GREATER GLASGOW NHS BOARD
RESEARCH

Consulting with equality groups on alcohol and drugs, 2003.
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Acknowledgments. The working group involved in each study would like to acknowledge the support and contribution of those who participated in the research process.

Thanks are extended to the Health Promotion Research & Evaluation Team.
Introduction
Alcohol and drug issues

Over the past 18 months the Addiction Team of Greater Glasgow NHS Board has commissioned the following three pieces of work:

Alcohol and drug issues affecting Pakistani, Indian and Chinese young people and their communities: A study in Greater Glasgow.

Alcohol and drug issues affecting those with a sensory impairment in Greater Glasgow.

The impact of gender in addiction service use, treatment outcomes and patterns of prevalence.

These studies were commissioned to help fill gaps in existing knowledge. It is hoped that the findings will help shape service provision throughout the country.

The purpose of this publication is to draw together the key findings from all three research studies and share our experiences in conducting research in these areas.

Conducting research with equality groups
The term 'equality groups' is used to describe a range of different groups that may experience inequality or discrimination (Scottish Executive Health Department Plan for Action on Alcohol Problems, 2002).

Recruiting participants for these studies was particularly challenging. Standard methods of recruitment are often inadequate as there is no simple method of identifying appropriate participants. Excluded groups may feel disempowered, which may increase the difficulty in accessing willing participants. In addition, individuals and communities may be distrustful of the motives of those carrying out the research and cynical regarding the value of participating in research. It is essential to come up with innovative ways of targeting the appropriate population through adapting standard research tools. Strong links with key people involved in equality groups can help facilitate this process.

Once participants are recruited, arranging and conducting any type of research generally takes longer than first anticipated. There are a range of issues that impact on completing robust research with equality groups. These include the shared experience of discrimination and in the case of some groups, the barriers of language and communication. During research, it is essential to maintain strong links with as wide a range of key people as possible who can facilitate the progression of the work. If however, there are only one or two key links available, progress can be delayed as they may have other commitments.

Ideally researchers should be members of the equality group being studied, although realistically this is not always possible. Therefore it is imperative that those conducting research are ever sensitive to the needs of equality groups.
Alcohol and drug

Research by: Neelam Bakshi NB Associates | Alastair Ross & Derek Heim Human Factors Analysts Ltd (Director: Professor John B Davies) with Nisha Bakshi | Kirsty Flatley | Simon Hunter | Neena Mahal | Kofi Tordzro.

Acknowledgement: Thanks are extended to the Steering Group.

Introduction
The primary reason for undertaking this research was a recognition that patterns of alcohol and drug use, awareness of issues and attitudes to service provision in black and minority ethnic communities have not been examined in detail.

This research study was therefore commissioned to consult with Pakistani, Indian and Chinese communities in Greater Glasgow. It’s purpose was to investigate patterns of alcohol and drug use, awareness and understanding of alcohol and drug use and access to and use of service provision. The research was targeted primarily at young people aged 16-25.

Methodology and sample
Three techniques were employed for the study. These were:
• An interviewer-administered questionnaire conducted across Greater Glasgow with young people aged between 16-25. A total of 174 responses were obtained
• Ten focus groups conducted with young people, alcohol and drug service users and key informants from the three communities, as well as police and agency workers
• Twenty-four in-depth interviews conducted with parents from each community.
Results: Alcohol

Table one summarises the number of respondents who said they drank alcohol along with the number of units they consumed per week. Results indicate that only 19% of Pakistani respondents drank alcohol, which is significantly less than Chinese and Indian respondents who reported higher levels of 73% and 49% respectively. Whilst results suggest that Pakistani respondents were less likely to drink alcohol, those who did drink were likely to consume larger amounts than their Chinese and Indian peers.

Exploration of those who did not drink alcohol indicated that religion was the main reason Pakistani (59%) and Indian (25%) respondents did not drink. However, focus group and interview data suggests that pressure to conceal alcohol use was especially strong for women which may have influenced disclosure and prevalence rates.

