Research papers

Rapid needs assessment of the provision of drug and alcohol services for people from minority ethnic groups with drug and alcohol problems

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ABSTRACT

Policy makers and service providers have recognised the need for culturally sensitive service provision for people from ethnic minority backgrounds. This paper reports on the findings of a study undertaken to inform policy makers and service providers of the needs of service users from minority ethnic groups with drug and alcohol problems, and issues related to access and utilisation of services. A rapid needs assessment was carried out in a London borough. One-to-one and focus group interviews were carried out with service users, family members, and representatives of voluntary and statutory service providers. Interviews were recorded and transcribed for content analysis. The findings showed differences in access to services by people from minority ethnic groups, and varying perceptions of underlying factors and attitudes to drug and alcohol misuse. The need for culturally competent services was expressed. The implications for service provision for a multiculturally diverse population, and the need for a programme of education in cultural competence are discussed.

Keywords: cultural competence, cultural perceptions and attitudes, diversity, drug and alcohol misuse, ethnic groups

Introduction

This article reports the findings of a rapid needs assessment carried out to explore gaps in service provision, identify training needs for staff and make recommendations on how to provide services that are culturally competent in dealing with people from different cultures and backgrounds. The findings of this needs assessment informed the development of a module in cultural competence in dealing with people with drug and alcohol problems, which is currently being delivered and evaluated.

Background

Alcohol and drug use amongst minority ethnic groups has increasingly become a concern for communities as well as for planners of health, social services and the criminal justice system (Sangster *et al*, 2001; Fountain *et al*, 2003; National Treatment Agency (NTA) 2003a,b). The extent of the drug and alcohol problem within minority ethnic groups is far from clear. There is an ongoing debate about whether the low uptake of services by minority ethnic groups reflects the real need for services, or whether the high barriers to services prevent people from seeking help. A number of publications have highlighted the particular vulnerability of minority ethnic groups to

developing problems with drug and alcohol use (see, for example, Westermeyer, 1995; Patel, 1997; Pearson *et al*, 1998; Fountain *et al*, 2003; NTA 2003a,b) and highlighted the low uptake of services by people from minority ethnic groups (see, for example, Abdulrahim *et al*, 1994; Johnson and Carroll, 1995; Perera, 1998; Sangster *et al*, 2001). The reasons were found to be complex, and included denial and lack of awareness that there is a problem, stigma within the family and community, a lack of knowledge about where to go for help, and a lack of services accessible to clients from minority ethnic cultures. Healthcare services that had been planned for the majority population are not always appropriate to the needs of people from minority cultures (Smaje, 1995; Sangster *et al*, 2001; Fountain *et al*, 2003). The perception persists that drug treatment services are run for and by white people (Awaih *et al*, 1992; Perera *et al*, 1998; Sangster *et al*, 2001). Few members of staff are members of minority groups, and consequently there is little empathy and understanding of culturally based needs or patterns of drug use (Perera, 1998; Sangster *et al*, 2001; Fountain *et al*, 2003). Additional factors that prevented minority ethnic groups from approaching services included general mistrust because of the service's closeness to the Home Office with its responsibilities for immigration and policing (Abdulrahim *et al*, 1994; Sheikh *et al*, 2001). Other issues included languages and communication problems, and worries about possible breaches of confidentiality (Khan and Ditton, 1999; Fountain *et al*, 2003).

Disparities in access and treatment are probably not due to any racial bias among staff but to constraints such as time pressure and the complexity of the job (Geiger, 2001). Moreover, while service providers may be keen to develop their services to include clients from minority ethnic groups, they may lack the experience, expertise and clear guidance necessary to make their service more culturally appropriate to attract clients from diverse cultural backgrounds (Johnson and Carroll, 1995; NTA, 2003a,b; Fountain *et al*, 2003).

