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Rapid evidence review: Drinking problems and interventions in black and minority ethnic communities

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Opinions and recommendations expressed in this report are those of the authors.

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Executive summary

Background

It has long been recognised that people from Black and Minority Ethnic (BME) backgrounds are under-represented in alcohol treatment services (Bayley and Hurcombe, 2011). While some evidence suggests that this is because there are higher rates of abstinence among ethnic minority communities (PHE, 2016), it has been noted that there are differences within communities and across generations in terms of the use of alcohol and other drugs (Beddoes *et al*., 2010).

In the UK, ethnicity is measured in broad categories both through national censuses and in alcohol treatment statistics. The lack of specificity in these data coupled with concerns of under-reporting of alcohol use in minority communities, can mean that services are unable to adequately meet the needs of these communities in their provision. This review aimed to better understand the prevalence of problematic alcohol use and support needs within BME communities. An evidence review of the literature was supplemented with interviews with key informants working within both specialist BME (N=3) and mainstream (N = 3) services.

Methods

This rapid evidence review had five main objectives:

1. To understand the prevalence of problematic drinking among diverse black and minority ethnic communities and the types of problems that exist.
2. To synthesise current knowledge on existing interventions aimed at BME communities.
3. To assess what works, when and for whom within these interventions.
4. To describe current understandings of the barriers and facilitators to accessing available interventions.
5. To use consultation with relevant key informants to check (and amend if necessary) review findings and conclusions, to stimulate dissemination of the report and further future discussion.

Eighteen peer reviewed articles and ten grey literature reports were included in the evidence review. We also interviewed six practitioners working in alcohol treatment services to better understand the literature findings and to record current interventions and service provision for people from BME communities.

Findings

Overall, the research literature reports higher rates of abstention among minority communities, although there are concerns about the prevalence of problematic alcohol use among Sikh males, refugees and asylum seekers, and that Irish nationals living in England, Wales and Scotland show higher rates of alcohol-related mortality compared to other groups. Key informants suggested that a true estimate of the prevalence of problematic alcohol use is currently unknown as it is not accurately recorded.

Some factors were identified in the literature and in interviews as increasing the risk of problematic alcohol use including; experiences of multiple exclusion; younger age; in some communities older males were at higher risk due to social perceptions of masculinity and; the hidden nature of women's drinking across cultures could increase harmful use.

There is variation across communities and individuals as to the types of support they are most likely to engage with and preference for whether it is delivered through community organisations or from family and friends. Key informants were focused on trying to ensure that people from minority communities were made aware of existing services and when to look for help.

We found little published research directly reporting on service provision for BME communities in the UK. Key informants report that they use individualised approaches to support depending on personal preference of service users as a way to ensure appropriate intervention. Cultural competence of staff was highlighted as a vital element of good service provision both across the research literature and from our interviewees.

Key barriers to accessing support identified in this research included; lack of understanding of the harms of alcohol use; lack of knowledge of services available; language problems; shame and stigma within communities in admitting to problems with alcohol and; cultural attitudes towards help-seeking that can view this as a weakness of character.

Key facilitators to accessing support included: providing materials in community language and broadcasters (e.g. Asian radio); including community members in developing services; emphasising confidentiality of services; raising awareness; peer led support and; being flexible and responding to changing community needs.

Implications

A key issue that was apparent from the research literature, and highlighted by our key informant interviews, was the difficulty of accurately estimating the prevalence of

problematic alcohol use across minority communities. Clearer definitions of what is meant by ‘minority ethnicities’ and an understanding of variations within and across communities are needed.

Some groups are largely missing from the research literature on alcohol support needs and experiences including: BME women; BME prisoner populations; refugees and asylum seekers; LGBT individuals from BME communities and; non-practicing individuals from religious minorities.

There is a need for more focused research on these groups, and also on services that are currently on offer to BME communities more widely and how they have been developed, implemented and evaluated.

Conclusion

There is no consensus within the literature as to whether a strong ethnic identity is more likely to act as a protective or restrictive factor in seeking help for problems with alcohol. More research is needed to better understand the role of ethnic and/or cultural identity and how this may vary in different contexts.

The full impact of austerity budgeting and how this will affect the provision of alcohol services to minority communities is still not fully known. The proposed introduction of business rates retention as a means of funding substance use services may adversely affect those specialist services that are unable to present an accurate picture of local need for minority communities.

Introduction and background

When compared to the White British population those from black and minority ethnic backgrounds are consistently reported to have higher rates of abstention from alcohol and other drugs (Eastwood *et al*., 2018; Hurcombe *et al*., 2010; PHE, 2016). National statistics (e.g. those published by NHS Digital) however, do not provide a breakdown of rates of alcohol use or misuse by ethnicity, so it is difficult to assess trends over time or regional variations by ethnic or cultural composition (PHE, 2016). This can create difficulties for services trying to develop culturally appropriate interventions if the scale of the problem is not clear. There is no national best practice guidance on how to develop or provide these services, with local services expected to adapt to local needs including those of people from diverse ethnic and cultural backgrounds. Current national estimates suggest that five out of six individuals with alcohol dependence are not accessing treatment (Alcohol Change UK, 2019).

Within the alcohol and substance use sector it has long been acknowledged that BME individuals are under-represented compared to their white counterparts in treatment services in both youth and adult interventions (Bayley and Hurcombe, 2011). It is difficult to determine why this may be the case in part because the literature available is of varying methodological quality with inconsistencies in the use of definitions of ethnic groups and the types of substances investigated (Beddoes *et al*., 2010; Thom *et al*., 2010). Some research suggests that younger generations of migrants experience greater levels of acculturative stress having to navigate both traditional family roles and peer norms of the host country which can be a risk for increased substance use (Marsiglia *et al*., 2012). Other studies report that minority groups are protected from alcohol and drug use through religious restrictions and close community ties that reduce the incidence and prevalence of substance use in these groups (Hurcombe *et al*., 2010).

Black and minority ethnic communities are not a homogenous group, there are differences both between and within communities (linked to migration, language, religion etc.) that need to be considered within the context of understanding both potential problems with alcohol use and levels of service use. Previous research has cautioned against assuming that treatment services that are shown to be effective for one minority group will be similarly effective for other groups (Burlew *et al*., 2013).

Ethnic diversity in the UK

The most recent censuses for England and Wales, Scotland and Northern Ireland were conducted in 2011 with statistics for each region published separately, using different categories to record citizen ethnicity data. In England and Wales 80.5% (48.2 million people) of the population identified as White British (ONS, 2019), in

Scotland the White Scottish population made up 84%, with combined White groups totalling 96% of the population (Scotland Census, 2013) while in Northern Ireland 98% of residents identified as White (NISRA, 2012). Ethnic minority groups make up a sizeable proportion of the populations of England and Wales and Scotland, some 8.7 million people in total; in Northern Ireland the non-White population was just 36,217. The breakdown of ethnic groups in England and Wales and Scotland is shown in Figures 1 and 2 respectively. Even within countries there is ethnic variation by geographical location as can be seen from Figure 3 below that shows ethnic groups by region in England and Wales.

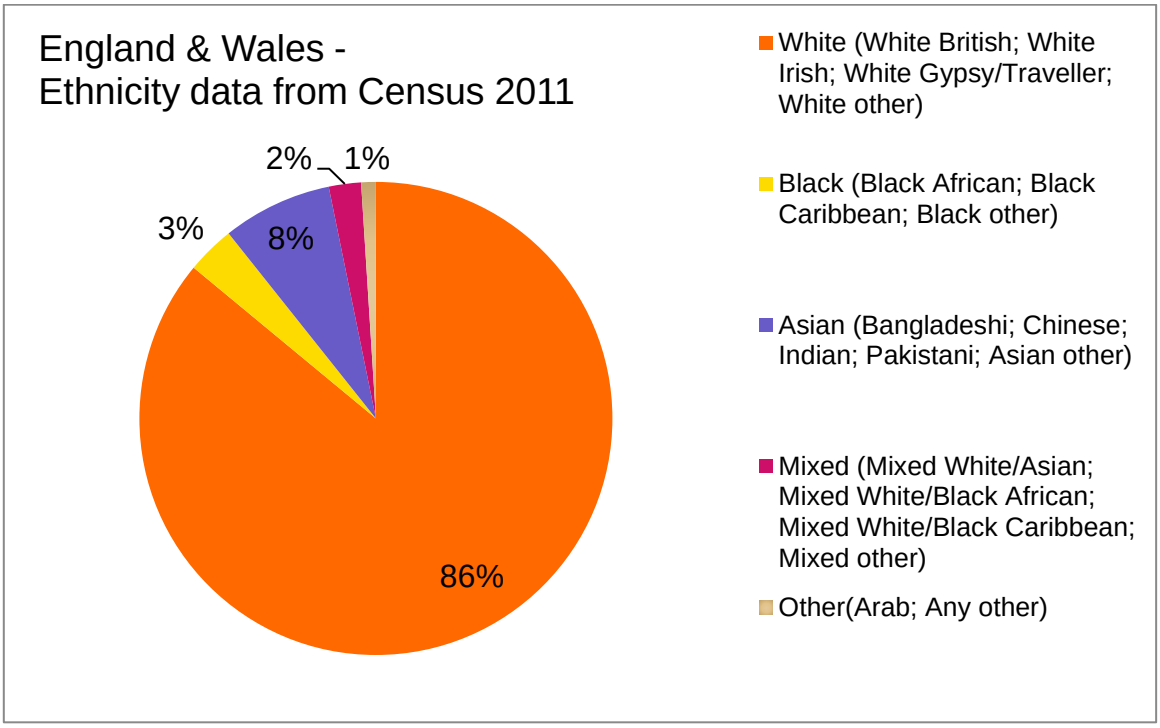

Figure 1: Recorded ethnicity from the England and Wales Census (2011)

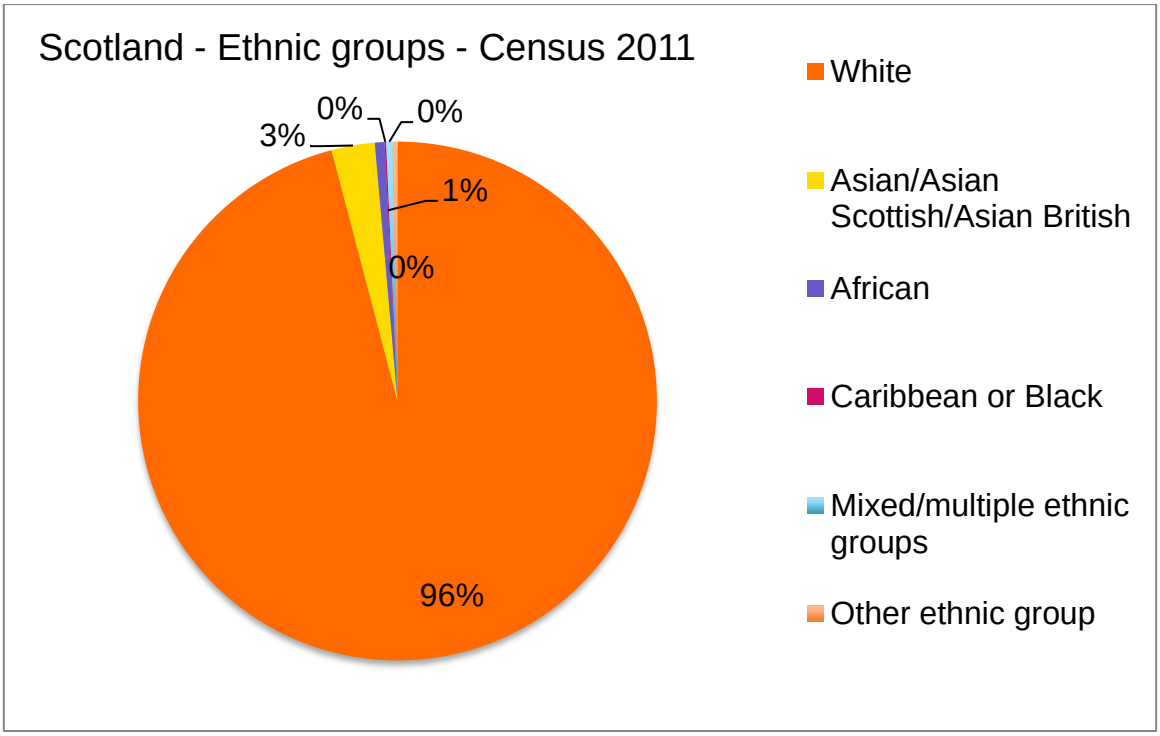

Figure 2: Recorded ethnicity in Scotland as per Census 2011

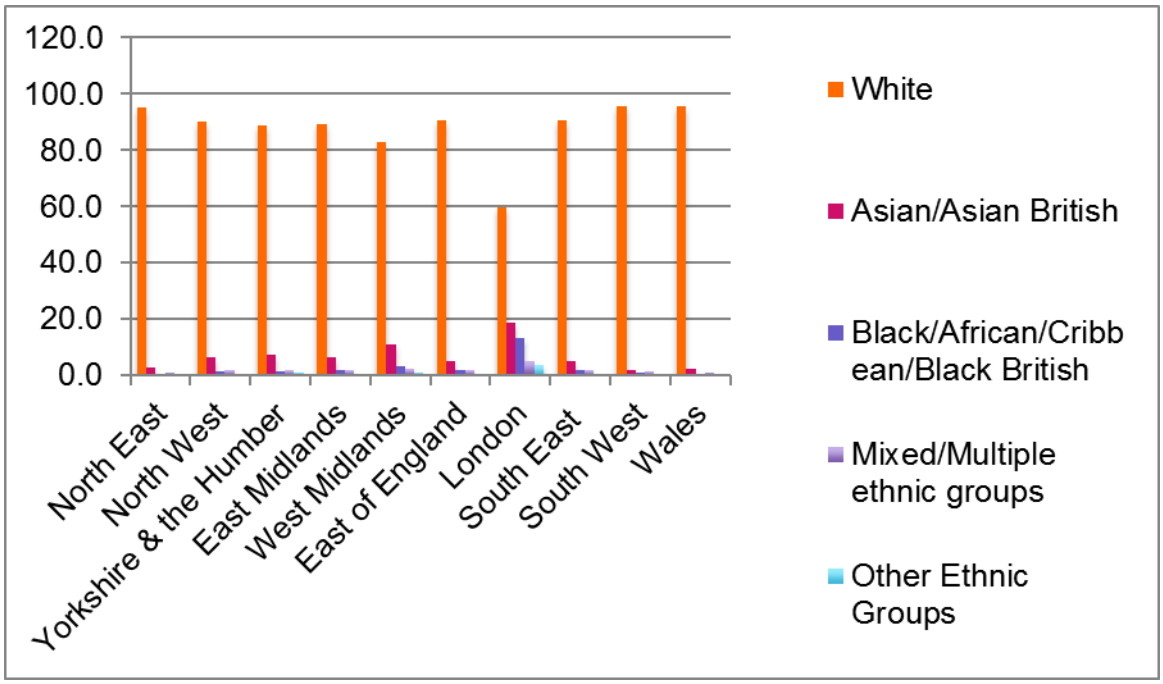

Figure 3: Ethnic diversity across regions in England and Wales (ONS, 2019)

Alcohol and health in the UK

Excessive alcohol use is related to more than 60 negative health outcomes including: a range of cancers such as mouth, stomach, liver and breast cancer; cirrhosis of the liver; and depression (PHE, 2016). Alcohol use has also been linked to an increased risk of a spectrum of additional health problems such as dementia, diabetes and heart attacks as well as numerous hospital admissions due to injury or poisoning as a result of excessive alcohol intake (PHE, 2016).