The most common type of alcohol consumed was spirits, with broadly similar patterns across gender. Being sociable was the most common reason respondents gave for drinking alcohol. Other reasons include: peer pressure, enjoyment of the taste, a way to de-stress and relax.

| Table 1 | Ethnicity and alcohol consumption/units of alcohol consumed by those who drink |
|-----------------|-----------------|-----------------|-----------------|
| ETHNICITY       | DRINK ALCOHOL? (N=162) | UNITS OF ALCOHOL/WEEK (SD) |
|                 | yes             | no              |                 |
| Pakistani (n=73) | 14 (19%)**      | 59 (80.8%)      | 13.18 (9.71)*   |
| Indian (n=47)   | 23 (49%)        | 24 (51%)        | 7.94 (9.81)     |
| Chinese (n=54)  | 38 (73%)        | 14 (27%)        | 4.76 (8.14)*    |

(*Chi - square, P<.001 [both other groups]; *ANOVA, P<.001)
Results | drugs

Respondents were asked two questions: firstly if they had ever taken illegal drugs and secondly if they had taken any illegal drugs within the last month. The results are summarised in Table 2 and indicate that 25% of Pakistani, 24% Chinese and 21% of Indian young people surveyed had tried some kind of illegal drug. In addition 12% of Pakistani, 9% of Indian and 4% of Chinese young people reported use of an illegal drug the month preceding the interview. There was a significant gender difference (P<0.001) across the three groups, with women more likely to report never having tried an illegal drug.

Results clearly indicated that cannabis was the most prevalent drug across the sample with 21-23% of all young people reporting some previous consumption.

Pakistani respondents were more likely than Indian and Chinese respondents to state that they had friends who consumed drugs such as cocaine or heroin.

Awareness of drug names amongst young people was generally high. There were, however, some notable misconceptions in terms of drug effects. For example, methadone and heroin were believed by many to be stimulant drugs.

Young people in all groups rated fun or enjoyment as the most likely reason for their own drug consumption.

Predictors of Drug Consumption

Using logistic regression analysis, the factors which were predictors of drug consumption were:

- Having friends from the same ethnic background who take drugs
- Gender (females being less likely to consume drugs)
- Non-importance of religion (associated with higher consumption).
Results | service provision
RESULTS INDICATED A DEGREE OF RELUCTANCE IN ALL THREE COMMUNITIES TO INVOLVE OR CONTACT A SERVICE PROVIDER WHEN IMAGINING THAT THEY HAD A FRIEND WITH DRUG OR ALCOHOL-RELATED PROBLEMS.

This reluctance was comparatively higher in Chinese young people (13% would contact services for drugs and 22% for alcohol) as opposed to Indian young people (17% drugs and 26% alcohol) and Pakistani young people (25% drugs and 29% alcohol).

Service provision was regarded as being insensitive to specific issues (religious, cultural and social) affecting black and minority ethnic communities. Respondents noted that information on substances and services is provided in a way which is not inclusive (as it focuses on the white population) and which inhibits black and minority ethnic access.

There were broad similarities between Pakistani, Indian and Chinese young people in terms of where they would obtain information about alcohol and drugs. The most frequently named options were GP/Medical personnel, the internet, friends and books/leaflets.

Exploration of views on service provision revealed no significant difference between communities on the question of whether services should be 'mainstream' or 'specialist black and minority ethnic'. Nor was there a clear consensus on this issue. A majority of young people (54% for alcohol, 56% for drugs) believed such issues should be addressed within 'mainstream' service provision.

Conclusions
The use and misuse of alcohol and drugs is present in the Pakistani, Chinese and Indian population in Greater Glasgow. However, this prevalence is still generally reported at levels below those in the general population.

Females reported less consumption of drugs and alcohol overall. However, it was also identified that females were under more pressure to conceal use. Pressures to conceal use and misuse were reported to be particularly strong for Pakistani and Indian respondents.

Young people were aware of most common illegal drugs, but conceded that they had limited knowledge of the effects that these would have. This suggests an area where information could be targeted.

All communities were reluctant to contact service providers. Views on the best approach for service provision (e.g., whether services should be 'specialist' or 'mainstream') vary widely according to personal preference, needs and experience.

Variation in experience and attitude means choice in service provision and information delivery is seen as vital. Not providing choice runs the risk of providing homogenous services which do not meet individual needs. This is particularly important given the belief that service provision is considered to be insensitive to specific issues affecting black and minority ethnic communities.
Alcohol and drug issues affecting those with a sensory impairment in Greater Glasgow.


