BME PERSPECTIVES ON SUBSTANCE USE AND MENTAL HEALTH PROBLEMS

Report of a consultation with people from African Caribbean and Bangladeshi Communities in Leeds

August – October 2008

Developed by a multi-agency collaborative

St. Anne's Community Services

St. Martin's Practice

TOUCHSTONE
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TABLE OF CONTENTS

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Dual Diagnosis Working & Strategy Groups, Leeds
BME Advisory Group, NHS Leeds

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Thanks to Ryan Sorhaindo for his time and contribution to the data analysis and evaluation phases of this project.

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EXECUTIVE SUMMARY

The Project: This project focused on consulting with members of the local Bangladeshi and African Caribbean communities in Leeds to identify barriers and facilitators to accessing mental health and alcohol & drugs treatment services. Focus groups and confidential interviews were used as methods to consult with a total of 40 people to explore perceptions related to combined substance use and mental health problems. The target population included general community members and service users. Efforts were made to include a broad range of respondents in relation to age groups and fairly balanced according to sex. Information was gathered based on a pre-planned set of themes: (1) awareness & prevalence of substance use; (2) definitions of mental health; (3) links between substance use and mental health; (4) community responses to these combined problems; (5) barriers and suggestions.

Drugs awareness and reported trends: Generally a good level of drugs awareness was found across groups and interviews, with younger people demonstrating more thorough knowledge. It is possible that this has to do with the features of people who decided to take part in the consultation rather than an accurate reflection of general awareness levels in these communities. African Caribbean respondents did provide more extensive and detailed information, which suggested greater awareness (or willingness to discuss) in comparison to Bangladeshi respondents. A less thorough awareness (or willingness to discuss) in the Bangladeshi community is likely to be attributable to (1) language barrier in older generations; (2) stronger sense of cultural taboo and repression related to drug issues; (3) less exposure to literature, information leaflets etc. in culturally relevant settings.

Cannabis was recognised as one of the most prevalent drugs used across both communities. African Caribbean respondents also suggested prevalent use of crack and heroin. Bangladeshi respondents suggested prevalent use of tobacco, paan, shada and prescribed medication (sleeping pills / pain killers) particularly with adult women – who may not be fully aware of side effects and potential for dependence.

Concepts of mental health: The concepts and ideas used to identify and define mental health were fairly common across respondents, regardless of ethnicity: Positive mental health associated with balance, sociability, independence, positive thinking and feelings of happiness. Negative mental health associated with isolation, withdrawal, self-neglect, erratic behaviour. Both communities recognised that 'poor mental health' is generally thought of as a taboo subject. Contrary to what the reviewers expected, very few references were made to spiritual / religious aspects when discussing mental health.

Awareness of Dual Diagnosis: Respondents from both communities recognised links between mental health and drug use in the way of: drug-dependence leading to mental health and behavioural problems (e.g. depression, paranoia, aggression, isolation, self-neglect, etc.); 'self-medication' to cope with emotional / psychological problems; reliance on prescribed medication. As above, African Caribbean respondents provided much more

detailed information, which may point at increased awareness and/or willingness to discuss these issues. Elements of shame, judgement, embarrassment, isolation were all commonly associated with the experience of dual diagnosis within both communities. Responses suggested that in the African Caribbean community drug problems were seen in relation to 'degrees' of severity or harm, and in some cases there is some 'normalisation' of substance use (e.g. problems are not paid attention to or even denial about the existence of problems). In contrast, Bangladeshi responses would suggest that in their community there is more secrecy and repression about drug use (E.g. it is actually concealed). Both communities discussed how dual diagnosis affects the family as a whole and often parents may be blamed for problems.

Facilitators and Barriers to accessing care: ***Confidentiality*** was raised as a key issue for accessing support. Bangladeshi respondents seemed to place more emphasis on accessing face-to-face, confidential support from ***culturally-aware professionals*** who they can identify with and who are ***visible in the community***. African Caribbean respondents placed emphasis on accessing information available in ***relevant community venues, activities and events***, also engaging with ***ex-service users and peer mentors***. Only African Caribbean respondents suggested that services should ***support the family*** as a whole, and it would seem that Bangladeshi respondents preferred to raise these issues only with trusted professionals (e.g. not necessarily informing or involving family members). Most barriers to care referred to: lack of information about services, shame – stigma – embarrassment – inability to identify problems and seek help. The language barrier was particularly problematic for older generations of Bangladeshi people.

Conclusions: Mental Health and Drug / Alcohol problems are often related in complex ways and affect many people regardless of their ethnicity, gender, education, social and economic status. Dual Diagnosis often increases the vulnerability, isolation and stigmatisation of sufferers, placing barriers and obstacles for support from close family networks and services alike. People from BME communities with a Dual Diagnosis may also have additional difficulties and barriers that relate to their cultural background: For example language barriers and absence of targeted information, low numbers / little visibility of BME workers, etc. These aspects may make it less likely for some people to recognise these problems and seek help.

Recommendations: Efforts to make mainstream mental health and addictions treatment services more culturally aware and accessible are likely to fail without clearly designated leadership and responsibility for diversity-focused work. Services should encourage ex-service users, volunteers and peer mentors from BME groups to contribute to the efforts to pro-actively engage with BME communities, particularly engaging people who speak community relevant languages to promote services in relevant venues and community events. This may also open opportunities for people from BME communities to enter into employment with mainstream services and make these more culturally diverse and responsive. Being mindful of the particular community trends, language and concepts used to understand mental health and substance use may aid in the development of more effective service promotion and information materials. The preferences of people in relation to confidentiality and family support should be considered when engaging with specific communities.

1. INTRODUCTION

1.1 The Project

The aim of this project was to engage members of BME communities in discussions regarding drug & alcohol use and mental health issues with the view to identify perceptions, barriers to care and ways forward. The need for a qualitative piece of work focusing on these *combined* issues became apparent following recent needs assessments carried out within the local mental health field and also within the substance use sector[1]. These 2 separate pieces of work highlighted the relatively small proportional engagement of people from BME communities in support / treatment services raising questions about effective access to care. If there are barriers to care for people with 'discrete' mental health problems or drug related problems, then those barriers are manifold for people affected by a combination of these problems, as is suggested by an increasing body of literature in the field of Dual Diagnosis. The Dual Diagnosis Good Practice Guide[2] suggests that people with these combined problems "have tended either to be treated within one service alone, which has meant that some aspects of their cluster of problems have not been dealt with as well as they might, or have been shuttled between services, with a corresponding loss of continuity of care. Some potential clients or patients have almost certainly been excluded from all the available services." (Department of Health, 2002, pp. 8). Knowing that a *dual diagnosis* can often result in the fragmentation of support networks and isolation, an underlying question in this piece of work was: Are there ethnicity-specific issues that add yet another layer of barriers to care for this client-group?

This piece of work could possibly serve as an initial scoping to explore further questions through formal research in the future, but it should be noted that the main intention was to gather practicable information: Feedback that could suggest ways in which services could be more responsive to the needs of the communities involved. This scoping was intended to be a heuristic process, where existing knowledge and skills of staff within these organisations could be marshalled quickly and easily to produce a rapid appraisal of the current situation. The African Caribbean and Bangladeshi communities were chosen because they represented two very different communities with two very different attitudes towards both mental health and substance use. They were also communities where the Community Development Workers had strong contacts of trust and understanding, and where it was felt there would be sufficient levels of engagement to make the process worthwhile.

This consultation was carried out in Leeds, between August and October 2008.

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[1] Williams, S. et al. (2008) The mental health needs of black and minority ethnic communities in Chapeltown and Harehills. Report to Leeds Adult Social Care.
Mwanje, L. (2007) Needs Assessment for adult drug treatment in Leeds. A report by Safer Leeds Drugs Team and Safer Leeds Partnership Team.

[2] Department of Health (2002) Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide. London; HMSO.

1.2 Definitions

Ethnicity
Descriptions of "race" and ethnicity are subject to change, discussion and dispute. The consultation team have chosen to respect the self-designations of the people and groups they have spoken with. Because of this, this report reflects the varied ways in which the communities refer to themselves. We provide a glossary of terms by way of explanation.

BME – Is used throughout this document to refer to Black and Minority Ethnic communities. By this, we mean any communities that are not White British.

Bangladeshi – Refers to people of Bangladeshi descent, including people born and brought up in the UK, born to Bangladeshi Parents.

Black Caribbean / Black British - This is a census category referring to people of Caribbean descent. Although it is a monitoring category used by the National Office of Statistics, the National Health Service, Leeds City Council and other statutory bodies, it was not widely used by the members of the Caribbean community that we spoke to.

Mixed Heritage – Is the census category referring to people whose ethnicity is described in reference to two or more ethnic categories.

