

A Qualitative Study of Drug Abuse Attitudes and Patterns among Drug Abusers in Ethnic Diversity Groups in Hong Kong

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Executive Summary

This study provides an in-depth exploration of drug use patterns, attitudes, and rehabilitation experiences among ethnic diversity drug abusers in Hong Kong, focusing primarily on Nepali, Pakistani, and Indian communities. Drawing from 36 abuser interviews and 10 service provider interviews, the findings reveal that drug taking behaviours are heavily shaped by cultural norms, social networks, and structural barriers that differ markedly from those of the local Chinese population. Initial drug use commonly began in early adulthood and almost always occurred in social contexts, primarily through friends, significant others, or casual gatherings, where substances were normalized and curiosity, contact opportunity, and peer influence played significant roles. Clear ethnic patterns emerged: Nepali participants predominantly used heroin, often mixed with tranquilizers or methadone, Pakistani respondents mainly consumed methamphetamine, commonly known as “ice”, and frequently paired use with gambling in game centres, while Indian participants generally favoured cannabis, viewing it as a recreational or stress relief substance rather than a harmful drug.

Drug use for many respondents remained social and communal even among long term abusers, diverging from the traditional five stage drug use model that predicts eventual isolation. Cost sharing, cultural cohesion, and shared coping practices contributed to sustained group use, meaning later stages of hidden or solitary consumption were less common among ethnic diversity abusers. Alongside these social factors, several risk factors influenced drug use initiation and continuation. Peer influence and closed circle dynamics were central, particularly as many ethnic diversity groups maintain tight, insular networks shaped by cultural familiarity and trust. Psychosocial pressures, such as adaptation difficulties, boredom, unemployment, bereavement, and misunderstanding of drug harms, further heightened vulnerability. Cultural perceptions also played a role, with cannabis normalized in some participants’ home cultures and misconceptions about the safety of substances like methamphetamine reducing perceived risk.

Despite these challenges, several protective factors emerged, with family attachment identified as the most powerful motivator for quitting or reducing use. Many participants expressed deep emotional ties to family members locally or abroad, influencing them to pursue sobriety or temporarily return to their home countries to break drug use cycles. Peer supporters, especially rehabilitated peers from similar cultural backgrounds, reinforced hope and fostered behavioural change. Structured environments, such as residential rehabilitation, halfway houses, and methadone clinics, also offered stability, though the benefits often depended on cultural compatibility.

However, the study highlights significant systemic and structural gaps that limit effective engagement and treatment outcomes for ethnic diversity abusers. Language barriers, lack of cultural competency, and religious incompatibilities within existing rehabilitation centres frequently discouraged participation or led to early dropout. Fragmented services, lengthy intake procedures, and fear of stigma or judgement further hindered help seeking. Many participants also struggled to access aftercare or employment support, contributing to boredom, re exposure to drug using peers, and relapse.

The report concludes that Hong Kong's current drug rehabilitation system could be further strengthened to support ethnic diversity populations. It recommends establishing culturally and linguistically tailored counselling centres and residential programmes, strengthening aftercare and employment support, formalizing peer supporter career pathways, and implementing multilingual, culturally adapted drug education initiatives. These reforms are essential for addressing both the structural inadequacies and the unique socio-cultural dynamics shaping drug use within Hong Kong's ethnic diversity communities.

報告摘要

本研究深入探討香港尼泊爾、巴基斯坦及印度等多元族裔吸毒者的吸毒模式、態度與康復經驗。研究共進行了 36 名吸毒者及 10 名服務提供者的訪談，結果顯示，多元族裔的吸毒行為深受文化規範、社交網絡及結構性障礙所影響，其模式與本地華人吸毒者相比具有明顯差異。多數受訪者在成年早期開始首次接觸毒品，而首次使用幾乎均在社交情境中發生，例如透過朋友、伴侶或聚會場合。在這些環境中，毒品被視為「正常」的一部分，而好奇心、有接觸機會與朋輩影響成為促使首次使用的主要因素。研究亦發現明顯的族裔差異：尼泊爾受訪者主要使用海洛英，常與鎮靜劑或美沙酮混用；巴基斯坦受訪者主要吸食甲基安非他明，俗稱「冰毒」，並常與遊戲中心的賭博行為連結；印度受訪者則普遍使用大麻，並視之為娛樂或紓壓方式，而非具危害性的毒品。

對多數受訪者而言，即使長期使用毒品，其吸毒行為仍維持群體性與社交性，這與傳統五階段吸毒模型預測走向社交隔離的結果有所分別。成本分擔、文化凝聚力及共同應對壓力的方式，使吸毒行為持續在群體中發生，令後期階段的隱蔽或單獨吸毒情況較少出現。除了社交因素外，數項風險因素亦會影響吸毒的起始與持續，包括朋輩影響、封閉的社交圈子、適應困難、沈悶、失業、喪親，以及對毒品危害的誤解。部分文化觀念亦是風險因素之一，例如大麻在某些原生地文化中被視為常態，而部分人誤以為「冰毒」等物質為較安全的毒品。

儘管如此，研究亦識別出數個保護性因素，其中家庭連結是促使戒毒或減少用毒品的最強動力。許多受訪者表示，即使家人身在海外，情感連結仍促使他們嘗試戒毒，甚至暫時回到原居地以打破吸毒循環。朋輩支援員，尤其是同族裔的康復者，亦能帶來希望並促進行為改變。結構化的治療環境，例如宿舍式康復中心、中途宿舍與美沙酮診所，同樣提供穩定支援，縱然其成效往往取決於文化的相容性。

然而，研究指出，多元族裔在使用現有康復服務時面臨顯著的制度性與結構性阻礙。語言障礙、文化敏感度不足，以及宗教需求得不到配合，常使受訪者抗拒參與或提早中途退出服務。分散的服務、冗長的入組程序，以及對污名與被批判的恐懼進一步阻礙求助。此外，由於部分受訪者難以獲得後續支援或就業協助，導致沈悶和重返舊社交圈，令復發風險上升。

本研究最終指出，可加強香港現行的戒毒及康復服務系統以支援多元族裔群體。報告建議設立具多元文化與語言配套的專屬輔導中心與住宿式治療服務、強化出院後支援與就業協助、建立恆常化的朋輩支援員制度，以及推行多語言、具文化適切性的毒品教育計劃。這些改革對於回應結構性的不足，以及多元族裔社群在吸毒問題上的獨特文化動態，均具有關鍵重要性。

Chapter 1 Introduction

1.1 Hong Kong Ethnic Minorities

Although predominantly Chinese, Hong Kong is considered an international city, with Hong Kong ethnic minorities taking up 8.4% of the overall population (Census and Statistics Department, 2021). Such ethnic minorities come from diverse backgrounds, with a large number of residents being ethnically South Asian. This includes Indians, Pakistanis and Nepalīs, taking up 15.6% of those who do not identify as Chinese. Existing Hong Kong studies often include the 3 ethnicities in their research (Erni & Leung, 2014; Liu & Gietel-Basten, 2019; Tang et al., 2006), however the three countries differ in customs, religion and societal structure, with within and between group differences that are worth exploring.

For example, from a religion context, Indians mostly practice Hinduism, Pakistanis mostly practice Islam, while Nepalīs mostly practice Buddhism or Hinduism. Furthermore, diverse ethnic groups exist within each country, containing their own various customs and practices. An example is the use of language within each country. In India, North Indians mainly speak Hindi, while South Indians mainly speak Tamil (Ranjan, 2021). In Pakistan, although Urdu is the official language, only 7.08% of Pakistanis use it in their everyday life, although most do understand (Abbas & Bidin, 2022). Whereas in Nepal, its caste-based society resulted in several language families, the largest being Indo-European and Sino-Tibetan (Shrestha, 2016). According to the 2021 Population Census, it was reported that only 44.5%, 9.3% and 15.4% of Indians, Nepalīs and Pakistanis speak English as their usual spoken language, in contrast to 46.5%, 84.5% and 74.7% of “other languages” (Census and Statistics Department, 2021). This suggests that many individuals in these communities primarily use languages other than English in their daily communication, which has implications for service access and for how research samples are recruited and interpreted. Thus, more culturally informed research is needed to capture specific group experiences and needs, rather than relying on broad South Asian categories.

1.1.1 Nepalīs in Hong Kong

One of the earlier South Asian settlers in Hong Kong, Nepalīs were brought on when the British first occupied Hong Kong Island in the 1840s (Erni & Leung, 2014). It is theorized that such recruits stemmed from the distrust and segregation between the British and the Chinese, while Nepalīs, specifically those under the Gorkha empire, had a prior established relationship with the British from trade, or were already previously recruited to the British Indian Army. Gorkhas were recognized by the British for their “bravery, loyalty and fierceness” (Erni & Leung, 2014, p. 18), a reputation gained during the Gorkha war, and were deemed excellent recruits to prevent illegal entry to Hong Kong. Such individuals were mainly stationed in Jordan, Yuen Long, Wan Chai and Shek Kong. After the handover, some decided to pursue Hong Kong residency, raising a new generation who were born and raised in the city.

1.1.2 Indians in Hong Kong

Around the same time, Indians were also recruited to be part of the police force, with most taking up constable positions and some in other forms of policing. Furthermore, as Hong Kong's economic prosperity grew, traders from South Asian countries came to the city via sea from the early 19th century, thus also bringing an influx of seamen. Some started small businesses, concentrated along Tsim Sha Tsui and Jordan, thus developing the area to become the shopping hub that we see today (Kwok & Narain, 2003). From the 1950s, their flourishing businesses continued to attract more traders to the city, creating a rise of economic and political standing for some Indian merchants.

1.1.3 Pakistanis in Hong Kong

In the mid-1940s, there was a steady decline of Indian recruits due to India's independence from British rule. In the wake of decolonization, the country underwent a political reformation to establish separate religious states, resulting in the modern-day Pakistan and India. Pakistanis were hereafter recruited, while the number of Indian policemen decreased. Likewise, they took on policing roles to maintain societal order. Before they were termed "Pakistanis", Indians of Muslim faith have resided in Hong Kong along with their Hindu counterparts. The sheer number of recruits led to the construction of the Kowloon Mosque in 1884 (Weiss, 1991), allowing the "Muslim Indians" to practice their religion and abide to their customs. To this day, the Kowloon Mosque remained a pivotal location for Muslims in Hong Kong, especially Pakistanis, to commence religious activities.

In conclusion, the arrival of South Asians enriched the diversity scene in Hong Kong, contributed by their unique characteristics and customs. Such historical context is imperative in ethnic minority research, allowing insights on how certain behaviours and patterns manifest in relevance to various cultural.

1.2 Drug Abuse in Hong Kong

For the purpose of reporting to the Central Registry of Drug Abuse, drug abuser is defined as an individual who has taken drugs that harm or threaten their physical health, mental health or social well-being in doses or periods beyond that of therapeutic usage, within a period of 4 weeks before the date of contact (Central Registry of Drug Abuse, n.d.). The emergence of varying drug types determined various drug policies, with Hong Kong administering a zero-tolerance policy towards dangerous drug use and investing in anti-drug campaigns and education starting from 1996 (Cheung & Lee, 2020). Some suggested that such harsh policies resulted in an overall downward trend of reported drug abusers, from 8777 reported cases in 2015 to 5068 reported cases in 2024 (Central Registry of Drug Abuse, n.d.). Others argue that drug abusers simply went underground, hidden from the authorities (Tam et al., 2018; Tang et al., 2006).

The Central Registry of Drug Abuse (CRDA) is an official voluntary reporting system for demographics of drug abusers. Updated quarterly, it is the most commonly referenced dataset for drug abusers' data. In 2024, out of 5056 recorded cases with known ethnicity,

8.8% were ethnic minorities. Amongst them, 37.6% were Nepali, 12.8% were Pakistani, and 9.5% were Indian. (Central Registry of Drug Abuse, n.d.). Heroin is recorded as the most common drug of choice among Nepali drug abusers, with 61% of reported cases involving heroin use. Similar phenomenon was observed in Indian drug abusers, with 49% of reported cases involving heroin use. On the other hand, psychotropic substances were more common with the Pakistani ethnic group, taking up 65% of reported cases.

While also observing an overall downward trend since 2016, there is a slight spike in reported ethnic minority drug abuse cases in 2023, going from 429 in 2022 up to 470 in 2023, and then down to 444 drug abusers in 2024. It is hypothesized that with the relaxation of social distancing policies and the lifting of the mask ban in 2023, the chances for reported drug abusers are higher, and is thus reflected in the statistics. In fact, it was noticed by Liu and Gietel-Basten (2019) that it is not uncommon for Hong Kong to observe occasional peaks in reported drug abusers, usually a patterned 2-year increase and a 5-year decrease, specifically in 1994, 2001 and 2008. Scholars have proposed that the ever-evolving drug trend often prompted strict anti-drug countermeasures, creating a dynamic relationship between drug abusers and policy makers.

1.3 The Hidden Stages of Drug Abuse

Despite the decreasing trend, it is entirely possible for the reported statistics to not completely reflect the current drug situations. In the early 2000s, the rise in ketamine, MDMA and other drug use were perpetuated by raves and dance parties, where drugs were mostly used as a party stimulant (Cheung & Lee, 2020). With police crackdowns at nightclubs, party goers were broken down into smaller groups, its location being kept secret and exclusive. This may have caused the reduction of reported cases, as drug abusers are harder to detect. Nowadays, as drug markets transferred from physical meetups to online purchase and delivery, authorities face increasing challenges to identify drug abusers.

The ability to avoid detection gave rise to the term “hidden drug abusers”, referring to the group of abusers that are undetectable by reported statistics. This includes abusers who choose not to seek social services, abusing drugs in a concealed, private space in a less organized setting (Tam et al., 2018). From the numbers provided by the Central Registry of Drug Abuse, the percentage of reported cases who only abused drugs at home increased from 56.4% in 2015 to 58.3% in 2024, while that who abused drugs both at home and in other localities, including public spaces, hotels and party rooms, karaoke and bars, internet cafes and game centres, and schools, decreased from 24.3% in 2015 to 19.9% in 2024. This can be interpreted as the prevalence of drug use privately behind closed doors. Nevertheless, drug addicts need to first be introduced to the drug before reaching the stage of hidden abuse. In a 2018 paper on hidden drug use, Tam et al. discussed the 5 stages of which a drug abuser could transform into a hidden one, modelled after qualitative interviews with local Hong Kong drug abusers. Each stage is briefly described in the following section.

1.3.1 The Passive User

Literature indicates that the first use is often caused by the influence of peers (Bassiony, 2008), introducing the individual into the world of drugs. Passive users may only occasionally take drugs as a simulant at social events, believing they are in control. Since they are newly introduced, the drug source could only come from peers, creating a limited access to its usage. However, with continued usage, the individual's drug network expands, leading to the second stage.

1.3.2 The Active User

Due to increased frequency of drug usage in social settings, active users begin to get closer to the drug community. Aided by the psychedelic effects of drugs, lowered social inhibition encourages free sharing of emotions, creating a sense of belonging and warmth towards the community and viewing them as a gateway to stress relief and emotional comfort. In addition, the likelihood of forming connections with drug dealers increase due to community connections, leading to easier access to drugs. What was originally an occasional occurrence transforms into a habitual one, leading to the third stage.

1.3.3 The Regular Abuser

Regular abusers take drugs at a higher frequency, supported by connections with drug dealers, thus building up a tolerance and requiring increasingly high dosages. As drug usage transforms into a habit, abusers start to perceive their relationship with others in the drug community as unnecessary. What once was an opportunity for emotional relief turned into a nuisance, preferring to abuse drugs alone rather than listening to the emotional ramblings of their group. As such sentiments grow, so do feelings of suspicion and distrust.

1.3.4 The Suspicious Abuser

At the fourth stage, the side effects of constant drug use lead to psychological consequences. Increased suspicion, anxiety and physical weakness are common symptoms of long-term heroin use, which further perpetuates the desire to be alone. Interviewees from the study reported slight feelings of anger and resentment towards their drug peers, nitpicking over equal distribution and possessive over their personal stash. A reflection of their dependence on drugs, such negative feelings could only be avoided by alienation, transpiring the individual to complete social withdrawal.

1.3.5 The Hidden Abuser

The final stage is the cumulative effect from the social, psychological and physical consequences of the previous stages. For example, a common physical symptom in long time ketamine abusers is an uncontrollable bladder, thus staying at home is often preferable for convenience. The dependence on drugs becomes a primary focal point in the abuser's life, and any other aspects is rendered irrelevant and unnecessary. This severely impacts any remaining relationships or desire to socialize, making it even harder for these hidden abusers to be discovered.

In summary, passive, active, regular, suspicious and hidden abusers are the proposed 5 stages of drug abusers, modelled by qualitative interviews with local drug abusers. The question is whether the model can be applied to ethnic minority drug abusers, as well as on drugs other than heroin use. A study conducted by Castro et al. (1991) explored a similar model of drug use in Mexican-Americans, defining the stages in association to their identity and labeling. The initiation stage is associated with a casual user identity, the treatment entry stage is associated with a drug addict identity, the late treatment stage is associated with a recovering addict identity, and finally the post-treatment recovery stage is associated with a recovered addict identity. The values and attitudes at each stage differs, building the core of their identity and determining the strength for recovery. Such values and attitudes become the protective factors to recovery or even intervention, while other factors could lead to increased risk to partake in risk behaviour.

1.4 Preventive and Risk Factors in Drug Use

1.4.1 Ethnic identity

When discussing ethnic minorities, it is difficult to not take into consideration of their ethnic identity, as well as their minority status in a predominantly Chinese society. Minority groups are often associated with lower self-esteem (Verkuyten, 1998) and feelings of being disadvantaged (Mulia et al., 2008), attributes illustrated by the Chinese University of Hong Kong (CUHK) in 2006 (Tang et al., 2006). In order to protect themselves, ethnic minorities must learn to adapt to a new cultural environment, and the success of such adaption is typically measured by the individual's ability to navigate the culture on a daily basis, as well as how comfortable the person feels in respect to being in said culture (Searle & Ward, 1990). The CUHK (2006) paper initially proposed that assimilation in the community protects minorities from negative outgroup feelings, such as racial discrimination and other language barriers, which may lead to risk behaviours. A US study regarding Mexican-American individuals also pointed out similar sentiments, in which individuals who feels shamed in being identified as ethnic self are often associated with psychological distress (Castro et al., 1991). Based on the proposed self-derogation theory, such individuals compensate the feelings of disadvantaged by participating in deviant group activities as an alternate reward method. On the other hand, the study also mentioned ethnic pride, a related factor that can potentially turn a risk factor into a preventive one.

Ethnic pride is defined as the rejection of negative stereotypes of one's group, maintaining a strong link with their cultural heritage (Kitano, 1980). In a globalized world, higher geographically mobility increases the chance for people to reside in an area that is not native to their culture. Further settlement even results in the rise of a "third culture", in which one's identity can encompass varying cultures (Moore & Barker, 2012). The balanced recognition of both home and host culture promotes resilience and self-regulation (Castro & Alarcón, 2002; Li et al., 2023), allowing the minority group to not be as susceptible to the negative feelings of being in the outgroup.

In conclusion, while there may be some truth on whether one's ethnic identity contributes towards drug abuse behaviours, there are incidents where it could be a protective factor

as well. Hence, it is important to view the context of whether other elements are also at play, as ethnic identity is typically associated with other factors (Castro & Alarcón, 2002).

1.4.2 Family, Peer and Neighbourhood Influence

Our environment and upbringing play a part in our perception, behaviors and attitudes towards various issues. Previous studies have linked negative experiences or adverse childhood experiences to deviant behaviours, that of which included drug abuse (Li et al., 2023). Predominantly, it has been reported that peer influence, specifically association with drug abusing peers, is associated with drug abuse in the ethnic minority population (Tang et al., 2006; Bassiony, 2008). In terms of rehabilitation, a local study on ethnic minority drug abusers found that the influence of peers was significantly greater on South Asians than that of non-South Asians, reporting that 23.7% of sampled South Asian drug abusers cited ‘friends’ as a reason for using rehabilitation services, compared to 0% of non-South Asian drug abusers (Tang et al., 2006). While this is interpreted as a positive note, there may be potential that South Asians may be more vulnerable to peer influence, potentially causing those who has close relations with drug abusing peers to be at risk.

A local youth study pointed out the possible association of deviant behaviours with neighbourhood characteristics, in which disorganized areas is a risk factor for drug, alcohol and cigarette abuse in youths, while that of low violence is a protective factor (Arat & Wong, 2018). As previously mentioned, most South Asians typically reside in the Yuen Long and Yau Tsim Mong districts due to prior settlement in the area. Concurrently, a 2019 study suggested that districts that are remote with high crimes rates or that of poorer regions with high population density show higher number of drug abuse distribution (Liu & Gietel-Basten, 2019). The two characteristics described Yuen Long and Yau Tsim Mong districts respectively, as supported by the reported distribution of drug abusers in 2016 which was also referred to in the study. This allows us to infer that such neighbourhood conditions may affect the ethnic minority population as well, explaining the susceptibility of drug abuse among residents of that area.

On the other hand, family appears to be a protective factor for both drug abuse and rehabilitation. The local youth study also reported that strong relationships with primary caregivers are less associated with substance abuse. Similar results were also reported in the ethnic minority drug abuser group, where 39% of drug abusers attributed family members to their desire to reduce drug taking (Tang et al., 2006). Family values are highly treasured in South Asian cultures, and a positive relationship with family members introduce resilience against strain or negative influences.

However, there are instances in which familial influences may create an opposite effect. For example, for third culture individuals, ethnic racial socialization also plays a part in their attitudes towards perceived discrimination, which depends on parent’s transmission of attitudes and behaviours (Nieri et al., 2019). Such socialization can be categorized into cultural socialization, where the third culture individual is aware of and appreciative their ethnic heritage; preparation bias, in which the parent would caution them of possible discrimination of society, thus unconsciously transferring their own biases, and;

promotion of mistrust, where parents may instill wariness of other ethnic groups, fostering a divide. Although not officially applied in a Hong Kong ethnic minority setting, it may be a plausible factor to one's perceived discrimination. For example, an ethnographic study on the relationship between masculinity and drug use among Nepali men in Hong Kong (Tang, 2017) observed rivalries between Pakistani and Nepali students, mentioning that "they always seem so arrogant and looked down on everybody" (p.218). Tang suggested that such confrontation their religious differences and racial superiority stemming from years of ethnic history. In other words, previous generations may have transferred such attitudes, resulting in the promotion of mistrust. With that in mind, perceived ethnic discrimination may reduce resiliency, moderated by their ethnic racial socialization, which in turn is correlated with substance abuse. Although the model has not been applied in the Hong Kong ethnic minority context, it is worth examining in this study.

