Research paper

Comparison of life events, substance misuse, service use and mental illness among African-Caribbean, black African and white British men in east London: a qualitative study

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ABSTRACT

This paper reports the findings of a qualitative study that explores the experiences of African-Caribbean, black African and white British men aged 18 to 35 years who report a dual diagnosis and are in contact with health and social care services in east London (UK). Dual diagnosis refers to service users with both identified mental health difficulties, for example schizophrenia, borderline personality disorders, bipolar disorders, and some problematic substance abuse issues, such as heroin, crack, marijuana, khat, prescription drugs or alcohol. We conducted semi-structured in-depth interviews with nine male service users: two African-Caribbean men, four black Africans and three white British men. Statutory and non-statutory services were involved in recruitment. The topic guide around which the interview was structured asked about social circumstances at the time of the interview, the services they had used and how the services worked to meet their needs, or if there were aspects that needed improving. The interviews were recorded, transcribed and subjected to the framework approach to qualitative data analysis. Findings showed that participants' histories were generally characterised by frequent hospitalisation, separation from family, and education problems. Participants reported varying effectiveness of services; this variation reflected the degree to which services addressed social and cultural needs. We identified khat use to be common among African male participants, cannabis use to be common among African-Caribbean participants, and poly-drug abuse, including cannabis, to be common among the white British subjects. Service providers were not consistently addressing substance misuse. Mental health issues seemed to be addressed more thoroughly, and there was some evidence that cultural aspects of health and social care were considered and addressed. In conclusion, we propose that healthcare providers reconsider the cultural capability of their services to engage hard-to-reach ethnic groups, that they reconsider the effectiveness of interventions for substance misuse, and develop skills in a range of interventions that reflect the patterns of substances used by specific ethnic groups.

Keywords: ethnicity and cultural competence, dual diagnosis, khat, substance misuse

Introduction

Tackling discrimination in mental health settings and improving the quality of services for black and ethnic groups play crucial parts in the UK government strategy of modernising the NHS (Department of Health, 2003). Recent influential developments include the Race Relations Amendment Act, 2000; Department of Health and National Institute of Mental Health policies *Inside Outside* (NIMHE, 2004); and the government's response to the David Bennett inquiry – an implementation plan for delivery of race equality (Department of Health, 2005). All policies support the need for cultural capability training for all staff working in mental health settings in order to provide equitable services that are responsive to the care needs of black and ethnic minority communities in Britain. Consequently, service providers have come under special scrutiny and are seeking interventions to enhance the cultural capability of the workforce. The Real Voices Survey (Walls and Sashidharan, 2004) was carried out as part of a national strategy to improve mental health services for black and ethnic minorities; this reported that 84% of ethnic minorities thought that lack of cultural awareness in staff was a problem; 60% thought that current mental health services were not culturally sensitive; 49% reported experiences of racial discrimination; and 98% endorsed the need for training in cultural competence. At the same time, dual diagnoses are known to challenge existing services, and complex care needs may contribute to inappropriate or perhaps over-simplistic care packages and policies that fail to fully address the care needs of black and minority ethnic groups with substance misuse problems. This is partly because little research has been done into the issues of ethnicity and substance misuse, including the nature, magnitude and experience of drug misuse among different ethnic groups (National Treatment Agency for Substance Misuse (NTA), 2003). In response to the lack of knowledge about the interaction between ethnicity and substance misuse, the UK government set up the NTA; this body has begun to explore issues of substance misuse by some black and ethnic minority communities.