Dual / Multiple Heritage – Is the way in which many people described by the census as 'Mixed Heritage' prefer to describe their ethnic origin.

African Caribbean – Is the way in which most of the people we spoke to (whom the census describes as Black Caribbean or Black British) prefer to describe their ethnic origin. As a term it recognises and respects the historical journey of slavery/forced migration experienced by their ancestors. It sets out to be -and is- an inclusive category.

Definitions of the sample Group
To avoid confusion, when we made reference to data collected using the National Office of Statistics ethnicity categories, we have retained their classifications. E.g. Chapter 2 – context.

In relation to the consultation, we have used the preferred designations of the participants themselves, reflecting the identities which make most sense to them:

- The Bangladeshi sample group was made up exclusively of people whom the Census would describe as Bangladeshi.

- The sample group in this consultation described as 'African Caribbean' included people whom the Census would identify as either 'Black Caribbean' or 'Dual/Multiple Heritage'.

Substance Use – In this consultation the expression 'substance use' makes reference to alcohol and drugs classified under the 'misuse of drugs act'[3]; including stimulant, analgesic and sedative medication classified under the act. Performance enhancing drugs, and inhalants / volatile substances such as aerosols, lighter fluid, etc. are also included.

Mental Health – One of the aims of this consultation was to use focus group and interview methods to actively encourage participants to explore concepts of 'mental health', and to explain these ideas in terms of patterns of behaviour, feelings and thoughts. Implicit in the focus group facilitation and interview questions was the intention to explore both 'positive' and 'negative' aspects of mental health, which was previously agreed by the consultation team during the planning stage. We have endeavoured to capture the expressions and language used by participants in reference to mental health (see chapter 3 – Findings).

Dual Diagnosis – In this consultation the expression 'dual diagnosis' refers to the co-existence of mental health and alcohol/drug problems. As above, one of the aims of this consultation was to encourage participants to explore the relationship between substance use and mental health and to explain it in terms of patterns of behaviour, feelings and thoughts. The focus group facilitation and interview questions also aimed to explore how general members of these BME communities (non-sufferers) react and respond to someone affected by co-existing mental health and alcohol/drug problems.

1.3 Methodology

1.3.1 Participants

This initial consultation aimed to involve members of 2 minority ethnic communities in Leeds: Bangladeshi Community and African Caribbean Community. The selection of participants was based on self-reported ethnic background; therefore the people involved identified themselves with these specific communities. General community members were invited to participate in focus groups held at local community and drop-in centres. Service users who reported combined mental health and drug related problems were recruited for confidential semi-structured interviews.

A total of 40 people were involved in this process and consultation fees were offered to all participants. For further details see Demographics under Findings section 3.1 (pp. 11).

[3] Misuse of Drugs Act found at:
http://drugs.homeoffice.gov.uk/drugs-laws/misuse-of-drugs-act/ [accessed on 02/12/08]

1.3.2 Data Collection

Qualitative information was gathered through a combination of focus groups and confidential semi-structured interviews.

Focus Groups

3 focus groups were held per ethnic group with the intention to get a fairly balanced number of participants across age groups and gender. Separate male / female and young people groups were organised for participants from the Bangladeshi Community. A young people's group and two adult groups were organised for participants from the Black African Caribbean Community, all of which were mixed gender groups.

The focus groups were facilitated following a set number of questions which can be found in Appendix 1. Feedback from all group participants was recorded via flipchart & notes which were later transcribed – see Appendix 3. The focus groups were facilitated by community development workers in a way that promoted discussion and lasted an average of one hour.

Confidential Interviews

Semi-structured interviews were held with service users who were accessing 3 different substance use services in Leeds. The interviews lasted an average of 35 minutes and followed a set format of open questions which can be found in Appendix 2. A standard questionnaire was utilised to elicit information in a way that minimised information bias and to ensure consistency of interviewing technique for all participants. The interviewers also provided summary statements related to each interview:

- In reference to the 3 central interview themes (see Appendix 2 – A, B & C).
- To comment on their impressions of the interview.
- To clarify any difficulties with the process or if any prompting was used which deviated from the standard interview format.

Interviews were conducted by 3 experienced community drugs practitioners who had continued involvement with the people interviewed and could therefore follow-up any issues emerging from the consultation. Interviews were held in a private setting and under the confidentiality policies and procedural safeguards of the above services. The responses to interview questions were transcribed verbatim, keeping the identity of participants confidential and known only to the interviewers and not the rest of the consultation team.

All participants provided informed consent to share anonymous focus group and interview data with the consultation team and granted permission for the interviewers to contact them again in order to share copies of any outcomes of the consultation.

1.3.3 Data Analysis

Two lead reviewers carried out a thematic analysis of all qualitative data. The data analysis followed the following steps:

- All transcribed Focus Group data was organised in a matrix that permitted the parallel comparison of the responses of all 3 focus groups per question. This parallel comparison was carried out separately for the Bangladeshi Community groups and the African Caribbean Community groups. (See appendix 3)

- Data was coded according to the following 3 categories: (yellow) common themes / responses emerging across all focus groups, (green) related responses between specific groups, (red) responses particular to one group / strata. The logic behind this coding was to identify those themes / responses that are common to all members of the community regardless of age / gender, and also to identify which responses were attributable to a particular group / individual.

- An interpretative summary of focus group data was agreed and drafted between 2 lead reviewers.

- Confidential interview data was organised in a matrix in order to undertake a parallel comparison of all interviews relating to each community group. As above, responses from all interviews were compared question by question.
  Note: *Transcribed interview data has been kept confidential and for this reason it is not attached to this report.*

- Interview data was coded following the logic described above.

- An interpretative summary of interview data was agreed and drafted between 2 lead reviewers.

- An overall summary and interpretation was presented to the rest of the consultation team in a focus group. A final draft was then produced based on the comments, reflections and contributions of the project team.

- The project team also had an opportunity to comment and evaluate the whole consultation process and an evaluation summary was produced based on completed feedback questionnaires (See Chapter 4.2).

2. CONTEXT

2.1 Ethnicity

At the time of the 2001 Census there were almost 78,000 people from BME communities living in Leeds (10.8% of the total resident population).

The following table shows the breakdown of the BME population in Leeds compared to the national averages:

	Leeds Numbers	Leeds Rates	England
White			
White British	637,872	89.2%	87.0%
White Irish	8,578	1.2%	1.3%
Other White	10,632	1.5%	2.7%
Mixed Heritage			
Black Caribbean & White	4,603	0.6%	0.5%
Black African & White	885	0.1%	0.2%
Asian & White	2,516	0.4%	0.4%
Other Mixed	1,733	0.2%	0.3%
Asian or Asian British			
Indian	12,303	1.7%	2.1%
Pakistani	15,064	2.1%	1.4%
Bangladeshi	2,537	0.4%	0.6%
Other Asian	2,386	0.3%	0.5%
Black or Black British			
Black or Black Caribbean	6,718	0.9%	1.1%
Black African	2,435	0.3%	1.0%
Other Black	1,165	0.2%	0.2%
Other Ethnic Group			
Chinese	3,447	0.5%	0.5%
Other	2,528	0.4%	0.4%

Source: 2001 Census of Population

Both the Black Caribbean and Bangladeshi communities are smaller than the national average. The proportion classified as of Mixed Heritage (Black Caribbean and White) is slightly higher than the national average.

The 'African Caribbean' community as defined in this consultation includes many people that the census places in Mixed: White & Black Caribbean category.
Geographic analysis of the Census data has shown how BME communities are concentrated in particular geographic areas of the city:

- Almost one third of the city's BME population reside in just 3 wards: Gipton & Harehills; Chapel Allerton; and Hyde Park & Woodhouse. (2 in the worst 3%, one in the worst 10% S O Areas).
- In Gipton & Harehills people from BME communities account for over 40% of the resident population; in Chapel Allerton 36.5%; and in Hyde Park & Woodhouse 31.4%.
- With just over 15,000 people the Pakistani community is the largest BME community in the city, and over ¼ of the Pakistani population lives in Gipton & Harehills
- 85% of the city's Bangladeshi community is concentrated in just 3 wards: Gipton & Harehills; City & Hunslet; and Chapel Allerton (all 3 areas ranked in lowest 3% of S O Areas).
- 55% of the city's Black-Caribbean community resides in just 3 wards: Gipton & Harehills; Chapel Allerton; and Hyde Park & Woodhouse

2.2 Ethnicity & Mental Health

The below data is taken from 'Count Me In' – a 1 day snapshot of MH Service use (388 service users 2007, 425 service users 2008). Of limited value, but the best quality information currently available to MH services around ethnicity.