Acknowledgement: Thanks are extended to the Sensory Impairment Research Sub Group.

Introduction
Despite the implementation of the Disability Discrimination Act 1998 (DDA), there is concern about the lack of access that people with a sensory impairment may have to health service provision. In particular, little is known about access to alcohol and drug services, nor about awareness and patterns of substance use among people with a sensory impairment.

This study was commissioned to assess knowledge regarding alcohol and drugs and to explore patterns of alcohol and drug use among people with a sensory impairment. The study also explored awareness of, access to and use of alcohol and drug related services, as well as barriers to health services.

Methodology and sample
Participants were recruited through a number of agencies that have contact with people who are sensory impaired in Greater Glasgow. The research involved both qualitative and quantitative methods, using self-completion questionnaires, face-to-face focus groups, an online focus group and in-depth interviews conducted either face-to-face or on the telephone. In each case, the media of contact was tailored to the communication needs of the individual.

The response from blind and partially sighted people was disappointing, despite attempting a number of routes to access them and encourage a response. Feedback from service providers to blind and partially sighted people intimated that this was the norm. A large number of blind and partially sighted people are older, as sensory impairment can be age related, and tend not to respond to consultation on any matter. Additionally, the topic of alcohol and drug services were considered to be more 'taboo' amongst the sensory impaired population than the general population. The number of participants in each element of the research is detailed on the following page.
Results | accessing general services

Opinions were mixed regarding the overall ease of accessing general health services (see Table 2). Forty-six percent of respondents considered ease of access to be ‘good’ or ‘very good’, whilst 24% considered it to be ‘poor’ or ‘very poor’.

The response from those who were deaf or hard of hearing was noticeably more negative than those who had a visual impairment or audio-visual impairment. Focus groups and interviews with those who have a hearing impairment also revealed that many who said that access was good went on to describe a number of difficulties in access, or explained that they had no difficulties because they relied on a family member to help them.

Several deaf people made the point that they did not believe they received the same level of service at the GP as hearing people, usually because the doctor did not take the time to communicate adequately with deaf patients.

### Self-completion questionnaires:

<table>
<thead>
<tr>
<th></th>
<th>Deaf</th>
<th>Hard of Hearing</th>
<th>Partially sighted</th>
<th>Combination of sight/hearing impairments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaf</td>
<td>54</td>
<td>9</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Blind</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Face-to-face interviews with deaf people (with BSL* interpreter): 9**

One focus group with deaf people (with BSL interpreter): 6

* British Sign Language

**One on-line focus group with deaf/hard of hearing people: 2**

One focus group with hard of hearing people (induction loop system): 6

In depth telephone interviews with blind people: 6

**Self-completion questionnaires:**

The respondent profile of the questionnaire survey by age and gender is shown in Table 1. Please note the high proportion of older respondents, which may affect the awareness and use of drugs in particular.

### Table 1 | survey respondent profile by age and sex

<table>
<thead>
<tr>
<th>SEX</th>
<th>16-24</th>
<th>25-44</th>
<th>45-54</th>
<th>65+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>4</td>
<td>8</td>
<td>9</td>
<td>12</td>
<td>33</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>11</td>
<td>15</td>
<td>22</td>
<td>50</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Number of respondents</td>
<td>7</td>
<td>20</td>
<td>25</td>
<td>37</td>
<td>89</td>
</tr>
</tbody>
</table>

(*Chi - square, P<.001 [both other groups]; *ANOVA, P<.001)

### Table 2 | ease of accessing general health services in Greater Glasgow

<table>
<thead>
<tr>
<th>DEAF</th>
<th>HARD OF HEARING</th>
<th>BLIND</th>
<th>PARTIALLY SIGHTED</th>
<th>AUDIO-VISUAL IMPAIRMENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
<td>15%</td>
<td>0%</td>
<td>20%</td>
<td>14%</td>
<td>33%</td>
</tr>
<tr>
<td>Quite good</td>
<td>24%</td>
<td>33%</td>
<td>30%</td>
<td>57%</td>
<td>44%</td>
</tr>
<tr>
<td>Neither good nor poor</td>
<td>17%</td>
<td>33%</td>
<td>20%</td>
<td>29%</td>
<td>11%</td>
</tr>
<tr>
<td>Quite poor</td>
<td>13%</td>
<td>22%</td>
<td>10%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Very poor</td>
<td>19%</td>
<td>0%</td>
<td>10%</td>
<td>0%</td>
<td>11%</td>
</tr>
<tr>
<td>Haven't tried to access any health services</td>
<td>11%</td>
<td>0%</td>
<td>10%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>2%</td>
<td>11%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Number of respondents</td>
<td>54</td>
<td>9</td>
<td>10</td>
<td>7</td>
<td>9</td>
</tr>
</tbody>
</table>
Table 3 | frequency of alcohol consumption

