Evaluating the service provision for ethnic minorities in Islington in the treatment of substance misuse

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Abstract

Purpose – *The purpose of this paper is to illustrate how local drug services use their senior staff to respond to emerging ethnic groups presenting to treatment using flexible thinking and innovative processes.*

Design/methodology/approach – *The methodology was a case study design that used a semi-structured questionnaire that looked at two drug services and their staff's influence on service delivery in different boroughs of east London.*

Findings – *The research found very innovative findings from the two boroughs. The boroughs had different racial mixes and therefore differing populations presenting to their local drug services. However, they used flexible approaches to structure their services to engage with emerging ethnic minority populations in drug treatment. From the findings, these different approaches and structures of providing drug treatment were very important. Approaches, for example, of clinical staff offering a "rapid assessment" are particularly important in engaging and retaining ethnic minority populations. Also, using flexible thinking within the staff team enables drug services to adapt treatments to be flexible in responding to emerging ethnic populations.*

Practical implications – *This paper shows that thinking in designing approaches to drug treatment shows that ethnic minority populations can be successfully engaged in drug treatment. This has implications for drug treatment nationally and across Europe where there are "emerging" ethnic populations presenting for drug treatment.*

Originality/value – *This paper shows that drug services can adapt and change to their different ethnic minority populations if they can able to be flexible in their clinical approach to service provision.*

Keywords *Drug use, Drugs, Ethnic minorities, Treatment, Flexible, Islington*

Paper type *Research paper*

Introduction

This paper illustrates the way some drug projects in London have adapted their services, to be more able to treat emerging ethnic minorities who are seeking treatment. It looks at two very different boroughs in London, one with a small but significant ethnic population which is Islington, and one that has a large immigrant population, Tower Hamlets.

Whilst this is a localised study in London, it is hoped that the flexible approaches to treatment and the application of knowledge from clinical staff, will appeal to a wider audience. This is because, the role of accommodating ethnic minorities is not just a problem for London but, Britain and all European countries with an immigrant population who use drug and alcohol problematically.

In Islington, drug services have seen a small but significant number of second-generation south Asian males presenting to drug services with their families. This can often be a very different presentation to standard white British clients, who usually presents on their own, due to poor family support and fragmented relationships within their family.

Received 17 November 2014
Revised 18 May 2015
Accepted 22 May 2015

Drug services in Islington struggled to treat South Asian men, as some were not set up to deal with their extended families. There were issues of confidentiality and an approach to medical treatment that made inclusion of family members difficult. This was an unmet need for this emerging population who found families supportive. Family support can often be beneficial in the recovery process, not just in the field of drugs (Fernandez, 2004), and there was a gap in local clinicians' understanding of the needs of this emerging South Asian (mainly Bengali) population, as stated in national research conducted and summarised in 2003 (Bashford *et al.*, 2003).

Bashford *et al.*'s research on ethnic minorities in the UK was collated with national studies conducted across the country in a literature review by the University of Lancashire in 2003. It was found that there were needs particular to ethnic minority groups who wanted treatment for substance use. This review found that there were low levels of knowledge about drugs across the gender and age categories; an absence of any perception of drug use as problematic; and denial that there was a drugs problem in the first place. There was also a lack of knowledge about the health complications associated with drug use and its impact on family life.

To further complicate matters, the study found that some services struggled to provide adequate service for ethnic minorities. To address these issues, services needed to be aware which ethnic minorities presented and to consider conducting a thorough needs assessment (Bashford *et al.*, 2003). This would hopefully lead to better planning of resources and more effective treatment services for this population.

Research on ethnic minorites and drug use in the UK conducted recently further verifies Fountain *et al.* work from 2003. This shows a high level of smoking heroin and crack with little movement to injecting. Also, the level of crack use was minimal, similar to the presentations discovered in previous research from 2000 to 2005 (Fernandez, 2002, 2004). This is further verified by the national 2007 survey completed in 2008 (Gordon *et al.*, 2008).