Even though there has been a growing concern in the UK about the clinical management of patients with mental health and substance misuse co-morbidity, our knowledge about the relationship between ethnicity and dual diagnosis remains poor (Bhui *et al*, 2003). Service-based studies are beginning to emerge but few address ethnic variations in patterns of co-morbidity, or the provision of effective interventions in the context of culturally capable services. A literature review of available articles in the USA has allowed for some patterns to be recognised. Black dual-diagnosis service users were more likely to use cocaine or cannabis, whereas white service users were more likely to be poly-drug or alcohol users (Mowbray *et al*, 1997). African-American service users with a dual diagnosis had a higher prevalence of major depression (Primm *et al*, 2000; Mueser *et al*, 2001), while their white counterparts were more often found to have major depressive disorders (Ziedonis *et al*, 1994). In the UK, studies show a similar risk of co-morbidity for both black and white service users (Weaver *et al*, 2001). However, multivariate analysis shows that age seems to be a confounder with co-morbidity being higher among younger ages, and black service users tending to be younger (Weaver *et al*, 2001).

Treatment programmes should show flexibility and reflect the need for a range of interventions that are appropriate for a culturally diverse population. For example, self-disclosure is more common among white service users than among African-American service users (Ziedonis *et al*, 1994). However, black service users are more aware of their problems and more ready to embark on a course of treatment (Salloum *et al*, 1998). Some studies recommended that dual-diagnosis treatment programmes improve their cultural focus and become more active in dealing with the complex needs of ethnic service users as a way of maximising effectiveness (Baker *et al*, 1999). Some of these recommendations included more active interventions, more staff time and education in culturally appropriate treatments, and a call for cultural training for all clinical staff who offer treatments as case managers, as well as for support staff, advocacy workers, and related staff in support services (Jerrell and Wilson, 1996, 1997; Bhui *et al*, 2004).

In order to assess the need for service development, we undertook a qualitative study to explore service users' perceptions of service effectiveness and adequacy; this approach enabled individuals to tell their own stories, lending a strong validity to their priorities and problems in securing health and social care. The aim of the study was to compare the experiences of three different ethnic groups with dual diagnosis, in order to represent their narratives to those responsible for local service development and policy. The qualitative approach allowed us to ask broad, open-ended, and interconnected questions and was thus ideal for scoping a new area of work, where there are limited data, and for ensuring that the views of service users with complex needs, a group that would not normally engage in formalised survey research that involves lengthy interviews, were included in any local service development (Ritchie and Spencer, 1994; Green and Thorogood, 2004; Warfa *et al,* 2005). Specifically, we aimed to:

- identify the role of culture and ethnicity in the treatment of service users with mental health and substance use problems

- do this from service users' perspectives about the adequacy of services
- identify existing gaps in the training needs of social and mental health professionals working with patients with dual-diagnosis issues
- generate a discussion about the relative policy and treatment priority for this group of patients with co-morbidity.

Method

Sample

We aimed to compare the experiences of dually diagnosed young men of African-Caribbean, black African, or white British ethnic origin; we recruited nine men aged 18–35 years from each ethnic group from a wide range of local voluntary agencies and statutory services (Table 1). Both service providers and the two interviewers (KP and NW) informed the participants about the aims and intentions of the study. The researchers also explained to the interviewees that participation or refusal to participate in the study would in no way compromise their rights to statutory services. Interviews were only conducted after seeking

and obtaining informed consent. We excluded subjects with learning disability or severe communication problems that compromised communication to a degree that raised concerns about informed consent, or introduced potential information biases. Ethical approval was granted by the local health authority ethical committee.

Data collection

Our definition of dual diagnosis by which subjects were included was based on self-report: the presence of identified mental health difficulties, for example, schizophrenia, bipolar affective disorder, severe anxiety or depressive states or even severe personality disorders, and problematic or harmful use of psychoactive substances such as heroin, crack, marijuana, khat, prescription drugs or alcohol. Using a semi-structured questionnaire, we gathered a detailed picture of the past and present circumstances of each interviewee's life, with special attention being paid to life issues that the subjects themselves believed had an impact on their health (see Box 1). We asked about housing, employment, education, relationships, religion, childhood and migration. We also asked about contact with health and social care services. We were