Latest figures estimate that there were 7,697 deaths directly attributable to alcohol in the UK in 2017 and up to 1.13 million hospital admissions related to alcohol consumption (Alcohol Change UK, 2019). The highest rates of mortality from alcohol-specific conditions occur in males aged 60-64 years old and females aged 55-59 years old. In Scotland the mortality rate for 2017 was at 20.5 per 100,000, in Northern Ireland it was 17.4 per 100,00, in Wales 11.5 per 100,000 and in England 11.1 per 100,000. Of these countries only Scotland showed a decrease in rates since 2001 but it remains as having the highest alcohol-specific mortality rate in the UK.

UK citizens and alcohol treatment

Nationally it is estimated that over 10 million people in England regularly drink at levels that have the potential to cause health-related harm and that approximately 589,000 adults are in need of specialist intervention for alcohol dependence (Public Health England, 2018a). Public Health England collects monthly data for the National Drug Treatment Monitoring System (NDTMS) from local authorities which is then compiled to give overview statistics on the numbers of adults receiving intervention for drug or alcohol problems.

In the latest report (for 2017-2018), which includes data from community services, specialist outpatient services, GPs, residential rehabilitation centres and inpatient units, the average level of unmet need for alcohol treatment is estimated at 82% nationally (PHE, 2018b). The number of adults entering alcohol treatment peaked in 2013-14 and has been declining each year since then, despite the level of need for treatment remaining largely the same. Of those in treatment, 40% were female while making up just 23% of the proportion for problematic alcohol use in the general population.

The majority of those in treatment were recorded as White British (85%) with 4% categorised as Other White, 2% White Irish and 2% Indian. All other ethnicities were at or below 1% of the total alcohol treatment population. Religion is also recorded in these statistics and figures for new presentations for 2017-18 report that more than half of those in alcohol treatment are of no religion (53%) with 30% identifying as Christian; all other religions represent 1% or less of the total presenting for treatment. Three-quarters of those over 50 in substance use treatment are seeking help for alcohol only. The vast majority of treatment interventions were based in community settings (97% of psychological interventions and 72% of pharmacological interventions; PHE, 2018b).

Multiple factors are likely to impact on any individual's alcohol use/misuse and need for intervention, but within BME communities these can be exacerbated by additional stressors such as racism, discrimination, language barriers, migrant status, increased risks of homelessness and often restricted access to welfare and health services.

Minority communities are at greater risk of poverty and are more likely to live in areas of deprivation (Becares, Nazroo and Stafford, 2009). Some evidence suggests that areas of greater deprivation are characterised by both fewer community services and a higher number of alcohol retail outlets (Jones *et al*., 2015), and there is evidence to suggest that areas with greatest levels of deprivation experience the most severe costs of alcohol misuse (PHE, 2016). Additional factors that can create barriers to accessing support services are also potentially overlooked within mainstream services such as a lack of information about services available,

reluctance to engage with services due to precarious immigration status or a desire to hide drinking behaviour from family or friends (Bayley & Hurcombe, 2011). An inter-sectional analysis of the research that can account for these varied factors is most appropriate to understand such differences in alcohol use and help-seeking and to provide a better understanding of current challenges and unmet needs (De Kock *et al*., 2017).

The last large-scale review that was conducted on alcohol and treatment service use among BME communities is more than eight years old (Thom *et al*., 2010) and since then changes to funding provisions have impacted local authorities' commissioning priorities and decisions. Latest analysis from Public Health England suggests that while the number of people accessing alcohol treatment has been steadily falling over the past three years, their estimates of the number of people with problematic alcohol use has remained steady (O'Connor, 2018). This suggests some gap between service need and service use, although, as noted above, it is not possible to determine which demographic group is most likely to be missing out on service provision due to the way current statistics are collected and presented. Across substance misuse services, training in culturally competent approaches to intervention with diverse service user needs is not routinely undertaken and is likely to have an impact on both the engagement of BME individuals in these interventions and their outcomes (Gleeson, Duke and Thom, 2019).

In one study (Herring, Gleeson and Bayley, 2019) it was reported that referrals to alcohol services made by GPs, for example, are not routinely followed up if the individual does not attend an assessment at the alcohol treatment service. Data on these instances of potential need for intervention being missed are not collected, which contributes to an under-estimation of levels of need nationally. Likewise, the number of individuals who may be in need of intervention for alcohol dependence or problematic drinking who are not entitled to access all services (due to immigration status or no recourse to public funds) is not recorded.

A reluctance to seek help for problematic drinking amongst some minority groups may lead to an under-representation, and lack of knowledge about, the levels of need within communities. Also, the way that ethnicity is currently recorded can mask other differences regarding culture. For example, 'White Irish' would include Travellers who may have similar social drinking cultures but are much less likely than non-Traveller Irish people to have good and consistent access to health or alcohol treatment services (Hurcombe *et al*., 2012).

This review will provide a timely and useful overview of the current alcohol intervention service need and provision amongst BME communities which will be of interest to existing services, commissioners and policy makers in understanding gaps in services and ways to better engage black and minority ethnic communities in alcohol interventions. We will also consider both early intervention and treatment

interventions delivered in different contexts, including specialist substance use services, hospitals and the criminal justice system. Factors such as age and gender will be examined.

Definitions

We will include within the scope of the review all BME groups included in the literature (including traveller groups, new immigrants, refugees and asylum seekers, as well as Black and Asian groups). We are aware of the debate within some of the literature around terminology used when referring to those of minority ethnicities or ethnic/cultural backgrounds. For the purposes of this review we will use the terms that have been used by authors of the literature within the broader definition of 'minority ethnic' referring to those of a collective population with a community background outside of Britain.

Structure of this report

This rapid evidence review is based on a literature search of peer reviewed and grey literature that is relevant to the topic of prevalence and support needs of people from BME communities. To supplement the review findings we also interviewed six practitioners working across alcohol treatment services in the UK. In the following chapters we have presented the findings from the literature review first and then present interview analysis of practitioners' views and experiences on these themes. Case studies from each of the services that took part in our research are presented in the appendices.

Methods

This rapid evidence review had five main objectives:

1. To understand the prevalence of problematic drinking among diverse black and minority ethnic communities and the types of problems that exist.
2. To synthesise current knowledge on existing interventions aimed at BME communities.
3. To assess what works, when and for whom within these interventions.
4. To describe current understandings of the barriers and facilitators to accessing available interventions.
5. To use consultation with relevant key informants to check (and amend if necessary) review findings and conclusions, to stimulate dissemination of the report and further future discussion.

The review focused on evidence directly relevant to the UK and on literature published in the past ten years (from 2008 onwards). A small number of studies drawn from the international literature base (e.g. Europe, USA, Australia and New Zealand) were also included where they could be used with a view to assessing how this evidence base could be accommodated within a British context. There are cultural, context and service provision differences between countries which will be important to consider in assessing the relevance and usefulness of the wider published literature in terms of how it can inform services, commissioners and policy makers.

Search Strategy

A list of keywords were agreed on by the research team and included the following (with some variation depending on the search capabilities of individual databases): BME OR BAME OR ethnicity OR black OR race OR Asian OR Eastern European OR Roma OR traveller OR gypsy OR minority ethnic OR ethnic minority OR religious minority OR migrant* OR refugee OR asylum seeker*) AND (alcohol OR alcohol intervention OR alcohol treatment OR alcohol service OR alcohol prevention OR addiction service OR drug and alcohol service) AND (problematic alcohol use OR problematic drinking OR alcohol addiction OR alcohol harm OR harmful alcohol use OR alcohol dependency).

A total of 9 databases were searched: BiomedCentral; CINAHL; Emerald; International Bibliography of Social Sciences (IBSS); NICE Evidence; OVID; PyschINFO; PubMed; Web of Science. In addition, Google advanced search functions were used to identify any non-peer reviewed reports/grey literature that would not be available through these databases and a range of individual websites

of identified alcohol treatment service providers were checked for published studies or reports. Through this method we found a total of 1,978 peer reviewed papers (after duplicates removed and title screening) and 23 grey literature reports. Four additional peer reviewed papers and eight additional grey literature sources were identified through reference list hand searches of included papers and research or organisations already familiar to the research team.

Abstracts/executive summaries of papers or reports were screened to assess relevance against the agreed-on criteria and were included or excluded at this stage. The remaining papers (N = 41) and reports (N = 26) were read in full by at least one member of the research team and a data extraction form was completed for each paper. After this process, 18 peer reviewed papers were included in the final review and 10 grey literature reports. Of these, ten were primary research studies (details of these papers are provided in Appendix B in table format), with five reporting systematic or literature review findings and three using secondary data analysis, the remaining literature was comprised of policy reviews and consultation reports. The progress of inclusion/exclusion of papers is summarised in the PRISMA diagram in Appendix A.

Interviews with key informants

Eight organisations either known to members of the research team or identified via internet searches were contacted to arrange interviews with practitioners working with BME groups. A total of six key professionals agreed to be interviewed, three of them working in specialist services and three in mainstream services. Although telephone interviews were originally proposed with all interviewees, three participants were keen to meet face-to-face. Consequently, three interviews were carried out by telephone and the others face-to-face. The table below shows a breakdown of type of interview by provider.

Table 1: Interviews by service type

Interview	Specialist	Mainstream
Face to face	2	1
Telephone	1	2
Total	3	3

A topic guide was devised so that the key findings and interpretations emerging from the literature review could be checked against practitioners' own experiences of working within the various BME groups they covered. Discussion around each finding was encouraged to gain further insight and probe issues raised in the literature review.

All interviews were digitally recorded and transcribed verbatim. Analysis was carried out thematically using the review findings as the framework for analysis. Each interviewee was also contacted with a view to providing a case study outlining their service from the interviews. Case studies were constructed and information verified with each practitioner. These are available in Appendices C to F.

The main BME groups covered by services delivered by informants and discussed in interviews were from South Asia, predominantly Indian and Pakistani. Table 2 shows the predominant groups and other minority ethnic populations identified in fieldwork.

Table 2: Geographical areas and identified BME groups

Areas covered	Main BME groups	Other minority groups
Midlands	South Asian communities: Indian, Pakistani, Bangladeshi	Somalian, Iranian, Algerian, Turkish, Afro-Caribbean
Outer London Boroughs	As above. Also Somalian, Afghan	Polish, Lithuanian, Afro-Caribbean, Indian-Nepali
Inner London Boroughs	White British*	Polish, Indian, Slovakian, Somalian, Irish and people from various African countries

**White British was the most significant ethnic group presenting in the Inner London Boroughs served by one mainstream provider*

Among ethnic groups from South Asia and some other BME groups, for example, Somalian, religious affiliation has and continues to play a significant role in shaping the ways in which problematic alcohol use is perceived and managed for many individuals within these communities. For others, such as Polish people, religion does not play the same significant role. Groups in which religious background is integral to shaping cultural beliefs, attitudes and practices around alcohol were identified as:

- British Punjabi Sikh and Hindu Indian groups living in the Midlands and outer London boroughs;
- British Muslim Pakistanis living in the North of England, the Midlands and in outer London boroughs;
- Somalian Muslims living in outer London boroughs and the Midlands.

Prevalence of alcohol problems among BME communities

The literature has consistently reported higher rates of abstention from alcohol and lower rates of drinking among Black and Minority Ethnic communities when compared to the majority White population in the UK (Bayley and Hurcombe, 2011; Bhala *et al*., 2009; 2010; 2016; PHE, 2016). Ethnic groups are not homogenous and there is considerable variation in rates of drinking by ethnicity, religion, gender, age and socio-economic status across communities (Thom *et al*., 2010). Certain groups tend to report higher rates of alcohol use than others which may persist into older age; for example, Irish males over 65 are reported to be a group at the highest risk of unsafe drinking, with 21% of those who drink doing so above the recommended limits (Rao *et al*., 2015). However, as pointed out by Rao and colleagues (2015), there is little substantial research that specifically looks at the drinking patterns, or intervention needs, of older people generally or how socio-economic and health status interacts with these needs. This is despite statistics indicating that females over 55 and males over 60 have the highest rates of mortality related to problematic alcohol use compared to younger people (Alcohol Change UK, 2019).

A number of studies have also reported on relatively high rates of problematic drinking amongst Sikh men, which is especially pronounced when compared to men from other Asian religious groups (e.g. Bayley and Hurcombe, 2011; Thom *et al*., 2010). For example, a BBC commissioned survey recently published findings from over 1,000 British Sikhs and found that 27% of respondents reported having a family member with alcohol problems (Kumar, Castelli and Syal, 2018). Bayley and Hurcombe (2011) also report on studies that show Sikh men are over represented in liver cirrhosis statistics which is not accounted for by the reported amounts that they drink, although the exact causes for this increased risk are not clear.

Another group that may be more susceptible to problematic alcohol and drug use, but who remain under-researched to date are forced migrants, including refugees and asylum seekers. A recent systematic review of the global literature (Horyniak *et al*., 2016) reported rates of harmful or dependent drinking between 17-66% for those based in refugee camps and between 4-19% of asylum seekers/refugees living in community settings. The wide variation in estimates of the scale of problematic drinking in these groups suggests a need for a greater research focus on these groups and a better understanding of the influencing factors and support needs of forced migrant populations.

Alcohol and mortality in minority groups

Studies looking at rates of mortality for alcohol-related conditions can offer some insight into problematic drinking among different ethnic groups. In England and

Wales, Bhala *et al*. (2009) reported the highest rates of mortality amongst men born in Ireland, Scotland and India and women born in Ireland and Scotland. Lower than average mortality rates were seen for men and women born in Bangladesh, the Middle East, West Africa, Pakistan, China and Hong Kong, the West Indies and East Africa. However, cases of mortality related to hepatocellular cancer (HCC), which is closely linked to alcohol use, were seen to be highest amongst men and women born in Bangladesh, China and Hong Kong, West Africa and Pakistan. The figures reported in this study are based on low numbers of individuals from minority groups but suggest some environmental and social factors beyond levels of alcohol use that could influence these differences in alcohol-related mortality.

In Scotland, a similar examination of mortality data showed that higher than average rates of alcohol-related mortality were only seen for those born in Scotland and the Republic of Ireland but were markedly lower for White populations born elsewhere in the UK and those born in Pakistan (Bhala *et al*., 2010). While the authors propose that individuals born in Pakistan are likely to be abstinent due to religious restrictions and therefore have low rates of alcohol-related mortality, those born in parts of the UK outside of Scotland are likely to belong to higher socio-economic groups which may be a contributing factor in lower rates of mortality.