1.4.3 Permissiveness

Drug permissiveness is defined as the extent of a person finding drug use acceptable. Despite government efforts in anti-drug promotion, some still underestimate the dangers of certain drug abuse. A notable example would be the smoking of cannabis. While its health risks are well documented, some studies have also pointed out its perceived medical benefits, resulting in an ongoing public and policy debate (Hoch et al., 2024; Solmi et al., 2023). Although cannabis remains illegal in Hong Kong, legalization in other countries may influence local perceptions and lead some to view them as less harmful (Lo et al., 2024). Thus, some may overestimate their self-control and perceive drugs to be non-addicting. Such permissiveness would promote further drug usage, subjecting further risk in unwanted effects. Furthermore, attitudes towards drug use determine the user's frequency and risk of abuse, depending on personal beliefs and cultural influences. For example, an ethnographic study on Nepali men pointed the importance of a masculine role within Nepali men. A threat to their masculinity could lead to deviant behaviours in an attempt to compensate, generating a culture of permissive drug abuse to protect one's identity. The therapeutic effects of drugs are also often taken advantage of by those with tough jobs, with long working hours and tough labour, drug use is commonly used to cope. Such jobs are common with ethnic minorities (Tang, 2017), potentially due to limited skills or lack of opportunities. Thus, varying cultures, backgrounds, or life circumstances could potentially lead to a high permissiveness to drug use.

1.5 Rehabilitation and Prevention

Hong Kong typically adopts a multi-modality approach to drug treatment and rehabilitation, enabling service users to choose the treatment option they deem suit them best (Narcotics Division, 2024). The available options include Residential Drug Treatment and Rehabilitation Centres (DTRCs), Counselling Centres for Psychotropic Substance Abusers (CCPSAs), Substance Abuse Clinics (SACs), Methadone Treatment Programme (MTP), Drug Addiction Treatment Centres (DATCs), Centre for Drug Counselling (CDC) and Enhanced Probation Service (EPS), with the first four being voluntary. This framework offers a more comprehensive range of treatment options that

are selectable to those with varying needs and level of readiness, allowing the flexibility to select their preferred service.

On the other hand, such flexibility may not apply to the ethnic minority population, as there are additional factors that need to be considered. Bounded by religious, language and cultural barriers, a modality that works for the local Chinese population may not suit those from different ethnic backgrounds, creating new challenges for both service users and service providers alike.

1.5.1 Barriers to service accessibility

Service accessibility can be evaluated by the ease of which individuals gather information about available services and the simplicity of the intake processes. Due to stigma and fear of judgement, it may not be too common for ethnic minority individuals to seek help in the first place, preferring to handle problems internally to save face (Tang, 2014). On the other hand, those who do choose to seek help may not know where to begin. For example, as observed from the list of voluntary residential drug treatment and rehabilitation programmes on the government's Narcotics Division website (Narcotics Division, n.d.), 6 out of the 14 organizations provide English translations for their website, suggesting that there is room for further improvement of language accessibility.

In terms of intake procedures, further communication barriers arise. Some older individuals, particularly first or second-generation immigrants, may have a heavy accent or lack fluency in English. For service providers unfamiliar with the accent, this poses a challenge to smooth exchange of information, resulting in prolonged interviews that causes fatigue and impatience (Tang, 2014). The more complex the initial process of seeking help becomes, the more energy it requires, and the greater the need for motivation to overcome such barriers, ultimately reducing the ease of access to essential services.

1.5.2 Cultural competence in Service Provision

Cultural competence is defined by being both culturally sensitive and culturally responsive. Service providers must not only be aware of potential cultural differences, but also possess the skills to respond appropriately without acting on predisposed beliefs (Arat & Kerelian, 2017). A common example is the heavy emphasis on family in South Asian cultures, in which the self is often de-emphasized (Kwok et al., 2018). Decisions are often made with consideration of family members, as going against family wishes or traditional values is often frowned upon. Service providers must strike a balance between offering the best course of treatment and respecting the difference in culture. Thus, it is important to not only understand the context of which a culture exist, but to also avoid assumptions and biases, approaching the topic in a manner that differs from the typical local population.

Another concrete example involves accommodating to special requirements, such as dietary restrictions for religious reasons or designated praying time. As most rehabilitation centres standardize their treatment approach, additional resources are

needed to cater specifically to ethnic minority populations, resources that may not be as readily available. Furthermore, revisiting the language barrier previously mentioned, ethnic minority drug abusers may not have the same experience as that of locals', as group counselling and programmes are often conducted in Cantonese. This not only limits opportunities in acquiring relevant knowledge and skills, but also reduces the chance to connect with other drug abusers, affecting relatability and the formation of a positive social circle. Consequently, there is a limit to what ethnic minority treatment seekers can gain from their treatment experience, further challenging their ability to gain the necessary skills to remain drug free.

1.5.3 Structural and institutional barriers

As mentioned, fluent communication and cultural competence are critical components in providing accessible and effective service to the ethnic minority population. From a systematic level, although Hong Kong is described as a multicultural society, there are clear indications that structurally, services were built to mainly serve the majority Chinese population, creating challenges for not only those in need of service, but also to those who provide the service.

Despite official narratives of inclusivity, studies show that Hong Kong's multiculturalism can be superficial or "performative," with limited commitment to long-term integration (Wong, 2010; Crabtree & Wong, 2013). The government's Race Relations Unit (RRU), for example, focuses heavily on "integration" through language and orientation programmes, yet lacks an overarching framework with explicit, measurable objectives for inclusion and equity, i.e. how the local majority should approach and include people of different ethnicities. As a result, policies tend to implicitly position EM communities as deficient, lacking language proficiency, employability skills, or knowledge of Hong Kong systems, rather than examining how the institutional structures themselves could be exclusionary. For example, beyond prepping individuals to better fit the system, some argue that there is a pressing need for institutional restructuring to ensure the system is inclusive by design rather than by exception. Lee and Law (2014) highlighted that social work training in Hong Kong is largely designed to serve the Hong Kong Chinese, contributing to a gap in professional knowledge. Such barriers were also highlighted in a study conducted by the University of Science and Technology, in which language, inadequate resources, and a lack of culturally sensitive services were brought up by the ethnic minority community as barriers to seeking help (Sharif & Chen, 2024). Service providers may overlook the diverse cultural and religious practices that shape ethnic minority clients' experiences, and may require more academic and practical support in handling ethnic minority cases.

On one hand, it is important to acknowledge that government support has expanded in recent years. The 2018 Policy Address tackled previously brought up concerns from the ethnic minority community, reconstructing efforts in education, employment, social welfare and cultural integrations (Chan, 2019). Key initiatives included strengthening Chinese language learning in schools, expanding outreach to EM families, and promoting cultural sensitivity training for new civil service recruits, all utilizing a bottom-up approach to better address community needs. On the other, while cultural sensitivity is increasingly

encouraged, institutional restructuring is still necessary to better equip frontline workers in handling ethnic minority cases. Relying solely on interpretation services and community ambassadors may overlook deeper systemic gaps. For example, a collaborative study by the Equal Opportunities Commission and the University of Hong Kong reported that although the switch to digital platforms, which offered more language accessibility, have mitigated barriers to entry, service satisfaction remains inconsistent (Equal Opportunities Commission, 2026). Thus, while improving accessibility and increasing touchpoints are critical first steps, genuine integration requires the equitable distribution of treatment and resources, requiring long-term commitment and evaluation.

Variations in service experiences and satisfaction may stem from Hong Kong's historical and institutional development. Originally built on Western centric foundations, Hong Kong's public systems have undergone significant localized adaption to better align with the socio-cultural needs of the Chinese majority, reflecting both Chinese and Western influences. Within this narrative, groups that are not readily associated with either "Chinese" or "Western" identities may be positioned as peripheral to the commonly imagined social mainstream (Lee & Law, 2016), which can affect how cultural difference is understood in policy and frontline practice.

While the Government generally classifies all non-Chinese groups as ethnic minorities, social visibility and patterns of service utilization may differ across groups. For example, white people are rarely socially viewed as a minority group, despite meeting the formal definition. According to the Population Census, a substantial income disparity exists between the Whites and South Asian ethnic groups, with Whites having the highest median monthly income from main employment at HK\$72,000 for males and HK\$45,000 for females, compared to HK\$22,000 and HK\$13,000 for their South Asian counterparts (Census and Statistics Department, 2021). This dictates their respective service needs and levels of accessibility, in which the perceived social status and 'expatriate bubble' (Knowles and Harper, 2009) enjoyed by the former often facilitates access to multicultural services through private means. Conversely, the South Asian community may lack such financial mobility, and remains insufficiently served by public systems that, in their initial design, failed to meaningfully account for their specific cultural and linguistic requirements.

In summary, it is apparent that the South Asian community is sometimes overlooked when establishing social service frameworks, highlighting the need to reassess the current situation and support mechanisms related to drug abuse. Henceforth referred to as "ethnic diversity" individuals to celebrate their diverse ethnic backgrounds, the study aims to provide insights into common signs and strategies in ethnic diversity drug abusers, specifically their drug abuse pattern, attitudes and experience in drug rehabilitation. Findings derived from the study can then be used to enhance early identification and further understand specific needs pertaining to rehabilitation and support of ethnic diversity groups, allowing the improvement of drug rehabilitation infrastructure and its service quality towards ethnic diversity individuals.

Chapter 2 Methodology

The study uses a qualitative research approach to collect phenomenological data on the experiences of drug abusers and relevant social workers. Such approach enables detailed understandings of participants' lived experiences and challenges, covering contexts that may have been adequately captured by numerical measures. Purposive sampling methods were used to recruit participants matching the required criteria. For the drug abuser pool, participants should:

- 1) be ethnically Nepali, Indian or Pakistani;
- 2) have abused drugs;
- 3) be aged 18 or above;
- 4) be a HKID card holder (including both permanent and non-permanent residents); and
- 5) have the ability to comprehend and communicate fluently in English, Hindi, Urdu or Nepali.

For service providers, participants should have at least one year of experience working with ethnic diversity drug abusers.

2.1 Recruitment process

In terms of participant recruitment, in addition to the organization's internal promotion, external rehabilitation organizations were contacted to diversify the participation pool. Outreach was also conducted around methadone centres and frequent locations of the target demographic, where flyers were distributed to raise awareness about the study. Furthermore, assistance from representatives of the ethnic diversity community was also enlisted to connect with hidden or hard to reach individuals who may otherwise be inaccessible through formal methods. As such representatives are trusted members of the community, rapport could be more easily built in comparison to direct outreach methods by service providers or the research team.

It should be noted that a snowball sampling method was used, mostly relying on community and service unit referrals to get in touch with the target population. As such, 16 participants were recruited from the organization's service users, 14 were recruited from community referrals, 3 were recruited from service units of other organizations, 2 were recruited by voluntary signups via external promotion, and 1 was recruited via outreach.

For the recruitment of service providers, both internal and external promotion were conducted, and interested individuals signed up via a QR code provided on the promotional poster.

2.2 Procedures

Interviews were conducted either online or in person, typically at one of the organization's various centres, at a corner of a restaurant, or in public parks. Before the interview, participants were required to fill in a 5-minute demographic questionnaire to

collect background and health-related information. Afterwards, a semi-structured interview was conducted, with questions relating to drug use habits and experiences. Participants were given a \$150 supermarket coupon as remuneration for their time.

For service providers, interview procedures remain largely similar, aside from the exclusion of health-related information in the demographic questionnaire. Service providers were asked to share their experiences in working with ethnic diversity drug abusers, with questions relating to their experiences and challenges in providing services to the community. Remuneration was not provided for this sample.

All interviews were audio-recorded and were subsequently transcribed with all personal identifiers removed to ensure confidentiality. Transcripts were then coded using Nvivo software, and thematic analysis was performed to identify recurring patterns and common themes across the dataset.

2.3 Participants

36 participants have been recruited for the drug abuser portion of the study, with 15 participants from Nepal, 11 from Pakistan and 10 from India. The participants are majority male ($n = 28$), and have ages ranging from 19 to 58 years old. Most of the participants were born in Hong Kong ($n = 23$), however it was observed that amongst this sample, 6 were raised in their respective home country from a young age, returning to Hong Kong only in their late teens to early twenties. In terms of marital status, 16 participants are married or in a relationship, 13 participants are single, 6 participants are divorced, and 1 participant is widowed. A majority hold Hinduism ($n = 13$) or Muslim beliefs ($n = 8$), with the remaining being non-religious ($n = 6$), holding Buddhist beliefs ($n = 4$), Christian beliefs ($n = 4$), or Sikh ($n = 1$). In terms of education levels, 19 have completed their secondary education, 9 have attained a tertiary degree or diploma, 4 have attained up to junior secondary, 3 have completed primary school and 1 had no formal education. Aside from their respective native language, the majority of participants ($n = 31$) have indicated spoken fluency in English, with half also indicating fluency in Hindi ($n = 18$). A third of participants ($n = 12$) have also indicated that they can speak Cantonese.

In addition, 10 service providers were also recruited to gain insights on their experience working with ethnic diversity individuals. Among the service providers, the majority are male ($n = 6$), and identify as Chinese ($n = 7$). All providers reported spoken fluency in English ($n = 10$), and those who were non-Chinese also indicated a proficiency in other languages such as Urdu ($n = 3$), Hindi ($n = 2$), Nepalese ($n = 2$), and Punjabi ($n = 1$).

Regarding professional backgrounds, 6 service providers hold a social work qualification, while the remaining indicated themselves as welfare worker ($n = 2$), peer educator ($n = 1$), and mental health worker ($n = 1$). Their service areas varied across the sample, including community-based drug treatment and rehabilitation ($n = 3$), supervisory roles that oversees projects related to the ethnic diversity population ($n = 2$), drug prevention and education ($n = 1$), integrated services for ex-offenders ($n = 1$), youth services ($n = 1$), residential drug treatment and rehabilitation ($n = 1$), and mental health services ($n = 1$).

Most service providers reported more than 10 years of experience in the social work sector ($n = 6$). However, years of experience specifically working in ethnic diversity rehabilitation services vary, with 3 providers reporting 2–3 years, another 3 reporting 4–5 years, 3 reporting 10+ years, and 1 provider has had 6–9 years of experience.

Chapter 3 Demographic Background

3.1 Patterns and Attitudes of Ethnic Diversity Drug Abusers

A total of 36 participants were recruited for face-to-face individual interviews in the drug abuser portion of this study (Table 1). The interviews primarily included three ethnic groups: Pakistani, Nepali, and Indian. The mean age of participants was 37.2 years, ranging from 19 to 58 years old, and more than half were employed ($n = 25$). The participants revealed several common points regarding their main drug of choice, with heroin being the most frequently chosen substance ($n = 15$), occasionally mixed with tranquilizers, followed by cannabis ($n = 12$) and methamphetamine ($n = 7$). Other substances abused are etomidate ($n = 1$) and cough syrup ($n = 1$). In some participants, mixing of drugs occasionally occurred. This report shall refer to participant's primary drug of choice when discussing patterns.

When comparing between ethnicity, it is noted that the mean age difference between groups slightly varies, with the Nepali group ($\bar{x} = 43.2$) being slightly older than the Indian ($\bar{x} = 32.1$) and Pakistani group ($\bar{x} = 33.82$). This age profile difference may influence interpretation of the findings, as heroin users are typically older.

Table 1*Overview of drug abuse patterns in research participants*

	Ethnicity (Gender)	Age	Main Drug abused	Other drug(s) abused	Frequency	Location most frequented^{b,c}	Alone or with others more?	\$HKD spent /month	Employment status	Treatment sought^a
1	Pakistani (F)	24	Cannabis	/	1/day	Outdoors	Alone	2000-3000	Employed	None
2	Nepali (M)	49	Heroin mix tranquilizers	/	2/week	Outdoors	Others	5000	Unemployed	MTP+DTRC
3	Nepali (M)	31	Heroin mix tranquilizers	/	1/week	Pan Zai	Others	3080	Unemployed	None
4	Nepali (M)	58	Heroin mix tranquilizers	/	2-3/week	Pan Zai	Others	7000-8000	Employed	MTP +CCPSA
5	Nepali (F)	47	Heroin	/	2/day	Friend's place	Others	7500-7750	Unemployed	DTRC
6	Nepali (M)	53	Heroin	/	2/day	Pan Zai	Others	2000	Unemployed	None
7	Nepali (M)	32	Heroin	/	3-4/week	Pan Zai	Alone	4500-4650	Unemployed	DTRC+MTP
8	Nepali (M)	49	Heroin mix tranquilizers	/	2/day	Public toilet	Alone	6000-9300	Unemployed	DTRC+MTP
9	Nepali (M)	30	Heroin	/	5/week	Pan Zai	Others	12000-15500	Employed	MTP

	Ethnicity (Gender)	Age	Main Drug abused	Other drug(s) abused	Frequency	Location most frequented	Alone or with others more?	\$HKD spent /month	Employment status	Treatment sought
10	Nepali (M) (Quitted)	27	Heroin mix methampheta- mine	/	2-3/day	Pan Zai	Others	9000-12400	Employed	MTP+DTRC
11	Nepali (F) (Quitted)	49	Cough syrup	/	1 bottle/2-3 days	Home	Alone	360	Unemployed	MTP
12	Nepali (M)	44	Heroin	/	Every day	Pan Zai	Others	A few thousand	Unemployed	MTP+DTRC
13	Nepali (M)	50	Heroin	Methampheta- mine	Every day	Pan Zai	Others	3000-4000	Unemployed	DTRC
14	Nepali (M)	36	Heroin	Cocaine	2-3/day (Heroin) + 1/week (Cocaine)	Pan Zai	Others	10000	Employed	MTP
15	Nepali (M)	50	Heroin	/	1-2/week	Home	Alone	5000-10000	Employed	MTP
16	Indian (M)	25	Cannabis	/	1/few months	Parks	Others	Free (given by friend)	Employed	None
17	Indian (F)	24	Cannabis	/	1-2/month	Friend's house	Others	Free (given by friend)	Employed	None
18	Pakistani (F)	28	Etomidate	Methampheta- mine	As often as I can	Everywhere	Others	30000-31000 (including gambling expenses, with drugs given for free)	Employed	None

	Ethnicity (Gender)	Age	Main Drug Abused	Other drug(s) abused	Frequency	Location most frequented	Alone or with others more?	\$HKD spent /month	Employment status	Treatment sought
19	Indian (F)	30	Cannabis	/	Every day	Rooftop	Alone	1400	Employed	DTRC+SAC
20	Indian (M)	34	Methamphetamine	Cocaine	3-4/day	Apartment	Alone	12000-12400	Unemployed	None
21	Nepali (M)	44	Methamphetamine	Cocaine	3-4/day	Apartment	Alone	12000-21700	Employed	None
22	Pakistani (M) (Quitted)	50	Cannabis	Methampheta mine, cocaine	Every day	Game centre /park/Pan Zai	Others	All money on hand	Employed	DTRC+SAC
23	Indian (M)	31	Cannabis	/	4/week	Home	Alone	2083- 4166	Employed	None
24	Indian (M)	45	Cannabis	/	1/few months	Friend's place/ indoors	Others	Free (given by friend)	Employed	None
25	Indian (F)	39	Cannabis	/	1/month	Friend's place/ indoors	Others	320	Employed	None
26	Indian (M)	48	Heroin mix tranquilizers	/	1/2-3 weeks	Public toilet	Alone	3000	Unemployed	MTP
27	Pakistani (M)	24	Cannabis	/	1/1-2 months	Friend's place	Others	100-200	Employed	None
28	Pakistani (M)	33	Methamphetamine	/	3-4/day	Game centre	Others	500-600	Employed	None
29	Pakistani (M)	37	Methamphetamine	/	6/week	Game centre	Others	30000-31000	Employed	None

	Ethnicity (Gender)	Age	Main drug abused	Other drug(s) abused	Frequency	Location most frequented	Alone or with others more?	\$HKD spent /month	Employment status	Treatment sought
30	Pakistani (M)	54	Heroin	/	2/day	Public toilet/friend's house	Both	12000-15500	Employed	MTP
31	Pakistani (M)	31	Methamphetamine	/	2nd time in two years	Game centre	Alone	240000-279000 (including gambling expenses, with drugs given for free)	Employed	None
32	Pakistani (F)	33	Methamphetamine	/	1-2/day	Home/game centre	Alone	Free (given by supplier)	Employed	None
33	Pakistani (M)	37	Methamphetamine	/	Every day	Game centre	Others	5000	Employed	None
34	Pakistani (M)	21	Cannabis	/	1-2/day	Parks	Others	3000-4000	Employed	None
35	Indian (M)	19	Cannabis	/	1-2/month	Friend's house /indoors/ rooftops	Others	300-500	Employed	None
36	Indian (M)	26	Cannabis	/	Every day	Home	Alone	1000-3000	Employed	None

^aCPS = MTP = Voluntary outpatient methadone treatment; DTRC = Voluntary residential drug treatment and rehabilitation; CCPSA = Counselling centres; SAC = Substance abuse clinics (Hospital Authority)

^bPan Zai = A Cantonese slang term for drug dens

^cOutdoors refer to open, non-enclosed spaces, such as parks, rooftops, alleyways etc.

3.1.1 Background of Drug Abusers

Notably, the type of substance consumed often varied by ethnicity. Indians preferred cannabis (n = 8), Pakistanis gravitated toward methamphetamine (n = 5) or cannabis (n = 4), and Nepalīs opted for heroin (n = 13). Their drug usage ranged from daily consumption to the occasional usage every few months. Most Indians reported abusing drugs around 1 to 2 times per month (n = 3) or every day (n = 3), while more Nepalīs indicated they used drugs every day (n = 8), anywhere from 1 to 4 times per day. The majority of Pakistanīs also reported daily drug abuse, varying between 1 time to as many times as possible (n = 8) every day. The most frequented locations for drug abuse are referred to as "Pan Zai" (棚仔) (n = 10), followed by friend's place (n = 7) and game centres (n = 6).

