATEGY

Contents Page

Forward 2

Acknowledgments 2

Introduction 2

Opening Speaker Jazz Iheanacho Race Equality First 3

Drug Use Treatment and Spirituality 4
Shafiur Rahman

Expectations of Service Providers 8
Erskine Grant

Cultural Competence and Service Provision
Michael Shiner

Building Upon Local Perspectives
Shirley Yendell

Overview of Conference Workshops

Workshop 1
Black and Minority Young People, Drug Use and Drug Education
Chester Morrison and Kirit Mistry

Workshop 2
Stimulant Use and Effective Service
Aidan Gray

Workshop 3
Diversity and Diversification of Treatment Options
Janaka Perera

Workshop 4
Black and Minority Ethnic Women, Drug use and Issues for Treatment and Support
Khatidja Chantler

Workshop 5
Building on Local Good Practice
Noward Hashi and Safeena Ghufran

Conference Recommendations

Feedback from conference evaluation forms

Forward

Edwina Hart AM MBE

I'm sure you will agree with me that it is vital for all agencies, organisations and communities in Wales to work together to deal with the problems we face in tacking substance misuse. I am reassured when I hear that organisations are working in collaboration with each other to bring such a worthwhile conference into being. As you know my aim is to ensure that substance misuse treatment services are increased and improved upon and are available to those who need them in Wales. I have placed the responsibility for delivering the National Strategy at a local level with the 22 Local Community Safety Partnerships and have increased the Substance Misuse Action Fund budget by £4.3 million for the financial year 2004/2005. We all know that there is still a lot of work to be done in this area, but conferences such as this are helping to take the agenda forward in Wales and I offer my best wishes for an interesting and productive day.

Acknowledgements

We would like the opportunity to thank all of those who attended the conference and offer a special thanks to the conference funders, Cardiff Community Safety Partnership and to all who contributed their time, effort and ideas, without which the conference and this report would not have been possible.

Special thanks also to Martyn Pengilley (Chair NewLink Wales) who welcomed delegates, to Jazz Iheanacho (Director of Race Equality First) who gave the opening address, to Rhoda Emlyn-Jones(Principal Social Services Officer) who was our Chair for the morning and Yasmin Hussein (Head of Equality Policy Unit of the Welsh Assembly Government) who was the Chair for the afternoon session.

Introduction

The notion of a conference to explore the impact of drug service provision on Black & Minority Ethnic communities emerged following discussions between DDMC (training and consultancy organisation) and NewLink Wales. The conference was felt to be necessary in order to raise awareness of the specific issues faced by members of our diverse communities in relation to their access to and experience of drug service provision. It is recognised, however, that social and economic factors, coupled with issues of education and social welfare, also impact on BME communities.

The Conference intended to offer the opportunity for service providers to meet with groups representing the interests of BME communities in order that both parties could share perspectives and begin to develop strategies to improve service delivery. This aim was not fully realized as representation of service providers was minimal. The participants from a vast range of statutory and voluntary sectors who did attend were able to learn more about the issues, consider how the matters presented impact on the work in which they are involved, and then contextualize and decide upon any further action required to address the issues.

This report will offer readers a flavour of the conference deliberations as well as the keynote speakers' contributions. An overview of the workshops and overall recommendations are also noted in this report.

Opening Speaker

Jazz Iheanacho : Director Race Equality First

Mr Iheanacho congratulated NewLink Wales on their success in organising the first national conference to focus on the needs of drug service provision to BME communities. He went on to identify some key areas for consideration. Firstly there was the issue of stereotyping both of drug users and BME community members. Mr Iheanacho suggested that individuals use drugs to feel good or stop feeling bad and the specific reasons must be explored in order the provide an effective response. The negative stereotyping of individuals can block the necessary investigation and stop discussion of the real issues. Mr Iheanacho's second key area was related to the myths that feed stereotypes. He pointed out that there is a common assumption that drug use within Indian, Pakistani and Bangladeshi communities is virtually non existent. The fact is that there has been a steady increase in drug use by young people from these communities over the past ten years. Mr Iheanacho also stated that people from BME communities face higher rates of imprisonment of drug related offences but research has indicated that that levels of drug use are much lower than that of the majority population. The issue of equal opportunities was also addressed by Mr Iheanacho and in particular the recruitment and retention of BME staff. He suggested that these areas could only be properly addressed by strategic planning at the highest levels and the commitment to undertake this work is questionable given that it required a small voluntary sector organisation to bring concerns regarding drug service provision to BME communities to the fore.

Drug Use Treatment and Sprituality
Presentation by Shafiur Rahman- Manager Nafas

Mr Rahman began his presentation by reminding delegates of a number of unspoken truth's. Drug treatment he suggested is located within a Health framework. As a result of this location the medical model / disease model of addiction holds primacy in terms of addressing the issues presented.

Additionally Mr Rahman noted that medicine in Europe had is genesis in an era when the functioning of the body was not viewed as separate to the operation of the soul and its connection to a greater power was a given. There was no separation between the physical and the temporal. There has however been a gradual erosion of the place of faith in medicine to the extent that in the 21st century for a "cure" to be verified it has to be able to sustain rigorous scientific investigation.In this context miracles and other non scientific happenings are regarded as either flukes, the influences of placebos or patient suggestibility. This shift has occurred in parallel with the European shift in the importance of religious observance and a disentanglement of church and state, the Vatican was highlighted as a lacuna in those arrangements.