<table>
<thead>
<tr>
<th></th>
<th>DEAF</th>
<th>HARD OF HEARING</th>
<th>BLIND</th>
<th>PARTIALLY SIGHTED</th>
<th>AUDIO-VISUAL IMPAIRMENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>25%</td>
<td>11%</td>
<td>30%</td>
<td>29%</td>
<td>44%</td>
<td>26%</td>
</tr>
<tr>
<td>Monthly or less</td>
<td>26%</td>
<td>11%</td>
<td>20%</td>
<td>14%</td>
<td>11%</td>
<td>21%</td>
</tr>
<tr>
<td>2 to 4 times a month</td>
<td>25%</td>
<td>33%</td>
<td>20%</td>
<td>14%</td>
<td>22%</td>
<td>24%</td>
</tr>
<tr>
<td>2 or 3 times a week</td>
<td>21%</td>
<td>33%</td>
<td>30%</td>
<td>14%</td>
<td>11%</td>
<td>21%</td>
</tr>
<tr>
<td>4 or more times a week</td>
<td>4%</td>
<td>11%</td>
<td>0%</td>
<td>29%</td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td>Number of respondents</td>
<td>53</td>
<td>9</td>
<td>10</td>
<td>7</td>
<td>9</td>
<td>88</td>
</tr>
</tbody>
</table>

Results | alcohol and drugs

Most respondents were generally unaware about the alcoholic content of drinks in terms of units. Only 4% (4 respondents) correctly gave the number of units in a bottle of wine, and 4% (4 respondents) knew the number of units in a pint of beer.

Focus groups and interviews with deaf people revealed that most deaf people were not familiar with the term 'units' of alcohol, and were not aware of any recommended 'safe' limits. About half of all respondents (47%) who completed the questionnaire said they drank alcohol once a month or less. Twenty-eight percent drank alcohol twice a week or more.

Table 3 shows the frequency that respondents drank alcohol. Few respondents appeared to drink excessively. Just 8% of those who ever drank (5 respondents) said they usually consumed seven or more drinks in a day when they were drinking.

Drug awareness varied among respondents (see Table 4). The drugs that were most widely known were cannabis, heroin, ecstasy and cocaine.

Respondents who were blind or partially sighted generally had a higher awareness of drugs than those who were deaf or hard of hearing. Only 11% of all respondents (10) had tried any of the drugs and one person was currently using cannabis.

Results | alcohol and drug services

About one-quarter of all respondents were aware of any services aimed at people with alcohol or drug problems. Younger people were the most likely to know about such services, with just under half of those aged below 45 saying that they knew of any service.

Only three respondents had ever tried to access alcohol or drug services in Greater Glasgow. However, three others gave reasons for not trying to access services, indicating they might have liked to, but they did not believe they would be able to access them. The lack of survey participants who had used or tried to use alcohol or drug services prevents us from learning what improvements could be made. Nevertheless, the difficulties in using general health services are also likely to apply here.

Opinion was mixed as to whether alcohol/drug services should be dedicated to deaf and/or blind people, or mainstream with special resources for deaf and/or blind people. Overall, 36% said they would prefer a mainstream service with special resources, 27% said they would prefer a service dedicated to those with sensory impairments and 37% said they did not know. However, among the hearing impaired, most thought services should be dedicated for people who were deaf and hard of hearing.