However, this recent research revisiting ethnic minorities in drug services also shows that many issues still exist, such as the lack of an understanding both of what drug services can be used for and of the cultural issues faced in these communities (Fountain, 2009c, d, e). This same research, however, went deeper into the issues that ethnic minorities feel deter them from treatment, such as waiting times, a major challenge for services.

"Once people access a service, the speed with which a person receives any treatment or other intervention is an important factor in whether they remain engaged" (Fountain, 2009a, b, c, d, e).

This is saying that an assessment that takes a short amount of time (rapid assessment) is beneficial for ethnic minority engagement in drug services and hopefully this paper will illustrate the importance of this concept and its benefits.

Therefore, in summary, the literature reveals gaps in knowledge regarding ethnic minorities' presentations to drug services. Some of these were covered by the literature review funded by the National Treatment Agency (Bashford *et al.*, 2003). All the findings from an updated literature search are shown below (it is noted that they are broadly similar to the previous literature review in 2003).

The main reasons that communities identified for their not seeking services, or for acting as barriers to access, were:

1. a lack of awareness of drug services and the help they could provide;
2. the perception that the services were not appropriate, e.g. not using hard drugs, or that they could handle the problem themselves; and
3. waiting times for assessment (Fountain, 2009e).

So what are services doing to respond to this and how are they engaging ethnic minority communities in their drug projects? This paper explores this and finds some evidence that having flexible and forwarding thinking senior clinical staff is an important part of treating ethnic minorities effectively in drug treatment.

Project design-methodology

There has been much localised research in this field and this paper illustrates providers' knowledge and understanding of the ethnic communities they are trying to service through a qualitative case study. This study also explores whether commissioners, key stakeholders and clinicians delivering services in the NHS understand the effects of race on poverty and hence drug use in their society. Since there is not much research into the provider side, this study hopes to resolve this.

Therefore the aim of this study was to examine areas of good practice within the London Borough of Islington and another neighbouring borough in London which was Tower Hamlets that manage ethnic minority service users in drug treatment. This was to explore whether there was transferable knowledge and effective treatment which could be shared to improve service provision for ethnic minorities undergoing drug treatment.

For the project, Islington was used as a case study, it was felt important that senior clinicians of each service and the managers in Islington were identified and sought by myself to participate in this project (Purposive sampling). This was because these figures are the leads of their respective services and shape the delivery of care in their institutions. This research, taking the clinicians' perspective, has not before been conducted in Islington thus had an original approach that informed service provision in the area of substance misuse.

Semi-structured interviews were also used. The interview can enable researchers to collect rich and descriptive qualitative data (Silverman, 1993). It can be constructed as either formal or informal questions, with much data collected through both (Silverman, 1993). However, a semi-structured interview can lead the participants a little, to focus on the field that needs to be studied (Bryman, 2001). This format was adopted for this project with interviews re-visited, sometimes twice, to verify the data and approach the state of "saturation" (Walliman, 2011).

In summary, the project adopted a qualitative approach with semi-structured interviews as it aimed to examine the perceptions and understanding of key decision makers locally. It was thought best to use a flexible approach to gather rich data that would capture the way that people understood their working worlds and the issue of race and how this impacts on access to services (Gomm, 2004). It was also semi-structured and therefore explorative in its approach in order to capture the thoughts and outlooks of the people working in the area of substance misuse.

Focus groups were also conducted, employing the existing forum of the Borough Drugs Strategy Group that all the lead clinicians attended. The sessions were used to validate further the data collected from the interviews (Bryman, 2001). Through the ethics process an information sheet and consent was given out with a request for the focus group discussion to be recorded. Consent and access, examined later, did not hinder this process. The undertaking provided additional rich data that complemented the interviews.

The study also looked at other boroughs in London. The main one examined here was Tower hamlets a local neighbouring borough. The same process of one to one interviews with purposive sampling was adopted in Islington. However, this was used to inform the research in Islington rather than be used as a comparative study. This did benefit Islington in its utilisation of this project to improve service provision.