"Pan Zai" is a Cantonese slang term for drug dens that sell a variety of substances and provide a private setting for drug-related activities. It is directly translated as "makeshift shack," derives from its easily collapsible nature. According to a newspaper article, these "Pan Zai" are typically equipped with thick iron doors and located in inconspicuous flats, allowing drug dealers time to conceal incriminating evidence during police raids (Sun News, 2003). Participants described these spaces as private locations where they could purchase and use drugs. Some mentioned that the "Pan Zai" they frequented were situated in the Yau Tsim Mong district. Regarding preferences among different groups, relatively more Indian participants reported choosing to take drugs at a friend's home (n = 4). In contrast, Nepalīs preferred "Pan Zai," (n = 9), while more Pakistanīs opted for game centres (n = 6) as settings for drug use.

When it comes to expenditure, the amount spent on drugs can range from \$0 HKD to \$31,000 HKD, with numbers reaching as high as 279,000 if gambling expenses, which are tightly intertwined with drug use, are included. Such gap in range can be explained by the amount of money available to the abuser, with factors such as employment determining overall expense. Many participants stated that they would spend as much as they earned on drugs until they ran out of money, while some also noted that they often received drugs for free from friends or suppliers.

"Everything, yeah, whatever, if I, if I have, like, maybe a thousand, I'll spend thousand, if I have a hundred, I'll spend hundred." (Participant 22)

"Um yeah, it's usually free. Usually it's like, I'll like pay them back in different ways, like you know, just get them dinner once or twice but, I would just say it's free." (Participant 16)

In terms of living experiences in Hong Kong, they vary systematically across Pakistani, Nepali, and Indian groups, reflecting differences in migration pathways, resources, and integration conditions. Pakistani participants are more likely to be born and raised in Hong Kong (n = 7), with families who migrated to Hong Kong generations before. Their earlier exposure to Hong Kong society often supports stronger local attachment, with some expressing that they "*feel closer to the city*" as they "*lived [their] whole life here*"

(Participant 1), alongside improved integration when linguistic resources are available, for example through Cantonese proficiency.

“Honestly I would love to say that I was Hong Konger. They keep saying to me like I understand a lot of Chinese- yes I do.” (Participant 18)

“(Do you see yourself as Hong Konger or Pakistani?) Hong Konger. Because all my life is staying here. My family stay here.” (Participant 30)

In contrast, Nepali participants are predominantly first-generation migrants, or those who are eligible for residency due to a relative’s participation in the British Army, thus spending majority of their childhood in their home country (n = 12) and moving to Hong Kong in their early 20s. Many described the movement as driven by economic necessity, limited opportunities in the home country, or family, reflected in explanations such as *“our country very hard to get a job ... here is more easy”* (Participant 4) and *“my parents they are already in Hong Kong”* (Participant 14). These backgrounds correspond with a stronger retention of origin identity and comparatively more difficult living experiences in Hong Kong, characterized by language barriers, limited integration and job opportunities. For example, participants note that *“the main is the language... it’s little bit hard in Hong Kong”* (Participant 7) and describe resorting to non-verbal communication. Among the Nepali participants, those who were employed were all engaged in labor-intensive jobs, and none of the participants hold a tertiary degree or higher, suggesting limited social mobility and potential stressors. Additionally, most Nepali participants retained a strong sense of ethnic identity, although some described their identity as more balanced (around 50/50) due to their time living in Hong Kong.

“I’m Nepali, so Nepali” (Participant 3)

“Hong Kong. It’s like... it’s like my home like that too” (Participant 13)

On the other hand, Indian participants occupy a comparatively mixed and more heterogeneous position. A majority were Hong Kong born individuals (n = 7), some of whom additionally had access to transnational educational or mobility networks, having spent time studying or working abroad. Their identities tend to be more reflexively negotiated, as seen in assertions like *“I identify with being Indian more ... definitely to my Indian self”* (Participant 16), or that *“I would call myself more of a Hong Konger, but then ... I think I’m still pretty, like, I acknowledge my roots”* (Participant 17). In terms of living experience, Indian participants reported relatively greater stability and institutional inclusion, with a majority (n = 7) attaining tertiary degree or higher and all being employed or studying. However, some participants also noted encountering forms of everyday exclusion, both subtle and explicit.

“Hierarchy wise, like as in from my supervisors and bosses, they’re all very good to me. But then like strangers of course yeah, definitely you know, they’re very uh... like they’re kind of hesitant of me” (Participant 16)

“Would tell me, go back to your country or something like that. And I would tell them I’m born in Hong Kong.” (Participant 24)

“I think when I was younger, it was more, more open towards me. Now I’m a, I’m sort of an adult, it doesn’t happen that much, and I think Hong Kong is maybe a bit more open.” (Participant 23)

Across all three groups, discrimination appears as a shared but differentiated experience, shaped by migration background and social positioning. Pakistani and Indian participants more often described institutional profiling. For example, one participant described he *“was definitely targeted by the police a lot for random checks”* (Participant 23). Others reported job discrimination, including a case where a participant was initially rejected for a position but later accepted after resubmitting the same application under a Chinese name. On the other hand, some participants mentioned that they had become desensitized to such experiences, choosing not to take it personally.

“I won’t say it doesn’t happen now, like I feel like there’s still some discrimination whenever you go out on the streets ... if it happens it happens ... I just don’t notice it as much.” (Participant 1)

“This kind of thing will happen anyway, maybe in primary school or secondary school. When you were young, I mean, these kinds of things would happen too, but gradually you will get used to it, and then you just ignore it like that.” (Participant 34)

Nepali participants share a more tolerant attitude towards discrimination, often downplaying its impact or normalizing it as part of everyday life. Some also acknowledged that such treatment may have more to do with their drug abuser status rather than ethnicity, expressing that differential treatment is understandable. This pragmatic stance reflects a tendency to accept discrimination as an expected aspect of migrant or drug abuse life, highlighting a more tolerant and adaptive orientation compared to the more critical responses seen in other groups.

“(Do you think you’re treated differently compared to local users?) No” (Participant 2)

“I don’t think I’m discriminated... Because every country have I think discrimination, right? So sometimes just people being rude” (Participant 9)

“Because of language, sometimes. But if you speak fluent in Chinese, they never discriminate, you know?” (Participant 12)

“A little bit, a little bit have. They know that we are the user, they will make us a little bit different” (Participant 5)

3.1.2 Early Exposure to Drug Abuse

The majority of participants reported using their first drug in their early 20s, typically cannabis. Most Indian participants indicated that their first experience with drugs was cannabis (n = 9). Nepalis mentioned a variety of first drugs, particularly cough syrup (n = 5), cannabis (n = 5), and heroin (n = 5). For Pakistanis, cannabis (n = 5) was the most common initial drug. A relatively higher number of Indians (n = 5) and Nepali (n = 10) participants reported that their initial drug use occurred at social gatherings or parties. On the other hand, Pakistani participants were more likely to attribute their first drug experience to environmental influences, trying drugs when an opportunity arose (n = 3) or due to pressure (n = 3).

21- 22? Something like that. 22. When I was young and Hong Kong and after that I used, using the drugs... Yeah, we... we hang out and a friend make a enjoy, like that. Now its become habit...Its a private place. In my friend house” (Participant 5)

“After... 18. 18/19...Before, smoked cigarette. And then, brown sugar...In the hotel, like that. We didn't spend the money on that, you know? He(friend) buy for us.” (Participant 11)

“I started when I was 16...Uh ex-boyfriend, I was with him and he passed me a joint and left the room to do something and I just took it by myself...at his house.” (Participant 19)

3.1.3 Predominantly Used in a Social Context

Drugs were commonly used in social contexts, with a clear preference for consumption among friends rather than taking alone (n = 22). They reported that their drug use often involved friends who could share costs and accompany each other.

“Yeah, sometimes we have a... some financial problem. So, we have each other (friend), sometimes... Cost and sharing those stuff.” (Participant 4)

“Sometimes purchase alone, sometimes friend buy ... Situation because no enough money so we got to share. have money we always share. Because one guy is not enough money. It's very expensive.” (Participant 30)

Some participants expressed common concerns about economic factors influencing their drug choices, often leading them to switch to more affordable alternatives. Financial limitations deeply influenced the types of drugs used, prompting participants to adapt their habits based on availability and cost.

“No. Sometimes I take cocaine also... Cocaine is okay, but, if you addicted to ice, at least if you took that, that thing make you sleepy always. That's why, if you want to get wake up, you have to do this both

ways. ...: Okay, because before every week we using cocaine. So it's too expensive and, yeah." (Participant 20)

"...Weed is like, very, very frequent. Ice is, like, once a day. Weed is, like, maybe, a few times a day... Cocaine, very, very, very... like, very less, very less...Reason is expensive. And then, and then the place, like, you know, no... resources for my type, like, for me, like, you know, the poor person, like how we say, yeah." (Participant 22)

3.1.4 Experiences of Drug Treatment

16 participants reported having received drug treatment, with a notably higher proportion of Nepalis (n = 12), while 2 were Indians and 2 were Pakistanis (Table 1). Most participant chose to receive assistance through voluntary outpatient methadone treatment. The methadone treatment programme (MTP) in Hong Kong provides both methadone maintenance and methadone detoxification programmes.

Some participants would combined this with other treatment methods, including the "Compulsory placement scheme" (Correctional Services Department), "Voluntary residential drug treatment and rehabilitation," "Counselling centres," or "Substance abuse clinics" (Hospital Authority).

While methadone is well recognised as a treatment for drug cessation, some participants indicated that they used methadone to help quit drugs and some others use methadone as method to reduce physical symptoms caused by heroin use. In particular, participants described methadone as a practical means of managing withdrawal and maintain daily functioning.

"If I drink the methadone, the methadone can recover from that, suppress those physical withdrawal symptoms." (Participant 2)

Rather than indicating an unequivocal commitment to immediate abstinence, this account suggests methadone could be used to stabilize the body and reduce withdrawal-related harm. This also implies that engagement with methadone may be partly situational and responsive to immediate physical needs, rather than consistently aligned with a single linear recovery pathway.

In addition, participants demonstrated some awareness that methadone has an intended role in cessation, yet also acknowledged that in practice it may be misused or used imperfectly. A participant described methadone as a treatment but noted misuse, explaining barriers to consistent clinic engagement: *"This one, from my point of view, yeah it's really a treatment but people, they misuse. This one is actually for quitting drugs, but we people like us, we misuse these things. So this will affect us, in a high way you know like, in a highly way if you take like...(Q: Then why you go to the methadone clinic?)... I said earlier, like sometime I don't have money"* (Participant 9)

This account illustrates that methadone use may reflect real-world constraints (e.g.,

affordability) and day-to-day coping, rather than a clear ideological preference for harm reduction over total withdrawal. In other words, participants' descriptions do not necessarily show they prefer harm reduction; instead, they suggest methadone may function as a compromise pathway when abstinence is difficult to achieve quickly or consistently, but withdrawal relief and stabilization remain attainable.

Other participants also described recovery as gradual and manageable through methadone, emphasizing a stepwise approach and reintegration into everyday life. Similarly, other participants framed methadone as a gradual and manageable approach to recovery.

"No need to rehab centre ... better you methadone, use to help ... You want to take methadone and then slowly, slowly. Many, many friends already use the methadone and then already, now it's normal life. (Participant 30)

"60 I think one week, because before I was 65, 70. I've just recently decreased the dose." (Participant 10) This highlights how methadone is perceived as enabling incremental improvement and reintegration into everyday life, even if complete abstinence is not immediately achieved. Meanwhile, participants like the above participants described reducing their dosage over time ("I've just recently decreased the dose"), indicating some engagement with the structured aspects of treatment.

Overall, these accounts support an interpretation that methadone was experienced by some participants as reducing harms associated with withdrawal and enabling incremental improvement, while cessation goals remained present for others (or were pursued in stages). Importantly, this harm-reduction orientation in practice does not automatically indicate a preference for harm reduction over total withdrawal; it may instead reflect pragmatic adaptation to immediate symptoms and structural limitations that constrain full abstinence.

3.1.5 Recreational and Functional Motivations

Additionally, recreational drug use was a common theme, described by many participants as a means to relax and enjoy time with friends ($n = 10$). Some participants shared that the habit of drug use was about finding relaxation from stresses, while another mentioned that they turn to substances as a way to socialize. This varied perspective on drug use highlights a dependence on substances for social enjoyment and as a way to escape life's pressures.

"I think it was mostly... the habit of smoking that I have to sort of get used to..... Yeah, for me, exactly. For me, it was purely for relaxation, to chill, and to sort of just zone out from the stresses of the day." (Participant 23)

"Some of us are doing it just for different reasons. It all depends. If they're in the second game centre or something, that's a different thing. But some of us... Actually most of us are like, going outside to work."

Coming there, relaxing.” (Participant 18)

In exploring the participants' functional motivations, a recurring theme emerged regarding their reliance on the energy and confidence gained from using drugs to regain their perceived capabilities. Some participants mentioned an absence of which would lead to extreme body pains and a lack of energy to perform daily tasks, making them unable to work or have the confidence to interact with people. Others specifically described using methamphetamine to stay awake, linking this practice to their desire to enhance performance, particularly in activities such as gambling.

“You know, once it becomes a habit, like, it's craving, you know?... It's a paradise, I guess? A good tripping. Feel confidence.” (Participant 3)

“Sometimes it give[s] courage us to face people. Without the drugs, it's very difficult to face people, the confidence will be very low.”
(Participant 4)

“I lose all my savings, because 2023, once I lose 600 000, because of drugs I play gambling too badly. ... Because after use this one (Ice) you cannot sleep right... then we start playing (gambling). Sometimes when you start as new, new person, you cannot sleep maybe two days, three days, if you use once, one time.” (Participant 20)

“To get up sometimes? To get up sometimes, yeah...More awake. More awake. So, I'm more energetic to do things.” (Participant 32)

Chapter 4 Risk and Protective Factors

4.1 Social influence as risk and protective factors

4.1.1 Initiation of drug use

4.1.1.1 Peer influence

Social influence takes a huge role in the drug abuser's initial drug use. Strickland and Smith (2014) showed that adolescents exposed to drug-using peer groups are significantly more likely to initiate substance use because they experience differential association, meaning greater contact with peers who model, reinforce, and normalize drug behaviours. The mechanism of modelling operates when adolescents observe peers engaging in drug use and acquire these behaviours through observation and imitation, without requiring direct personal experience. A substantial body of research has consistently shown that the influence of peers on adolescent drug use is robust for different ethnic groups and surmounts the effect of parental drug modelling (Brook et al., 1990; Hawkins et al., 1992). 32 out of 36 participants reported that their initial drug use was introduced by their social circle, including friends, significant others, colleagues and relatives.

One participant explained his experience of first engaging with drugs, *“My wife offered it to me. Like she said, she just said, ‘Oh, you gotta try, you gotta try.’ And I’m like, okay.”* (Participant 24)

Another participant reported his first drug uses situation, *“I have a girlfriend before. She used to smoke and playing gambling. Yeah, I never do this. I never done this kind of things before. So, I try to stop her. But because, yeah just, the way I love her, like, so I do everything.”* (Participant 33)

Multiple participants reported that their initial use was significantly influenced by their peers’ introduction to drugs. Taken together, these narratives suggest that initial drug use is often a relationally mediated event, occurring in the context of trust, affection, and a desire to maintain belonging, rather than a purely individual decision. This aligns with social learning accounts in which close peers and partners act as powerful models and reinforcers of drug-taking, making experimentation more likely when use is presented as normal or rewarded within the group. Given this, prevention and early intervention efforts may be more effective when they address peer-group dynamics (e.g., shifting perceived norms, disrupting opportunities for social reinforcement of use, and recruiting prosocial peers as alternative role models) rather than focusing only on individual motivation or family influences.

4.1.1.2 Ethnic network cohesion and influence

A key factor distinguishing ethnic diversity drug use patterns is the role of ethnic network cohesion. Initiation was commonly described as a socially mediated process in which peers lowered the perceived threshold for trying drugs, especially when use was already occurring in the immediate group. Participants framed early experiences as unfolding

through subtle and gradual social cues, which then shifted into internal pressure to conform. This may be particularly salient for ethnic diversity individuals, whose social networks are often shaped by shared language, migration experiences, and cultural familiarity. Such reliance on close-knit, co-ethnic social circles may lead to more concentrated and persistent peer influence.

A participant described the situation of her first drug use, *“he left the room and he just asked me to hold the joint for him. I just hold it for a minute and then, once I held it I heard a voice- just try it.”* (Participant 19)

Another described how it is quite common to do so in social situations, *“No, not a special occasion, but you know sometime we are hanging out you know and together, we smoke together.”* (Participant 14)

Furthermore, association with drug-abusing peers among ethnic diversity individuals is often not entirely a personal choice, but reflects the influence of previously mentioned co-ethnic social circles. Leaving an antisocial group may be especially difficult when opportunities to form alternative relationships within a shared cultural community are limited.

One participant lightly touched on their ultimatum to quit drugs, *“I can stop I just, like, right now, this, the place where I'm at, it's just like once- If I get out of Jordan, then it's easier for me.”* (Participant 32)

4.1.1.3 Normalization

Casual social gatherings and parties were described as one of the key initiation contexts because shared leisure reduced perceived risk and made experimentation feel typical. In these settings, participants emphasized visibility and implied norms as mechanisms through which drug use became reinterpreted as ordinary behaviour rather than a high-risk action. For many South Asian youth, adherence to a strong ethnic identity in a racialized system can lead to associating primarily with co-ethnic friends who may already be involved in substance use. This exposure makes drug-taking appear familiar and culturally "safe" within their specific social bubble.

Another participant mentioned, *“I thought it was just some cigarette, I never know its drugs... Because everybody smoked, it was just, like, a normal thing.”* (Participant 22)

Regular attendance at drug-involved social gatherings may increase the risk of initiating or sustaining drug use among individuals who are already vulnerable to developing problematic use. Such exposure may normalize consumption, lower perceived harm, and increase the likelihood of experimentation, leading to the initial use of drugs, especially for individuals already susceptible to problematic patterns.

4.1.1.4 Accessibility in private environments

Initiation also occurred in low-pressure environments, for example, close friends or family settings, where drugs were mundanely offered in relationships and everyday

activities rather than framed as explicit “drug use.”

Participants highlighted availability as a decisive trigger, “*(what made you finally try it at that time?) Availability. (it's your 18th birthday and it's like available and you're like, might as well?) Yeah, exactly.*” (Participant 35)

Across accounts, specific locations shaped not only initiation but also the conditions that followed onset, particularly through differences in monitoring and supervision. Friends’ homes or backyards were characterized as enabling heavier use for later adolescents due to limited oversight, while early initiators more often described onset in their own homes, where parental facilitation or absence integrated use into familiar routines. Participants further linked neighborhood-level exposure (e.g., entertainment-oriented areas) with increased opportunities to continue and escalate use after initiation.

4.1.1.5 Previous exposure to drugs

Another commonly reported reason for first-time drug use was prior exposure to drugs through everyday observation. This exposure contributed to the normalization of drug-taking and shapes perceptions of acceptability and desirability, thereby facilitating initiation. Many participants reported that they had already been exposed to drug use through older peers, siblings, or people in their surroundings, which made drug-taking appear familiar. First use was often framed as copying what others were doing.

One participant explained that their perception of drugs was changed by exposure to it, “*Older brothers are doing it... First I thought smoking was cool. Like that, I got hooked in.*” (Participant 10)

4.1.1.6 Curiosity

Among the 36 participants interviewed, 17 indicated that their initial drug use was primarily motivated by curiosity. Several respondents noted that their interest originated from a desire to gain firsthand knowledge of the effects or taste of drugs. This curiosity was often heightened by observing others around them about drug use, which made the prospect of trying drugs seem more intriguing and less intimidating. For these individuals, curiosity served as a significant risk factor influencing their decision to try drugs, caused by direct opportunity and encouragement from peer.

A participant expressed the reason of their initial use of heroin, “*I know the name of the heroin, but I didn't, we didn't taste either, I wonder what kind of taste is like that, that's why it's become like that.*” (Participant 5)

One participant explained that curiosity was the main reason for their initial drug use, “*The first time? It's the same thing you know, everything is the curiosity*” (Participant 7)

A participant described curiosity and opportunities provide facilitate the drug use habit, “*I want to have- give it a try. How, how is it feelings... just give it a try. That's it. Seen before, take cuz there is opportunity*” (Participant 15)

4.1.2 Continuity of drug use

In addition to initiating drug use, social circles also facilitate a continuous drug use habit. Although a few participants reported during the interview that they prefer taking drugs by themselves, the majority of them considered that drug taking habit as a regular social event with their peers. Socializing with their peers promoted a sense of safety for them to normalize their drug-taking habit.

A participant explained their feelings while using drugs in a social situation with their friends, *“I enjoy smoking with my friends more... (Is it more fun or less lonely or?) Less lonely. (So it's like a social thing?) Yeah”* (Participant 10)

Another participant reported that they felt more secure and a sense of trust when taking drugs with their friends, *“If someone is using, then we'll just use together... They're childhood friends, quite close... Because being with friends feels... safer, you know? Like... they're friends, so you can definitely trust them.”* (Participant 34)

These practices are shaped by both economic constraints and collectivist cultural values, making drug use a shared social activity rather than an individual behavior. This differs from traditional models that predict increasing isolation, as ethnic diversity drug abusers often continue to use drugs within their social groups over time.

4.1.2.1 Entertainment venue for recreational gambling activities

Although many participants preferred using drugs in private settings, such as their homes (n = 5) or friends' homes (n = 7), to avoid risks like arrest, numerous others also frequented entertainment venues including Pan Zai (n = 10), and game centres (n = 6) for drug use. These locations not only enabled continuous access to substances amid social gatherings but also reinforced patterns of use post-initiation, turning occasional encounters into daily habits. Although activities like gambling or arcade gaming do not promote drug-using behaviours directly, the availability perpetuates the tendency for drug abusers to partake, leading to a possible correlation.

