Cultural considerations – improving community involvement

The number of British Asians presenting to drug services is going up, particularly in London. Heroin and crack use is also prevalent among these communities (Bashford et al 2003). But what is being done to meet the needs of these and other minority ethnic clients? Jeff Fernandes from Islington PCT looks at the case of young Asian heroin smokers presenting to his service. The example reveals some important considerations for making a service reach out and work with different cultures.

At the Margerete Centre in London we explored the needs of Bengalis and Muslims presenting to the service with drug problems. What we found altered our perception of the service.

Not only were there significant differences in use patterns and related needs, the service was also underachieving in their care.

Different routes

In particular we found a marked difference in routes of administration of the Asian group compared to the ‘White British’ group. All Asians who presented to the centre, chased and smoked heroin and had no history of injecting. For white users, the majority injected and had a history of injecting on average between 5 to 7 years. In percentage figures this was applicable to 93% of white/European users.

The length of drug history for Asians was also shorter. Typically an Asian service user had been using on average for three years. For white/European service users this was 10.4 years with a period of initially smoking/chasing heroin of one year.

White UK/European are also more likely to be more prone to polydrug use. Almost all (95%) of this group have an injecting history of a minimum of three years, with 90% using heroin, crack, benzodiazepines and alcohol routinely – indicating they are poly drug users.

For people who described themselves as Asian, all were smokers and had been smoking for two years on average. The main drug of choice was heroin. They did not use alcohol or benzodiazepines, though they did tend to use crack occasionally (such as once a week).

Inappropriate detox

With a small drugs history and uncomplicated drug presentations, many of the clients from the Bengali community requested an outpatient detoxification programme. From the users point of view this was a quick and easy way of getting ‘clean’.

From a clinicians’ point of view, uncomplicated drug profiles and small drug histories seemingly make the Asian clients suitable for an outpatient detoxification programme. There was a general consensus for trying to catch their ‘habit early’ and therefore detoxifying this cohort of clients before their habit had become more ingrained and problematic. This reasoning was to prove unfounded over time. Many of the Bengali clients while requesting detoxification on an outpatient basis failed to stay ‘stable’, on the detoxification regime and began to use heroin ‘on top’. All the Bengali clients who completed a detoxification programme relapsed within a fortnight or earlier after their medication regime had finished. In contrast, the White/European clients showed a greater ability to stay opiate free after the medication regime finished, despite having more problematic presentations with poly drug use. Therefore, the ethos of ‘catching their habits quickly’ was misplaced.

Devil’s in the detail

So why the big difference? On reflection, it was felt the clinical team did not pay enough attention to key details while making an assessment. In particular, they failed to address family background and support, motivation and at what stage and where the user was prepared to stay ‘clean’.

Identifying these key factors during assessment is crucial if an outpatient detoxification regime is to work. In fact, it is felt the current Bengali population emerging for treatment are being ‘set-up to fail’.

More credence also needs to be given to the influence of the family of Asian service users and their prominence in his or her decision-making process. The Bengali interviewees told us that their families were influential in them accessing a detoxification programme. In hindsight the respondents said they were not ready for this treatment, admitting that a stabilization package with methadone was more suitable.

From the clinic’s point of view, it emerged that the Bengalis and their families had a very ‘medical’ model way of thinking about substance misuse, thereby ignoring important psychological aspects.

What is clearly needed is for services to change existing practices to better accommodate factors that can affect and motivate Asian clients. Services like the Margerete Centre therefore had to make their assessment forms and clinical approaches more appealing and effective to a wider group of clients. In other words to accommodate ‘new’ emerging groups an element of ‘fine-tuning’ is required to make their assessment and provision culturally responsive.

Family fortunes

As a result of these findings, changes to the assessment process at the Centre were put in place. This meant re-designing the assessment form to incorporate a section on family and aspirations for the client. There is also an option when the client is in treatment, if consent is given, for the family to be included in the first session. This allowed the service workers to explain the practical ways treatment services can help the user and possibly the family. The result of these changes is a vast improvement in the assessment and treatment of all clients.

Ultimately, the challenge is now for all services is to find new ways of accommodating ‘new’ emerging groups into their existing assessment/clinical procedures and to improve their quality of care and never assume drug users using heroin are a homogenous group.

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References