- ***Black Caribbean:***
  Local – largest proportion of BME MH patients (2.3%) Count Me In Census 2007 – a 0.3% decrease on the previous year (Equivalent to a single person).
  National – largest proportion of BME MH Patients (4.3%) 2007 – a 0.4% increase on previous year

- ***Bangladeshi*:**
  Local – Bangladeshi people did not feature in the CMI 2007 – a decrease of 0.2% on the previous year (equivalent to a single person).
  National –.4% of BME MH Patients – a decrease of 0.1% on previous year.

2.3 Ethnicity & Substance Use

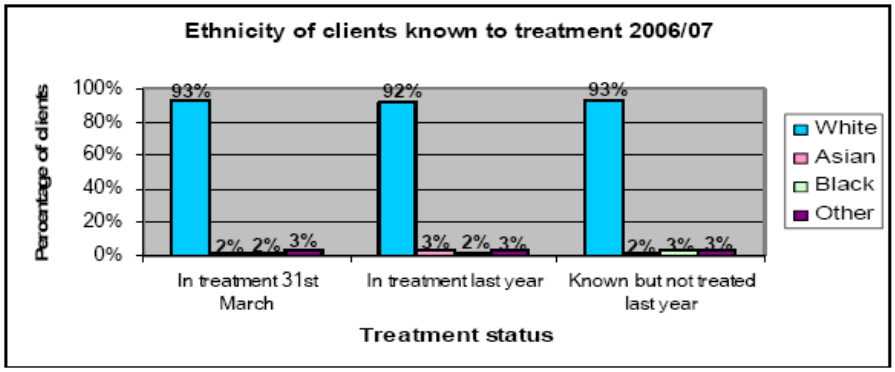
A literature review carried out by the University of Central Lancashire and commissioned by the National Treatment Agency (NTA) in 2003 looking into the needs of BME communities in relation to substance use suggested that:

- BME communities across England very commonly live in areas of high unemployment and social deprivation, which –among other factors– increases the risk of problematic substance use.
- There appears to be generally a low level of awareness of drugs and related health issues in BME communities.
- There appears to be a lack of awareness of support options and accessibility.
- Although there were insufficient scientifically rigorous epidemiological studies assessing the prevalence of substance use in BME communities; the above review cited numerous surveys and small-scale UK studies which suggest that patterns of drug use have been increasing over time within BME communities. In some localities with dense BME population (e.g. Bradford), for example, a survey suggested that the prevalence of drug use amongst young South Asians proportionally matched that of the general (White British) population.

The below information was extracted from the 2006/2007 Needs Assessment for Adult Drug Teatment in Leeds Report (A report by Safer Leeds Drugs Team and Safer Leeds Partnership Team. Author, Lydia Mwanje - Needs Assessment Coordinator).

- National treatment monitoring data (NTA, 2003) appeared to suggest a 3:1 gender ratio for treatment seeking behaviour (more men accessing treatment); although there also appeared to be some regional and generational variations that contradict this. Local figures support this gender ratio in Leeds.

Ethnicity



The ethnic distribution of clients known to treatment shows that the majority of clients were White.

[Table taken from above cited report, pp. 39]

- As can be seen in the above graph, the proportion of people from BME communities known to treatment is minimal. Furthermore, the report highlights that the ethnicity of 15% entering treatment was not known (not reported or recorded).
- It is estimated that 2072 drug users in Leeds (in 2007) were unknown to treatment services, though it is uncertain what proportion of these people may be from BME backgrounds.
- In relation to people from BME communities, the above report concluded that "there are less clients from these ethnic groups known to each stage of the treatment journey. Black and Asian clients also have the highest unplanned discharges" (Mwanje, L, 2007, pp 30).

3. FINDINGS

3.1 Demographics

The total number of participants according to consultation method is reported in the table below:

	Bangladeshi Community	African Caribbean Community	Total
Focus Groups	20	13	33
Interviews	4	3	7
Total	24	16	40

Very basic demographic data was collected in order to safeguard the confidentiality of participants and to have the minimal information necessary for data analysis.

	Bangladeshi Community		African Caribbean Community	
	Males 58%	Females 42%	Males 62.5%	Females 37.5%
Young People (16 – 21) 37.5% of total number of participants	8	0	3	4
Adults (21+) 62.5% of total number of participants	6	10	7	2

3.2 Findings from Focus Groups

All of the information gathered from groups has been transcribed and organised in tables which enabled reviewers to analyse responses to each of the 5 main questions that guided focus group facilitation. The transcribed, coded and tabulated information from each of the individual focus groups can be found in Appendix 3 for reference.

The below tables present an *interpretative summary* of the main themes and common responses to the focus group questions. The tables are set out in a way that enables the reader to compare / contrast responses pertaining to specific BME communities.

3.2.1 Awareness and Prevalence of Substance Use

Bangladeshi Respondents	African Caribbean Respondents
Comprehensive lists produced by all focus groups across age ranges and genders, covering descriptions of drugs belonging to most major categories (depressants, stimulants, hallucinogens, performance enhancing drugs, prescribed medication, volatile substances / inhalants, etc). The group of young people was the only one that listed steroids in their description of substances.	Comprehensive lists produced by all focus groups with young people producing the longest list. Knowledge of common street names was seen across all age groups and genders, covering descriptions of drugs belonging to most major categories (depressants, stimulants, hallucinogens, performance enhancing drugs, prescribed medication, volatile substances / inhalants, etc.)
Cannabis, Tobacco and Alcohol were identified as the most commonly used substances. Older generations, particularly first generation immigrants have been suggested to use shada more frequently, which relates to traditional use of this substance in Bangladesh. It was suggested that younger generations of people tend not to use shada as often.	Crack and Heroin, were identified as commonly used drugs across the community, with two groups also identifying cannabis and *benzos* / prescribed medications. Adult groups attributed the use of the following drugs mainly to young people: crystal, glue, sprays and steroids. It was suggested that crack use tended to be used by older people (mid 20's and older).

3.2.2 Defining Mental Health

Bangladeshi Respondents	African Caribbean Respondents
The key term that was raised across all group was 'balance', with two groups making reference to 'emotional' and 'spiritual' balance in relation to positive mental health. Some of the 'signs' of positive mental heath listed by the groups were: being sociable, showing interest, being motivated, making an effort, etc.	Positive Mental Health: Little consensus and comments on this – two groups identified "balance" or "wholeness" as key concepts. One group suggested mental health was a socially constructed concept which varied in time/space. Another group alluded to "independence" e.g. 'able to do things for themselves'. Negative mental health produced more agreement – with isolation, withdrawal from social life as common themes across all groups
The older age groups made reference to problems with 'functioning' (e.g. "not functioning well, in the head") when asked about how they understood poor mental health. In contrast, the young people's group	Older groups painted a richer picture of mental

made references to a lack of 'structure' to life when defining poor mental heath, and conversely related 'having a structure to life' with 'being emotionally well'. Some of the 'signs' of poor mental heath listed by the groups were: being isolated, withdrawn, unsociable, not being seen, etc.	distress identifying Stress, self neglect and lower levels of coping. One group of adults suggested that mental health is still a taboo subject, which leads men to have to cope with long-term depression due to a reticence to speak about this. It was suggested that more females look for help compared to males because of male / female role expectations. Younger people were more likely to identify behavioural changes in the way people act, and interact with others.

3.2.3 Links between Mental Health and Substance Use

Bangladeshi Respondents	African Caribbean Respondents
Overall, the groups suggested that it is difficult to identify mental health problems and the links with drug / alcohol use. Problems escalating – It was recognised that using drugs could deteriorate people's mental health and lead on to signs of poor mental health such as: depression, isolation, aggression, irritability, getting into debt, becoming involved in crime, etc. Addiction to medication – It was suggested that some people may become 'addicted' or come to rely heavily on drugs prescribed to deal with primary mental health conditions.	Peer Pressure - All groups identified peer pressure as a significant factor in substance use in that intake was largely determined by the amount peers were using. Two groups suggested problematic usage as being that which happens outside of a social context. Self medication – Two groups talked about the use of Drugs to calm one down, with one group explicitly linking substance use to deal with difficulties which were not being addressed by prescribed medication. Dealing with Past - Two Groups identified substance use as an effective way of dealing with previous negative experiences (implied trauma). Confidence - Respondents across groups saw drugs as boosting confidence in social situations ("as a boost for partying") and more mundane settings – ("a way of facing things – Dutch courage"). Irrationality - Two groups identified substances as causing irrational behaviour, before linking this agitation with increased aggression or "flar[ing] up for no reason".