Reasons given for preferring a mainstream service included not wanting to be 'segregated' and not wanting other people from their community to 'know their business'. On the other hand, those who preferred a dedicated service thought that more people with a sensory impairment would use it because they would feel more comfortable and confident.
Table 4 | knowledge of specific drugs

<table>
<thead>
<tr>
<th>Drug</th>
<th>DEAF</th>
<th>HARD OF HEARING</th>
<th>BLIND</th>
<th>PARTIALLY SIGHTED</th>
<th>AUDIO-VISUAL IMPAIRMENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>70%</td>
<td>67%</td>
<td>90%</td>
<td>100%</td>
<td>78%</td>
<td>75%</td>
</tr>
<tr>
<td>Heroin</td>
<td>61%</td>
<td>67%</td>
<td>90%</td>
<td>100%</td>
<td>78%</td>
<td>70%</td>
</tr>
<tr>
<td>Methadone</td>
<td>48%</td>
<td>56%</td>
<td>70%</td>
<td>57%</td>
<td>56%</td>
<td>53%</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>46%</td>
<td>44%</td>
<td>80%</td>
<td>43%</td>
<td>33%</td>
<td>48%</td>
</tr>
<tr>
<td>Semeron (bogus drug)*</td>
<td>11%</td>
<td>11%</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>Crack</td>
<td>39%</td>
<td>44%</td>
<td>70%</td>
<td>86%</td>
<td>67%</td>
<td>49%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>57%</td>
<td>56%</td>
<td>80%</td>
<td>100%</td>
<td>67%</td>
<td>64%</td>
</tr>
<tr>
<td>Temazepam</td>
<td>41%</td>
<td>56%</td>
<td>80%</td>
<td>71%</td>
<td>44%</td>
<td>49%</td>
</tr>
<tr>
<td>Valium</td>
<td>35%</td>
<td>56%</td>
<td>80%</td>
<td>100%</td>
<td>56%</td>
<td>49%</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>61%</td>
<td>67%</td>
<td>80%</td>
<td>86%</td>
<td>67%</td>
<td>66%</td>
</tr>
<tr>
<td>LSD</td>
<td>44%</td>
<td>56%</td>
<td>80%</td>
<td>57%</td>
<td>44%</td>
<td>51%</td>
</tr>
<tr>
<td>Solvents</td>
<td>43%</td>
<td>22%</td>
<td>70%</td>
<td>71%</td>
<td>67%</td>
<td>48%</td>
</tr>
<tr>
<td>Temgesic</td>
<td>9%</td>
<td>33%</td>
<td>10%</td>
<td>29%</td>
<td>0%</td>
<td>12%</td>
</tr>
<tr>
<td>DFs</td>
<td>7%</td>
<td>22%</td>
<td>10%</td>
<td>0%</td>
<td>0%</td>
<td>8%</td>
</tr>
<tr>
<td>None of these</td>
<td>28%</td>
<td>33%</td>
<td>10%</td>
<td>0%</td>
<td>22%</td>
<td>24%</td>
</tr>
<tr>
<td>Number of respondents</td>
<td>54</td>
<td>9</td>
<td>10</td>
<td>7</td>
<td>9</td>
<td>89</td>
</tr>
</tbody>
</table>

*Note: the list included the bogus drug 'semeron' in order to test over-reporting or completion errors.

Table 5 | resources needed to use the service

<table>
<thead>
<tr>
<th>Resource</th>
<th>DEAF</th>
<th>HARD OF HEARING</th>
<th>BLIND</th>
<th>PARTIALLY SIGHTED</th>
<th>AUDIO-VISUAL IMPAIRMENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction loop system</td>
<td>10%</td>
<td>56%</td>
<td>0%</td>
<td>0%</td>
<td>50%</td>
<td>17%</td>
</tr>
<tr>
<td>Text phones</td>
<td>51%</td>
<td>33%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>38%</td>
</tr>
<tr>
<td>Good lighting (for lipreading or improved vision)</td>
<td>35%</td>
<td>56%</td>
<td>17%</td>
<td>50%</td>
<td>33%</td>
<td>37%</td>
</tr>
<tr>
<td>All information provided in minimum 18pt font size</td>
<td>4%</td>
<td>0%</td>
<td>33%</td>
<td>73%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Staff with BSL skills</td>
<td>71%</td>
<td>33%</td>
<td>0%</td>
<td>0%</td>
<td>33%</td>
<td>54%</td>
</tr>
<tr>
<td>BSL interpreters provided</td>
<td>55%</td>
<td>11%</td>
<td>0%</td>
<td>0%</td>
<td>17%</td>
<td>39%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>0%</td>
<td>50%</td>
<td>0%</td>
<td>17%</td>
<td>8%</td>
</tr>
<tr>
<td>Number of respondents</td>
<td>51</td>
<td>9</td>
<td>6</td>
<td>4</td>
<td>6</td>
<td>76</td>
</tr>
</tbody>
</table>

Improved lighting and large print documents were the preferred resources of partially sighted people. Amongst deaf people, the most common resource required was staff with BSL (British Sign Language) skills. However, most also said that they would be happy talking about alcohol/drugs through an interpreter.