People from minority ethnic backgrounds do not have the same access to appropriate drug education, treatment and care. Service providers and members of minority ethnic communities acknowledge that both cultural competence and specialist knowledge on substance misuse problems are needed to provide a high-quality service to drug- and alcohol-using individuals from minority ethnic groups. The need for more and better quality services for people from minority ethnic groups has also been recognised in recent government policies (Department of Health, 1998, 2001; Home Office, 2000).

Against this background, the Ealing Drug Reference Group commissioned the Substance Use and Misuse Team at Thames Valley University to develop training in cultural competence targeted at professionals from a range of services working with people who have drug and alcohol problems. As part of this exercise a rapid needs assessment was carried out in the multicultural London Borough of Ealing, with the intention of:

- providing an overview of the extent of alcohol and drug misuse within minority ethnic groups in Ealing
- identifying underlying factors of drug and alcohol use within these communities
- recognising gaps in service provision
- identifying specific training needs of staff in general and specialist services.

Methods

The use of a rapid needs assessment as the methodological tool was chosen for a variety of reasons. A rapid needs assessment is a methodology that quickly collects locally relevant data. It is designed to shorten the time gap between research and the implementation of intervention strategies, in particular for local conditions (Needle *et al*, 2003). Rapid needs assessment procedures have been shown to be effective as a pragmatic research tool in examining social, cultural and economic issues, especially when only limited data exist (Ball *et al*, 1998; Rhodes *et al*, 1999; Needle *et al*, 2003). This is particularly the case in the context of drug taking within minority ethnic groups, among whom treatment uptake is low, and drug use remains hidden because of its illicit nature and the stigma within the community. Rapid needs assessment procedures are preferable to conventional research methods as they enable the delivery of a quick response to inform policy or decision making in time (Manderson *et al*, 1992; Needle *et al*, 2003). This is of particular relevance in the constantly changing field of substance misuse. As rapid needs assessments are undertaken with the aim of developing interventions and not merely to generate knowledge, they can be perceived as an integral part of the response and development process of an intervention (Rhodes *et al*, 1999). Rapid needs assessments have also evolved as a tool for community development (Manderson *et al*, 1992; Needle *et al*, 2003). Interventions developed in response to an assessment not only depend on knowledge of the local situations and practices, but also require the active participation of the targeted local communities for whom these interventions are intended, in the assessment and the design of interventions. The development of a bottom-up community response rather than an outside-expert view is likely to increase the community's adherence and commitment to change, to encourage participation and collaboration and eventually to enhance the success of the intervention.

Although rapid needs assessment procedures may have their limitations regarding the depth, quality and quantity of data which longer-term needs assessments can deliver, they offer a quick way of obtaining an initial snapshot. It was therefore chosen as the appropriate tool for the purpose of this research and to inform the development of a training pack and module.

The rapid needs assessment was carried out between July and September 2001. The review of the literature drew on a variety of sources including electronic databases, such as Medline and PubMed, Home Office and Department of Health websites, government guidelines and reports. Further database and library research included the libraries of DrugScope, King's Fund and Thames Valley University, where unpublished literature on examples of good practice was found and included. The literature review informed the background of the rapid needs assessment and guided the design of the questionnaire and the data analysis.

Data collection included documentary analysis of the annual attendance data in selected treatment centres, and demographic statistics from the local borough of Ealing. Of the four Ealing treatment centres, two were alcohol services and two catered for drug users. Treatment uptake data were also selected from an alcohol treatment centre in the neighbouring borough of Hammersmith, to compare uptake by different ethnic groups.

Ethics committee approval was not sought. A multidisciplinary and multicultural steering group guided the study. This group included representatives from the local drug reference group, who commissioned the research, as well as local service providers. The drug reference group consisted of local professionals from health, social and specialist drug and alcohol services, schools, youth, homeless, the criminal justice system and community services, and from the statutory and non-statutory sectors. Its members recommended individuals and services as key informants for interviews from a broad range of settings, that included health, social, educational and community areas. The criteria for inclusion were that the participants needed to be well informed and knowledgeable about the specific area of the focus of the study. For example, service providers who were directly involved in a caseload of patients with drug and alcohol problems were invited to participate. The recommended individuals or services were approached. They were informed about the aims and outline of the study. They were asked about their willingness to take part and their availability. Frequently, those initially approached recommended other individuals or services for inclusion. Those approached expressed a genuine interest in the study. However, two declined to take part for reasons of time constraints. The distribution of the key informants was mixed in terms of their sex, age and ethnicity (see Table 1).

