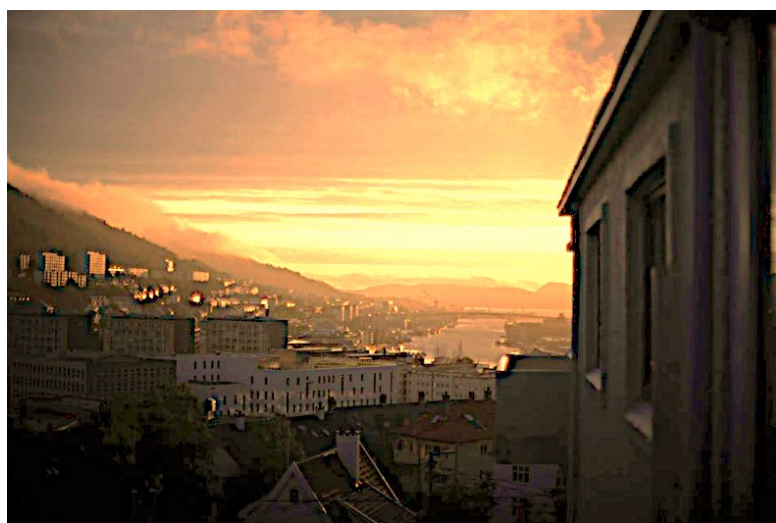


ERASMUS MUNDUS SCHOLARSHIP PROGRAMME



Slipping through our fingers:

A qualitative study into the barriers minority groups, with substance misuse problems, face accessing healthcare. From the perspective of health professionals working in Bergen, Norway.

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and Primary Care**

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September 2015

((Page 2))

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Master's thesis submitted to the Centre for International Health, University of Bergen
in partial fulfilment of the requirement for the degree of Master of Science in
International Health.

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Faculty of Medicine and Dentistry

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September 2015

Declaration

Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis:

Slipping through our fingers

A qualitative study into the barriers minority groups, with substance misuse problems, face accessing healthcare. From the perspective of health professionals working in Bergen, Norway.

is my work.

Signature and Date:



15/09/2015

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Abstract

Non-native born populations with substance misuse problems are a minority group at high risk of neglect within healthcare systems. However, there is a paucity of existing research within Scandinavia looking at this issue. This study explores the perceptions of healthcare professionals working with this marginalized group in the city of Bergen, Norway. This is a qualitative research project involving nine one-to-one interviews with health professionals in a variety of addiction services. Analysis was made via qualitative content analysis. Findings suggest that hurdles to service access include: language, organization of services, co-existing health or social issues, along with lack of patient and staff information provision. This study did not find equitable services provision for this marginalized group. More qualitative research is needed into the views of minority addiction groups along with better epidemiological data to help guide appropriate service provision.

“I have absolutely no pleasure in the stimulants in which I sometimes so madly indulge. It has not been in the pursuit of pleasure that I have periled life and reputation and reason. It has been the desperate attempt to escape from torturing memories, from a sense of insupportable loneliness and a dread of some strange impending doom.”

Edgar Allen Poe (1)

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Acronyms, Abbreviations and Translations

Akuttposten - The Acute Post (Emergency room for overdoses)

Asylmottak – Detention Centre for Asylum Seekers

Bergen Kommune Utekontakten - Bergen Community Outreach

Bergensklinikkene – The Bergen Clinics

Blå Kors - Blue Cross

Distriktpsychiatrisk Sentre (DPS) – District Psychiatry Services

GP – General Practitioner or General Practice

Helse Bergen Avdeling for Rusmedisin - Health Bergen Department for Addictions

Helsehjelp til Papirløse - Healthcare to the Paperless (Asylum seekers)

Helsestasjon - Health Station

Kirkens Bymisjon - Church City Mission

Legemiddel Assistert Rehabilitering (LAR) program - Opioid substitution program

OECD - Organisation for Economic Co-operation and Development

Politiets Utlendingsenhet (PU) - National Police Immigration Service Norway

Rus og Psykiatri (ROP) – Addiction and Psychiatry patient cohort and service.

Senter for Arbeidslivsforberedelse (ALF) - Centre for Employment Preparation

Tolk – Translation

UDI – Utlendingsforvaltningen - The Norwegian Immigration Administration.

Universitet i Bergen (UiB) - University of Bergen

Introduction

Definitions

Acculturation – “Cultural modification of an individual, group or people by adapting to or borrowing traits from another culture” (2)

Asylum seeker – “A person seeking refuge, in a nation other than his/her own.” (3)

Migrant – “A person who moves from one place to another, in order to find work or better living conditions.” (4)

Refugee – “A person who has been forced to leave their country in order to escape war, persecution, or natural disaster.” (5)

Substance Misuse – “...the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.” World Health Organization (WHO) definition. (6)

Undocumented – “Not recorded in or proved by documents.” (7)

Please note: these groups defined above will be referred to as ‘Minority Groups’ for the remainder of this document for simplicity.

Background

Minority groups with substance misuse problems are a population at high risk of neglect even within developed healthcare systems (8). This may be due to cultural or language differences; yet stigma or marginalization via the health system itself can also be the cause (8,9). These factors can be both legally mediated or via a cultural sense of mistrust (9).

The extent to which health systems are capable of dealing with marginalized populations, who may suffer from substance misuse problems, varies widely, even within Europe (8). The reasons for this include: lack of existing healthcare policies for

minority groups, insufficient financing to carry out policies and policies targeting specific areas of minority group healthcare which may not include mental health or addictions (8). Addictions are a complicated area of healthcare due to patient needs spanning across medical and psychiatric services. Whilst the right to health is advocated by international agreements, health systems are often structured with legislation or financial targets, which restricts access to particular minority groups such as asylum seekers and other undocumented migrants (8).

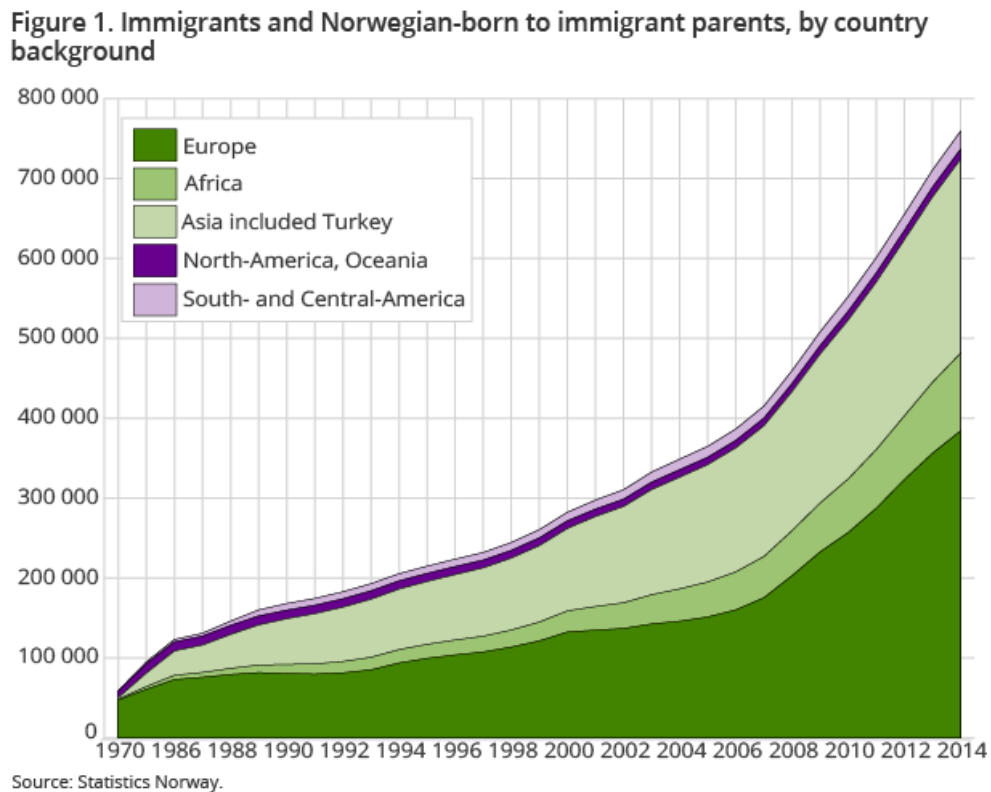
This study aims to explore what problems, documented and undocumented migrants, asylum seekers and refugees with substance misuse problems in the city of Bergen, Norway face in accessing healthcare, from the perspective of health professionals working in the city of Bergen.

Norway

Norway has a democratic approach to immigration and in the last few decades has seen a rapid growth in the number of migrants moving to the country (9). From 1992 to 2014 the number of immigrants and children born to immigrants rose from 183,000 to 759,000. This was an increase relative to the total country population from 4.3% to 14.9% (10).

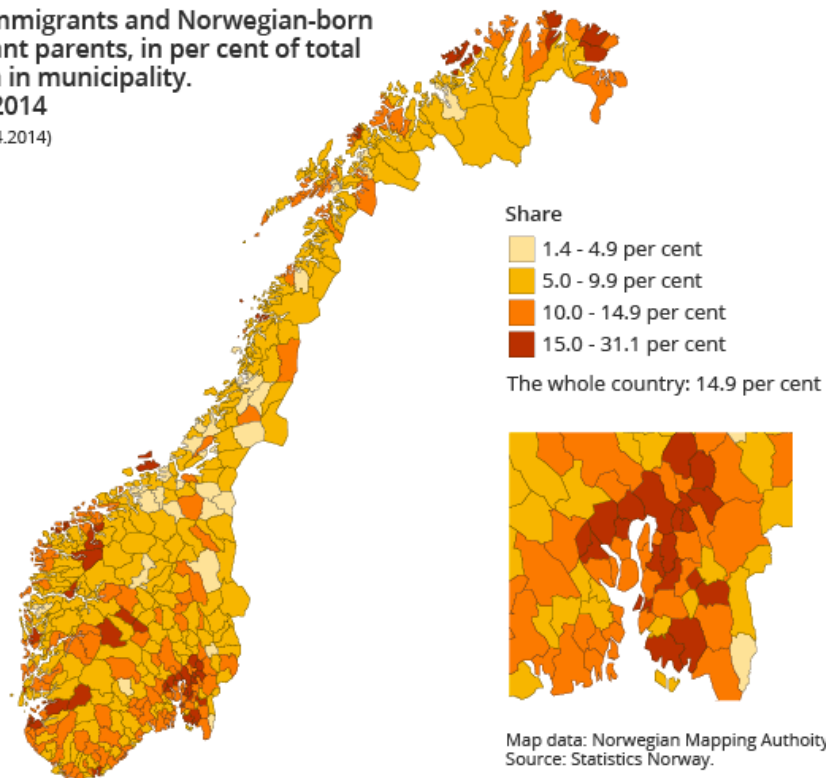
Whilst the majority of migrants moving to Norway are European, this demographic also includes large populations of African, Middle Eastern and Far Eastern individuals, see Figure 1 (10). With such rapid, relatively recent demographic change within Norway, it has been a challenge to adapt and adequately support this group within the population (11). 221 different countries and independent regions are

represented in this population. Immigrants from Poland are the largest group in this populace (10). The main concentration of this population geographically is around the cities in the south of the country; where the majority of the native population also lives, see Figure 2 (10).



[Figure 1 – Statistics Norway. Immigrants and Norwegians born to immigrant parents by world region and background from 1970 to 2014. World regions presented in the key are plotted in in the same order on the graph beginning with Europe at the bottom of the graph.] (10)

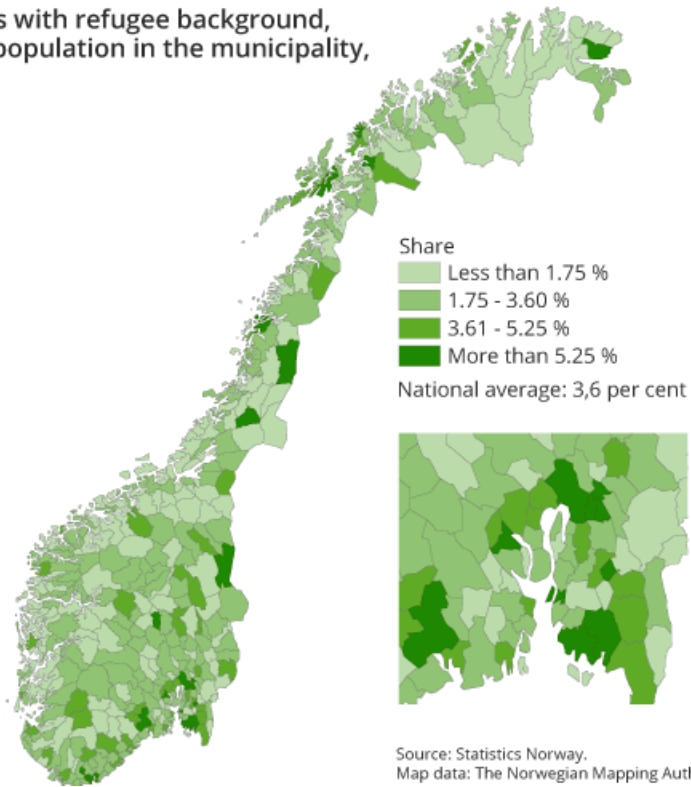
Figure 2. Immigrants and Norwegian-born to immigrant parents, in per cent of total population in municipality.
1 January 2014
(Corrected 25.04.2014)



[Figure 2 – Statistics Norway. *Immigrants and Norwegians born to immigrant parents as a percent of total population in the municipality in 2014.*] (10)