4.1.2.2 Given for free

Several common reasons to take drugs while in the entertainment venues were mentioned in the interviews. First, some entertainment venues use drugs as an attraction to regular drug abusers with a gambling habit.

Participants commonly described entertainment venues, especially game centres, as environments where drug use was not only present but sometimes actively incentivized as part of the venue's business strategy. In particular, some participants suggested that venues targeted regular drug-using patrons who also gambled by pairing the participating gambling with free access to drugs, positioning drugs as an additional draw to keep customers coming back, justifying both drug use and gambling behaviours. Because drugs, framed as complimentary, could be offered in small amounts, participants implied that the immediate barrier to using drugs in these venues was reduced, and drug-taking became embedded in the venue experience rather than treated as a separate activity. This

perceived bundling also blurred financial boundaries.

One participant described daily spending as drugs as a combined package with gambling expenditures, highlighting how drug use and gambling were experienced as intertwined practices in these settings, “*(how much did you spend on ice every day?) A lot, a lot. Every day game, at least like gambling, it included with ice. It must be maybe around 9,000, 8,000 every day... Every day. Gambling, including gambling.*” (Participant 31)

Another participant reported a similar reason for spending time in entertainment venues, “*Ice is given free game... (In game centres) the way they attract you, is by gambling. You have a way to win a lot. And the second way, the second way is through, you know, ice. (Those are how they attract you. So, ice is usually free?) Yeah, a bit... It's more complimentary.*” (Participant 18)

4.1.2.3 Maintaining alertness

Drug use in entertainment venues was also described as serving a functional purpose for sustaining longer gambling sessions, particularly by counteracting fatigue and delaying sleep. Participants linked stimulant effects to an increased capacity to remain awake for extended periods, which in turn enabled prolonged, continuous play. Staying awake was not a side effect but part of the motivation for use. Drugs were understood as a tool that helped maintain the physical and mental state needed to keep gambling.

As a participant explained, the inability to sleep after using drugs could translate directly into more time spent gambling, “*(how does gambling and drugs connect with each other?) Because after use this one you cannot sleep right... then we start playing... Sometimes when you start as new, new person, you cannot sleep maybe two days, three days, if you use once, one time.*” (Participant 20)

4.1.2.4 Boredom

Boredom was another frequently cited reason for drug use. Drug use became a way to spend their free time, as individuals often turned to substances to fill idle time and create a sense of excitement or engagement.

As one participant put it, “*When I feel bored, you know, you can take.*” (Participant 13)

The pattern demonstrated that drug use functions not only as a response to social factors or fatigue, but also serves as a coping strategy for managing boredom and seeking stimulation.

4.1.3 Reason for stopping drug use

4.1.3.1 Social influence

However, peer and social influence do not necessarily lead to drug use as a risk factor.

Prosocial opportunities for involvement, when reinforced and linked to strong social bonds, are theorized to inhibit antisocial and substance-using behaviours within the Social Development Model (Catalano et al., 1996). Given this protective mechanism, positive social influences can counteract deviant peer associations by promoting prosocial bonds, skills, and reinforcements that reduce substance use risk.

A participant reported that his thought after witnessing peers successfully quit drugs fostered his motivation for personal change, *“some of my friend they are like out of drugs nowadays. When I look at them I also think like, maybe I also can quit and do good like them and so, they are, just looking at them like, I get inspired from them”* (Participant 7)

This bidirectional dynamic of social influence underscores the need for interventions in Hong Kong to prioritize peer networks, empowering transforming deviant social associations into pathways for desistance and improved wellbeing.

4.1.3.2 Family attachment

Such social influences extend towards family members as well, with studies reporting how family involvement increases the likelihood of drug abuse reduction. For example, a CUHK ethnic diversity study reported that family factors were the most frequently cited reason for drug reduction, accounting for 39% of respondents (Tang et al., 2006). This finding aligns with the social control theory, which emphasizes that strong attachment to conventional social institutions serves as a protective factor against continued deviant behaviour (Nagasawa et al., 2000). Family therefore functions not only as emotional support but also as a source of informal regulation and motivation during treatment and recovery, a statement frequently brought up by this sample of participants.

A participant mentioned that his mother is the main motivator in his quitting journey, *“it’s because I love her so much, that’s why. I get motivated to not use it anymore.”* (Participant 10)

It is also worth noting that some participants noted the absence of family proximity as an obstacle to recovery. Given that many participants’ family members reside overseas, emotional disconnection and loneliness emerged as common experiences.

One participant described how *“living without parents [feels] very lonely [and] very much stress.”* (Participant 4)

Thus, it can be seen that family support is an important form of recovery capital, shaping motivation for drug cessation and sustaining engagement in rehabilitation. This reinforces the need for treatment and rehabilitation services in Hong Kong to incorporate family-inclusive approaches, particularly for individuals experiencing social isolation due to transnational family separation.

4.2 Permissiveness as risk factor

Individuals’ attitudes toward drug use are an important determinant of substance-use

behaviour. Specifically, beliefs about the acceptability of drug use, perceptions of harm associated with different substances, and self-efficacy to refuse drugs may shape initiation, frequency, and escalation of use patterns. Such beliefs are often shaped by cultural norms and transnational influence, which may not align with the cultural norms practiced in Hong Kong society.

4.2.1 Cannabis as a gateway drug

Greater acceptance of “soft” or “recreational” drug use can make escalation more likely because it shifts what young people see as “acceptable” to try, lowering psychological barriers to experimenting with other substances over time. Cappelli et al. (2021) found that latitude of acceptance toward substance use statistically mediated the association between earlier gateway drug use, for example, cannabis, alcohol, tobacco, and later hard drug use.

As different types of new drugs, such as cannabis and etomidate, become more visible in youth drug scenes, some participants framed it as relatively harmless, *“Like soft drugs, like marijuana and something like that, maybe it's not a big problem, you know. But if you are taking heroin and then you like that drug then, of course it will, you know”* (Participant 8)

Another participant shared his/her view on the effect of cannabis and other harder drugs, *“those are obviously very harmful drugs to a person's physical and mental and highly addictive. So, yeah, obviously those, I think they're on a different sort of level, different tier. I don't think marijuana shares that, that same, those same properties.”* (Participant 23)

One participant described how cannabis is easily accessible in their home country, *“You can get [cannabis] anywhere, yeah no need money ... You can go anywhere and you can find it.”* (Participant 13)

In this way, cannabis is not always described as directly causing hard drug use later; rather, it can function as a gateway by normalizing drug-taking, broadening what is considered acceptable and making later opportunities to try other drugs feel less extreme or less morally prohibited over time.

4.2.2 International influences

International exposure also shapes how individuals in Hong Kong perceive and understand the harm of drugs. News, social media and physical exposure for the overseas environment where certain drugs were described as culturally common and easy to access can reshape individuals' expectations and their social norms. It provides individuals who are vulnerable to drugs with alternative reference points for judging what drug use means and how risky or acceptable it is.

A participant comments on the drug policy in Hong Kong, *“I advocate for marijuana, obviously, the Hong Kong government's sort of behind on their, their laws when it comes to marijuana.”* (Participant 23)

Another participant compared their exposure to drugs between Hong Kong and other countries, *“I studied in Europe, so it was very very common there, it’s very easy to get. So I think almost all my friends within the last year have like done it... You know they have their lives together, it’s just like an occasional thing to them... although I might have one or two friends who like kinda, try harder drugs, like meth and stuff. But they’re also relatively like, put together, they like do it at parks and stuff like that... yeah, very occasionally”* (Participant 16)

Overall, these accounts suggest that international exposure can recalibrate how people in Hong Kong interpret drug-related harm by offering alternative social norms about what acceptable use looks like and where different substances sit on a perceived risk hierarchy. Overseas contexts where cannabis was described as commonplace and socially embedded appeared to weaken the link between drug use and deviance, making it easier to frame cannabis as manageable, while still keeping “harder drugs” symbolically separate and more clearly harmful. Participants may be evaluating risk not only through local law and messaging, but also through what they see normalized abroad and in international peer networks.

4.2.3 Misconception of different types of drugs

Beyond culturally shaped attitudes toward drugs, misconceptions can also increase the risk of drug use by lowering perceived harm and inflating perceived benefits, thereby shifting drug use into an “acceptable” range for some abusers. Some participants described overestimating the functional benefits of drug use, for example, using stimulants to enhance energy or capacity, while others minimized associated harms.

A participant expressed, *“I think ice, not too much affected. Heroin too much danger. Heroin I one week smoke, then after no smoke, my body, no have power. No power. Cannot move, cannot anywhere going.”* (Participant 26)

A participant compared their view on different drugs, *“Ice is the one thing that’s safest, I would say it’s the safest drug of the rest. It has a physical difference like, to make you get addicted. Well, it will give you, physically, you know, like, physical differences. Then, you know, experience and all that. But other than that, I think it’s one of the things you can’t get overdose. You can puke yourself out of it like, you can like, feel like you can puke it out, but you wouldn’t get overdose. So that’s why it’s the safest drug.”* (Participant 18)

Overall, these accounts suggest that misbeliefs about relative safety can create a false sense of security, encouraging continued use of drugs perceived as less dangerous, even when the risks remain substantial. Such misconceptions are further reinforced by limited access to culturally and linguistically appropriate drug education, leaving many ethnic diversity individuals reliant on peer-based knowledge within their own communities.

4.2.4 Misjudgement of the ability to stop drug using habit

Drug abusers often describe a strong sense of self-efficacy regarding their ability to quit drug use, often attributing their continued engagement to personal choice rather than

dependency. This perception of control may contribute to minimizing the perceived risks associated with methamphetamine, reinforcing the belief that stopping is straightforward if the desire arises. While some acknowledged feeling tired or weary from their usage patterns, they maintained that cessation was within reach whenever they decided it was necessary.

A participant expressed that they felt confident in their ability to quit using methamphetamine if they truly wanted to, *“I can tell like, confident that if I want quit, I can quit, cuz I stopped gambling. When you do gambling, you must do this shit.”* (Participant 33)

Another participant expressed their opinion on self-treatment compared to rehabilitation facilities, *“If I want, if I want to stop, I’ll stop. Why do I have to go stay there (rehabilitation facilities) one year? I cannot, cannot. And then, honestly, I tell you, I don’t mind. Because I cannot handle one year, in that kind of place. And, my position there, it’s... I think, probably the people in charge of the care of the... from here, local. Yeah, I can’t handle that.”* (Participant 33)

A participant characterizes the use and quit of drugs as a recurring pattern, *“So, it’s just... It’s a cycle. But it’s easy. I can stop.”* (Participant 3)

The misconceptions and attitudes among drug abusers that often act as a risk factors that downplay the risks of drugs, viewing it as less harmful and expressing strong confidence in their ability to quit if desired, which may reinforce continued use. These beliefs are shaped by personal experiences and cultural influences, sometimes resulting in a false sense of control and minimized recognition of potential harms.

4.3 Health as a protective factor

Health considerations can often motivate individuals to reduce or discontinue drug use. Recognizing the value of health as a key component of personal well-being may act as an important protective factor, encouraging those who use drugs to refrain from further substance use. This heightened awareness of health risks and benefits may act as a protective factor, fostering a desire for lasting change and providing a sense of accomplishment when progress is made.

4.3.1 Maintaining abstinence from drugs

Maintaining abstinence from drug use often requires ongoing commitment and self-monitoring, as individuals navigate daily challenges and temptations. Support from peers or family, as well as establishing routines that reinforce healthy choices, can play a significant role in sustaining efforts to remain drug-free.

A participant described their progress in remaining drug-free over the past several months, noting improvements in their life, *“Last two months, his (translator translating for and referring to the participants) drug use pattern is improving, means he didn’t use a lot. So that’s why he also found maybe his health also a little bit getting better. So that’s why he satisfied.”* (Participant 2)

Another described how health issues may have motivated them to consider quitting, as translated from her son, “*Because she’s getting older, and she know not to.*” (Participant 11)

In conclusion, recognizing and prioritizing health can serve as a protective factor against ongoing drug use. The desire to improve physical and mental well-being provides motivation to reduce or stop substance use, fostering resilience and a sense of accomplishment in recovery. This awareness not only encourages healthier choices but also helps individuals to sustain abstinence, even in the face of daily challenges. By valuing health, drug abusers can find renewed purpose and strength to maintain their commitment to a drug-free lifestyle.

Overall, risk and protective factors among ethnic diversity drug abusers are not merely individual-level determinants, but are deeply embedded within cultural, social, and structural contexts. These findings highlight the importance of adopting a culturally responsive framework when understanding and addressing drug use among ethnic diversity populations in Hong Kong.

Chapter 5 Treatment Experience, Attitudes and Needs

5.1 Experience in using drug treatment and rehabilitation programmes

Out of 36 participants, 16 reported engaging with drug treatment and rehabilitation programmes. Among those who tried related programmes, 12 were Nepali, 2 were Indian, and 2 were Pakistani. 13 participants used heroin or heroin mixed with other substances, 2 consumed cannabis or cannabis with other substances, and 1 drank cough syrup.

Participants mentioned four main types of drug treatment and rehabilitation programmes:

- Methadone Clinic
- Residential Drug Treatment
- Substance Abuse Clinic
- Halfway House

5.1.1 Methadone Clinic

12 participants reported that they were using or had used Methadone Clinic services, with the majority being Nepali. Most of them agreed that methadone treatment had a positive impact, especially in suppressing withdrawal symptoms:

“Every day, yeah. Then my body no feel sick. Maybe no methadone now, very body pain.” (Participant 26)

Participants also highlighted the affordability of methadone treatment:

“So one dollar, drink methadone, no withdrawal symptom then it’s ok.” (Participant 2)

They mentioned that methadone treatment was effective in helping people quit drugs:

“Many, many friends already use the methadone and then already, now it's normal life.” (Participant 30)

Some noted that methadone was a replacement therapy and should not be used together with drugs.

“Like me, I misuse. Doctor review, if you really want to quit this is treatment. But me, I always take methadone also, I always do drugs also.” (Participant 9)

“It's helpful but, you have to go in the systematic way. If you taking methadone and drugs also then, cannot. If you take only methadone then, day by day decrease.” (Participant 12)

One participant highlighted methadone's limitations:

"In terms of your physical pain, it helps, it helps a lot. But your mental, mentally, you still you still want them." (Participant 8)

While methadone treatment was widely regarded as effective and affordable for managing withdrawal symptoms and stabilizing daily life, participants' comments reveal two critical gaps: (1) persistent mental cravings despite physical relief, and (2) misuse when methadone is combined with illicit drugs. These findings suggest that methadone alone is insufficient for long-term recovery. Strengthening counseling and educational support alongside methadone treatment is essential to provide emotional care, address psychological dependence, and ensure clients follow a structured tapering plan rather than misusing the therapy.

5.1.2 Residential Rehabilitation Services

9 participants stated that they had previously been admitted to residential rehabilitation services. Among them, 5 joined local centres without any religious background, while 3 attended local residential drug treatment centres with a religious affiliation. Additionally, 3 participants had tried residential drug treatment in their home countries.

Several participants described the structured environment of these programmes as helpful in keeping individuals occupied and reducing drug-related thoughts:

"Yeah, very very effective ... they just put the patient, you know, get busy all the time rather than thinking the drugs... they check the one, the one particular job for you. It was like you just cleaning or doing some kitchen work. Or go for yourself fishing or hiking, for other... other like, other sports things you can do... Because people, if people be busy, they will not think about drugs. Or if you feel alone, you always think about." (Participant 4)

For some participants, the presence of a community of their own ethnicity within the centre was considered an advantage, particularly for ease of communication:

"I've been there 6 or 7 times right... I find [rehab centre] is a nice place you know... because we can like, the Nepali, they can stay together in one house. So it's easy for us" (Participant 7)

"In terms of communication, it's helpful but... but for me, if you stay with Chinese or Vietnamese or Nepali, it doesn't make any difference." (Participant 8)

Participants also reflected on the balance between freedom and restriction, noting that longer stays and strict rules could support recovery, even if they were challenging:

"Yeah, it's very strange, you know. Most of them are, they are not relapsed because they have a longer period of time to stay there, because you have to stay there for a least one year, you know? And then you cannot smoke there, you cannot have beer, you cannot have... there are some restrictions there... Of course I like freedom, but I

think restriction is also helpful you know?” (Participant 8)

However, some expressed discomfort with religious requirements in certain centres:

“I don’t like the Christian thing in there you know, they just force you to like read the Bible and just force you to be Christian and something like that” (Participant 7)

Some participants emphasized that language was a barrier to engagement and comfort:

“(Q: Is there any language barrier there?) ... Some, yeah, some staffs they speak English a little bit” (Participant 4)

“Well it's a Christian-based rehab, so I have to like read the bible in Chinese and I don't- I can't read Chinese. And I can't write either, and... yeah. So that was a bit of a struggle...So that's when the discrimination started...because it is a Chinese-based environment, my parents would have to speak- just communicate in Chinese, which they are not able to do so fluently so I just could call my spiritual mother, so my church mother, who is a Chinese.” (Participant 19)

For those who attended programmes in their home countries, the approach often included detoxification and educational classes:

“Does a stay detox, detox attendee, something like that. And after that we have a class, we have to take some class to how... to didn’t use the drugs, it will be harmful, and you... they give the solution of the good things, this one is good, this one is bad, is like that.” (Participant 5)

“Like counselling they will share like, likewise they will share their experience and they will motivate us to stay clean (Q: Did you get motivated?) Yeah” (Participant 10)

Finally, participants highlighted the need for community rehabilitation services after discharge to prevent relapse:

“Sometimes, they have a problem where they came back from the treatment, they didn’t, don't know the right track of the... after quit the drugs, you know? And they sometimes they came back at a previous track and then again, relapsed. A lot of chances to relapse, so it's better to give them one separate way, two separate way or give them busy all the time, doing something else rather than doing nothing else.” (Participant 4)

Residential rehabilitation services were generally valued for their structured environment, which helped participants stay occupied and reduce drug-related thoughts. Ethnic familiarity within centres was seen as supportive, while strict rules and longer stays were perceived as both challenging and beneficial for recovery. However, barriers such as language difficulties, religious requirements, and a lack of culturally sensitive practices limited engagement for some participants. Those who attended programmes in their home countries appreciated the inclusion of educational and counseling components, which

were often missing locally for ethnicity diverse groups. Participants also stressed the need for community-based aftercare to prevent relapse after discharge. These findings highlight the importance of integrating culturally competent approaches, language support, and post-treatment services into residential rehabilitation models in Hong Kong.

5.1.3 Substance Abuse Clinic

One participant who used substance clinic reported positive experiences, highlighting the supportive attitude of medical staff and the flexibility offered during treatment. They appreciated being able to communicate openly with doctors without fear of judgment and noted that honesty was met with encouragement and practical support.

“Yeah very good yeah. Very very helpful, the doctor is very helpful yeah.... I tell him very frankly that I smoke, and he's also like, no problem... And then, if I stop, so I explained to him like, okay, now I stop, and then he is... very, like, you know, good. And then he give me a lot of privileges when I stop, you know?” (Participant 22)

This reflects the importance of a non-judgmental approach and personalized care in substance clinics, which participants felt that it helped them maintain motivation and progress toward recovery.

5.1.4 Halfway House

One participant was living in a halfway house and emphasized the friendliness of staff and the sense of family-like care, which contributed to feelings of safety and stability during recovery.

“it's very friendly, very friendly the staff, 24/7 they're here for you, yeah. And they give you other basic, like, you know, more than the basic rights, yeah, that one you need, yeah. And then they look after you like family” (Participant 22)

In addition, the participant viewed halfway houses as a place to escape from the drug circle.

“I have, like, you know, forced myself to stay this places, you know. Otherwise I have many friends living outside that want me to go and share the flat with them. And then I know myself, I cannot control.” (Participant 22)

This feedback highlights the value of halfway houses in offering continuous support and basic needs, fostering trust and reducing the risk of relapse after formal treatment.

5.1.5 Limited Salience of Counselling-Based Services among Ethnically Diverse Participants

Although several participants reported having attended counselling-related services, including NGO-based counselling and community support services, their narratives indicate that these interventions were not prominent in shaping their recovery experiences. Rather than identifying counselling as a central form of intervention,

participants consistently emphasized other treatment modalities, such as methadone clinics and residential drug rehabilitation programmes, as more directly relevant to their needs. This limited engagement with counselling-based services appears to be closely linked to cultural and structural barriers. Participants described difficulties engaging with services that are primarily Cantonese-speaking, with some treatment centers “*speak a little bit English ... English and Chinese mix together and speak like that*” (Participant 13). In contrast, services that employ service providers with the same ethnicity allowed greater comfort and engagement, with one participant noting that “*it makes it easier for us*” (Participant 7). There is also some discomfort with culturally unfamiliar service environments, especially if the majority of service users were of Chinese ethnicity. When asked how programmes at an NGO can be improved, one participant recommended having “*more Nepali*” (Participant 11) or individuals who speak the same language as her.

In addition, there is limited awareness of treatment or social services within ethnic minority communities, with many participants relying on peer referrals or low-threshold services, such as methadone clinics. Participants who have never engaged in any treatments noted how they “*never heard of them*” (Participant 32) or that “*if you're an NGO, you're the first. I don't know any*” (Participant 29). From this perspective, the limited role of counselling-based services reflects not only issues of accessibility, but also a broader mismatch between mainstream service design and the lived realities of ethnic minority drug users.

The limited salience of counselling within participant accounts suggests challenges in meaningfully engaging ethnically diverse drug users. Importantly, even when counselling services were accessed, they were not strongly embedded in participants’ recovery narratives, pointing to a gap not only in accessibility, but also in perceived relevance and practical impact.

5.2 Attitudes Toward Rehabilitation

For those who tried residential rehabilitation, they overall reported a positive image to the services. However, among those who didn’t use any rehabilitation services, they had mixed attitudes toward rehabilitation services, with some showing strong doubt, fearing stigma, and some of them believing that they could manage without formal treatment.