3.2.4 Community and Dual Diagnosis

Bangladeshi Respondents	African Caribbean Respondents
All groups suggested that people with combined mental health and drug problems often face isolation, discrimination and exclusion. Also it was suggested that the whole family may be stigmatised on account of problems with a family member. The women's group, for example, suggested that the	Exclusion – Two groups initially described the community response in the way of walking away or shunning people. Problematic users were also felt by these same two groups as separating themselves off from the wider community ("segregated", "you see them in a group").

parents and upbringing may be blamed for these problems. The men's group suggested that in a lot of families, parents may not know how to identify signs of poor mental health or drug use.	Duty to those close to you – However both these groups said that Community responses and individual responses are different depending on how well you knew a person with these problems, with young people describing a sense of duty and obligation to help people in trouble, particularly family members. Normalisation - Previous questions identified problematic substance use as being outside of usual patterns of social usage. Two groups also suggested that parental attitudes to drug usage are dependent on how well these correlated to parental usage. Hence, people who either use or know others who use are less likely to problematise substance use. Denial – One group suggested that parents "did not want to know" if their children's usage was problematic, and that lack of willingness to confront this was associated with shame. Some comments seemed to suggest that parents tend to be rather collusive with involvement in drugs and/or in denial about this.

3.2.5 Barriers and Suggestions

Bangladeshi Respondents	African Caribbean Respondents
Barriers Lack of awareness of services and support options. Not having people from a similar background working in these services, someone who may identify and understand cultural issues such as language, family issues and religion. **Facilitators** A confidential space where service users may not necessarily be identified as having specific mental health or drug issues. Accessible, well promoted and local area services. Language facilities. Range of professionals being able to signpost to the appropriate sources of support. Some professionals that could signpost would be: teachers, mentors, youth workers, counsellors.	**Barriers** Lack of knowledge - of services / available interventions were identified by two groups as key barriers. Lack of community engagement - One group suggested greater use of community engagement techniques and produced a long list of potential venues/partners including cultural, educational and social centres. Handing out leaflets – was not an effective intervention, according to two groups. Leaflets could be a useful tool, but needed to be talked with detailed knowledge and a personal touch. Two groups were particularly critical of Ask Frank campaign – seeing it as irrelevant and out of touch with reality. Recognising the need to change – Two groups suggested the biggest barrier was the lack of motivation to seek help/address problems. Not connecting problematic usage with certain types of interventions – One group member spoke eloquently on his own problematic experiences with heroin and those around him – however he "did not know anyone who had needed rehab". Fear – One group spoke about the people being scared to talk to each other (and the implication that conflict will escalate if negative comments are

	made). Anonymity – One group suggested that effective services needed to be situated outside of their community or with sufficient safeguards for addressing these issues anonymously. **Most appropriate type of support to people with MH and SU problems:** Service user involvement – Two groups suggested the best people to engage with users were people with direct experience of problems themselves – who are perceived as "knowing what they are talking about". Promotion of Services – Two groups suggested services need to actively engage the communities and inform them of their work ("we didn't even know you were here"). Engaging Young People – One group suggested more activities and places for young people to engage in constructive activity, focussed and innovative activities at a range of community centres to disseminate information about available support.

3.3 Findings from interviews

All of the information gathered from interviews has been transcribed and organised in tables which enabled reviewers to analyse responses to each of the interview questions. The interview questions were structured to elicit responses that relate to the same 5 themes considered by focus groups as described above. The transcribed, coded and tabulated information from each of the interviews is not provided in this report, in order to safeguard the anonymity of the respondents.

The below tables present an *interpretative summary* of the main themes and common responses to the interview questions. The tables are set out in a way that enables the reader to compare / contrast responses pertaining to specific BME communities.

3.3.1 Awareness and Prevalence of Substance Use

A1 What drugs are you aware of…which of these are most commonly used?	
Bangladeshi Respondents Most commonly used: Cannabis Medication: Sleeping Pills / Painkillers Tobacco / Paan	African Caribbean Respondents Most commonly used: Heroin Crack / Cocaine Cannabis Amphetamines Ecstasy

3.3.2 Defining Mental Health

A2 What does good mental health mean to you? How would you know if someone is not coping well with his/her feelings or thoughts?	
Bangladeshi Respondents	African Caribbean Respondents
Happiness - Three of the four associated mental well being with a sense of happiness. A healthy mind comes from a healthy body - half those we spoke to associated mental wellbeing with physical wellbeing. Not coping leads to behavioural changes – for most of the Bangladeshi people we spoke to with anger and irritability the most common indicators. Women also identified emotional distress – being upset or crying as a sign of not coping. Only women commented on declining standards of personal care or care for one's own appearance as a marker of difficulties	Positive Mental Health: Being Positive, Thinking Clearly. Poor Mental Health: Depressed, down and isolated.

3.3.3 Links between Mental Health and Substance Use

B1 Do you think that drug or alcohol use can affect someone's mental health? How?	
Bangladeshi Respondents	African Caribbean Respondents
There was a clear link between substance use and mental health for everyone we spoke to. The two women both made specific reference to psychotic symptoms of hearing/seeing things other people don't hear/see; and a majority saw a clear link between the short term effects of drugs and their long term affect on mental health. Addiction and dependence was only mentioned by one participant.	Yes, for example drugs / alcohol can make people feel: • Paranoid • Depressed • Confused • Emotionally upset • Push other things to one side and focus on drug use

3.3.4 Community and Dual Diagnosis

B2 If somebody in the African Caribbean community was worried about his/her own drug use and mental health, what would that person do?	
Bangladeshi Respondents	African Caribbean Respondents
Everyone agreed it was something to be hidden, or to feel embarrassed about. Half mentioned the importance of relationships to family or parents, and half spoke of the wider impact that someone's difficulties might have on family and wider community. One person saying that a family would intervene if someone had problems with their mental health but would ignore the problem if difficulties were associated with substances. At least half those questioned suggested that ignorance of	The common thee across interviews was that people would feel embarrassed, ashamed and unable to admit that they have problems. Some of the reasons given for this were: pride, fear of stigma, doubt about other people's ability to empathise with this condition.

signs and symptoms of substance use/ mental health problems and a judgemental attitudes towards those with difficulties made it harder for people with either or both difficulties to get help. One person seemed doubtful that people with such difficulties would be offered any kind of help.	

B3 How do other people respond?	
Bangladeshi Respondents	African Caribbean Respondents
Most talked about the apparent indifference of the community to people's difficulties, with two people saying they felt people did not want to get involved, for fear of being associated with another person's difficulties, or "bad" people. The two women mentioned an inability to speak English as a barrier. The fact that people do not know about the help available was a factor cited by half the respondents, with one person saying there was a greater role for community centres in raising awareness of services.	Some suggested responses were: • Denial that there is a problem. • Some people wouldn't understand and wouldn't know how to help.

3.3.5 Barriers and Suggestions

C1 Some people with mental health and drug problems don't get help. Why do you think they don't?	
Bangladeshi Respondents	African Caribbean Respondents
There was wide agreement that people with problems did not know where to seek help. The other main concern was that even if they did know where to go, acknowledging their problems in front of their family/community would lead to blame and shame, and judgement by others. Half the people asked located the reason for not seeking help in the people themselves – that they were in denial.	As above, some of the major barriers raised related to: • Fear of stigma. • Pride, shame, embarrassment. • Not wanting to disclose problems to family or employers. • Difficulty in taking the first step towards asking for help.

C2 What type of support or information do you think helps people who have drugs and mental health problems?	
Bangladeshi Respondents	African Caribbean Respondents
• Information which was culturally relevant was a common theme, with people citing materials in Bengali as part of the solution. But material which had a clear audience in mind: younger people or older people: the important but was crafting the message to the audience and "not assuming that one size fits all". • GPs, Schools and community centres were key places for information, and more than half the people we asked felt they were not doing as much as they could to raise awareness of drugs and mental health.	• Better information and promotion about available services, e.g. leaflets, posters, contact details, high local visibility, translated in different languages. • Accessing counselling and one-to-one support. • One interviewee suggested support for the family.

• Finally an active approach to awareness raising was suggested – that leaflets and posters were important, but in answer to another questions the way in which they were given out was also felt to be important – ensuring people knew why it was important to read them/look at them.	

C3 What would be your message to services that aim to help people with drugs and mental health problems?	
Bangladeshi Respondents Almost everyone said that visible outreach workers, based where young people were at (youth centres, on the street) were important. Two people spoke of 7 and 8 year olds who were already using substances, and the need to ensure messages around substances reached them sooner. One person spoke about how the mainstream anti-drugs campaigns (Frank) meant nothing to Asian communities, and how culturally appropriate campaigns were needed for young and old people alike. Their role would be to actively spread knowledge and awareness, and to target information appropriately – by age, linguistically etc, with half the people we asked saying it was important to have Bangladeshi staff who knew the community dynamics well enough to help others navigate them effectively. The need for information was broader than just those people with problems – it should be targeted at the whole community. One person said they thought there should be harsher penalties for people selling substances to underage people.	African Caribbean Respondents The responses to this question were very diverse and no common theme was seen across the interviews. Some of the individual comments were related to: • The helpful nature of personalised one-to-one support: "I have always had someone there to come and check that I'm alright. That helped a lot with my mental health" • One person stated that tougher situations such as imprisonment have a more powerful impact on drug use: ", it should be like rehab or prison because everyone goes to jail and comes out clean. Get locked away from it. Once you've asked for help, then you should have control taken away – it's the only real way to do it". • Another person highlighted that the reassurance of confidentiality is a key factor in enabling access to care: "services should let my community know that they are confidential. Otherwise people are not going to access them."