Emprical evidence is refracted through the prisms of perception of those in power. Views or understandings from other sections of the wider community are left unheard. The impact of racism on a social, psychological, physical and economic levels is given scant regard. Mr Rahman suggested that the lack of regard to other views and approaches particularly in the drug treatment field is detrimental both to the systems and organisation seeking to address issues and to the individuals caught up in such a system.

Mr Rahman outlined that Health and Illness can not be viewed as value free terms. They are like all things constructed to fit the reality to which they belong. For the World Health

Organisation "Health" is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. Whilst within the Chinese tradition "Health" is the harmony of two life forces (Yin and Yang) Illness is viewed as a disruption to this harmony. In African Cosmology Health is part of an entire magico – religious fabric. Protection from disease is in obeying religious and social norms, maintaining good relations with neighbours and abstaining from forbidden practices. If we are seeking to investigate treatment and spirituality then these views cannot be over looked.

In traditional Islamic medicine treatments are based on humours of hot cold dry and wet. Health however is related to a wider concept of the effect of ones deeds diet and is ultimately a gift from god. Mr Rahman noted that different cultures and religious traditions view health and illness from a diversity of approaches. Similarly there are views and understandings of substance misuse and addictions that will accord to those differing views.

In Britain as a whole the BME communities account for some 12.5% of the population. The majority of the population would associate themselves with religion of some sort in deed 75% of the White British population claim some Christian adherence. In terms of the BME population who claim some degree of religiosity the percentage is higher. Mr Rahman commented that it was surprising (given the level of knowledge regarding religious affiliations) that treatment services in the drugs field had not yet engaged with that aspect of their service users experiences. Mr Rahman further commented that whilst he would not necessarily expect to see prayer become part of a treatment plan he would have anticipated that some acknowledgement of spirituality would figure in some aspect of the service if only to give the nod to an understanding of the holistic nature of the drug dependence and therefore the necessary treatments.

Mr Rahman commented further that some interesting work was coming out of America. Research from the USA had highlighted the effectiveness of religious / spirituality based programmes in relation to alcohol and substance misuse. Indeed he noted wryly that god is often cited as a factor in the shaping and saving of individuals who were formally drug dependent, however because this is deemed a secular society the influence that the

individual would accord to god is dismissed as suggestibility, placebo or in more extreme circumstances taken as evidence of a psychotic episode. This reflection was made in the face of evidence from the US department of Health and Human services in 2003 that for,

"youths aged 12 to 17 with higher levels of religiosity were less likely to have used cigarettes, alcohol, or illicit drugs in the past month than youths with lower levels of religious belief"

Mr Rahman then went on to reflect on how in a secular setting such as drugs treatment, it may be practicable to incorporate faith and spirituality. It was suggested that within the commissioning sphere spirituality and or religious observance could form a criteria. However for that commissioning intention to be made real it would be important to widen the understanding of religious observers and observances from "Christian God botherers" who would be believed to have little or no understanding of the cycle of change or dependence, to the recognition that spirituality and religious observances are not incongruent with service management and staffing. He went on to note that training for staff and commissioners to show or demonstrate to them the value of spirituality and the inclusion of religion in the treatment process would be of benefit.

In assessments and care planning spirituality and religious observances would have not only to be noted be there should be some opportunity for their inclusion. Publicity and positive P.R. would assist the approach to move from viewing religion and spirituality as the exclusive domain of "Christian God botherers" to the interest of the service providers and the service users as a whole.

Mr Rahman outlined the benefits of incorporating faith and spirituality in treatment as:

- Anti racist as it would demonstrate equality of cultures and world views
- Creating better empathy with clients
- Enabling clients to relate to the service better as they would not have to dismiss ignore or hide a part of their belief system culture or background
- Making faith based communities more receptive to drug treatment services and hence increase their engagement with treatment services

Nafas, the service managed by Mr Rahman was outlined as one approach to the incorporation of spirituality in the commissioning and treatment cycle. Nafas was identified as a culturally sensitive model of working with Muslim drug users generally and Bangladeshi drug users in particular. Nafas' cultural sensitivity was outlined as their ability to work within the world view / cultural framework of the target community.

The key elements of the Nafas model were identified as being

- Community led through thorough needs analysis
- Multifaceted and holistic in their approach
- Management and staffing reflecting the local and the target communities
- Pro-active, by way of reaching into the community rather than waiting for the community to com e to the service.

In conclusion Mr Rahman outlined that the content of treatment is as important as the construct of treatment services. The model of service is as important as the way that model is developed managed and delivered. For an appropriate way forward at the national level, policy and guidance documents need to expand discussions on existing recommendations; good practice with BME communities needs to be documented and promoted. Promotion of diversity needs to take place so that communities and key organisations are aware of their rights. Service commissioners and providers need no longer see treatment as mutually exclusive. But rather spirituality and or religiosity could be better regarded as a component of the whole package of treatment and diversity in the range of treatment options available.

Expectations of Service Providers
Presentation By Erskine Grant

Erskine Grant's presentation addressed the requirement for all public authorities to produce and publish a Race Equality Scheme under the RRA (2000) and the specifity of its acts application to the developing drugs field. Mr Grant suggested that the scheme requires public authorities to publish and evidence how it will review its functions and policies to ensure race equality, consult with minority ethnic communities, provide information to communities, train staff on race equality and supply information on the staff profile by ethnic origin.