Moving away from mortality data to look at alcohol-related liver disease in Scottish populations, a recent study reported higher risks for Chinese and Other South Asian men and lowest risks for women in Other White categories (Bhala *et al*., 2016). Despite having lower than average rates of alcohol-related liver disease, this study reported an approximately 50% increased rate of any liver disease hospitalisation for Pakistani men which the authors attribute to a high incidence of chronic viral hepatitis in this population. This highlights the need to determine the causes of liver disease to effectively inform service provision, and public health messages, for different ethnic groups.

Across the UK there is variation in the types of alcohol services available in the locality, usually based on data collected from a range of sources that are used to create local needs assessments. These assessments highlight the fact that different parts of the country will show differing levels of problematic alcohol use amongst ethnic minority communities. As there is no central repository of these needs assessments it is difficult to determine national prevalence rates of problematic alcohol use within diverse communities or how local authorities are currently responding to them.

Key informant interview perspectives

Key informants from both specialist and mainstream services report difficulties in assessing whether people from BME groups have lower rates of problematic drinking than white British groups and higher rates of abstinence. Specialist service providers

in particular are frustrated by the absence of data that accurately captures prevalence of problematic drinking either at the local or national level for the BME groups they support. In a needs assessment provided by one key informant working in the Midlands for example, data was limited in only representing ethnic breakdown of people in structured alcohol treatment and failed to provide any indication of hidden problematic alcohol use:

> *'I mean in terms of prevalence, problematic drinking and higher rates, it's lower, that's not true… That literature is not capturing what we've seen, what the BBC captured recently. What the BBC captured is far lower than what we know, our intelligence knows. This one is even below the radar here. When I saw that I was so angry, because I get that, see that cited.'* (Specialist service)

> *'…I'd agree with lower rates of problematic drinking. But I don't think the difference is as much as we think in terms of BME communities. I think there's very significant drinking and drug taking.'* (Mainstream service)

In the interviews it emerged that the specialist providers were aware of each other's services and also the extent of drinking problems particularly evident among Punjabi males in their communities. One specialist practitioner was aware of statistics cited in Galvani's research:

> *'…her research found that for every 100 white males that were dying from alcohol-related diseases, there were actually 160 Punjabi males dying of the same disease.'* (Specialist service)

Key informants discussed how alcohol issues manifested themselves in different BME groups. In some groups, problematic drinking was easily observed, particularly among Polish homeless street drinkers. Lithuanian groups and to some extent Somalis and people from South Asian countries alongside White British individuals were also mentioned in this respect.

Several key informants observed that problematic drinking and its effects was one of the most significant health-related issues among Punjabi Indian Sikhs. This is especially the case among those who may not be baptised but believe in and practise Sikhism. While alcohol is forbidden in Sikh religion, culturally, drinking is an essential part of Sikh gatherings. Similarly, alcohol is forbidden in Islam, but in contrast culturally alcohol cannot be openly consumed. One participant highlighted this in observing the difference between a Sikh wedding where alcohol is free-flowing and a Muslim wedding where abstinence is strictly observed.

Discussions around alcohol use are traditionally taboo among people from South Asia, hence problematic drinking is stigmatised and hidden. People risk losing their respect and standing within their community and can quickly feel guilty and become

ostracised and isolated. This remains a deeply ingrained vestige from former times when India and Pakistan were unified and when harsh sanctions would have been imposed by the village council on a family where one of its members transgressed religious mores. Although sanctions nowadays are less severe, families still risk repercussions, for example, they are fearful that people will not marry into a Sikh or Muslim family where a family member has drinking problems:

> *'…With the Muslim community obviously there is a large religious sort of side. You know their local mosques and their religious leaders and we've never had a massive kind of interaction, because I think with them they, especially in terms of the people at the mosques, I think they would rather, and this is not a criticism or anything, but I think they would deny the problem. They would kind of just perhaps try and kind of manage it within the family or the community.*
> (Mainstream service)

Acculturation and changing patterns of alcohol use

Some recent research has begun to argue for a different approach to understanding links between ethnicity and substance use than primarily through reference to processes of acculturation. These researchers (DeKock *et al*., 2017; Hunt and Kolind, 2017) have suggested that alcohol and/or drug use (or abstinence) may be one way for people to either identify with, or reject, societal definitions of their own ethnic identity. Future research reflecting this theoretical framework would involve a close investigation of the ways that social, political and economic policy and practice influence expressions of ethnic, or cultural, identity within different generations. Such an approach may provide a more holistic understanding of the reasons behind low uptake of treatment services among ethnic minorities and offer more useful means of engaging communities in prevention and harm reduction services (DeKock *et al*., 2017).

It has been noted that since the 1990s some minority groups have shown an increase in both the amount and frequency of alcohol use compared to the previous 10 years and that Asian and Chinese men and Indian women, in particular, were drinking at increased rates in this time (Hurcombe *et al*., 2010). More recently there has been a suggestion that alcohol is becoming more acceptable within Asian communities living in the UK despite religious restrictions and that this can be seen across generations (Galvani *et al*., 2013).

Most research, however, points to changes in alcohol use across generations as younger people from minority communities begin to adopt the majority population's drinking patterns (Bayley and Hurcombe, 2011; Marsiglia *et al*., 2012). Strong evidence of this phenomenon is currently lacking, with recent statistics showing reductions in alcohol use by young people across ethnic backgrounds challenging this theory (Bhattacharya, 2016). One group that seems to show a contrasting effect

of acculturation are Polish migrants who may reduce their drinking levels when living in the UK because of additional restrictions on alcohol use in their work places compared to those in Poland (Herring *et al*., 2019).

While in general it is argued that the more acculturated a minority group becomes to the majority society norms the better their access to healthcare and additional services, there is some evidence to suggest they are also more exposed to unhealthy behaviours such as excessive drinking (e.g. Hurcombe *et al*., 2012). The reverse may also be true when considering there has been a reduction in alcohol use across all ethnicities in young people aged 11 to 15 and a greater reduction in those who are in schools with higher proportions of Muslim students (Bhatttacharya, 2016).

Close family ties may act as a protective factor in these instances where evidence shows that some young people initiate substance use as a means of fitting in with a majority peer group but may resist substance use due to traditional cultural attitudes and influence on behaviour (Martinez, 2006). However, it has been suggested that younger people from ethnic minority communities will be more inclined to try to hide substance or alcohol use and any subsequent problems associated with use in order to avoid family conflict or shame (Marcu, 2016). Other research has reported that it is older generations that are more likely to keep their drinking hidden in order to present a more traditional, culturally appropriate, persona to their own communities (Galvani *et al*., 2013).

Older generations believe that younger people are better informed and educated as to the harms of excessive alcohol use and are therefore more inclined to either abstain or drink within recommended limits (Galvani *et al*., 2013). Clearly this remains a contested area that would benefit from further research to inform services and prevention approaches.

Service provider's views on generational differences and alcohol use

All service providers that we interviewed were seeing rapid increases in the numbers of young men in particular, but also more women aged 18-30 years, across South Asian communities using cocaine as well as alcohol. Cocaine was socially accepted and readily available. Promotion of the negative consequences of alcohol consumption was sometimes blamed for the move to greater drug use among younger people. Use of other drugs such as cannabis and heroin was observed to be generally on the increase too:

> *'You see the more we've kind of gone out there and said alcohol is bad, alcohol is bad, alcohol is bad, they've gone okay well if alcohol is bad then I'll just have a couple of lines. And now we're going okay alcohol is not so bad really. So and I think we've kind of brought that one on ourselves.'* (Specialist service)

One specialist practitioner suggested that for those young men who were drinking less than their elders, this was less to do with learning from the previous generation's experiences of problematic drinking; rather, cultural expectations around the norms of heavy drinking were felt to be more relaxed for younger men. These were associated with changing entrenched norms around heavy drinking as a measure of masculine identity. Previous generations felt that men were not seen to be in control of their lives if they could not handle their drink:

> *'So you know sibling rivalry, cousin rivalry, I want you to drink him under the table, I want to show that my son is more of a man than my brother's son, or my sister's son. And it sounds really daft talking about it in this generation, but that is what we grew up with, you know I want you to be more successful, I want you to and drinking a lot was part of the criteria, or part of your success…so youngsters have broken away from all that.*' (Specialist service)

Constantly changing populations of new undocumented migrants (formerly classified as illegal immigrants) fleeing war, violence and political persecution from Syria, Somalia and Algeria were observed both in outer London Boroughs and the Midlands. They were often reported to be using alcohol and opiates problematically. In the same areas, a shift from khat use to alcohol dependence has been seen recently among Somali men, with suggestions that making khat illegal in 2014 created an unforeseen switching to alcohol and subsequent issues with drinking:

> *'women were bringing their husbands in saying he's been chewing Khat for 15/20 years and he came over from Somalia and he used to get it in England, but you can't get it anymore and because of that dependency, he has now turned to alcohol'* (Specialist service)

A shift was being seen among younger generations within BME communities with more drinking alcohol and this was attributed to increased acculturation, however drinking still remained mostly hidden:

> *'I think there's more, more people drinking for reasons that we touched on, like growing up with their friends and other influences from all different walks of life, feeling more pressure to integrate'* (Mainstream service)

> *'…um I think it would be more in the Muslim country because there's been that element of people not drinking because of religious beliefs and another generation being in almost conflict with that, from what they see their friends doing and people they grew up, doing..'* (Mainstream services)

> *'With the acculturation comment, I think there's definitely something in that, because you do see that. Again I mean I'm looking at the Muslim community as*

kind of the opposite to that, because obviously I see them locally. I see the local assessment, so I do see younger people with Muslim names and I do see alcohol as an issue with them. Compared to like you know the wider population, it is definitely probably a lot lower.'

And later:

'Yeah I mean, especially within the Muslim community, there's going to be a lot hidden, because of course alcohol is prohibited in Islam, so there really would be, you know you're not going to get people accessing the treatment and people perhaps not even firstly admitting to having an issue within their family. Especially obviously there's large, you know local sort of religious communities with the local mosques.' (Mainstream services)

Key informants reported that people who are newer UK residents and mostly mixing with others from the same ethnic group are much less likely to be knowledgeable about the kinds of support available for alcohol problems. For example, one mainstream service provider working near a very large Somali community had observed very low engagement with services in general, as well as their alcohol and drug service, and was aware of drug and alcohol problems among 13-15-year-old boys and girls. Attitudes around using alcohol and drug use were deeply embedded for these more recent arrivals. For some with very strong Islamic faith it would be against their religious principles to ask for help. Religious beliefs coupled with lack of assimilation into the broader community can act as a barrier to help-seeking. Conversely, increased acculturation was felt to encourage people to access support:

'I think if someone, if an individual has been here for quite a significant period of time and their English and their way of, the way they conduct themselves is more westernised, they are more likely to attend the drug and alcohol service. But if someone from that community is quite, migrated more recently…Two years, three years, if it's within that period, I think more people are reluctant to access a mainstream drug and alcohol service, which is not specialised in anyway.' (Mainstream service)

Gender and alcohol use

It is well reported that most cultures (including majority white communities) see differences in the amounts and frequency of alcohol use between men and women (e.g. Bayley and Hurcombe, 2011; Herring *et al*., 2019; Marcu, 2016; Thickett and Bayley, 2013). In most cultures, women are either expected to be abstinent from alcohol entirely or are socially stigmatised for drinking frequently or to the point of intoxication. They are also likely to be more closely monitored for appropriate behaviour by the wider community when compared to men. This leads to significantly

lower reported levels of drinking among women across minority ethnic groups (with an exception being Irish women; Bhala *et al*., 2010).

The veracity of these reports is unclear however, as it may be that women in cultures where drinking is not socially acceptable may simply not report (or not be asked about) their actual drinking behaviour. Another possibility is that women tend to underestimate the amounts they drink when surveyed and this inaccurate reporting may lead to incorrect assumptions about the need for intervention amongst women more generally (Jones *et al*., 2015). There is also evidence that suggests the rate of substance use among women is higher than has been previously reported and that this is due to motivation to hide use from the wider community (Pavee Point, 2011).

Drinking amongst women can be linked to perceptions of promiscuity, leading to social stigma and exclusion of some women but also as a symbol of a younger generation becoming more westernised and independent (Marcu, 2016). There is some evidence that suggests young BME women have increased their alcohol use and frequency of drinking when compared to older generations of women (Galvani *et al*., 2013; Pavee Point, 2011). While some research links such increases in alcohol use among women to migration and minority groups becoming more 'Westernised' there is a counter argument that suggests it is the experience of feeling alienated from one's traditional culture, that can occur through migration, that influences the use of substances as a coping strategy (Unger, 2012). Further research, with Traveller women using heroin in Ireland has reported that for the 18 women interviewed in this study almost all had been introduced to substances by their husbands indicating a particular risk for women with partners who also use substances that is rarely addressed in the research or within services (Pavee Point, 2011).

Despite likely increases in drinking amongst BME women, it is still men who are most at risk of harm from alcohol use including physical health implications, violence related to alcohol use and mental health difficulties (Weaver and Roberts, 2010). This may be partly due to a cultural association between drinking alcohol and particular expressions of masculinity that can be seen in most cultures (e.g. Herring *et al*., 2019; Savic *et al*., 2016). Such beliefs that alcohol and masculinity are connected in a socially acceptable way could influence the likelihood of recognising problematic drinking amongst these groups and delay help-seeking until more severe negative consequences are experienced.

Key informants views on gender and alcohol

In many of the BME communities discussed by key informants, especially South Asian Sikh, Hindu and Muslim groups but also in Somali and Afghan communities, women are forbidden to drink alcohol and are expected to abstain from drinking. In these communities drinking carries feelings of guilt and shame so almost universally,

women drink secretively in isolation to avoid being stigmatised and ostracised by their communities. In extreme cases, there were reports of young women being flown to another country and forced into arranged marriages or treatment. In contrast, men were enabled to stay at home which was seen as supporting any problem with their drinking. Consequently, the extent of problematic drinking among women in these BME communities is difficult to estimate. Relationship problems and domestic violence were often reported to be a feature of these women's lives and were exacerbated by denial and not seeking support:

> *'…there seems to be more dishonour associated with that, dishonour amongst the family. So family members would be more shocked by it. So community members would be more, so it's like more official like men are, do indulge, engage in that behaviour and even though it is shocking, but not to the same extent as "oh wow there's a Muslim woman that's out drinking, on the street drinking", that would make more headlines…'* (Mainstream service)

> *'I still think it's, it's one of those things and this will be across the board, sort of a lot of the stuff that you are probably like looking into, it's hard to assess, or know because it's hidden, we don't know if that is actually happening and how much actually they are accessing.'* (Mainstream service)

Discussions around alcohol in the family could take place if the person needing help was a male family member whereas the traditional cultural taboo around women drinking prevented similar discussions for female members of the family needing alcohol-related support:

> *'Yeah so much more likely to try and keep it away from her husband or her family members. If that involves not drinking at home, it might involve drinking at home, but it also could involve drinking at home, but trying to hide it. Or even when it is realised by other family members, that discussion is not had, it's just easier not to talk about it than to actually speak about it, when no one really knows how to navigate that conversation.'* (Mainstream service)

It was suggested that families in South Asian communities often deny any possible association with the taboo of alcohol dependence even when women had clearly died as a result of problematic drinking. A couple of the specialist services had contacted funeral services to establish the true cause of death of people as a way of obtaining accurate data on the extent of alcohol problems in their communities and reported increasing suicides among women with drink related problems. One specialist service provider had recently met a funeral director serving the local Punjabi community who had recorded the cause of death as alcoholism for seven out of ten recent deaths among Punjabi women:

'…a funeral I'd gone to, a 36-year-old woman, clearly died of alcoholism, it's so bad that you know even after death her body was still yellow with jaundice. But the family were saying, "no, no unfortunately she's died of a heart attack", you know that's the message that is given to the relatives, to disguise the real cause of death.' (Specialist service)

Women are the gatekeepers to seeking help for issues arising with a family member's drinking; typically it is women going behind a family member's back, contacting services and asking for support. In their efforts to raise awareness of alcohol issues in their communities specialist providers were often approached by women in mosques and temples seeking help.