3.4 Discussion

Overall findings from all groups and interviews have been analysed to explore any similarities and differences between the responses generally attributed to each of the BME communities involved. The below tables present a general summary of this analysis, organised according to the 5 main themes that guided the consultation.

THEME 1: Awareness and Prevalence of Substance Use
Similarities: • There was a fairly thorough level of drugs awareness across all focus groups and interviews from both BME communities. This may suggest that people in both communities have a good level of awareness of substances, effects and risks. However, it could also be argued that people who agreed to take part in the consultation would have felt more aware and comfortable in discussing drug-issues, which isn't necessarily the case for other members of these BME communities. • Overall, younger people tended to display a more thorough awareness of drugs. Cannabis was identified by both communities as one of the most commonly used drugs.

Differences / Particularities:

- Aside from the common reference to cannabis, African Caribbean respondents identified crack and heroin as common and particularly problematic substances for their community. No information in this consultation is available, however, to assess if this is any different or proportionately similar to crack / heroin use in the general (e.g. White British) population. This contrasts with most Bangladeshi respondents, who did not identify the latter 2 substances as particularly prevalent. Perhaps this finding may only suggest that crack and heroin use is perceived to be less common in the local Bangladeshi community as compared to the level of use in the local African Caribbean and general populations.
- Bangladeshi respondents discussed the prevalent use of tobacco, paan / shada within their community. This was deemed to be more particular to older generations (e.g. first generation of migrants) rather than young people.
- Bangladeshi respondents also raised particular concerns about the 'misuse' of prescribed medication such as sleeping pills and painkillers. It was suggested that a lack of insight into the side-effects and potential for addiction to these drugs could be attributable to the language barrier (e.g. people with poor English skills may not be receiving accurate information about risks). It was suggested that this was more problematic for adults, particularly women with poor English skills.

THEME 2: Defining Mental Health

Similarities:

- There were concepts and ways of describing 'positive mental health' that were common to respondents across both BME communities. References to 'balance', 'sociability' and 'independence' commonly came up throughout the consultation, regardless of ethnicity.
- Similarly, throughout the consultation respondents associated 'being positive' and 'feeling happy' with positive mental health.
- 'Isolation', 'Withdrawal' and 'self neglect' were the most common themes that were associated with 'negative mental heath', and this was common among respondents from both BME communities.
- It was also acknowledged by most respondents that 'negative' mental health generally is a taboo subject and a matter for embarrassment or a topic that is not easy to broach.

Differences / Particularities:

African Caribbean respondents suggested that generally females are more likely to be open about mental health and seek support, compared to males.

THEME 3: Links between Mental Health and Substance Use

Similarities:

Respondents from both BME communities discussed:

- The potential for drug-use to escalate into an addiction and lead on to deterioration in mental health: depression, confusion, paranoia, aggression, irritability, etc.
- It was also largely recognised that people may well 'self-medicate' to cope with personal issues such as stress, emotional problems, etc.
- Both communities also highlighted the potential for people to become dependent on prescribed medication and there seemed to be a perception that this is fairly common.

Differences / Particularities:

Generally speaking, African Caribbean respondents provided much more thorough and detailed information about the possible links between mental health & substance use: e.g. using substances to 'boost confidence' and deal with anxiety in social settings, using drugs as a means of coping with traumatic events or 'past issues', etc.

The reviewers considered that this difference that suggests 'greater awareness' in African Caribbean

respondents may possibly be attributable to:

- Local African Caribbean community has tended to be more open to exposure of drug and mental health related information.
- Language and translation of information is not as significant a barrier as it is for Bangladeshi people, particularly older generations.
- Some Faith organisations are not as open to discussing and disseminating information about drugs and this may have more of an impact on awareness levels within the Bangladeshi community compared to the African Caribbean community.

THEME 4: Community and Dual Diagnosis

Similarities:

Respondents from both communities considered that:

- People with mental health & drug / alcohol problems are likely to experience exclusion and isolation from both community and family.
- People with these problems are likely to be embarrassed / ashamed and unable to admit that they have a problem. They might also not feel able to admit their problems and in many cases wouldn't know how or where to seek help.
- The element of shame related to suffering from these problems would seem to be reinforced by common attitudes within the communities. There were suggestions that in some cases people who disclosed their mental health or drug problems would be outcast, wouldn't be believed (inability to identify the problem) or wouldn't necessarily be helped.
- The onus and blame for the existence of these problems often is attributed to the family.

Differences / Particularities:

- A common theme in responses from members of the African Caribbean community was 'denial'. E.g. Some parents may choose to 'ignore' drug use in their children. "I know its there, but I don't see it as a problem". Respondents suggested that this attitude to drug problems depended on how familiar the parents themselves were with drug use. It was also suggested that people in this community tend to see drug-use in relation to 'degrees' of harm: E.g. some patterns of drug use may be more problematic than others.
- In contrast to the above, Bangladeshi responses suggested that there may be much more secrecy related to drug use in this community. E.g. People actually ignore / don't realise that drugs are being used.
- Responses suggest that there may be more 'normalisation' of drug use (e.g. seeing it as a matter of degrees of harm) within the African Caribbean community, compared to the Bangladeshi community where it is more strongly condemned (except for culturally accepted drugs such as Paan, etc.)
- There was more emphasis on the whole family unit over the mental health / drug problems of a family member in the Bangladeshi community.
- Bangladeshi respondents discussed the language barrier as part of the problem in identifying problems and seeking help. Language was not raised as a concern by African Caribbean respondents.

THEME 5: Barriers and Suggestions

Similarities:

The following feedback was common to respondents from both communities:

Barriers to Care

- Lack of awareness and knowledge of services.
- Shame and pride.
- Difficulty in taking first step in seeking help – could be unsure of going to the right place.
- Blame, stigma from others / judgement.

Suggestions for Service Development

- Methods of Community engagement – promoting ways of accessing services.
- Services need to actively engage with community members and be well promoted, preferably through face-to-face contact, rather than only written form / leaflets, etc. Crafting the message in different ways is important, targeted promotion of information.
- Importance of confidentiality.
- Community languages are important to take into consideration.

Differences / Particularities:

It was suggested by African Caribbean respondents that involving ex-service users & peers would be a positive way to engage with the community. In contrast, Bangladeshi respondents seemed to emphasise more about involvement with paid professionals from the same cultural background.

Bangladeshi respondents suggested that:

- Many people from this community are unaware of which services are out there and how to access them.
- It is important to identify with staff from a similar background: visibility of workers promotes opportunity to engage.
- Culturally sensitive and appropriate information campaigns.

African Caribbean respondents suggested that:

- There is a particular concern about anonymity / confidentiality and in this sense the location of services is important.
- Support for the family is also required in some cases.
- Promotion of community activities to engage with young people at risk of using substances and developing related problems.

4. CONCLUSIONS

4.1 Recommendations

- A wide range of publicity methods should be used to raise awareness of existing services that can support people with mental health and substance related problems: Pro-active, visible face-to-face methods of community engagement are more likely to promote access, in comparison to printed information and already existing campaigns (e.g. talk to frank, etc.). These methods of publicity and engagement should be targeted in culturally-relevant venues / event / locations and should be mindful of language and generational factors. A detailed list of suggested venues, events and creative engagement strategies suggested by focus group members can be found in Appendix 3.
- Confidentiality is of utmost concern to people with combined mental health and drug / alcohol problems and services should be particularly aware and sensitive

about how and where to establish contact with service users from specific communities in order to encourage and maintain access to care.

- Services should encourage ex-service users, volunteers and peer mentors from BME groups to contribute to the efforts to pro-actively engage with BME communities, particularly engaging people who speak community relevant languages. This may also open opportunities for people from BME communities to enter into employment with mainstream services and make these more culturally diverse and responsive.
- Efforts to make mainstream mental health and drug treatment services more culturally accessible are likely to fail without clearly designated leadership / responsibility for diversity-focused work and regular review incorporated into broader audit and governance frameworks.
- Drugs Treatment and Mental Health services should finds ways to work together to raise awareness in BME communities regarding: how to recognise combined mental health and drug problems and how to access support.

4.2 Evaluation of the Process

Four consultation team members submitted evaluation forms. All of the responses have been collated below, according to each of the questions on the evaluation form.