The scheme also requires an examination of all public authority functions for their impact on race equality. It was suggested that a desk-top analysis should be carried out by public authorities prior to any other form of analysis taking place. All new, as well as existing functions of the authority should undergo an assessment for potential impact on race equality.

Erskine Grant went on to outline further that Under the RRA the public authority is required to produce and publish a Race Equality Scheme. Broadly speaking, this scheme should show how the Public authority will address race equality issues in its work. A key aspect of the Scheme will be for the authority to decide which of its many functions and policies are relevant to race equality, and to prioritise them in terms of their impact.

A Race Equality Action Plan, upon which a scheme is based should set out 7 key objectives:

- Integrate race equality into all aspects of our work.
- Provide care which is accessible and appropriate to the needs of ethnic minority people.
- Provide effective training to prevent and challenge racial discrimination.
- Respond effectively and sensitivity to complaints of racial discrimination and harassment.
- Identify and address the under-representation of Black, Asian and other ethnic minority people in the workforce.
- Consult with ethnic minority people in the planning, development and review of our services.
- Publicise the commitment to race equality and valuing cultural diversity.

Mr Grant suggested that public authorities, particularly those funding and or addressing approaches to tackling drug misuse should priorities the following,

- Management information systems to provide accurate and reliable information on the ethnic origin of clients

- Community Engagement with various community forums and representatives. The impact of this engagement needs to be evident to managers and staff.

- Developing and communicating a comprehensive Equality Policy and Strategy for Service Delivery.

- Develop practice guidance for responding to complaints about harassment and bullying of staff from service users.

- Monitor staff profile by disability, and develop recruitment initiatives to target staff from underrepresented groups.

- Develop clear policy on staff using their language skills in the course of their duties.

In all aspects of achieving equality in the development and delivery of drug services it was suggested that, the three distinct objectives of eliminating racial discrimination, promoting equality of opportunity, and promoting good race relations need to be considered. A simple “equal opportunities” paragraph in reports is no longer sufficient. What needs to be considered and evidenced is the following:

What is the impact of policy / service on,

--- eliminating discrimination in services and employment
--- promoting equality of opportunity
--- promoting good community relations and social inclusion

Conclusion

1 The Race Relations Amendment Act requires public authorities to demonstrate through the Race Equality Scheme its practical commitment to race equality it is necessary to demonstrate that all authorities can identify that policy and functional priorities, and that race equality issues are fully considered in all policy and service developments.

Mr Grant presented information that would be useful to strategists and planners, that information is reproduced here.

RACE EQUALITY SCHEME

What is a Race Equality Scheme (RES)?

A Race Equality Scheme is a statement of how a listed public authority plans to meet both its general and specific duties to promote equality under the amended Race Relations Act. It is meant to help public authorities make sure that they address their general duty at a corporate level. The scheme can be part of an authority's general equality strategy, but the race equality sections must be clear and specific. Public authorities should have had their plans for meeting their duties in place by 31 May 2002.

The general duty

The general duty applies to all public authorities listed in Schedule 1A of the Act (see Appendix 1 of the draft Code of Practice). The aim of the duty is to make the promotion of racial equality central to the work of the listed public authorities. The general duty also expects public authorities to take the lead in promoting equality of opportunity and good race relations, and preventing unlawful discrimination.

In practice, this means that listed public authorities must take account of racial equality in the day to day work of policy-making, service delivery, employment practice and other functions.

To do this, public authorities should take two factors into account.

The weight which they attach to racial equality should be in proportion to its relevance to a particular function. In a local authority, for instance, attainment levels in schools are going to be much more relevant than, say, highway maintenance.

Since public authorities must meet all three parts of the duty — **eliminating unlawful discrimination, and promoting equal opportunities and good race relations — they must make sure they know how all their policies and services affect race equality.** For example, a new recruitment policy may help to promote equal opportunities, but if it is badly introduced, it may actually damage race relations.

Under the Race Equality Scheme, public authorities will have to:

- assess whether their functions and policies are relevant to race equality
- monitor their policies to see how they affect race equality
- assess and consult on policies they are proposing to introduce
- publish the results of their consultations, monitoring and assessments
- make sure that the public have access to the information and services they provide
- train their staff on the new duties

The Race Equality Scheme – itself one of the specific duties – essentially packages the other duties into a coherent strategy and action plan.

What must a RES include?

A Race Equality Scheme must make clear how a public authority plans to meet both its general and specific duties. It is a public document and public authorities will be answerable to the public for delivering the programme set out in the scheme. The scheme should be able to answer the following questions:

- How will the authority decide which of its services and policies are relevant to the general duty?
- How will the authority assess and monitor its services and policies, including services and policies it is proposing to introduce, to make sure that they are not affecting some groups negatively, and that all communities are satisfied with them?
- How will the authority deal with evidence that its services and policies are not in line with the general duty?
- How will the authority consult the general public and, particularly, involve ethnic minorities at all stages?
- How will the authority deal with complaints about the way it is meeting the duties, or other complaints about racial equality?
- How will the authority publish the results of its assessments, consultations and monitoring?
- How will the authority make sure that everyone, whatever their ethnic background, has access to information about the authority and its services?
- How will the authority make sure that all its staff understand their responsibilities under the duty?

  How often will the authority review the scheme?