5.2.1 Perceptions of Residential Rehabilitation Services

Several participants viewed residential rehabilitation services negatively, associating them with confinement and loss of freedom:

“Oh my god, sounds like prison no... I can just stop myself.” (Participant 32)

“I'm not really interested in the application. Why? Just, like, stay in the prison, you know.” (Participant 33)

These sentiments echo findings from Tang (2014), who reported that some ethnic diversity drug abusers in Hong Kong described residential centres as offering “no human

rights,” prompting their preference for methadone clinics instead (Tang, 2014).

One participant got negative experiences and emotional impact after the residential rehabilitation service rejected his application, as reported by his social worker:

“One time he applied [rehab centre]. It’s a Christian-based rehab, but he completed all the procedure, fellowship, intake, but he failed in the medical, because he has schizophrenia. So that’s why they said they don’t accept...he gets very angry, always. Because he has a very, like, traumatized from that incident.” (Participant 2)

This rejection reflects systemic exclusion of those with co-occurring mental health issues, commonly schizophrenia, underscoring a need for integrated care. The emotional trauma expressed supports calls for more inclusive eligibility approaches in residential services.

5.2.2 Concerns About Stigma and Judgment

One of the female participants expressed fear of being judged as a barrier to seeking help, as translated by her son:

“She’s saying she’s a woman, so she cannot go (to rehab). She doesn’t want to go because she thinks women cannot go...she feels like people will judge” (Participant 11)

According to Tang (2014), compared with male drug abusers, female Nepali drug abusers have to hide their drug activity very carefully due to their very marginal position in the Nepali community. Fear of stigmatization remains a barrier, especially among female minorities, reinforcing the importance of stigma-reduction efforts that address cultural and gender-based sensitivities.

5.2.3 Belief in Self-Control and Non-Addiction

Among the 11 participants who used cannabis, 8 of them felt that they were not addicted and could stop without assistance:

“No. You will get addicted if you consume daily.” (Participant 27)

“I’m able to stop it when I want to, I’m able to control myself to not smoke.”
(Participant 1)

“No, I don’t think I get addicted to it, maybe for habitually, like, just as a smoking habit, but not, I’m not mentally, reliant on it.” (Participant 23)

5.2.4 Preference for Alternative Coping Strategies

Some participants relied on personal strategies, such as returning to their home country to break the cycle:

“Normally every year I go back to India. But after I go, I don’t use this because of

my family... Yeah, few days maybe, two weeks later you don't need this. Only first two weeks is difficult. That two weeks you have to sleep to recover.” (Participant 20)

These attitudes reflect their misconceptions about addiction and treatment, highlighting the need for culturally sensitive education and outreach to build trust and awareness.

5.3 Needs

Participants identified several needs and areas for improvement in existing rehabilitation services.

5.3.1 Culturally and Linguistically Inclusive Services

Participants emphasized the need for programmes tailored to ethnic diversity groups so as to lower the language and cultural barriers:

“(Prefer) more Nepali” (Participant 11)

“Maybe they should try to consider open up a place for people with different places...everyone's like, not to sound mean, everyone's Chinese. Like I sometimes think how come there isn't a place for like- not me because I'm Hong Konger, but for other ethnic minority people. Like a specific place where they can... like a specific rehab, or a specific like, counseling place” (Participant 19)

Participants clearly expressed the need for culturally and linguistically inclusive rehabilitation and counseling services. Creating ethnic diversity-specific services or ensuring multilingual staff and culturally sensitive practices would improve accessibility and trust. This aligns with findings from Tang (2014) and Tang et al. (2006), which highlight that Nepali drug abusers in Hong Kong often avoid residential rehabilitation services due to cultural mismatch and language difficulties, preferring low-barrier methadone clinics instead.

5.3.2 Mental Health and Emotional Support

Participants highlighted the importance of psychological care and social connection:

“It will help, for example, mentally also. Mentally free, it will make free, happy, right? Togetherness.” (Participant 15)

Given the dual stigma of substance use and mental health issues for ethnic minorities, integrating psychological support into rehab programmes is essential. Services should include counselling, peer support, and activities that foster emotional well-being and reduce isolation.

Additionally, several participants reported gambling as a co-occurring issue, often linked to stimulant use and financial stress. Gambling was described as both a coping mechanism and a trigger for continued drug use, with some participants experiencing severe financial losses and relapse risks. For example, one participant shared:

"I lose all my savings, because 2023, once I lose 600,000, because of drugs I play gambling too badly." (Participant 20)

Another noted:

"Because we're more into gambling...the gambling that happens together."
(Participant 18)

These accounts underscore the need for integrated gambling addiction therapy within rehabilitation programmes. Addressing gambling alongside substance use would provide a more holistic approach to recovery, reduce relapse risk, and support overall mental health and financial stability.

5.3.3 Diversified and Engaging Programmes

Participants suggested incorporating hobbies and recreational activities to keep individuals occupied and motivated:

"I think there is some useful method, like programme like you know... like counseling, like some activities." (Participant 14)

"Organize more activities to attract them. Maybe give them hobbies they like, so they can focus on those instead of drugs. For example, if someone likes playing football, then arrange more football activities and create a football team so they can focus on football" (Participant 34)

Participants emphasized that rehabilitation programmes should go beyond basic treatment by incorporating diverse and engaging activities, such as sports and hobbies, to keep individuals occupied and motivated. These suggestions reflect a desire for programmes that provide meaningful alternatives to drug use and foster social connection. Structured recreational activities can help reduce boredom, a common trigger for relapse, and promote a sense of purpose during recovery.

5.3.4 Employment support

Unemployment was common among participants who consumed heroin, and many linked joblessness to continued drug use:

"Family affect. Job affect. Friend, friendship affect...first time I coming Hong Kong, first time I was very good...good job, find good money...(after) I'm coming to drugs, drug life, everything is poor." (Participant 26)

One participant who used heroin and methamphetamine emphasized that stable employment could serve as a protective factor against relapse:

"If you get a job then you can focus on the job, that's right. You don't got anywhere to go like that, otherwise you can go through again" (Participant 13)

This observation aligns with findings from our previous study on local drug abusers with criminal records, which suggested that employment is not only important for financial stability but also for occupying time and fostering a new social circle, both of which reduce the risk of relapse (SideBySide, 2023). Employment support therefore plays a critical role in reintegration and long-term recovery.

5.3.5 Safe Spaces Away from Drug Circles

Several participants pointed out that their social environment was a major factor hindering recovery. Maintaining contact with peers who use drugs was perceived as a trigger for relapse:

“Just only hi-bye like that. If they don't want to meet again, I don't want to meet with them again. Because if I meet with them again, then they will start again then.”
(Participant 13)

Others emphasized that physical relocation could make quitting easier:

“If I get out of Jordan, then it's easier for me.” (Participant 32)

A few participants even planned to leave their drug circle by returning to their home country as a strategy for quitting:

“Normally every year I go back to India. But after I go (to India), I don't use this because of my family...few days maybe, two weeks later you don't need this. Only first two weeks is difficult. That two weeks you have to sleep to recover.” (Participant 20)

These accounts highlight the importance of creating safe spaces away from drug-prone environments. Community-based housing, relocation support, and structured aftercare programmes can help individuals break ties with high-risk social circles and sustain recovery.

5.3.6 High-Quality Social Work Support

Participants emphasized that social workers should be empathetic, patient, non-judgmental, and genuinely caring. They valued qualities such as attentiveness and compassion:

“You should be attentive, kind, understanding, compassionate, empathic, diligent”
(Participant 19)

Social workers who adopted a welcoming and non-judgmental approach were particularly appreciated:

“They support is like...even though you are taking drugs, but they still welcome you...And they try to give you awareness. They're not like, forcing you by like, don't smoke, don't come here. Okay, next time, don't want to see your face. I don't want to

give you a dollar or something like that.” (Participant 21)

“The social worker took on a role like an elder brother. They want to see you do well, want you to improve. They don’t just tell you all at once, ‘Don’t take drugs.’ Instead, they slowly help you understand that you shouldn’t do this. They are very friendly and don’t judge people. You can tell when some social workers genuinely care and want the best for you. Some are different, and you can see the difference.” (Participant 34)

These accounts highlight that empathy, cultural sensitivity, and a non-judgmental attitude are key factors for building trust and engagement, especially among marginalized groups.

Chapter 6 Comments from Service Providers

Service providers interviewed can broadly be divided into two categories based on their target service provision: (1) youth services and (2) services for the general population. Consistent with patterns identified in the drug abuser participants (Table 1), younger demographics predominantly use cannabis, whereas older service users tend to prefer heroin. Providers also noted that the majority of their service users are Nepali, with some Pakistani clients and only a small number of Indian individuals.

“Around 90% are Nepali, yes. Very few, just a small number, are Indian or Pakistani, and people from other ethnic groups are even fewer.”
(Service Provider 10)

There is a distinct difference in the methods used to engage different service-user populations. Youths are most commonly approached through school talks and interest-based programmes, whereas older generations are typically reached via peer supporters’ networks and outreach efforts. Regardless of demographic, both groups also participate in programmes such as outings and support groups, which function as important points of engagement. Service providers described these programmes as opportunities for relationship-building, fostering a supportive community, and allowing regular check-ins, thereby offering a low-barrier entry point into services. One provider also noted that these activities enable staff to observe any abnormalities that may indicate relapse, creating an entry point for intervention. In addition, across both youth and adult populations, case referrals and family involvement also play key roles in bringing individuals into services.

“I feel that the mothers in the mothers’ group all really like this programme. First, it gives them a chance to share, they can talk about how they may feel they’ve let their families down. Second, there’s truly a group of sisters who support one another.” (Service Provider 10)

“Suppose they join a sports activity, they might experience some effects after taking drugs, like getting shortness of breath or feeling very tired. We would use these observations to talk with them, and also ask how much this is affecting their daily life.” (Service Provider 5)

In terms of treatment approaches, several service providers noted that they do not focus solely on the topic of drug use itself, but instead address the underlying consequences of substance use, supporting clients in developing insight and gradually building motivation. They described this process as helping clients gain that “flicker” of understanding (Service Provider 1), which is often more effective than directly confronting drug use.

“And, the thing is that don’t always talk to them about drugs, drugs,

drugs, you know. I think the thing is that we should see the problem behind it and get the solution.” (Service Provider 8)

Service providers also emphasized the importance of family involvement as key activation mechanisms. Families were described as primary carers who offer emotional support and hold clients accountable throughout the recovery process. One service provider noted that they often coordinate with family members to “cross-check” information, ensuring the accuracy of clients’ narratives when planning treatment interventions. In retrospect, clients who do not have family residing in Hong Kong, or have complicated family dynamics, generally do have more difficulties in staying clean.

“Sometimes the brother will lie to us that, you know, that they will get money from family and then telling family, ‘oh, I have already applied rehab like that’... So we’ll call them and ... cross-checking and also, um, emotionally supporting them.” (Service Provider 1)

“So actually, if there’s no one monitoring them, the success rate of quitting will be lower. Because basically, if no one is watching you, then relapsing doesn’t really matter, who would care, right? So for this group, the success rate ends up being even lower.” (Service Provider 7)

In addition, various support groups, such as mother’s group, brother’s support group, and youth programmes, were regularly organized to help cultivate a community of individuals working toward similar goals. These groups provide opportunities for mutual information-sharing and create a space for open discussion, with the aim of fostering a supportive, non-judgmental atmosphere.

6.1 Service Providers’ Opinions on Drug Abuse

6.1.1 Peer influence

8 out of 10 service providers reported that peer influence is the primary reason for drug use, with many cases arising from individuals following the behaviours of their peers or from a lack of clear drug-awareness education. Several providers also noted that this pattern does not differ significantly from that of local drug abusers, who are similarly shaped by their immediate social environments and networks.

“In the five [people] maybe if I take the heroin, then easily I can affect the [other] four. Yeah so this is why the trend, why so many youngsters become a drug user, just follow the friend.” (Service Provider 2)

“In every country, the reason is similar, you know. For us is probably, influence, you know, your circle.” (Service Provider 1)

On the other hand, it was suggested that humans' natural tendency to gravitate toward those who share the same cultural background may contribute to increased risk, particularly given the "minority" status of many ethnic diversity groups. Ethnic diversity individuals often live under a set of circumstances that differ markedly from those of the local Chinese populations, navigating distinct customs, languages, and ways of life. Instinctively, they may feel more secure remaining within their in-group, where they are surrounded by familiar practices and likeminded peers. For many, this social circle is all they have ever known, and the prospect of leaving and engaging with people from vastly different backgrounds can evoke fear and uncertainty. This hesitance to leave the group, combined with the reinforcement of shared norms and behaviours, may perpetuate a vicious cycle that makes it more difficult for individuals to distance themselves from risky environments or seek support beyond their immediate community.

"I think peers have a huge influence... Among Cantonese people, or Chinese people in general, we have a saying, 'You turn red when you're near vermilion, and black when you're near ink.' So, if we had many different social networks, then I probably wouldn't always be sticking with the same group of bad friends. But for them, their sense of ethnic identity is very strong, and so they tend to fall together as a group, for better or worse." (Service Provider 3)

"If they suddenly leave, it's like they've already broken through something ... they may feel unsecure, or feel that if they leave this place, they are 'nothing.' Because their whole circle lives there, eats there, uses drugs there, and they already have no contact with their family... Leaving the Yau Tsim Mong area feels just as difficult as leaving their entire drug abuse circle." (Service Provider 10)

6.1.2 Permissiveness

An ongoing challenge highlighted by service providers is the high level of permissiveness towards cannabis, a drug that is commonly abused among the youth. One service provider (Service Provider 9) noted that many of the court-referred cases entering their hostel are cannabis related, where clients were mandated to attend as part of their probation order. When abusers were asked whether they had plans to quit, most reported no intention of doing so, viewing cannabis as something recreational that should be enjoyed from time to time, albeit perhaps in places that are legal. Several providers suggested that this perception is reinforced by cultural and international influences, which shape users' beliefs about cannabis being harmless or socially acceptable.

"Hong Kong people do this as well. In general, when it comes to marijuana, the cultural influence is strong. They think that since it's not a problem overseas, if I just want to relax a bit, it's fine. So because of this, this perception also influences them." (Service Provider 9)

"In their world, marijuana may not even be considered a drug. So in

their world, it may not even be illegal. And in Nepal, many singers and musicians use marijuana to write songs or play rock music. So I think, to them, it feels somewhat normal.” (Service Provider 10)

Although service users are aware that cannabis is illegal in Hong Kong, they often do not understand the rationale behind its prohibition, and therefore continue to use it regardless. This permissive attitude complicates intervention efforts, as users may not perceive their behaviour as problematic or requiring change.

“At first, I didn’t even know what was illegal in Hong Kong’, so they would be even less aware, and more resistant, thinking, ‘Why do I need to quit? I’m not addicted.’ So if you’re talking about treating marijuana use as something requiring rehabilitation, it’s actually quite difficult, especially for young people.” (Service Provider 3)

6.1.3 Relationship with Family

Service user’s relationship with family was often brought up in interviews, citing that familial relationships takes a huge precedence in their lives, especially in comparison to local youths. One service provider mentioned how they view this as a strength and an area of engagement, noting that they have “stronger family bonding” and would “treasure their festivals and gather with their family members” (Service Provider 5). As mentioned, family involvement plays a role in maintaining a drug-free environment for service users, often serving as the primary motivating factor for quitting drugs, even for those who live far.

“No matter how they didn’t see their family 20 years, somebody 30 years they didn’t see them, but still, they have all, when we talk about that issue, they become emotional. So this is the, I think also that can, connected, you know?” (Service Provider 2)

“Their family is no longer in Hong Kong, maybe in the UK, but their motivation is that they want to return to the UK and reunite with their family.” (Service Provider 10)

On the other hand, the absence of such relationships can have the opposite effect. Several service providers mentioned that parents sometimes have long working hours, leaving youths with a lot of free time that is spent primarily with friends. As mentioned earlier, peer influence is widely regarded by service providers as the leading factor contributing to drug use. Without parental supervision, youths experience increased freedom and heightened risk of falling into harmful social circles, making it more likely that they will be introduced to drug use through their peers. For individuals from the older generation, the absence of significant family members can have a profound impact on their motivation to remain drug-free. Some believe that there may be no point in getting clean and perceive no sense of purpose to life. Thus, the motivation to stay clean is very minimal.

“Parents, they don't have enough time to take care of them also, because the parents they need to work, both of them for very long hour, so that's why those kids they spend a lot of time with their friends.”
(Service Provider 2)

“They feel that life has no meaning, or that they can't find anything that would motivate them to change.” (Service Provider 10)

6.1.4 Adaptability in Hong Kong

Ethnic diversity service users can generally be divided into two groups, those who were born and raised in Hong Kong, and those who have immigrated. For the former, it was noted that the onset of drug abuse does not vary too far from local service users, although the pressures faced may slightly differ.

“The reasons they use drugs are, for the most part, very similar to those in the Chinese community. Often it's curiosity, peer influence, underestimating the side effects of the substance, or even misunderstanding that something isn't a drug when in fact they are taking drugs. What I've heard what may differ a bit is that, for them, stress plays a bigger role. Compared with the Chinese community, a higher proportion of them use drugs because of stress.” (Service Provider 4)

For immigrants coming from countries with different customs, cultures, and languages, adaptability issues may arise. Half of the service providers interviewed agreed that difficulties in life adjustment play a role in increasing pressures on ethnic diversity individuals. One mentioned that they think for ethnic diversities, *“in general their life pace is much slower... not like us, who were born and raised in a fast-paced city, where everything is very quick, very rushed”* (Service Provider 7). Coupled with other stressors such as employment difficulties, language barriers, and/or difficult relationships with family, ethnic diversity individuals who have immigrated could easily fall into the at-risk group.

“I need to refer client for the employment service also, means for the work. But uh, I think the requirement is not matching with my client, like language and skills, those things.” (Service Provider 2)

“But I think that if they originally come from another country, meaning they came to Hong Kong from their home country, you can imagine that they may have less family support and less financial support... Local people also face economic pressures, but it's different. Because they have left their hometown and come to Hong Kong, they may not have many working opportunities, so the challenges they face are different.”
(Service Provider 9)

6.2 Challenges in engagement

Engagement also differs across ethnic groups, with service providers reporting that most of their clientele are Nepali, whereas Indian and Pakistani service users tend to remain hidden. Nepalis were commonly described as “*more open, willing to talk, seeking help*” (Service Provider 2), while Indian and Pakistani individuals “*do not wish to disclose ... even their families also*” (Service Provider 2). There is a significant cultural difference even within South Asian communities, which shapes not only their patterns of drug use but also their help-seeking behaviours. These distinctions influence how comfortable individuals feel approaching services, how open they are to hearing recommendations and how committed they are in following suit.

“We do actually have some Pakistani cases, but really, although there are some who actively participate in our drug rehabilitation services, you could count them on one hand, fewer than five. As for Indian friends in Hong Kong, they tend to be a bit more well-off, many of them run businesses. Even if they themselves aren’t running a business, their relatives are often respected businessmen or shop owners.” (Service Provider 7)

6.2.1 Stigma and hesitance to seek help

Service providers repeatedly describe saving face, shame and closed-group dynamics decreasing their motivation to seek external help. Especially for Pakistanis and Indians, there is general distrust for individuals outside of their ethnic group, especially with sensitive issues such as drug abuse.

“Because their community is, by nature, very much a closed group, they often are not very willing to interact with people outside their own circle.” (Service Provider 4)

“Their social circle is relatively small, so there may be things... I wouldn’t exactly call it gossip, but there are many internal dynamics, the whole ethnic group has many internal dynamics. ‘I know what this person is like, this person knows what this other person is like’, these relational situations can create a lot of pressure for them.” (Service Provider 9)

Even within the community itself, oftentimes ethnic diversity individuals need to navigate potential in-group repercussions when considering whether to seek help. One service provider described a situation in which the wife of a drug abuser chose not to proceed with seeking help for her husband due to fear of being alienated by her husband’s family, who she was also dependent on for her livelihood (Service Provider 5). Another provider noted that there is a general sense of embarrassment associated with drug use, and within a “minority” community, it is easy for such information to spread, therefore intensifying stigma and shame. These dynamics may create powerful social barriers that discourage individuals from accessing available support and disclosing their struggles.

“We really saw it happen, and it was quite serious. The father would even take a knife to threaten them. So during the assessment, we felt that they might need placement in a protective shelter. We actually accompanied them to seek help from the IFSC, but in the end they didn’t follow through. They did attend the initial session, but they didn’t continue because the mother works at a restaurant owned by the father’s older female cousin. She was terrified that if she reported him, she would lose her job.” (Service Provider 5)

“Take the example of a mother, if her daughter were involved with drugs, but their social circle already had a lot of internal dynamics, she wouldn’t want other relatives to find out that her daughter, or her son, uses drugs. That makes it even harder for her to seek help, like she has nowhere to turn. The most difficult part is that they really don’t want others to know.” (Service Provider 9)

In addition, one service provider noted that there may be general unfamiliarity with social services among ethnic diversity populations, leading to some assuming that seeking help would alert the authorities. Thus, many would choose to handle issues privately, or to return to their home country to avoid potential societal repercussions.

“General families, probably they might have, they don’t want to reach, or they feel, kind of not comfortable to reach the, I would say, the government, or for the services, you know” (Service Provider 1)

“Because back in their home countries, many of them didn’t know what NGOs or social services were. And even when they do know, they often have a misunderstanding that Hong Kong NGOs or social services might actually be connected with the Hong Kong government or the police. They think that if they use our services, we will report them, tell the government, and cause them trouble. So because of this misunderstanding, many of them are unwilling to approach social services.” (Service Provider 4)

6.2.2 Service fragmentation and boundaries

6 service providers noted that social services in Hong Kong are often divided into several sectors. Given that drug abuse cases tend to be complex and multidisciplinary, service users frequently need to engage with several parties to receive comprehensive support. For example, rehabilitation centres for detoxification and hospitals for psychiatric treatment. This fragmentation becomes particularly challenging when trust is worker-specific, as service users often feel uncomfortable when introduced to a new worker, having to reiterate their condition again. This is especially tricky when the worker is of a different ethnicity, as there is a certain level of cultural gap and cohesion that needs to be overcome before trust is established. Furthermore, some service providers have also expressed that it can be difficult to follow up on cases, especially if the case have been transitioned and referred out. As a result, both clients and service

providers may find themselves caught in an uncomfortable loop, where repeated handovers disrupt continuity of care and ultimately affects treatment efficacy.

