

**Evaluating the Service Provision for Ethnic Minorities in
Islington in the Treatment of Substance Misuse**

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Abstract

This project studied ethnic minorities with substance misuse problems to establish how services adapt to accommodate this presentation. It was conducted for the London Borough of Islington and its drug services to see how far they meet the needs of ethnic minorities.

For Islington, the study identifies areas needing more focus to improve provision by comparing it with neighbouring Tower Hamlets. It takes a qualitative approach, looking at each borough and interviewing staff who run and structure services, evaluating their knowledge of each borough's ethnic community and explores how the boroughs use this to meet needs. Purposive sampling selected for interview those with the influence to shape services.

The project reveals interesting findings and some differences:

- a) The population of the ethnic communities is different in each borough, influencing how services have responded to their problems concerning substance misuse.
- b) Clinicians' knowledge base on ethnic minorities and their issues with approaching drug services is adequate, but needs updating.
- c) Rapid assessment is seen as the best tool to engage ethnic communities.

It is hoped that some of the findings from this study are beneficial to the London Borough of Islington and its drug services.

- 1) Flexibility is an important concept in drug service planning, but is it enough to accommodate ethnic minority needs? Will budget cuts limit drug services' flexibility?
- 2) Do other boroughs' approaches need to be adopted to enable ethnic minorities to engage with mainstream drug services, such as setting up 'rapid assessment'?
- 3) Is an ethnic-specific project needed in Islington, as in Tower Hamlets?
- 4) More educational sessions are needed to update staff knowledge on ethnic minorities.

The findings will be shared with local boroughs' drug services and commissioners, and disseminated to all workers and service user groups in Islington. It is hoped the recommendations will be implemented.

Chapter 1: Introduction

This project seeks to identify effective clinical approaches to ethnic minorities with issues of substance misuse that accommodate the needs of a growing population of Asian drug users in Islington. This population is mainly Bengali.

This project's aim is to look at the Borough of Islington, London, as a whole and to examine the services that provide drug treatment, and to evaluate the effectiveness of treatment provided and the flexibility of treatment packages. It attempts this by interviewing and then analysing the responses of key decision makers in the London Borough of Islington, examining their knowledge base and clinical approach to treatment. Where good practice is described, this work will ascertain if these approaches are transferable to services in Islington. It therefore aims to be an informative piece of research making local recommendations for treatment in the Borough.

There has been a considerable amount of research in the last decade on Asian populations coming to services for treatment. Much of this was conducted in the early years of 2000–2005, and there has been little work since then in England. The statistics of ethnic minorities presenting to drug services is still relatively small at 1 per cent (www.nta.nhs.uk/2013). Recent national figures are given below:

Table 1.1: General Statistics of People Presenting to Drug Services in England and Wales

Number of Opiate/Crack users (OCUs) in England	298,752
Number of adults receiving alcohol treatment in England	108,906
Number of adults in contact with treatment services	197,110
Number of adults effectively engaged in treatment for 12 weeks or more, or if leaving treatment before 12 weeks did so free of dependency	185,428
Number of adults successfully completing drug treatment free of dependency*	29,855
Number of people successfully completing alcohol treatment	38,174
Number of under 18s accessing substance misuse services	20,688

Source: www.nta.nhs.uk/2013

When this is analysed further, one can see the percentage for ethnic minority presentations:

Table 1.2: Demographic Profile of People Presenting to Drug Services (England and Wales)

White British	162750	83%
White Irish	2372	1%
Other White	6950	4%
White & Black Caribbean	2674	1%
White & Black African	509	0%
White & Asian	751	0%
Other Mixed	1168	1%
Indian	2085	1%
Pakistani	2274	1%
Bangladeshi	1408	1%
Other Asian	1922	1%
Caribbean	3042	2%
African	1240	1%
Other Black	1931	1%
Chinese	84	0%
Other	1938	1%
Not stated	2113	1%
Unknown	498	0%
Total	195709	100%
Inconsistent/missing	1401	

Source: www.nta.nhs.uk/2013

As shown in Table 1.2, the number of Asian and Black Caribbean/African is over 12,000, significantly smaller than the White population presenting to drug services, occurring in cities and towns with established Asian and Black British populations such as London, Manchester and Preston. The focus of this project is London, particularly the two boroughs of Islington and Tower Hamlets. We next look at previous research conducted in the area of substance misuse.

Previous research

Statistics on ethnic minorities presenting to drug and alcohol services are recorded and updated every year by the National Treatment Agency (Public Health England). Much of the research on ethnic minorities in the UK was collated in a literature review by the University of Lancashire in 2003. It was found that there were needs particular to ethnic

minority groups who wanted treatment for substance use. This review found that there were low levels of knowledge about drugs across the gender and age categories for ethnic minority populations; an absence of any perception of drug use as problematic; and denial that there was a drugs problem in the first place. There was also a lack of knowledge about the health complications associated with drug use and its impact on family life.

To further complicate matters, the study found that some services struggled to provide adequate service for ethnic minorities. To address these issues, services needed to be aware which ethnic minorities presented and to consider conducting a thorough needs assessment (Bashford et al., 2003). This would hopefully lead to better planning and more effective services.

In Islington, drug services have seen a small but significant number of second-generation Bengali males presenting to drug services with their families. This can often be a very different presentation to standard White British clients, who usually presents on their own with, at best, poor family support and fragmented relationships within their family. Drug services in Islington would have helped these Bengali men, but some were not set up to deal with their extended families. There were issues of confidentiality and an approach to medical treatment that made inclusion of family members difficult. This was an unmet need for this emerging population that found families supportive. Family support can often be beneficial in the recovery process, not just in the field of drugs (Fernandez, 2004), and there was a gap in local clinicians' understanding of the needs of this emerging Bengali population, as stated in national research.

More up-to-date research on ethnicity and drug use in the US shows that research does inform and improve practice (Field et al., 2012; Molina et al., 2012; Daniulaityte et al., 2012). It identifies how ethnic groups have different needs when presenting to drug services and that their treatment packages need to be tailored to achieve effective outcomes (Daniulaityte et al., 2012). This is useful, as factors of clinical presentation mean flexible treatment is needed, similar to what UK research has found (Fountain, 2009a-e). This is also very similar to the Camden and Islington research conducted in 2004 (Fernandez, 2004). It appears a different presentation should always be treated using a flexible clinical approach if it is to be effective (Molina et al., 2012).

Also, in the area of health and ethnic minorities in the UK there has been much research into mental health and unmet needs (Bruce et al., 2012). There are gaps in understanding

ethnic minorities presenting for treatment, and racial discrimination in service provision may often occur, yet research has informed and changed service provision to secure a better understanding.

Recently, research in the UK and US identified low socio-economic class and poverty as the main factors of mental illness (Tobler et al., 2013, Lê Cook et al., 2011), similar to studies in the US examining ethnic minority populations in substance misuse (Field et al., 2012, Molina et al., 2012). The US research focus was on socio-economic factors, making drug users from poorer backgrounds more vulnerable to contracting HIV and Hepatitis C. As healthcare in US is mostly insurance-based and private, ethnic minorities are often unable to afford treatment and hence test positive when they present to drug services, with more comprehensive needs than the White population (Field et al., 2012). This is similar to the ethnic minority population's presentations in the UK, with Bengali and now Eastern European individuals often coming from lower socio-economic backgrounds (Fountain, 2009a-e). Poverty and socio-economic class are certainly factors influencing people with substance misuse problems in the UK. This research looks at this indirectly, as it asks the senior clinicians of each service in Islington how they adapt and react to accommodate these issues to provide an effective service for emerging ethnic minorities.

Since the focus of the research project is to examine what senior clinicians know and how they adapt their services accordingly, I concentrated on research conducted in the field in the UK. Recent research revisiting ethnic minorities in drug services show that many issues still exist, such as the lack of an understanding both of what drug services can be used for and of the cultural issues faced in these communities (Fountain, 2009c, 2009d, 2009e).

This same research, however, went deeper into the issues that ethnic minorities feel deter them from treatment, such as waiting times, a major challenge for services:

Once people access a service, the speed with which a person receives any treatment or other intervention is an important factor in whether they remain engaged. (Fountain, 2009a-e)

An important issue in this research concerns whether rapid assessment has been instrumental in attracting ethnic minorities into treatment. This is further explored in the conclusion.

Similar research on ethnic minorities and drug use in the UK further verifies Fountain's work, showing a high level of smoking, whether heroin or crack, with hardly any from this population switching in time to injecting the drug. Also, the level of crack use was minimal, similar to the presentations discovered in previous research from 2000–2005 (Fernandez, 2002, 2004). This is further verified by the national 2007 survey completed in 2008 (Gordon et al., 2008).

Therefore, in summary, the literature reveals gaps in knowledge regarding ethnic minorities' presentations to drug services. Some of these are covered by the literature review funded by the National Treatment Agency (NTA) (Bashford et al., 2003). All the findings from an updated literature search are shown below (it is noted that they are broadly similar to the previous literature review in 2003).