Cultural Competence and Service Provision
Presentation by Mike Shinner

Mike began by outlining that the national drugs strategy includes an emphasis on ethnic equality. The study upon which the presentation was based was commissioned in order to inform the development of *UKADCU's* drugs and ethnicity initiative it aimed to:

- provide a clear overview of the issues surrounding the delivery of drug prevention and drug services to Black and minority ethnic communities; and
- identify specific issues and prioritise areas of work that require further attention.

The research was located within a review of the existing literature and was built around case studies in six Drug Action Team areas - the London boroughs of Lambeth Southwark and Lewisham, the London borough of Ealing, Birmingham, Leicestershire, Bradford and Lancashire..

Ethnicity and drug use

Mike began by suggesting that the idea that levels and patterns of drug use may vary by ethnicity has proved to be controversial and this is reflected in concern within the existing literature about racist stereotyping. Although illicit drug use is apparent in a wide range of

Black and minority ethnic communities, statistical indicators suggest that overall levels of use within such communities are lower than that which is evident among whites. Important differences are also evident between Black and minority ethnic communities. Low levels of use are particularly evident within south Asian and Black African communities. While Black Caribbeans show levels of drug use which are comparable to those of whites, this is primarily driven by cannabis.

Presentations to services, together with qualitative data, point to important ethnic differences in patterns of problematic drug use. These data suggest that problematic drug use among African Caribbean users includes a particular focus on crack and that Black and minority ethnic opiate users are less likely than whites to inject. While this appears to be particularly the case in relation to south Asian users, there is some evidence of injecting within these communiites and among African Caribbeans. There is also some evidence that problematic drug use among African Caribbean users is more likely to focus on cannabis than is that which is evident among other groups.

Recently established minority ethnic communities based, largely, on refugee migrations are largely invisible in quantitative records. However, qualitative data indicated that problematic drug use exists in Vietnamese and Somali communities, although it was considered to be largely limited to men. Particular concern was expressed about the effects of Post Traumatic Stress Disorder, the role of khat within Somali communities, the availability of drugs which were unknown in Somalia and Vietnam, and the way that the criminal justice system facilitated contact with problematic forms of drug use.

Drug services and institutional racism

The problematic nature of relationships between drug agencies and Black and minority ethnic groups was a dominant theme in respondents' accounts. While this emphasis was located within a broader context of racism and social exclusion, it also focused on the institutional failing of existing drug services, which were described as relating to:

1. The image of services and their isolation from the community;

2. An inability to respond to distinct patterns of drug use shown by Black and minority ethnic communities;

3. A more general inability to respond to diverse needs.

These failings were seen to be particularly acute in relation to specialist residential services.

Defining cultural competence and cultural appropriateness

Respondents placed considerable emphasis on the notion of cultural 'competence' and other related ideas. Here cultural competence describes an ability to meet the diverse needs of a

given community. Mike suggested that cultural 'competence' rests on the following dimensions:

1. Cultural ownership and leadership;
2. Symbols of accessibility;
3. Familiarity with, and ability to meet, the distinct needs of communities;
4. Holistic, therapeutic and social interventions;
5. Diversification of services;
6. Black and minority ethnic workers;
7. Community attachment / ownership and capacity building.

Although Mike highlighted the role of cultural competence in relation to service delivery he argued that its importance is not limited to this arena. It is, he suggested, equally important in terms of the planning and commissioning of services.

Models of provision

Mike highlighted the importance of the distinction between generic services - which are, in theory at least, open to users from all communities - and specialist or 'stand alone' services which target specific communities. Each approach was associated with particular advantages and disadvantages. Most respondents felt, however, that while specialist services could have an important complimentary role it was important that mainstream providers developed appropriate ways of working with Black and minority ethnic communities. There were examples of generic services which showed many of the dimensions on which cultural competence rests and which sought to integrate the perceived advantages of a specialist approach within a more generic framework.

Levels and patterns of presentation to services

In the case study areas outside of London there was strong evidence that people from Black and minority ethnic groups, particularly south Asians, were under-represented among individuals presenting to drug services. There was, furthermore, good reason to suppose that this reflected the nature of service provision rather than low levels of problematic drug use within these communities.

Within the London case study areas a certain degree of diversity was apparent in relation to Black and minority ethnic representation. While the largest minority communities (Black Caribbean's and Indians) were reasonably well represented among people presenting to services in these areas, there was evidence of under-representation among the smaller groups (Black Africans and Pakistanis and Bangladeshis). There was, furthermore, generally little evidence of work with recently established Black and minority communities and concern was expressed about the low level of presentations to services by Turkish people.

Patterns of presentation to services confirmed the importance of cultural competence as Black and minority ethnic users tended to be concentrated in a small number of services which showed a particular commitment to their needs. African Caribbean presentations were largely made to non-statutory sector services and this was explained partly by the way in which crack services were concentrated in this sector. Black and minority ethnic users were less likely than whites to present drug episodes to GPs. This may reflect particular concerns

about anonymity on the part of potential clients from these communities and highlights the way in which the role of workers, and the structure within which they operate, are crucial in defining the perceived accessibility of services.

Regional strategy

Although there were examples of strategic thought at the regional level, services tended to be commissioned on the basis of historical precedent. There was little evidence of systematic needs assessment and community consultation and monitoring often lacked a clear rational. The continued focus of most services on injecting opiate use is an important part of the process by which the needs of Black and minority ethnic communities are marginalized. This was seen to reflect broader problems around cultural ownership and leadership and Black and minority ethnic representation at the regional level.

The recommendations indicated the need for the following

- The development of a national strategic response
- working towards cultural competence,
- tackling institutional racism
- improving systems of data collection.