“In Hong Kong, the service boundaries are really limited ... We need to go to another social worker or another, you know, NGO to talk to them. And that's sometimes because, they youth the thing, they are more comfortable with us. So they don't want to talk to someone else and share it again.” (Service Provider 8)

“Because we provide community-based support, we usually continue following up on their situation. But if they are referred to another organization and are later discharged, as far as I know, very few people will follow up afterwards.” (Service Provider 10)

Furthermore, such fragmentation limits the accessibility of services, evident among ethnic diversity populations who may face delayed awareness or uptake of available resources due to communication barriers. One service provider mentioned how *“their information mostly relies on being spread within their own community. So how much of it is correct and how much is wrong, maybe they themselves also don't really know”* (Service Provider 5). To combat this, such barriers are often mitigated by bridging and escort services, with service providers acting as mediators to ensure effective communication and to ease the client in foreign environments.

“When some ED service users encounter this kind of situation, they themselves may not be the most motivated to seek help. But sometimes it's their parents or relatives who try to seek assistance. But do they actually know what community resources are available to help them?” (Service Provider 9)

“Maybe, they cannot communicate well, or they have... they feel a little bit not comfortable as local, you know? So, what they do is that they will always reach out to their families or friends around, relatives, and somehow they will end up in getting to the NGOs or hospital. Unless they have someone to help them, then they probably will get ready to, approach to where they have to go. Otherwise, they are not really comfortable to go by themselves.” (Service Provider 1)

However, it is often the case that service users may have misunderstandings about such bridging services, expecting their concerns to be solved only by one party. It is this unfamiliarity with the social service system that often leads to feelings of frustration and disappointment.

“When she came to seek our help, she really wanted us to place her child into a rehabilitation centre. But first of all, the mother was not very clear about how Hong Kong's rehab centres work, the voluntary options, the procedures, the choices available. Because in their home

country, children can be forced into such centres. So that's the first gap, there is already a mismatch in expectations." (Service Provider 5)

6.2.3 Motivation and Relapse

Although family was observed to be the main motivating factor for service users to quit, service providers also noted that individuals from ethnic diversity backgrounds tend to move more collectively, allowing for stronger community bonding and support groups. Several service providers mentioned distinctive differences of service users when interacting in a local environment and being with those in their community.

"Our community people always think about, why not we make our own community, we have this kind of mindset also." (Service Provider 2)

"They may feel that their lives are quite unsupported, but on Wednesdays there is something for them to engage in, and they get to see a group of 'brothers' who speak the same language, and they actually enjoy that. It may not necessarily be about gaining knowledge; sometimes it's simply for a meal, or because they have nothing to do at night, so they come. For some of them, I think they want to express their feelings, but they don't have any channel to do so." (Service Provider 10)

However, service providers also described persistent challenges in sustaining service users' motivation, noting that programme consistency is difficult to maintain, as many individuals struggle to attend regularly despite initial engagement. One worker reflected that even when clients express willingness, *"eight out of ten will try their best but somehow... they will relapse or go back to the same circle"* (Service Provider 1), underscoring how other factors often overpower initial motivation. Furthermore, some service providers highlighted the feelings of shame and embarrassment that service users may experience after an accidental relapse, forming a mental block that prevents them from returning to the group as they fear facing them. As such, inconsistent participation and shame after relapse reinforce one another to lead the individual to fall into drug abuse again, making sustained progress even more challenging.

"We are embarrassed. We feel too embarrassed, you know, when we see our old friends, or maybe I would say classmates, they have been much better, you know, when we face them." (Service Provider 1)

"They feel shameful and don't dare to face us. I had two clients who were quite close to me, but after they used drugs again, they felt they had no face to see me, or didn't want me to discover it, so they disappeared." (Service Provider 10)

As such, inconsistent participation and shame after relapse reinforces one another to lead the individual to fall into drug abuse again, making sustained progress even more challenging.

6.3 Service Gaps

While service providers reported similar onset of drug abuse between local Chinese service users and those from ethnic diversity backgrounds, the challenges of engaging with the population are distinctively complex, requiring further considerations of cultural, linguistic, and structural factors. Although it may appear straightforward to suggest increasing engagement through more accessible means, such as offering programmes in service users' native languages or hiring more ethnic diversity staff, the implementation, manpower, and resources required are often underestimated, resulting in service gaps that stem from a lack of cultural competency.

6.3.1 Lack of Culturally Sensitive Rehabilitation Services

Across interviews, service providers consistently noted the absence of a culturally responsive rehabilitation option, creating a barrier to effective treatment among ethnic diversity service users. 4 service providers specifically raised the possibility of establishing an ethnic diversity-focused CCPSA, which would offer mainstream, tailor-made services for any ethnic diversity individuals seeking relevant support, therefore lowering service barriers and improving accessibility.

“So over the past ten years, our caseload has been continuous, and there have always been new cases. It’s not like we’re just working with the same people over and over. I feel that the community consistently has this need. And when you see how influential PEER is, and how it can support the community, I think some services really need to be made mainstream. For example, could this service be institutionalized? Or could it be incorporated into CCPSA? Or maybe we could even create a new CCPSA service category specifically for ED. Because right now, among all the CCPSAs, none of them actually hire staff who are ED. So they rely on people who happen to speak a bit of English, or they outsource interpretation. It’s really hard to build any kind of meaningful bonding that way.” (Service Provider 7)

“Actually, if we don’t work hard, don’t put effort into writing proposals, or if Beat Drugs Fund suddenly stops, then the service would simply disappear. Of course, there are some mainstream local services, CCPSAs do provide drug treatment services, and they haven’t explicitly excluded this group of people. But the reason we keep writing proposals, and Beat Drugs Fund continues to fund us, is because they also see that there is a meaningful impact and a clear service gap ... So the question is, could there be a CCPSA that specializes in serving ethnic minorities?” (Service Provider 3)

Despite efforts in community-based harm reduction in priming the mindset and motivation for service users to quit, some service providers reported that such motivation often declines when clients are placed in unfamiliar residential environments, where language, dietary needs, and religious practices cannot be accommodated, resulting in

cases immediately leaving early. All service providers raise concerns regarding the suitability of existing centres, with some suggesting users' hesitancy and discomfort are due to various cultural incompetency.

"The next day I couldn't stand. Not because I was sick or like that, because the place- I was alone there, right? And the next day I just came out" (Service Provider 1)

For example, half of the interviewed service providers brought up religious factors as a source of hesitancy. Particularly, Pakistani service users frequently avoid rehabilitation services because halal food is not available, or because the majority of rehabilitation centres are founded on Christian faith. Such a clash of religious beliefs may deter some from accepting the treatment approach, leading to an early discharge.

"If you go into a residential treatment centre, you might not even have friends to talk to. They may organize many activities inside, but they might not suit you. The language they speak, you don't understand. Then when they serve meals, the food may not be suitable for you. Gradually, there's no rapport built, and they may end up leaving." (Service Provider 3)

"(Would that belief contradict with their own religion?) Some brothers would mind, so they don't have a choice. But some would feel that quitting drugs comes first." (Service Provider 10)

Consequently, service providers highlighted that users have a clear preference for centres with a sizable ethnic diversity population, arguably one of the highest motivating factors to stay in rehab. The collectivist nature of ethnic diversity individuals generates feelings of belongingness and comfort, and the breakdown of language barriers facilitates ease of communication. As such, service providers stressed the benefits of having individuals of the same background.

"I've also heard from some clients that, in places like [rehabilitation centre], they actually speak Nepali more often inside than outside. They feel as if they've gone back to Nepal, everyone speaks the same language and they talk about how to quit drugs. Or they share what they've been through, and they genuinely have that kind of sharing space." (Service Provider 10)

"Because, you have to use the same resource. Same community, or same person from their own living environment, you know?" (Service Provider 2)

"ED youth are very concerned about whether there are young people of their own ethnicity there. Local clients usually don't ask what kind of people are inside, they just go in. But EM clients will ask very detailed questions, and they also want to know how long they're required to stay." (Service Provider 5)

For some individuals, the misalignment is so significant that they choose to seek treatment back in their home country, where they would “*understand every word that was taught*,” (Service Provider 1), and feel greater cultural resonance within the rehabilitation process. When discussing communication and education, service providers also pointed out the general lack of comprehensive educational programmes that teaches skills relating to maintaining sobriety and navigating life after rehabilitation. Instead, service users are tasked with labour-oriented activities, and as a result, they do not receive adequate education or develop the necessary skills to support their life post- rehabilitation, which increases their susceptibility to relapse.

“But at least, we have a program in Nepal. Program means like, sharing session, relapse prevention, and we have also the pre-release service before going back to the community, what principle you have to apply ... There is no any group therapy, individual counseling, those are, there is no any, those kind of info sessions in there,” (Service Provider 2)

Extending beyond the rehabilitation process, there is a gap in the accessibility of suitable aftercare services for ethnic diversity service users, with the core issue being language. One service provider detailed an incident where a user tried to hand in an application for a subsidy, yet had to go back and forth several times because of difficulty in understanding each other (Service Provider 1). Another mentioned how it was difficult to invite ethnic diversity service users to hostel support groups and programmes, as majority, if not all of the occupants, are Cantonese speaking (Service Provider 9). Hostels often act as a bridge to help the rehabilitated person transition back into society, providing a safe space away from their former drug circles and allowing them to be surrounded by others who are also on a recovery journey. Therefore, when hostels are not suitable or supportive for individuals from diverse backgrounds, their susceptibility to relapse increases. They may be more likely to return to their previous social circles, especially when there is limited monitoring or support.

“But adapting to the hostel environment really depends on the individual case and their hostel mates, whether the person can speak Cantonese. Because we found that, previously there was someone who didn’t speak Cantonese at all, and it was genuinely difficult for them to adapt to the hostel environment. Even basic communication wasn’t possible, and our other service users’ educational levels or backgrounds may not allow them to communicate in English either; maybe at most “hello,” “hi,” “bye.” So when even simple communication cannot be done, adapting becomes quite challenging.” (Service Provider 9)

“If I run a group and I have a non-Chinese person attend but the entire session is in Cantonese, then if they don’t understand Cantonese, they just end up sitting there clueless.” (Service Provider 3)

Reflecting on these gaps, multiple service providers reiterated the need for an

independent, ethnic diversity-specific rehabilitation centre. A space designed around linguistic accessibility, culturally and religiously appropriate routines, and a workforce with ethnic diversity representation.

6.3.2 Importance of Peer Supporters

There is strong emphasis on the importance of having ethnic diversity staff members, as well as peer supporters familiar with the community. 7 service providers have raised the benefits of having an ethnic diversity individual on the team, as they are able to better connect with service users and grasp cultural nuances more readily. This facilitates the development of rapport and trust in the community, as service users often instinctively seek those who share a similar cultural background. Such staff are perceived as easier to communicate and more comfortable to interact with.

“Whether it’s during outreach or when we approach cases individually, some youths directly ask us, ‘Do you have staff of the same ethnicity?’. So I think the first engagement is very important.” (Service Provider 5)

“Because very often, our users or our ED friends don’t recognize the agency, or don’t really recognize the social workers. But they do recognize the ED staff working inside.” (Service Provider 4)

“The reason we’ve been doing this for so long, and why we keep emphasizing the need to have peers and people from diverse ethnic backgrounds, is exactly because of this. Even with local cases, if your whole team consists of very fresh workers, you can’t engage the community, you can’t engage them. That’s why we need to develop peer workers, because they share common experiences and a common language. And for our ethnic diversity communities, even placing a local drug user as a peer worker isn’t enough to gain access. We need someone with the lived experience and who shares the same culture and the same language. That really facilitates the whole process.” (Service Provider 3)

Besides regular ethnic diversity staff, peer supporters were also often brought up as an indispensable component of effective service delivery. Their unique characteristics of shared culture, language, and lived experience positions them as key first-contact figures within the community. One service provider noted that ethnic diversity clients *“won’t talk like this with social workers... but with us, we are the same,”* (Service Provider 1), highlighting peer supporters’ capacity to access conversations, disclosures, and emotional expressions otherwise unavailable to local staff. Another service provider described how peer supporters and social workers are key components in delivering effective service, both contributing in their respective areas of expertise to engage with clients (Service Provider 7). Beyond relational access, peers serve crucial bridging functions, facilitating understanding between service providers and clients, decoding cultural cues, navigating expectations, and identifying early signs of relapse that may not be evident to local

Chinese workers.

“Relatively speaking, we really require ED staff to understand their upbringing and their inner journey, and then coordinate with social workers or peer staff to follow up with the necessary work.” (Service Provider 7)

“The mutual support group is basically a group of brothers, some who have already completed rehab, and others who are current users, mixed together. Actually, we rely a lot on the brothers who have gone through rehab to share their experiences, the difficulties they faced, and to help anticipate situations that might come up during the detox process.” (Service Provider 4)

“Some brothers really like to lie, but if you are someone newly entering the field, or someone who is not very familiar with these groups, you will think they are really being serious with you, and then you will spend a lot of time walking many repetitive paths. If there are peer colleagues who are already familiar with the community... sometimes, peer supporters can even be faster than social workers in noticing whether a client needs follow-up, because they can detect that his mental state is not very good.” (Service Provider 7)

Despite their importance, however, peer supporters face substantial role sustainability issues. Service providers reported that the position offers limited career progression, unattractive salary levels, and heavy dependence on short-term project funding. These structural weaknesses jeopardize continuity, as one service provider explained, “if [Peer supporter A] and [Peer supporter B] are not there, the project may not run long,” (Participant 10). Ensuring sustainable peer involvement, therefore requires structural investment in long-term employment, clearer progression pathways, and enhanced professional development opportunities. Having a structured peer supporter system would also be beneficial in attracting more ex-drug abusers to take up the role, therefore creating more manpower to support this service.

“Before, we also had a colleague called [Service Provider], but he, because he had to support his family, and we all understand this, the positions here are ultimately not at a professional grade. When you reach the max pay point, that’s it, that’s as far as it goes. So the colleagues who are able to stay here long-term now are basically those who don’t have the pressure of supporting a family.” (Service Provider 3)

“Normally, in my cases, is more manpower ... Because otherwise, one worker can handle how many, it can affect the service also.” (Service Provider 2)

6.3.3 Lack of Familiarity and Preparedness Among Service Providers

A final set of service gaps relates to the preparedness of non-ethnic diversity service providers to work effectively with ethnic diversity populations. As illustrated by the challenges discussed above, working with ethnic diversity communities requires a certain degree of cultural competencies and sensitivities to establish a trusting, comfortable service environment. However, 5 workers reported that their first exposure to ethnic diversity clients occurred only after they began frontline work, with several describing structural constraints that complicate therapeutic communication. For instance, counselling is conducted in English, despite the fact that “*in the social work system in Hong Kong, [they] are actually not taught how to conduct interventions in English,*” (Service Provider 4). This leads to situations where both provider and client are communicating in a second language. Furthermore, service providers need to be familiar with the cultural nuances and behaviours of the ethnicity, which is not easy without prior training and experience. As with the local population, time and exposure are essential in developing specialized skills in working with various communities, yet there seem to be fewer opportunities to do so for social workers in Hong Kong.

“They may be able to tell you the knowledge, but when it comes to interacting with clients, it’s completely different. And that difference isn’t something you can apply just because you’ve learned the knowledge. You really need long-term, day-to-day interaction to understand, ‘Oh, this is how I should approach this brother,’ or ‘This is how I should interact with people of this particular ethnicity.’”
(Service Provider 4)

“You need to have enough cultural sensitivity. Not to say it needs to be really high, but at least adequate. I think that’s very important. They may have certain taboos, and if you don’t pay attention, you might end up offending things they believe in, or aspects of their religion. The relationship then may sometimes break at exactly those moments. Or maybe a client was beginning to feel motivated to quit drugs, but suddenly becomes hesitant again, simply because we weren’t sensitive enough in those small but important areas.” (Service Provider 3)

In addition, ethnic diversity related competencies remain “elective, not compulsory” within their professional education, resulting in inconsistent knowledge across teams. These gaps contribute to worker burnout, as staff attempt to navigate complex cultural and religious expectations without adequate support. The shortage of ethnic diversity social workers further exacerbates these issues, in which recruitment is challenging because few applicants possess both relevant cultural backgrounds and formal social-work training. One service provider explained the reason for the scarcity of ethnic diversity social workers, suggesting that language is often the barrier for individuals to academically progress, as the “*services they are able to choose are quite limited to those*

that relate to ethnic diversities”. (Service Provider 3).

Even in services that employ ethnic diversity staff, they are often not professionally trained in social services, necessitating “*additional time to train*” and creating double responsibilities for social workers in supervisory roles as they simultaneously serve as trainer, caseworker, and project coordinator (Service Provider 5).

“When there are so many different religions, and each has different practices, sometimes when a case shares something with me... I’ll think, ‘Oh... OK, OK, let me write this down first’. But then when another person says something similar, I might need to relearn it all over again. Because we don’t always have long-term, everyday exposure to people from all these religions or ethnicities, it’s really hard to remember all the differences among each group.” (Service Provider 5)

“To be honest, the professional support within the project itself wasn’t really sufficient. We mainly needed to rely on the organization and internal support. Because at that time, I was already the project in-charge, but even so, my cases still needed support. And when cases presented with intense emotions, or a lot of hallucinations or delusions, I wasn’t necessarily able to handle everything.” (Service Provider 7)

Collectively, these findings point to an urgent need for an expansion of ethnic diversity staff representation within mainstream services, and the development of standardized, culturally informed intervention frameworks. Such efforts would mitigate burnout, strengthen culturally competent practice, and improve the accessibility and continuity of care for ethnic diversity service users.

Chapter 7 Discussion

7.1 Attitudes and Patterns of Drug Abuse among Ethnic-diverse Abusers in Hong Kong

Our interviews revealed that initial drug exposure among our respondents overwhelmingly occurred in social contexts, primarily with friends ($n = 23$), followed by significant others ($n = 6$). The most common reasons for first use were curiosity ($n = 17$) and peer influence ($n = 12$), usually during social gatherings or parties ($n = 20$). A notable feature was cost-sharing, particularly among heroin abusers, which facilitated communal consumption even among long-term abusers.

Drug use patterns varied across the three ethnicities:

- **Nepali:** The predominant drug was heroin (often mixed with tablets), typically consumed in Pan Zai or public toilets. Many reported daily use and frequent co-use with methadone.
- **Pakistani:** Drug use primarily centered on methamphetamine (ice), often intertwined with game centres and gambling. Abusers reported multiple daily sessions, significant weight loss, and employment disruption.
- **Indian:** Cannabis was the most common substance, framed as recreation or stress relief. Use patterns ranged from occasional group use to daily solitary use, with some reported memory problems and withdrawal from non-using friends.

Additionally, drug use patterns diverged by age groups, with younger respondents commonly using cannabis, while those using methamphetamine were generally aged between 31 and 50. The majority of those aged over 40 typically consumed heroin or heroin mixed with blue gremlin. Unemployment usually co-occurred with heroin use.

Moreover, the choice of substance would switch based on availability, price and the desired effects. Some abusers transitioned from using brown sugar, an adulterated form of heroin often laced with impurities, in their home countries to heroin in Hong Kong, while others experimented with cough syrup or cannabis initially but switched to heroin for a sense of "power." A few respondents mentioned that they changed to methamphetamine from cocaine for gambling purpose or stamina enhancement.

Attitudes towards drugs also varied by substance. Most heroin and methamphetamine abusers framed their drug use as a habit or necessity ("to feel normal," "to work," "to stop withdrawal symptoms"), whereas cannabis abusers more often emphasized recreation, stress relief, or 'medicine' for anxiety, often asserting they were not addicted. Many cannabis abusers did not perceive cannabis as a "drug", citing its legal status in some countries.

7.1.1 Attitudes and Patterns of Indian Drug Abusers

With cannabis as the main drug of choice, Indian participants generally demonstrate a pattern of recreational and individualized abuse, characterized by low frequency, situational engagement, and a strong emphasis on personal control. Drug abuse is typically framed as a matter of choice, often associated with relaxation, curiosity, or stress relief, rather than as an integral component of identity or social belonging. One participant described use as *“just for fun occasionally... not often”* (Participant 16), emphasizing that *“there are many situations when it’s there and I don’t take it.”* Family relationships remain relatively stable and do not appear to be significantly disrupted by drug abuse, though some participants have also indicated its hidden nature, with family members either unaware of their habits or are tolerant of them as long as they maintained a respectable appearance and daily functioning. One participant indicated, *“my siblings are open to it, but my parents, they are, um, old school so, not really”* (Participant 37), and another mentioned *“I wouldn’t be afraid to tell [my parents] that I did try it, cause they know that I’m not an addict or something like that ... my brother doesn’t smoke weed regularly, but is open to it for socializing”* (Participant 24). Thus, for the majority of the group, drug abuse appeared to remain bound and did not substantially disrupt broader life trajectories. Exceptions were more likely among those without a stable family structure or those living with a mental disorder, suggesting that structural stability may help limit escalation into dependency.

7.1.2 Attitudes and Patterns of Pakistani Drug Abusers

In contrast, with methamphetamine as the main drug of choice, Pakistani participants occupied an intermediate position, characterized by either concealed or normalized drug abuse. Although they acknowledged potential health risks, they often viewed these substances as acceptable in comparison with other drugs that are perceived to be more harmful. One participant mentioned, *“Ice is the one thing that’s safest, I would say it’s the safest drug of the rest”* (Participant 18). Substance use among this group is more routinised in comparison to the Indian group, often linked to stress, employment pressures, or social environments such as game centres, yet is still perceived as manageable or controlled. One individual described usage as *“a routine habit... mostly I do it at the end of the day”* (Participant 1), while others indicate that *“when I do gambling, every day. I do with people, because I’m playing with them and then smoking”* (Participant 33). Participants recognize that drug abuse is undesirable, yet continue to rely on it as a coping mechanism. This contradiction is further reflected in perceptions of drugs as both beneficial and harmful. For example, one participant noted that *“it’s like good, good ice, lot of energy ... even helps, you know, get my health even more worse”* (Participant 29), explaining the duality of effects. Hence, such accounts indicate how the Pakistani group negotiate a balance between perceived functional benefits and awareness

of harm, reinforcing ongoing patterns of normalized yet conflicted abuse.