Results

Tower Hamlets

The Mental Health Trust is the leading agency prescribing and managing patients in the London boroughs of Tower Hamlets, for drug treatment. It works with voluntary sectors to treat people who present to services in the borough. The Trust has positioned itself as the complex needs service, with a tiered system for the voluntary sector to organise the assessment and key working of patients who are not complex. This includes patients in the Primary Care sector, as shown in Table I.

There is a significant south Asian population accessing services in both boroughs. In Tower Hamlets, the south Asian population is mainly Muslim and Bengali, with a minority of Pakistanis.

Table I Service map hierarchy for Tower Hamlets

Complex patients: poly drug users who have mental health problems such as schizophrenia, bi-polar disorder, clinical depression	Mental Health Trust
Patients without poly drug use such as heroin/crack dependence: no diagnosed mental health problems	Mental Health Trust
Patients without poly drug use such as heroin/crack dependence: no diagnosed mental health problems	Mental Health Trust with Primary Care GPs

The main reasons why the services are able to work with a significant population of Asian drug users is due to several factors:

- specific voluntary sectors projects target Asian populations;
- good clinical links with community projects in the area by the Mental Health Trust;
- rapid assessment (explained in detail later); and
- the Asian drug-using population is able effectively to communicate good service provision within their community through "word of mouth".

However, the aim of this project is to examine what services have learnt from the literature produced over the last decade and how this has influenced the clinical approach to services in Tower Hamlets. The interviews were conducted as those indentified in the methodology and the results are shown below.

Knowledge of previous research. Some of the staff in leading roles were interviewed with a semi structured questionnaire and the ones who could not be interviewed were included in the focus groups. All the data collected is provided here and the main findings are categorised in terms of the main themes that emerged.

One encouraging sign was that all who participated were aware of previous research, particularly in Islington, as both helped on the completion of the work at the Margerete Centre. Some staff had even participated and learnt much in the interviews and the feedback from the research sessions as well. From this experience both have applied their knowledge in Tower Hamlets, which had helped make a head start in treating the South Asian population in this area, a very diverse part of London.

Engagement. Factors identified in the research in Camden and Islington drug services are applicable here, such as the clients' expectations of detoxification and the aim of having as short a treatment episode as possible, this information often passed within the community through "word of mouth". The South Asian population tended to come to the service and engage supported by a friend who had had good experiences of the drug service in Tower Hamlets (is similar to the findings of Camden and Islington). Their main reason for presentation.

Therefore, the way treatment is communicated is very much by "word of mouth" in the community, is recognised by the service and used to encourage other patients' family members to come forward for treatment. In their experience of the Camden and Islington South Asian (mainly Bengali) population, in certain circles, it was recognised that patients' personal experiences and narratives are important in bringing the community into drug services. Therefore, the most important way to reach an ethnic population is for one or two people to have a positive experience of the service and go back to their communities then talk about their experiences. This "word of mouth" communication was vital in bringing this population into drug services.

All interviewees stated that the high level of ethnic minorities treated in Tower Hamlets and neighbouring Newham was due to this ethnic population being numerous compared to other boroughs. The non-white population comprised over half of the overall population of Tower Hamlets and Newham, and this has an impact. All staff felt that to provide effective treatment for ethnic communities that it was important to understand how these communities operate. But they felt they were aware of what worked for these communities and used this to try and provide effective treatment.

Rapid assessment. In terms of engaging and retaining this population, in treatment with significant numbers, the majority of staff felt this had been achieved due to the rapid assessment and prescribing within 24 hours currently practised in the service. There is a 24-hour maximum from assessment to prescription, and in many cases a patient can be assessed in the morning and leave with a prescription in the afternoon. This rapid treatment model has helped capture an Asian population that has historically been "treatment shy" and ambivalent to substitutes. Being assessed and prescribed in 24 hours enabled clients' goals to be accommodated quickly and effectively, hence the significant numbers retained in drug treatment.