Mike suggested that any future research should investigate how far the above had been addressed

Building Upon Local Perspectives
Presentation By Shirley Yendell

Shirleys presentation opened with the comment that this conference and her insights were born out of five years of experience. In those five years Shirley had developed a number of initiatives which engaged BME communities, all of the work undertaken had emanated from New Link Wales and sought to demonstrate the agencies commitment to inclusivity. She went on to highlight how the substance misuse strategy is delivered across Wales and the structures within which substance misuse agencies operate.

Shirley detailed that the welsh strategy is composed of four areas. The BME substance misuse task group feeds in to the local SMAT. SMAT is the body which ensures all issues are fed in to the local CSP. The existence of the BME task group ensures that the SMAT also feeds BME community safety issues through to the appropriate body. However the good intentions and work arising from them that seeks to address BME issues seriously is hampered by the lack of effective monitoring systems.

In 1999 local research undertaken by Laxmi Budhwar on behalf of Bro' Taf, DAAT highlighted the lack of BME substance misusers accessing mainstream treatment services. Less that 1% of those accessing were from BME communities. The research led to a conference with community groups and subsequent establishment of the BME task group. At the same time the local action teams of Cardiff and the Vale also established NewLink South Wales substance misuse volunteering and training organisation. One of New Links primary goals was to undertaken the recruitment of volunteers for BME communities to work with and to support users form those communities.

Shirley continued by outlining how New Link established a foundation from which they build links with local BME communities. The approach was essentially to develop an in depth knowledge of treatment agencies, the range of communities in the locality and to establish relationships with key individuals. The treatment agencies were approached as placement providers for the BME volunteer outreach teams. Preparation for the recruitment and training of volunteers was undertaken with consideration given to appropriate information and materials.

In 2001 Noward Hashi carried out a piece of research that sought to investigate the needs of Cardiff's BME communities in relation to drug services. Some of the needs identified were:

- People were unsure of what drugs looked like
- Did not know where to find treatment services or how to access them
- Feared lack of understanding of cultural issues by treatment providers
- Unsure with regards to confidentiality
- The need women only sessions
- Fear of authorities
- Concerns for young people
- Language issues

As a result of the research New Link developed 17 different drug information cards and made them available in a range of community languages including, Bengali, Arabic, Urdu and Albanian. Newport and Swansea identified a need for similar resources. The research also identified two distinct areas of training needs. Firstly for treatment providers (level 3) to explore the need to diversify the range of treatment options available and the modalities for their delivery. Secondly to provide free basic substance misuse awareness courses to local communities.

Lessons Learnt

Shirley gave an overview of the learning gained from her years of experience

- Nothing can be done in a hurry, the need to extent consultation periods with the aim of building both understanding and trust in the confidentiality of the service
- Working at grass root level, actively engaging the communities in the mannor in which services are implemented. This is achieved by consulting many individuals and groups within each community rather than focusing on one particular community leader
- Organisations wishing to develop effective interventions for local BME communities should not rely upon assumptions about those communities but should become informed through research, developmental work and effective consultation
- Patterns of substance misuse differ from one community to another

- Treatment providers need to work in an holistic manner and treatment is led by the individual and his or her own cultural needs
- To take on board that any service must provide support for clients families understanding the important role that family plays in many BME communities.

In closing, Shirley noted with interest that the local Health, Social Care and Well Being Strategy for Cardiff identifies that differing communities have special needs . The strategy mentions that a number of inequalities have been identified between groups and the wider Cardiff population. These inequalities include factors that influence health such as; poverty, special needs. The patterns of needs of these communities can change over relatively short time scales and there fore services need to be flexible in adapting to changing patterns of need. Shirley suggested that despite the fact that only 1.2% of BME substance misusers are accessing treatment is part of the wider inequality being experienced throughout health care services as these are currently being addressed then there is hope for substance misuse services too.

Workshop and Recommendations

BME young people drug use and Drug education
Workshop led by
Chester Morrison   Kirit Mistry

In considering BME young people this workshop focused on 4 specific areas

- Needs Assessment process
- Self-healing and BME young People
- Support Services
- The way forward

Needs Assessment process

Many attempts to respond to the needs of BME young people are influences by a particular power relationship, namely that decisions are made on their behalf. It is therefore important to engage in a process of needs assessment (including a clear understanding of local demographics) as many services are developed for young people rather than with them.

Questions such as "Who is your service for? What is the makeup of your local community? Who do you liaise with to represent the views of BME young people?" are important when assessing need as they speak to the significance of recognising the stakeholders who are required for effective intervention to take place. Stakeholders include: Young people and their carers, statutory organisations, funders and business.
To make solid advances requires a very together approach. It is not a notion of either/or but rather collaboration and co-existence

Self healing

The term 'self healing' is considered to be a useful term than education as it correctly places an emphasis on young peoples capacity to change. The association with drug use and violent crime which has been strengthened by a whole range of media is a reality for many BME young people. The difficulties of making the changes necessary for a drug and crime free life is often recognized by BME young people as are the consequences of not making those changes. Sometimes all we can do is to support young people through their own processes rather than try to change the process.

Support Services

Yong people are often unaware of the services on offer as these services are not advertised. It is noted that in some instances the nature of the service are provided is not stated so as to prevent other organisations setting up a similar service. Practitioners have knowledge of services available to young people in Wales but the young people don't.