7.1.3 Attitudes and Patterns of Nepali Drug Abusers

Nepali participants display the most distinct pattern, characterized by collective marginalization and dependency. With heroin as the main drug of choice, drug abuse within this group is highly social, often occurring in networks of co-users, where substances are shared and costs are pooled. One participant described “*their relationship is like a partnership, they treat each other when either of them have money*” (Participant 2), highlighting the collective nature of consumption. Participants also indicated that a close, interpersonal relationship with other drug users was not necessary for communal drug use, expressing a willingness to share with any individuals present. Such pattern contrasts sharply with the Indian group, in which drug abuse is strictly confined to close peers and trusted individuals. Furthermore, many Nepali participants report experiences of familial breakdown, including bereavement, divorce, or physical separation. In this context, peer networks often replace family structures, reinforcing both social belonging and continued drug dependency. Although strong ethnic pride is maintained, individuals simultaneously experience marginalisation in Hong Kong, compounded by language barriers and discrimination, which further entrenches reliance on insular community networks.

7.1.4 Attitudes and Patterns of Drug Abuse Across Ethnic Diversity Groups

Across all groups, a number of shared cultural paradoxes emerge. First, drugs function simultaneously as a means of social connection and a driver of social isolation. While initial use is often motivated by a desire for belonging, prolonged use frequently results in deteriorating relationships and withdrawal from non-abusing networks. Second, there is a clear trajectory from perceived control to dependency, particularly pronounced among Pakistani and Nepali participants, where early experimentation evolves into habitual use. Finally, drugs are widely perceived as a coping mechanism for stress, loneliness, and life instability, yet they ultimately exacerbate these very conditions by contributing to financial strain, health deterioration, and social fragmentation.

Overall, it is observed that the degree of social embeddedness and structural vulnerability plays a decisive role in shaping drug-related behaviour. Indian participants, situated within relatively stable social and economic contexts, maintain largely recreational patterns of use. Pakistani participants navigate a tension between expectations and coping mechanisms, resulting in controlled but persistent use. Nepali participants, facing greater structural precarity and weakened family support systems, exhibit patterns of intensive, socially reinforced addiction. These distinctions highlight the importance of culturally and structurally sensitive approaches to understanding substance use across ethnic minority communities.

7.2 The Applicability of 5 Stages of Drug Taking from Social Acquaintance to Social Isolation to Ethnic Diverse Drug Abusers

The classic five-stage model of drug taking (Tam et al., 2018) outlines a trajectory that includes:

Stage 1: Passive user- Using drugs for social purposes;

Stage 2: Active user- Expanding the social network;

Stage 3: Regular abuser- Use of drugs as a habit;

Stage 4: Suspicious abuser- Loss of trust; and

Stage 5: Hidden abuser- Complete social withdrawal

However, this model only partially fits the trajectories observed among ethnic diversity abusers in Hong Kong. While our participants demonstrated patterns consistent with the early stages, particularly social initiation, peer influence, and expansion of drug-using networks, many did not progress toward the later stage of full isolation. Instead, respondents across all three ethnic groups continued to use drugs in communal or semi-communal settings, even after years of drug use. This persistence of group use was largely driven by practical and structural factors, particularly cost-sharing, which significantly reduced individual financial burdens and allowed sustained access to substances. For example, heroin abusers frequently pooled resources to purchase drugs and consumed them together in shared spaces such as Pan Zai or public toilets. Similarly, Pakistani participants commonly described game centres as social hubs for methamphetamine use, where drug taking occurred alongside gambling activities.

Rather than moving steadily toward complete social withdrawal, many participants oscillated between solitary and group use. Solitary use typically served specific functions, such as personal downtime, managing withdrawal, or retaining larger share for personal consumption, while group use remained the dominant mode due to cultural cohesion, economic necessity, familiarity, and perceived safety. These patterns indicate that social and economic dynamics, including cost-sharing practices, localized ethnic networks, and collectivist cultural norms, play a critical role in interrupting the linear progression proposed by the five-stage model. As such, the model requires adaptation when applied to ethnic diversity contexts in Hong Kong.

Substance-specific differences further illustrate this divergence. While heroin and methamphetamine abusers exhibited some characteristics of Stage 3 and Stage 4 (e.g., mistrust, irritability, physical deterioration), they did not transition into the complete withdrawal characteristic of the hidden-abuser stage. Cannabis abusers, on the other hand, tended to remain in early social stages, often describing their use as recreational, casual, and embedded in social routines, with little indication of withdrawal or isolation.

In summary, although the five-stage framework captures important psychological and behavioural processes, it does not fully account for the socio-economic loop observed among ethnic-minority drug abusers in Hong Kong. This loop, characterized by peer networks, communal coping, cultural familiarity, and shared financial burdens, creates a sustained communal environment that interrupts the trajectory toward social isolation. As a result, the final stage of the model (hidden abuser) is rarely observed in this population, suggesting the need for a culturally and structurally adapted model of drug-use progression.

7.3 Risk, Protective, and Relapse Factors Among Ethnic Diverse Drug Abusers

Our findings revealed a complex interplay of risk factors, protective factors, and relapse triggers that shape drug use trajectories among ethnic diversity communities in Hong Kong.

7.3.1 Risk Factors

Several common risk factors were identified through interviews with drug abusers and service providers:

- Peer influence: Initiation and continued use were strongly linked to social circles. Furthermore, service providers noted that many ethnic diversity groups form closed networks, where drug use habits spread easily within the circle.
- Psychosocial vulnerabilities:
 - Bereavement from life events: Some respondents reported using drugs to cope with the loss of loved ones.
 - Boredom: Some respondents cited boredom as their main reason for relapse, which is congruent to the most recent CRDA's statistics (n.d.5) that indicated boredom, depression, and stress as the most common reason for current drug use. They are also often associated with unemployment.
 - Stress: Some respondents mentioned that drug use could help them relieve stress. Service providers linked stress to challenges in life adjustment and integration into local communities.
- Cultural differences: Cultural norms and practices sometimes influence attitudes toward drug use. For example, bhang (an intoxicant made from the leaves of the female cannabis plant) holds ritual significance in Hinduism (Ramadurai, 2022), shaping perceptions of acceptability.
- Lack of drug education: Both drug abusers and service providers highlighted limited awareness of drug-related harms. Despite curiosity being frequently

mentioned as the initial reason of drug use, misconceptions were also common. For example, some believed drugs could aid in weight loss.

7.3.2 Protective Factors

Protective factors offer critical insights for service development. Several protective factors were identified through our interviews.

- Family attachment: For those who successfully quit drugs, strong family ties, especially parental influence, were the most frequently cited motivators for reducing or quitting drug use. This was also recognized as one of the protective factors in our previous study on post-release substance use in ex-offenders in Hong Kong.
- Positive peer models: Both drug abusers and service providers spotlighted the importance of peer supporters, who served as role models, sources of encouragement, and frontline engagement. This was particularly facilitated as they share a similar cultural background and experience.
- Structured support systems: NGO programmes offering tangible support and counselling in the community provided stability and reduced harm. Methadone treatment, when used appropriately, also helped manage withdrawal symptoms.

7.3.3 Relapse Factors

Relapse into drug use was commonly reported by participants and was often tied to specific triggers within their social and personal environments. These triggers reveal the persistent challenges individuals face after attempts to reduce or cease drug use.

- Re-exposure to old networks and environments: Returning to familiar social circles or high-risk locations was the most common relapse trigger.
- Unemployment and boredom: Lack of structured daily routines increased vulnerability to relapse.
- Methadone co-use with heroin: Some participants admitted to misusing methadone alongside heroin, undermining its effectiveness as a treatment tool.

These relapse factors highlight the enduring influence of social, economic, and environmental contexts on sustained drug use. The overlap between risk factors (e.g., unemployment, peer influence) and relapse triggers underscores the cyclical nature of substance abuse among this population. Effective relapse prevention, therefore, necessitates interventions that extend beyond individual treatment to address these persistent contextual challenges, such as fostering alternative social networks and improving economic opportunities.

7.3.4 Ethnic-specific Risk Factors

As previously stated, peer influence, normalization, exposure and curiosity are observed risk factors for initial drug abuse. While the onset of abuse is similarity related to peer influence and exposure, conditions of such circumstances differ slightly between groups.

7.3.4.1 Nepali Drug Abusers

Among Nepali participants, risk is strongly linked to closed co-ethnic networks, where drug use is highly socialised and sustained within peer groups. Drug abuse is often described as routine and collective, as one participant explained, “*we hang out, we smoke together... now it's become habit*” (Participant 5), while another described sharing resources because “*they bring heroin turn by turn ... it's like a partnership*” (Participant 2). These dense networks increase exposure and make disengagement difficult, as social life becomes inseparable from drug abuse.

There is clear evidence that escalation to harder substances, particularly heroin, occurs in Hong Kong rather than in the home country, with participants noting that “*we don't have [heroin] in my country ... first time I try heroin is in Hong Kong*” (Participant 15). At the same time, low socioeconomic status is also a significant factor in the initiation of substance use. Limited language proficiency or skill sets often restrict individuals to labour-intensive jobs, contributing to heightened stress levels. In such environments, drug use may already be prevalent within the community, creating a domino effect that increases exposure and normalizes substance use. This fosters a cycle in which drugs are introduced, often unintentionally, to vulnerable individuals. Furthermore, migration-related stress and unemployment are evident, with individuals linking drug use to boredom, lack of work, and financial instability. One participant noted, “*if you don't have a job... automatically decreasing (use)... no income, no drugs*” (Participant 15), highlighting how economic conditions regulate use. Together, these findings underscore how local availability and socioeconomic factors shape drug trajectories post-migration.

7.3.4.2 Pakistani Drug Abusers

For Pakistani participants, risk is more closely tied to structural environments, particularly the overlap between drug use and gambling spaces such as game centres. These venues operate as key sites of exposure and reinforcement, where individuals both meet and consume substances. One participant mentioned, “*we just end up going to like, the same hangout spots ... Like if not in one game centre, then in the other game centre. We kind of bump into each other*” (Participant 18). Within these spaces, methamphetamine abuse is often framed as functional and necessary. Participants described using it to sustain activity, explaining the cyclical pattern of use for work or gambling. A participant mentioned, “*I work, and then three o'clock, and then start, energy*

going down, down, down, down. Then five o'clock, again, need [methamphetamine]" (Participant 28). This reflects a misconception of methamphetamine as a useful or 'functional' drug, which lowers perceived harm despite clear negative effects.

At the same time, drug use is often hidden and normalized within peer groups, reducing opportunities for early intervention and a false sense of control. For example, one participant noted how *"it's a cycle. But it's easy. I can stop"* (Participant 32) and another, *"if I want quit, I can quit"* (Participant 33). The combination of peer reinforcement and venue-based exposure is evident, creating a reinforcing loop between gambling, socialising, and substance use.

7.3.4.3 Indian Drug Abusers

Among Indian participants, risk factors are largely shaped by cultural normalisation and cognitive perceptions, particularly around cannabis. Cannabis is frequently framed as a recreational and low risk substance, as reflected in statements such as *"I see it as something recreational ... like something you do once in a while and it doesn't affect your day-to-day life"* (Participant 16) and *"it's mainly like, social. Like I wouldn't, I wouldn't go out of my way to do it by myself"* (Participant 36). This framing fosters a perceived sense of control over drug abuse, with participants emphasizing moderate and infrequent use. For example, one participant explained, *"there would be times I would meet them and maybe just have a little bit, and there would be times I go there and maybe have one or two with myself, but it was very occasional"* (Participant 24).

Consequently, reduced perceived harm and a delay in help seeking is observed in this group, reinforced by the idea that cannabis is harmless compared to other drugs: *"I don't want to do like harder drugs. Even the weed, like I'm only doing it just to like feel better"* (Participant 17). Such perceptions may also be shaped by the group's relatively international networks and mobility, where exposure to more permissive legal frameworks and cultural landscape surrounding cannabis further normalises its use. Thus, there is an added challenge in reframing the group's perceptions towards casual drug abuse.

7.4 Service Needs and Evaluation of Existing Rehabilitation Services

Our findings highlight both the strengths and limitations of current rehabilitation services for ethnic diversity drug abusers in Hong Kong. While existing programmes provide essential harm reduction and recovery pathways, structural and cultural gaps persist, limiting accessibility and long-term effectiveness.

7.4.1 Strengths of Existing Services

7.4.1.1 Methadone Clinics

Methadone clinics continue to serve as a foundational component of Hong Kong's harm-reduction system, and were widely regarded by participants as effective in stabilizing physical withdrawal symptoms and enabling daily functioning. Their affordability, accessibility, and minimal entry requirements make them particularly suitable for ethnic diversity drug abusers, many of whom face language barriers or discomfort with more structured rehabilitation settings. These strengths echo prior research indicating that Nepali drug abusers prefer methadone services because of their biomedical focus and low cultural demands (Tang, 2014).

However, participants also highlighted a recurring pattern in which methadone provides physical stabilization but does not sufficiently address psychological cravings or patterns of polysubstance use. This reinforces findings by Tang et al. (2006), who argue that methadone programmes are often limited by the absence of integrated psychosocial support. While the clinics themselves remain a vital harm-reduction resource, the experiences of our participants suggest that methadone is most effective when complemented by counselling, relapse-prevention planning, and culturally attuned educational support.

7.4.1.2 Residential Rehabilitation Programmes

Residential services were valued for their structured environment, which helped participants remain occupied and reduce drug-related thoughts. Longer stays and strict rules were perceived as protective against relapse, despite challenges related to autonomy. Ethnic familiarity within centres and occasional English-speaking staff facilitated comfort and communication. Service providers highlighted the importance of curfews, urine testing, and peer supporters as relapse deterrents, reinforcing the role of structured routines in recovery. However, language and cultural mismatches remain barriers to engagement, as noted in both service users' and providers' narratives and prior studies.

7.4.1.3 Community-Based NGOs

NGOs offering flexible engagement and non-judgmental support were highly appreciated by participants. These programmes provided tangible supports and fostered trust, even during active drug use. Service providers emphasized the value of outreach and peer supporters in bridging cultural gaps and sustaining engagement, particularly for marginalized ethnic groups.

7.4.2 Identified Gaps and Challenges

Despite the presence of multiple service modalities, significant structural and cultural barriers continue to impede equitable access and sustained engagement for ethnic diversity drug abusers. These challenges are not isolated but interwoven with systemic design issues, creating a fragmented service landscape that fails to fully accommodate linguistic diversity, cultural norms, and post-treatment needs.

7.4.2.1 Language Barriers

Participants frequently reported difficulties in communicating with staff and understanding programme content, particularly drug education materials designed for local Chinese abusers. Limited availability of bilingual staff and interpretation support exacerbated these challenges, leaving many ethnic diversity abusers unable to fully engage with treatment plans or educational sessions. Intake interviews were also described as long, repetitive, and emotionally exhausting, with limited interpreter support. Service providers echoed these concerns, citing limited bilingual staff and insufficient English or minority language resources in mainstream services. Interpretations may also compromise contextual accuracy, and is generally nonconductive to building trust. Such barriers hinder effective communication and reduce treatment adherence.

These observations are consistent with empirical evidence of markedly low utilization of community mental-health services by ethnic diversity groups, identifying language as a key barrier to access (Kwan & Lo, 2022).

7.4.2.2 Cultural Barriers

Opinion on religious-based programmes were polarizing, while some participants found moral guidance helpful, others perceived coercion and exclusion, particularly when faith-based requirements conflicted with personal beliefs. The dominance of Christian-based residential services has been documented as a structural barrier for non-Christian South Asians, with reports of perceived coercion and reduced relevance of interventions (Chan & Cheah, 2016). Service providers noted that cultural insensitivity extended beyond religion to dietary practices, social norms, and gender roles, creating discomfort and disengagement among ethnic diversity users. Scholars have similarly highlighted that cultural mismatch contributes to low uptake of residential rehabilitation services and mental health services among ethnic diversity groups (Tang, 2014; Sharif & Chen, 2024).

7.4.2.3 Stigma and Trust Issues

Fear of judgment, both from service providers and within ethnic diversity communities, remains a significant barrier to treatment engagement. Female abusers, in particular, expressed concerns about being stigmatized, while others feared breaches of confidentiality. Service providers observed that mistrust toward formal institutions or

those from the out-group often leads clients to delay or avoid seeking help, reinforcing cycles of hidden use and relapse. This aligns with research documenting “double stigma” among ethnic diversity groups, where substance use and cultural marginalization intersect to compound barriers to care (Suen et al., 2023).

7.4.2.4 Lack of Relapse Prevention

Both participants and service providers identified insufficient structured aftercare as a major vulnerability, with relapse commonly triggered by unemployment, boredom, and re-exposure to high-risk environments. Ethnic diversity individuals face additional challenges in securing stable employment in Hong Kong due to language barriers, limited recognition of qualifications, and systemic discrimination (Leung et al., 2018; Kwan & Lo, 2022). These employment difficulties not only perpetuate financial stress but also restrict opportunities to build positive social networks, leaving them socially isolated and more likely to return to drug-using circles. Research on addiction recovery underscores that unemployment and lack of alternative social engagement are significant relapse predictors, as they exacerbate boredom and reinforce dependence on high-risk peer groups (Tang et al., 2006). Furthermore, a lack of ethnic diversity-focused aftercare services, such as culturally sensitive hostels, further exacerbates the likelihood of returning to former drug circles post-rehabilitation. The absence of mechanisms to support social reintegration, such as fostering new, non-drug-related social circles or bridging services through community hostels, remains a critical gap in current rehabilitation services.

7.4.2.5 Fragmented Service Design

Service boundaries and referral discontinuity interrupt continuity of care, creating a “step-gap” where users complete initial stages but fail to transition to subsequent services. This fragmentation weakens treatment efficacy and highlights the need for integrated pathways across substance use, mental health, and social services.

Service providers noted systemic fragmentation between substance use and mental health services, which undermines holistic recovery and exacerbates dual-diagnosis challenges. Such fragmentation also creates confusion for those unfamiliar with Hong Kong’s social service system, resulting in barriers to accessibility and mismatch expectations.

Chapter 8 Recommendations

Based on the lived experiences of participants and the thematic analysis of treatment needs, a comprehensive strategy must address both upstream determinants (prevention and education) and downstream needs (treatment, rehabilitation, and long-term reintegration), aiming to strengthen Hong Kong's rehabilitation landscape for ethnic diversity drug abusers. Therefore, the following recommendations are organized into two tiers: (1) Primary Prevention targeting early intervention and community-level risk reduction; and (2) Secondary and Tertiary Prevention focusing on culturally competent treatment, rehabilitation, and aftercare support.

8.1 Primary Prevention (Education, Prevention, and Early Intervention)

8.1.1 Implement culturally adapted, multilingual school-based drug education

Our findings indicate that curiosity, peer influence, and misinformation were prominent early drivers of drug experimentation among participants. Many respondents reported that their initial exposure to drugs occurred in their late teens, thus strengthening school-based drug education in Hong Kong remains essential. International research consistently demonstrates that adolescence constitutes a critical developmental window in which effective prevention strategies can delay or reduce substance use, making schools one of the most equitable and impactful settings for primary prevention. Global prevention guidelines highlight the education sector's central role in equipping young people with accurate information, resistance skills, and social-emotional competencies that reduce vulnerability to drug use (United Nations Office on Drugs and Crime, 2017).

Given the linguistic and cultural diversity within Hong Kong's ethnic diversity student population, drug-education materials should be culturally adapted and provided in multilingual formats, including Nepali, Urdu, Hindi, and English, to ensure equitable access and comprehension. Such education can be further strengthened through the involvement of ethnic diversity staff, who are better positioned to connect with ethnic diversity students by drawing on shared cultural backgrounds, languages, and lived experiences. Particular emphasis should be placed on addressing widespread misconceptions about specific substances. Recent government statistics show that cannabis and etomidate are the most commonly abused among young drug abusers in Hong Kong (The Government of the Hong Kong Special Administrative Region, 2025), underscoring the need for targeted myth-busting on those drugs in the education content.

In addition to curriculum development, enhancing teachers' capacities for early identification is critical. Many students, especially those from ethnic diversity backgrounds, may exhibit subtle behavioural or emotional indicators that go unnoticed in the absence of culturally responsive training. Providing teachers with structured guidance, professional development, and clear identification tools can strengthen early response mechanisms. Furthermore, establishing standardized referral protocols to school

social workers, counsellors, and appropriate drug-rehabilitation or support services will ensure timely intervention and improve coordination across school and community systems.

8.1.2 Strengthen Support Service Centres for Ethnic Minorities' Role on Prevention Through Parent Education and Early Support

The Support Service Centres for Ethnic Minorities aim at facilitating individuals with ethnic diversity backgrounds to integrate to the community and enhance their access to public services. They serve as trusted community spaces where ethnic diversity individuals can access information, social support, and navigational assistance. Given the long-standing relationships built with the ethnic diversity communities, the centres are well positioned to deliver culturally sensitive and multilingual drug education programmes and support.

Parent education is a particularly important focus, given that strong family attachment emerged as one of the most consistent protective factors against drug use in our interviews and has been similarly identified in previous studies of ethnic diversity drug abusers in Hong Kong (Tang et al., 2006). Education programmes should include accessible workshops, talks, and sharing groups on local drug trends, misconceptions about substances such as cannabis and etomidate, early behavioural indicators of drug involvement, and most importantly, the structure of Hong Kong's treatment system and how to access it. Such content aligns closely with global standards on drug-use prevention, which emphasize the role of family-skills programmes and parent empowerment in fostering resilience and reducing youth vulnerability (United Nations Office on Drugs and Crime, 2017).