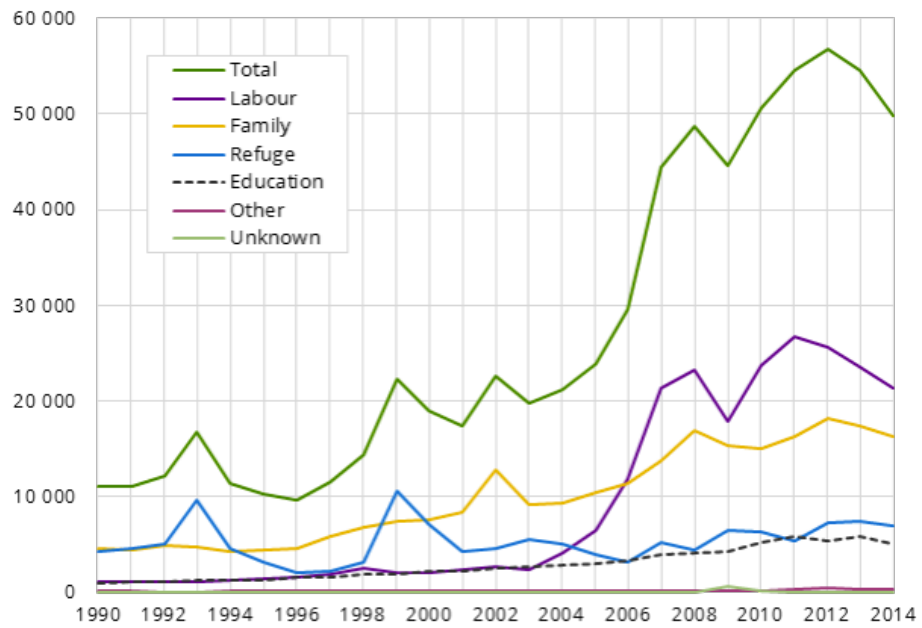
In 2014, 49,000 people immigrated to Norway with non-Nordic Citizenship. The highest increase in refugees was people arriving from Syria, when compared with the previous years' data. The population of refugees in Norway is widely distributed across the countries geography as can be seen in Figure 3 below. Currently, Norway has its lowest level of immigration since 2009 (12).

Figure 5. Persons with refugee background, portion of total population in the municipality, 1 January 2015



[Figure 3 – Statistics Norway. People with a refugee background as a proportion of the total population in the municipality in 2015.] (12)

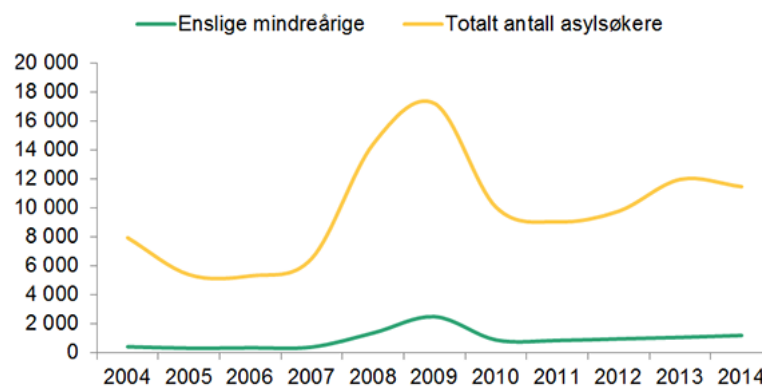
Figure 1. Immigrations, by reason for immigration



Source: Statistics Norway.

[Figure 4 – Statistics Norway. Immigration shown by reason for immigration from 1990 to 2014. Presented in the key and on the graph in order of most common reason working down the categories.] (13)

The most common reason for immigration to Norway is to work, followed by family reasons and then thirdly those seeking refuge, see Figure 4 above (13). In 2014 11,500 people sought asylum in Norway, a decrease of 4% from the previous year, a small minority of this number are unaccompanied minors see Figure 5 below (14).



[Figure 5 – Utlendingsforvaltningen (UDI) The Norwegian Immigration Administration. Graph showing total annual number of asylum seekers applying for asylum (upper line) and the number of these, who are unaccompanied minors (lower line).] (14)

The majority of asylum applications made within Norway are successful. In 2013 and 2014 Norway received approximately 12,000 applications for asylum per year (15). Of these roughly 65% of applications are successful (14). However a recent report from the National Police Immigration Service Norway (Politiets

Utlendingsenhet - PU) indicated that around 15,000 foreigners are living illegally in Norway (16).

Substance misuse

Minority groups and their families are known to be at increased risk of substance misuse (17,18,19). Whilst evidence has suggested that overall prevalence of substance abuse is higher in the Norwegian native population than among the minority groups, the use of Khat within the Somali population and drug use among adolescent immigrants is becoming an increasing problem (17). However there is only limited evidence and there could be a much larger hidden problem, particularly with minority groups being less likely to access healthcare (9,17,19).

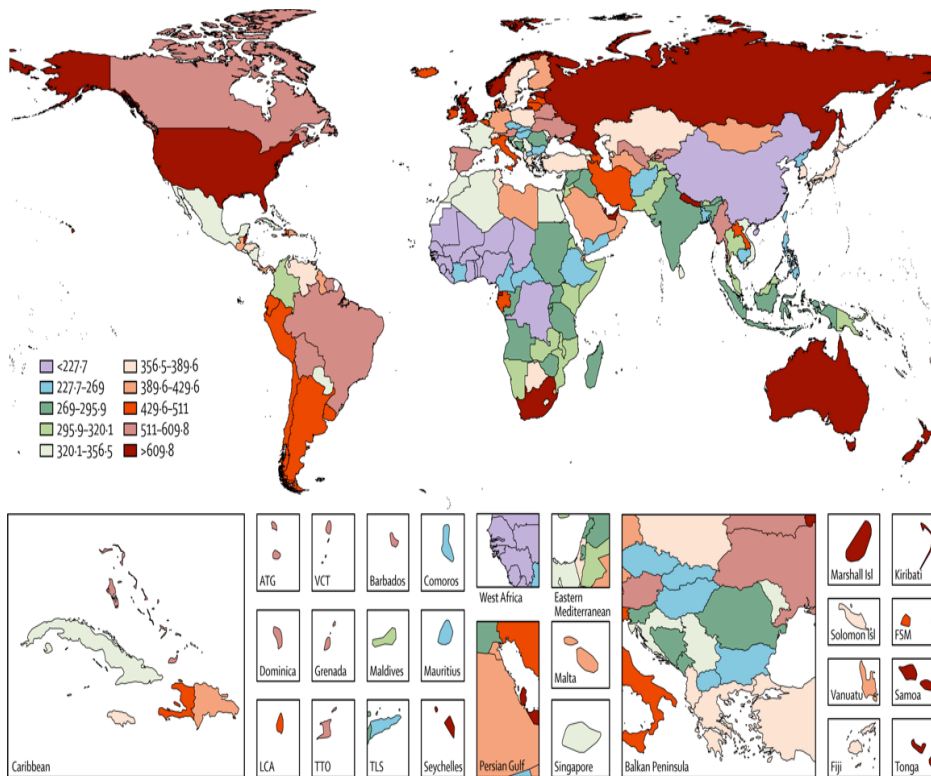
The reasons for this are thought to include, marginalization, stress, loneliness and self-medication for mental health conditions, such as depression. There may also be lack of treatment for existing substance misuse problems, due to poor access to healthcare (9,17,19). Those with no permission to stay in Norway such as undocumented asylum seekers may be at particular risk due to them having even less healthcare rights. Further, they might be at risk for being recruited into informal activities including drug dealing (20). It has been highlighted within Western Europe that migrants make up a large proportion of those selling illegal drugs (21).

In 2014, Norway had 76 deaths from overdose per million of the population which was the second highest rate in Europe after Estonia (22). Within the Norwegian drug using population, over half of the heroin use is done via injectable methods (23). In 2011 Bergen, had the largest number of drug overdoses in Europe

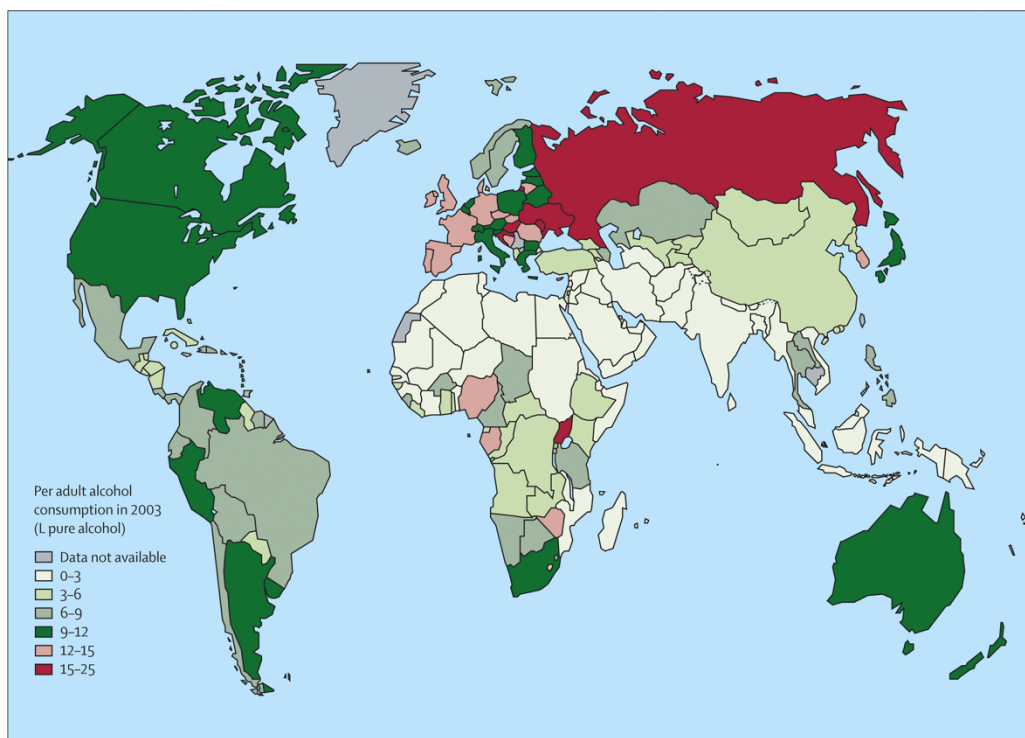
(24). Bergen also has one of the largest drug populations in Norway; the main groups using drugs are North African, Norwegian and Eastern European (25). The Bergen local authority and health service have been actively collaborating to try to tackle this problem (25).

In 2013 there was 987 people in Norway registered with the LAR program for opiate detoxification (26). It was estimated in 2008 that there are around 8,200 to 12,500 injecting drug users in Norway (27). In 2010 Police in Bergen recorded 416 drug offences made by 292 different people (28). There are obvious difficulties gaining accurate continuous figures for drug using populations due to their hard to reach nature.

Norway is noted to score poorly for age-standardised disability adjusted life years attributed to illicit alcohol use, being rated significantly higher than the global mean, see Figure 6 (29). There is also less extreme but still significant recorded and unrecorded adult consumption of alcohol compared to global trends, see Figure 7 (30).



[Figure 6 – The Lancet. Age-standardised disability-adjusted life years (DALYs) attributed to illicit drug use in 2010. Age-standardised DALYs per 100 000 population. Norway is rated High=significantly higher than the global mean.] (29)



[Figure 7 – The Lancet. Exposure to alcohol - recorded and unrecorded adult consumption by country.] (30)

Justification

Preliminary literature searching indicated there is a lack of research looking at the barriers faced accessing health services by minority groups with substance misuse problems within Norway. The findings of this study aim to generate new insight and inform health and social services within the Bergen community district and relevant stakeholders in the Norwegian health system on what problems this minority population is facing. Furthermore, it will propose ways in which this health issue can be further investigated and supported across Norway.

Aim of the Study

This study aims to explore what problems, documented and undocumented migrants, asylum seekers and refugees with substance misuse problems in the city of Bergen, Norway face in accessing healthcare, from the perspective of health professionals working in the city of Bergen.

Additional aims

- To explore what substance misuse problems the documented and undocumented migrants, asylum seeking and refugee populations in the city of Bergen experience.
- To explore the views of the professional organizations who are working with this population.
- To explore views on gender issues and social backgrounds of this population of substance misusers.
- To explore whether any disparity exists between sub groups in this minority population.
- To explore whether there is any crime, trauma, comorbidities or prostitution related to this minority group within the city of Bergen.

Literature Review

This review looked at substance misuse within minority groups in Norway and the rest of Scandinavia. The themes investigated were: substance misuse, minority groups, Norway and Scandinavia.

The search engines used were: Pubmed, Science Direct, Google Scholar, PsycINFO, Web of Knowledge and the University of Bergen article library. The first three aforementioned search engines are noted to be roughly equally effective in searching for literature on addiction research in prevention and treatment (31).

I had originally intended to just look at literature concerning Norway, but finding my results yielded just 5 articles, I decided to expand to include Scandinavia as a whole and also look at Danish and Swedish research. Justification for this is that Scandinavian countries share similar language and culture. Alcohol was included but smoking excluded in my literature review, in agreement with the World Health Organization definition of substance misuse (18).

This review looked at scientific articles published within the last 15 years and excluded research on Sami populations. This is due to the Sami being a distinct indigenous population, which has been the focus of targeted separate health inclusion campaigns within Norway (32).

This review did not include grey literature and only focused on English language, peer reviewed publications. English language literature was chosen because preliminary searching suggested the majority of the published literature was

written in English. Additionally, whilst I am able to read Norwegian to a practical level I felt I would not be able to review this literature to the equivalent standard with English literature.