The Way Forward

- Take conferences such as this into local communities

- We can only be effective by working in partnership – seek out and pass on good practice

- In our practice, give consideration to the fact that in a period of transition BME young people want respect and a sense of power and belonging.

- Need to develop new opportunities to help break the cycle for BME young people

- We work in organisations in conflict and therefore have to be prepared to feel
- uncomfortable at times.

Putting the Khat amongst the pigeons-
Stimulant use and Effective services
Workshop led by Aidan Gray

This workshop sought to address issues arising from stimulant use that is associated with BME communities. This included an exploration of Khat (What is it? Cultural Context) and Crack (Historical Perspective, Barriers)

Khat

What is it?

2 psychoactive alkaloids- cathinone and cathine.

- Initially induces a euphoric energy then after a few hours a trance like state.
- Symptoms disappear after 48 hours.
- Problems caused by prolonged use are similar to other stimulant use:

Prolonged use may lead to

- Insomnia
- Anxiety
- Weight loss
- Depression, irritability, mood swings
- Psychological rather than physiological dependency.

Cultural context

Khat is usually used socially in much the same way as alcohol is used in our society. Problematic use normally occurs when khat use is conducted outside of this social context. Consideration must be given to the fact that communities n which Khat use in prominent may have suffered traumatic experiences and are coping with adjustment to an often discriminatory local community.

Crack

Historical Perspective

Our perspective of crack use is heavily influenced by reports from the USA. These reports when filtered by the media are sensationalised and the information provided is often inaccurate. They are however the prime source of information for the public. When considered critically much of the media reports are inherently racist and are manipulated for

political purposes i.e. crack make causes violence especially in young black males, three hits of crack will cause addiction.

Barriers

- Political Barriers

- Drug treatment is now largely based on the Criminal justice agenda.
- Welfare based approaches to drug use will not win votes?.

Service Barriers

- Low numbers of presenting stimulant users
- Very low numbers of Khat users
- When compared to heroin practitioner knowledge and experience of stimulant use is low.
- Low numbers of BME practitioners

User barriers

- Lack of trust in authorities
- Fear of legal consequences

Main Points

Serious consideration is being given to making Khat use illegal. There is a danger that this decision could be taken without the benefit of adequate information. Resources should be made available in order that we can learn more about khat use from users and their communities. Sheffield Black Drug Project has some information.

We must be aware of prejudice within the media, government and statutory authorities.
We need to listen. Resources could be directed into outreach services and begin an on-going dialogue with communities whereby we listed to them and provide them with the benefit of our expertise.

Diversity and Diversification of Treatment Options
Workshop led by Janaka Perera

This workshop began with the Janaka exploring out understanding of the term diversity. It was made clear that diversity in its broadest form includes individuals and groups that can be identified by their age, gender, religion, sexual orientation as well as race and ethnicity. Janaka suggested that it is common for the term diversity to be used as a euphemism when the topic of 'race' is to be discussed.
He went on to point out that diversity should be seen as a 'golden thread' which runs through our thinking in relation to treatment options. " within any group identified as being different from the majority of the community there will be elements of diversity". The notion that diversity was an issue to be fully considered during strategic planning was one that Janaka strongly supported.

Key considerations identified by Janaka were:

- Issues of employment /unemployment
- The impact of criminal justice interventions
- Legal imperatives (Disability Discrimination Act, Race Relations Act (Amended), Sex Discrimination Act)
- Low levels of cultural competence amongst commissioners

It was suggested that unfortunately for service commissioners there is no "**black drug**". This of course makes the task of devising, developing and delivering drug treatment service to members of the BME Communities all the more challenging. Janaka proposed that developing practice to meet the needs of BME communities would provide an appropriate frame work to meet the needs of a diverse service user group. He suggested that the notion of "Cultural Competence" is significant and used the definitions outlined below.

"The demonstrated awareness and integration of three population-specific issues:

- health related beliefs and cultural values,
- disease incidence and prevalence,
- and treatment efficacy" Sangster et al p.25

"…services perceived by Black and minority ethnic users as being in harmony with their cultural and religious beliefs and not just provided by people who are, or assumed to be 'culturally sensitive' (Chandra, 1996,1; see also the institute of ageing, 2001" cited in Sangster et al p25.

The application of cultural competence <u>*to systems of care*</u> *rather than to individual providers is a significant development. Commissioners should no longer be looking to an individual agency within their areas providing culturally appropriate services, this should be part and parcel of the*

- *SYSTEMS OF CARE DEVELOPED TO SUPPORT ALL SUBSTANCE MISUSERS*
- *AND SHOULD BE INCLUDED IN ALL SERVICE LEVEL AGREEMENTS.*

It brings into play the culture of organisations, their aims and core competencies, their management structures and their use of monitoring. Ibid.
This will also serve to provide agencies with the tool to meet the requirements of their legislative obligations with regard to diversity. Cultural competence as it relates to drug services requires the following elements:

- Cultural ownership and Leadership
- Symbols and accessibility
- Familiarity with, and ability to meet, the distinct needs of communities;
- Holistic, therapeutic and social interventions;
- Diversification of services;
- Black and minority ethnic workers; and
- Community attachment/ownership and capacity building.

These elements cannot exist or be adopted in isolation but must be seen as being interdependent.

<u>Planning for Diversity</u>

Pragmatically, based on what we have learned so far in terms of service development historically and the means and need to provide for all service users in a culturally competent framework, commissioners could start to address the planning process for more inclusive services by:

- Independently review current services to establish a base line detailing what treatment is available and to whom (including those not directly commissioned by the local JCG but funded alternatively).