In particular, the one participant stated that a service that can treat people quickly is indeed important in reaching out to ethnic populations and retaining them in treatment. Treatment in the rapid access clinic is often a positive experience for ethnic minorities in Tower Hamlets (and Newham). For many clients, it can be related back to their communities, potentially bringing a greater ethnic population into drug services. In the clinics, assessment is jointly undertaken by the doctor and the nurse/pharmacy prescriber, which enabled a thorough and quick assessment without duplication. Using only a single urine sample, if it is found appropriate from the assessment, the patient is started on substitute prescriptions (buprenorhine or methadone). This is quick and vital in retaining in treatment ethnic minorities such as the Bengalis.

Flexibility. Tower Hamlets recognises that the rapid assessment and operating a flexible and responsive service has created a highly positive experience for the patient, who will feed this back to family and friends, resulting in more referrals from the ethnic group.

In Tower Hamlets, it appeared that having a flexible approach meant:

1. making staff resources available to ensure assessment to prescribing can be completed in 24 hours;
2. staff were able to be flexible in their thinking and knowledge to understand and accommodate a south Asian population presenting to treatment with different needs; and
3. staff were educated about ethnic groups and drug and alcohol presentations in their educational sessions.

Therefore in Tower Hamlets, in terms of making staff as a resource available, in order to treat patients quickly, is essential. It can accommodate ethnic minority patients in services, which the literature would verify in this case (Fountain, 2009a, b, c, d, e). Also, flexible thinking to treatment was evident and enabled a different clinical approach to be effective and thinking beyond the medical model to increase its effectiveness.

Many of the patients asked to be started on buprenorphine (they heard this medication from their peers) rather than on methadone when starting on substitute prescribing for opiate addiction, under the impression that it is the chief detoxification medication. Therefore, their goal to treatment is clear. They want to stop using drugs by stabilising on substitute medication such as buprenorphine, and then to detoxify off the drug as quickly as possible (useful in the current climate of recovery). This is very similar to the findings in Camden and Islington ten years ago. It seems the concept of detoxification for the south Asian male population is still popular, and is not confined to Camden and Islington. A flexible approach can enable this request to be given but working with the individual to increase insight and the idea of achieving stabilisation and then to reduce towards a detoxification which can take time. Clinical staff are all encouraged to be open and flexible in their thinking to treatment to accommodate south Asian ethnic groups.

Barriers. Barriers tend to be perceptions and limited knowledge of "how to use" services from ethnic minority groups. The south Asian clients tend to be young men, with a very small number of women. Their knowledge of treatment services is often limited, with this cohort at times, unable to use treatment effectively to meet their aims.

When presenting as a cultural group, South Asians are the main group with the aim of having a short period of treatment and detoxing. Staff interviews felt the South Asian males that came to the service with the fixed idea of stabilising quickly on substitute medication, unaware that stabilisation is a step towards detoxification and often detoxification will not be completed without

the patient being stabilised on their medication first. This is a major challenge for accommodating this ethnic group but can be achieved with a flexible approach to thinking about how treatment can be delivered.

Another barrier to the South Asian and a "new" emerging ethnic group is work. Eastern Europeans are often in employment and will frequently move elsewhere in the country for jobs. Therefore, they comprise a mobile and high functioning population in Newham and Tower Hamlets and the challenge is to treat this population safely, when it is constantly on the move. This can be a barrier to effective treatment for this cohort and limits the outcome, so stability and detoxification may be delayed or hard to incorporate due to the priority of "looking for work".

Another barrier that can led to a lack of understanding of drug services is that often, in Tower Hamlets, ethnic populations have limited English. A lack of adequate English can often delay the assessment process and the start of treatment. To try and resolve this in Tower Hamlets there is a bank of translators who can be reached by telephone or who work within the treatment system. They are often used to complete an assessment and to start the treatment, proving invaluable in retaining this population in drug treatment services.