Thirty-eight semi-structured one-to-one interviews were conducted with key informants within the borough (see Table 1). In addition, a focus group was conducted with parents ($n = 12$) of drug-using young people in Ealing. The focus group consisted of a mix of ethnicities, genders and ages: five were females, seven were males, ten came from minority ethnic background, two were white British. The age range was 40–60 years. Interview and focus group data were recorded as written notes on paper rather than being tape recorded. As a substantial number of participants, particularly from minority ethnic groups, had expressed their wish not to be tape recorded, we adapted this approach to all interviews. Notes were taken in each interview and anonymised using a coding system, as were the notes from the focus group. In order to ensure confidentiality of data, only the researchers had access to the personal details of the participants.

An interview frame was developed from an understanding of the issues raised in the literature, from policy guidelines and unobtrusive observation in shops and parks in the borough. The interview frame and key questions were discussed and approved by the steering group. Questions focused on participants' perceptions and possible explanation of what were the underlying factors within the cultural context of drug and alcohol use within minority ethnic groups, and how this would impact on help-seeking behaviour. Participants were also asked what they thought of the current practice in services, if they identified any gaps, and what makes a service culturally competent.

Data analysis consisted of a constant comparison analysis of interview notes from both the one-to-one interviews and focus group (Strauss and Corbin, 1998). Content analysis of the interview notes and the notes from experimental field work (observation where people from the local community were met and geographical factors were explored in shopping centres, public parks, local off licences and local shops) was carried out. The one-to-one interview data were read. Key themes and patterns were identified by coding and segmenting the data. Initial codes were attached to words, phrases and sentences. Similarly coded responses in interview notes of each case were given a corresponding number. Similar codes assisted in generating categories through comparison of data from each case. A reiterative process was utilised in deriving categories to ensure that these were in synchrony with the questions asked, and to transform data into meaningful concepts (Richards, 2005). Categories were collated into particular concepts or ideas explored. Concepts were scrutinised to identify their relationships with each other.

Analysis of the focus group data adopted the same processes of coding words, phrases and sentences, and deriving of categories. These were then collated into concepts. The findings are presented in statements with actual data as quotes from interview notes.

Table 1 Key informants by service settings and ethnic groups

Setting	n	Ethnicity	Sex
Statutory alcohol treatment service	3	2 white British	M, F
		1 white other	M
Statutory drug treatment service	4	2 white British	F, F
		1 African-Caribbean	M
		1 white other	F
Voluntary sector alcohol service	4	1 African other	F
		2 South Asians	F, F
		1 white British	M
Voluntary sector drug service	2	1 African-Caribbean	M
		1 white Irish	F
Community mental health services	3	1 African other	F
		1 black African	M
		1 South Asian	F
HIV services	1	1 South Asian	M
Generic health service	2	2 white British	F, F
Youth services	2	1 white Irish	F
		1 African-Caribbean	M
Community centres	3	1 black African	M
		2 South Asians	F, M
Criminal justice system	2	1 South Asian	F
		1 white British	M
Community and religious leaders	4	3 South Asians	M, M, M
		1 black African	M
Politician	2	1 South Asian	M
		1 white British	M
Family members	3	2 South Asians	M, F
		1 white British	F
(Ex-)users	3	1 South Asian	F
		1 white British	M
		1 white Irish	M