1. Why did you get involved in the project?
• As part of my work but also I have a real interest in the views of the BME community regarding dual diagnosis & the services available. • It was an essential part of my work. • Interest in mental health and BME communities in accessing services re: their substance misuse. • Out of interest, to gain more experience, gain more insight into the study.
2. What did you get out of being involved?
• I enjoyed expanding my knowledge of people in the community and of Learning/ acquiring new information about substance use & mental health from a community perspective. • I got to form further partnerships, meet new people, engage & build stronger links with my community. • Further insight into client's own perceptions of both BME communities and mental health. • Insight, different perspectives, performance satisfaction.
3. What can be improved for next time?
• Nothing. I feel everything was done appropriately. • Nothing really! I think everything went smoothly as clear instructions were provided and support & guidance was given at all times. • Having longer timescale to collect information. • Client group is not always easily accessible and do fail to keep appointments! • Bigger sample size.
4. a. What do you think should happen next? **b. And how do you think you can help that process?**

4a.

- I feel follow-up focus groups should be run to feedback the report findings and to inform participants of the steps, if any, to be taken as a result of information/ comments shared.
- A report with recommendations and changes to actually happen.
- Action taken on findings and future plans for change to service delivery if required.
- Community awareness / involvement.
- Putting together our findings and drawing up conclusions, plan of actions, and piloting the next bit of study.

4b.

- By re-grouping the groups and planning process.
- Start to implement some of the recommendations through work.
- Remaining involved and supporting change.
- I'm very keen to participate / provide assistance / input on any of the above.

5. The following questions are to be rated according to the below scale:

[Not at all] 0 1 2 3 4 5 [Every step of the way]

	Scores for 4 respondents:
How relevant was this consultation to your existing work? …….	4, 5, 5, 5
How involved were you in deciding which people we'd talk to? ……..	5, 5, 5, 4
How much influence did you have over the questions we asked? …….	3, 5, 4, 1
Overall, how easy was it to get people talking about this subject? ……	5, 4, 4, 3
How likely are you to help with something like this again? ……..	5, 5, 5, 5

6. As you did this work, did anything surprise you?

- How knowledgeable people were about the subject, regardless of age or gender.
- I found about a lot of things I was very surprised to know how much the community knew about drugs however were not much aware or not so outspoken about mental health.
- No.
- Yes, lots of information that was new and beyond my perception. It was a very rewarding experience.

7. How would you like to be involved in the next steps?

- Unsure. In any way I can. Please contact me when needed & as long as I am available, I would be happy to be involved.
- Sharing information – involving the groups.
- By being kept aware of future action plans and any further research.
- Interviews / focus groups.

8. What can you do to make sure the learning from this consultation is put into action?

- By communicating with the participants, other facilitators & the organisers regarding monitoring.
- Discussing learning with wider team.
- Follow it to the end, where we can provide input until the completion stage.

5. APPENDICES

APPENDIX 1. Focus Group Facilitation Agenda

1. **Defining Drug Use:** Perceived substance use trends within specific BME community.
   - What drugs are you aware of?
   - Which of these are most commonly used?

2. **Defining Mental Health:** 'Positive' and 'Negative' definitions. How do you know someone is mentally 'well' or mentally 'unwell'?

3. **Interaction of drug use & mental health:** What is the relation between drug / alcohol use and mental health? How does someone behave if they have co-existing drug and mental health problems?

4. **Community responses:** How do people in the community respond to the behaviour of someone with drug & mental health problems?

5. **Barriers & Suggestions:** What type of support or information would help someone with these combined problems? Is that type of support & information available? What are the barriers to accessing support? How can the barriers be overcome?

APPENDIX 2. Confidential Interview Forms

DRUG USE AND MENTAL HEALTH ISSUES IN YOUR COMMUNITY

INTRODUCTION

Purpose:
I am part of a group of workers that are doing some short interviews and I would like to know if you would like to help us. In return for 30 to 40 minutes of your time, we are offering a £5 payment.

We know that people cope with mental health and drug & alcohol problems in different ways, and we are doing interviews because we would like to know how the _____ community deals with these issues.

Confidentiality:

The notes of the interview will be anonymous, so personal information like your name, date of birth or address won't be shared with anyone. All we need to know is your age, gender and ethnicity. The notes will be shared with a small group of workers who will put a report together based on many interviews, which you will get a copy of.

INTERVIEW
[The interview won't take more than 40 minutes; I will keep time during the interview]

Record: Age, Gender and Ethnicity in separate response sheet.

A. DEFINING DRUG USE AND MENTAL HEALTH
A1. What drugs are you aware of…which of these are most commonly used? (Prompt – can you think of any other drugs / substances that people might use?) **A2. What does good mental health mean to you?** **How would you know if someone is not coping well with his/her feelings or thoughts?**
B. VIEWS ON DUAL DIAGNOSIS AND COMMUNITY RESPONSES
B1. Do you think that drug or alcohol use can affect someone's mental health? How? **B2. If somebody in the _____ community was worried about his/her own drug use and mental health, what would that person do?** (Prompt - What would they think? How would they feel? How would they behave?) **B3. How do other people respond?** (Prompt - Would they know how to help or how to get someone else to help?)
C. VIEWS ON BARRIERS AND SUGGESTIONS FOR SUPPORT
C1. Some people with mental health and drug problems don't get help. Why do you think they don't? **C2. What type of support or information do you think helps people who have drugs and mental health problems?** **C3. What would be your message to services that aim to help people with drugs and mental health problems?**
Would you like to add anything else?

[APPENDIX 2 continued – *header of the transcription sheet for interviews*]

CONSULTATION:
DRUG USE AND MENTAL HEALTH ISSUES IN YOUR COMMUNITY

INTERVIEW RESPONSE SHEET		
Interview code : _____ *(interviewer's initials followed by a number)*	**Gender: _____**	**Age: _____**
	Ethnicity: _____	

NOTE: Please write answers to the questions below and overleaf, clearly labelling each answer with the appropriate code (e.g. A1, A2). Use a separate sheet to write your summary statement, making sure that you label it with the same interview code as above. Keep photocopies of your interviews and submit both sheets in provided SAS envelopes.

APPENDIX 3. References

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APPENDIX 4. Coded Transcripts: Focus Group Feedback

	AFRICAN CARIBBEAN FOCUS GROUPS		
	FG1 – YOUNG PEOPLE (16-22) Male & Female	**FG2 – ADULTS Male & Female**	**FG3 – ADULTS Male & Female**
Q1	**1.Defining Drug use:** **1(a) What drugs are you aware of?** 2CB, Alcohol, Allergy Amphetamine, Angel Dust, **Anti-Deps,** **Benzos (valium, temazepam, diazepam, lorazepam**) **Caffeine –** **Cannabis,** cocaine, **Crack,** Crystal Meth, Ecstasy, Geebees/GBH, Heroin, Ice, Ketamine, LSD, Magic Mushrooms, MD, **Nicotine,** **Pain Killers,** Poppers, **Prescription Meds – esp anti-depressants,** Slimming Pills, **smack**, Tablets **1(b) Commonly used drugs in the Community?** Anti-Deps, Benzos (valium, temazepam, diazepam, lorazepam) Caffeine – Cannabis, Crack, Nicotine, Pain Killers, Prescription Meds – esp anti-depressants, smack,	**1.Defining Drug use:** **1(a) What drugs are you aware of?** aerosol sprays (gas), angel dust, brandy (heroin or crack), cannabis, cigarettes, cocaine, **crack** – mid 20s upwards + older crystal - (young people mainly), e.g Ecstasy, Glue (young people mainly), glue, Heroin (whisky?), magic mushrooms, methadone, Moroccan, **morphine** pain killers, poppers, rape-date drug (Rohypnol), **smelly(skunk),** Sprays, (young people mainly), **Weed,** white lightening (crystal dust), Whizz (speed), Subutex, **1(b) Commonly used drugs in the Community?** crack – mid 20s upwards + older morphine smelly(skunk), Weed, Older people just smoke weed – minority do cocaine	**1.Defining Drug use:** **1(a) What drugs are you aware of?** acid, **alcohol** amphetamines, **cigarettes** cocaine, **Crack** Ecstasy, **Heroin (smack),** man-made Substance (chemically enhanced) i.e skunk, Marijuana, sleeping tablets Speed, **Steroids (mostly young people; 18-28),** serum tabs, tranquilisers, **valium,** **1(b) Commonly used drugs in the Community?** alcohol cigarettes Crack Heroin (smack), Steroids (mostly young people; 18-28), serum tabs, valium,