Table 1 Demographic, diagnostic and historical characteristics of participants

Code	Age (years)	Ethnic group	Diagnosis (self-report)	Drug used	Early parental separation	Recent migrant	War traumas
JB	28	Black Caribbean	Schizophrenia	Cannabis	Y	N	N
AA	28	Somali	PTSD	Khat	N	Y	Y
BM	18	Ethiopian	Psychosis	Khat	N	Y	N
JA	26	White British	Schizophrenia	Multiple drugs	N	N	N
DA	21	Ghanaian/ Scottish mother	Psychological problems	Cannabis	Y	N	N
DD	27	Black Caribbean	Schizophrenia	Cannabis	Y	N	N
IM	35	Somali	Psychosis/PTSD	Khat	N	Y	N
JD	25	White British	Bipolar affective disorder	Cannabis + suspected multiple substances	Y	N	N
MA	34	White British	Depression	Alcohol	N	N	N

Box 1 Topic guide for the dual-diagnosis and ethnicity study

1 Introduction
- Start off by saying a little about yourself
- Who you live with
- Age
- Ethnicity

2 Current circumstances (get extensive details)
- Get a picture of recent life events
- Housing and household relationships
- Employment
- Education and training
- Other activities outside the home
- Wider family friendships
- Religion
- Spirituality
- Conceptions of life
- If happy or any difficulties or problems

3 Past circumstances (get extensive details)
- Childhood
- School life
- Leaving home
- Developing friendships and relationships
- Previous working life
- Home
- Moving
- Migration

4 Current use of services and coping mechanism
- Which services do you use and which health professionals are involved in your care (e.g. do you have a community psychiatric nurse, a social worker, etc.)?
- How long have you been attending services?
- What are meetings with the professionals involved in your care like?
- How often are these meetings?
- How long do they last?
- What is the agenda of these meetings?
- Would you like these meetings to be different in any way?
- How helpful are these services?
- Are there any kinds of help that you might benefit from but have not been offered?
- How much help do you have with coping with your mental health problems?
- Help from whom?
- What sort of help?
- How useful is this help?
- How much help do you have with coping with daily living, e.g. cleaning, preparing meals? What is the most useful help you have received?

5 Substance misuse
- What do you think of the support that you've been given to manage your substance use?
- Do you think that your substance use causes you any problems?
- If so, what sort of problems does it cause you?
- Does your substance use affect your mental health or vice versa?

6 Ethnicity and service use
- Do you think that your particular background, ethnicity, religion, culture and/or lifestyle have been taken into account when help is provided for you?
- Do you think that these things could be taken into account more, and if so, in what way?
- Since your initial contacts with mental health services, what sort of treatments or therapies have you been offered (e.g. medication, counselling)?
- Which of these treatments/therapies has been helpful/unhelpful?
- Which area of the mental health services do you think most needs to be changed? (Probe: why? how should it be done?)

especially interested in exploring service users' views about the adequacy of existing services, and their recommendations for improvements. This included professionals' attention to cultural issues and whether more attention to these might have a more positive impact on health and social functioning. All interviews were audiotaped and transcribed.

Data analysis

The framework method was used in the analysis of material from the in-depth interviews. This is a content analysis method which is used to summarise and classify data from qualitative research within a thematic framework and well-defined procedure (Ritchie and Spencer, 1994). The framework method consists of a number of stages including familiarisation with the transcribed interviews, identifying a thematic framework, indexing key themes and subthemes, charting, mapping and interpretation. The advantage of the framework method of qualitative analysis is that the data are ordered within an analytical thematic framework which is grounded in respondents' own accounts; but once charted, these thematic frameworks are available for inspection. In this study the charting and interpretation of the data were undertaken by two researchers, until saturation and conceptual convergence were reached. After familiarisation with the transcripts, a thematic framework evolved by continuous comparison. This was broadly organised according to current and past circumstances: what services were being used; what worked and what did not work or needed improving; and recognition of dual diagnosis, how it was treated and whether cultural background was being considered.

Findings

The key themes that emerged from the analysis were: life events linked to mental distress; education/satisfaction with life; mental health and social care services/ perceptions of effective treatments and processes; limitations of services and challenges for providers; cultural capability of practitioners and services; the range of diagnoses and symptoms; and dual-diagnosis treatment. Each of these is discussed below. Participants are referred to using the codes given in Table 1.