Findings

Demographic and treatment uptake data

Multicultural Ealing

Analysis of the demography of the London Borough of Ealing showed that it is a highly multicultural area with a large minority ethnic population (41.3% of the total population – 9.1% in England and Wales). It also has a high proportion of young people; 19.8% of Ealing's population is under the age of 16 years (census data, 2001; Neighbourhood statistics, 2001). According to census figures the largest minority ethnic group in Ealing is of Asian origin (24.6%), of which the Indian population is the largest group (16.5%) with other Asian 3.9%, Pakistani 3.8% and Bangladeshi 0.4% forming the remainder of the Asian population. People of black origin form the next largest group (8.8%), of which Caribbean people form the largest proportion (4.5%). Africans 3.7% and other black people 0.6% make up the remainder of the black population (London Borough of Ealing, 2001). The Irish population is the only white ethnic minority category listed in the census. Irish people form 4.8% of the minority ethnic

population in Ealing. According to the Office of National Statistics Mid-Year Estimate (2000), the minority ethnic population in Ealing is increasing, particularly in those areas with an already high proportion of minority ethnic groups. Black Africans and other ethnic communities are those groups with the most rapid growth.

These demographic data illustrate the diversity of Ealing's minority ethnic communities, which is expressed in a range of lifestyles, religions, cultural norms and values. This diversity is also shown in a range of views on the use of substances, knowledge of treatment services and expectations upon these services. Given the predominant South Asian population in this borough, what is reported here is weighted heavily towards a South Asian perspective.

Treatment uptake

Review of the treatment uptake data of five participating statutory and non-statutory treatment providers revealed that people from minority ethnic groups are approaching drug and alcohol services for help, but to a lesser degree than the indigenous white British population. The treatment uptake data (see Figure 1) reflect the ethnicity profile of the borough. The highest proportion of clients within most of the services under study was 'white British', followed by either 'white Irish' (Alcohol Gatehouse 16.8%), 'Indian' (23.2% Gatehouse Drug Treatment Centre (DTC) and 49% Southall Alcohol Advisory Service (SAAS)), or 'Asian UK' (21% Ealing Drug and Alcohol Service (EDAS)). Compared to data from a treatment centre in the neighbouring borough of Hammersmith, an area with a predominantly white British population, the treatment

uptake clearly shows a reflection of the ethnicity profile (The Wolverton Gardens Centre: 75.8% 'white British', 10.9% 'white Irish' and 4.7% 'white others' followed by 2.3% 'others'). Local treatment data also indicated differences in the uptake of services with regard to sex and age. Drug treatment services have been taken up to a higher extent by young white British individuals, and declined with age (under 20 years 68%, 20–29 years 58%, 30–39 years 50%). The reverse is true for minority ethnic groups who accessed services at an older age group (40–49 years 57%, 50–59 years 70%, 60+ years 78%). Analysis of the sex distribution showed a higher proportion of white British females in all services, for example, 62% white British, followed by 8% white other, 8% Indian, 6% mixed other at the Gatehouse DTC.

Treatment uptake data show that members of minority ethnic groups use some services more than others. The findings indicate that those services with a cultural mix of staff were more likely to be visited by minority ethnic groups than those with only white members of staff. However, the data on the uptake of treatment do not give information about client satisfaction or the quality and success of interventions, nor do they indicate whether these services met the needs of their clients.

Findings from the one-to-one interviews with key informants

Underlying factors

When asked about what factors they thought influenced substance use, 90% of participants thought that
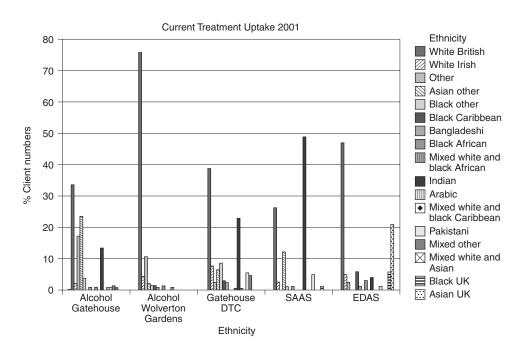