Relevant articles were identified via their titles and then abstracts were reviewed to ensure only relevant articles were selected. Reference lists of selected articles were also checked to ensure further relevant publications not found via literature searching were selected. Articles had to be focused on addiction within Scandinavian countries' minority populations, including first and second generation immigrants, refugees and undocumented migrants. Articles were also quality checked using the Greenhalgh and Taylor assessment tool before final inclusion (33). See Appendix 1 for the flow diagram of the literature searching.

A total of 5 relevant articles Norwegian articles were found. In addition a total of 10 articles from the rest of Scandinavia were included, all of which came from Sweden. The research consisted mainly of cross-sectional studies along with some qualitative research.

Current research highlighted: the double marginalization of this population, the social 'pull factor' within drug scenes that can prevent minority groups seeking treatment, the two way effect of migrants upon the native population and pattern of increased cannabis use in young second generation migrants compared to the Norwegian born population. There was no existing research looking at barriers to accessing addiction services within minority populations.

Norwegian Literature Review

Adolescent drug use patterns

The first article study described is a cross-sectional study based on a Norwegian Social Research (NOVA) school based survey looking at adolescents aged 14-17 in Norway in 2015. It focused on binge drinking, cannabis and tobacco use. This study was not focused on diagnosed cases of addiction but more general patterns of substance misuse within young people. It found that significant differences existed between the substance use behaviours of ethnic Norwegian and immigrant youth. Second generation Europeans and those from the United States appeared to have the highest levels of cannabis and tobacco use and Ethnic Norwegians had the highest levels of binge drinking (34).

Significant associations were found between ethnicity, age, gender, religion, parental education, parent-adolescent relationships, mental health status, binge drinking, cannabis and tobacco use. This study highlighted patterns of lower levels of alcohol use within immigrant populations but greater use of cannabis within immigrant youth populations. When accounting for other variables, the study modelling revealed older age, being male, being in a non-Christian/Muslim group and having symptoms of depression was associated with higher odds of cannabis use. For binge drinking: older age, higher levels of parental education, greater depressive symptoms and loneliness were associated with higher odds of binge drinking. For tobacco use older age, membership of Islamic religious groups, non-religious groups and greater symptoms of depression were associated with greater levels of tobacco use (34).

This study had a large sample size of 10,934 of which 95.6% were included in the final analysis and used odds ratios with 95% confidence intervals along with statistical significance based on a p value of 0.05 or less. However this study was not randomized as it used schools as the primary sampling unit. In addition there was a great variation between the sample size of ethnic Norwegians and minority adolescents. Ethnic Scandinavians were not separated from the European population; only Norwegians were differentiated. The sample size was also too small to allow stratification by country of birth. This study highlights that a target group for intervention and outreach is the young second-generation migrants (34).

Drug scene cohesion for minority groups

The second study was ethnographic fieldwork looking at the street based drug scene in Oslo. The study highlighted that immigrants and others who may experience poor integration within other areas of society may find solidarity and a sense of community within street drug scenes (35).

The study looked mainly at immigrant men and observed that interaction within the community for drug transactions supported isolated immigrant men. Whilst this was only a small ethnographical study of 17 interviews with drug users along with participant observation and informal conversation, it did reveal useful insights, which hold external validity for other cities across Norway (35).

It was suggested that drug-using minority groups may be doubly marginalized and the sense of community they may derive from a closely-knit drug scene may act as a factor, which prevents people from seeking treatment. This suggests minority

groups with substance misuse are in need of targeted help in order to encourage them into treatment (35).

Middle Eastern minority group alcohol consumption

The third article was another cross sectional survey using The Oslo Health Study (HUBRO) conducted in 2000 to 2002 looking specifically at alcohol drinking in two generations of non-western immigrants of Middle Eastern background in Oslo. The first group was adolescents 15 to 16 years and the second middle aged to elderly 30-75 years. This study found again that ethnic Norwegians reported more frequent alcohol use than immigrants. Levels of alcohol intake differed between Middle Eastern subgroups and were noted to be higher with increased social integration and host culture competence. Interestingly longer periods of stay in Norway within first generation migrants along with increased age and female sex were associated with lower alcohol use. Conversely, increased levels of work, education or participation led to more frequent alcohol consumption (36).

This study used a youth cohort of 7343, 15 to 16 year olds with a response rate of 88.3%, a larger adult cohort of 18,770, 30 to 75 year olds with a much lower response rate of 46% and the five largest immigrant groups in Oslo a cohort of 3019 aged 20 to 60 years with a response rate of 39.7%. The analysis only looked at those born in Norway, The Islamic Republic of Iran, Pakistan and Turkey. Therefore this may be generalizable to other parts of Norway. Minority group demographics are likely to differ between cities, which may limit validity outside of Oslo. Two of the response rates: for the adult and immigrant groups were very low. Analysis was done via chi-square testing for alcohol frequency usage between groups along with a

Structural Equation Model and significance levels of 5% used along with some p values. The findings suggest that increased length of stay is protective and helps decrease frequent alcohol consumption, perhaps as a result of better cultural integration (36).

Adolescent alcohol consumption

The fourth article looked at alcohol consumption within first and second generation non-Western minorities in Oslo. This was a cross sectional school survey of adolescents in Oslo via the Oslo Health Study during 2000 and 2001. The population was a total of 8361 students with a response rate of 88.3%. Within the sample 1213 students were from an immigrant background and 4627 had a Norwegian background (37).

The findings suggested a two-way influence upon alcohol use by minority populations related to length of stay. Short stay was associated with less common alcohol consumption amongst immigrant students where there were a large proportion of Muslim students in school. Conversely native Norwegian students were more likely to abstain from alcohol or drink less frequently if the proportion of Muslim students was greater in their school. Analysis was done with T tests and significance levels at 5%, 1% and 0.1% were highlighted within the relevant results. There was also adjusted two level logistic regression analysis between people and schools to account for possible dependency relationships. This study suggests that short stay migrants were less likely to consume alcohol and perhaps the more integrated they become, the more alcohol intake will increase. The article also suggests that large

minority populations in school exert an influence upon the alcohol habits of native Norwegians (37).

Minority groups' experiences of substance misuse in Norway

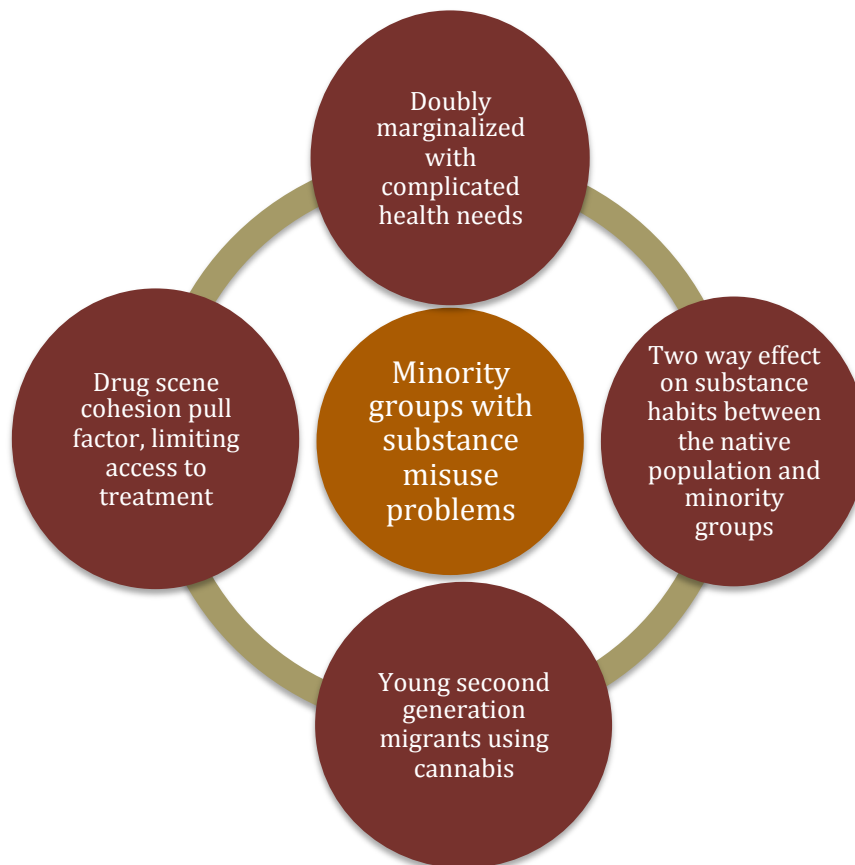
The final study was a phenomenological-hermeneutic qualitative study interviewing 4 migrant men, aged between 20 and 40 years of age who had previously used illegal substances. This study explored both substance misuse and suicidal behaviour. The main theme found was "*living in a maze*" which described both their experiences of immigration, substance misuse and suicidal behaviour. Issues raised by the men centred on insecurity in life along with a sense of lack of belonging, unclear identity and external conflicts. Whilst only being a small exploratory study it raised some useful themes regarding why minorities may be struggling to access healthcare. The study indicates that minority groups with substance misuse problems are a complicated vulnerable population with multiple treatment needs (38).

Literature discussion

Figure 8 shows a model of the key Norwegian literature findings. These are the four main issues that surround minority groups with substance misuse problems, which emerged from the literature.

This population is doubly marginalized within the general Norwegian population. Young second generation migrants were highlighted as being particularly at risk of cannabis use. Minorities also experienced social cohesion within drug communities which may limit how likely they are to seek treatment. In addition

substance misuse habits appear to influence the native population with a two-way effect. Minority groups are influenced by the substance misuse habits of the native population, but minority populations can also influence the habits of the native Norwegian population.



[Figure 8 - Model of the key Norwegian literature findings.]

These five studies were based on research in around the capital in Eastern Norway, which has the most ethnically diverse city in Norway, however the findings do still hold relevance for cities such as Bergen with similar drug scenes and a significant minority population.

There is a lack of research on barriers to accessing health services for minority groups with substance misuse problems. There is limited existing published

literature on addiction health problems within marginalized minority groups within Norway, only five articles were found in this literature search. This may in part be due to the difficulty in characterization of addictions within healthcare, as it falls awkwardly between medical and psychiatric disciplines. Norway has strived to address this and has become the first country to introduce the standalone healthcare specialty for doctors in Rusmedisin (Addiction Medicine) (39).

Whilst addiction is a psychiatric health disorder, it is to be noted that studies looking at mental health problems within immigrant populations, often do not subclassify addiction problems within their research (40,41). The scarcity of knowledge may also be explained by the relatively short period of high volume immigration to Norway compared to other European countries (39). From 1970 to 2012 the number of immigrants moving to Norway, including second generations born to immigrant parents, rose from 57,041 to 710,465 (42).

Researchers in Norway, with conflicting results, have looked at immigrant use of primary care and emergency services. A study in Oslo suggested wide variation in emergency service utilization between different minority populations but a general trend describing these populations as more likely than the native population to use the emergency services over routine primary healthcare (43). Another study looking nationally again found variation between minority subgroups but showed that immigrants utilized emergency primary healthcare less than native Norwegians (44).

This variation in minority group participation has also been noted in a qualitative research study interviewing leaders of Norwegian minority group

organizations. This study highlighted: duration of stay, country of origin, reason for migration, health literacy, level of permanence of stay in Norway, language proficiency and comprehension of information as factors influencing how well minority groups access general practice services along with patient doctor communication (45).

There is also no literature looking at the difficult issue of 'paperless' migrants who do not have rights to access non-emergency healthcare. Not only is the population poorly understood demographically but also it is likely some will be accessing emergency services for addiction related health problems however they are not subsequently referred on for further treatment. This raises the issue of cost benefit, not treating these cases may cost less in the short term but chronic illness resulting from untreated addiction related problems might lead to much greater healthcare cost in the future.

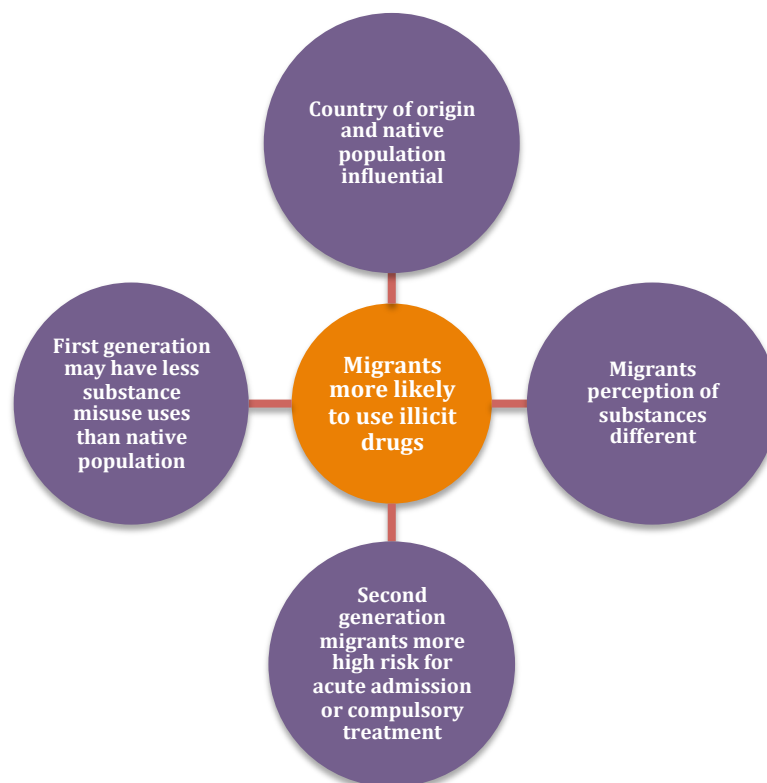
The short but high volume migration history in Norway may now place greater pressure upon health services to deliver care in an adequate manner that provides more equal access to minorities with substance misuse problems. The demographics of addiction problems in minority groups appear to vary in age and ethnicity. Cannabis appears to be more prevalent in young adults and alcoholism is seldom seen within the Muslim community. It is worrying that despite the clearly growing ethnic diversity within Norwegian society there is still a lack of research on minority group substance misuse and how this population are accessing health services.