In communities such as Irish and Polish ones far more women were presenting for treatment compared with women from South Asian communities. Around half of Irish women with problems and a third of Polish women had accessed the services of one mainstream provider in an outer London borough for example.

Multiple exclusion and alcohol use/problematic drinking

Fitzpatrick *et al*. (2011) investigated the experiences of multiple exclusion amongst homeless people in the UK including migrant status, experience of institutionalisation, mental health difficulties and substance use using a mixed methods research design. They found that of the more than 1,200 homeless individuals included, 17% were migrants with high rates of alcohol use (i.e. above six drinks per day). Particularly high numbers were seen in central London where almost 80% of those included identified as migrants including Eastern Europeans and asylum seekers. Looking in particular at Polish migrants currently homeless, Thickett and Bayley (2013) reported on the social groups formed through rough sleeping where drinking together became a form of safety and protection for those sleeping on the streets and a means of securing social acceptance whilst excluded from other opportunities.

A recent study of pathways through alcohol treatment amongst Polish migrants in London also reported strong associations between experiences of poverty, unemployment and homelessness and harmful drinking in this population (Herring *et al*., 2019). Practitioners interviewed in this study reported particular difficulties for those with No Recourse to Public Funds (NRPF) in accessing treatment as they may be excluded from some services due to their migrant status. Discrimination experienced in employment, housing and community services has been linked to both alcohol and Class A drug use among second generation Bangladeshis in London in a recent study, suggesting multiple deprivation can impact on both initiation into substance use and difficulties in accessing and completing treatment for minority groups (Mantovani and Evans, 2019).

Those from minority communities are more likely to experience poverty and unemployment and live in more deprived neighbourhoods (Fitzpatrick *et al*., 2011). When surveyed, those living in lower socio-economic status households report similar levels of alcohol use compared to their wealthier counterparts. However, it has been noted that despite little difference in amounts of alcohol consumed, people from poorer communities experience greater levels of alcohol-related harm, a phenomenon that has been termed the alcohol harm paradox (Jones *et al*., 2015).

It has been reported that over half of the more than one million hospital admissions related to alcohol use occur among people in the poorest socioeconomic deciles (PHE, 2016). The most likely explanation for this paradox, as determined by Jones and colleagues (2015) using a variety of methods, appears to be a higher rate of frequent binge drinking among people living in more deprived communities. In this study however, additional factors that may also contribute to poor health outcomes, such as mental ill-health, poor housing conditions, poor diet and reduced access to primary healthcare services, were not accounted for and their cumulative influence is not known.

Key informant views on multiple exclusion

There was little doubt among all service providers that there were many other challenges that people from BME communities experienced alongside and often related to their problematic alcohol use. The comment below from a specialist practitioner trying to address the whole array of support needs succinctly highlights many of the issues faced:

> *'So one of the things that we deliver, well we have campaigned for it and we've been saying to commissioners as well is develop, we have a front door which is around safeguarding, but what we want is basically a model that has a pathway system for individuals around alcohol dependency that covers all areas, like mental health, domestic violence, homelessness, discrimination. So basically, so someone could have a route, you know like a pathway.'* (Specialist service)

People drinking on the street were particularly at risk of multiple exclusion, such as homelessness, mental health issues and poverty. A mainstream practitioner working in inner London noted that the street drinkers they saw were of mixed ethnicities. Having No Recourse to Public Funds created further difficulties in offering people with migrant status treatment alongside being homeless:

> *'It's really tricky because if people have got no recourse to public funds as well it's really tricky offering treatment because even if we can offer a certain amount of treatment there is no place for people to live… I mean you can't sort of work with somebody on reducing or becoming abstinent and then they're back on the street, it just doesn't really work.'* (Mainstream service)

Multiple exclusion was not necessarily associated with particular BME groups as one mainstream practitioner pointed out; these were more often characteristics of deprivation in a geographical area. Other service providers also spoke of multiple exclusion cross-cutting BME communities:

> *'… I think the area you're in has a lot to say about substance misuse as well as race… I think there's more, because there's more unemployment, or more poverty, yeah there's more drinking and there is more drug taking'* (Mainstream service)

All agreed that multiple exclusion needed to be addressed and support put in place to give a person with alcohol problems the best chance of successful treatment;

> *'If someone is motivated enough to make a change we need to make sure we look at all these other things, to make that change and the support will be done with that change.'* (Mainstream service)

> *'…you can't just address the alcohol use… I mean especially people who are of no fixed abode, haven't got any housing, people who are from that kind of ethnic minorities, if there's any chance of experiencing racism… of course socio-economic deprivations, all these are multiple you know additional vulnerabilities and if you don't address them and you're just trying to address the alcohol, all the stuff that's going on around that person is still going on. So of course it needs to be and that's like we need to as a service be, you know taking a holistic support with the person, but also make sure we're working with all the other organisations that are out there…'* (Mainstream service)

> *'…when you've got people who come to the country and English isn't their first language and they're perhaps in an abusive relationship and then there's a family breakdown and that is another thing we have seen in the past hoping there's change there. But definitely, again with all the vulnerabilities I mentioned earlier, domestic abuse is a big one'* (Mainstream service)

Specialists working with Punjabi and Sikh communities drew attention to the fatalism often attached to poverty among people in their communities with alcohol problems. People resigned themselves to being poor as it was the will of God and attempts to address poverty and offer support were constantly resisted:

> *'God has done this to me, you know God has been so kind to them and fate has been so kind to, they believe a lot in fate and karma, so karma has been good to them and you know I drew the short straw…..The self-pity is very, very hard to crack. When somebody is in that state of mind it' s very hard to get through, because they will just throw it back at you, what do you know, you know when*

was the last time that you had to go to a food bank, right. We have the free kitchen at the temples, the temples won't let me in because I'm always stinking of booze, see, God doesn't want to know me either way. So every single scenario that you put to them, they've got an answer for it. An answer that's so deeply engrained that they believe what they're saying. So poverty in a community like ours, is very, very difficult.' (Specialist service)

Support needs of BME communities for alcohol-related problems

Individuals from different ethnic backgrounds may have varied preferences for where they get help or support for alcohol problems from. For example, Bayley and Hurcombe's review (2011) reported that men of Black and Christian backgrounds expressed a preference to speak to a GP for information and advice while men from Sikh or Hindu backgrounds would first look for support from family. In contrast, for Black and Christian women family was the preferred support option while for South Asian women family were reported to be the least preferred option, possibly due to social unacceptability of women drinking amongst this group.

People from BME communities are reported to be the least likely to access services for a variety of health issues including alcohol-related problems (Hurcombe *et al*., 2010; PHE, 2018b). This can in part be explained by research suggesting a preference amongst some minority ethnic groups to address such problems within the family or close community circles. However, it may be that fear of the reaction of family members could contribute to non-disclosure of difficulties with alcohol. For example, Hurcombe and colleagues (2010) report on studies that found among some Asian communities revealing a drug or alcohol problem could lead to violence against the person alongside threats to have them 'returned' to the home country.

A study conducted with men and women from Traveller communities in treatment services in Ireland reported that most people became aware of the existence of services from other substance using Travellers and none of the participants had been alerted to support through posters or leaflets (Pavee Point, 2011). Travellers in particular are likely to have low levels of literacy so written materials are unlikely to be of most use in promoting access to service, and this is likely to be the case for some minority groups who do not have high proficiency in the English language also. The use of peer outreach workers has been suggested as one way to ensure those using substances are made aware of the support services available to them and encouraging people to look for help.

It is well documented that minority communities are at higher risk of experiences of multiple exclusion within society. Problematic alcohol use may only be one of many support needs that those from BME communities will have that can also include a need for support in relation to insecure housing and/or homelessness, mental health difficulties, past trauma (e.g. for forced migrants), experiences of exclusion from education or employment and difficulties in accessing welfare support (e.g. Fitzpatrick *et al*., 2011; Herring *et al*., 2019; Horyniak *et al*., 2016). Various reports have also highlighted the need to take account of the high rates of domestic violence, against women and children in particular, that can be associated with male drinking. If problematic alcohol use is continuously hidden this potentially puts family

members in physical danger that will not be addressed or confronted (Galvani *et al*., 2013; Herring *et al*., 2019).

Evidence from a study conducted in Belgium with Turkish and Eastern European first and second-generation migrants reported that for the Muslim participants their substance use (including alcohol) had led to them being excluded from their communities (DeKock and Decorte, 2017). Religious restrictions on alcohol and drugs had meant that these migrants were unable to attend religious or other cultural events and had been ostracised from community gatherings by other Muslims. These participants also spoke about feeling discriminated against by the majority Belgian population in terms of employment, education and social events leaving them largely isolated in their substance use and without access to either social support or treatment services. Similar studies have not to date been conducted in a UK context, but it is acknowledged that those from religious communities where alcohol is prohibited are more likely to try to keep their drinking hidden and to avoid help-seeking for fear of being found out within the community (Galvani *et al*., 2013; Hurcombe *et al*., 2010; Pavee Point, 2011).

Some studies have reported that individuals from BME communities may avoid seeking help for problematic drinking until they have experienced serious health consequences related to alcohol use (Herring *et al*., 2019; Galvani *et al*., 2013). Reasons for this are often related to cultural attitudes, such as a failure to recognise alcohol use as problematic when drinking is part of everyday behaviour across that community or a belief that problematic drinking should be tackled by the individual or within the community. There is some evidence that those from minority groups who are trying to keep their substance use hidden may put their health at further risk by attempting to detox at home rather than seek outside help (Pavee Point, 2011). A full discussion of identified barriers to accessing treatment is presented later in this report.

Raising awareness and education

All service providers agreed that encouraging open discussions around alcohol and related problems was a vital step in supporting the various BME communities they saw. Significant inroads had been made by specialist services especially those working with Sikh communities and some mainstream providers in awareness raising and education in temples and mosques in Sikh and Muslim communities:

> *'…say we did a talk at the temple or on the channel, they have seen us, because I will communicate bilingually with the community, so their mothers will have seen me, or the sisters and they will ring me and say "X, I'm calling you, I've seen the show, I've seen you at the temple, my son has got, my brother has got a problem, can you have a word with them, can I give you his number?" I say "I*

can't speak to him, but you need to get him to call me. This is how we do it, can you get him to call me,"' (Specialist service)

Religious leaders were seen as the gatekeepers for entering into discussions around alcohol. Engaging religious leaders demanded sensitivity in navigating the taboos around drinking in Muslim and Sikh groups in particular and some workers had found considerable resistance in discussing drinking, especially among some Muslim leaders:

'…They want to give a good image of what's going on in their community and they will have their own prejudices against alcohol and those who are alcohol addicted.' (Specialist service)

'It's what we've found with approaching mosques and things. If we could get the buy-in from community leaders, I think that would be really a lot more effective because it would remove some of the barriers' (Mainstream service)

'In the Punjabi community I think there's definitely been a big headway being made in the sense of before it was really ... people would just admit to alcohol being an issue, fortunately in this borough we were able to do some great work. So this is a few years ago now if I'm honest when there was a lot more money in service provision, but we had strong links with the local, especially with the local Gudwara …' (Mainstream service)

It was important for workers going into places of worship to be seen as authentic in the community. Specialist practitioners in particular spoke of the need to be 'embedded' within a community. Workers visited and gave talks regularly in places of worship and had strived to engage and build relationships with religious leaders and community members, often one and the same individual, thereby gaining familiarity and trust. These were considered essential to working with BME communities. One specialist practitioner had appeared on local radio discussing alcohol problems within his local BME community and written in community magazines on the topic, while another specialist practitioner who was a well-known performer clearly benefited from his recognition, familiarity and standing in the community. Building relationships with other stakeholders in these communities, such as councillors, the mayor etc. and encouraging these well-known and respected figures to introduce discussions around alcohol was useful in engaging BME communities:

'…for us in the past, a few years ago, we had like the Deputy Mayor, she actually became really interested in our service. She actually sat, and she did our peer mentoring course and I remember that was a real benefit because you know it just, you know because she sits on the local council or whatever and it just, I noticed that we just, you know lots of people ringing, there was a lot more active

and we had you know more people accessing the treatment just because it was at the front of people's minds…' (Mainstream service)

Training was another way of facilitating engagement and some specialist services delivered basic alcohol awareness training to a variety of stakeholders such as professionals in housing, police, funeral organisations etc.

Concerted efforts such as those identified above were highly effective in creating an open dialogue about drinking and opportunities for people to approach workers for support.

Raising awareness and education among BME communities involved not just talking about problematic alcohol use and the presence of the service, but also significantly, discussions around what support represents among people unfamiliar with support and treatment for alcohol issues.

Interest in prevention

Several service providers mentioned that more young people especially younger women and families from Sikh and Hindu communities were now accessing their service asking for advice about prevention. Women were concerned about drinking responsibly and asking if they might have a problem. One mainstream provider has also seen older people from the Muslim community coming into mosques and asking for advice on how to recognise alcohol and drug problems in their sons or nephews and how best to support them. However, significantly no one from this community had enquired about issues among their female relatives. The rise in questions around prevention was attributed to increased efforts in raising awareness especially in local temples about alcohol issues by specialist service providers. While there is generally greater awareness of the damaging effects of problematic drinking, clients were nevertheless still presenting for support often after experiencing significant health-related problems and service providers wanted to see more young people accessing their services with alcohol issues before they became dependent:

'…ideally if we're looking at it from a health and wellbeing perspective, we would like to see younger people maybe who have identified that it's becoming a problem, or they're using it to manage their emotions or you know, before they lose their job or ...' (Mainstream services)

Mainstream vs Specialist services

Due to the need to be culturally sensitive in providing healthcare services, including alcohol treatment, some services have designed specialist treatment interventions that directly target those from identified communities in need. Specialist services can include close working with community leaders and employing support workers

from the community with the necessary language skills and cultural understanding to encourage more people to access the service. They may also use culturally specific approaches that are thought to be more attractive to that community compared to mainstream services.

Some research has reported that younger people from minority communities (i.e. who are second-generation or later migrants) state they would prefer to access services through mainstream provision as opposed to specialist services targeting ethnic or cultural groups (Bayley and Hurcombe, 2011). Similar findings have been reported from young people accessing other substance use services where young people were more concerned with the type of relationship they had with a substance use worker than their ethnic identity (YJB, 2010).

However, it has been argued that, by only providing mainstream interventions for substance use those from diverse cultural backgrounds may feel that they are forced to adapt to these service structures which can impact on willingness to engage (Pavee Point, 2011).