In summary the most important concept for Tower Hamlets was the idea of a "rapid assessment" clinic which has led to a better engagement and throughput model in the Borough for ethnic minorities.

Islington

Islington is structured differently and has a tiered system approach and part of my research focused on projects where new patients come to the services: Isis, based in Finsbury Park, and PCADS, the Primary Care Service. The other major service in the Borough is IDASS, the specialist service dealing with complex drug-dependent patients.

The tiered system is shown in Table II.

The Isis service has been in operation since 2009, arising from a re-designed pathway at the last drugs review. Throughput was seen as a problem in the Borough and Isis was created to enhance this through the tiered system. So far, it has developed strong links with Primary Care, offering assessment and initial treatment for all new patients, thus was a good place to interview key staff on their experience of ethnic minorities and what kind of treatment approaches are offered.

Results from the interviews with Islington staff. The data is presented below under the themes emerging from the semi-structured interviews.

Theme: engagement. All interviewees responded that they were aware of the issues in engaging ethnic minority patients with drug services. It was stated that some ethnic minorities are more difficult to engage in any health service, in particular drug services, probably because of the stigma attached to drug use in their communities. Often, services are not designed to their needs, and there are cultural differences such as the need for detoxification from direct pressure from patients' families and a lack of understanding of the families' role in the issue. This has been underestimated by drug services, and has often led to ill-matched treatments.

In Islington, as in Tower Hamlets, the need for a detoxification was common. The Detoxification Service (City Roads), saw a significant South Asian population using the service. Often, those who presented to City Roads (Islington Detox Service) wanted the same detoxification package more than once, and the relapse rate was high. However, the only way they would engage with the services was to receive a detoxification package.

Table II Service map hierarchy for Islington

IDASS	Complex needs drug patients
ISIS	Non-complex drug patients and all new patients into the treatment system
PCADS	All patients who are suitable to be treated by the GP. This patients group can vary in complexity
DAAP	All new clients and substitute prescribed patients and also offering a service for stimulant and cannabis use only

"We are aware of the work completed in the area over the last decade but not the real specifics of it. There are barriers and cultural differences. However, if your clinical team are responsive and flexible they will look to improve things. We were lucky that this was picked up by the staff at City Roads".

Manager of city roads.

Research into ill-matched treatments for ethnic minorities had had an impact here. Ethnic minorities were not detoxified again and again, but were instead directed to engage long-term with drug agencies to work on their "insight" (as in Tower Hamlets). This improved the outcomes when patients from ethnic minorities came in for their second detoxification. This, however, needs to be an ongoing process. The push from ethnic minority patients to receive detoxification as their preferred treatment is still high in Islington.

Theme: barriers (lack of resources). "Resources can often be an issue and a lack of resources can lead to less flexible services and an inability to meet needs. This can affect engagement".

Clinical lead for Isis.

Some interviewees expanded on this, feeling that in the current climate services were being cut, and this further compromised what they could do. Services were being stretched to the limit and, as a result, were becoming less flexible in terms of resources and staff.

This is a wider issue in healthcare across England and Wales and many NHS resources are stretched. Cuts in drug services had been made to Isis and had led to a less accommodating service, so would a high-profile, culturally specific project improve access to services for all in this area? This is emerging as a point for discussion, but would clearly incur some expense.

It appears that all interviewees stated that flexibility is directly dependent on the level of resources. The speed of treatment and the way clients are assessed and prescribed for quickly is important but, can only be achieved if there are suitably skilled staff and resources applied flexibly.

In Tower Hamlets, all the staff felt that rapid assessment and prescribing was indeed critical to retaining new populations in treatment. For many of the interviewees in Islington, the challenge was how the resources were organised in order to produce that model and flexibility. There was no joint assessment for patients by a doctor and a non-medical prescriber, as in Tower Hamlets. A doctor completed all new assessments and initiated prescription before non-medical prescribing could take place. This may be an area that could re-think the assessment process to speed things up. It would also use resources more efficiently in challenging times. However, both Isis and the Primary Care Service said that they process patients within 48 hours, from assessment to prescribing. In many cases, it can be even quicker, but if resourcing is cut then this service would be difficult to maintain.