Figure 1 Treatment uptake by ethnicity. Source: Luger (2002)

the clash between traditional and western culture had a huge impact as to why people drank and took drugs. It was suggested that while first-generation immigrants might use drugs and alcohol to overcome their isolation and anxiety because they lived in a foreign society, young Asian or black people born in Britain tend to drink or use drugs to fit with their white British peers from school or work. The issues are complex but it was simply stated thus:

> 'Being South Asian in Britain – everything changes.' (South Asian community drug worker and mother)

Furthermore, the stigma of drug use, shame and guilt, and the pressure of keeping up appearances within the community were found to have a huge impact on their ability to seek professional help. For example, one respondent suggested that:

> 'If you have a good reputation as a hard working man/woman, who goes to the temple and your family is OK, you have obviously done well, then society treats you well.' (South-Asian community alcohol worker)

Respondents also believed that it is often difficult to live up to the public image, especially when the traditional values and beliefs disintegrate with the increasing influence of western culture.

> 'It's a shame when your husband is drinking or if the son is taking drugs. It's your fault. Blame yourself!!' (South Asian community worker and mother)

Private behaviour, be it extramarital affairs, drinking alcohol and taking drugs or domestic violence, was accepted by the family, as long as no one outside the family got to know about it. In the event of private behaviour becoming public, the family was overcome by shame and guilt. As a result drug and alcohol problems tended to remain behind closed doors.

The overwhelming majority of respondents (90%) reported that a variety of issues were found to be vital in a family's perceptions of alcohol and drug use, and their knowledge and attitude to treatment. These included lifestyle, family structure, religion and socio-economic background, approaches to solving problems and giving support within the family and community. While it was believed that Islam, Sikhism and Hinduism prohibit the consumption of alcohol, it was thought culturally acceptable for male Sikhs and Hindus to drink. Male behaviour was associated with drinking:

> 'Sikh and Hindu bring about macho masculine behaviour. Drink alcohol to progress to being a man, a masculine man!' (Male South Asian sexual health worker)

A belief commonly held by participants (about 60%) was that adherence to religious and cultural taboos was slowly being eroded. One example given suggested that young South Asian women did not seem to care about the old taboos but wanted to go out and enjoy life just like their white British friends did. Nevertheless,

views were expressed that the influence of religion and culture is still very strong and that its impact on the individual should not be underestimated. Breaking taboos and violating the rules and social conventions of one's community was still perceived as a source of considerable guilt and shame.

Ten percent of the respondents made reference to the role of religious or community leaders in the context of drug and alcohol taking. They felt that while some understand the problems their community members are facing, others ignored the existence of drugs and alcohol:

> 'They don't even want to have leaflets about drugs in the temple.' (South Asian drugs worker)

Community leaders were seen as protecting or defending their community and not admitting to the existence of drug and alcohol problems.

> 'Community leaders are often defending their race and do not admit that there are drugs and alcohol problems. But they need to see the reality of their people.' (South Asian drugs worker)

Participants reported that ignorance of the problem, and lack of knowledge concerning what to do and where to go, were reasons for not accessing services. Families with a drug user often took drastic measures such as locking the drug user into the bedroom to keep him/her away from the bad influence of friends. The family might act in good faith, hoping that the person will get better, without being aware of the dangers and effects of withdrawal without appropriate medical treatment and supervision.

Another measure was to send the drug user back home to the subcontinent. Families believed that removing the person from the environment would help in changing behaviour.

> 'They hope to get them away from western influence, from drugs and their drug-using friends.' (South Asian drug prevention worker)

Professionals from drug treatment centres highlighted the frequent use of private detoxification units by South Asian families who believed that detoxification would solve the drug problem.

> 'Families try to get their kids in private detox. They pay up to £3000 per week and think everything is fine afterwards. But things don't go like this. As soon as the kid is back, he gets addicted again.' (South Asian drug worker in statutory service)

Current practice in services

In order to highlight current practice in services, the participants were asked what they saw to be the key challenges for the provision of services for clients from different ethnic groups. Seventy per cent of staff from a white British background admitted that they often felt

uncomfortable because they were aware that their white clients and those from minority ethnic backgrounds had different needs.