There is no consensus within the literature as to whether mainstream services or specialist service provision is the best approach to ensure engagement of individuals from BME communities with alcohol treatment services. Professionals report that both approaches should work alongside each other to have the largest effects within a community where the mainstream service will have wider general reach and the specialist service can provide necessary cultural knowledge (Adfam, 2015). Peer-led recovery services, that include those from local minority communities may have an advantage over mainstream clinical services in that they can provide a cultural understanding as well as lived experience, and can serve as role models of recovery within communities, encouraging others to seek help themselves (BAC-IN, 2019).

The inclusion of religious leaders and organisations in providing support for problematic alcohol use within communities has been advocated as a way of ensuring cultural competence in delivery of services and a way of gaining the trust of the wider community (Thom *et al*., 2010). However, other researchers have suggested this should not be assumed as there can be tensions within religious groups. For example, baptised Sikhs are strictly prohibited from drinking alcohol whereas unbaptised Sikhs are more likely to consume alcohol especially at celebrations (Galvani *et al*., 2013).

Whether families should be included in services has also been an issue of debate within the literature where there can be an assumption that BME communities prefer to have a whole family intervention approach as opposed to individual treatment. Again, there are cross and inter community differences in which approach is most acceptable to those in need of support (Bayley and Hurcombe, 2011). Within some migrant communities, culture may dictate how the community responds to

problematic drinking amongst one of their members and the idea of seeking outside help for such problems may not occur to those who have migrated from countries where statutory services are generally not available for alcohol dependency (Jaworski *et al*., 2016).

Key informant views of specialist and mainstream services

Practitioners working in both specialist and mainstream services generally agreed that both types of service were necessary and that they would ideally complement each other through sharing their knowledge and expertise of local BME groups. For this to happen, both specialist and mainstream services needed to work together and be involved in the commissioning process:

> *'I mean in an ideal world I think there would be the option to have either, whichever one they would prefer. But there would be like a mainstream service like us, but there'd be some kind of provision for specialist services, if they could fund it locally, or maybe if it was something that was like a national sort of thing that was available to people.*' (Mainstream service)

Not surprisingly, specialist practitioners with long-standing experience of delivering support were well aware of their own strengths. They had fostered relationships with community stakeholders, built trust within their communities and were an established and stable presence, compared with the constantly changing structures that are a feature of mainstream services:

> *'…we are here all the time and there are always constant issues going on, community meetings going on, local councillors being elected, deselected, we build relationships with these people and they know who we are, what we do and we know who they are. And we've developed these avenues and pathways that would take years for a bigger provider to build. They still wouldn't be able to do it. And then the other aspect of trust will come in. So a lot of it isn't about just linking in with community leaders, it's about having a presence in the community, having trust within the community, within communities, within religious leaders and having a long term relationship with them.*' (Specialist service)

> *'We missed one point here. Specialist versus mainstream. They both can complement each other, but the specialist can be an asset to the mainstream. They did a scoping exercise in 'Name of city' a couple of years ago, like the commissioners, the mainstream service providers and local sort of specialist services, so they had a big discussion about it and in the end what came was, the conclusion was is it one or the other, or both and the conclusion was right, let them, let the specialists do what they're doing and let the mainstream do what they're doing. But for the specialist to work alongside the host sort of service but sharing expertise wherever one is lacking.'* (Specialist service)

There were reports from specialist professionals that mainstream providers often do not have the capacity to deal with client referrals from them and to see a local mainstream practitioner could take several weeks. This was attributed to unrealistic tendering and budgeting in the commissioning process that resulted in limiting the capacity required to deliver adequate support:

> *'And these people have got like 80/90 to 100 clients on their caseloads, how do you get through that a week? How many clients are you supposed to get through a day? Then once you've seen a client you get so much paperwork, because you've got to cover your back to do, at what point are you actually delivering recovery material, at what point are you helping these people?'* (Specialist service)

Professionals from mainstream services spoke of the importance of inclusivity as a key value underpinning the delivery of a mainstream service. All offered meetings or groups to cater for specific needs in a variety of languages. This was particularly important for new arrivals to this country who did not speak English:

> *'I think there has to be provisions in place for someone that hasn't lived here, like we spoke about it before that hasn't lived here for a very long time. So there will be more barriers, so just making sure that process is smoother, easier for them, or more likely for them to access. ...So we have Narcotics Anonymous meetings and stuff like that that happens in other languages as well. So you've got Spanish-speaking meetings, you've got Farsi speaking meetings, so Arabic people and Iranian people will be speaking Farsi. So those options are there. But in terms of from our perspective I don't know about having specific groups that are only for Arabic, or only for Somalian people'* (Mainstream service)

In terms of establishing what the support needs in a community are, specialist services were clear and attributed this to their insider knowledge of their local BME groups. A couple of mainstream providers on the other hand suggested that communities needed to be consulted to determine actual needs:

> *'Yeah I would say it's probably unclear because it's not perhaps being done. If you go in and ask people from those communities and ask what they actually would like and would like to see, you'd get a much better idea. So the only way you can know I would say is to do that piece of work and ask people and get a cross-section from the community of what the things are.'* (Mainstream service)

Current services and interventions available

Considerable changes within alcohol and drug services have been seen over the past decade with a trend towards integrating more services, including substance use and mental health, into a single provision. While this has the potential to create more holistic services, which is something that professionals have advocated for (Recovery Partnership, 2017), there are concerns that problematic alcohol use will not be seen as a priority to be addressed in these services (Recovery Partnership, 2017). In our search for relevant UK-based literature on active interventions and services that are aimed at BME communities we found very little published evidence that could support a 'what works' determination or could provide adequate information to form a national map of service provision. Interviews with identified services were vital in helping us to form a more complete picture of current services, motivations to develop specialist services (or not) and what services themselves have found to be effective methods of encouraging help-seeking and maintaining recovery. Analysis of these interviews are presented in the following chapter and will be referred to here where appropriate.

In the last comprehensive review into problematic alcohol use among BME communities, Thom and colleagues (2010) identified a number of examples of best practice in treatment services for a range of communities. These included having a dedicated health visitor to work intensively with the Traveller community to encourage them to register with and visit a GP, drug and alcohol services or attend hospital appointments. This was described as a resource intensive service where the health visitor was frequently required to provide reminders of appointments and to collect and travel with individuals to services. Another service described developing sermon packs that were delivered through mosques by Imams who collaborated in the creation of the packs. It was recognised that alcohol use is a sensitive issue among Muslim communities, but the service providers felt that this method of delivery of information, with an alcohol worker available after sermons, could help to generate discussion around alcohol use and potential problematic use.

Polish Catholic church organisations have hosted Alcoholic Anonymous (AA) groups for a significant length of time in the UK and currently run a number of groups across the country that are conducted in the Polish language. Some community services also have Polish speaking key workers available in areas where there is a relatively large population of Eastern European migrants (Herring *et al*., 2019; Thickett and Bayley, 2013). However, these services often only provide support through one language (primarily Polish) and it has been noted that other Eastern Europeans (e.g. Lithuanian) have to rely on translators which cannot always be funded by community services (Herring *et al*., 2019).

Peer support interventions have been growing in number across substance use services for a number of years. There is an increasing evidence base for the effectiveness of this type of support but to date there have been no substantial investigations into how they have been implemented, or what impact they have, within BME communities specifically (Adfam, 2017).

Culturally competent interventions

A school-based intervention piloted in the US supplemented a universal alcohol prevention programme with a targeted culturally specific intervention for Mexican American students. In general, universal school-based alcohol education programmes have been found to show little impact on drinking behaviours of young people (PHE, 2016). This programme (titled REAL Groups) framed cultural norms and resources as protective factors in reducing alcohol use and abstinence for young people as a way of resisting acculturative stress that has been shown to increase alcohol and substance use in previous generations (Marsiglia *et al*., 2012). The programme showed statistically significant reductions in young people's alcohol use over the course of 12 weeks in those previously identified as most at risk of problematic drinking. Similar interventions could be an effective means of providing culturally appropriate prevention approaches in the UK.

In the UK there are limited published evaluations of BME specific alcohol or substance use interventions. In our search for evidence for this review, we found no literature that presented evidence of service or intervention approaches that had been assessed over the past 10 years. In light of this lack of published information, we interviewed six professionals from a range of specialist and mainstream alcohol treatment providers to give an overview of examples of how services are responding to local needs of BME communities. Case studies for each of these services that outline the main approaches used and communities served are available in the Appendices.

Tailoring support to individual needs

Responses from key informants were polarised on the question of whether some people prefer *not* to engage with workers from services within their own community. On the one hand specialist services were of the view that this constituted a tiny minority of people in their experience while it was not surprising that mainstream service providers had experienced working with people who preferred the greater anonymity of engaging with their services:

> *'…a lot of people have disclosed from the BME community particular, is they would rather just work with (Name of specialist service) than the bigger providers. So that is a large proportion. So we are seeing the opposite of that.*

Now the other thing that is quite important with this, is services, the bigger providers, they come and go.' (Specialist service)

'That is a very interesting point and what I find interesting is that that is the point that seems to get put out there, rather than what about those that ***do*** *want to engage. It seems to be that's the one that's latched on…*' (Specialist service)

'X city council carried out a BME needs assessment, I think there must have been one person that put in didn't want to engage and I had to challenge it. In our experience yeah, people want to see us when we're right there in the community when we speak on their level….And there is another part to this, when people say they wouldn't want to, they've never seen such a service in action, to know how to compare it and how beneficial it would be to them, if that makes sense.' (Specialist service)

It was agreed by all service providers that being able to tailor support and treatment pathways to individual needs was key, although there was some variation in how this should be implemented in practice. While mainstream services mentioned the importance of gender, language and ethnicity in choosing an appropriate key worker for a client, a couple of specialist services believed that cultural identification through offering a peer-led approach based on 'lived experience' was crucial to people's recovery:

'…you all have a certain way of life that you adhere to, certain ideals, certain rituals, certain whatever it is, certain principles that are ingrained in your DNA that are thousands and thousands of years old. Your problem and paradoxically your treatment will always have something to do with that and that needs to be addressed with someone who can identify with those thousands and thousands of years old ideals, principles, rules, call it what you will. That identification is the most important of somebody's recovery.' (Specialist service)

'This is the problem, you put people into boxes and I don't think we need, we can't do that within BME community, it just doesn't work. Commissioners make this mistake too' (Specialist service)

As noted earlier, being part of the community means that specialist practitioners are aware of needs and can respond to them. For example, one specialist service had developed a 'diversity and recovery' programme alongside their 'faith-based recovery' programme to give their clients a choice:

'…So we have a lot of Muslim guys who don't want a faith based recovery. They want to do the diversity and recovery programme because I'm not a very religious Muslim.' (Specialist service)

Clients needing to be able to talk freely about factors related to their problematic drinking were more likely to find the open and non-judgmental environment they were looking for among professionals who were not from the same ethnic background, particularly so in Asian communities. This was the view of one mainstream service provider who believed that services needed to consider how to facilitate environments where there was could be open discussion about taboo subjects such as relationships and sex:

> *'…So for example if I was in a room with just Asian people, particularly Asian people, there's no way I'm having a conversation about sex and girlfriends or anything to do with, that are all contributing factors to drinking... it's just not the done thing in our culture to speak about things like that, or even alcohol, I would not have an open discussion with a family member that hasn't got much of a, that is more traditional, let's use that word. If they have more traditional cultural values, I'm not, I'm much less likely to have an open discussion about anything like that, with that individual. So I think that can be a barrier.*' (Mainstream service)

Acculturation was also thought to play a part among younger people in particular who might prefer not to work with a professional from their own community, though instances of this were rare:

> *'And again it would really depend on what the person wants, I mean you know sometimes could come in and they're quite and they will want to speak to someone from the, someone who perhaps, the language thing as well, they might want to speak to someone like myself, or one of my colleagues who speaks the language. But then they might sometimes there are people from a younger, the young people who can* speak *English quite well themselves and they'd actually prefer not to work with someone like myself.'* (Mainstream service)

Approaches to supporting women

All practitioners spoke of the complexity of women's needs when they were drinking problematically and trying to access support. A variety of approaches had been developed among both specialist and mainstream services to support women whose primary objective was to tailor support to individual needs with the resources available. It was significant that one mainstream practitioner spoke of current plans to develop a specific women's service rather than just women's groups because of the more complex needs of women in recovery.

Addressing individual needs could include offering support through a female or male worker depending on individual preference:

'I think a similar pattern, the peer-led model works. If women are supporting women and we've seen it, we have had it here, we have done it here, that would, a woman drinking alcohol having a problem, is more likely to talk to another woman, who has had the same issue and has worked through it and is now confident and well and standing on her feet and has dealt with the issue, they are more likely to connect and I see that developing and then the same with men. So the peer, not a professional, not a community leader, not ...' (Specialist service)

Women-only groups were generally available in most services for those women who felt able to disclose issues around their drinking. Female workers who could work one-to-one with women preferring not to disclose personal information were also readily available. Women needed to feel safe in a women-only environment where there was no possibility of being seen by men from their ethnic group and where they could talk openly about alcohol and any accompanying problems, for example about domestic abuse and their relationships. Mainstream services tended to run these sessions for mixed BME communities:

'I know in our service they do have a women's group. We do have a specific day where half the day we do abstinence work, in most cases it does work out this way, where no males enter the building, in terms of clients and staff, even staff will not go downstairs. It is a women-friendly zone for that afternoon.' (Mainstream service)

One of the most significant and common barriers to accessing help among women was the fear and stigma of having their children removed by social services:

'I think with women, just by their nature, you are going to have women that are mothers and that will be a fear as well. I know lots of women coming into treatment that's their fear that if they come and get support round this and they've got children, will there be any social services involvement, what will happen there.' (Mainstream service)

Several services offering family support were mindful of separating women from other family members during home visits so women would not be afraid of revealing any concerns about domestic abuse. Interestingly, one specialist provider used the same approach for men who may not want to disclose their feelings of vulnerability, isolation and fear in front of their partners and the cultural shame of appearing weak.

With respect to supporting women, specialist practitioners and some mainstream providers spoke of increasing demands and far more limited resources compared with those formerly in place. One specialist provider for example, had lost a women's recovery group, outreach workers and a number of female staff involved in community events raising awareness and education about drinking.

Known barriers and facilitators to accessing support

Across the literature similar barriers to accessing support for problematic alcohol use among minority ethnic communities have been cited. These include; difficulties in understanding how to navigate, the often multi-layered, services (Herring *et al*., 2019; Thickett and Bayley, 2013); not knowing where to go initially to ask for help; having problems which are not recognised by services or professionals (Thom *et al*., 2010); not being aware of the types of support that are available (Bayley and Hurcombe, 2011); low awareness of the health implications of excessive drinking (Thom *et al*., 2010) and; experiences of stigma and exclusion (Galvani *et al*., 2013; Thom *et al*., 2010). In addition, there may be a lack of trust in the confidentiality of alcohol treatment services among some minority communities especially if these services are provided through collaboration with individuals from that community (Galvani *et al*., 2013).