The main reasons that communities identified for their not seeking services, or for acting as barriers to access, were:

- 1) A lack of awareness of drug services and the help they could provide.
- 2) The perception that the services were not appropriate e.g. not using hard drugs, or that they could handle the problem themselves.
- 3) Waiting times for assessment. (Fountain, 2009e)

Previous research in Islington was from the users' perspective. This research project examines what the providers of drug treatments have learnt from past local research and also the recent national research outlined in this chapter. Has this resulted in better services for this population in the last decade? Is there good practice in the Borough? If so, where is it and what does it do? As mentioned earlier, the Borough would find that this new local knowledge would enable them to plan better services in future.

The main emphasis of this research project is an evaluation of the knowledge base of the key clinicians in the Borough who shape the services that deliver drug treatments. It looks at whether they are aware of the research on ethnic minorities and the barriers to treatment that this population can sometimes face.

Chapter 2: Project Design—Methodology

Study aims and objectives

This study examined the services concerned with substance misuse in Islington. Is there now a greater responsiveness in services for ethnic minorities? Has recent research, outlined nationally and locally, both in the US and the UK, given rise to more effective treatment approaches? If so, what makes these approaches more effective? What are the outcomes for ethnic minority drug users?

There has been much localised research in this field and this study sought to gauge providers' knowledge and understanding of the ethnic communities they are trying to service through a pilot study. The pilot also explored whether commissioners, key stakeholders and clinicians delivering services in the NHS understand the effects of race on poverty and hence drug use in their society. Since there is not much research into the provider side, this study hopes to resolve this.

Therefore, the main title is:

Evaluating the Service Provision for Ethnic Minorities in Islington in the Treatment of Substance Misuse

Aim:

To examine areas of good practice within the London Borough of Islington and other boroughs in the UK that manage ethnic minority service users in drug treatment to see if this is transferable knowledge, and to use this work to make recommendations to improve service provision for ethnic minorities undergoing drug treatment.

Objectives:

1. To conduct an extensive literature review on substance misuse treatment of emerging minorities and establish if any areas can be identified where knowledge may be used to enhance service delivery in Camden and Islington.

2. To review current services from the perspective of the senior clinicians who lead them, to see how they respond to ethnic minority needs in the area of substance misuse.
3. To identify aspects of innovative and good practice that enhance current substance misuse services.
4. To discover areas of practice where recommendations for a change of practice can be made in the Borough.

Research questions

1. What sort of services are required to support ethnic minority drug users?
2. Can services accommodate ethnic minorities for drug treatment effectively and can these be transferred to other areas for treatment?
3. How are multi-structured treatment systems in drug services deployed to meet the needs of ethnic minorities in drug treatment?

In order to answer these research questions, I chose a methodology of examining the Islington treatment system as a case study. A case study is an in-depth analysis of a singular entity that can demonstrate how people make decisions at work (for example, Bryman, 2001). There are many forms that the case study can take, from the individual case study to an in-depth look at community groups such as British Asians. Alternatively, a case study can be an examination of an organisation or institution, similar to the focus of this study (Fernandez, 2005). This project has hopefully produced enough data to provide evidence for back recommendations for changes to practice to improve drug treatment for ethnic populations.

Case studies usually examine the culture and people in institutions (Bryman, 2001), applicable to this project as it studied participants' perspectives on drug and alcohol services in Islington. It examined Islington as a single healthcare provider and evaluated the knowledge base of the senior clinicians and how it was used by them in providing drug treatment services.

An evaluation is commonly conducted to assess service provision, particularly in public services where accountability is a highly important concept (Robson, 1993). Very often the evaluation is undertaken by senior clinicians of services, yet in this case I was the

researcher and undertook an evaluation of senior clinicians and how they think to shape their services (Wilkinson, 2003).

For the project, using Islington as a case study borough, it was important that senior clinicians of each service and the managers in Islington were identified and sought by myself to participate in this project. This was because these figures are the leads of their respective services and shape the delivery of care in their institutions. This research, taking the clinicians' perspective, has not before been conducted in Islington thus has an original approach that will inform service provision here in the area of substance misuse (Walliman, 2012).

Reasons for a qualitative approach

The thoughts and perspectives of the drug treatment workers in Islington in this case study were best examined by adopting a qualitative approach. The views of the clinicians were necessary: as the clinical leads of their drug services, they shape clinical delivery. I also looked into how they respond to ethnic minorities presenting to their services and what they understand about how this has led to unequal access in the past, and how they structure their services to accommodate this. Therefore, a qualitative perspective was adopted in order to generate data from clinical staff, with an interpretative approach conducted using the interview as its tool.

The interview can enable researchers to collect rich and descriptive qualitative data (Silverman, 1993). It can be constructed as either formal or informal questions, with much data collected through both (Silverman, 1993). However, a semi-structured interview can lead the participants a little, to focus on the field that needs to be studied (Bryman, 2001). This format was adopted for this project with interviews re-visited, sometimes twice, to verify the data and approach the state of 'saturation' (Walliman, 2011).

In summary, the project adopted a qualitative approach with semi-structured interviews as it aimed to examine the perceptions and understanding of key decision makers locally. It was thought best to use a flexible approach to gather rich data that would capture the way that people understood their working worlds and the issue of race and how this impacts on access to services (Gomm, 2004). It was also semi-structured and therefore explorative in its approach in order to capture the thoughts and outlooks of the people working in the area of substance misuse.

Focus groups were also conducted, employing the existing forum of the Borough Drugs Strategy Group that all the lead clinicians attended. The sessions were used to validate further the data collected from the interviews (Bryman, 2001). Through the ethics process an information sheet and consent was given out with a request for the focus group discussion to be recorded. Consent and access, examined later, did not hinder this process. The undertaking provided additional rich data that complemented the interviews.

Outcome frameworks informing the methodology

An evaluative framework, adapted for this project, was of value to underpin and verify the approach of the project. Frameworks that measure outcomes from data collected from qualitative work inform the conclusion, so outcome evaluation is discussed here.

Stafford et al. (1999) examined the outcome of medication in treatment in Boston and identified four outcome measures from their research to inform the medical profession on prescription, as follows:

- 1) How well does the disease fit the medication for which it was prescribed in the context of other factors and co-existing diseases? This dimension considered known long-term outcomes of each individual medication and co-existing diseases. These considerations may provide the rationale for selecting a certain medication, for example, the use of alpha blockers in a patient with benign prostatic hyperplasia (BPH) and known positive interactions between the drug and a co-existing disease merited a positive rating on this scale. Conversely, an adverse interaction merited a negative score.
- 2) How well does the medication fit with the other medications or therapies the patient receives? This dimension considered both the probability of an interaction and its seriousness. This included: a) interactions that place the patient at risk for adverse event, b) interactions that may diminish the effectiveness of treatment, c) interactions that may influence the biochemical profile, e.g. lipid or glycemic control, and d) interactions that may benefit the patient.

- 3) How well does the medication fit the social behaviour of the patient? This dimension considered a) convenience of the regimen, b) the side-effect profile, c) ease of titration, and d) likelihood of unintended use.
- 4) How well does the medication fit the external environment from a cost-effectiveness standpoint? This dimension considers peer-reviewed publications of cost effectiveness analyses.

However, for this project there needed to be a broader framework if it was to evaluate people's knowledge and perspectives on ethnic minorities in treatment. There are ways of adapting the many design frameworks used in the research world to evaluate the effectiveness of policy or a service approach, and one has to decide what is being measured. Process evaluations and summative evaluations could be used here; one would investigate the processes in meeting the needs of ethnic minorities attending services in Islington for drug use or, the summative approach, evaluate the impact and effectiveness of the process. An outcomes framework would be designed to ask questions on whether the implemented plan had achieved its desired effect from the outset.

This would be hard to achieve in Islington as this was not a longitudinal study but an evaluation to see whether the clinicians have knowledge they can utilise to change services for a better outcome for ethnic minorities' treatment. In this project the summative evaluation seemed the most appropriate framework to apply, asking: 'Did the programme make a difference?' (impact evaluation) and 'Did the programme meet its stated goals and objectives?' (outcome evaluation). In this case it investigated the current Islington approach to drug users from ethnic backgrounds and its effects, whether intended or unintended. This was applicable as the project looked to evaluate what the professionals have learnt from the national and local research to inform their decisions.

Evidence on the evaluation from local and wider sources, such as local audits, was gathered from focus groups and semi-structured interviews.

Ethnic minority data was also sourced (as described earlier) from outcome data collected nationally for the National Treatment Agency (NTA). This looks at the national population and is known as the National Treatment Data Management Scheme, henceforth referred to as the NTDMS. This informs the project and paints a national picture of the emerging ethnic population presenting to drug treatment and whether Islington is typical.

The evaluation will cover:

Are there effective treatments for drug abuse in ethnic minority patients in Islington from senior clinicians and their services?

This outcome measure enabled the project to take an evaluative outlook and inform me of effective treatment outcomes for ethnic minorities in Islington overall. This is explored in more detail in the conclusion.

Data analysis

Data analysis was thematic, and this gave an insight into the perceptions and social constructs an individual would have about race and access to drug treatment services in the NHS.

Transcription of the data was the main way qualitative data was analysed. This can be time consuming, as all interviews conducted were recorded and then transcribed in full. I undertook 'coding', identifying the main themes that emerged during analysis (Silverman, 1985). These were categorised, with the interviews being thoroughly examined to extract good qualitative data relevant to the research question (Gomm, 2004).

Demographic data and local audit data were analysed and included in the data as they could be influential, reflecting the representativeness of the sample (Bryman, 2001).