Life events linked to mental distress

Stress brought about by migration, both within nation and internationally, emerged as a common theme. AA, BM and IM, as recent immigrants from Somalia and Ethiopia, all reported migration as a stressful event,

while DA recalled being kidnapped by his Ghanaian father as a child and taken to Ghana as a time of hardship. JA, a white British participant, believed that his mental illness began when he moved from Essex to London as a child, and that this precipitated his mental illness:

> 'When I was 9, we moved to east London ... It was moving to the city that initially started my problems, my issues.' (JA, white British)

Education/satisfaction with life

A common problem for all was interrupted early education; this was seen for the vast majority of interviewees as a key to future recovery and wellbeing. AA was forced to interrupt his education by war in his homeland. BM, DA and JB all left education prematurely. IM had no formal education at all in his homeland of Somalia, while DD, JA and MA, another white British participant, all stated that they had some degree of behavioural problems and academic difficulties in school despite graduating from high school and/or gaining college qualifications. JD was the only participant who did not have problems in education; he left school with A-levels. All subjects claimed to be happy with their lives with the exception of AA who had become disillusioned:

> 'I thought when I came to this country I'm gonna get better life, but I'm getting worse life now. I haven't got good life ... I was younger than this age before, so I didn't know what was going on in this country and I was enjoying the life, going with my friends and going everywhere and now I realise the truth ... I'm getting old at the moment that's why I feel unhappy at the moment.'(AA, Somali).

JB, who had suffered racial abuse and violence in the predominantly white neighbourhood where he lived, wished to be moved from his supported hostel to a new place in a more diverse district of London:

> 'I'm getting harassed by these white guys ... they pretend to be my friends, but then they beat me up on a number of occasions, so I don't keep friends ... They just don't like me. I don't cause nothing, they just come at me. They just don't like me ... They call me a ''chief'' and a ''nigger''.' (JB, black Caribbean)

Mental health and social care services/ perceptions of effective treatments and processes

All except one participant had some history of hospitalisation in psychiatric wards. AA stated that he had attempted to gain admission when he felt suicidal, but that he was not admitted. Most of the men had seen a

psychologist or a social worker. Some used general practitioners, community psychiatric nurses, and outreach services, including home help. Some participants mentioned that they used support or alternative services, often culturally specific. AA and IM used Somali support services, while BM visited an Ethiopian community centre. AA and IM also used more general support drop-in services, as did MA. JA used spiritual services that were accessible to patients at his hospital.

Most participants took the view that medication worked for them and was improving their mental health. Others noted the positive influence that the hospital had on their wellbeing. For BM and DA, the advice of hospital staff was seen as being positive. For IM, JA and JD, the hospital admissions limited their access to illegal drugs and were thus helpful. JA went further to describe the hospital's impact on his health:

> 'This place is a kind of sanctuary. I feel safe here. Which is its main aspect, the main [...] of being here is just freedom from the problems of the outside world that I have. I can get away from that.' (JA, white British)

Some participants singled out the work that the social worker did as working well for them. Only two interviewees specifically mentioned counselling as working for them. For those participants who utilised the local counselling services or similar alternative treatment options like the spiritual services or specific cultural support groups, these were seen as being a very important part of their healthcare. For those interviewees who used outreach services, these services were seen to be important to their treatment. JA went as far as to say:

> 'I feel like some of the guys here they get no visitors, no nothing. But obviously they have outreach workers which probably would be a life saver because there's a lot of stigma attached to people with mental illness.' (JA, white British)

Special mention must be made of the useful role that police intervention played in the hospitalisation of IM. He was brought to hospital by the police after being arrested for a dispute with his wife. He states:

> 'I was lucky that I was jailed because they took me to the hospital. Before this I was really in such a state, if you hide your health problems they [the health problems] will kill you.' (IM, Somali)

Limitations of services and challenges for providers

Some participants believed that better cultural awareness and sensitivity could improve mental health services. AA thought that there should be more services like that of the Somali support he received. IM asked specifically for a Somali social worker:

> 'My whole life depends on this because I can't speak to them in Somali. I would have liked to have a Somali social worker, that is what I would have liked to have ... The only thing I would have changed in the system is if I have a Somali social worker, I can't come and see [the support worker] every day.' (IM, Somali)

> 'I would have liked people [health providers] to know about my culture and I know about their culture.' (IM, Somali)

Others felt that their health professionals could provide more time and care. AA and MA both stated a need for regular home help. DD (black Caribbean) and MA (white British) both stated that they felt that not enough time was being spent with them in the meetings they had with their clinicians:

> 'They didn't wanna know what was on my mind and that, just trying to get me out in about 5 minutes ... you did sort of feel like you wasn't part, you were just like a number, basically all you was a name of a client, service user, you weren't a person.' (MA, white British)

Some interviewees remarked that too much emphasis was being placed on counselling and mental health issues, and meetings that were often repetitive, with not enough attention paid to social activities. BM stated that he met with his doctor and social worker 'too many times'. DD felt that his social needs were being neglected:

> 'Well I can go to their offices, but they talk about mental health things and to me they don't really listen enough ... They're not giving me help in any way, they just come and try and talk to me and I don't class talking to as help, they gotta do something, actions ...' (DD, black Caribbean)

Both JA and MA believed that the hospital environment itself should be improved. JA stated:

> 'I think the system works alright you know. It's just the general state of the hospital is a bit of a downer ...' (JA, white British)

while MA stated:

> 'I think, it's just something, at ... I feel antiquated. It could do with maybe moving into the 21st century.' (MA, white British)

Cultural capability of practitioners and services

Interviews showed that khat use was being recognised as a significant and particular cultural problem for black East African communities. AA stated:

> 'They said don't chew [khat]. They see a lot of Somalis and they're getting mad about the chewing. Don't chew it. I said OK, but if I see my friends, they chew it, so I'll sit and chew it, 'cause I can't sit without chewing because they sit there chewing.' (AA, Somali)

In the case of BM, his clinicians seemed to know that he was a khat user without him telling them so or

knowing how they knew. Both black Caribbean participants remarked that hospital staff and other health professionals showed a lack of sensitivity with regard to culture. DD stated:

'No ... they're [background, ethnicity, religion and culture] not being taken into account by the doctor at all and they're not helping me. They bring me here year after year talking about my DJing career and they don't do nothing about it ...' (DD, black Caribbean)

'My religious needs. They're not recognising things ... because they come from a different society than what I've been brought up in; they believe in some way that they're controlling me just because they got me here ...' (DD, black Caribbean).

It is important, however, to note that DD was a cannabis user who believed that cannabis was part of his religious faith, while the health professionals believed that the cannabis use was having a detrimental effect on his mental health, leading him to state:

'They don't want to take it into account with me anyway, so I don't think they will. I been coming in here for too many years now, they haven't taken it into account at all.' (DD, black Caribbean)

Other interviewees, however, remarked that they felt that at the very least, some staff members were culturally sensitive and aware. DA, when asked if he felt that the hospital staff had an understanding of his cultural background, stated:

'Not all of them, no, but only some of them. And the ones that do have it are the ones that I do trust, that I do work with.' (DA, Ghanaian)

JA also felt that staff at his clinic had some cultural awareness and went as far as to say that he felt that because he had a shared culture with many of the hospital staff, that this was beneficial. When asked if he felt that he and the hospital staff had similar backgrounds he stated:

'Yea, yea, more so in fact, 'cause I did go to private school. Lots of doctors go to university and stuff and we're kind of on a level ... I have strong environmental concerns and they understand that, and that's how they managed to sort me out with the gardening project, and that was really cool.' (JA, white British)

All the recent immigrant participants were having problems with the English language, with IM's entire interview having been conducted in Somali. BM and IM were recognised to require translators, and in the case of IM, his brother often helped out in translation services.