Delays in help-seeking for problematic alcohol use are seen in all communities with estimates suggesting that people do not access treatment for an average of nine years after recognising the need for help (Naughton *et al*., 2013). There may still be subtle differences in the timing of when people from BME communities and those from majority White communities look for support for alcohol use or dependence. For example, Naughton and colleagues (2013) reported that the main motivation for accessing treatment in their White British sample of interviewees was the threat of disruption to their lives, such as the ending of a relationship, losing their job or criminal sanctions related to their drinking. In a similar study with Polish migrants (Herring *et al*., 2019) it was reported that for this group, help-seeking did not happen until after these types of disruptions to their lives had already happened. While both studies included small samples from a single geographical area, they suggest that majority and minority groups may require different levels of intervention when they do make first contact with support services.

Research with minority ethnic and religious communities has emphasised the barriers created by community shame and stigma, especially among communities where there is a religious restriction on alcohol, that prevents help seeking for problematic use (Galvani *et al*., 2013). This loss of status among the family and community was reported to be one source of fear for participants that would prevent them from admitting to needing help with their drinking.

General health research has reported that those from ethnic minority backgrounds who live in areas where they form a majority of a local population have better overall health compared to those who live in more diverse communities, a feature known as the co-ethnic density effect (Becares *et al*., 2011). Using national health data Becares and colleagues (2011) found a protective effect of living in high co-ethnic density areas for all ethnic groups, except for White people, where rates of current

drinking were lower than national averages but for those that did drink this did not lead to a greater incidence of sensible (i.e. within government guidelines) drinking.

Reluctance to seek help for problematic drinking

The taboo around drinking carries with it considerable stigma and shame both for men and women in these cultures which results in problematic drinking being denied and hidden and is coupled with a reluctance to seek help. As in alcohol dependence more generally, relationship problems and domestic abuse or violence often accompany problematic drinking and remain hidden:

> *'…my dad came over in the sixties, everybody was of the view that we don't want to compromise our culture, our identity, we don't want to lose our language, so if we all stick together, we can keep it together. So paradoxically when you've got these stats here that Muslim communities where alcohol is prohibited still see lower rates of drinking, well that's probably why, because that coupled with the sanctions, the religious prohibition, you know there is nowhere for them to hide. They are all so closely huddled together that if there's one bad apple it's kind of spotted…'*

And later:

> *'But again that's not to say it doesn't happen, but it makes it worse because the individual that is drinking is then hiding and disguising and it just means that they are having to be a bit more sharper in their efforts of concealing what they're doing and that in my experience make the problem worse. Not only are you then drinking for whatever you're drinking for, but there's that extra buzz of being able to hide it and conceal it and putting one past someone. It's almost like when we were kids'* (Specialist service)

Key informants reported that people who are newer UK residents and mostly mixing with others from the same ethnic group are much less likely to be knowledgeable about the kinds of support available for alcohol problems. For some with very strong Islamic faith it would be against their religious principles to ask for help. Religious beliefs coupled with lack of assimilation into other ethnicities can act as barriers to help-seeking:

> '… *if someone's faith is quite strong, they think everything they need is by the form of prayer. So anything that you access outside of that, can be almost like you going against your own ethics and morals.'* (Mainstream service)

One key informant, however, observed that Islamic religion, where strict abstinence is required, could act protectively once a person had accessed help for drinking problems:

'… So if someone is in the Muslim community, they've somehow made a few bad choices, or certain circumstances in their lifetime has led them to drink and then they access the help for the drink, they will be much more likely to go and have a go to be abstinent. Especially if they are still kind of involved in their religion, even though it might be at a distance, or in and out on occasions…' (Mainstream services)

Other cultural norms acting as barriers to maintaining hidden alcohol problems and not seeking help include superstition and the cultural value place on self-reliance. Several key informants had witnessed people resorting to ancient remedies or cures or expensive tablets to stop drinking:

'…people have reported taking it and it's probably just a paracetamol, where you can buy a packet for 50p and saying yeah take this tablet and your person, son or daughter, brother, sister, whoever it is, will be cured of alcoholism.'
(Specialist service)

In South Asian cultures in particular high value is placed on self-reliance which serves to reinforce the attitude that seeking help is a sign of weakness:

'I think it's more a cultural attitude isn't it, self-sufficiency, self-containment. I mean there's an idea, a lot of the communities are closed and they can sort out their own problems. That's not true. They have problems, they believe they can sort them out, but they're not sorting them out. There's a false perception of it.'
(Specialist service)

Additional barriers identified by key informants

- Lack of engagement especially in communities where drinking is hidden or prohibited and therefore denied;
- Lack of awareness of health problems associated with problematic drinking such as diabetes;
- Cultural and religious beliefs resulting in shame and stigma and leading to denial of the problem, women with more complex needs are particularly vulnerable in this respect;
- Cultural attitudes that regard self-help as a weakness; yet paradoxically that enable people with alcohol problems to be supported at home, visible among Punjabi men;
- Mistrust in services stemming from early experiences of racism and discrimination.
- Inadequate translating and provision of information about safe drinking in languages spoken by people especially those who are more recent arrivals;

- Newly arrived migrants who may not speak English and are unaware of available support and systems for accessing it especially recent Somali and Afghan arrivals;
- Lack of awareness and knowledge about newly arriving groups such as Syrians who may have problems that are a response to their new status, for example, mental health issues;
- No Recourse to Public Funds affecting recent Polish and Lithuanian migrants in particular, and likely to be affecting new migrants or refugees;
- The presence of a drug and alcohol service that people from BME communities are inclined to visit can act as both a barrier and facilitator for some.

Facilitators enabling access to support

Using community broadcasters such as Asian radio or TV has been suggested as one way to get information about services out to minority communities and to disseminate public health information (Adfam, 2015). Used in conjunction with discreet literature placed in GP surgeries, community centres and places of worship, this could overcome one barrier of minority communities not being aware of the types of support that are available and where to go for help. This approach could also help to reinforce the idea that alcohol treatment services are confidential, and that people have options available to them about who they see for support.

In their ethnographic study with Punjabi Sikhs, Galvani and colleagues (2013) report that most participants would look for advice and help through either the internet or their GP suggesting possible points to promote safer drinking and education on potential harms as well as signposting to services available. Interviews with service providers in this study also suggested that it was important to be able to give support and information to the wider family (primarily women married to problematic drinkers) who are likely to take on the role of the help-seeker for their family member and that services need to be able to accommodate these requests for intervention as well as from the individual directly.

A need for culturally competent and informed staff and services has been advocated as one way to overcome some of the identified barriers to accessing services (Adfam, 2015; Galvani *et al*., 2013). In particular a lack of understanding of the ways that shame and stigma can impact on a person's willingness to engage with services in certain communities has been highlighted as a culturally specific issue that should be addressed in future service provision (Galvani *et al*., 2013).

Researchers in Australia have created a guide for community-based groups to reduce alcohol harms among African migrant groups (Jaworski *et al*., 2016). These guidelines, produced in collaboration with the local community, staff from healthcare services, and migrant/refugee support services, reiterated the need to have active involvement of community members in developing services targeted at minority

groups. As was seen in other UK research (Galvani *et al*., 2013) the impacts of problematic alcohol use were primarily discussed in the context of how it affected families and children rather than the direct health implications on the individual and may offer a useful means of communicating the value of intervention to some communities.

The subsequent guide produced by Jaworski and colleagues (2016) includes advice on how to contact and engage community stakeholders in the initial stages of service development, engaging communities in often difficult discussions, using ongoing community feedback throughout development and planning and implementing evaluation of services as they are being introduced.

Facilitators identified by key informants

- Client confidentiality within communities and families;
- A non-judgemental approach;
- Offering a free service was important to communicate, especially in South Asian groups likely to be exploited by the promise of expensive miracle cures;
- Encouraging open dialogue about alcohol problems and related health and relationship issues in a community;
- Working with family members who may be influential in a client's life and educating family members about their treatment and recovery;
- Maintaining contact and encouraging people to attend appointments, sending reminders etc.
- Professionals who are embedded in a local community with fluency in the local language and with a strong community presence which help to reinforce their authenticity;
- Peer-led support through the lived experience of a professional from within the BME community having successfully navigated the process of recovery from alcohol problems;
- Flexibility to tailor support to individual needs and preferences, for example offering home visits or meetings in community settings such as cafes etc.;
- Flexibility in responding to changing needs in a community e.g. offering a choice of support. A recovery programme for Muslims who wanted a faith-based programme had recently been developed by one specialist service for example.

Discussion

The purpose of this rapid evidence review was to gain a better understanding of the prevalence of problematic alcohol use among BME communities, the types of services that are currently available to these communities and to identify ways that services can better meet the needs of minority ethnic communities. Overall, we found only a small body of literature that addressed these issues published over the past ten years. In order to enhance the findings from the literature review we also interviewed six key informants from specialist and mainstream alcohol services which helped to put these findings into current practice context.

We found a much smaller body of literature on the prevalence, support needs and services available to minority ethnic communities compared to two previous similar reviews (Hurcombe *et al*., 2010; Thom *et al*., 2010). This suggests that research interest either focused on minority communities, or in alcohol treatment studies more generally, has declined in the past decade, as the focus has shifted towards public health aspects of alcohol use. As discussed in the introduction there is no indication that the need for alcohol treatment services has reduced in any significant way over this time period, so questions remain as to why the research literature has not been keeping pace with current demand and need for intervention. Our key informant interviews also suggested an increased need for services among minority communities and growing concerns about the levels of hidden alcohol use that are not being addressed.

Some minority groups are notably under-represented in the literature.

For example, there is limited research and understanding about the needs of forced migrants, refugees and asylum seekers (Weaver and Roberts, 2010). The experienced trauma of these groups, and potential for difficult acculturation makes them potentially high risk for both substance use and mental health difficulties. Other groups that may have a significant BME population including prisoners, young people excluded from school and LGBTQ individuals, are also missing from the research literature and their particular experiences of alcohol use and needs for intervention are currently unknown. Service providers also spoke about challenges in gaining access to some Muslim communities where they felt there may be a tendency to deny alcohol use within the community due to religious restrictions on drinking.

While the literature overall still argues that BME communities are much less likely to experience problematic alcohol use compared to the White British majority population (e.g. Bayley and Hurcombe, 2011; Bhala *et al*., 2016; PHE, 2016), this was somewhat disputed by our key informants working with minority groups. They suggest that alcohol use, and especially alcohol dependence, is largely hidden within

some minority communities and that current means of surveying populations to estimate levels of harm and support need are inadequate to properly convey the true extent of these issues. The consequences of lack of information on prevalence become apparent in commissioning where failing to identify the needs of BME communities impacts critically on funding decisions:

> *'…when the commissioning services when they're doing, what do you call it, the specification, you know once it's completed, they always put that under BME, yeah under BME community, more needs to be done for BME communities'*

> And later: *'They are not capturing it, but it's informing commissioning, so that's why we can't get to the commissioning table, if you've got someone, all this shows is that it's not identified in the consultation, the research, so there is no problem.'* (Specialist service)

The literature is not clear on the influence of acculturation, or length of time living in the UK on patterns of alcohol use among younger and older people from minority communities. Some research has shown that younger people are more likely to drink in ways that reflect that of the majority population regardless of cultural or religious restrictions from their communities (Hurcombe *et al*., 2012; Marsiglia *et al*., 2012). Contrasting findings have been reported in other research that suggests close ties to the community act as a protective barrier to problematic drinking (Martinez, 2006). Key informants interviewed for this review reported that they had noted changes in the types of substances being used by those from minority groups but also changing social attitudes around masculinity that have led to reduced drinking among some men.

Our interviewees suggested that there was less pressure on young men from some minority communities to prove their masculinity by the amount they could drink in recent years. However, earlier research with a diverse sample of university students suggests, for some young men at least, the correlation between drinking large amounts of alcohol and being seen as 'manly' exists for younger men also (De Visser and Smith, 2007). For the young men in De Visser and Smith's study (2007) strong religious ties were a protective factor against feeling pressured into drinking to display their masculinity. Nonetheless, attitudes that link alcohol and masculinity are likely to have an impact on young men's willingness to seek help if their drinking becomes problematic as it could be seen as an act of weakness.

Women from BME communities may require particular approaches to service engagement and support for alcohol use. Social attitudes towards women across all communities often mean that their behaviour is more closely monitored than that of men, and this has led to an assumption that women's substance use is therefore lower. However, as seen in the literature and from our interviewees, it is likely that women who do use alcohol do not report problematic use due to fear of shame and

stigma from within, and outside of, their communities. Also of note is the finding from a Pavee Point (2011) study with Traveller men and women that found most women in their study had first been introduced to heroin by their partners. Recurrent issues with the measurement of alcohol use and any associated problems are particularly pertinent to understanding the extent of need amongst women from minority communities.

Experiences of multiple exclusion have been discussed in the broader literature including those from minority groups as well as in alcohol specific research (e.g. Fitzpatrick *et al*., 2011). This concept is yet to make an impact on alcohol use or intervention studies but there appears to be a recognition among service providers to also support additional issues such as homelessness, welfare applications and job opportunities (see Herring *et al*., 2019). There are good arguments for making these issues more prominent within the literature on alcohol/substance use as ways of better informing service development and provision. One proposed advantage of a national move towards more integrated services is that it could potentially create a genuinely holistic service to individuals and communities and encourage cross-agency working where it is most needed.

However, there are concerns within the alcohol treatment field that problematic alcohol use is already considered a 'low-level' issue within services and can be missed in initial assessments (Recovery Partnership, 2017). An investigation by Public Health England to understand falling numbers of people in alcohol treatment in 2018 also reported that most service providers felt service reconfiguration (primarily into broader substance use services) had led to a reduction in alcohol specialist staff and consequent numbers in treatment. Reduced funding was also identified as one further reason for this reduction in treatment access as it was reported that more of the services' limited budgets were being directed towards opioid substitution treatment (PHE, 2018c).

Encouraging discussion about alcohol use and potential harms was identified as a key issue within BME communities by our interview participants. How successful this is varies among communities with Muslim groups being particularly challenging to engage in such discussion in some areas in light of religious restrictions on drinking alcohol. Changes have been noted in recent years by some providers however, where they have seen an increase in the number of family members seeking advice and information about treatment services. Effective outreach with communities that are uncomfortable discussing alcohol use may take some time to have an impact on help-seeking as it will require some level of attitude change within families and wider communities. As many individuals are likely to become aware of services through word of mouth within their own communities, the use of peer outreach workers may be a useful means of encouraging access (Pavee Point, 2011).

We found no research that reported directly on BME-specific alcohol use interventions from a UK perspective, although some promising culturally focused work with young Mexican Americans has been conducted that could be transferred to the UK (Marsiglia *et al*., 2012). Interviews with key informants highlighted what is happening in services to ensure culturally responsive treatment approaches are being implemented where needed. They also pointed out the importance of engaging with the individual and not making assumptions about preferences for treatment approaches based on the person's religion or ethnic background. This echoes the argument made by Burlew and colleagues (2013) in not trying to create a single approach that is then offered to all minority groups.