Further Scandinavian Studies

Studies looking outside of Norway but within Scandinavia only came from Sweden. No Danish research was found on this topic. Research mostly focused on alcohol and first and second-generation migrant substance use, peer effect and hospitalization.

Literature review model from the rest of Scandinavia

Figure 9 shows a model of the key literature findings from the rest of Scandinavia. It shows the key factors the literature highlighted to be stemming from minority groups being more likely to use illicit drugs.



[Figure 9 - Model of the key literature findings from the rest of Scandinavia.]

One study looked at first and second generation immigrants to Sweden. It used a register study of 1.23 million children born in 1968 to 1979 and 1.47 million adults born in 1929 to 1965 using multivariate analysis of demographic data. It found that the country of origin was highly determinant for alcohol disorders but that second generation immigrants are more influenced by both their parents' country of origin and also the native population. Within Sweden the Finnish population was highlighted for being at particular risk of alcohol disorders. Other populations such as first and second-generation migrants from Europe, Middle East and other non-European countries were at lower risk of alcohol-related disorders than the native Swedish population. The focus of the study on Finnish migrants is less relevant to Norway due to there being fewer Finnish migrants compared to Sweden. However the differences between first and second-generation immigrants suggest native populations are much more influential on the drinking habits of second-generation migrants which holds relevance for this population in Norway (46).

In contrast to this, a recent study from a 2010 survey, with multiple level logistic regression on a sample of 13,070 adolescents, found that all immigrant groups were more likely to use illicit drugs than the native population and was highest in Nordic and non-European migrant populations. Alcohol use problems were mainly noted to be more problematic within second-generation Nordic immigrants in Sweden. This study highlights that immigrant groups are in need of targeted substance misuse outreach for treatment (47).

A third study looked at peer effects of alcohol use between the native and immigrant adolescent populations in Sweden. This was based upon a 2005

adolescent survey of 13,070 participants and used a multiple level logistic model. This found that the majority native population had a peer effect upon native Swedish and immigrant populations from Nordic or European countries but not upon those from non European countries. This suggests that peer effects are more influential between more similar cultures for example within Europe, than between distinctive cultures (48).

Looking more specifically at illicit drug use in second generation immigrants a register study with cox analysis and proportional hazards looked at a national cohort of 1.25 million residents aged 10 to 30 years of age. This found that second generation immigrants had a two to three times higher risk of hospital admission due to illicit drugs compared to the Swedish native population with limited variation between different ethnic groups. This agrees with previously discussed studies that second generation migrants are a group at particular risk of substance misuse issues (49).

Another study looked again at hospitalization for alcohol and drug abuse within the immigrant population in a cohort follow up study of 2,243,546 people aged 20 to 39 followed from 1992 to 1999. Hazard ratios were calculated using a Cox regression model which revealed again that Finnish migrants both first and second generation were highest risk for hospitalization. This study did not look in further demographic detail at other immigrant populations but did show that first generation immigrants were at lower risk of hospital admission than the native population. Again the focus on Finnish migrants is less relevant for this literature study (50).

A Swedish phenomenographic study, interviewing 14 men and women, looked at Khat use amongst Somali immigrants to explore the perceptions of the drugs use within the community. It found that Khat was often perceived as a kind of food or drug and so may not be perceived by this migrant community as something with a negative impact on health. This raises interesting questions about how both illicit and legal drugs are perceived by minority populations in Scandinavia and may be important for helping to focus health interventions based around patient education (51).

A cross-sectional study looked at the association between immigrant status and history of compulsory treatment for substance abuse disorders. This sample of 13,903 individuals from the Swedish welfare system between 2002 and 2008 found that second generation immigrants with non-Scandinavian parents were 41% more likely to have had compulsory treatment. This was a study using logistical regression and controlling for: age, gender, education, mental health treatment, homeless status history and criminal justice history. This paper supports the argument that culture outreach needs to be targeted and that second generation migrants are an at risk population (52).

Alongside this a Swedish study looked at hospitalization due to drug and alcohol abuse in first and second generation immigrants within a group of 2,243,546 between the ages of 20 and 39. Whilst highlighting high levels of alcohol and drug abuse in the Finnish population, other immigrant groups were noted to be equal to or lower in substance misuse than the native population. First generation immigrants were noted to be lower risk than the native population but a large proportion of this

group 20% were noted to be Muslim and so none-users of alcohol. As mentioned before Finnish results are less useful in a Norwegian context but other findings contrast some of the other papers discussed which state immigrant groups had higher substance misuse than the native population (53).

Another is a study of 2000 immigrants and refugees between the ages of 20 and 44 arriving in Sweden between 1980 and 1989. It suggests strong associations between ethnicity and long standing psychiatric mental illness, along with psychotropic drug use. Protective factors appeared to be marital status, decreased acculturation, employment and increased levels of self-perceived coherence. These findings support the need for outreach to help avert both substance misuse and mental health issues which can co-exist in vulnerable minority group patients poorly integrated into new societies (54).

The final study described here found that female migrants are at risk of alcohol consumption issues. This was a postal survey of 10,766 women aged 50 to 59 living in southern Sweden. Heavy drinking was found to be more common in non-Nordic immigrants, immigrating at a younger age. European immigrants were less often alcohol consumers. This suggests acculturation problems may be affecting older migrants more and European female migrants may have less alcohol issues than males (55).

There is also a deficit of research within Scandinavia looking at migrant substance misuse; it was not possible to find any existing Danish literature. There is a clear pattern of increased risk for alcohol and illicit drug use within second-

generation immigrants, which presents a clear area for targeted intervention. Within Sweden the Finnish population has been highlighted as at high risk of alcohol related health problems.

In conclusion, the literature review reveals that there is firstly a lack of research within Norway and the rest of Scandinavia looking at barriers of access to health service. Secondly, within Norway research highlighted that migrants, in particular second generation, were more at risk of substance misuse. Thirdly this doubly marginalized group may also be less likely to seek support as they are relying on social networks, which exist through drug using communities. Fourthly, migrants are both influenced by the native populations substance misuse use habits and they themselves in turn influence the native population. Additionally the other Scandinavian literature revealed no Danish results but the Swedish literature agreed with some of the Norwegian findings as well as suggesting that fifthly, migrant perception of substance misuse differs from the general population and that the country of origin is highly influential in substance misuse patterns.

Methodology

Study design

Data collection was made through one-to-one semi structured interviews in English or Norwegian. The interview subjects were professionals working for organizations dealing with minority groups with substance misuse problems. The fieldwork period for interviews was for two months during May and June 2015.

Initially it was intended to use two different groups of informants. Firstly using semi-structured interviews with professionals working in organizations that help minority groups with substance misuse. See Appendix 2 for the interview guide questions. These informants and organizations would then be used to recruit the second group of informants, substance misuse clients themselves via a snowball style of recruitment. The second group of informants would be non-Norwegian born first or second generation documented and undocumented migrants, asylum seekers and refugees who have experienced substance misuse problems in Bergen.

They would also have semi-structured interviews with similar questions. The second groups of informants would also be used to find minority group drug users that are not in touch with the organizations and health system.

However during recruitment it was only possible to find health professionals willing to be interviewees. In total, nine interviews with health professionals from a variety of services were held. This is a qualitative research study conducted between March and September 2015; see Appendix 3 for the research timeline.

Study setting

The study setting was the city of Bergen, the second largest city in Norway. Recruitment for interviewees was made via contacting local organizations working with substance misusers and minority group healthcare in the city.

Sampling and recruitment of informants

Interviewees were collected via ground level purposive and convenience sampling. Based on previous qualitative research this sample size is deemed adequate to give sufficient data saturation and variance given the time available for a single researcher to conduct this research for a master thesis (56). Interviewees were male and female adults, above the age of eighteen. The informants were professionals working with substance misusers and minority group healthcare in the city of Bergen. 'Snow-ball' recruitment was used to access further relevant health professionals.

Recruitment took place through health services including:

- Akuttposten (The Acute Post)
- Bergen Kommune Utekontakten (Bergen Community Outreach)
- Bergensklinikkene (Bergen Clinics)
- Blå Kors (Blue Cross)
- Helse Bergen Avdeling for Rusmedisin (Addiction Medicine Department)
- Helsestasjon (Health Station)
- Helsehjelp til Papirløse (Healthcare to the Paperless)
- Kirkens Bymisjon (The Church City Mission)

- Senter for Arbeidslivsforberedelse ALF (Centre for Employment Preparation)
- University of Bergen

Information and consent forms were available in English and Norwegian.

Interviews were also conducted in English and Norwegian. In the event of any translation being required, funding had been allocated for this, however this was not needed.

Data collection methods

Semi-structured interviews were conducted with the organizational staff at the various centres. These were recorded with a dictaphone and deleted after transcribing. Formal informed written consent was obtained before interviewing. The interviews were roughly one hour in length. They were conducted in English and Norwegian and then transcribed to English if required. Interviewing took place in the facilities of the organization from which the interviewee has been recruited, or alternatively a convenient private location.

Analytical approach

Interviews were recorded and then transcribed into English verbatim transcripts using Microsoft Word. Microsoft Excel was used to ease qualitative content analysis. The transcribed interviews were allocated to cells according to meaning units. Thus close text meaning units were then created, followed by meaning units interpreting the underlying text, coding was then made followed by categorization and overall themes determined. This process is in line with the

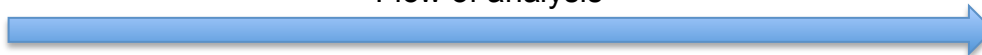
accepted methods of condensation of manifest data for qualitative research, allowing the research to then interpret the key issues raised from the interviews (57).

Below is an example of the data analysis Table A and the list of themes in Table B.

[Table A – Example of interview data analysis with excerpts from two interviews.]

Interview	Meaning Unit	Condensed meaning unit close to text	Condensed meaning unit interpretation of underlying text	Codes	Themes
INT A	<i>I have also seen individuals that say that it has been very negative [their experiences of healthcare] and I think that, that is primarily due to being confused and things not being the way they thought they were</i>	Confusing health system, patient knowledge	Patients need more information	knowledge	1, 4
INT I	<i>Working legal and illegal eastern European workers using alcohol [migrants seen in service]. We've also have refugee patients with traumatic backgrounds from warzone countries using heroin. But often it is difficult to get this information with short stay patients that have not been here that long as they will not talk until they feel safe</i>	Vulnerable patients, paperless migrants, trauma, lack of trust	Migrants can be difficult to contact. Coexisting health and social issues. Specific migrant populations, eastern European patients, warzone patients using hard drugs, staff not gaining patient trust, need outreach, staff need to gain patient trust	contact, complicated, lack	1,2,4

Flow of analysis



[Table B – Results theme categories.]

Results Theme Categories	
1	Hurdles preventing minority groups accessing effective care
2	Marginalised subgroups within this population
3	Invisibility of this population within the system
4	Disparity between minority groups and the native population

The theme categories listed above are those, which emerged during the process of data analysis. The themes highlight a variety of issues: hurdles to accessing care, marginalisation of subgroups, invisibility within the health system and disparity between minority groups and the native population.

About the researcher

I am a junior doctor from the United Kingdom studying a Masters of International Health at the University of Bergen. I have an interest in drug addiction and social determinants of health. I have worked within addiction services as a doctor in Mersey Care NHS Trust, Liverpool. I therefore have prior perspective on the UK addiction services. During the study, being a UK student in Norway, I was myself a migrant with a migrant's perspective on the healthcare system. My personal view on healthcare is based upon an English system that is, free at the point of access, in a country with a longer history of significant levels of multiculturalism within the population as a result of its extensive trade links during the empire period. Therefore one clear bias is that I am not used to a system which charges patients for doctor consultations as exists in Norway.

The style of analysis used was Inductive Analysis as this provides a logical method for reflecting upon frequently reported patterns within the single method of data collection chosen (58). This was then compared with the results from the literature review in the discussion.

Ethical considerations

All interview information was anonymized; written informed consent was obtained before interviews commenced. All interviewees had the right to withdraw at anytime and the right to request information from the study after completion. No sensitive personal issues were discussed in the interviews and interviews did not discuss specific client cases professionals had worked with. Before commencing the study ethical approval was gained from the Regional Committee for Medical and

Health Research Ethics (Regionale Komiteer for Medisinsk og Helsefaglig Forskningsetikk REK) reference 2015/550/REK. See Appendix 4 for the details of ethical approval subject to the small amendments including the wording of the interview guide.

In line with the Helsinki Declaration special consideration was being paid to the vulnerable minority populations being discussed, in order to ensure their protection (59). Interviewees only discussed specific cases with the patients anonymized.

Funding

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Results

Participation

Only a selection of contacted organizations agreed to participate. The main reason given almost unanimously for all organizations choosing not to contribute to the research was a lack of experience working with this patient group. This finding suggests that minority groups with substance misuse problems were not being adequately represented in various services in the city of Bergen.

Organizations are listed below in Table C with their participation status and reason for non-participation, if relevant. Norwegian names are given with the English translation in brackets.

[Table C - Organization Participation Information.]