Beyond Islington

The scoping of good practice went beyond the Borough, as there was good practice was being undertaken nationally with similar ethnic populations and substance misuse (Bashford et al., 2003). This was conducted through face-to-face interviews and by telephone. The area of interest was the neighbouring borough of Tower Hamlets in London, as this has a similar but larger population of both Bengalis and Pakistanis experiencing problems with substance misuse.

Through my professional network I found out from both doctors and nurses who run services there about what works in treatments for ethnic minorities. These experts were interviewed to enable verification and wider applicability of the potential data discovered in Islington. It is hoped this information will inform and enhance this research project.

Sample

Surveys aim to target samples with a high degree of representation, reflecting the population. For example, MORI polls try to use a representative population of the UK in terms of race, gender, ethnicity and religion. However, often these samples are too small and lack validity and reliability (Bryman, 2001). This project examined the key staff in Islington delivering services in the field of substance misuse. I was hoping to interview a sample of senior clinicians and managers who influenced services, so had a wide choice, but over time stratified this to identify the major senior clinical and managerial staff who ran services in Islington. This is often referred to a purposive sample, as defined by Walliman (2012). I needed those who shaped their services, and managed and clinically supervised their staff (Walliman, 2011). This was quite unlike a survey or a general research of opinions for which a representative sample might have been considered appropriate (Gomm, 2004).

The sample of participants is shown below. All the individuals led drug services in the London Borough of Islington, and are representative of the drug and alcohol services in the Borough. These people are the main decision makers, influencing service delivery for drug treatment in Islington, chosen for their position in the drug and alcohol field. The order of the participants is also given to identify their position in the field.

1. Islington Borough Clinical Lead for Drug and Alcohol Services (complex needs)
2. Clinical Lead for Primary Care Drug and Alcohol Services
3. Manager of City Roads Detoxification Service
4. Deputy Commissioner for Islington Drug and Alcohol Service
5. Manager for Drug and Alcohol Services at Isis, Islington
6. Manager of Drug and Criminal Justice Service
7. Lead Pharmacist: Tower Hamlets: Newham
8. Lead Consultant: Tower Hamlets: Newham
9. Lead Project Leader of NAFAS: Tower Hamlets.

Ethical approval

This project was subject to ethical approval from the Institute for Work Based Learning Ethics Sub-Committee at Middlesex University. Applications for ethical approval of the Category A proposals forms need to include the following:

- Participant Information Sheet
- Consent Form
- Risk Assessment Form

I liaised with the research department at Camden and Islington, and also the former Primary Care Trust (PCT: now part of Whittington NHS Trust services and therefore on Whittington Health trust forms). The former PCT saw this project as an evaluation of their workforce's knowledge base in the area of drugs and alcohol and therefore regard it as an evaluation (www.islingtonpct.nhs.uk/research governance). However, as the interviews were conducted with healthcare staff, only a participant information sheet and consent for the interviews were needed, informing participants that the data was collected for research purposes only, with an information sheet (www.socialresearchmethods.net). In any research project the confidentiality of the study, its risk and informed consent are important aspects to include in the proposals (Hakim, 2000).

As I wished to interview lead nurses in other boroughs such as Tower Hamlets in London it was important to state clearly that this was covered by the same ethical approval in order to maintain consent and governance standards. For this part of the evaluation process I produced a separate participant information sheet and consent form, also processed by Middlesex University's ethical approval system.

There must be protection for the participants of research to ensure that the data produced will be used for the research project and no other purpose (Gomm, 2004). Data was gathered for this reason alone and after analysis was destroyed to protect confidentiality of the participants. This was outlined in the information leaflet stating the research aims, confidentiality, risk and informed consent. The information sheet stated how the identity of all interviewees would remain anonymous in that no names would be given, but that the roles of the individuals in Islington's alcohol and drugs services would be included, as specified in the informed consent declaration.

In summary, the information sheet outlined the research topics and the role of the participants and the way the data would be used only for this research project. It aimed to reassure participants that the data generated from the interviews would not be used for other purposes.

As it was seen as an evaluation, the information sheet and consent form were examined by the clinical governance group at the PCT (Islington) and not the Camden and Islington ethical board.

Ethical approval from the University was sought, however; this included essential items such as a risk assessment, consent and the participant information sheet (Appendix 2).

The project's research findings will be disseminated through the PCT senior management team and the clinical leads of the substance misuse in Islington at the local drug reference group. I aim to publish in a national journal (where I have a good publication record) and present the findings at research conferences in England.

Gaining access

Access was not perceived to be a challenge when the project was designed, but in reality it was problematic to gain access to some interviewees. Working within the Islington drug services and across many services as a Nurse Consultant, I was able to meet many of the key personnel there. However, the PCT provides services for 250,000 people. Participants were obviously busy and I had to adapt my schedule to accommodate many in this research project as their diaries were full and their commitment to this project proved never to be a priority, as budget cuts seemed more important.

While the majority of participants, when eventually interviewed, agreed that the study was valuable and were open to be involved in the project, the procedure of organising when and where to conduct the interviews was problematic. Some senior clinicians in Islington proved elusive, yet all interviews were conducted formally.

My close relationship with some people was used to conduct formal interviews more than twice, when possible. These interviews offered a potential opportunity to collect good rich and descriptive data that approached the point of 'saturation' (Bryman, 2001). It made the best use of my working relationships with people to benefit this project.

I thought the place to start would be to contact some of my peers outside Islington. In Tower Hamlets, a neighbouring London borough with high levels of ethnic minority populations, I had previously worked with some senior clinicians and duly made contact. Interviews were arranged fairly quickly, with tours of their clinics in Tower Hamlets. Voluntary organisations such as NAFAS proved harder to access as they seemed wary of the research and, as they were in a re-tendering process, initially did not want to participate. However, persistence paid off in the end and secured a telephone interview with the manager, although this was less fruitful than exchanges with the senior clinicians of the Mental Health Trust.

I meet the senior clinicians of Tower Hamlets at their place of work and observed some clinical work while there. It gave me a way of seeing the clinicians at work, applying their knowledge of the ethnic populations in practice, which was an added bonus for me. This was verified by later findings that the senior clinicians in Tower Hamlets had good knowledge of their communities and were able to apply this to the benefit of patients.

Insider status

This project could be classed as practitioner research, that is, research undertaken and completed by a practitioner in the field (Fuller & Petch, 1995). The emphasis of this approach can be argued to be ‘action’ research where the researcher is looking to improve a defined part of a process such as an aspect of care or assessment process delivered on a day-to-day basis (Walliman, 2011).

In action research, practitioners play an active role in designing the project, collecting the data and implementing the change (Wilkinson, 2003). However, practitioner research need not be exclusively associated with action research and may use other methods to conduct research in the real world. I used a different approach, employing a framework of a case study and undertaking semi-structured qualitative interviews. The approach can be classed as practitioner research (Fuller & Petch, 1995) with myself the practitioner, establishing if the knowledge base and clinical approaches were effective in delivering treatment to ethnic minorities in the area of drugs and alcohol. Acting as the central researcher, I had several things to consider.

As mentioned, this research project used one-to-one interviews and focus groups, with myself as the researcher and practitioner. I worked with and knew the participants I was

researching. A potential source of influence and bias was that the interviewees knew me as the Nurse Consultant for Islington and were aware of my research project. This might have influenced the answers I was given, and there might have been bias in their responses in 'giving me what I wanted to hear'. I tried to make interviewees relax as much as possible and to build upon my good working relationships with them to extract as much data as possible, but the bias is a limitation of this study, hard to avoid in practitioner research of this kind (Wilkinson, 2003).

Thus, the problem of bias was taken into consideration. Some bias can be alleviated if interviews are conducted again and again (Grix, 2002). By undertaking two and sometimes three formal interviews I attempted to do this, to follow the data until it reached the point of saturation (Gomm, 2004). This proved valuable as it verified what I collected and made me confident that the conclusions from this project were still applicable.

I interviewed professionals in senior roles. I felt my non-Caucasian race was not a problem, as participants felt comfortable with my presence and some commented 'I thought you were Caucasian' when speaking to me on the phone, or were surprised when they saw me in person. I am treated as 'one of them' and my race appears not to matter at a superficial level. I felt the main problem was one of objectivity and the problems associated with being an 'insider' and therefore receiving answers to my questions with some bias (Bryman, 2001).

Confidentiality was maintained throughout the research process, as outlined earlier in the section on ethical approval. All participants received an information sheet and signed a consent form describing how confidentiality would be protected. Since I have conducted research in this field before, I was experienced in this process and foresaw no potential problems.

In summary, the process of the research was to make contact with some of my ex-colleagues who had now taken their expertise to neighbouring boroughs to work with ethnic minorities. The next stage was to meet them and conduct interviews. As mentioned, an added bonus for the research project was being able to watch them working.

I researched borough census data to construct background profiles of ethnic minority groups in Tower Hamlets and Islington. This was referenced to establish how services were treating their ethnic minority populations.

Summary

The case study used semi-structured interviews to ask senior healthcare professionals of Borough-wide partnerships about their perspectives and experience in meeting the needs of their ethnic minority populations. The sample was chosen using purposive sampling (Walliman, 2011). The questions were designed in a semi-structured way to lead the interviews yet to remain open enough for them to elaborate. The main issues addressed were: Are services delivering effective treatments for their emerging Asian populations? And, if so, what do they think works?