- Ensure treatment is not limited to availability but can in fact address need (NTA requirement).

- Explore a range of service options.

- Broaden or at least clarify what counts as treatment (that is move from a linear to lateral view of treatment modalities, including treatments that speak to social economic and cultural factors that influence drug use).

Building on Good Practice
Workshop led by Noward Hashi and Safeena Ghufran

This workshop provided an overview of the work Newlink Wales had conducted with regard to improving its services to BME communities. The participants were then asked to respond to three questions.

Outline of the developments by Newlink Wales

As a result of research into the needs of BME communities Newlink Wales began to asses the information required to bridge the gap in substance misuse awareness. There followed the production of information cards that were distributed across BME communities and the development of information desks in BME community sites. The use of BME volunteers highlighted as a very positive step. The volunteers receive tier 1 training and this knowledge is then used by treatment agencies and within their communities. A number of volunteers form specific outreach teams to work with BME young people and have gone on to become paid practitioners within treatment agencies.

Questions to Participants

Question 1

1.1 What concern you in your community about drugs and alcohol?
1.2 Would you like to raise more awareness in your community?
1.3 If so how would you like to do it?

Responses

1.1 – Crime, Anti-Social Behaviour, Fear of crime, Poor health, Reduction in overall quality of life, Family breakdown, An increasing tolerance by society to drug and alcohol use, The aggressive promotion of alcohol, Broken windows syndrome.
1.2 – Yes
1.3 – Consider the enforcement of the laws against drugs as a gateway to treatment, Education within schools, Use school premises for family drug education, Provide support for parents, Outreach, training for community members, Peer education and wider use of standard drug prevention packages.

Question 2
What can treatment agencies do to be more approachable to BME communities?

Responses

- Independently review current services to establish a base line detailing what treatment is available and to whom (including those not directly commissioned by the local JCG but funded alternatively).

- Ensure treatment is not limited to availability but can in fact address need (NTA requirement).

- Explore a range of service options.

- Broaden or at least clarify what counts as treatment (that is move from a linear to lateral view of treatment modalities, including treatments that speak to social economic and cultural factors that influence drug use).

    - Develop culturally appropriate services
    - Work in partnership with all agencies
    - Place greater emphasis on prevention
    - Strive for long term funding as this will promote continuity of staff and develop a bank of local knowledge
    - Use Race equality schemes to ensure accountability and monitor progress
    - Utilise mentoring and befriending approaches
    - Employ a workforce that reflects the makeup of the community to be served.

Question Three
New Link Wales is working to establish a referral project for BME communities. It will be a link between BME communities and treatment agencies. What should be the key elements of this service and what other kinds of services could be established to address the substance misuse needs of BME communities?

Responses
A treatment process that is based on service user reality; includes the gains and losses of substance misuse; considers the impact of substance misuse on user and others; considers the exploration of self and has a holistic approach.

- A wide range of treatment services

- Through care and follow up services
- Drop-in sessions
- High level of service user consultation.
- Skilled staff that network widely gaining up-to-date local knowledge
- Develop the respect of BME communities
- An integral monitoring and evaluation system
- A young person information sessions or integrated youth service
- Effective internal and external communication processes.

Black and Minority Ethnic Women, Drug use and Issues for Treatment and Support
Workshop led by Khatidja Chantler

Khatidja's workshop covered four pieces of research in which she had a key role, and she drew together some common elements, which surfaced across the studies. The studies covered 'race' and drugs, as well as gender and minoritisation. The presentation covered 3 key themes:

1) Splitting 'race' and gender
2) Gender and Substance misuse
3) Current configurations of treatment services

Splitting 'race' and gender

Khatidja started by outlining how current equalities legislation failed to work at the intersections of 'race' and gender. This split has been carried over into the way local governments, health and voluntary organisations approach diversity and inclusion polices and practice in a range of sectors. However, the specific experiences of Black women are largely excluded, both in the literature on 'race' in the literature on women and mental. Similarly, white feminism has been challenged by Black feminists as the differentiated experiences of Black women have traditionally been. Indeed even within the drugs field, there is very little evidence about how black women are faring in the use of drugs. Just as ethnicity was not looked at in drug use by women, so women were not looked at specifically in the ethnic minority booster sample of the 1994 BCS. A classic example of Black women being excluded both from studies about women and studies about "race" In preparation for this presentation Khatidja had contacted the regional drug misuse research unit and found out that this exclusion still occurs – so that none of their annual reports with various tables and numbers connect gender with ethnicity.

Gender and Substance Misuse

Khatidja pointed out that issues of gender may on the whole be less prominent within treatment services, given that the majority of service users are male. However, recent reports (by Jane Becker and Clare Duffy) have shown that women drug users have a high incidence of past traumatic experiences such as sexual abuse and domestic violence. Some estimates suggest that as many as 70% of women who are in contact with treatment services are survivors of abuse. Khatidja outlined reasons why women do not access treatment services and these include concerns about child care and child protection issues. She also indicated that the 'split' between 'race' and gender issues mean that the needs of Black women are likely to be even more invisible within treatment services. Khatidja then outlined specific issues that impacted on women drug users:

The concept of dependency at a societal and at an individual level portrays women as weak and passive, as unable to look after themselves - financially or emotionally. So whereas this

idea of dependency is actively encouraged and approved of, dependency on substances is most definitely not – unless of course they are prescribed.