8.2 Secondary and Tertiary Prevention (Treatment, Rehabilitation, and Reintegration)

8.2.1 Create a Centralized Ethnic Diversity Counselling Centre for Psychotropic Substance Abusers to Reduce Service Fragmentation

Although the existing Counselling Centres for Psychotropic Substance Abusers (CCPSAs) are formally open to all service users, including those from ethnic diversity backgrounds, our interviews indicate that ethnic diversity communities remain hesitant to use these centres. Service providers highlighted persistent barriers such as linguistic mismatch, limited cultural understanding, fears of discrimination, mistrust of mainstream institutions, and negative past experiences within public service settings. As a result, many ethnic diversity psychotropic-substance abusers remain disengaged or rely solely on informal networks for support.

Given these gaps, establishing a Centralized Ethnic Diversity CCPSA represents a critical structural reform. The Centre would improve accessibility and continuity by consolidating multilingual counselling, culturally adapted mental-health care,

harm-reduction support, and practical assistance into one dedicated, culturally responsive platform. This reduces fragmentation and provides clearer, more coherent pathways for an underserved population.

Importantly, the centre should also include strong outreaching capacity, recognizing that many ethnic diversity abusers remain hidden or avoid formal services due to mistrust, stigma, or previous negative encounters. Outreach teams, comprising bilingual workers and peer supporters from similar cultural backgrounds, can proactively engage abusers in high-risk environments, such as game centres, parks, and informal gathering spaces. Once contact is established, warm hand-off procedures to the hub can reduce service attrition and enhance continuity.

Because family attachment emerged as one of the strongest protective factors, and family issues were identified as one of the risk factors of drug use among ethnic diversity groups (Tang et al., 2006), centres should also incorporate family-inclusive services, including joint counseling, family education on relapse prevention, and structured family involvement throughout treatment. This dual focus on cultural acceptance and family connectedness will enhance engagement and treatment outcomes.

8.2.2 Establish Ethnic Diversity Residential Rehabilitation Centres with Multilingual Staff and Strengthened Aftercare Services

In parallel with the centralized hub, there is a need to expand and strengthen ethnic diversity residential rehabilitation centres that can provide structured, culturally responsive, and linguistically accessible treatment environments. Participants in this study emphasized the benefits of residential settings, including structured routines, reduced exposure to drug-using peers, and clear boundaries, yet repeatedly reported challenges related to language barriers, religious incongruence, and cultural discomfort within existing facilities. Previous research similarly indicates that ethnic diversity drug abusers experienced cultural mismatch, limited English or heritage-language support, and difficulty navigating Christian-based treatment models, reducing uptake and treatment completion (Tang, 2014)

To address these gaps, new or reformed residential centres should employ multilingual frontline staff (e.g., Nepali, Urdu, Hindi, and English), provide culturally sensitive daily living arrangements (including diet and festival accommodation), and ensure the availability of non-religious treatment pathways. This is essential for fostering psychological safety and improving engagement among ethnic diversity communities.

Equally important is the development of robust aftercare services, as relapse frequently occurred after discharge due to unemployment, social isolation, and re-exposure to high-risk networks. Aftercare should include structured case follow-up, linkage with the centralized hub, employment support referrals, community integration activities, and opportunities to build new non-drug-using social networks.

8.2.3 Strengthen Employment Support Services as a Core Component of Rehabilitation

Participants consistently identified boredom and remaining in the drug circle as contributors to ongoing drug use and relapse. Prior research similarly highlights that stable employment provides daily structure, reduces idle time, and helps individuals distance themselves from drug-using environments (Lo et al., 2024). However, job opportunities for rehabilitated individuals, particularly those from ethnic diversity communities, remain limited (Lo et al., 2024).

Rehabilitation should therefore include employment-focused interventions, such as job-readiness training, partnership pipelines with employers willing to hire ethnic diversity clients, and tailored vocational tracks.

Embedding job matching and coaching before discharge increases continuity and reduces the likelihood of returning to drug-using environments out of boredom or necessity. Sustained employment is also critical for reshaping social circles and restoring dignity, financial autonomy, and purpose.

8.2.4 Expand Access to Meaningful Leisure and Serious Interest Development

Some participants expressed that exercise, team sports, photography, hiking, and nature-based activities helped them stay motivated, improve emotional well-being, and shift attention away from drugs. Rehabilitation programmes should therefore integrate structured leisure development as a formal component, rather than optional recreation.

Providing opportunities for clients to form interest-based peer groups fosters healthier social networks and reduces boredom, which is one of the most frequently cited relapse triggers. Hobbies and interests can occupy clients' time and provide a sense of purpose to remain drug-free, supporting long-term habit replacement.

8.2.5 Develop a Formal Peer Supporter Career Pathway

Peer supporters, particularly those who share clients' language, cultural background, or lived experience, play a central role in outreach, engagement, and trust-building. Many participants noted that peer role models were among the few individuals they felt comfortable confiding in, underscoring their unique value.

To strengthen and sustain this resource, the sector should establish a formalized peer supporter career framework that includes:

- Standardized training and certification, ensuring consistent competencies and quality of practice.
- Clear job descriptions and role boundaries between peer support, outreach, and casework assistance.

- Fair and transparent salary scales aligned with responsibilities and sector standards.
- Progressive advancement pathways, enabling peers to specialize in outreach, group facilitation, casework support, programme coordination, or community education.

Formalizing this pathway not only strengthens capacity but also leverages the credibility and lived experience of peers as a powerful engagement tool. Many participants shared that peer role models were among the few people they would trust, making this a high-impact investment. Such standardization also supports retention and recruitment by creating a clear progression ladder with fair salaries, therefore ensuring sufficient manpower to serve the community.

Chapter 9 Limitations

Despite providing valuable insights into the attitudes, patterns, and service needs of ethnic diversity drug abusers in Hong Kong, several methodological limitations should be acknowledged.

9.1 Sample Size and Scope

Although the study generated rich qualitative data, the sample size was relatively small, particularly when distributed across three ethnic groups. As a result, the findings may not fully reflect the diversity of experiences, drug-use trajectories, and service-engagement patterns within each ethnic community. The limited number of participants per subgroup also restricts the extent to which nuanced within-group variations, such as gender differences, socioeconomic factors, or differing migration histories, could be explored. Consequently, the results should be interpreted as indicative rather than representative of all ethnic diversity drug abusers in Hong Kong.

9.2 Sampling Bias Due to Snowball Sampling

This study relied primarily on snowball sampling through NGOs, peer networks, and community contacts. While this approach was effective for reaching hidden or hard-to-reach populations, it inevitably introduced sampling bias. Participants were likely connected to existing service networks or socially linked to individuals with similar drug-use patterns, which may over-represent more socially networked abusers and under-represent isolated or higher-risk individuals who are not connected to services. As a result, the findings may not fully capture the diversity of experiences among ethnic minorities who abuse drugs but remain entirely outside institutional or community networks.

9.3 Limited Ethnic Representation

Although the study focused on ethnic-minority drug abusers in Hong Kong, the sample included participants from only three South Asian ethnic groups- Nepali, Pakistani, and Indian. Thus, the results cannot be generalized to all ethnic diversity groups in Hong Kong, such as Filipino, Indonesian, Sri Lankan, Vietnamese, African communities, etc. Given the cultural, linguistic, and religious differences across groups, drug-use patterns, attitudes, and service needs may differ substantially beyond those represented in this study.

9.4 Gender Imbalance

The sample contained relatively few female participants. This gender imbalance limits the ability to understand women's unique pathways into drug use, experiences of stigma, and barriers to accessing services. As some participants and service providers noted, female drug abusers are often more hidden due to cultural and community expectations, making their experiences potentially under-represented.

9.5 Social Desirability and Recall Bias

As data were collected through in-depth interviews, participants may have under-reported socially undesirable behaviours, such as criminal involvement, polysubstance use, or relapse, or over-emphasized motivations that present themselves in a more favourable light. In addition, some participants with long histories of drug use may have had difficulty recalling early experiences with accuracy, introducing possible recall bias.

9.6 Language and Interpretation Constraints

Several interviews required interpretation support. Although care was taken to ensure accuracy, nuances in emotional expression, cultural context, and meaning may have been lost or unintentionally altered during translation. This may have affected the depth and precision of certain narrative accounts, especially from participants with limited English proficiency.

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Annex 1 Drug Abuser Interview Questionnaire

**SideBySide, Hong Kong
Research and Development Division**

**A Qualitative Study of Drug Users' Attitudes and Patterns among Drug Users in Diversity Groups
in Hong Kong**

Questionnaire (Participant)

Participant no. :

(1) Basic Information

1. Gender	☐ Male	☐ Female	☐ Others: _____
2. Date of Birth	_____ (DD/MM/YYYY)		
3. Education level	☐ Kindergarten	☐ Primary	☐ Junior secondary
	☐ Senior secondary	☐ Tertiary degree/diploma	☐ No formal education
4. Born in Hong Kong?	☐ Yes ☐ No Age when moved to Hong Kong: _____		
5. Marital status	☐ Single	☐ In a relationship (Unmarried)	☐ Married
	☐ Widowed	☐ Divorced / Separated	☐ Others: _____
6. Languages Spoken (Choose all that applies)	☐ English	☐ Cantonese	☐ Hindi
	☐ Urdu	☐ Nepali	
	☐ Others: _____		
7. Religion	☐ Hindu	☐ Buddhist	☐ Muslim
	☐ Christian	☐ Non-religious	☐ Others: _____
8. District	☐ Islands	☐ Kwai Tsing	☐ North
	☐ Sai Kung	☐ Sha Tin	☐ Tai Po
	☐ Tsuen Wan	☐ Tuen Mun	☐ Yuen Long
	☐ Kowloon City	☐ Kwun Tong	☐ Sham Shui Po
	☐ Wong Tai Sin	☐ Yau Tsim Mong	☐ Central and Western
	☐ Eastern	☐ Southern	☐ Wan Chai
9. Living with whom (Choose all that applies)	☐ Parents	☐ Partner	☐ Grandparents
	☐ Children	☐ Roommates	☐ Friends
	☐ Siblings	☐ Alone	☐ Others: _____
10. Housing type	☐ Public housing	☐ Private housing	☐ Village house
	☐ Bed / cubicle	☐ Dormitory	☐ Subdivided flat
	☐ Homeless	☐ Others: _____	
11. Rent or own property?	☐ Own property ☐ Rent		
12. Occupation: _____ (Please specify)	☐ Full-time	☐ Part-time	☐ Freelance
	☐ Homemaker	☐ Student	☐ Retired
	☐ Unemployed		

13. Main source of income	☐ Work	☐ Partner's support	☐ Family's support
	☐ Friend's support	☐ CSSA	☐ Disability allowance
	☐ Borrow from others	☐ Other: _____	
14. Gross monthly personal income	☐ Less than \$2000	☐ \$2000-\$4999	☐ \$5000-\$9999
	☐ \$10,000-\$14,999	☐ \$15,000-\$19,999	☐ \$20,000+
15. Gambling habits	☐ Yes, _____ times per <u>day / week / month</u> (Circle that applies)	☐ Quitted	☐ No
16. Alcoholic habits	☐ Yes, _____ times per <u>day / week / month</u> (Circle that applies)	☐ Quitted	☐ No
17. Smoking habits	☐ Yes, _____ times per <u>day / week / month</u> (Circle that applies)	☐ Quitted	☐ No

(2) Health and Status

1. Do you have a diagnosed chronic illness?	☐ No		☐ Yes, _____ (Please specify)
2. Do you have a diagnosed mental illness?	☐ No		☐ Yes, _____ (Please specify)
3. Do you have a criminal record?	☐ No		☐ Yes
4. Reason for arrest(s) (Choose all that applies)	☐ Petty theft	☐ Robbery	☐ Drug possession
	☐ Assault	☐ Intimidation / Blackmail	☐ Molestation / Rape
	☐ Smuggling	☐ Criminal damage	☐ Commercial crime
	☐ Engaging / running a sexual establishment		☐ Others: _____
5. Have you ever received treatment for drug addiction?	☐ Yes		☐ No
6. If yes, what type of treatment did you receive? (Choose all that applies)	☐ Compulsory placement scheme (Correctional Services Department)	☐ Voluntary out-patient methadone treatment	☐ Voluntary residential drug treatment and rehabilitation

<End of Questionnaire>

Annex 2 Drug Abuser Interview Questions

Current Drug Habit

Let's start with some drug habit questions

1. When was the last time you took drugs? What were they?
2. What drugs do you usually take?
3. How frequently do you take them? (How many times a week / month?)
4. Where do you prefer to take drugs?
5. Do you usually take them alone or with other people?
(If both, which would you say happens more often?)
 - a. **If other people**
 1. Who are they? Where are they from?
 2. How often do you meet them?
 3. Would you say you have a close bond with them?
 4. Do you meet them outside of drug taking, e.g. at work/events where drug isn't consumed?
 5. Who usually brings the drugs?
 - b. **If alone**
 1. **(If didn't say both)** Would you take drugs with other people?
 2. Take them alone more than half the time?
6. Any particular reason you prefer to take them alone / with people?
7. In what situations do you typically take drugs? Is that the main reason?
8. If you have to estimate, how much do you typically spend on drugs in a month?
 - i. Where do you usually get them?
9. How do you think drugs have helped you?
10. Have you noticed any effects on your
 - i. Social life
 - ii. Physical health
 - iii. Mental health
11. Do you know anyone else who are taking drugs?
12. What are your views on using drugs recreationally? How do you define recreation?

History

Now I'm going to ask you some questions about the first time you ever taken drugs

1. How old were you, and what was the first drug you took?
2. Who were you with / who gave it to you?
3. Where were you?
4. Why did you decide to do so then?
5. Were you ever exposed to drugs beforehand? Who?

6. From that first time, tell me how you got to this point. Was there any changes in frequency or who you take it with along the way? Difference between now and before?

i. Ask the presumed cause for every / any change

7. What do drugs mean to you?
8. Do you think drugs have changed your life? In what way?
9. How does your family view your drug taking habits?

General questions

1. **(If not born in Hong Kong)** Why did you / your parents decided to move here?
2. **(If not born in Hong Kong)** Where in _____ are you from specifically?
3. Do you see yourself more as a Hong Konger, or a _____? Why?
4. Do you feel proud to be _____?
5. Have you ever felt discriminated? How so?
6. When you were using drugs, do you feel there is a relationship between drugs, your race, and how you are perceived?

Wellbeing

1. How satisfied are you with your life right now? Why?
2. Do you feel stressed or experience any negative feelings lately?
 - a. **Yes**
 1. Where do you think it came from?
 2. Have you tried any strategies to deal with such feelings?
 - b. **No**
 1. What do you attribute to this feeling?

Treatment

1. Do you personally think you are addicted to drugs? What makes you say that?
 - a. **For casual takers / people who don't think they're addicted**
 1. Do you think you'll ever get addicted?
 2. Have you ever considered quitting? Why / why not? How?
 3. Have you ever gone to a treatment clinic for assessment / methadone / counselling?
 - b. **If they said they're addicted**
 1. Have you considered getting help for cutting down your drug use?
 - a. **Yes**
 - i. Have you gotten help? What kind / why not?
 - ii. What led you to this decision?
 - b. **No**
 - i. Are there any barriers preventing you from seeking help?

- ii. At this stage, do you think you need treatment?
I. (if yes) What needs to change?

Treatment experience

- a. **(Indicated yes)** Would like to confirm, you have sought treatment for you drug usage? Specifically, _____
- b. **(Indicated no)** Would like to confirm, you have never sought treatment for your drug usage? Never done intake assessment / just visited a clinic? **(Skip to Q7)**
 - 1. Besides _____ did you seek other types of treatment?
 - 2. How did you find out about this service? **(If not compulsory)**
 - 3. Describe your experience when receiving the treatment:
 - i. What happened on the first day? How do you find the intake assessment?
 - ii. **(If continued treatment)** How are the regular sessions, what did you do?
 - iii. Were you comfortable with the attending staff? **(If applicable)** How was your relationship with them?
 - iv. How was your relationship with other treatment seekers **(if applicable)**?
 - i. Group activities?
 - ii. Support?
 - 4. How effective do you feel the treatment is?
 - i. What effects have you noticed?
 - 5. Did you finish the course for treatment? If not, what made you stop?
 - 6. While you were undergoing treatment, what helped you stay motivated? Any support systems?
 - 7. Have you ever taken treatment back in your own country?
 - i. Any differences? (Intake, sessions, staff, methods used, relationship with others, language etc.)
 - ii. Which do you prefer?
 - 8. **(If parti didn't recount related experience)**
 - i. While receiving treatment, have your ever felt discriminated or racially targeted?
 - ii. Was there any trouble communicating with staff / other patients?

Improvements

- 1. What qualities do you think a service provider should hold?
- 2. Can you think of any improvements to be made at the treatment centre?
- 3. How can the government improve treatment options?
- 4. What other support do you wish the treatment centres / Hong Kong society in general give?

Annex 3 Service Provider Interview Questionnaire

SideBySide, Hong Kong
Research and Development Division

A Qualitative Study of Drug Users' Attitudes and Patterns among Drug Users in Diversity Groups
in Hong Kong

Questionnaire (Service Provider)

Participant no. :

(1) Basic information

1. Gender	☐ Male	☐ Female	☐ Others: _____
2. Job title	_____		
3. Ethnicity	☐ Chinese	☐ Non-Chinese	
4. Language(s) Spoken (List all applicable)			
5. Type of rehabilitation services	☐ Drug Addiction Treatment Centres (DATC)	☐ Methadone Treatment Programme (MTP)	☐ Residential Drug Treatment and Rehabilitation (DTRC)
	☐ Counselling Centres for Psychotropic Substance Abusers (CCPSA)	☐ Centre for drug counselling (CDC)	☐ Substance Abuse Clinic (SAC)
	☐ Enhances Probation Service (EPS)	☐ Others: _____ (Please specify)	
6. Years of ED drug rehabilitation services	☐ < 1 year	☐ 2-3 years	☐ 4-5 years
	☐ 6-9 years	☐ 10+ years	
7. Years of service in social work industry	☐ < 1 year	☐ 2-3 years	☐ 4-5 years
	☐ 6-9 years	☐ 10+ years	
8. Previous related job titles (if applicable)			

<End of Questionnaire>

Annex 4 Service Provider Interview Questions (Chinese version)

背景

1. 你可唔可以簡單介紹下你嘅職位，同埋喺呢行嘅經驗？你做咗呢行幾耐？
2. 係乜嘢推動你去幫多元族裔嘅吸毒人士？
3. 工作之外，你之前有冇同多元族裔接觸過？如果有，係喺咩場合？

工作與日常

4. 你哋機構為多元族裔提供邊啲戒毒服務？
5. 請你描述一下你每日工作嘅流程。
 - 你每日會見幾多個案？
 - 平均每次會面幾耐？
6. 你哋點樣進行接案面談(intake interview)？會問邊啲關鍵問題？
7. 你哋點樣為多元族裔個案制定治療計劃？
 - 你會考慮啲乜嘢因素？
 - 同本地個案相比，有冇咩唔同？
8. 你哋點樣衡量個案嘅進展同服務質素？
9. 為多元族裔吸毒者提供治療/服務時，有冇啲特別嘅流程或者方法？
 - 有冇基於信仰嘅方法(faith-based)？
 - 有冇「伙伴制度」或者朋輩輔導員(peer supporter)？
 - 住院戒毒服務有冇提供後續照顧？
10. 你點樣將案主嘅家人融入同教育到康復過程當中？

上癮原因

11. 從你嘅角度睇，有啲乜嘢因素導致多元族裔人士出現吸毒問題？
 - 會唔會同文化有關或者社會方面嘅影響？

經驗

12. 同多元族裔個案工作嘅時候，你有冇遇到挑戰？
 - 語言障礙？
13. 你哋點樣鼓勵個案進行康復？
14. 可唔可以分享一個成功個案，說明康復過程中用咗邊啲有效策略？
15. 從你同多元族裔吸毒者工作嘅經驗裏面，你哋吸收到咩經驗？

質素

16. 你覺得一個有效嘅服務提供者需要具備啲咩重要特質？
17. 你覺得點樣可以改善對多元族裔吸毒者嘅服務質素？
18. 你哋機構點樣同本地社區合作去支援呢啲個案？
19. 你覺唔覺得喺支援呢啲個案方面得到足夠支持？
20. 你覺得你哋機構或者政府可以再提供啲咩額外支援？/ 你覺得而家對多元族裔嘅戒毒服務有冇咩缺口(service gap)？

Annex 5 Service Provider Interview Questions (English version)

Background

1. Tell me a bit about yourself. What is your current position? How long have you been in this industry?
2. Why did you decide to service EDMA? What is your total years of experience?
3. Other than work, do you frequently come in contact with ethnic diversity individuals? In what aspect?

Work and Routine

4. Can you introduce the services your organizations provides for ED drug rehabilitation?
5. Describe your daily operation routine
 - i. How many patients do you see in a day?
 - ii. How long does each session last?
6. How were the intake interviews conducted? What kind of questions are asked?
7. How are treatment plans for ED service users drafted?
 - i. What do you take into consideration?
 - ii. Is there a difference between local and ED?
8. How do you measure patients' progress and ensure service quality?
9. What strategies does your organization use to conduct treatment programmes?
 - i. Does your organization utilize a faith-based approach?
 - ii. Does your service use the buddy system or employ peer counsellors?
 - iii. Does your service provide any aftercare services?
10. Are there any touchpoints created with the abusers' family?

Reason for Abuse

11. In your opinion, what factors contribute to drug abuse among ethnic diversity individuals?
 - i. Are there cultural or social influences involved?

Experience

12. Have you encountered any challenges when working with ethnic diversity service users?
 - i. Any language barriers?
13. Do you have any specific strategies to motivate patients?
14. Can you share a success story, and what treatment strategies were effective in the recovery process?
15. Based on your experience working with ethnic minority drug users, what are your key takeaways or lessons learnt?

Quality

16. In your opinion, what qualities should a good service provider have?
17. In your opinion, what can be done to improve the service quality for EDs?
18. How does your organization collaborate with the local community to support these clients?
19. Do you think you have sufficient support in handling ED cases?
20. How can the agency / government further support you in handling ED cases? / Do you see any current service gaps in drug rehabilitation services for ethnic minorities?