Most of the interviewees claimed to follow a religion or believe in God, but did not consider themselves to be religious. In contrast, JA considered himself to be Christian, JD was a recent convert to Islam, while DD had a very individual and personal concept of religious practice.

The range of diagnoses and symptoms

The participants varied in their self-reported diagnoses, the symptoms they suffered and the substances they abused. With regard to substance abuse, khat use was a problem exclusively for the black east African participants who happened to be recent immigrants (AA, BM and IM). For the black African client who was born in the UK (DA) and the black Caribbean subjects (DD and JB), cannabis use was a problem. Cannabis use was also a problem for JA, though he had a long history of abusing a variety of illicit drugs, with cannabis and alcohol being the enduring substances he continued to use. MA also was recovering from his problems with alcohol. Only BM and JA readily admitted that their substance use was a problem, while DA and JB did not see their substance use as being problematic. DA stated:

'Yea I have smoked cannabis before, yea I have. But dope and cannabis I don't think they match ... Weed is good. Weed is positive. Meditation.' (DA, Ghanaian)

JB stated that cannabis had a 'good impact' on him and that after smoking cannabis it gave him a feeling of being 'strong'. JD would not admit to any substance misuse at all. In the case of DD, he believed that cannabis was part of his religious practice, but also showed understanding that he had to stop using cannabis for the benefit of his mental health.

With respect to mental health issues, most subjects were aware of their diagnosis, and sometimes they were aware of the medication they took and gave reasons for taking it. AA, a post-traumatic stress disorder (PTSD) sufferer, took medication for his paranoia and his inability to sleep. IM, also a PTSD sufferer, took medication for his inability to sleep. BM took antipsychotic medication to control the voices he heard. DA took medication for his psychological defects. DD and JD did not consider themselves to have any mental illness despite having been inpatients at some stage.

JA had a history of self-harming, while MA had once attempted suicide. JA had also suffered a breakdown after his mother died. MA had suffered claustrophobia and panic attacks. AA and IM suffered PTSD symptoms including inability to sleep, migration stress and poor memory, while AA also expressed loneliness, paranoia and a desire to suppress the past.

Dual-diagnosis treatment

All subjects were treated with medication; the vast majority had been hospitalised before or at the time

of the study. The majority of interviewees were encouraged by their healthcare providers to stop using drugs or alcohol, but rarely reported specific advice or specific intervention to deal with substance abuse. BM and DA stated explicitly that no practical advice was given to them, with DA stating:

> 'They're supposed to have leaflets out there saying no weed ... they ain't got it.' (DA, Ghanaian)

However, in the case of AA, his health professionals did give him some practical advice:

> 'They said don't go to Somali places where khat is being used. Go to the park, like cinema or football ground, stuff like that ... Other places, different areas ...' (AA, Somali)

In one case (DA) counselling was given, and in two other cases (DD and JD) it was offered and refused. Alternative hospital treatment was also used: BM and JA used physiotherapy, BM used art groups and JA used occupational therapy. Moreover, JA made use of the spiritual advisory services that were on offer at his hospital, and was also allowed to visit the local chapel even when his leave had been revoked:

> 'There is a chapel in the hospital and even when my leave status is completely nil, they let me go, and they say yea, this is beneficial to my spiritual needs ...' (JA, white British)

Outreach services were currently a part of the treatment for DD, JA, JB, JD and MA, or had been in the past.

Discussion

Race, ethnicity and dual diagnoses: challenges for practitioners and providers

Dual-diagnosis service users shared a history of disrupted education, parental separation, migration and isolation. Despite these problems, most black African and white British subjects were eager to return to education. The strengthening of educational access by mental health providers may help to provide more effective interventions that impact on total wellbeing, rather than concentrating on alleviating psychological ills. Black Caribbean subjects were primarily focused on being employed and may benefit from employment schemes. However, common to all groups were unemployment issues, alongside problems with housing, homelessness, racism, living in crime-ridden areas and inadequate services for home repairs. There are some projects in London, largely in the voluntary sector, that work on providing home repairs and decoration services for those with mental health problems. Perhaps