Conclusions

Very few of those who took part in the research knew the number of units of alcohol in a pint of beer or a bottle of wine. Few respondents drank in excess of recommended 'safe' limits and there were very few 'binge' drinkers.

Although the majority of respondents were aware of cannabis, heroin, ecstasy and cocaine, awareness of other drugs was less common. Very few had ever tried drugs and only one respondent was currently using any drug (cannabis).

Only 27% of people with a sensory impairment said that they knew of any specific services aimed at people with alcohol or drug problems in Glasgow.

There was a considerable difference of opinion as to whether alcohol/drug services should be mainstreamed or based on specialist services for people with a sensory impairment. Perceived disadvantages of a dedicated service were the feeling of being excluded from mainstream services and the threat to anonymity. Perceived advantages were that more people would be likely to use a dedicated service because they would feel more comfortable and confident.
Impact of gender on addiction service use, treatment outcomes and patterns of prevalence.

Research by: MRUK

Acknowledgement: Thanks are extended to Amanda Thompson, and to the Gender Research Sub Group.

Background

There is growing recognition of the importance of gender as a key influence on health. However, the integration of a gender perspective into the planning and delivery of health and social care services has yet to be fully realised.

In relation to problem drinking and drug use, there is clear disparity in the prevalence between men and women. Additionally there is little indication that the significance of gender has been incorporated into the design and provision of services to ensure a gender sensitive service. Similarly there is a lack of information on the nature of alcohol and drug related problems amongst men and women and the degree to which either is affected by sex or gender.

To explore this issue further, Greater Glasgow NHS Board (GGNHSB) commissioned research with both Health Service staff and addictions staff working in the GGNHSB area.

Aim

The aim of the research was to assess the extent to which awareness of sex and gender differences is incorporated into the work of staff within the Alcohol and Drug Directorate of the Primary Care Trust and within Local Authority staff.

Objectives

The objectives were to investigate:

• Staff attitudes to, and awareness of, the contribution of sex and gender in the development of alcohol and drug problems
• Staff views of gender differences and how this should inform service planning and delivery
• Staff perceptions of the way in which gender affects treatment outcomes
• The extent to which a gender analysis informs the assessment and treatment of service users
• Staff attitudes towards the development of gender sensitive services, including perceived barriers.

Methods

Given the exploratory nature of this research, the following qualitative methods were used:

• 4 focus groups with addiction staff from 4 local authority areas within GGNHSB
• 3 focus groups with nursing staff in Greater Glasgow Primary Care Trust (GGPCT)
• 7 semi-structured interviews with nursing staff and nurse managers in GGPCT.

The group also drew on the literature review carried out as part of the Purchased Service Review by GGNHSB.
Results

Understanding of sex and gender

Whilst acknowledging that many of the factors precipitating or sustaining addiction problems are broadly similar for women and men, respondents from both agencies demonstrated some awareness of sex and gender differences in this regard. The importance of cultural factors was raised. For men this was primarily around the social acceptance of heavy alcohol consumption and its association with masculinity. By contrast, there was a perceived stigma associated with women drinking which contributed to the often hidden nature of women’s problem alcohol use. Other factors, such as the high incidence of child sexual abuse and domestic violence amongst women with addiction problems, were also highlighted. For some participants, particularly within the health service, gender was viewed as synonymous with ‘women’ and the focus was correspondingly on how to provide services for women as opposed to considering the most effective means of working with both sexes.

Impact of Gender Awareness on Practice

Participants in both sectors experienced some difficulty in describing how such awareness informed or directed their assessment and ongoing work with clients. Both agencies emphasised that their practice was based on an individualistic, ‘client-centred’ approach within which gender was only one of a range of factors they would consider. Few appeared able to see how a gendered approach would ‘fit’ with their current response to meet the needs of clients.