Organization	Participation	Non-participation	Reason for non participation
Akuttposten (Emergency room for overdoses)	x		
Bergensklinikkene (The Bergen Clinics)	x		
Distriktpsychiatrisk Sentre DPS (District Psychiatry Services)	x		
Helse Bergen Avdeling for Rusmedisin (Bergen Department for Addictions)	x		
Universitet i Bergen UiB (University of Bergen)	x		
Bergen Kommune Utekontakten (Bergen Community Outreach)		x	Not seeing enough of these patients to comment
Blå Kors (Blue Cross)		x	Stated not dealing with this patient group
Helsehjelp til Papirløse (Healthcare to the Asylum seekers)		x	Not seeing enough of these patients to comment
Helsestasjon (Health Station)		x	Not seeing enough of these patients to comment
Kirkens Bymisjon (Church City Mission)		x	Not seeing enough of these patients to comment
Senter for Arbeidslivsforberedelse ALF (Centre for Employment Preparation)		x	No response

Service Users

Despite the limited timeframe, I had the potential to interview four migrants who were provisionally recruited from three of the organizations where I interviewed professionals. Unfortunately two of these subsequently declined to take part, one did not attend their scheduled appointment on two occasions and the final migrant left the department before the interview was able to take place. The difficulty I experienced accessing the minority group service users was limited by my time frame however the repeated problems accessing potential interviewees highlights the 'hard to reach' nature of this client group.

Interviewees

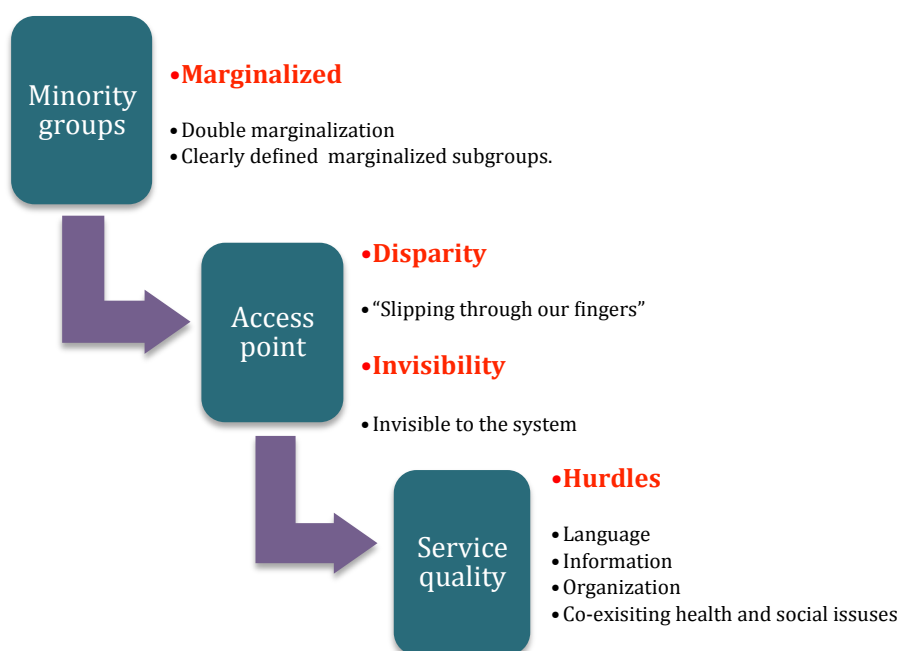
The nine interviewees came from a range of first and second line services. In order to protect confidentiality they are described, by profession and whether they work in first or second line services. One doctor worked across both first line and second line public healthcare services. Three of the staff were currently working in first line services and six were currently working in second line services at the time of the interviews. Seven of the interviewees were female and two were male. There were five native-born interviewees and four non-Norwegian born. The professionals interviewed were doctors, psychologists, nurses and counsellors, some of who had research and leadership capacities in addition.

The sample therefore contains a highly varied sample of professionals working directly with minority groups with substance misuse problems in a variety of public healthcare services, see Table D below for the breakdown of interviewee information.

[Table D - Interviewee Backgrounds: Gender, healthcare sector level and profession.]

Interview Code	Description of Interviewee
A	Female Foreign Psychologist second line service
B	Female Norwegian Counsellor second line service
C	Female Foreign GP/Associate Professor first line care
D	Female Norwegian Addictions Specialist/GP second line care
E	Female Norwegian Addiction Nurse second line service
F	Male Norwegian Psychologist second line service
G	Female Foreign Addiction nurse second line service
H	Male Scandinavian Doctor specializing in addiction
I	Female Norwegian Addiction Nurse/Team Leader acute care

Factors, key themes and sub themes



[Figure 10 - Overview model developed from the interview data. The boxes represent key factors in minority group treatment for substance misuse problems. Relating to the specific key factors are themes represented as large bullet points and subthemes represented as smaller bullet points.]

The three main factors identified as determining minority group access to addiction services are the specific minority group, access point to service and quality of the service. Through the analysis process the four major themes that evolved have been defined as 'marginalisation', 'disparity', 'invisibility', and 'hurdles' and within these are further sub themes. These are now explored in further detail.

Marginalization

One observation made by an interviewee was the doubly marginalized nature of the minority groups suffering addiction populations. As separate factors, being a minority group or a drug addict alone is a situation that has the potential to isolate individuals but both factors together have the potential to create an even greater problem.

This double marginalisation was described as a 'double pity' for some people contrasting the more successful in terms of social and working life. A doctor working in services noted *'it looks to me that some, those with some degree of success, manage to integrate, get a job, get a good place to live, have a family and have the language. They also have resources to seek and get help but it is a double pity for those who do not manage to.'* This comment appears to reinforce the need for outreach to minority groups that are struggling to connect with the health service.

The most important reason for this contrast was understood as 'why' people migrate: *'what we see in research it is not where you come from it is big issues around why, if you come here to work or to study or marry or if you come here because you are escaping from something and I guess when it comes to mental*

health and addictions that it is more important'. The comment alludes to co-existing health and social problems that these patients may be suffering from. Co-morbidities whether physical or mental health problems need to be identified in order to be effectively treated. However minority groups may find it difficult to articulate these problems in order for them to be addressed.

It was furthered implied that those who remained doubly marginalised were more vulnerable to remain addicted due to a sense of social belonging among the minority group drug users, as highlighted by a psychologist in the second line service: *'I have talked to some patients that say that quitting would be next to impossible but that drinking with their friends is an activity that they can't stop because of how they connect socially.'* Whilst the social community pull factor discussed here was around alcohol this situation is likely to be relevant in the wider drug community. This also indicates that services need to try to reach out to minority groups who may be unwilling to stop using substances partly because of the sense of community they feel they may lose.

The same community embracing the minority group drug users and maintaining their addictions also served as a comforting zone against a more hostile public environment *'to be away from home, its very painful and the further away you are and more difficulty you have with language, can be quite traumatic to not understand or be understood, and there is also a lot of racism in Norway which is a very particular kind, it is a very mild superiority, maybe because we are high on the OECD (Organisation for Economic Co-operation and Development) ranking for places to live'*. This comment by a second line service psychologist suggests that

within the Bergen context, the public perception of minority groups might be contributing to their marginalization. It may be that the cultural attitude towards minority groups in Norway needs be addressed in the steps towards encouraging inclusivity of this marginalized population.

Minority groups with substance misuse issues are a population at high risk of marginalization both due to their minority status and their health issues. In order to combat this problem, at risk individuals need to be effectively identified, reached out to, have their health problems comprehensively addressed and also be supported by the health service and wider society.

Clearly defined marginalized subgroups within this population.

The interviews revealed a variety of minority subgroups that were observed to be particularly at risk of neglect by the health system. The interviewees revealed a variety of reasons for certain groups being particularly marginalized. These included cultural differences; trust problems with health professionals along with system mediated factors preventing some patients from receiving second line care. The specific groups described during the interviews are listed below:

- 'Paperless' migrants
- Romanians
- Eastern European, in particular the Polish population
- Female minorities
- Rus og Psykiatri patients (Addiction and Psychiatry)
- Older aged minorities

- Africa, in particular North Africa
- Middle East
- Asian countries, in particular China
- Latin Americans
- Poor minority groups

One of the most obvious focuses within the interviews was marginalized 'paperless' migrants. A doctor in the first line service pointed out how precarious their treatment options can be. *'I haven't seen so many refugees, I have met one refugee but it wasn't acute it was from the Legemiddel Assisteret Rehabilitering (LAR) program (opioid substitution program) but we said we will not treat him because if we [the Norwegian government] want to send him back he wouldn't get treatment'* This precarious access to treatment can lead to these patients being neglected and lost from the system. They may also re-present later much more seriously ill due to lack of treatment.

It was highlighted that the African and Asian community sometimes struggle because of cultural differences in how healthcare staff are perceived. In order to help these individuals their lack of trust needs to be overcome. *'most of these people from Africa or Asia...if they need an interpreter there are several communities that may not trust if this information is going to be spread around or not [the information given to the doctor].'* This comment from a first line service doctor indicates that some communities lack trust in health professionals. This may be due to bad experiences in their home culture and may restrict how open and cooperative they will be in the Norwegian system.

It was also described that some of the minority groups within Bergen are much less open to healthcare intervention for addiction problems and may seek help first within their own community. *'those from Somalia, they very much tend to keep to themselves but also Sri Lanka for instance, they have their markets, their places, if you know them. If you know these days in this week they will meet very many of them. Latin Americans for instance they have their own parties and meetings, probably many groups. They will ask inside the group if they ask at all'*. This observation by a first line doctor illustrates that cultural differences may mean that certain minority groups will treat themselves within their own community first rather than seeking healthcare assistance. These groups could benefit greatly from outreach support to encourage more use of the health service in Bergen.

Difficulties were also highlighted in the ability for patients to express themselves talking about their problems, again partly due to a lack of trust. They also suggested that the older population may be struggling more in asking for help. One case example was from the Middle East: *'One patient I have had from Iran had problems with addiction over a number of years and never had any complaints and was never demanding anything but also found it very difficult to open up and talk through difficulties because he felt it more difficult to feel safe in treatment. The young are much more open to help than the older population and are more likely to ask for help I have found.'* This comment by a second line service nurse highlights both the issue of trust preventing treatment but also that older minorities may struggle more than younger, perhaps better-integrated minorities.

Another at risk group for marginalization, discussed by several interviewees, were Dual Diagnosis patients, most likely in patients coming with history of traumas. *'the Rus og Psykiatri (ROP) patients have had post-traumatic and addiction problems'* mentioned here by a second line service nurse who also gave examples of geographical origins for this group: *'The Middle Eastern and North African populations have come with war related mental health problems.'* This group present bigger challenges for treatment due to comorbidities but also need to be effectively identified which may prove difficult with patients who have poor language skills or lack of trust in the healthcare system.

Worryingly there was also evidence that minority groups left untreated were developing new addiction problems whilst in Norway. *'We had one patient that actually started using drugs in the Asymottak (detention centre for asylum seekers), he was actually trying to treat his disorders and learnt how to smoke heroin whilst in the asylum centre, applying for asylum, so he was here illegally but he had starting taking drugs while he was waiting, so we felt it was a shame that he didn't get any treatment for his post traumatic stress disorder, he treated it himself with drugs, he was from a warzone I think, most of them seem quite poor and uneducated, we haven't seen any migrants from high income educated sectors.'* The worrying example described by a second line nurse highlights the vulnerability of this population and the potential consequences of leaving comorbidities left untreated.

With regards to language barriers leading to marginalization, the Chinese population was mentioned by a second line service nurse *'The Chinese population has also been a problem because they speak so many different dialects of*

Chinese... It has also been difficult with Chinese patients when their dialects are very difficult to find good translation for them.' Whilst in general the provision of languages was described as adequate, some less common Chinese dialects pose challenges for translation services.

One population highlighted multiple times during the interviews was the Romanian population; it was unclear however whether they were under presenting to addiction services. A first line doctor stated *'What I haven't seen is Romanian people despite them being quite obvious in the city begging, either they help themselves or they aren't in the same group of addicts in the city, even though we see them sleeping on the street...We never see Roman patients, is it because they never overdose, or never binge drink or because they don't want to come I'm not sure'*

Various other interviewees also spoke in agreement with the previous statement: *'people that come from Romania they have a particularly bad time.'* remarked a second line service counsellor. Along with a second line service nurse who observed: *'I think some groups are more marginalized than others and one in particular is the Roman migrants'*. Whilst these are worker's opinions this group may need to become a focus for research identifying if they are indeed underrepresented in services.

The eastern European population was also highlighted as a particularly struggling group by a first line doctor: *'Eastern Europeans maybe try and stop drinking slowly at home, but it is dangerous because they can get delirium and then they come to us.'* This group which includes the Polish population, who are the

largest minority group in Norway, seem mainly to present to services with acute alcohol problems. It may be that this group is using not enough second line care as interviewees often described them as repeat presenting patients in the acute first line service.

A potentially very large, hidden population is the under represented female population that many interviews pointed towards. A first line service nurse highlighted the stark gap she perceived. *'We see less women in the migrant group. In Norwegians we see 3/4 men and 1/4 women roughly but in migrants we see much fewer women than that, maybe 99% are men. I think there must be many more migrants and women in particular in the city needing treatment. But only acute intoxications come to us. With women we usually see poly drug use and heroin. Most of the female migrants are European, some from African and Asia also but much less.'*

A second line service Norwegian Nurse also agreed with this perception: *'I get the impression sometimes women are less likely to present unless they have a more serious addiction problem'*. It was clear from the interviewees that women in particular across many sub groups of minorities are not presenting to the service. More research is needed to identify how big this disparity is and why they are not accessing services.

Finally, another observation about the differences of minority groups with addiction problems to native Norwegian addicts was noted by a first line doctor with migrant health research interests: *'What I have definitely not seen is the high income*

level, just for fun addiction problems, I have never seen that. It is more like low income poverty, no social contact profile'. This comment implies that most of the minority group addiction patients being seen are from middle or lower class backgrounds.