There is little agreement either within the literature or among our practitioner interviewees as to whether specialist or mainstream services are most appropriate to offer services to those from BME communities. For interviewees this was determined largely by the type of service they were currently working in, which may be a reflection of local needs as much as the service construction. Overall, the evidence suggests that there should be a choice available to those who come to services and that, at a minimum, services should have culturally competent staff providing intervention. Developing services in collaboration with the local community would be one positive way of ensuring the wishes of that community, in terms of having mainstream or specialist services available, are met.

The barriers and facilitators to accessing support for problematic alcohol use that were identified through our literature search and key informant interviews are similar to those that have been highlighted in previous reports (e.g. Hurcombe *et al*., 2010; Thom *et al*., 2010). Issues remain around effective awareness raising of, and education on, alcohol harm amongst BME communities, communicating confidentiality of services and language barriers encountered by some BME individuals. Debate exists however, as to whether specialist services are more attractive to those from BME communities compared to mainstream services and the involvement of local community leaders has been seen to be both a facilitator to engagement and a barrier for some.

Conclusion

Some evidence suggests that a strong ethnic identity can act as a protective factor against problematic substance use (Becares *et al*., 2011) and there is evidence that services that include cultural teachings and community leaders are effective in offering support to those from BME communities. However, recent research has also shown that those who use alcohol or other substances may find themselves isolated from their communities through their use, while also feeling excluded from the mainstream society that they live in (DeKock and Decorte, 2017). More research is needed to better understand the role of ethnic/cultural identity in help-seeking for problematic alcohol use and the variations within different ethnic contexts.

Future research needs to more clearly describe and define what it means by 'ethnic minority' as a group and how intersections between ethnic identity, acculturation and acceptance/rejection of such identities are expressed by individuals. This arguably becomes more nuanced with second, third etc. generations of migrants who increasingly may find themselves straddling two or more cultural and ethnic identities/worlds – how this may affect an individual's sense of self and whether they embrace or struggle with this needs greater attention in understanding how and when alcohol (or other substances) may be used as a coping mechanism (Unger, 2012).

It is still unknown what the full impact of austerity budget cuts on the wider alcohol treatment sector will be and how the business rates retention form of funding will affect how and what services will be on offer in future. Potentially, this could impact on the ability of services to offer culturally specific approaches. The local nature of alcohol and drug treatment service funding also means that there is extensive variation across the country and what is or is not funded is largely determined by what local commissioners deem most important (Recovery Partnership, 2017). This adds to difficulties in establishing common strategies for addressing the needs of minority groups and for developing an understanding of what works.

Recommendations

The following recommendations are drawn from both the evidence review and key informant interviews and have been selected to represent a majority perspective on how services should be developed and implemented.

- Need for culturally competent staff across services – for young people there is a particular need to be aware of potential cultural conflict between traditional/family values and majority cultural norms where young people are likely to be embedded in both (Bayley and Hurcombe, 2011; Pavee Point, 2011). However, the way that staff are trained in cultural competence needs to be considered carefully as it has received criticism in the past in the context of training within mental health services (Fitzpatrick *et al*., 2014).

- Work in collaboration with community groups and leaders and promote local community groups to deliver information and services to their own communities (Thom *et al*., 2010), and to ensure services are tailored to the preferences of that group (Galvani *et al*., 2013).

- Some individuals may not feel comfortable attending services for the first time alone, this needs to be recognised and measures to facilitate family or friends to attend early sessions should be put in place in order to encourage more individuals to look for support (Pavee Point, 2011).

- Advertise services (in discreet literature) in community spaces and through radio, newspaper and TV advertising in the community language (Adfam, 2015; Galvani *et al*., 2013).

- Proactive outreach into the community to disseminate information about the health risks of excessive alcohol use and support services that are available (Adfam, 2015). The use of peer outreach workers has been suggested as a useful way of ensuring correct information is spread through word of mouth among some communities (Pavee Point, 2011).

- Embed alcohol support services within other health and wellbeing services to reduce stigma associated with alcohol dependence and to provide more holistic approaches (Galvani *et al*., 2013).

- For some minority groups that will not have much experience of Western focused services it can be useful to include them in induction sessions for the individual so that they understand the likely processes and pathways that are to come. Some service users have reported conflict with families after they enter treatment as

there can be unrealistic expectations from treatment and the length of time needed to enter recovery (Pavee Point, 2011)

- From our discussions with service providers for this report it is evident that there is a need for a mechanism or system that would allow services to share their practice and/or models with each other. Currently it seems many are operating in isolation and would be interested in opportunities to meet with and talk to other service providers doing similar work.

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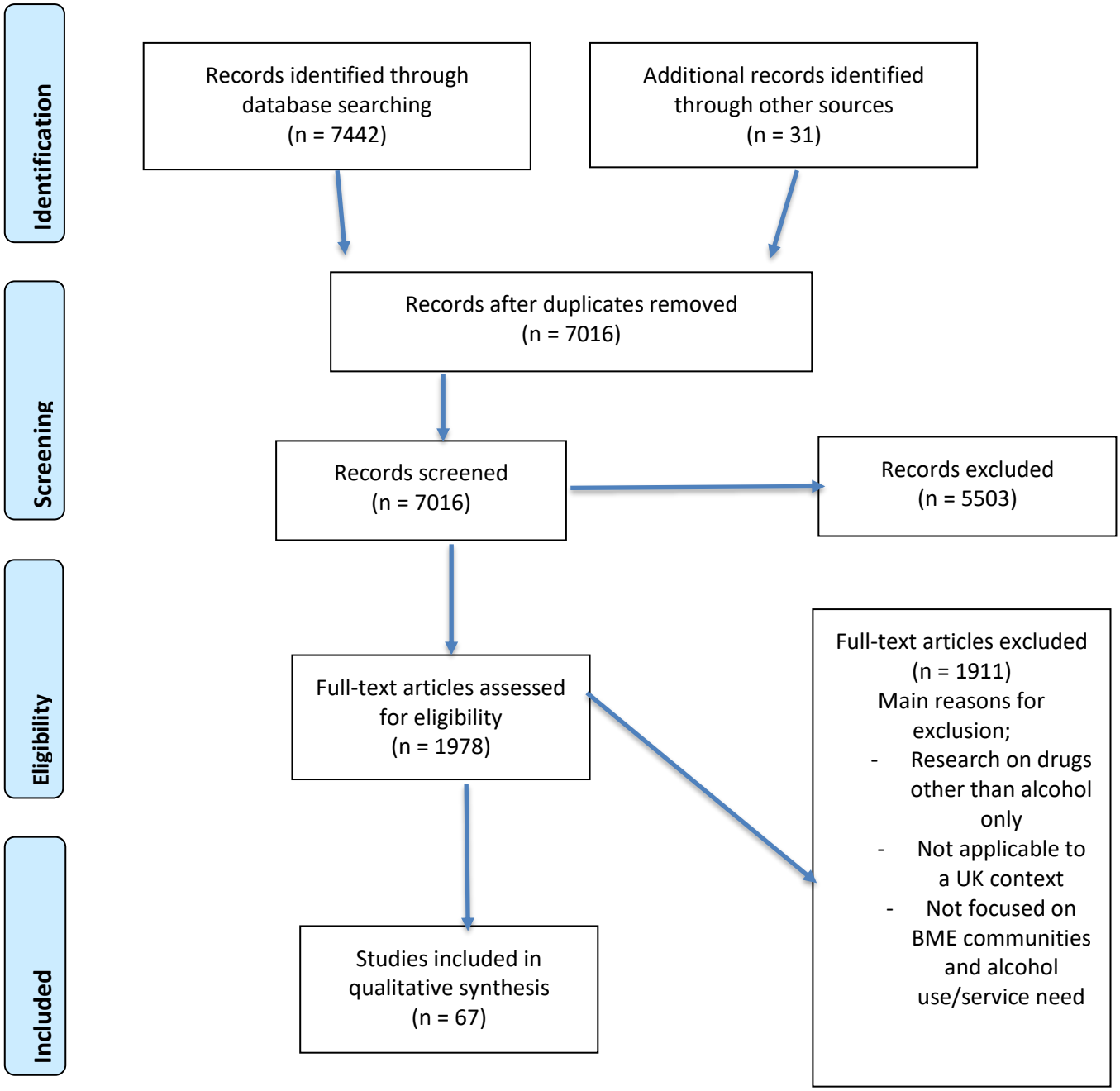
Appendix A: PRISMA diagram



Appendix B: Summary tables of primary research studies reviewed

Reference & location	Sample & Inclusion	Aims & Objectives	Methods & Setting	Main Findings
Adfam (2015), England (West Midlands)	Substance use commissioners, drug and alcohol service managers, frontline workers, volunteers.	To consider how the systems and services involved in substance misuse can better address needs of BME communities	Roundtable discussion. 23 professionals	That specialist and mainstream services work best alongside each other Need for cultural competence to run through the whole system, including commissioning Priorities in informing communities about services include; community language, stressing confidentiality of services; use of social media, community radio etc. to advertise Proactive outreach should be used for hard to reach communities Western, mainstream therapeutic approaches may not be most suitable for some cultural groups – alternatives need to be offered
Galvani *et al*. (2013), England (Birmingham)	152 participants total from Punjabi Sikh community including; 15 professionals; 16 community service providers; 10 Punjabi Sikh service users; 60 local residents (young	To identify existing service provision To explore evidence of effectiveness	Mixed methods. Evidence review Ethnographic observation	High levels of awareness of alcohol harms shown in survey responses and further education seen as important for younger generations Focus groups – shame and stigma associated with problematic drinking; tensions exist between religion and culture; increased public drinking among younger women noted; domestic violence major factor; no agreement on generational differences in levels of

	people, older people, women and men).	of interventions To establish views on support needs for community from providers and service users Identify opportunities and challenges for developing community interventions	Survey Focus groups Semi-structured interviews All completed in local areas in Birmingham	alcohol use; divided views on whether religious leaders should be offering main support Service providers – important for services to understand community shame associated with alcohol problems; need for more holistic services within a framework of health and wellbeing; fears around confidentiality of community service providers are a challenge; awareness raising should include use of local radio and Sikh television; need for greater partnership working but will be affected by budget cuts into the future.
Herring *et al*. (2019), England	Polish migrants in London with experience of alcohol treatment services (N=13) and professionals across Polish organisations (N = 4)	To further understanding of pathways into, through and out of alcohol treatment for Polish migrants	Semi-structured interviews	Significant negative life events tended to occur prior to seeking help Men and women had different pathways The goal of treatment for this group was abstinence, harm reduction was not considered appropriate by service users Those with 'no recourse to public funds' were limited in the types of treatment they could access, many refused to return to Poland due to experiences of past trauma, having poor family relationships Strong work ethic amongst this group could be used as motivating factor to stop drinking if services offered routes into employment as an addition to alcohol treatment

Hurcombe *et al*. (2012), England	Irish traveller men (N=4) and women (N=6)	To explore alcohol use, health needs and health service access within Traveller population in England	Oral life history approach through interviews	Improvements in general health were noted in recent years Increasing tendency to more 'settled' lifestyles were important in having access to healthcare but also concerns about young men becoming more involved in risky drinking behaviour Older participants were concerned about young people mixing with 'settled' communities and not being as closely monitored as in previous generations.
Jaworski *et al*. (2016), Australia	African migrant community members (N = 48 from 6 African countries) and service providers (N = 31)	To develop a guide for services to deliver culturally sensitive alcohol and substance treatment	Literature review Consultation with community members External review of findings	Need to address acculturative stress in migrant populations to reduce alcohol problems and increase interaction with health services Addressing harm of alcohol was seen as a community and individual responsibility by community members
Marcu (2016), Europe	Roma young people in 5 European countries (N = 199; including 74 in research design) and professionals (N = 103, involved in design)	To understand young Roma's perceptions on drugs To describe the profiles and patterns of drug use in young Roma To develop selective prevention	Participatory action research Visual focus groups using collages Biographical interviews	Trends identified in the Roma youth. • Early onset of tobacco use • Exposure to consumption of alcohol by adults • Underestimation of the consequences of many drugs • Addiction to injecting drugs in specific areas • Gender roles being associated with patterns of consumption Reclaiming positive social status and belonging by using certain types of drugs and sharing with consumption patterns with non-minority young people

		strategies and shed light on the circumstances of drug use and addiction among Roma youth in five countries		
Marsiglia *et al*. (2016), USA	Mexican-American young people – total 3,038 from 30 public middle schools 361 of these in REAL groups intervention	To test the efficacy of 'REAL Groups' as a secondary substance use prevention programme.	Randomised controlled trial study	One of few intervention programmes that targets young people who are already using substances Results here support theory that providing additional secondary prevention intervention (with primary, universal intervention) is effective in reducing alcohol use.
Mentor (2011), Scotland	6 established youth projects (3 x urban immigrant community (including Chinese, Muslim, Indian, Afro-Caribbean, Bangladeshi & Polish); 3 x rural projects) 2-year intervention	To pilot alcohol misuse prevention programmes with young people from BME and rural communities	Co-produced prevention programmes in each project. In year 2 – residential weekend for all groups – focus groups with participants	77% self-reported reductions in alcohol consumption Increased safety precautions when drinking reported 47% young people permanently took up a sport they had not tried previously In BME groups – all expressed negative ideas about alcohol but these reduced with increased age; existing high levels of confidence/self-esteem related to abstinence; free time tended to be spent with family, which may have influenced opportunities to drink; high levels of parental and community concern impacted

	Total of 244 young people aged 11 to 25 years			programme with some sudden withdrawals of young people from projects once issue of alcohol was introduced.
Pavee Point (2011), Ireland	Traveller men (12) and women (18) accessing substance use treatment services	To explore Traveller's experiences of engaging in drug and alcohol services To produce good practice guidelines for services	Semi-structured interviews Literature review Focus group and questionnaire with service providers	Women were not comfortable attending a service alone for the first time Main source of information on services was through word of mouth between other drug using Travellers Outreach was also important in raising awareness of services Primary importance for service users was guarantee of confidentiality Having a key worker was reported as beneficial by service users and helped them engage with service Need for services to explain addiction, dependence and treatment processes to family as well as individual so they can be supportive
Thickett and Bayley (2013), England	Polish migrants in London experiencing homelessness (N= 12)	To identify pathways to street drinking among Polish migrants in North London To examine awareness, experiences and attitudes on services	Participatory interview mapping and semi-structured interviews	Participant's experienced multiple adverse events in the lead up to becoming homeless and street drinking Informal support networks were often the only form of support available and encouraged continued street drinking Language barriers were most common reason for not engaging with services Homeless support services were also important in giving additional help such as for lost passports and documents

		To identify barriers to service engagement		

Appendix C: Case Study 1: KIKIT pathway to recovery

Name of the service

KIKIT Pathways to Recovery supports the health and social care needs of people from hard to reach and marginalised communities, including Black, Asian and Minority Ethnic Communities (BAME)

Who is the service for?

KIKIT works with people of different genders, ages, cultures and faiths**.** The treatment population consists of a range of different BAME groups from many different faiths including Muslims, Sikhs, Hindus, Christians and also non-faiths. The staff speak a range of languages and there are a variety of ethnic groups who access KIKIT, such as Somalians, Iranians, Algerians, Turkish, Syrians, Ethiopians, Polish and many more.

What are the issues clients present with?