Barriers to Gender-Sensitive Services

A number of barriers to the provision of gender-sensitive services were identified at both an individual and organisational level. These included:

• Differential access to services
  The predominance of men within addiction services was raised by participants who considered that there needed to be greater flexibility in the service provided, e.g. around appointment times, home visiting etc. Local authority staff highlighted the need for services to be more child-friendly to encourage women to use the service and for the development of support services for family units. The lack of ability to provide the option of a male or female worker was further noted by some participants as a problem.

• Lack of Understanding
  Although able to articulate some of the gender differences that exist in relation to addictions, staff in both sectors struggled to define a gender-sensitive service. Descriptions of a gender-sensitive approach tended to focus on separate services for women, which implied a lack of understanding of the impact of gender on men.

• Staff Development
  The need for training on gender issues and clear direction on how these should be incorporated into practice was identified by many of the participants. Responding to issues such as domestic violence and child sexual abuse was also raised as a training and support issue.

• Lack of Priority
  The issue of gender was given a low priority within both agencies by their management. Accordingly staff did not feel that it was integral to the delivery of their service or were they clear on what was required in this respect. The gender-blind approach adopted at an organisational level was thus echoed at operational level.

In addition, staff perceived the inclusion of gender as an additional dimension that was expected of them and that would require new resources and new duties. There was little appreciation of this as a prerequisite for good practice.
Results

**FUTURE ACTION**

To progress the integration of a gender perspective within addiction services the following recommendations have been agreed:

- To develop gender sensitive commissioning of services
- To capacity build with trauma services in order to work more effectively with addiction issues
- To effect the joint training agenda
- To provide a toolkit for services to improve their understanding of gender issues.

Conclusions

There is clearly some understanding amongst addiction staff of the role of gender in the development of addiction problems for women and men. The extent to which this informs service provision, however, appears to be minimal and is primarily at an implicit rather than explicit level.

The research findings suggest that a better understanding of how to implement a gender-sensitive service is required. This will involve commitment to embedding such an approach within addiction services and a corresponding process of staff development to ensure they are equipped to undertake this practice. The introduction of a gender-sensitive perspective will contribute to both more efficient and more effective service delivery.
Conclusions

Addressing the range of issues identified by the research requires good planning and well-developed contacts within equality groups. Below is a checklist to facilitate research with equality groups:

Offering the tender:
- Ensure you ask those submitting a tender to demonstrate sensitivity to and awareness of the group(s) in question, including evidence of previous experience
- Send the tender out to a range of agencies, including those from academic institutions, market research companies and freelance researchers
- Support those from equality groups to submit a tender by accepting group / joint bids
- Capacity build with equality groups to enable participation in the tender process
- Identify and build relationships with key players/gatekeepers
- Set up a steering group with professionals who have experience of equality groups to ensure sensitivity of research.

Conducting the research:
- Offer language /communication aids where appropriate
- Maximise information gleaned from the research i.e. ensure to cover drugs as well as alcohol, make connections with specific equality issues e.g. discrimination
- Establish quota sampling with minimum requirements in terms of deprivation, gender, age bands
- Build in training time for field workers to carry out the research
- Where appropriate, ensure field workers are drawn from equality groups e.g. same gender, ethnicity to enable maximum recruitment of participants
- Ensure an appropriate time frame is established and adhered to, as recruitment and conducting research generally takes longer than anticipated.

Post research:
- Disseminate the results of the research widely
- Feedback of research findings to those within equality groups is essential in accessible formats.

Longer term:
- Monitor equality groups' use of addiction services as standard to ensure better sampling framework and indication of need
- Ensure legislation is adhered to as part of service delivery, e.g. Disability Discrimination Act (1994); Race Relations Amendment Act (2000); Sex Discrimination Act (1976).
For further information or additional copies including appropriate formats, contact: May Skelly on 201 4898 or may.skelly@gghb.scot.nhs.uk

**REPORTS AVAILABLE IN THE FOLLOWING FORMATS:**

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<th>Black and minority ethnic groups:</th>
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Sensory impairment groups:  
standard font size summary
large print summary
audio cassette summary

Gender:  
summary report

**Web:** For full black and minority ethnic report and sensory impairment report see:

http://www.show.scot.nhs.uk/ggnhsb/Depts/p+c_care/addictions/Addictions_%20home/addictions_team.htm