Q2	**2.Defining MH:** **2(a) What is positive mental health** "how do you know if you're well or not?" [discussion about how to define] "Mental wellbeing is somewhere in the middle is about right – balanced" **2(b) What is negative mental health** Silence, people becoming withdrawn into themselves, avoiding people **2(c) How do you know someone is mentally well/ unwell?** **Well** "Well is what the majority of people say it is" **Unwell** "someone can look like a nutter - doesn't mean they are" "the way she acts – fighting… starting for no reason. Taking drugs makes her more mad" Irrational behaviour Being Unwell M: "being taken for a fool – not reacting no matter how far you are being pushed"… F: "I disagree – not reacting doesn't necessarily mean you're mad"	**2) Defining MH:** Feeling "what am I suffering for?" **2(a) What is positive mental health** **2(b) What is negative mental health** **2(c) How do you know someone is mentally well/ unwell?** Isolation Stress, neglecting their appearance 'like they don't care.' dressing inappropriately Suddenly someone you know is acting very differently than usual Talking to themselves Unusual change in someone's behaviour Someone suffering from abusing substances, drug use – experiencing effects of withdrawal low level of coping	**2. Defining Mental Health:** **2(a) What is positive mental health** Able to do things for themselves MH is a part of holistic wellbeing **2(b) What is negative mental health** **2(c) How do you know someone is mentally well/ unwell?** Debilitating – unable to get out Stress Self neglect – distant – not looking after self Self harming anxiety – dealing with it on a day to day basis More dialogue still needed – it is still taboo Men coping with long-term depression as don't talk about it – macho image Different tolerance – resilience Maybe don't recognize it until it becomes a problem Don't really realize what is happening Fear – what will happen if disclose it – result of that Women may look for help – men don't Expectations – misconceptions – male/ female roles
Q3	**3. Interaction of drug use & Mental Health:** "When everyone's on it, you join in." [note: general comment on using drugs]	**3. Interaction of drug use & Mental Health:** [general comments on drug use and social influences] Need a role model – "good strong mind" to show you the way Not accepted by groups – pressure Peer pressure You are as good as person you go with If do drugs etc in front of kids, sending message out "this is ok." Can be a good or bad thing – want you to stay the same – can be jealousy When doing rehab, can't return to old groups of friends If giving up – need willpower	**3. Interaction of drug use & Mental Health:** [general comments on drug use and social influences] Recreational use – drink, drugs, situations of life Friends are smoking – when friends have gone, you are still doing it Influencing factors – Social determinants/ expectations Things become you [peer pressure & young people, drug habits 'happening' or unfolding] Way of life

	3(a) What is the relation between drug / alcohol use and mental health? "Drug use can calm you down." "If you keep on [drugs] it becomes normal" [relating to balance / imbalance of mental health] "the length of time you're taking drugs takes it toll, one becomes two becomes three…" "Being out of balance can send you mental" "Drugs send you into an irrational state. Prolonging that irrational state can affect your mental health." [Note: context relates to an idea about 'everybody having mad moments', but mental health problems occur the longer people 'stay in these mad moments'] "Drugs and alcohol can make you more mental" "Drugs can be used as an escape from thoughts even though they can make things come back on top." "a way of letting emotions out" "a way of controlling how you feel" " a way of facing things - Dutch courage – but your confidence can drop when you're not on it" "when it's got extreme, everything feels slow" "Using drugs can improve your mental health if you are out of balance in the first place" **3b) How does someone behave if they have co-existing mental health & drug / alcohol related problems?**	**3(a) What is the relation between drug / alcohol use and mental health?** Medication not strong enough? Vicious circle – as soon as feel down need to take more drugs To blot out something bad that happened, to forget Sometimes it's the company you keep – can lead to more drug use, etc Insecurity due to taking drugs Need to get buzz to face the day Need to feel confident – get boost for partying Takes the edge off stuttering etc **3b) How does someone behave if they have co-existing mental health & drug / alcohol related problems?** Reacts aggressively/ impatiently to ordinary things, people etc You meet someone who looks quiet, but suddenly flares up for no reason **[Note: stereotypical association of MH and aggression]**	**3(a) What is the relation between drug / alcohol use and mental health?** What's happened before hasn't been dealt with Cycle - - alcohol / \ \ / problem Which comes first Human experience **3b) How does someone behave if they have co-existing mental health & drug / alcohol related problems?** Back down the same road – after recovery Side effects – affects people differently
Q4	**4. Community Responses:** **How do people in the community respond to the behaviour of someone with drug & mental health problems?** "You push them aside if it's not someone you know or family" "It's different if it hits close to home – you feel obliged to help" "If they are strangers they're segregated – they stay away from you, they don't talk to no one" "you wouldn't speak to them. If you know them, you speak to them out of a sense of obligation" it's bad when they're going to score and they've got their kids with them" "the only people that don't use drugs are the people who	**4. Community Responses:** **How do people in the community respond to the behaviour of someone with drug & mental health problems?** How does the community respond? The below are all comments/ views "They walk away – don't want to know" "When you see them in a group, don't approach them; walk away." "When alone with someone, you can talk one to one with them." Parents' attitudes – my child doesn't do that (in denial) "When I ask them why they are doing it they say "'Everyone else	**4. Community Responses:** **How do people in the community respond to the behaviour of someone with drug & mental health problems?** Negative way – lack of understanding – nothing/ nowhere to address issues Community centres were a resource e.g 10 to 2 Club Negative press - media

	have tried them and find they don't get on with them. Everyone's at it, in the clubs you see everyone and you'll say I'll have some of [that]" Wider community attitudes tend to depend on personal experiences and what is usual for them. Implication is that people unwilling to judge if they are familiar/behaviour chimes with their own experiences [Note: people who either use or know others who use are less likely to problematise substance use] Asked what they would do if a person was having a bad time, ▪ "tell them to go see a Doctor" ▪ "take him home, get him to smoke a spliff, keep someone around"	is doing it.' I try to tell them' you don't need to do it.'" "Easier to talk to older age group, but doesn't mean they take your advice" "If I knew the family I would do something – I ask them to ring me." Drug dealing "parents in denial. Son buys new telly, trainers etc, Parents don't challenge them – I'd say 'take it back.'" "Parents keep quiet – why? Shame thing." [Note: within this community some parents are seen to be more collusive, in contrast to Bangladeshi community]	
Q5	**5. Barriers & Suggestions:** **5(a) What type of support or information would help someone with these combined problems?** Very positive feedback on recent TV ads re Alcohol – "it's about time they did something like this for drugs" "need to use people with experience who have lived it" "get actual users going and talking" "they need incentives to go get help" **5(b) What are the barriers to accessing support? How can the barriers be overcome?** Q: "Do you see information about Drugs and Alcohol around?" General consensus: "no" except in pharmacists/chemists Q: what about Drugs services? "Don't know about places – we didn't even know you were here" Q: What about Rehab – nb previous discussions of acquaintances with serious heroin habits "Don't know of anyone who's needed it" [Note: not connecting problem drug-use with rehab; services need to communicate clearly what and how they do it, and who it's for] Barriers "getting people to admit to there being a problem" "people push themselves away"	**5. Barriers & Suggestions:** **5(a) What type of support or information would help someone with these combined problems?** **5(b) What are the barriers to accessing support? How can the barriers be overcome?** Lack of information & knowledge Don't want to go to services – afraid Need to know someone – a person's name as contact, not just given a leaflet Someone they can talk to Frank advert/ helpline – no opinion. Don't think that makes sense [note: criticised , not useful approach] People running services/ manning talklines – no experience of what people are talking about Who wants help, needs to want to change, give up, want help? Classed as disabled – paid to take drugs/ alcohol etc (by govt through benefits) No incentives – young people need more support & focus in their lives More under 30's killing themselves No life skills Services need to be outside of Chapeltown e.g City Centre as everybody knows everybody – no discretion Even if they know where to go, need to trust staff More places needed for kids to release tensions Don't mind opening up to one person but don't want to open up to different people Nobody heard of Mayisha Project – where is it? What does it do? Need to promote Lack of community – people now scared to talk to others Have become the three monkeys – see no evil etc	**5. Barriers & Suggestions:** **5(a) What type of support or information would help someone with these combined problems?** **5(b) What are the barriers to accessing support? How can the barriers be overcome?** ALL SUGGESTIONS: GP, access, posters Meet people where they are Organisations working together Art project Key events – carnival – get out there to promote service Don't just hand out leaflets – one to one explaining required Community events – local gyms West Indian Centre Mandela Judo – behind Chapeltown Business Centre Thomas Danby College Host Media Centre RJC Northern School of Contemporary Dance [Note: also mention of pubs & clubs as places of discussion and engagement re: above issues]