The interviews were conducted to examine both the perspectives of the managers and clinicians, and the commissioners and those delivering care for the Borough of Islington. This would highlight any gaps in service provision resulting from structural communication problems or a lack of a clear focus. Also, it would show whether practitioners felt that anything more should be done to services with drug and alcohol problems to meet the needs of an emerging ethnic minority.

Chapter 3: Findings

Tower Hamlets has a large ethnic population, with more than half its inhabitants from ethnic backgrounds described as non-White. The percentage stands at 53 per cent and only Newham, Brent, Redbridge and Harrow have a more ethnic population. Newham has the highest percentage, at 70 per cent.

In terms of the drug-using population attending services in Tower Hamlets, according to information supplied by the NTA the vast majority (87% or 1,321) of the White category is British, with the rest described as 'Other White' and 'Irish' (with 141 and 56 notifications respectively). The largest ethnic group in the Asian category is Bangladeshi, accounting for 1,075 (92%), with the remainder comprising 'Other Asians, Indian, Pakistani and Chinese'. The rest of the overall sample consists of 'Mixed Race', 'Black' and 'Other and Unknown' ethnic categories (156 or 5%, 137 or 4%, and 98 or 3% respectively).

Newham

As stated, Newham has a high percentage of its population from different ethnic minorities, according to recent figures. In the last census in 2001, with Brent, Newham was one of only two boroughs with more than half its population from Black and Minority Ethnic groups, and is the borough with the largest proportion of its population from non-White ethnic groups (www.TowerHamlet.gov.uk/2013).

Census data shows that 62 per cent of Newham's residents were born in the UK. Of the 38 per cent born abroad, 90 per cent come from 47 different countries. It is clear from National Insurance Number applications and registration with GPs that Newham is home to a significant and growing Eastern European community.

Newham has the second largest percentage of Muslims in England and Wales, and the fourth lowest percentage of Christians. Almost a quarter (24%) of Newham residents stated their religion as Muslim and just under a half Christian (www.TowerHamlets.gov.uk/2013).

The ethnic population is one of the highest in the country and this would hopefully be reflected in the experience of the clinicians working in the area.

The Mental Health Trust is the leading agency prescribing to and managing patients in the London boroughs of Tower Hamlets and Newham. It works with voluntary sectors to treat people who present to services in these boroughs, however there is a varied approach to the working of the Mental Health Trust in each. In Tower Hamlets, the Trust has positioned itself as the complex needs service, with a tiered system for the voluntary sector to organise the assessment and key working of patients who are not complex. These includes patients in the Primary Care sector, as shown below:

Table 3.1: Service Map Hierarchy for Drug Services: Complex Needs-led Model

Complex patients: poly drug users who have mental health problems such as schizophrenia, bi-polar disorder, clinical depression. No assessments are conducted, but patients are referred.	Mental Health Trust
Patients without poly drug use such as heroin/crack dependence: no diagnosed mental health problems.	Voluntary Sector
Patients who have achieved stability of their substitute medication.	Primary Care

In Newham, the approach is different as the Mental Health Service assesses all patients who approach services for treatment and then manage them through resources wholly owned by the Trust, as shown below:

Table 3.2: Service Map Hierarchy for Tower Hamlets

Complex patients: poly drug users who have mental health problems such as schizophrenia, bi-polar disorder, clinical depression.	Mental Health Trust
Patients without poly drug use such as heroin/crack dependence: no diagnosed mental health problems.	Mental Health Trust
Patients without poly drug use such as heroin/crack dependence: no diagnosed mental health problems.	Mental Health Trust with Primary Care GPs

Interview with Head of Pharmacy

There is a significant Asian population accessing services in both boroughs. In Newham, the Asian population is mixed, with a large Sikh and Punjabi community in the areas of Plaistow and Ilford. In Tower Hamlets, the Asian population is mainly Muslim and Bengali, with a minority of Pakistanis.

The main reasons why the services are able to work with a significant population of Asian drug users is due to several factors:

- Specific voluntary sectors projects target Asian populations
- Good clinical links with community projects in the area by the Mental Health Trust
- Rapid assessment (explained in detail later)
- The Asian drug-using population is able effectively to communicate good service provision within their community through ‘word of mouth’.

However, the aim of this project is to examine what services have learnt from the literature produced over the last decade and how this has influenced the clinical approach to services. This is now examined in an interview with the two clinical leads in Tower Hamlets.

Interview with Lead Chief Pharmacist

I interviewed the Lead Chief Pharmacist for Tower Hamlets for substance misuse to see what he has learnt and how this has improved his practice: What has been learnt from the Margerete Centre research and other studies on ethnic minorities and drug use in the last decade?

As the Head of Pharmacy for Substance Misuse, he was aware of the research, as he helped on the completion of the work at the Margerete Centre. He participated and learnt much in the interviews and the feedback from the research sessions as well. From this experience he has applied his knowledge to his current position, which has helped him make a head start in this area, a very diverse part of London.

Factors identified in the research in Camden and Islington drug services are applicable here, he found, such as the clients’ expectations of detoxification and the aim of having as

short a treatment episode as possible, similar to the findings in Islington research many years ago. Also, that many of the Asian population tend to come to the service through a friend who had had good experiences of the drug service in Tower Hamlets is similar to the findings of Camden and Islington. This made him confident in treating this cohort of patients, as he had experience of this ethnic group presenting to services. Therefore, the way treatment is communicated is very much by word of mouth in the community, and the service uses this fact to encourage other patients' family members to come forward for treatment.

Many of the patients asked to be started on buprenorphine rather than on methadone when starting on substitute prescribing for opiate addiction, under the impression that it is the chief detoxification medication. Therefore, their goal to treatment is clear. They want to stop using drugs by stabilising on substitute medication such as buprenorphine, and then to detoxify off the drug as quickly as possible (useful in the current climate of recovery). This is very similar to the findings in Camden and Islington ten years ago. It seems the concept of detoxification for the Bengali male population is still popular, and is not confined to Camden and Islington.

In terms of engaging the population in significant numbers, he felt this had been achieved due to the rapid assessment and prescription practised in the service. There is a 24-hour maximum from assessment to prescription, and in many cases a patient can be assessed in the morning and leave with a prescription in the afternoon. This rapid treatment model has helped capture an Asian population that has historically been 'treatment shy' and ambivalent to substitutes. It has enabled clients' goals to be accommodated quickly and effectively, hence the significant numbers undergoing treatment.

This flexible and responsive service has created a highly positive experience for the patient, who will feed this back to family and friends, resulting in more referrals from the ethnic group.

Interview with Lead Consultant

Similar to the Head of Pharmacy Service, the Lead Consultant stated that the high level of ethnic minorities treated in Tower Hamlets and neighbouring Newham was due to this ethnic population being numerous compared to other boroughs. The non-White population he knew about comprised over half of the overall population of Tower Hamlets and

Newham, and this has an impact. It was also important to understand how these communities operate. In his experience of the Camden Bengali population, in certain circles personal contact and narratives are important in bringing the community into drug services. Therefore, the most important way to reach an ethnic population is for one or two people to have a positive experience of the service and go back to their communities then talk about their experiences. This word of mouth communication was vital in bringing this population into drug services, as noted in the previous Camden and Islington study as the way the Bengali population presented to drug services.

In Tower Hamlets and Newham, the main groups seen are a sizeable Bengali population and a growing Eastern European population. The main problem drug here is heroin. There is a significant Afro-Caribbean population, for whom crack and alcohol seem to be the primary drugs for presentation to drug services, not heroin. However, most patients presenting to drug services use alcohol and crack to varying degrees.

The Bengali clients tend to be young men, with a very small number of women. They come to the service with the fixed idea of stabilising quickly on substitute medication, whether this is methadone or buprenorphine. Once this is achieved, the goal is to detoxify off this and become clean. Their focus is different to other ethnic minorities, for whom stabilisation is a more common goal. Culturally, these Bengalis are the main group with the idea of a short period of treatment, but in reality this may not happen as stabilisation on buprenorphine or methadone often proves difficult to achieve in the first 12 weeks of treatment.

Eastern Europeans are often in employment and will frequently move elsewhere in the country for jobs. Therefore, they comprise a mobile and high functioning population in Newham and Tower Hamlets and the challenge is to treat this population safely, when it is constantly on the move. This affects the treatment for this cohort, limited in both duration and thus outcomes, so stability and detoxification may be delayed or hard to incorporate due to the priority of 'looking for work'. However, the anecdotal evidence is that in real terms the Eastern European population stabilises quickly on substitute medication.

Like the previous interviewee, the Lead Consultant stated that a service that can treat people quickly is indeed important in reaching out to ethnic populations and retaining them in treatment. Treatment in the rapid access clinic is often a positive experience for ethnic minorities in Newham and Tower Hamlets. For many clients, it can be related back to their

communities, potentially bringing a greater ethnic population into drug services. In the clinics, assessment is jointly undertaken by the doctor and the nurse/pharmacy prescriber, which enables a thorough and quick assessment without duplication. Using only a single urine sample, if it is found appropriate from the assessment the patient is started on substitute prescriptions. This is quick and vital in retaining in treatment ethnic minorities such as the Bengalis.