such services are also more necessary in mainstream services to work more closely with mental health services. Parental separation at an early age and family separation and isolation were tragedies for all. These may of course be interconnected through attachment patterns becoming engrained, through impacts on personality development and interpersonal and social skills deficits. The fear among service users may be that this experience is repeated with service providers where there is a high turnover of staff, closure of services, or too many services providing for any one individual. There was some evidence to suggest that dual-diagnosis issues were being recognised and treated concurrently for some; however, across ethnic lines there was nothing to suggest that subjects were being specifically treated for the substance misuse component of their problem. Substance use and abuse were discouraged, but this seldom went further than vocal discouragement. In one case, practical advice was given as to the ways in which social habits could be changed to facilitate the discontinuation of khat use. In another case pamphlets about the dangers of cannabis were said to exist but had never been seen. Apart from these two instances, vocal discouragement seemed to be the most-used means of treating the substance abuse issues, along with the restriction of substance use that hospitalisation brought.

Cultural capability

Culturally specific services were more heavily used by the immigrant black African interviewees, although the religious white British interviewee did make use of the religious support that was available to him in hospital. Culturally sensitive treatment was a recommendation that all black subjects thought was required, though some believed that some cultural awareness and sensitivity was present among health professionals; most believed that more could be done in this area. Of most interest was the case of the black Caribbean client who felt that his care providers were violating his religious needs when they prevented his cannabis use. But even he eventually acknowledged that he had to stop using cannabis for the sake of his health, suggesting a possible success on the part of the staff in balancing religious needs and health needs. Cultural and ethnic sensitivity and awareness in all these areas of concern should not be thought to be a problem of only minority ethnic groups and migrant communities. Cultural sensitivity matters as much to the white British devout Christian and the white British Muslim convert as it does to recently migrated Somalis and hospitalised black British Caribbean men. However, this should not devalue the fact that minority ethnic groups live lives with different and complex problems that may not affect the majority white

British population. More interventions, staff input and education to improve culturally relevant and effective approaches within mental health services should be emphasised in policy, and practice. For example, taking account of racism in providing housing options, and being able to deal with discrimination are important skills that are rarely taught or engrained in personal development programmes. Dual-diagnosis treatment overall was mainly medication and hospitalisation, though counselling was offered and sometimes taken, and outreach services and alternative treatment were also used. Substance use itself differed across ethnic lines. Khat use was exclusively a problem for immigrant black Africans, while cannabis use was a problem for black British interviewees, both black African and black Caribbean subjects. For the one white British client who admitted cannabis use, it was one of many illicit drugs that he had used, including alcohol which was also a problem for another white British client. On at least one occasion, cultural awareness was seen with regard to khat use as a potential problem for the Somali community.

In recent years, the use of khat by immigrant communities in Europe and elsewhere has raised alarm among policy makers and some healthcare professionals (Bhui *et al*, 2006). Warfa *et al* (2006) reviewed the current literature on the relationship between khat usage and mental disorders, and found that there was no conclusive association between khat use and psychological problems, although the review showed some associations between excessive khat use and psychiatric problems. The results of this qualitative study show that the issue of whether khat causes psychosis or not is complex. In the case of AA (Somali immigrant), it was not clear whether khat caused his PTSD or if he was ill before he started chewing khat excessively, and therefore was using khat to cope with this condition. Other immigrant participants experienced both social and economic problems in the host nations. For most of the participants, there was loss of family network, loss of social support and homelessness. Both khat and cannabis usage can interact with each other and with every one of the above-mentioned problems which are additional risk factors for mental illness. This suggests that people with experiences of mental illness and substance misuse may have a complex and multidimensional profile of health and social care needs.

