Adapting drug services to accommodate the different needs of drug users from ethnic groups is vital in reducing social exclusion. **Jeff Fernandez** explains how family expectations changed the way one project treated heroin users from Bengali backgrounds

A family affair

MUCH has been written about the emerging needs of South Asian drug users in Britain. Drug services have, most notably in London, seen a steady rise of drug users seeking treatment who are from Bengali backgrounds. A report published in 2003 by the University of Central Lancashire showed, through an extensive literature review, that the use of heroin and crack is prevalent in these communities. This raises the issue of how we best approach service provision in Britain for emerging ethnic minorities.

A detailed case study analysis of Bengali clients presenting to the Margerete Centre, a local drug service in Camden, north London, was conducted between January and December 2002. It revealed marked, culturally specific, differences between those categorising themselves as Bengali and white/European users, in both the method they take heroin and the nature of family involvement.

HEROIN SMOKERS

Most Bengali clients were males aged between 18 and 28 and were born in the UK. Their drug histories were short, in that they had only been using heroin for two to three years. All of them smoked heroin instead of injecting and only a handful used it with crack cocaine. It is useful to note that although South Asian heroin users are generally seen as non-injectors, a switch to injecting may occur at a later date. Drug services in Tower Hamlets, east London, have found that many Bengali clients with longer drug histories than those in Camden switched to injecting. Nevertheless, injecting has a poor image in these communities and detoxing was seen as one way to avoid this progression.

All the Bengalis coming into the centre asked for a detox regime in the first instance. From the users' point of view this was a quick and easy way of getting 'clean'. From the clinicians' point of view, uncomplicated drug profiles and short drug histories made them suitable for an outpatients' detox programme. There was a general consensus of 'trying to catch their habit early' before it became more ingrained and problematic.

Yet this reasoning was to prove unfounded. Many of the Bengali clients failed to stay stable on their dose whilst detoxing. All relapsed within a fortnight or earlier after their medication regime had finished. In contrast, the white clients showed a greater ability to stay clean after the medication regime finished, despite having more problematic presentations with poly drug use. Therefore, the ethos of 'catching their habits quickly' was misplaced.

The clinical team felt on reflection that key factors in assessing a client's suitability for a detox regime – such as family support and personal motivation – were not picked up. Without these insights, the clinical team felt the current Bengali population emerging for treatment where being "set-up to fail".

FAMILY PRESSURE

From the research conducted with the Bengali client group it was evident they had family pressures to get 'clean'. This was the main pressure and the over-riding factor of why this particular client group requested an outpatients detox programme. They acknowledged that in many cases they were not ready to completely detox and that they would be better suited to methadone maintenance.

Families had a strictly medical way of thinking about their relative's drug use - that the only solution was a chemical one. They saw it as something, like a low-grade infection, to be cured through a course of medication. Along with clients, they were not aware of, or under-estimated, the psychological factors linked to

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above: Heroin users from Bengali families in London receive Thai massage and boxing therapy as a way of breaking the cycle of drug addiction

drug dependency. As a result, the clinic felt treatment for Bengali clients should go hand in hand with educating families because of the powerful sway they had over clients.

One client, Jamin, a 24-years-old living with his parents in Camden, came for an opiate detoxification through an outpatients programme. It was initially felt this was a suitable way of treating Jamin because he had a 'small' habit, short-drug history and was young. He completed his outpatients detox but failed to stay clean after the medication finished.

MOTIVATION

In hindsight, Jamin wasn't psychologically prepared for staying 'clean'. It became clear from interviews with Jamin and other Bengali clients that the role of the family was highly influential in his request for an immediate detox regime.

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Bengali clients seeking treatment seem to have the families' wishes as central to their decisions upon which treatment modality they are seeking. It can be argued that 'the family' is the over-riding factor, unlike white clients who make more self-motivated choices for treatment. As Jamin said: "I wanted to detox because my parents wanted back the son they knew. My family is important which is why I wanted to detox, it was very much out of respect for them."

What is clearly needed is an inclusion of the factors affecting and motivating the Bengali clients coming for treatment into existing approaches. This would accommodate the emerging 'new' group of clients coming into the Margerete Centre and make already existent assessment forms and clinical approaches appeal and be effective to a wider group of clients. Effectively it is fine-tuning what is already in place to make it cultural responsive.

Staff redesigned the assessment form to incorporate a section on the family and their aspirations for the presenting client. There is also an option when the client is in treatment, if consent is given, for the family to be included in the first session to explain the practical ways treatment services can help their family member, as well as the kind of support they can provide themselves. These changes have improved the assessment and treatment for clients at Margerete. The challenge is not only for staff at the Margerete, but for all drug workers to look at how they can adjust services to cater for the myriad ways in which drug problems are perceived by, and impact on, different ethnic groups. ■

BENGALI USERS: THE EAST LONDON EXPERIENCE

By Shafiur Rahman, manager of the drug service, Nafas

BENGALI Heroin users have the same issues as other groups, but the difference is the context and the faith/cultural framework that affects their attitudes and approaches to those issues.

In recovery people talk a lot about motivation and will power. Whether or not clients currently practice their faith, the majority have a basic understanding and respect for their faith, which forms an early part of their education at home and from classes at the Mosque. Most of them feel guilty about their drug use due to its prohibition in Islam and the overwhelming majority say abstention is their goal. If a drug worker/counsellor can genuinely understand and tap into this, then the faith framework can become a powerful tool for recovery as it has been for many clients. Contemplation, prayer, and a purpose in life are just some of the practical tools that can aid treatment and recovery.

Most of the clients live at home with their parents and families. Despite their drug use, they usually have a strong bond with their families particularly their mothers, a reverence inculcated from an early age. These values and relationships can again play an important supporting role if they can be integrated into the care plan of the client and seen as part of a holistic recovery package rather than the traditional 'clinical' separation that usually happens due to 'confidentiality'. Understanding families are well placed to continue support and motivation 'out of hours' when the client needs it most.

Clients who are smoking heroin rather than injecting are potentially younger, or at an earlier stage of their 'drug career'. They are also less likely to present with the health complications and risks usually associated with an IV drug user. This adds to the general good prognosis for their potential recovery.

The Nafas day programme received 229 referrals last year of which 70 clients started the programme. Three quarters stayed on for more than four weeks with half staying on for the full 12 weeks. After the programme more than a third left drug free, while half the clients went onto either employment and or education and training.

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