> 'I am comfortable talking about drug issues with someone from a minority ethnic group, but when it comes to cultural issues then I feel I am sort of stuck, because I do not know exactly what it is that they need.' (White drug worker)

However, many white drug and alcohol workers said they were not able to identify exactly what these needs were. Service staff reported feeling comfortable talking about drug issues with someone from another ethnic group, but did not feel competent in relating to the cultural issues of their clients. Twenty per cent of staff stated that they treated all people equally, regardless of their cultural background. Only about 10% of staff stated that they felt comfortable in dealing with clients from all other cultures. These staff mainly came from a minority ethnic background themselves and were, therefore, socialised into a multicultural environment.

Staff and community members identified a number of issues that needed to be addressed when providing a service for clients from different cultural backgrounds. In their view, staff needed a knowledge base about other cultures that included knowing how to pronounce names, the meaning of titles, dietary requests, lifestyles, religious rules and dress code. People from minority ethnic cultures might be reluctant to access what they perceived as 'white' services. Possible reasons for this were not feeling respected and understood, and maybe mistrust of service providers from other cultural backgrounds. White staff who were unaware of cultural differences might fail to recognise their needs. Clients were more likely to approach a service when someone from a minority culture was working there. Even if clients chose not to consult someone from their own culture, a mixed cultured service would demonstrate more openness.

Gender differences in treatment uptake were explained with reference to cultural norms and restrictions. Societal stigma often made it difficult for women to admit an alcohol or drug problem. Respondents from the minority ethnic communities highlighted that women might be prohibited from leaving their homes without a male companion, or might be uncomfortable accessing mixed-gender services. It was, therefore, suggested that service providers needed to ensure that their services were confidential and safe for women.

Language-related problems formed one of the over-riding concerns about service provision to minority ethnic clients. Linguistic differences could lead to misunderstandings or even misdiagnosis, and prevent people from accessing services. While most young British-born individuals were fluent in the English language, first-generation immigrants, especially females, might not be able to converse effectively with staff in services. Language was not the only issue here. Poor communication between services and communities was likely to lead to mistrust in services.

What makes a service culturally competent?

Participants were asked what they believed made a service culturally competent. A number of issues were raised, including awareness of the cultural mix of the potential client group, the implementation of race equality policies and non-discriminatory practices. The concept of a culturally competent service should become the norm for working with all clients. A cultural needs assessment should be conducted in order to tailor the service to an individual's particular needs. A cultural mix of staff would signal that services were more accessible and open to the needs of minority ethnic groups.

Most participants felt it was important that services made contact with the communities they worked for, through outreach work in the community and the training of peer educators. Further suggestions included more key workers, frontline staff from minority ethnic groups, and partnerships between services and the community.

A number of training needs were identified in relation to knowledge and understanding of the underlying factors of drug and alcohol use within different cultures. Skills were needed to enable staff to identify and meet the needs of drug and alcohol problem users from these population groups and their families.

There was a common view that the development of culturally competent services is not just an educational issue. Education must go hand in hand with a range of structural adjustments and government policies that support the development of culturally competent organisations and services. Examples given included:

- increasing funding for drug and alcohol treatment to decrease waiting times and to increase the capabilities of staff to reach out to hidden populations in need of services
- creating opportunities for clients to choose white-, mixed-culture- or ethnic-specific services
- ensuring that culturally specific services did not become isolated ghetto services, vulnerable to marginalisation and closure in time of resource constraints.