As in many other spheres of life, women are expected to conform to a particular mould which restricts or punishes particular behaviours. Most obvious of these are around criminal activity, sexual activity and drug use.

A woman who is dependent on substances such as alcohol, heroin or crack is doubly marginalised and stigmatised. This is further compounded as minoritised women, mothers, in particular, are also expected to transmit cultural values across generations.

Current Configurations of Treatment Services

Three key design features of treatment services were analysed across the studies undertaken by Khatidja and these were described as follows:

- universal services
- approaches which privilege 'race' and/or culture over gender
- 'cultural' matching

Universal Services

A universal approach is where treatment services are organised around the assumption that experiences of substance misuse in general are very similar, so no special provision needs to be made for any particular group. Hence issues such as class, 'race', culture, disability, sexuality or gender are not considered, as the image of the universal client is dominant.

Privileging Culture over Gender

Practitioners and managers in the caring services often refer to understanding other cultures as an important part of providing culturally sensitive services. In general terms the focus on 'culture' serves to detract from or even further buttresses wider social inequalities based on racism, class and sexism. Furthermore, explorations of 'culture' are strongly linked to religious traditions and this poses particular difficulties for the development of anti-racist, gender sensitive services. Religious traditions of most faiths tend to gravitate towards conformity and the sanctity of family life. So issues such as abuse, violence and substance misuse, which challenge such unity are likely to be denied and indeed this denial, (both by members of minoritised communities as well as by practitioners) did emerge particularly in the gender-specific studies.

'Cultural' matching

A further response to the call for culturally sensitive services has been to 'match' service users with practitioners from the same ethnic/cultural background. This approach is voiced through the call for a larger number of black workers in treatment services, or is used in work

teams with a mixed staff group where black clients are allocated to black workers, or by referring service users to what is assumed to be a culturally appropriate service.

But what are we ‘matching’ for? As Sheikh (1996) and Burman et al (1998) have pointed out, matching often occurs at an elusive level where one aspect of identity is latched on to regardless of other indicators of sameness or difference, such as gender or age. Questions such as which variables are to be matched, what gets included and what is omitted, and whose choice this is, are often overlooked in what can only be described as a desperate attempt to shift the responsibility of providing culturally sensitive services (personally and institutionally) onto Black communities themselves, whilst mainstream providers do little to change their own services.

Conclusion

The Race Relations Amendment Act (2000) offers opportunities for change. However, if we are to prevent previous exclusions, we must take this opportunity to work at the *intersections* of both ‘race’ and gender

Conference Recommendations

The recommendations generated as a result of the conference were both strategic and operational in nature. Conference delegates identified the need for planned ie strategic medium and long term initiatives, as well as operational changes. The operational recommendations suggested were one that could immediately alter practice. It was suggested that many of the operational suggestions could form "quick wins". Progress towards inclusivity for BME communities could be demonstrated with some small adjustments in emphasis of existing practice approaches.

Strategic Developments should include

- Develop an annual standing conference to review progress and set targets for future action
- National strategic response to the delivery of services to BME communities
- Improve systems of data collection.
- A strategy to ensure that staff receive appropriate training regarding cultural competence.
- Research into the pro's and con's of making Khat use illegal.
- In all aspects of achieving equality in the development and delivery of drug services it was suggested that, the three distinct objectives of eliminating racial discrimination, promoting equality of opportunity, and promoting good race relations need to be considered. A simple "equal opportunities" paragraph in reports is no longer sufficient. What needs to be considered and evidenced is the following:
- ***What is the impact of policy / service on,***
- ***--- eliminating discrimination in services and employment***
- ***--- promoting equality of opportunity***
- ***--- promoting good community relations and social inclusion***
- Ensure treatment is not limited to availability but can in fact address need (NTA requirement).
- Explore a range of service options.

- Broaden or at least clarify what counts as treatment (that is move from a linear to lateral view of treatment modalities, including treatments that speak to social economic and cultural factors that influence drug use).

- Use Race equality schemes to ensure accountability and monitor progress.

Operational Developments Should Include.

- Work in partnership with allied agencies. – seek out and pass on good practice
- Engage in high levels of community / service user consultation.
- Take conferences such as this into local communities
- Give consideration to the fact that in a period of transition BME young people want respect and a sense of power and belonging.
- Resources should be made available in order to learn more about khat use from users and their communities
- Independently review current services to establish a base line detailing what treatment is available and to whom (including those not directly commissioned by the local JCG but funded alternatively).
- Strive for long term funding as this will promote continuity of staff and develop a bank of local knowledge
- Utilise mentoring and befriending approaches.
- Employ a workforce that reflects the makeup of the community to be served.
- Develop skilled staff that network widely gaining up-to-date local knowledge
- Organise for a young person information sessions or integrated youth service
- Place greater emphasis on prevention particularly in work with young people

Feedback from Conference Evaluation Forms

- Excellent service in action by Newlink. Keep up the good work-for others it may be a good model to follow.
- Extremely good conference
- More time to debate a two day conference maybe better- overall a good informative day
- Should have been longer (2 days)
- Very good conference, long awaited. Thank you for bringing the issues to the fore in Wales.
- Very informative day with some constructive ideas.

Main suggestions for future conference

- The presence of senior representatives of statutory agencies and service providers
- Case studies from service providers giving examples of their practice with members of BME communities
- Input from service users relating to their experience of receiving drug services.