Because ethnic populations have limited English, language can often delay the assessment process and the start of treatment. In Tower Hamlets and Newham there is a bank of translators who can be reached by telephone or who work within the treatment system. They are often used to complete an assessment and to start the treatment, proving invaluable in retaining this population in drug treatment services.

The model of the rapid access clinic can also lead to a better throughput model in the Borough, as the clinic will build towards stabilising the patient quickly and then moving them on. If patients stabilise quickly they can transfer to shared care systems in both boroughs. If the patient is assessed as complex, often with mental health/physical health problems as well as their substance misuse problems, this information is passed to specialist services under the Mental Health Trust.

Islington

Almost one in four (24.7%) Islington residents belong to an ethnic minority group. This proportion, although high in the national context, is below the average for Greater London and only two thirds of the level of Inner London. The mixed ethnicity group is larger than the Inner London average, ranking fifth among local authorities nationally. Within the broad ethnic categories of Asian or Asian British, Black or Black British and Chinese or other ethnic groups, the most significant categories locally are Black African, Black Caribbean and Bangladeshi, in that order, although all these are represented in Islington at levels below their proportions in Inner London. While the proportions of residents in the Black or Black British and Chinese/other groups in the Borough are above the average for London as a whole, the proportion of Islington residents in the Asian or Asian British group is well below half that of London and only slightly above the national average.

However, Islington has the eighth highest proportion of residents in the 'other White' group, which almost certainly includes Turkish residents.

Therefore, in summary, the percentage of the general population of Islington coming from ethnic minorities is 24.7 per cent of the overall population. This is significantly less than the percentage for Islington’s neighbours, Tower Hamlets and Newham. However, this figure includes a significant Turkish and Indian population, together only 12 per cent of the overall population (www.Islington.gov.uk/2013). Therefore, the presentation of ethnic minorities to drug services in Islington should be lower than Tower Hamlets and Newham. As stated in the interviews with two senior clinicians from these boroughs, the reason for the high percentage of ethnic minorities attending for treatment is the high overall figure for ethnicity in these boroughs. However, in poor housing in the south and north of Islington are significant Turkish, Indian and Bengali populations, and this prompts the question of what should be offered locally by way of treatment approaches.

Islington takes a tiered system approach and part of my research focussed on projects where new patients come to the services: Isis, based in Finsbury Park, and PCADS, the Primary Care Service. The other major service in the Borough is IDASS, the specialist service dealing with complex drug-dependent patients.

The tiered system is shown below:

Table 3.3: Service Map Hierarchy for Islington

IDASS	Complex needs drug patients
ISIS	Non-complex drug patients and all new patients into the treatment system
PCADS	All patients who are suitable to be treated by the GP. This patients group can vary in complexity
DAAP	All new clients and substitute prescribed patients and also offering a service for stimulant and cannabis use only

The Isis service has been in operation since 2009, arising from a re-designed pathway at the last drugs review. Throughput was seen as a problem in the Borough and Isis was created to enhance this through the tiered system. So far, it has developed strong links with Primary Care, offering assessment and initial treatment for all new patients, thus was a good place to interview key staff on their experience of ethnic minorities and what kind of treatment approaches are offered.

Interviews with Clinical Lead for PCADS/Isis; Deputy Commissioning Manager; City Roads Service Manager; Isis Service Manager; and Service Manager for PCADS

The data is presented below under the themes emerging from the semi-structured interviews.

Theme: Engagement

The theme of barriers to engagement was noted in the literature review, and in the interviews it again emerged as a prominent problem. Also, there was evidence of a change in the ethnic groups presenting for treatment and their different needs, summarised here by some of the data.

All interviewees responded that they were aware of the issues in engaging ethnic minority patients with drug services. It was stated that some ethnic minorities are more difficult to engage in any health service, in particular drug services probably because of the stigma attached to drug use in their communities. Often, services are not designed to their needs, and there are cultural differences such as the need for detoxification from direct pressure from patients' families and a lack of understanding of the families' role in the issue. This has been underestimated by drug services, and has often led to ill-matched treatments. A little knowledge of the role played by the family in Asian communities and its influence should have been beneficial to clinical thinking to address the issue and provide treatment more effectively. As it is, there is a cultural gap in clinicians' understanding of the patients they are treating (Fernandez, 2002).

In Islington, especially in the Detoxification Service (City Roads), a significant Asian population has been reported using the service, therefore this 'need' for detoxification still exists and has increased over the past decade. City Roads service stated that this was often patients' first experience of drug services and there was a naivety that affected the outcomes achieved by this population. Often, those who presented to City Roads wanted the same detoxification package more than once, and the relapse rate was high. However, the only way they would engage with the services was to receive a detoxification package.

We are aware of the work completed in the area over the last decade but not the real specifics of it. There are barriers and cultural differences. However, if your clinical team are responsive and flexible they will look to improve things. We were lucky that this was picked up by the staff at City Roads.

Manager of City Roads

Research into ill-matched treatments for ethnic minorities had had an impact here. Ethnic minorities were not detoxified again and again, but were instead directed to engage long-term with drug agencies to work on their 'insight'. This improved the outcomes when patients from ethnic minorities came in for their second detoxification. This, however, needs to be an ongoing process. The push from ethnic minority patients to receive detoxification as their preferred treatment is still high, and at City Roads the staff are still offering detoxification for this cohort, and this needs to be examined further to see whether improvements can be introduced.

Both the Manager of Isis and the Manager of City Roads stated that there were barriers to certain people in accessing drug services. In particular, women were seen as a hard-to-reach group. This was documented throughout the past decade by the National Treatment Outcomes Studies, referred to as NTORS (Gossop, Marsden & Stewart, 2001). This showed that, nationally, levels of women in drug treatment are low compared to men, who outnumber them 4 to 1. The barriers are fears around child protection and repercussions from accessing services, and domestic violence. However, while this is worth further research and I feel would be interesting to explore in a further project and be valuable to the Borough of Islington, it is beyond the scope of this particular project.

All managers were aware of the work completed in the last decade of the research that highlighted the barriers to treatment for ethnic minorities. Their experience was that more recently there is an emerging group presenting for treatment who face the same barriers to treatment. This new population comprises the Eastern Europeans who present with little English and often cultural differences, similar to the Asian population of a decade ago. Similarities include coming to treatment with an emphasis on detoxification, for example. Interpreters are often needed, and an understanding of the cultural context in order to provide more apt treatment for this emerging group, as was the case previously. However, the issue of resources was raised. Resources to accommodate these needs would appear to be a general theme throughout the project and the lack of funds compromise the response to this emerging ethnic group's needs.

Theme: Barriers (lack of resources)

Resources can often be an issue and a lack of resources can lead to less flexible services and an inability to meet needs.

Clinical Lead for Isis

This session looked at resourcing and some interviewees expanded on this, feeling that in the current climate services were being cut, and this further compromised what they could do. Services were being stretched to the limit and, as a result, were becoming less flexible.

This is a wider issue in healthcare across England and Wales and many NHS resources are stretched. Cuts in drug services had been made to Isis and had led to a less accommodating service, so would a high-profile, culturally specific project improve access to services for all in this area? This is emerging as a point for discussion, and would clearly incur some expense.

It appears that all interviewees stated that flexibility is directly dependent on the level of resources of any single project. The speed of treatment and the way clients are assessed and prescribed quickly is important but can only be achieved if there are suitably skilled staff and resources.

In Tower Hamlets, all the staff felt that rapid assessment and prescribing was indeed critical to retaining new populations in treatment. For many of the interviewees in Islington, the challenge was how the resources were organised in order to produce flexibility. There was no joint assessment for patients by a doctor and a non-medical prescriber, as in Tower Hamlets. A doctor completed all new assessments and initiated prescription before non-medical prescribing could take place. This may be an area that could re-think the assessment process to speed things up. It would also use resources more efficiently in challenging times. However, both Isis and the Primary Care Service said that they process patients within 48 hours, from assessment to prescribing. In many cases, it can be even quicker, but if resourcing is cut then this service would be difficult to maintain.

Services in Islington aim to be flexible, and if they can be more so they are best able to service their treatment populations, whatever their needs and wherever they are from. However, all interviewees noted Eastern Europeans presenting to services in Islington.

This was similar to the experience of Tower Hamlets, and is the new ethnic population presenting to drug services.

Overall, the interviewees in Islington acknowledged that services are not designed with ethnic minorities in mind. Also, additional problems with cultural differences and language barriers prevent patients from engaging with services. At times, services tend to blame the patients for their often complex presentations. The need for interpreters can be costly and often difficult to arrange, making patients even more difficult to treat and creating a barrier to treatment.

Services could be more flexible around meeting the needs of its ethnic population if it had leaflets which are translated in different languages which could go some way as to address this problem at a low cost.

Clinical Lead at Isis

Therefore, while all the interviewees stated resources were important, everyone tried to work in their environments as well as possible. Flexibility and low cost ways to meet needs are important concepts.

Theme: Education and clinical approaches

The concept of what has been learnt and applied is important to this project. The outcomes assess whether previous research has influenced and improved the knowledge of senior clinical leads. This in turn helps them to lead their services more effectively. Therefore, the question is whether the senior clinical leads are able to identify some of the perceived barriers to treatment discovered through research in the area. Hopefully, this can be illustrated in this section.