A variety of groups have been highlighted as more marginalized than others and the reasons vary between these populations. More research is needed to look at the groups struggling most, in particular the female population, Romanian, Eastern European and 'paperless' patients.

Disparity

Minority groups with addiction problems were considered as a population that *'slip easily through our fingers'*. This was an overarching theme that emerged from the interview data and the quote was given by one of the interviewees, a doctor working in second line services. Minorities with addiction problems were highlighted as individuals that were often well known to the health services. A sentiment of inadequate care provision; both in terms of number of people seen, along with quality and quantity of services provided to the individuals they reached, was clearly articulated. The general consensus among all nine interviewees was that more could, and should be done to help bring this population in to treatment.

Of particular significance was the fact that first line health personnel felt they were seeing too few cases from this patient group, and informants in the second line service repeated this. Another interviewee, a psychologist working in second line services noted that they felt they had seen: *'less migrants with addiction problems*

presenting to the service than there are in reality in the community, I checked with my co-workers and they agree’.

It is important to note that a key aspect of the health provision for addiction problems, in Bergen and Norway as a whole, is that emergency care is free to all regardless of status. However, follow up treatment for chronic disease is only available to officially registered individuals not ‘paperless’ migrants. Alongside this, the disparity described appeared to be particularly related to a lack of patients in second line services.

First line workers described patients who often do not know about the service and are brought by other people when intoxicated. *‘Not everyone that comes to the “Legevakt” (Emergency Room) knew about the service, some are just picked up by the ambulance or brought by other people, and didn’t know about the service.’* A first line service doctor raised this point. It is clear therefore some of the first line patients are not actively seeking care but being brought by others recognizing their acute illness.

Alongside this difference between first and second services was the suggestion that minority groups’ perceptions of services may effect where they are choosing to access them. A counsellor from a second line service commented that *‘they think they will come through the “Legevakt” (Emergency Room) faster [than the second line service]’* when discussing perceptions minority groups held about addiction services. Thus, a general finding from the data was a disparity within the

minority groups using the addition services, particularly in the second line services that could be related both to the actions of the service and patient choices.

Those interviewees in the first line services with experience of this patient group also felt they lost patients easily. In addition to this, the acute first line service struggles with the same patients repeat presenting. *'Most of the patients we have are people who are coming again and again anyway'* explained a first line doctor. Focus is needed to ensure this problem group of repeat presenting patients is brought through to second line services, if they are eligible.

Invisibility

As a consequence of minority populations being underrepresented in the health system, the patient group were thus not visible to the system and in part, system factors were responsible for that. A key quote described how the current healthcare system is making this population less visible due to the way in which services are organized. A doctor working in the first line services talking about minority groups stated: *'They are made invisible by the system'*. This was particularly in relation to 'paperless' migrants, who suffer from fewer rights than the minority populations who have official registration in Norway.

One insightful observation was given by a nurse working in second services: *'There is a problem with acute patients not being able to come through to the next line of services who are 'paperless' migrants, but that is a difficult situation, as some are not entitled to care. There is also a problem with patients coming in through the GP services as maybe more should come through this way but are not accessing the*

GP services. The acute post is just for withdrawal stabilization and then they go home again so if they do not come into the system then there is a dance-round where they keep repeat appearing at the acute post.' This comment suggests two points where patients are being lost. Firstly via General Practice services which can be hard to access for minority groups. Secondly 'paperless' migrants refused second line care after coming through the first line acute service are then repeat presenting at the acute services. Interventions need to happen at a system level across the service to help this population.

The difficulties for access, noted in this observation above, were in multiple areas. 'Paperless' migrants appear to be getting refused second line services despite there now being some option for continuity of care through voluntary services provided by health professionals at Helse Hjelp til Papirløse (Health Help to the Paperless). However, the knowledge of this service varied among the professionals being interviewed. A nurse working in first line services had used the service before *'We have also referred some patients to Helse Hjelp. So for further treatment it would have to be arranged through these kinds of services. So we have managed to use this service before'*. However a doctor working in the first line service was not aware of this service *'No we haven't used that [Helse Hjelp], we use the Legevakten (Emergency Room) if they wouldn't get normal treatment.'* With better knowledge amongst health professionals across the addiction services perhaps more care could be provided to the 'paperless' migrant population.

Uncertainties about clinical or ethical obligations versus administrative responsibilities lead to uncertainties and variation in care delivery. The interviews

revealed instances where patients were given treatment at the discretion of management in second line services. One example was given by a counsellor: *'I must ask my boss if am I allowed to speak to this patient without getting any money, so I do but not everybody will do it, I am lucky with my boss here and maybe others don't have the opportunity to do it'*. So alongside an irregular variation in availability of access to service, staff are also sometimes able to offer treatment whilst others not. In addition there is perhaps low awareness of services that exist to help patients not qualifying for treatment in the public sector. A female psychologist in the second line service reflected on this feeling: *'Maybe the staff are not referring because they are not aware. We could be as an organization be better at knowing if we cannot offer help that is beneficial and whether there are other organizations that are better.'*

The lack of migrant patient visibility within the system was shown to be system related. The contributing factors suggested were: lack of knowledge within the system regarding routes of referral, variability of obligations towards treating 'paperless' migrants and issues around financial responsibilities within the service.

A profound story from a first line GP summarized the extent of invisibility, particularly with 'paperless' migrants, who by being denied second line care, are required to be severe enough with their illness to need emergency care. *'This is a 'paperless' man in his twenties/thirties from Africa who had lived in Norway for 10 years who came as an asylum seeker and was denied possibility of staying here, ... he could not find any kind of community and I did believe him, so he only felt acceptance among drug abusers in Bergen so he stayed and became one of them, and he was a very heavy user, when he came to me he did not want to continue...he*

had no home, no address, not possibility of being referred to any places, so we unfortunately agreed that I could not help, and that was a shame, because he was not entitled and his health did not become worse at quick enough rate to be entitled although he was in bad health. I have not idea what happened, we took some tests and I tried to contact him with SMS but he will probably comes again one day if he feels that he is bad enough.'

In order to avoid the perpetuation of an obscured population, interventions targeting minority groups are needed on a system wide approach due to the multi factorial reasons for their poor visibility.

Hurdles

A number of key hurdles came out as important factors hindering minority groups from accessing service. They are grouped as language and information hurdles as well as organisational challenges. Further, the inherent difficulties patients have of medical, psychological and social kinds are discussed separately.

Language challenges

Whilst translation is available in the form of physical interpreters and a telephone service, the staff knowledge of both services appeared to vary considerably. One-second line psychologist stated *'I have never used telephone translation due to being unaware that this was available.'* A first line doctor who has taught students on translation services also was aware of a problem: *'That's a big problem, that we do not have enough awareness of availability of telephone translation services, the law says that you have to do it if the other person is not*

understanding you, we health personal have the obligation to make us understood in the language that the other person can talk and understand' Better awareness is needed across the health service to ensure a standard level of translation is provided to patients.

Opinions on the quality of the translation services varied, a second line psychologist stated *'I have never asked for a language that they didn't have'*. However a first line doctor felt: *'the quality is unfortunately not very good because up until now the translation system in Norway, they do not have the special competence so whoever can speak a language can do it, but anyway you are able to understand each other but sometimes you feel that you have to be very careful with what you say.'* The opinions varied on the quality of service, many interviews state they were satisfied with the service. However the second quote here highlights that perhaps more standardization and training is needed in the service used in Bergen.

A second line psychologist noted that obtaining patient contact to arrange meetings can be difficult: *'It's difficult to get a hold of patients on the phone without being able to speak the language they speak...you can send messages via phone to invite them to a clinic appointment and that would be in Norwegian, not in English.'* There was also suggestion that some minority groups find language more of an issue than others, as noted by a first line doctor: *'We have had some language problems, mostly eastern Europe patients who speak only Russian and their native language.'* The importance of translation was also noted to be greater for those who were inpatients by a second line doctor: *'It's maybe more difficult with inpatients than with outpatients.'* The availability of translation was also not universal with a second line

psychologist suggesting there were problems with ensuring adequate provision: *'patients saying that they didn't get a translator when they needed one and translators that have also said that they hear that'*.

Information

Another area highlighted as a hurdle was the inadequate provision of information both to patients and staff. Ill informed staff will not be able to provide the most appropriate care, if any and ill informed patients may not access services or follow the correct treatment plans.

Staff themselves repeatedly described their own difficulties understanding the health system, in the words of a second line psychologist: *'the system is really confusing...I can count myself as an immigrant and it takes some time to understand how a system works'*. This was echoed by a first line doctor *'It took me a while to understand how the health system works, it is not as easy as it could be.'* Patients also struggled with problems understanding. A second line psychologist gave an example of confusion with minority group inpatients: *'not understanding for instance the difference between a closed in patient unit where you can't leave as opposed to one which is open'*. These comments suggest that clear information is needed both to staff and patients to ensure the best possible care.

A first line nurse also echoed the lack of information and suspected this could be in part due to lack of support networks around minority groups: *'migrant patients do have more problems knowing where to find help for health problems partly because they do not have as much of a network around them, family that can watch*

out for them or help them find services which natives would have had available to them when growing up'. In addition a second line psychologist noted that there was a general lack of research in this area to help guide where support should be placed: *'We need research basically, to find out what the issues are and why. There are lots of things we could then do'* These comments suggest that the isolated minority populations would benefit from more guidance by the health service. In addition to this more research is needed in order to effectively target the groups in most need of this support.

Organization

Alongside a lack of information, the organization of the service was highlighted as perhaps hindering how patients could access treatment, particularly with regard to the communication between primary and secondary services.

Due to the existence of multiple second line services, some of whom offer similar services, it was also suggested by a first line doctor that too much choice may be creating confusion for the treatment of patients: *'this problem falls between psychiatry and medicine which is problematic, OK so one group might say to me, send them to me, when they are done with the cannabis and you send to the clinics but he's only smoking cannabis, so send him to the Psychiatrist, I think it has more to do with no-one taking responsibility of the whole problem, it is not that difficult learning a list of where you can send people, the problem is where can you send people, and would they accept it'*. This situation sounds both confusing for patients and staff and perhaps merits better inter-organizational communication as to who can take responsibility for which patients.

Interaction between first and second line services was noted to be limited. A second line second psychologist highlighted: *'the emergency room sees a lot of patients, but we don't meet there or have somebody that liaises between those two areas'*. Similarly a lack of communication was also highlighted between organizations and the wider community. A first line doctor who had experience working within first and second line services stated: *'We don't really have that much outreach work'*. It could be that improved communication between first and second services along with more outreach to the community could greatly benefit the minority populations.

Outreach work is an area that could have great impact for issues of marginalization. A second psychologist noted that within the city of Bergen there were various sites that could be good points for the service to attempt outreach: *'getting in touch with these communities if we know what the problems are, for example using the catholic church where there are Polish priests or others speaking Polish, but this is difficult to do from the second line services. The church has services in many languages and similarly for the Philippino population in Bergen there is a community.'* Clearly defined communities would make ideal targets for outreach programmes to approach communities that are not accessing addiction services well.

Co-existing health and social issues.

Together with the problems of information, access and language is the complicated nature of this patient cohort. Interviewees also raised points regarding

the complicated physical and social health problems that may accompany these patients.

Minority groups may have coexisting psychiatric issues, particularly if coming from areas of unrest around the world. A second line psychologist explored this issue: *'we have a lot of patients with social anxiety and I think that would be exacerbated not being able to speak the language in a group'* This was a view also shared by a second line counsellor: *'Everyone I have had from first generation migrants has trauma and psychiatric diagnosis but the second generation are safe and not going out'* and also by a first line GP *'you see here generally among refugees that they have higher degrees of post traumatic stress disorder and this can go together with addictions'*. Vulnerable populations need extra focus to ensure their needs are adequately met. If they are not then the service may not be able to gain the trust of this group, which could undermine effective treatment.

These patients may also be under stress due to the risk of deportation highlighted a second line counsellor: *'I think the main reason they are not coming is their fear because I have only worked with the young adults under 23 and they are afraid all the time because they don't know if they are going to stay in Norway...they are don't want to row or be thrown out of treatment early'*. This is a difficult topic to address due to the political nature of asylum seekers. However it is important that all care that they are entitled to, they receive.

Furthermore the stresses of being a foreigner in another country may be detrimental to health as explored by a second line psychologist *'exacerbated by*

being lonely and in another country and being an immigrant not knowing what services are available and that's not just substance abuse services that's medical services'. These stress factors may be making some of these populations less visible and therefore merit more work in the community to encourage patients into treatment.

Other important issues included the difficulty of identifying physical health problems in minority groups when communication is limited, a problem seen in patients by a second line service nurse: *'the ones with other physical problems, an old wound, sometimes we might not know their other physical ailments until much later with a Norwegian patient you would know this from day one but with migrants it can sometimes take a few days...they don't complain a lot and are just very thankful for everything, they suffer a lot in silence I think.'* Good translation provision along with adequate training to staff can ensure that physical health problems are not ignored with patients whose language abilities may not be good enough.

Additionally another area needing further exploration is the problem of poly drug use and prescription drug use discussed by a first line service doctor: *'Prescription drugs are also a problem but that is usually poly drug use in combination with other things. Tablets is also a big problem'*. This was again referred to by another first line doctor *'here you see a lot of patients using, paracetamol, codeine, NSAIDs naproxen and paracetamol, pain killers where you can not really understand that there is that much pain'*. This is a poorly understood grey area, which will need further research exploration to find out what patterns of use are occurring within minority groups.