BANGLADESHI FOCUS GROUPS			
	FG1 – Women's Group	**FG2 – Young People's Group**	**FG3 – Men's Group**
Q1	**1.Defining Drug use:** **1(a) What drugs are you aware of? (10)** Heroin Ecstasy Coke weed solvents Tobacco Tranquilizers Alcohol Speed/ amphetamines magic mushrooms **1b) Commonly used drugs in the Bangladeshi Community?** **Marijuana/ganja** by (young people) many discussed that this starts from experimenting and then becomes very social and the attitude around this drugs is seen as just having a cigarette and think it is legal **Tobacco (Shada)** mainly (women) This is a drug that is chewed by Bangladeshi men and women it's a tradition from back home and comes in a brown leaf it is guaranteed to be found in all Bangladeshi homes however the British born generation refrain from this drug as it is not a custom and ruins the colour of your teeth. This drug is also a cause of mouth ulcers and cancers **Cigarettes** (men) very common here and back home **Alcohol** now is becoming apparent with the young generation **Heroin** by (young people) a few examples were given of how local boys have gone on from using Marijuana then experimenting with harder drugs	**1.Defining Drug use:** **1(a) What drugs are you aware of? (10)** cannabis, alcohol, cocaine, steroids, shada (tobacco), cigarettes, heroin, ecstasy, magic mushrooms, solvents	**1.Defining Drug use:** **1(a) What drugs are you aware of? (14)** Cannabis Weed Heroin Chicka's (pills) Magic Mushrooms Cigarettes Gas Rat poison Alcohol Crack Methadone Cocaine Ecstasy Tabs Amphetamine Glue Caffeine **1b) Commonly used drugs in the Bangladeshi Community?** Cannabis Tobacco (Shada) Cigs Caffeine Cocaine Crack Alcohol
Q2	**2.Defining MH:** **2(a) What is positive mental health** It's about the body, soul, emotional and spiritual balance of the mind **2(b) What is negative mental health** Something that is not functioning appropriately in the mind. **2(c) How do you know someone is mentally well/ unwell?**	**2) Defining MH:** **2(a) What is positive mental health** 'Having a balanced lifestyle and keeping the mind clear.' 'Being emotionally well and having a structure to life' **2(b) What is negative mental health** 'Feeling down and not having a structure to life' 'Being unsociable and on medication' 'Don't look well a bit ruffed up like they've been on drugs or something' **2(c) How do you know someone is mentally well/ unwell?**	**2. Defining Mental Health:** **2(a) What is positive mental health** 'The ability to enjoy life' 'Enjoying a balanced lifestyle' ' Buzzing with happiness' **2(b) What is negative mental health** 'Something wrong with the head' 'Head not functioning properly' 'Tapped in the head' **2(c) How do you know someone is mentally well/ unwell?**

	Well Socialises, Want to do stuff/ shows interest, Active in the community **Unwell** Isolates oneself, Some on medication, No participation, Negative comments, Doesn't be seen, Suicidal thoughts.	**Well** Happy, sociable, looking clean, making an effort with friends, showing they care **Unwell** You can tell people are mentally unwell by looking at them, not acting normal, 'eyes red,' 'deformed body.' 'Don't look well.' [Note: emphasis on the visual, overt nature of mental health problems. Possibly more telling of inexperience or age?]	**Well** Happy Sociable Positive Behaving Excited Eating Healthy Enjoying life 'Interested in doing things' Confident Assertive 'Has a structure to life and a plan for the future' Motivated Committed 'On a high' **Unwell** Sad Lonely Isolated 'Has no interest in doing things' depressed stressed cant sleep panic paranoid unsociable 'Has no friends' loses interest Withdrawn Slow [Note: Hedonistic view on drug use? The negative symptoms cited appear to be those commonly associated w/ stimulant use.]
Q3	**3. Interaction of drug use & Mental Health:** **3(a) What is the relation between drug / alcohol use and mental health?** Many at first could not see the link between the two however after a discussion and talking around the subject a link was becoming clear. They also discussed how sometimes medication is used to come off certain drugs and how will power and support is needed. **3b) How does someone behave if they have co-existing mental health & drug / alcohol related problems?** The group was finding it difficult to explain this question. When someone has a MH problem using drugs can make things worse and vice versa if they are on medication it might not be effective. They were describing the symptoms of coming off certain drugs and how a person would feel- paranoid, aggressive, unsociable, ratty, anxiety, stressed, low, panic. Confused Dependant Isolated Suicidal Stress Sleepless Depressed Irritable Low Violent Vulnerable	**3. Interaction of drug use & Mental Health:** **3(a) What is the relation between drug / alcohol use and mental health?** 'With some people you might not able to tell the difference as to whether they have a mental health problem or a drug problem' 'Some people might be getting treated for a mental health problem and then later might become addicted to the drug 'Some people might be on the drug for so long that they later have mental health problem' **3b) How does someone behave if they have co-existing mental health & drug / alcohol related problems?** 'People get into a lot of bad habits because of using drugs e.g. stealing, get into debt'	**3. Interaction of drug use & Mental Health:** **3(a) What is the relation between drug / alcohol use and mental health?** 'Some people use drugs to help their mental health problems who then become addicted to the drugs they have been prescribed' 'People who use drugs for along time can develop mental health problems later on in life I know someone who was smoking weed for years and now he hears voices he's proper lost it he's finished' 'I know three crack heads around this area and their well mad know body wants to know them' **3b) How does someone behave if they have co-existing mental health & drug / alcohol related problems?** 'Their behaviour is odd some days they are ok and other days they are bad you cant quiet figure out what's going on with them. It's easier to guess when someone has a drug problem but it's harder to know when someone has a mental health problem'. 'no care for themselves or others so as long as they feed their drug habit' 'some start stealing' 'get into a lot of debt' 'get into a lot of fights' 'get involved with groups and gangs' crime weapons. Withdrawn, Sad, Ratty, Shaky, Smiling, Powerful, on a downer, Isolated, depressed, aggressive,
Q4	**4. Community Responses:** **How do people in the community respond to the behaviour of someone with drug & mental health problems?** Shuts them out/Isolation Labelling Blaming parents Blaming upbringing	**4. Community Responses:** **How do people in the community respond to the behaviour of someone with drug & mental health problems?** People are treated like outcasts, people will call them names, they will be isolated by the Community, nobody will go to help them, some people will get others to stay away from them too	**4. Community Responses:** **How do people in the community respond to the behaviour of someone with drug & mental health problems?** They call them names, nobody wants to help or will help, for one person in the family the whole family gets a bad name, some people don't know why the person is behaving like that, people don't know how to help because they are unaware, in a lot of

	Stigma People don't want to help Media Name calling		families parents don't know what drugs or mental health are.
Q5	**5. Barriers & Suggestions:** **5(a) What type of support or information would help someone with these combined problems?** Knowing where to go to and who to go to Not being passed around from one service to another Proper support not just phone numbers of help lines Services to be more accessible Having language facilities Services being culturally and religiously aware Rehab to be promoted to the South Asian communities so we know what it is and how we can help our loved ones A centre where information can be obtained Counselling for the person experiencing the problems and family members to prevent further siblings getting involved in drugs or gaining understanding of mental health **5(b) What are the barriers to accessing support? How can the barriers be overcome?** Currently don't know who to go to for help	**5. Barriers & Suggestions:** **5(a) What type of support or information would help someone with these combined problems?** Go to chemists; go to doctors who will give information and signpost you. 'Talk to Frank, although I've never rung or don't know anyone who has.' Talk to Youth Workers, teachers and mentors. 'I don't know of any local or voluntary organisations around this area who can help, I feel safe in the youth setting and talking to the youth worker' A lot of support is not available **[NOTE:** Is This about figures of authority? Or about people who are perceived to have helpful knowledge?**]** **5(b) What are the barriers to accessing support? How can the barriers be overcome?** 'Don't know many organisations' 'Services too far' 'People might judge you' 'People will find out' 'Confidentiality' 'Services not accessible' How to overcome barriers Promotion of services better Don't have your own people working there Don't have a massive sign outside, so a discreet service Services to respect culture and religion	**5. Barriers & Suggestions:** **5(a) What type of support or information would help someone with these combined problems?** Raise awareness about drugs and mental health, preventative work with young people, practical programmes rather than just sitting and talking to a group so that people can reflect and remember. **5(b) What are the barriers to accessing support? How can the barriers be overcome?** 'The support is not available I don't know of any and if there is obviously it's not local or these people are not selling themselves well' Services are too far, don't know of any, everyone says they'll help you but they really don't, people judge you, 'I feel comfortable with someone I know or someone who will understand me from my own background/culture' Have a service that's local and that can cater for the people in the community so that means language, culture, religion etc. 'I don't mind talking to someone I know in the community as long as they keep my stuff confidential' 'They should have a centre where all sorts is going on then people wont know what your going in for' 'Theirs no point having leaflets in different languages because people don't read them its just a waste of money I think, instead they should use that money for activities in a centre'.