Services in Islington aim to be flexible, and if they can be more so, then they are best able to service their treatment populations, whatever their needs and wherever they are from. However, all interviewees noted Eastern Europeans presenting to services in Islington was the "new" ethnic minority group presenting for treatment. This was similar to the experience of Tower Hamlets, and is the new ethnic population presenting to drug and alcohol services.

Overall, the interviewees in Islington acknowledged that services are not designed with ethnic minorities in mind. Also, additional problems with cultural differences and language barriers prevent patients from engaging with services. At times, services tend to blame the patients for their often complex presentations. The need for interpreters can be costly and often difficult to arrange, making patients even more difficult to treat and creating a barrier to treatment.

Theme: flexibility. This was strongly linked to the discussions throughout this paper, with all interviewees stating that flexibility is directly linked to resources. However, all were realistic in accepting that more funding was not forthcoming under the Coalition Government, so there was a need to be creative with existing resources.

Flexibility to accommodate ethnic minorities and other groups was often the aim of services in Islington.

This meant:

1. being flexible with staff resources and planning resources to meet demand; and
2. being aware that education of staff through their education and development sessions to increase awareness of ethnic minority needs of South Asians presenting to drug and alcohol services.

Despite the good intentions of staff to improve their knowledge (through their educational sessions: as in Tower Hamlets) and be flexible in how resources can be planned to respond to treating their patients, proved difficult. Often there were not the resources to make the services culturally responsive. All drug services had had problems encouraging women to come for drug treatment, recognised nationally as well as locally. The issue of trying to engage ethnic minorities into drug services is similar, and what is needed is effective outreach into ethnic communities. Outreach models for services could be promoted and modelled to use from the experience of other services such as the ones in Tower Hamlets; such as, understanding these communities "word of mouth" is the best way to encourage ethnic minorities to engage with drug services. Therefore, some outreach if provided, would enable a potential cohort to be attracted to drug treatment. Well-designed outreach services could result in increased numbers of ethnic populations presenting to services for drug treatment.

In addressing the issue of flexibility, all interviewees expressed the opinion that flexibility costs money (e.g. opening hours and staff costs) and this is in short supply. It was acknowledged that services offered great flexibility in terms of when people can attend during the day, but that Islington services often have poor access to interpreters, a fairly basic requirement, and that sessions have to be organised at least a week in advance. As a whole, the Borough employed workers from a range of ethnic backgrounds but had problems with emerging ethnic populations as staff numbers from these communities are not high enough to meet the need. If services are struggling to have flexible opening hours, how can one expect flexibility for clinical treatments for ethnic minorities with complex needs and no English? It would appear that the level of resources of some services was a real issue.

Discussion

Therefore there are important points raised in this research which can be taken forward to improve service provision in drug services. They are further discussed now.

Flexibility

Flexible services can accommodate different needs, not just for ethnic minorities but other minorities such as women. All senior clinical staff are aware of the local research and national research conducted in 2003, and lead their drug and alcohol services to meet ethnic minority needs for substance misuse. They all aimed to render their services flexible to accommodate ethnic minority needs, but few had updated their knowledge since the Borough-wide training in 2004. It is fortunate that this had not affected drug treatment, as the same issues discovered in UK research continue to affect ethnic minority populations (Fountain, 2009a, b, c, d, e), and a teaching session for the Borough would be useful for all managers and senior clinician staff.

All clinical staff in Islington felt there were barriers to treatment for patients who presented from ethnic minority backgrounds. These barriers were language and a poor understanding of drug services and, as mentioned, were similar to previous research findings in the UK (Bashford *et al.*, 2003; Fountain, 2009a, b, c, d, e; Fernandez, 2002). However, some of the barriers are created by limitations of funding. The current cuts to services in Islington were felt by most staff to force them to be less flexible and less responsive to ethnic minority needs. This is a poor situation, going back to a time when services struggled to meet the needs of emerging ethnic minorities (Fountain, 2009a, b, c, d, e).