All stated that the literature they were aware of had informed their practice. Research makes practitioners look at the latest trends in the field of substance misuse, so this will improve knowledge in this area. This enables it to be incorporated into a professionals' clinical thinking to improve treatment outcomes. As maintained by all the interviewees, notwithstanding encouraging a learning environment in the workplaces, good clinicians behave like this anyway to widen their knowledge. Motivated staff will always be looking to improve their practice, and it is fortunate that the boroughs had such a group of workers. This is good for the services and helps improve from within. However, all stated again that being responsible and flexible in your practice was the most important concept.

All interviewees were aware of the research conducted in Camden and Islington in 2001–2002, but some did not know who produced it (myself). All stated that it highlighted the issue and made them aware of ethnic minorities in drug services. They were aware of the problems facing women, and acknowledged that the barriers to their treatment were very different from those of ethnic minorities'. They found that the majority were men, with few women coming forward for treatment, which they felt needed examination. All were aware of the need to be culturally sensitive to their patients and had access to interpreters, although this was hard to organise on a day-to-day basis. The majority of staff understood the different patterns of drug use in some ethnic groups and the different cultural pressures on people from different cultures (for instance family pressure, stigma, etc).

Some of the interviewees stated that there were low numbers of Asians presenting for treatment in Islington, unlike Tower Hamlets. The small but significant population in Islington may encourage commissioners to look at providing flexible services for patients rather than the specific, culturally sensitive services aimed at engaging ethnic minorities undertaken in Tower Hamlets.

City Roads staff had developed a cultural understanding of the Asian population presenting for detoxification. Over time and as their experience grew of this population, they found they had to develop clients' insight and understanding of detoxification and the idea of staying drug-free. They worked with local services in Tower Hamlets to ensure that patients from the Asian community were prepared for detoxification and understood it was a process that needed them to change their lifestyle. This was an ongoing process, but shows how a staff team can adapt and learn to improve services through their experiences of this community.

A further point raised was the issue of outreach services. All stated that education and outreach into communities was needed and indeed vital to address the issue of drug use in their communities as a whole. Isis as a service had been invited to the local mosque in Finsbury Park to deliver a teaching session on drug use. This was seen as giving information to the community, as often the Muslim community in Islington is a closed community thus without knowledge of where drug services are located and what is offered. More of these sessions were needed, and services need to go out to their communities to show how there is a service for them.

However, as stated by all interviewees, there is an emerging Eastern European population that needs attention. Were Islington services able to adapt to the challenge? All thought this was possible.

Theme: Flexibility

This was strongly linked to the discussions throughout this chapter, with all interviewees stating that flexibility is directly linked to resources. However, all were realistic in accepting that more funding was not forthcoming under the Coalition government, so there was a need to be creative with existing resources.

Flexibility to accommodate ethnic minorities and other groups was often the aim of services in Islington. Despite the good intentions of staff to improve and be flexible in treating their patients, at times there were not the resources to make the services culturally responsive. All drug services had had problems encouraging women to come for drug treatment, recognised nationally as well as locally. The issue of trying to engage ethnic minorities into drug services is similar, and what is needed is effective outreach into ethnic communities. Outreach models for services could be promoted and modelled to use the experience of other services in Tower Hamlets that in these communities ‘word of mouth’ is the best way to encourage ethnic minorities to engage with drug services. Well-designed outreach services could result in increased numbers of ethnic populations presenting to services for drug and alcohol treatment.

In addressing the issue of flexibility, all interviewees expressed the opinion that the drug and alcohol services in Islington probably do not operate flexibly to meet the needs of other groups, for instance people who work all day or elderly people. Flexibility costs money (e.g. opening hours and staff costs) and this is in short supply. It was acknowledged that services offered great flexibility in terms of when people can attend during the day, but that Islington services often have poor access to interpreters, a fairly basic requirement, and that sessions have to be organised at least a week in advance. As a whole, the Borough employed workers from a range of ethnic backgrounds but had problems with emerging ethnic populations as staff numbers from these communities are not high enough to meet the need. If services are struggling to have flexible opening hours, how can one expect flexibility for clinical treatments for ethnic minorities with complex needs and no English? It would appear that the levels of resources of some services were a real issue, as it was a

common issue for nearly all questions. A lack of resources was stated to prevent flexibility. This issue may need further exploration.

Chapter 4: Discussion

Did this research meet the research objectives and research questions outlined earlier in this project, listed below?

Objectives:

1. To conduct an extensive literature review on substance misuse treatment of emerging minorities to see if any areas can be identified where knowledge can be used to enhance service delivery in Camden and Islington.
2. To review current services from the perspective of the senior clinicians who lead services to see how they respond to ethnic minority needs in the area of substance misuse.
3. To identify aspects of innovative and good practice that can enhance current substance misuse services.
4. To discover areas of practice where recommendations for a change of practice can be made in the Borough.

Research questions:

1. What sort of services are required to support ethnic minority drug users?
2. Can services accommodate ethnic minorities for drug treatment and are these effective and be transferred to other areas for treatment?
3. How are multi-structured treatment systems in drug services utilised to meet the needs of ethnic minorities in drug treatment?

In terms of meeting the above requirements, some answers covered several objectives and research questions and are summarised in this conclusion.

Flexibility

The literature review on drug services in the US and the UK showed that ethnic minority groups presented with different needs from the indigenous population (Bashford et al.,

2003; Lê Cook & Alegría, 2011; Molina et al., 2012). This research stated that different treatment approaches are needed and, when provided, treatment is more effective. In Islington, clinical staff felt that providing flexibility of services is what is needed to support ethnic minority drug users.

Flexible services can accommodate different needs, not just for ethnic minorities but other minorities such as women. All senior clinician staff are aware of the local research and national research conducted in 2003, and lead their drug and alcohol services to meet ethnic minority needs for substance misuse. They all aimed to render their services flexible to accommodate ethnic minority needs, but few had updated their knowledge since the Borough-wide training in 2004. It is fortunate that this had not affected drug treatment, as the same issues discovered in UK research continue to affect ethnic minority populations (Fountain, 2009a-e), and a teaching session for the Borough would be useful for all managers and senior clinician staff.

All clinical staff in Islington felt there were barriers to treatment for patients who presented from ethnic minority backgrounds. These barriers were language and a poor understanding of drug services and, as mentioned, are similar to previous research findings in the UK (Bashford et al., 2003; Fountain, 2009a-e; Fernandez, 2002). However, some of the barriers are created by limitations of funding. The current cuts to services in Islington were felt by most staff to force them to be less flexible and less responsive to ethnic minority needs. This is a poor situation, going back to a time when services struggled to meet the needs of emerging ethnic minorities (Fountain, 2009a-e).

Despite this pressure, senior clinical staff felt that services had developed in such a way that flexibility was a prominent part of treatment in substance misuse and would be an advantage in accommodating and treating ethnic minorities such as the Bangladeshi community in Islington. Flexibility was seen as an approach to structuring drug and alcohol services to meet ethnic minority needs and therefore answering the research objectives and research questions from Islington's perspective. However, different presentations need different treatment plans and, in order to provide this, services must be flexible (Lê Cook & Alegría, 2011).

Pragmatically, some of the interviewees stated that not all needs could be met for the whole population, as long as there was an effort to be flexible and accommodate difference, which was indeed welcome. Funding to provide flexible services for substance

misuse is a real issue, however, and does not seem likely to be solved in the current political climate. Adequate resource provision is needed to increase services' flexibility in terms of opening hours and the ability to meet the needs of a population that is culturally different. Is there an alternative?

Rapid assessment

The speed at which ethnic minorities are engaged is important and, if funding causes delays, might lead to a reduction of the number of ethnic minority patients coming to services.

Once people access a service, the speed with which a person receives any treatment other intervention is an important factor in whether they remain engaged. (Fountain, 2009a-e)

Fountain's report showed that South Asians' poor experiences of drug services were linked to waiting times:

While some drug users were satisfied with the drug services they received and felt that their needs had been met, more drug users rated services poorly (including those in prison), particularly because of:

- Too long waiting times for treatment
- The lack of follow-up support, particularly after detoxification
- The services' lack of understanding of South Asian clients' cultural and religious background. (Fountain, 2009a-e)

Rapid assessment is therefore a major attribute identified by both this project and UK research to accommodate ethnic minority populations. It is conducted in Tower Hamlets, where assessment and prescription are completed within 24 hours. In Islington this takes 48 hours, at times with a longer wait for prescription. Tower Hamlets' drug services had responded directly to current literature findings and the senior clinicians there felt this was vital in keeping ethnic minorities in treatment. This needs to be undertaken in Islington, where the high level of flexibility could be argued to be less effective than the introduction of rapid assessment.

Culturally specific services

Another option from this research is to examine drug and alcohol services in Tower Hamlets that are set up differently. There is a culturally specific voluntary sector project to

address some of the identified problems. It was funded to increase the referral rate from the local Bengali population, known to be using heroin. This had a certain degree of success and, by identifying the Bengali drug-using sectors from their understanding of the community, was able to signpost them towards the right services to receive treatment and build towards abstinence.