The service users come from a variety of communities with different substance use issues. Alcohol addiction is often seen among men in the Muslim, Sikh, Hindu and Polish community however seeking help is very difficult for these men as alcohol is forbidden in some religions for example, Islam and Sikhism. In the Muslim, Sikh and Hindu communities alcohol addiction is often seen as taboo and alcohol is only accepted in the Sikh and Hindu communities at cultural events such as weddings. Some Sikh and Hindu women are seen addicted to alcohol and drinking in isolation. This may be due to troubled marriages and domestic violence but getting help is not something these women would do openly due to cultural barriers. People from the Somalian communities who were regular users of Khat have been seen turning to alcohol and diazepam since Khat was made illegal in the UK. The Polish community often present to the KIKIT service with alcohol problems rather than drug problems.

What does the service offer?

KIKIT offers a range of recovery focused, harm reduction and abstinence-based approaches. KIKIT builds relationships and trust with community leaders and promotes their service through the community to ensure it reaches the people who need it. KIKIT provides community-based activities and structured treatment programmes to support people with substance misuse, health, social wellbeing and community safety. KIKIT provides culturally sensitive help, advice, support and mentoring for anyone suffering the effects of drugs and alcohol addiction, dependence or abuse. It offers a drug and alcohol drop-in centre, mutual aid support groups which are peer-led, one-to-one key works, groups work (women only groups available), 12 step programmes tailored to Muslim service users known as the Muslim recovery network. KIKIT also works with larger projects which aim to target radicalisation and extremism, gangs and gang violence, and carers support. The Birmingham BME Recovery Forum was also developed by KIKIT as a voice for BAME service users. KIKIT delivers another programme called Diversity in

Recovery which covers obstacles and barriers to recovery. This is for service users from the BAME community who find it difficult to access drug and alcohol treatment. KIKIT links in with other key services to provide holistic support for clients with issues with domestic violence and mental health.

Conclusions

Services like KIKIT are key as they are embedded in the community and have the reach to access BAME communities. There is a range of cultures and faiths KIKIT works with and it is crucial to maintain good relationships with the community and community leaders to promote this service to the people who need it most. Organisations such as KIKIT are trusted and have practitioners on the ground who have a long history of delivering the service locally.

Other current issues

A key issue for KIKIT is when the larger organisations do not engage with specialist grassroots BAME services when they are tendering for contracts. Larger organisations that are delivering drug and alcohol services to BAME communities need to work more closely with organisations such as KIKIT. A good example of partnership working is with Change, Grow Live who have sub-contracted KIKIT to deliver BAME specialist provision which has proven to work well. More organisations need to work closely with grassroots organisations like KIKIT who are community intelligent, have community engagement and are embedded within the community.

Appendix D: Case Study 2: BAC-IN recovery

Name of the service:

BAC-IN: culturally sensitive, peer led drug and alcohol recovery support service. Located in Nottingham.

Who is the service for?

BAC-IN works with vulnerable adults and families from BAME communities. The service was created in 2003 by people in recovery in response to the lack of culturally appropriate support in mainstream services. BAC-IN has a holistic focus that offers a choice of cultural, faith-based and spiritual interventions to addiction recovery. Many people from different backgrounds access this service such as Christians, Buddhists, Hindus, Sikhs, Muslims, even non-believers, and atheists, there is no judgement, no one is turned away regardless. BAC-IN sees addiction as an issue that affects the whole family therefore their work can involve a lot of family members. People primarily from South East Asian communities such as Indian, Pakistani and Bangladeshi as well as from Dual heritage and Afro-Caribbean communities use the service.

What are the issues clients present with?

BAC-IN are seeing more young people aged 18-30 combining the use of alcohol and cocaine. They have seen a growing alcohol problem within the Punjabi Indian communities. There is a rise in liver and pancreatic damage where the problem is left for so long it becomes life threatening. Females from the South East Asian communities are not coming forward for treatment because alcohol is forbidden and seen as dishonour on the family. However, there are women who are dying from alcohol-related suicide and liver damage and men are dying from alcohol-related illnesses because they don't come forward about their problems until it is too late. This issue is growing partly because of honour and protecting the family name. Shame, stigma and mistrust are common strands in the community that can often prevent people reaching out for help. Shame for the whole family reflects the hiding of the problem which can lead to the situation escalating. There are people suffering in silence and we aim to break this barrier and create an open dialogue where families can get the help they need from a service they trust before problems become too harmful.

What does the service offer?

A peer led approach rooted in the essence of lived experience is at the heart of BAC-IN's guiding philosophy and organisational principles. Cultural identification, cultural empathy and spiritual connection underpin their approach that shape their ability to engage effectively whilst building strong therapeutic relationships with people they support. Relationships are built on mutuality and shared equality. BAC-IN offers culturally sensitive support groups, one to one sessions, counselling, mentoring, family mediation and links in with mainstream services. The support group allows service users to connect

with people of similar cultures, faiths, ethnicities and values which can be lacking in mainstream services. BAC-IN carries out awareness events in BAME communities through places of worship, TV and radio. They have supported the Sikh Channel to raise alcohol and drug awareness, a programme watched by around 400,000 viewers nationwide. They link in with 12 step fellowships such as NA, CA and AA. BAC-IN is great at reaching the people who need it however cuts to their funding has meant that some hard to reach groups such as women are not being reached and encouraged to access treatment.

Conclusions:

We need culturally responsive, culturally embedded services, whether integrated or working alongside mainstream ones. These services must be culturally structured, constituted and self-governing, and possess the capacity to deliver a broad range of culturally responsive interventions, from the point of access, engagement, to completion of therapy and treatment.

Other current issues:

The current literature is not covering the hidden populations who are not in treatment. This literature is influencing commissioner's decisions, service design structures and influences the availability of culturally appropriate support. It has become specialist services versus mainstream services. However, they can both complement each other and the specialist can be an asset to the mainstream. They can share knowledge and expertise wherever one is lacking.

Appendix E: Case Study 3: Shanti

Name of the service

Aquarius SHANTI: Aquarius, part of Recovery Focus, is working to tackle growing alcohol misuse in the Sikh Punjabi community after research from the University of Bedfordshire found that members of this community are 'slipping through the net' of services. SHANTI, which means 'being at peace and taking care of oneself' in Punjabi, has been running for three years thanks to Big Lottery funding and has provided support and advice for people in the Sikh community as well as helping to raise awareness of alcohol and risks of alcohol misuse.

Who is the service for?

The service is for the Punjabi and Sikh community. There is a mix of Punjabi men and women who use the service.

What are the issues clients present with?

Alcohol misuse is a taboo issue in the Sikh Punjabi community and has gone under the radar for a long time; this growing issue has been missed by existing services in Birmingham. SHANTI has connected with communities throughout the area, bridging gaps, providing support and sharing vital information about alcohol misuse and the risks associated with it.

Data collected by Aquarius showed that 16% of people accessing alcohol misuse services identified as Asian or Asian British, but that this group had lower knowledge of the harms of alcohol misuse. The data also showed an increase in incidents of domestic violence, hospital admissions and financial difficulties as a result of alcohol abuse. Since working with the University of Bedfordshire and collecting their own data, SHANTI has seen a growing number of people from the Punjabi Sikh community accessing support for alcohol misuse. However barriers such as language, a lack of awareness and alcohol being a cultural taboo have prevented many people from accessing services. Speaking directly to the Sikh Punjabi community and working past the taboo and stigma surrounding alcohol means they can provide meaningful information and support that will ultimately help families who are struggling with the impacts of alcohol misuse.

What does the service offer?

SHANTI is a community based service for people with alcohol problems. They offer free and confidential bilingual advice and support from non-judgmental male and female support workers, one-to-one support, group sessions, telephone support, home visits and links to mutual aid support groups such as AA and Al-anon. They also offer support to family members who are affected by alcohol misuse and support access to other Aquarius services.

Conclusions

There has been a huge amount of learning, reflection and commitment from all involved in SHANTI to date; unfortunately, a full evaluation of the project is not possible within the existing resources. It is, however, important to harness the successes, challenges and lessons learned, for practitioners delivering alcohol support and for wider health and social care professionals. It is also important for this information to feed into future service commissioning and wider policy decisions which seek to support alcohol services within ethnically and culturally diverse communities. These lessons learnt will do just that, and allow Aquarius to continue sharing good practice and improving access to support for all communities.

Appendix F: Case Study 4: WDP New Beginnings

Name of the service

WDP is the lead provider of New Beginnings; a community-based substance misuse service delivered in the London borough of Brent.

Who is the service for?

New Beginnings offers support and advice for individuals and their families affected by drug and alcohol problems in Brent. The services aim to enable people to live meaningful and fulfilling lives away from substances. They offer a mix of harm reduction and abstinence-based interventions and the treatment goal is always defined by the client.

What are the issues clients present with?

Brent is one of the most diverse London boroughs and therefore houses a large Somalian community as well as Afro-Caribbean, Indian Nepalese, Afghan and Eastern European communities. From these communities a number of individuals access New Beginnings; particularly men from the Somalian community and Polish and Lithuanian drinkers. In addition, drinking is more prevalent among the younger members of these communities as it is more acceptable within our western culture. Core issues associated with these communities are that many religions believe that prayer is the only answer and therefore their problems remain hidden. Additionally, women are much less likely to access help because of the dishonour that this would bring to the family. There are also many Polish people who are drinking excessively and experiencing homelessness.

What does the service offer?

A variety of psycho-social treatments such as one to one support, group support, motivational techniques, women's only groups and afternoons. The service also offers a unique form of contingency management known as the Capital Card, medical treatment, needle exchange, health assessments, harm minimisation advice and, if needed, referrals into community and residential detoxes and rehabs. New Beginnings have also developed strong links with local community centres and mosques to raise awareness around drugs and alcohol and offer advice. The service also works closely with other agencies and support services such as Brent's independent service user group, the police, employment services and homeless charities.

Conclusions

Whilst culture appears to affect substance misuse it is also intertwined with other factors such as how deprived an area is, poverty levels and unemployment. This can influence how acceptable drinking and drug taking is in a community. It is about being inclusive, not about separating people. Specialist services are needed for those who have language barriers but often people from BME groups find it easier to open up and be

honest in mainstream services and they feel they can discuss issues that would not be spoken about in their own communities.

Appendix G: Case Study 5: Anonymous provider 1

Name of the service

This service has requested to remain anonymous

Who is the service for?

The aim of the service is to help people overcome their drug and alcohol addictions. The service encompasses a recovery-based approach as well as harm reduction. Support is tailored to the individual's needs with the hope that the service users will eventually aspire to abstinence. The local community is diverse which is reflected in the people that access the service. There are White British men and women as well as people of South Asian origin including Punjabi Sikh men and others from the Indian and Pakistani communities. Women from these communities also access the service although the proportion tends to be lower than men. There is also a large local population from Eastern Europe, with a high proportion being Polish as well as Lithuanians, Estonians, Albanians and Bulgarians.

What are the issues clients present with?

There is street drinking within the borough amongst a mix of communities such as White British, Polish and South Asians. Domestic abuse is more common when there is alcohol misuse present. Anecdotal reports from neighbouring boroughs suggest that some Somalian men who previously used khat when it was legal in the UK have started to drink alcohol instead. In some parts of the Punjabi Sikh community there is a culture of heavy alcohol use and consequently a significant number access treatment for alcohol dependence. Stigma can be a barrier to accessing treatment for people from all backgrounds and especially for those from the South Asian community. Some women do not access treatment as they fear that social services and other agencies may become involved with their children. The service receives referrals from social services regarding alcohol use and risk to children. A number of Muslim men have attended the service for alcohol treatment even though the public perception can be that the Muslim community don't drink alcohol and won't access support. The service supports people with any substance misuse issues with many accessing treatment for opioid dependence. Opioid Substitution Treatment is one of the main treatments used in the service.

What does the service offer?

The service in partnership with the NHS provides a free and confidential service for everyone in the borough who wants help and support with their alcohol or drug use. They offer: one to one support, groups, links with housing, links with prisons and probation, pathways to community detoxes, pathways to residential detoxes and rehabs, links in with a hospital alcohol liaison nurse and prescribing. The service has volunteers and peer mentors with lived experience of drug and alcohol misuse who are integrated into the service. They support service users through their treatment and recovery journey. There

is also a strong local recovery community with a number of SMART Recovery and 12 Step fellowship meetings taking place at the service.

Conclusions

It is important to understand what a community needs by gathering information about what the community want. This could be using a questionnaire, through local radio stations or by getting in touch with people in positions of influence. Each community has their own needs whether its BME groups or LGBT groups but finding out directly from the community what services are needed is key.

Appendix H: Case Study 6: Anonymous provider 2

Name of the service

This is a mainstream alcohol service that offers support to people affected by alcohol use. The service would like to remain anonymous. Who is the service for?

Adults, families and carers who are affected by alcohol use. There are a mix of clients who use the service but they are predominantly White British men. Others include clients from Poland, India, Slovakia, Somalia, Ireland and various African countries. Just under half of the treatment population are women. They also have a family and carers service. Most clients tend to be in their 30's or 40's and they find it harder to reach younger problematic drinkers. They have a language bank of workers who speak Polish, Italian, Russian, French, Bengali, Hindu, Urdu, Greek, Punjabi and quite a few different African languages. This enables the workers to engage more effectively with clients. They work with various community centres such the Muslim Cultural Centre, the Bangladesh Centre, the Somali Community Centre, African Women's care and the Moroccan Women's Centre.

What are the issues clients present with?

Older clients in their 30's or 40's tend to only access this service when problems start to emerge later in life, for example liver problems. The younger problematic drinkers are harder to reach as alcohol is socially acceptable so many don't come into treatment until they become older dependent drinkers. A barrier for women accessing the service is concern with having their children removed. If they do come in for treatment then they prefer one-to-one work, not group sessions. The homeless population often present to the service but many have no recourse to public funds so they can be offered treatment but they still have nowhere to live. Another common issue is that alcohol use is a hidden problem among many communities and many people are not coming forward for treatment because of the stigma and shame it may bring to their family. Therefore, many communities and community leaders believe there is no problem with alcohol use as it is not spoken about.

What does the service offer?

The service is described as using an "outward facing" approach which operates out in the community and is not project based. To enable the service to be more accessible to those affected by alcohol use key workers meet with clients directly in the community either through home visits, at GP surgeries or at various community centres. The service aims to engage with community leaders to ensure all communities are aware of the services available. They take referrals from GPs, family members and self-referrals. They are a recovery-based service that offers brief interventions and harm reduction advice. They help clients identify their treatment goals (abstinence or reduction) and support clients to achieve them. They offer; assessment referral, advice and information, access to community and in-patient detoxification and residential rehabilitation, counselling,

home visits, specialist key work sessions, support groups including women only groups and Polish speaking groups, family and carer support, training for professionals and health and wellbeing checks.

Conclusions

There is a lot of shame and stigma around people from certain communities accessing treatment or acknowledging they have a problem. Some clients prefer to be treated within their community and others see more anonymity in mainstream services. What is important is to give clients the choice of where they want to access treatment. Funding cuts mean that specialists services have been cut and mainstream services are struggling to develop specialist areas of their service. There is a lot of firefighting going on in services meaning often they don’t have the time or the resources to develop these specialist areas as much as they would like.