Discussion

The findings of the literature review and the interviews revealed a variety of findings. No existing literature was found looking at barriers to accessing healthcare for minority groups with substance misuse problems in Norway. The Norwegian research focused on patterns of substance misuse within adolescents and young adults, the two way effect of minority group and native substance misuse, cohesion pull factors within the drug community along with the double marginalization of this population and their complex health needs.

The research found for the rest of Scandinavia, was only from Sweden, no Danish literature was seen. This highlighted the influence of both country of origin and the native population as influential in minority group substance misuse, first generation migrants being less problematic, perception of substances varying within minority groups and second generation migrants were described as more likely to require emergency admission or compulsory treatment.

The interview results provided an overview of the current situation in the city of Bergen regarding access to healthcare for minority groups with substance misuse problems. The findings agreed with the literature that this population is doubly marginalized and suffers from a disparity in healthcare provision making them an invisible population. Hurdles existed in a number of areas, which were preventing this population accessing the services.

European perspective

Within Europe only 5 countries offer minority groups full access to healthcare service: Belgium, France, the Netherlands, Portugal and Switzerland (57). The United

Kingdom gives free emergency care but limited access beyond into secondary care in a similar manner to Norway but with no charge for General Practitioner appointments. It is thought that there are currently around 1.9 to 3.8 million undocumented migrants living in the European Union (60). This is a significant population size many of which will require healthcare. Underlying this variation within European attitude to minority groups is politics, and this topic is likely to be extremely contentious within European cities.

Language and communication

Language barrier issues have been highlighted in other areas within the Norwegian health system. One research paper looked at problems with immigrants from Pakistan holding misconceptions and being confused about generic substitutions of medication. Generic substitution of medications led to problems with drug adherence and this was primarily due to insufficient information as a result of language barriers and minority groups' preconceptions based on their previous healthcare system (61). The interview results revealed instances of patients being confused within the service and unsure what was available to them or the procedures they were to follow for inpatient care. This holds relevance for the treatment of minority group addicts who may not comply adequately with treatment regimes if more time is not taken to ensure understanding and trust between patients and healthcare staff.

Backgrounds to addiction

When looking at the backgrounds of drug users in Norway it has been identified that persistent opioid use is strongly associated with: disability pension,

unemployment, divorce, low income and low levels of education. These are high risk factors for minority groups (62). The example given in the interview results, of the man who began using opiates in the asylum detention centre whilst in Norway, suggests that this population need to be reached out to before their existing drug habits worsen or new habits develop. Outreach is needed along with work to help improve the social determinants of health for marginalized groups.

Prescription medication

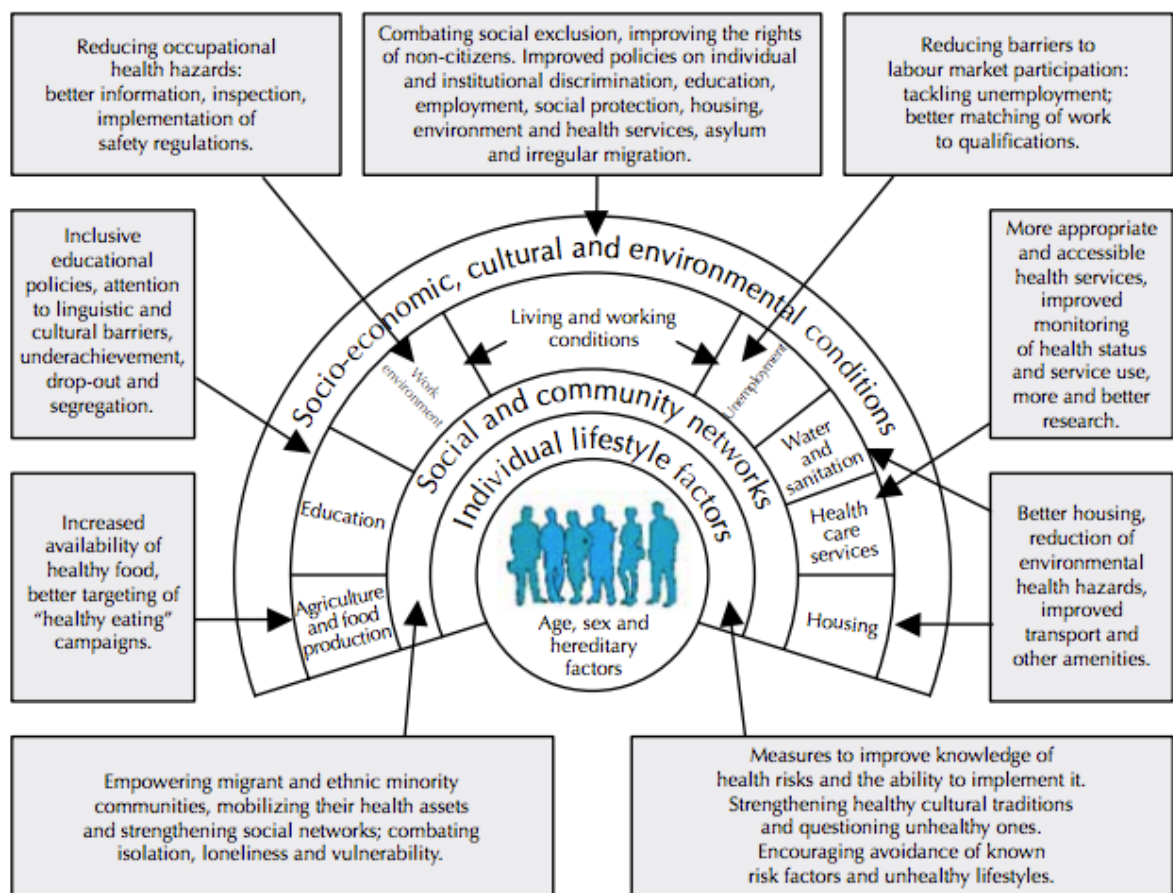
Prescription medications were highlighted as a potential problem area for minority groups. However research is conflicting within this topic. One paper looking at analgesic use between young people born to Muslim parents against young people born to Norwegian parents found no difference in consumption habits (63). Interview data in this study discussed prescription medication abuse issues co-existing with other substance misuse problems, which is a health problem that will need further research investigation in Norway.

Health systems

The World Health Organizations (WHO) has recommended guidelines to assist in the adjustment of health systems to account better for this population. The systems based approach suggested by the WHO asks for health services '*not only to improve the services available to migrants and ethnic minorities, but also to address the social determinants of health across many sectors.*' This process ideally should be based upon research, education and training along with the consolidation of expertise. It is clear from these recommendations that minority group inclusion is a complex multi factorial process that needs to be implemented comprehensively

across a healthcare system. Ultimately this is likely to require overarching political support from a country's government to have significant impact. Figure 11 below shows the variety of policy recommendations suggested to help improve the social determinants of health for migrants and ethnic minorities into health systems (64).

Fig. 1. Policy measures required to tackle the social determinants of health for migrants and ethnic minorities



Source: The diagram is inspired by a presentation from Dr Nani Nair, TB Regional Advisor, on 15–16 September 2005 at the WHO Regional Office for South East Asia consultation on the social determinants of health, subsequently adapted by Theadora Koller to address determinants of the health of socially excluded migrant populations, and further adapted for the purposes of this policy briefing. The well-known “rainbow” is from Dahlgren & Whitehead (1991).

[Figure 11 – WHO. Policy measure required to tackle the social determinants of health for migrants and ethnic minorities.] (65)

Creating a migrant sensitive workforce

Suggestions made by the WHO to help improve health service access to migrants include: staff education and utilizing of migrants within the health service (64). Research in Norway has already highlighted the use of immigrant general practitioners as an important resource to help gate keeping (65). Alongside effective gatekeeping outreach was also discussed as a means of spreading information about health systems into the community (64).

Within Bergen this appeared to be quite effective within the Utekontakten service, which focused on young adults, but there appeared to be little or no service helping other demographics in the population. Young adults have been highlighted as a significant population for monitoring an outreach. A cross-sectional study in Bergen looking at young adults between the age of 17-19 highlighted that early debut of alcohol drug use is associated with increase in mental health symptoms suggesting substance misuse may be a good indicator of mental health issues in young adults (66).

Co-existing problems

Post-traumatic stress has been identified as being ten times higher in prevalence within refugee populations than the general population (67). In addition rates of depression and anxiety are thought to be twice as high with in refugees than within labour migrants (68). It is clear that mental health is an important area of consideration when treating minority group populations. In order for this to be effective good coordination is required by services when addiction is also involved.

The interviews highlighted both the confusing nature of the service in Bergen and that many minority groups were presenting with co-existing mental or physical health problems, some of which were difficult to identify due to language barriers. Problems were also posed in determining which service was most appropriate to help these patients. The WHO notes that poor service provision may itself exacerbate or trigger mental health and substance problems within vulnerable minority groups such as refugees and asylum seekers who are living in stressful circumstances (64).

Routes of access to services

Interview data revealed that minority groups with substance misuse problems might be more likely to access acute services because they feel they will be seen faster. Research looking nationally at general minority group use of services has highlighted that there is large variation within immigrant groups but that generally they utilize emergency primary care services less than native Norwegians. However some groups such as populations from Somalia and Iraq were shown to use these services much more than native Norwegians (69).

This is a special population that needs focus

A recent unpublished qualitative research project for Oslo Kommune “Vi lever i Rus” (We live in addiction) looked at the views of health professionals working with minority groups with substance misuse problems. The study suggested that there was a lack of experience within the health system to deal with these patients and that they were perceived by the health system as a separate population with individual needs (70).

The theory of acculturation has been highlighted within young Norwegian minority groups. Research has identified that relationships may exist between acculturation experiences and emotional disorders (71). It is important that staff are adequately trained to respond to the needs of this vulnerable population to effectively treat them.

Methodological and analytical challenges

This research project gives an overview of the current situation in the city of Bergen regarding access to healthcare treatment for documented and undocumented migrants, asylum seeking and refugee populations with substance misuse problems.

Language barrier may be an issue, non-English speaking potential interviewees may not have wished to take part due to this. Recruitment bias by selecting those working in treatment is also a problem, however this group provided insight into other less accessible groups. Data sampling took place at the secondary level, interviewing professionals working with minority groups, so there were no direct views from minority group clients, which may give less valid perspective on access issues.

Reliance on purposive and convenience sampling will most likely have lead to selection bias. It is likely that the method of selection through existing organizations working with minority group substance misusers did not provide good access to undocumented asylum seekers, as they are hard to access. By definition those involved in the service are treating patients that have already accessed the service

so it may be difficult to gauge the true issues preventing others accessing the service.

Interviews that were not conducted in English may have lost some data through the process of translation. However these interviews were translated by myself and double-checked by a native Norwegian speaker.

The time scale for the study is limited to 7 months from planning to completion, which limited the number of interviews that could take place and be analysed. Furthermore the single method of data collection, also due to time scale and feasibility, limits the study.

It is likely that due to the setting of this qualitative research, the findings are probably applicable for Norway and perhaps Scandinavia but not more externally valid than this due to the small scale of the study and methodology.

Limitations

The language barrier during some of the interviews with non-native English speakers may have lead to the loss of further interviewees both professionals and patients. Possibly using a translator known and trusted by interviewees, especially service users would have increased uptake, with myself present to conduct interviews. There may also have been some loss of data through the process of translation, however these interviews were translated by myself and double-checked by a Norwegian speaker.

By recruiting from organizations working with addictions, selection bias may have been introduced, however the group of professionals interviewed did provide insights into the other less accessible groups. In general the data is likely to have been skewed towards those who have actively sought help for substance misuse problems.

Data sampling was only made at secondary level by interviewing professionals working with minorities and so no direct primary level data was collected. Greater insight could be gathered in a further study focusing on the views of minority groups themselves. In addition, by relying on purposive and convenience sampling, the views of the professionals were mainly based on experiences with minority groups who had managed to access services. More research is needed, focussing on those not accessing the services as it is difficult to gauge the true issues preventing their access of the service. More time to build relationships was required to gain the trust of service users in order to get them to participate in interviews. Possibly other strategies such as paying for the time inconvenience may have helped increase participation. It is likely undocumented populations will be more difficult to access and recruit, they may also be even less willing to take part in studies.

The study was further limited by time constrictions as the entire project was completed in 7 months from conception to thesis completion. With more time, further recruitment and interviewing could have taken place, which would have likely yielded more data including minority group views. Possibly employing a translator to befriend and recruit service users to be interviewed before I arrived to carry out my research would have been a useful strategy to gain deeper reach into the service user group.

In addition to this the time limitation also restricted the number of methods of data collection. A longer study could have incorporated focus groups and ethnographic data to compliment interviews.

Due to the single method of data collection and the context specific topic of minority groups accessing addiction healthcare services in the city of Bergen, the external validity is likely to be applicable to the rest of Norway and possible other Scandinavian countries. However the small scale of the study and its methodology are likely to limit external use further afield.

Conclusion

The Oslo Municipality Welfare Administration Report 'We Live In Addiction' on minority group addictions in Norway referenced Hippocrates in its opening pages: '*It is better to know the patient who has the disease than it is to know the disease which the patient has*' (70). This holds relevance to minority groups with addiction problems who need to be understood in the broader context of both health and social issues. As noted by Edgar Allen Poe's poem at the beginning of this study, minority groups suffering substance misuse may well be self-medicating in order to escape or forget difficult circumstances in their lives(1).

Non-native born populations with substance misuse problems are a minority group at high risk of neglect within healthcare systems. This study highlighted that minority groups with substance misuse problems in Bergen are experiencing a variety of problems accessing services. Findings suggest that hurdles to service access include: language, organization of services, co-existing health or social

issues, along with lack of patient and staff information provision. This study did not find equitable services provision for this marginalized group.