Would another tier of service, targeted on a culturally specific group, have relevance to increasing the level of ethnic minorities in drug treatment services in Islington? This is the major question that commissioning needs to consider from the findings of this study, as the evidence of providing a project such as NAFAS can indeed provide such an increase in the number of ethnic minorities, in this case Bengalis, presenting for treatment.

An obvious point is that there is a significantly higher ethnic minority population in Newham than in Islington. This leads to a greater number of ethnic minorities, on the whole, presenting to Newham drug services than to Islington. This is a factor that all interviewees of both Newham and Islington thought valid; however, greater exposure to ethnic minorities should be accompanied by expertise and experience in dealing with these groups. It appears that Newham may be seen as a borough that offers learning and improving practice in this area, and the potential is there to be utilised.

Lessons from Newham

This project is not designed as a comparative study, but in practice there were some highly useful findings worth highlighting as they reinforce previous research findings and approaches that should be adopted by other boroughs to improve practice. These include how Tower Hamlets drug services engage the ethnic population, similar to many projects researched nationally in 2002–2005 (Fountain, 2003). The senior clinicians interviewed used their experience and knowledge to promote the idea that ethnic minority patients would pass on their positive experience of services by ‘word of mouth’, and this was used by services in Tower Hamlets to increase the number of ethnic minorities presenting. This still seems the best way to engage ethnic minority patients in significant numbers. This did not seem to be the case in Islington, where the services are taking a broader approach to engage emerging ethnic minority populations.

The most important finding, which could be examined further for transfer to Islington, was the process of assessment and treatment termed ‘rapid assessment’. As mentioned in the

previous section, Tower Hamlets staff aimed to assess and prescribe to patients within 24 hours, something Islington at times struggled to manage due to budget restrictions and a lack of resources. Tower Hamlets enabled a 24-hour prescribing service, judging it to be a successful way to treat ethnic minorities as recruiting new populations quickly enabled long-term engagement with drug services, supported by research completed in the UK (Fountain, 2009a-e). This could be adopted by Islington services.

One major difference is the undertaking of a culturally specific project in Tower Hamlets to engage and target for treatment ethnic minorities using drugs. This was seen as positive as it seemed to locate patients from the ethnic minority community to enter treatment and, coupled with the speed of assessment, enabled them to stay in treatment and engage effectively.

To summarise: The advantages of the Tower Hamlets model is that staff were able to engage ethnic minority populations because of:

- 1) Specific voluntary sectors projects targeting the Asian populations
- 2) Good clinical links with community projects in the area through the Mental Health Trust
- 3) Rapid assessment (explained later in detail)
- 4) The Asian drug-using community is able effectively to communicate good service provision within their community through 'word of mouth'.

In Islington they had:

- 1) Flexible service provision
- 2) Awareness of the issues of ethnic populations engaging with drug services such as effective communication within groups being the best for effective communication and good service provision
- 3) Assessment and treatment started within 48 hours.

Tower Hamlets has a higher population of ethnic minorities than Islington and this has arguably forced through the idea of a two-tier voluntary sector project. However, using its existing services, Islington should investigate developing points 2 and 3 as this would add to drug treatment provision in the Borough. However, it should be recognised that among inner-city drug services with large minority population, Tower Hamlets is an exemplary model that could be transferred and become more widely adopted.

To return to the project and the conclusion, the next section asks if the project met the aims of the overall framework with an outcome evaluation on the previous local research provided in the Borough of Islington in 2004:

The evaluation hoped to cover:

- 1) Whether there effective treatments for patients from senior clinicians and their services for ethnic minorities' drug treatment in Islington.

From the data gathered it was clear that all the clinicians interviewed are aware of ethnic minorities and the problems they sometimes face in trying to engage in service provision. They used this knowledge to the best of their abilities to design effective services. There were approaches to ethnic minorities that were well received and could be shared, for instance flexible service provision in Islington.

However, it is important to note that Islington and Tower Hamlets both stated that new ethnic minority populations were emerging, and the same processes of flexibility and rapid assessment seemed important in engaging these populations in drug treatment. It appears from this project that there are useful tools to produce and develop to help meet ethnic minority needs in drug treatment:

1. Rapid assessment
2. Two-tier culturally specific drug and alcohol services.

This project attempted to evaluate senior clinicians' knowledge of research into ethnic minority issues and how this influences them in shaping effective services. Part of the study was to enable commissioners to assess whether they were up-to-date with research in the area of ethnic minority populations. On this note, many cited awareness and knowledge of the issues ethnic minorities face in barriers to treatment, such as language and a poor understanding of service provision, yet most were unaware of research conducted beyond the UK. Some were aware of the local research completed by myself (Fernandez, 2004) and the research literature review completed by Jane Fountain (2003). However, there was no knowledge of the work conducted in the US (Lê Cook et al., 2011; Molina et al., 2012), thus there is a need to run sessions to update staff members' knowledge base on some socio-economic factors.

Limitations to the research

Most of the clinicians interviewed in this project were working in Islington when Borough-wide research and educational sessions were delivered in 2004, and all claimed that they had learnt from these sessions and had applied this knowledge directly to their work and the design of their approaches. A few were not employed here at that time, and others changed posts and did not complete more than one interview during the course of the study. This could have limited my data verification, yet I conducted at least two interviews with all remaining participants.

Also, as the project developed, there seemed to unfold a greater scope for completing a comparative study of the two inner London boroughs of Tower Hamlets and Islington. There are some positive points that can be drawn from Tower Hamlets' practice, and a comparative study would lead to examining in detail the different approaches of both and to highlight what could be transferred to Islington, and vice versa. This would be a valuable project for both boroughs and can perhaps be explored as an extension of this project in future.

Chapter 5: Reflection

Reflective account

This is a practitioner research project and I am satisfied that something was revealed that could improve and change the delivery of treatments in drugs and alcohol for ethnic minorities, namely rapid assessment. I was able to talk to the clinical leads of all the drug services in Islington to encourage them to think about how this could be implemented. At Isis, I now assess and prescribe for patients immediately following a single appointment with the GP. As a Nurse Consultant I am able to triage patients' substitute prescription, whether methadone or buprenorphine. This had not been a way of working until this year and the completion of this project influenced the reduction of time from assessment to prescription.

As the Nurse Consultant for Islington for drugs and alcohol, I have experience of how to plan a project that has real influence on decision making (practitioner/action research). This particular project was a piece of work I felt really proud of completing. It was useful for me to undertake a piece of research that started by asking how to provide services for ethnic minorities in Camden and Islington drug services, then exploring how this research and similar studies had changed people's perception of treatments and opened their thinking to treating ethnic minorities.

Through completing this project I achieved a higher level of confidence, as it was good (actually, great) to hear my work mentioned by some of the interviewees. Even better was their acknowledgement that it had been important in changing the way clinicians think about treating ethnic minorities for substance misuse.

Importantly, the project was valuable to me and my professional standing. It made me aware of the importance of using contacts as, without this, I would have found examining practice at another borough such as Tower Hamlets quite impossible. Through my work as a Nurse Consultant and my previous research in Camden and Islington, I was able to use the contacts and friendships to collect data. When I contacted people I did not know in Tower Hamlets, they did not return my calls at all. It appeared, at times, very difficult to

get this research off the ground. However, knowing some key staff in the service enabled me to access the Borough of Tower Hamlets service map. I had underestimated the importance of contacts in conducting broad research projects such as this, but will never do so again.

By contrast, being a well-known member of staff in Islington I was able to gain access to many parts of the service in terms of information and key people. In many respects, this was easy as I have working relationships with most of the people. This does involve regular contact. As mentioned earlier in the study, however, there is a perception that some of the data will be compromised by this fact. Indeed, it is a relevant point and the only way I felt this could be diminished was by conducting formal-style interviews with my everyday contacts to attempt to make the data consistent in its findings. I am confident that this led to a consistent pattern of responses to the questions forming the bulk of the data in this project.

I also learnt that, in commissioning and thinking about delivering effective services to the Borough population, it is important not to be too insular in your thinking. It is valuable to examine other boroughs to see how they address issues, as they may have some good ideas. In this project, accessing Tower Hamlets was indeed valuable and formed my thinking on how Islington could shape services in substance misuse in future.

Therefore, from this work I learnt that completing research and introducing a longitudinal research concept is invaluable. It enhances the original research and completes it, as well. It strengthens some of the prior findings that are important for a researcher to discover. It is also important to understand that the best research is one that is broader than that defined by the captured population, such as the Borough of Islington. Looking at neighbouring boroughs such as Tower Hamlets was of key importance to support some of my findings in Islington. However, it also gave some new ideas that would not have occurred to me if I had not looked further afield.

The most valuable lesson was to learn to undertake research in which I have an interest in difficult socio-economic times. My role is seen by the commissioners who I wanted to involve in this project as having been downgraded. They were reluctant to meet me as they did not want to support a project with relevance to a post of which they were now highly critical. Also, they and myself felt uncomfortable in meetings when the question arose of the value that I add to the Borough of Islington. This was a challenging part of the research

process and I focussed on the commissioners taking part, rather than on my job. I wanted the project completed.

This focus enabled me to reach the end of the project. It demanded a single-mindedness that I developed, although at first I did not realise I possessed it. I learnt that this attribute can be vital in starting and finishing a project such as this. It will hopefully be a resource that can help me professionally, just as it certainly helped me to complete the project.