Therapeutic relationships and ethnicity

Emotional support, care and time invested by service providers were also seen to be important across cultural groups. Dissatisfactions were expressed with regard to short meetings and a perceived lack of consideration. However, satisfactions were expressed by service users in the relationship they were able to foster with staff over time (where a white British participant felt that the fact that he shared a similar culture with the healthcare professionals was beneficial). While medication was seen to have a positive effect in the cases of most of the interviewees across ethnic lines, there was a sense that medication could also be detrimental to health. There has been much debate about whether ethnic matching is necessary for effective care; notions of ethnicity are themselves limited, and racial and cultural variables may be better units of analysis taking account of racism and prejudice and more cultural factors such as religious and health beliefs, explanatory models, and treatment expectations. Ethnic matching as a solution may be a hopeful but inappropriate and ineffective response, if professionals of all ethnic groups are equally poor at assessment and treatment of dual diagnosis. Ethnic matching may be a critical factor in early engagement for some service users, but is not uniquely crucial. However, studies of dual diagnosis have not addressed this issue.

Conclusions

With the relative dearth of research in this area and the general movement towards expanding cultural competence in mental healthcare, we hope that our study, with its emphasis on listening to the voices of patients with dual-diagnosis needs, is able to stimulate debate and effect change. This study shows that more work is needed on health promotion and healthy living, as well as more attention among practitioners to ambivalence towards medication needs, to be addressed in the context of an active therapeutic relationship in which trust and confidence help motivate people with complex needs, histories of numerous tragic life events, and poorer physical and social functioning. Moreover, the specific health and social care needs of diverse ethnic groups using a range of substances including khat and cannabis while coping with a severe and enduring mental illness do require urgent attention. We conclude that further research is necessary but must be linked directly to (a) establishing the needs of distinct ethnic groups for dual-diagnoses services and interventions, detailing the specific combination of problems they face; and (b) including a larger range of ethnic, religious and cultural groups; evaluation of interventions for dual diagnosis and evaluations that develop interventions for specific ethnic, religious and cultural groups.

The predominant discourse of healthcare provision to ethnic groups in the UK and US has revealed tension between specialist or generic services, and notions of racism at an individual and institutional

level. The manner in which countries, even within the EU, perceive and conceive of racism and the subsequent response to the needs of ethnic groups requires analysis and understanding, as very diverse solutions are proposed. In the UK, there is insufficient knowledge to drive a specialist service policy or to mandate ethnic matching, but the skills of the workforce and the recognition of psychological vulnerabilities to dual diagnoses do need emphasis. Multiple triggers and vulnerability for distress may be managed differently by distinct ethnic and social groups. Understanding the relationship between race, ethnicity and psychological vulnerability and social adversity seems essential. Alongside this understanding we need a better evidence base for effective interventions that embrace service users' views and offer hope, practical assistance and effective interventions, while retaining flexibility to respond to new challenges so that services remain relevant, appropriate and accessible.

Limitations

This was a small exploratory study. A major review of dual diagnoses conducted by the Department of Health demonstrated that little is known in the UK context about dual diagnoses and ethnicity. Our sample size is relatively small, but we undertook in-depth interviews and reported those findings that were most consistently raised by subjects. Given the nature of the problems of engagement in services, we found similar problems recruiting for the study. Although we aimed to sample three ethnic groups, one might argue that the findings cannot be representative of people from each ethnic group. We could agree with this assertion, but the valid findings are important to bear in mind for some service users, and *may* be relevant to other groups and peoples from the same and other ethnic groups. Larger qualitative and quantitative studies can address this further; treatment and service models need to be developed and evaluated using service user outcomes alongside conventional symptom-based approaches and reports of using substances. However, cultural capability in dual-diagnosis care, or complex needs care, has not been sufficiently theorised or evaluated; such work is part of a series of reviews on cultural competency, dual diagnosis and ethnicity, and learning networks to enhance clinical effectiveness among ethnic groups. This work is being undertaken by our research group along with colleagues at the Royal Free & UCL School of Medicine, as part of our virtual institute called CHIMES (Centre for Health Improvements in Ethnic Services). Our MSc programme students in Transcultural Mental Healthcare, a course open to all disciplines and available in e-learning and distance learning format from October 2006, are building the evidence base and evolving a range of interventions in anticipation of future effectiveness studies.

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CONFLICTS OF INTEREST

None.

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