Despite this pressure, senior clinical staff felt that services had developed in such a way that flexibility, in resource provision and thinking, was a prominent part of treatment in substance misuse and would be an advantage in accommodating and treating ethnic minorities such as the

South Asian community in Islington. Flexibility was seen as an approach in structuring drug and alcohol services to meet ethnic minority needs from Islington's perspective. However, different presentations need different treatment plans and, in order to provide this, services must be flexible (Lê Cook and Alegría, 2011).

Rapid assessment

The speed at which ethnic minorities are engaged is important and, if funding causes delays, this might lead to a reduction of the number of ethnic minority patients coming to services.

"Once people access a service, the speed with which a person receives any treatment is an important factor in whether they remain engaged" (Fountain, 2009a, b, c, d, e).

Fountain's report showed that South Asians' poor experiences of drug services were linked to waiting times:

> While some drug users were satisfied with the drug services they received and felt that their needs had been met, more drug users rated services poorly (including those in prison), particularly because of:
>
> - too long waiting times for treatment;
> - the lack of follow-up support, particularly after detoxification; and
> - the services' lack of understanding of South Asian clients' cultural and religious background (Fountain, 2009a, b, c, d, e).

Rapid assessment is therefore a major attribute identified by both this project and UK research to accommodate ethnic minority populations. It is conducted in Tower Hamlets, where assessment and prescription are completed within 24 hours. In Islington this takes 48 hours, at times with a longer wait for prescription. Tower Hamlets' drug services had responded directly to current literature findings and the senior clinicians there felt this was vital in keeping ethnic minorities in treatment. This needs to be undertaken in Islington, where the high level of flexibility could be argued to be less effective than the introduction of rapid assessment.

Lessons from Tower Hamlets

This research is not designed as a comparative study but an explorative case study, but in practice there were some highly useful findings worth highlighting as they reinforce previous research findings and approaches that should be adopted by other boroughs to improve practice.

The most important finding, which could be examined further for transfer to Islington, was the process of assessment and treatment termed "rapid assessment". As mentioned in the previous section, Tower Hamlets staff aimed to assess and prescribe to patients within 24 hours, something Islington at times struggled to manage due to budget restrictions and a lack of resources. Tower Hamlets enabled a 24-hour prescribing service, judging it to be a successful way to treat ethnic minorities. The rationale being that in recruiting new populations quickly, enabled long-term engagement with drug services, this is supported by research completed in the UK (Fountain, 2009a, b, c, d, e). This could be adopted by Islington services.

One major difference between Islington and Tower Hamlets was there was a culturally specific project in Tower Hamlets that successfully engaged and targeted ethnic minorities using drugs. This was seen as positive as it seemed to locate patients from the ethnic minority community to enter treatment and, coupled with the speed of assessment, enabled them to stay in treatment and engage effectively.

Tower Hamlets has a higher population of ethnic minorities than Islington and this has arguably forced through the idea of a two-tier voluntary sector project. However, using its existing services, Islington should investigate developing structures like the rapid assessment as this would add to drug treatment provision in the Borough. However, it should be recognised that amongst inner-city drug services with large minority population, Tower Hamlets is an exemplary model that could be transferred and become more widely adopted.

However, it is important to note that Islington and Tower Hamlets both stated that new ethnic minority populations were emerging, and the same processes of flexibility and rapid assessment

seemed important in engaging these populations in drug treatment. It appears from this project that there are useful tools to produce and develop to help meet ethnic minority needs in drug treatment:

1. rapid assessment; and
2. two-tier culturally specific drug and alcohol services.

Wider implications. This research is focused on London drug service provision. However, the need to be flexible and reflective on one approach to drug treatment to accommodate ethnic minorities is an important one. Therefore the ethos of this paper has wider national and international implications can could inform policy-makers and senior clinicians.

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