There is also a significant lack of research into this area within Norway and Scandinavia in general. The limited existing research in allied topics appears to focus on young adult minorities, a group highlighted as being at risk of substance misuse and mental health issues, more work is needed to address the other demographic groups in this vulnerable population. More qualitative research is needed into the views of minority addiction groups along with better epidemiological data to help guide appropriate service provision.

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Appendix

Appendix 1 - Flow diagram for literature search

Step 1 - Preliminary title searches for single search terms using the truncation asterisk (*) to increase result returns for words with multiple endings



Search term	PubMed	Science Direct	Google Scholar	PsycINFO	Web of Knowledge	University of Bergen library catalogue
Substance*	41645	19,032	1,700,000	15585	48,618	70,306
Use*	55242	200,272	4,110,000	84293	500,816	859,088
Misuse*	3981	1,144	160,000	1957	2,886	7,536
Abuse*	35337	11,168	1,520,000	24552	26,862	61,135
Addiction*	8871	3,220	178,000	6118	5,545	16,662
Drug*	259347	82,421	1,920,000	33139	182,131	354,117
Illicit	2204	811	119,000	1082	2,120	4,069
Illegal	1123	517	720,000	374	1,675	8,816
Alcohol*	92088	40,368	1,400,000	39010	113,702	157,170
Immigrant*	6694	2,016	350,000	5379	10,749	25,132
Minorit*	6022	2,299	17,200	4877	10,892	28,387
Migrant*	3661	1,159	190,000	1677	6,766	13,603
Asylum*	1048	1,073	124,000	617	1,186	8,589
Refugee*	3498	784	154,000	1838	4,074	12,072
Norway	6172	4,539	531,000	1325	14,688	32,687
Norwegian	4105	2,307	198,000	1275	7,478	16,656
Sweden	9152	6,427	1,350,000	1920	15,111	41,842
Swedish	9393	3,966	750,000	2649	12,792	26,445
Denmark	4518	3,055	670,000	640	6,435	25,473
Danish	6090	2,327	269,000	999	7,554	13,989
Scandinavia*	1817	1,169	73,300	273	3,182	7,798



Step 2 – Grouped title search term searches using Boolean operator OR in between.



Search term	PubMed	Science Direct	Google Scholar	PsycINFO	Web of Knowledge	University of Bergen library catalogue
(Substance* OR Use* OR Misuse* OR Abuse* OR Addiction* OR Drug* OR Illicit OR Illegal OR Alcohol*)	6206402	338,798	1,740,000	1037763	1,410,218	1,439,274
(Immigrant* OR Minorit* OR Migrant* OR Asylum* OR Refugee)	93931	7,211	357,000	43528	32,958	81,211
(Norway OR Norwegian OR Sweden OR Swedish OR Denmark OR Danish OR Scandinavia*)	607427	22,896	1,700,000	27467	65,744	158,078



Step 3 – Combined title search linking the previous steps' grouped searches using the Boolean operator AND. Only including English language, In-press, full text and limit of 20-year-old articles.



Search term	PubMed	Science Direct	Google Scholar	PsycINFO	Web of Knowledge	University of Bergen library catalogue
(Substance* OR Use* OR Misuse* OR Abuse* OR Addiction* OR Drug* OR Illicit* OR Illegal OR Alcohol*) AND (Immigrant* OR Minorit* OR Migrant* OR Asylum* OR Refugee*) AND (Norway OR Norwegian OR Sweden OR Swedish OR Denmark OR Danish OR Scandinavia*)	411	3	12	168	33	47



Step 4 – Titles and abstracts read, quality assessment performed. Duplicate studies removed.



Step 5 - 5 Norwegian papers selected and 10 Swedish papers selected. Date stamp for literature search – 1st July 2015

Appendix 2 - Amended research questions

Barriers to Migrant Substance Misusers Accessing Healthcare in the City of Bergen
Revised Interview Guide - 15/05/2015

Health Professionals

Helsepersonell

What problems do you think migrants with substance misuse problems face accessing health services in the city of Bergen?

Hvilke problemer med tilgang til helsetjenester tror du innvandrere med substansmisbruk møter i Bergen?

What do you feel can be done to improve access to health services for migrants with substance misuse problems in Bergen?

Hva føler du kan gjøres for å forbedre tilgangen til helsetjenester for innvandrere med substansmisbruk i Bergen?

Do you think some subgroups of migrants are more marginalized than others?

Tror du noen undergrupper av innvandrere er mer marginalisert enn andre?

What substance misuse problems do you think migrants are facing in Bergen?

Hvilke substansmisbruksproblemer tror du innvandrere har i Bergen?

What do you feel is the perception of substance misuse services by migrants in Bergen?

Hva føler du er synet på tjenester for substansmisbrukere blant innvandrere i Bergen?

What difficulties do you feel organizations have faced in reaching migrant populations with substance misuse problems?

Hvilke problemer føler du organisasjoner har møtt i å nå innvandrergupper med substansmisbruk?

Do you get the impression there are any gender issues regarding substance misuse in migrant populations?

Har du inntrykk av at det er noen kjønnsforskjeller ved substansmisbruksproblemer i innvandrergruppene?

Barriers to Migrant Substance Misusers Accessing Healthcare in the City of Bergen
Revised Interview Guide - 15/05/2015

In your opinion, what are the different social backgrounds to substance misuse in the migrant populations?

Etter din mening, hva er de ulike sosiale bakgrunnene til substansmisbruket i innvandrergroppene?

Do you feel there are differences between the views of clients and the organizations working with them?

Føler du det er noen forskjeller mellom synet til klientene og organisasjonene som jobber med dem?

Do you feel there are any disparities between sub groups in the minority population?

Føler du det er noen forskjeller mellom undergrupper i minoritetsbefolkningen?

In your opinion is there any crime, psychological or physical trauma, co-morbidities or prostitution related to the minority groups within the city of Bergen?

Etter din mening, er det noen kriminalitet, psykiske eller fysiske traumer, ko-morbiditeter eller prostitusjon relatert til minoritetsgroppene i Bergen?

Migrants with experience of addiction

Innvandrere med erfaring med avhengighet

What substance misuse problems do you have or have you had in the past?

Hvilke substansmisbruksproblemer har du eller har du hatt tidligere?

What is your social background and how did your addiction become a problem?

Hva er din sosiale bakgrunn og hvordan ble avhengigheten et problem?

Have you faced problems accessing health services in the city of Bergen?

Har du hatt problemer med tilgang til helsetjenester i Bergen?

Have you noticed other migrants with substance misuse problems facing difficulties accessing health services in Bergen?

Har du lagt merke til andre innvandrere med substansmisbruk som har hatt vanskeligheter med å få tilgang til helsetjenester i Bergen?

What do you feel can be done to improve access to health services for migrants with substance misuse problems in Bergen?

Hva føler du kan gjøres for å forbedre tilgangen til helsetjenester for innvandrere med substansmisbruk i Bergen?

Do you think some subgroups of migrants are more marginalized than others?

Tror du noen undergrupper av innvandrere er mer marginalisert enn andre?

What substance misuse problems do you think migrants are facing in Bergen?

Hvilke substansmisbruksproblemer tror du innvandrere har i Bergen?

What do you feel is the perception of substance misuse services by migrants in Bergen?

Hva føler du er synet på tjenester for substansmisbrukere blant innvandrere i Bergen?

What difficulties do you feel organizations have faced in reaching migrant populations with substance misuse problems?

Barriers to Migrant Substance Misusers Accessing Healthcare in the City of Bergen
Revised Interview Guide - 15/05/2015

Hvilke problemer føler du organisasjoner har møtt i å nå innvandrergupper med substansmisbruk?

Do you get the impression there are any gender issues regarding substance misuse in migrant populations?

Har du inntrykk av at det er noen kjønnsforskjeller ved substansmisbruksproblemer i innvandrergruppene?

In your opinion, what are the different social backgrounds to substance misuse in the migrant populations?

Etter din mening, hva er de ulike sosiale bakgrunnene til substansmisbruket i innvandrergruppene?

Do you feel there are differences between the views of clients and the organizations working with them?

Føler du det er noen forskjeller mellom synet til klientene og organisasjonene som jobber med dem?

Do you feel there are any disparities between sub groups in the migrant population with substance misuse problems?

Føler du det er noen forskjeller mellom undergrupper i innvandrerbefolkningen med substansmisbruksproblemer?

In your opinion is there any crime, psychological or physical trauma, co-morbidities or prostitution related to the migrant population with substance misuse problems within the city of Bergen?

Etter din mening, er det noen kriminalitet, psykiske eller fysiske traumer, ko-morbiditeter eller prostitusjon relatert til i innvandrerbefolkningen med substansmisbruksproblemer i Bergen?

Appendix 3 - Timeline

Research period – March to September 2015

Month	March	April/May	June	July	August	September
	Ethical application, organizations contacted					
		Informant recruitment, data collection and literature reviewing.				
			Further interviewing, transcribing, data analysis and writing up.			
				Data analysis and writing up.		
					Final writing up.	
						Final writing up.

Appendix 4 - Ethical approval



Region:	Sakbehandler:	Telefon:	Vår dato:	Vår referanse:
REK vest	Dyvind Straume	55978498	08.05.2015	2015/550/REK vest
			Deres dato:	Deres referanse:
			24.03.2015	

Vår referanse må oppgives ved alle henvendelser

Ingunn Marie Stadskleiv Engebretsen
Senter for Internasjonal Helse

2015/550 Rusmisbruk blant minoritetsgrupper i Bergen, Norge

Forskningsansvarlig: Universitetet i Bergen
Prosjektleder: Ingunn Marie Stadskleiv Engebretsen

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK vest) i møtet 23.04.2015. Vurderingen er gjort med hjemmel i helseforskningsloven (hfl.) § 10, jf. forskningsetikkloven § 4.

Prosjektomtale

Formålet med prosjektet er å beskrive barrierer voksne mennesker med minoritetsbakgrunn som har rusproblemer møter i kontakt med helsevesenet. Studien skal bruke kvalitative metoder, hovedsakelig intervjuer med helsepersonell i rus-sektoren og intervjuer med mennesker som har minoritetsbakgrunn og problemer med rus. 20 personer skal rekrutteres, 10 helsepersonell og 10 med minoritetsbakgrunn og rusproblemer. En induktiv kontent metode vil brukes for analysen.

Vurdering

Søknad/protokoll

Komiteen bemerker at tittelen på prosjektet er noe misvisende. Formålet med studien er å vurdere hvilke barrierer minoritetsgrupper med rusproblemer møter i kontakt med helsevesenet.

Rekruttering

Komiteen presiserer at helsepersonellet som skal bistå med rekruttering er underlagt taushetsplikt og har dermed ikke anledning til å peke ut enkeltpersoner eller gå ut med navn til studenten. Vi har ingen innvendinger til at helsepersonell brukes til å informere om studien og bistå med rekruttering, men dette må gjøres på en måte som ivaretar taushetsplikten.

Språk

I følge søknaden vil prosjektet rette seg mot personer som snakker norsk eller engelsk. Komiteen ser det praktiske aspektet i dette, men vil presisere at språk ikke kan være et eksklusjonskriterie i en studie som handler om barrierer i helsevesenet. Tolketjeneste, som det legges opp til i protokollen, må derfor tilbys om nødvendig.

Intervjuguide

Intervjuguiden bør revideres, og rettes mot dem/de som faktisk skal spørres. Formuleringene bør endres til f.eks. "Har du opplevd..." og "Hvordan anser du..." Det bør utarbeides en guide rettet mot helsepersonell og en egen mot studiedeltakerne med rusproblemer. Reviderte intervjuguider skal ettersendes til REK vest.

Decksadresse:
Armuer Hansens Hus (AHH),
Tverrfly Nord, 2 etasje, Rom
281, Haukelandveien 28

Telefon: 55975000
E-post: rek-vest@uhb.no
Web: <http://helseforskning.etikk.no/>

All post og e-post som inngår i sakbehandlingen, bør adressert til REK vest og ikke til enkelte personer

Kindly address all mail and e-mails to the Regional Ethics Committee, REK vest, not to individual staff

Bruk epost post@helseforskning.etikkom.no og oppgi vår referanse.

Håndtering av data etter prosjektslutt

Tillatelsen til å oppbevare og behandle data gjelder i utgangspunktet til prosjektslutt 06.09.2015. REK vest setter som vilkår at koblingsnøkkelene slettes ved prosjektslutt eller så snart det ikke lenger er bruk for dem. Indirekte personidentifiserbare data kan oppbevares opp til fem år etter prosjektslutt for etterkontroll.

Vilkår

- Helsepersonellet som bistår med rekruttering må overholde sin taushetsplikt.
- Språk kan ikke brukes som eksklusjonskriterie.
- Intervjuguiden bør revideres i henhold til ovenstående merknad.
- Lagring av data skal håndteres i henhold til ovenstående merknad.

Vedtak

REK vest godkjenner prosjektet på betingelse av at ovennevnte vilkår tas til følge.

Sluttmelding og søknad om prosjektendring

Prosjektleder skal sende sluttmelding til REK vest på eget skjema senest 06.03.2016, jf. hfl. § 12. Prosjektleder skal sende søknad om prosjektendring til REK vest dersom det skal gjøres vesentlige endringer i forhold til de opplysninger som er gitt i søknaden, jf. hfl. § 11.

Klageadgang

Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK vest. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK vest, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

Ansgar Berg
Prof. Dr.med
Komitéleder

Øyvind Straume
sekretariatsleder

Kopi til: post@uib.no