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www.socialresearchmethods.net/2013

www.towerhamlets.gov.uk/2013

www.Islington.gov.uk/2013

Appendix 1: Glossary

Buprenorphine:	Substitute medication used by NHS services in the UK for opioid dependency. Usually used for patients who wish to detoxify and become drug free.
Complex needs	This describes a patient who has opioid dependency and also mental health problems i.e. schizophrenia or severe physical health problems i.e. liver damage, or have young children under the age of 16 that involves social services input.
Crack	Illicit stimulant drug bought on the street.
DAAP	Crime Reduction Initiatives service to engage drug-dependent patients.
Dependent Alcohol consumption	A pattern where someone drinks every day.
Detoxification	A process in treatment where the patient stabilises on their substitute medication (does not use illicit drugs on top of their prescribed methadone or buprenorphine) and then reduces their dose gradually.
Heroin	Illicit depressant drug bought on the street.
IDASS	Islington Drug and Alcohol Specialist Service.
Isis	Islington Drug Service.
Methadone	Substitute medication used by NHS services in the UK for opioid dependency.
Non-complex needs	Patients with no physical or mental health problems and no children.
NAFAS <i>Breath of Life and Freedom</i>	A specialist centre established to meet the drug-related education, prevention and treatment needs of the Bangladeshi community in the London Borough of Tower Hamlets.
NTORS	National Treatment Outcome Results Study.
PCADS	Primary Care Drug and Alcohol Service.
Poly drug use	Use of more than one drug dependently i.e. heroin and crack and alcohol and benzodiazepines daily.

Appendix 2: Project Documentation

Summary of Research: Information Sheet

This proposal is seeking to identify effective areas of practice in the field of substance misuse that accommodate the needs of a growing population of Asian drug users in Islington. This population is mainly Bengali. The proposal aim is to look at the Borough as a whole and look at services that provide drug treatment. It seeks to evaluate whether treatment has effective outcomes. It will attempt to evaluate this by interviewing the key decision makers in the London Borough of Islington and key clinicians and examine their knowledge base and clinical approach to treatment. Where good practice is described, it will look to see if these approaches are transferable to other services in the Borough. It will therefore aim to be an informative piece of research which will hopefully lead to local recommendations for treatment in the Borough of Islington for engaging ethnic minorities.

Many institutions in the health service, in substance misuse, tend to have many white British populations with very few from ethnic minorities. This has led to services being slow to adapt to addressing the emerging Asian population in London to produce effective outcomes. This research examines what has changed and what good practices are nationally practiced in providing ethnic minority care. This can lead to effective local recommendations or introducing care pathways that work in other boroughs hopefully discovered from this research.

Ethical Information

This research has been ethically approved by Middlesex University and is logged as an audit with the Whittington Health NHS Trust.

The data gathered will be for research purposes only and will be destroyed once the project is complete.

All interviewee's identities will be protected and no personal names or individual job titles will be identified.

If any recommendations or findings are useful to the Borough of Islington a summary of this research can be accessed through the University.

Semi-structured interviews: All questions were used in the formal and informal interviews

What do you feel are the issues for ethnic populations presenting to drug services in Islington?

Expand this question with Socratic questioning.

Do you feel services are able to best service ethnic populations presenting for substance misuse problems?

Are you aware of any literature on ethnic minorities presenting for treatment in substance misuse? if so, has this challenged your thinking?

Are there any ideas of practices you feel work for ethnic minorities presenting for substance misuse?

Expand with Socratic questioning on all questions.

Ref Number:

Clinical Audit Registration Form

The Quality Improvement and Clinical Audit Committee oversees the audit process and monitors all audit activity within the Trust. This form is designed to help in this process and for you to plan and complete your project in line with the Clinical Audit Policy. **Once completed, please return with a copy of your data collection tool to Sue Ellis, Clinical Audit Co-ordinator, Clinical Governance Department, Jenner Building or Email: Sue.Ellis5@nhs.net Telephone: 020 7288**

Contact Details

	Name	Designation	Email address	Tel / Bleep Number	Division	Speciality
You (main audit project contact)	JEFF FERRADICE	NURSE CONSULTANT	Hernandez@nhs.net		PCADS	PRIMARY CARE - ALCOHOL & DRUGS
Project Supervisor	CHRIS SERGEANT	CLINICAL LEAD PCADS	christopher.sergeant@nhs.net		PCADS	PRIMARY CARE - ALCOHOL & DRUGS

Project Details

Title (Once submitted the title is not to change)
Evaluating Service provision that Ethnic Minorities receive for treatment of substance misuse in Islington

Is the project (please appropriate boxes):

An initial clinical audit A clinical re-audit Including a patient survey

Collaborative audit with another Dept or Trust: _____

Part of the Audit Programme Reactive Audit Additional Audit

By signing this Clinical Audit Registration form you are agreeing to the following:

- No patient identifiable audit data is to be removed from your place of work unless on a Whittington Health encrypted lap-top or data-stick. All paper audit tools are to remain on Whittington Health premises.
- All audit data and reports are to be stored on Whittington Health computers only.
- Once the audit is complete (report written and agreed) all paper data collection tools are to be destroyed. The audit report is to be kept for 5 years.

1) Does your project involve sharing data across different organisations? Yes No

2) Have you sought patient consent to do so? Yes No

3) Does your project involve the collection of patient identifiable data locally? Yes No

If yes to questions 1, 2 or 3, please answer:

Has consent been sought by using the Trust's consent form? Yes No

Has the patient been given an information leaflet? Yes No

Approximate time-frame for the project (month/year)	Start:	Date you plan to present the results:
	Complete:	Date by which you expect actions to be implemented:
		<i>JANUARY - MARCH 2014</i>
		<i>TO BE ARRANGED</i>
Do you require help from the Clinical Governance Department? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		

Who will be collecting the data?
Please list, below, details of all the people who will be collecting data (continue on separate paper if necessary).

Is this audit multi-disciplinary? Yes No

	Name	Job Title	Contact number
1	JEFF FERNANDEZ	NURSE CONSULTANT FOR	07795 822773
2		PRIMARY CARE WHITTINGTON	
3			

Do you plan to undertake a pilot? Yes No

If no, please state why: THIS IS A PILOT INVESTIGATORY PROJECT

Audit sample - State your population or target group and your method of sample selection (eg. All patients attending clinic by random selection - see note 3)

ALL PARTICIPANTS WILL BE STAFF AND SENIOR MANAGERS AND CLINICIANS IN WHITTINGTON DRUG SERVICES

Estimated sample size (eg: 50 case notes OR 25% of target group...)

10 INTERVIEWEES

Data collection period (dates relating to sample eg: 1 Jan 11 - 31 Dec 11)

from OCT 2012 to FEB 2013

How will you disseminate the findings of this project? - see note 4

THIS WILL BE PRESENT AT THE BOROUGH SENIOR CLINICIANS MEETING.

Data Protection and Confidentiality:
The collection and use of clinical data must follow acceptable guidelines and principles in relation to Whittington Health NHS Trust's Confidentiality and Information Security Guidelines. Please ensure that all data and results are anonymised. This audit must be undertaken with consideration given to the implications of the Data Protection Act 1998 and Caldicott arrangements. - to confirm

	Project Lead:	Project Supervisor:	Specialty Audit Lead (see note 5):	Date Project Proposal form received by CG Dept:
Please sign	<u>CS</u>		<u>CS</u>	
Please Print	CHRIS SARGEANT		CHRIS SARGEANT	05/10/12
Date	01/10/12		01/10/12	

Eastern Europeans in Newham

Dr Ron Alcorn
Consultant Psychiatrist
Specialist Substance Misuse Team-Newham

Clinical Director, Specialist Addiction Services
East London Foundation Trust



East London 
NHS Foundation Trust

East London Foundation Trust (NHS) services in Newham

- Complex needs service in Stratford (SSMT), Tier 3-4 (serious physical, psychological, social or forensic problems)
- Healthy Options Team (HOT) in Plaistow
- CSSS, Young Person's Substance Misuse Team (CAMHS)
- Community needle exchange coordination
- Blood Borne Virus (BBV) team (nurse-lead health screening and health improvement)
- Alcohol and drug liaison nurses at NUH
- Dual Diagnosis workers in adult mental health
- Close links, and joint working, with other agencies in Newham (CDT, CJIT, DASL, LBN)
- Close links with other east London boroughs through ELFT (Tower Hamlets and Hackney)

Newham – Eastern Europeans

- Last quarter (2011) SSMT
New referrals; 13/102
Numbers on caseload; 32/257
- Community pharmacy needle
exchange data

Specific issues

- Housing / communal living / sharing
injecting equipment and supplies of
drugs
- Blood borne infections (Hep B, Hep C
occasionally HIV) – occasional
outbreaks / rapid spread
- “discovery” of and access to crack and
strong beers/ciders
- Travel back and forth to home countries
(often short notice, no documentation)

Barriers to treatment and recovery

- Language (assessment / appointments / physical health care / AA and NA options)
- Peer networks
- Distance from (non-using) friends and family supports
- Access to public funds (for residential or day-care options)
- Treatment "systems" (e.g. clinic hours and pharmacy supervision of methdone/buprenorphine interfering with work schedules)
- Differing concepts/perceptions of "treatment" and "cure"
- Limited cultural, linguistic, historical awareness of these countries in staff groups