Findings of the focus group with parents of drug users

The participants in the focus group estimated that approximately 30–40% of the families in Ealing of all

ethnicities were facing problems with their offspring's drug use. Yet, they stated that there were few local services that young drug users and their parents could access. Those that existed were not open in the evenings when working parents were able to attend. In the opinion of the parents, the waiting time for accessing drug treatment was too long. The limited number of rehabilitation centres, and the time between detoxification and rehabilitation was also too long to be effective. Some families reported trying detoxification at home, but were not given any advice on how to deal with withdrawal symptoms. It was commonly felt that the staff in services did not understand young people's needs and the cultural background they were coming from. In particular, parents from South Asian backgrounds criticised staff who did not understand the importance of the role that families play in their culture, or that the head of the family needed to be involved in the decisions on treatment issues. These parents admitted that they found it very hard to be excluded from the treatment for reasons of confidentiality.

All participants agreed that the treatment needed to include the parents and their drug-using offspring. Parents needed help because they did not know what to do or how to support a drug-using child. They were often not informed about the impact of drug use and possible treatment options. They did not understand and were frequently scared because they felt left alone with their problem. A significant number of parents (40%) reported that they had received little understanding and help from their general practitioner (GP), while others (30%) felt their GP was very helpful. Some (20%) admitted they were too ashamed and frightened to ask their GP for help.

> 'I thought that it would never happen to me and that my kids would never take drugs. I was wrong. I ignored it for too long because the thought of it was too frightening.' (South Asian mother of a drug-using son and daughter)

> 'Sadly, I had to realise that covering up for my son's drug use only worsened the problem.' (Black Caribbean mother)

All participants in the focus group agreed that the Families Anonymous Group was very useful to them. The group had helped them to accept their son's or daughter's drug use and to understand that family conflicts were important factors in their children's drug use. The group helped them to change their different attitudes and to understand that they couldn't solve their children's problems.

> 'Being in the Families Anonymous Group changed my attitude to my son's drug taking. I needed to accept that I can't solve the problem for him. No matter, if I lecture, moralise, blame or argue with him, whether he is stoned or sober, it does not help. It may make me feel better, but it makes the situation worse. Losing the temper with my son will destroy our relationship and any possibility of me helping him.' (South Asian father)

> 'My wife does not go to the meetings, which is sad. As a consequence she does not have the same attitude towards him as I have. She does not understand him and goes on arguing. But when he is not willing to stop using drugs we need to consider what we can do to avoid standing in the way of his recovery.' (South Asian father of a drug-using son)

Finally, all participants expressed their great relief at meeting others with similar experiences and problems. The group helped them to learn more effective ways of coping with the situation and, at the same time, gain some peace of mind and hope for a better way to live in the future.

Discussion

Comparing the treatment uptake figures was difficult because the ethnicity categories vary between the individual treatment centres. For example, only one service used the category 'UK Asians', which referred to young South Asians born in the UK. Furthermore, the categories were not detailed enough to detect certain ethnic groups, such as people from Iran, Poland or Somalia. This may explain the high number of clients in the category 'others' where clients probably could not identify themselves with any of the existing groupings. The category 'white others', for example, embraces everyone who defines themselves as white. This may include people from East, West, North or South Europe, Turkey, Iran, the United States and Australia; countries whose cultures differ widely from each other.

These findings show that the concept of ethnicity is very complex, and ethnic categorisation does not embrace the diversity within ethnic groups. There has been much debate on the issue of ethnic identity and the categorising of population groups (Bradby, 1995; Aspinall, 1998). The usefulness of monitoring ethnicity and conducting research into ethnicity and equity in health has been questioned as to whether it is racist, simplifying complex issues, blaming the victim or a vital requirement in improving services (Bradby, 1995; Bhopal, 1997; Kaplan, 2003). Furthermore, the long-standing association between material deprivation, minority ethnic status and the experience of racism means that ethnicity and socio-economic group cannot be treated as independent variables (Bradby, 2003; Nazroo, 2003). Therefore, ethnicity on its own does not seem meaningful, as it does not take into account factors such as the socio-economic situation that may impact on the vulnerability of particular population groups with regard to health problems and their help-seeking behaviour.

The findings of the study confirmed the complexity of reasons for low treatment uptake that were highlighted in the literature review. For example, the low

uptake of these services by African or African-Caribbean people may partly reflect their relatively low proportion within the local population. It may also reflect referral procedures based on misdiagnosis, stereotyping or prejudices in GP practices or primary care settings, which commonly referred black clients to mental health units, and may be due to a lack of understanding of minority ethnic culture by staff in services (Sangster *et al*, 2001; Fountain *et al*, 2003). In the case of black Africans, particularly Somalis, the low treatment uptake appears to reflect participants' perceptions about the attitudes of service providers, and results in a lack of trust in services. Again, this confirmed earlier explanations which suggested that mistrust may be the result of a number of factors, including the perception that drug services are for white people only, experience of discriminating attitude, little empathy, and lack of understanding by staff.

The findings also highlighted that a variety of reasons may either hinder or facilitate access. These include whether the location of the service is easily accessible by tube or bus; the proportion of minority ethnic groups within the local population; the degree of staff mix in the service; whether the service is also offered in the languages spoken within the community; whether it is provided by a voluntary or statutory treatment organisation; and whether the service is known to the community or the referring GP. The stigma attached to drug and alcohol problems may cause people to access services in other boroughs, in order to avoid meeting someone from their own community. In addition, the feeling of guilt and shame is not easily overcome and may even lead to more drug and alcohol consumption or prevent the person from accessing help.

Further findings pointed to the lack of awareness about drug problems and the lack of knowledge about what to do and where to go for help (Johnson *et al*, 1995; Perera, 1998; Sangster *et al*, 2001; Fountain *et al*, 2003). The well-meaning practice of South Asian families sending their drug-using adolescent back home in the hope that, once there and away from their peers, they would recover and become drug free is very often not successful. The young person may develop a much heavier drug habit, as drugs, particularly heroin, are purer, cheaper and more easily available in South Asia than in Southall (Pearson and Patel, 1998). Alternatively, a young person may be drug free on return to the UK, but may quickly revert back to their old habits if no aftercare support is offered.

Similarly, the frequent use of private detoxification units by South Asian families may be of limited success. Families often underestimate the complexity of drug dependence. Detoxification is only the first step of a long hard road to recovery. In order for drug treatment to work, the drug user needs to be motivated to stop using drugs. In addition, substance use is often a means of coping with problems in a person's life. Unless these problems are addressed, drug treatment may not be successful.

In summary, the findings of the study supported many of the key issues highlighted in the literature review. The findings demonstrated the seriousness of the problem and the desperate need for support from drug and alcohol services. Many of the problems remain hidden because people do not access services because of shame or guilt, lack of knowledge about where to go for help, or because they feel the services are not appropriate for them. On the other hand, service providers often lack understanding of minority ethnic cultures and time constraints, and the lack of resources often makes it difficult for them to provide a service that is culturally appropriate. There was agreement among service providers and people from minority ethnic groups that the education and training of staff are vital in enabling the development of culturally competent service provision. However, training alone does not make a service culturally competent. Improving the communication between healthcare staff and clients from a different cultural background is as important, as is improved networking between services and communities.

Conclusion

In conclusion, the study showed that increasing the knowledge and understanding of the underlying factors of drug and alcohol misuse within minority ethnic groups, and developing the skills of staff to deal appropriately with the needs of their clients were vital for the development of culturally competent services. In addition, more emphasis needed to be placed on working in partnership with communities and training peer educators and key workers from within these communities. More resources were needed to increase the capacity of treatment services. Education needs to go hand in hand with the implementation of recent government policies that aim to minimise inequalities and social exclusion, bringing into effect race equality policies and non-discriminatory practice in all public authorities, including health, social services, the criminal justice system, education and employment. It needs to be recognised that culturally competent services can only be developed within a mutually symbiotic partnership between the different cultures, characterised by openness, trust and mutual respect. An educational and training programme informed by the findings of this study was developed and has been delivered. The effectiveness of the programme is currently being evaluated.

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CONFLICTS OF INTEREST

None.

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