ALCOHOL ISSUES AND THE SOUTH ASIAN & AFRICAN CARIBBEAN COMMUNITIES

IMPROVING EDUCATION, RESEARCH AND SERVICE DEVELOPMENT

Mark R D Johnson, Pam Menzies Banton, Harrinder Dhillon,

Gersh Subhra (Project Coordinator)

Juliette Hough, (Alcohol Concern)

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Notes on the Authors

Pamela Menzies- Banton has worked in the alcohol and drug field since 1985, in a range of services. In 1992, she joined Rugby House to work within the Mobile Alcohol Service where she undertook a community engagement programme with BME communities in central London. She has developed and managed New Roots since 1996. She trained as a nurse, holds a qualification in training & development, diploma in alcohol counselling and drug & alcohol policy and intervention.

Harrinder Singh Dhillon has many years of experience in the alcohol field, especially with BME communities in East London. He has managed a counselling service and an outreach development team during his time with DASL (formerly Alcohol East), and has contributed to a number of publications over the years to furthering the work around BME communities and alcohol.

Mark R D Johnson is Professor of Diversity in Health & Social Care, Mary Seacole Research Centre, De Montfort University, Leicester. The Centre for Evidence in Ethnicity Health & Diversity, in collaboration with the University of Warwick Medical school, hosts the NHS Specialist Library for Ethnicity & Health.

Gersh Subhra is the Coordinator of the Research Centre for Community Regeneration at the University of Derby. In addition to lecturing on community development, his work has included researching issues facing new refugee and asylum seeking communities and wider Black & Minority communities. He has also been involved in evaluation resources and undertaken several project evaluations.

Juliette Hough & Anne Jenkins: Alcohol Concern
The authors are grateful for the support and contributions made to this report by Juliette and Anne from Alcohol Concern.

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Introduction:

The Alcohol Research Forum, in its report for Alcohol Concern (2002) sought to identify areas for future research and to show where it existed, what research might assist in dealing with the problem of alcohol misuse. Among its key findings was the observation that past research had pathologised and homogenised the black and minority communities, and had in general failed to lead to effective action to address their needs (Subhra 2002). Much needs analysis was based on poorly conducted research, small samples and outdated studies, and there were significant gaps in the knowledge base. Adebowale's (1994) research, cited there, noted that the activity of service delivery agencies ranged 'from ignoring the issue to paralysis' and the report demonstrates that there was virtually no evidence of research into interventions or evaluation.

This study was commissioned by the Alcohol Education Research Council to ensure that there was no possibility that the recommendations of the Alcohol Concern report were themselves based on an inadequate or outdated view of the field, and to contribute to the debate surrounding the national strategy on alcohol. In particular, we have sought to ensure that we took one of its key recommendations on board, by beginning with communities themselves, and with projects and agencies embedded in meeting the specific needs of black and minority ethnic groups.

In preparing this report, we have drawn on a wide-ranging review of literature related to black and minority ethnic groups, their health and use (or abuse) of alcohol, and all possible identified sources of information relating to this issue. All relevant papers have been listed in a full bibliography and data extracted to a 'systematic-review' type grid to permit ease of access and review of the evidence. Not all items included in that analysis would meet the normal criteria for a systematic review, of peer-reviewed publication. Indeed, some of the community-based studies, practice-based reports and unpublished papers provide greater insight, sensitivity and understanding of diversity issues within the Black and minority ethnic (BME) population (such as language, cohort, and religious and cultural background) than the papers which may have created the 'accepted wisdom' in the field.

Copies of all items located have been filed in a central collection held at the Mary Seacole Research Centre (MSRC) in Leicester for reference, along with items of 'good practice' submitted by agencies seeking to meet these needs.

Alcohol & Black and Minority Ethnic (BME) communities - A Policy Overview

The Alcohol Harm Reduction Strategy for England, published in March 2004, was England's first national alcohol strategy. When the commitments made in the Strategy are followed through, it will begin to address many of the problems caused by alcohol misuse. However, it is particularly poor in addressing the needs of problem drinkers from black and minority ethnic (BME) communities.

Before the publication of the Strategy, the provision of treatment and the planning structure for treatment services were uncoordinated, there were no national targets and there were limited resources. One of the key points stressed by critics was the need for appropriate understanding of, and provision for, the needs of people from BME groups.

In 2002, Alcohol Concern set up a Commission on the Future of Alcohol Services, which brought together commissioners, services providers, service users, and policy and public health professionals, to produce a statement of priorities for the development of alcohol services. One of the areas highlighted by the Commission was the

'failure of commitment to the provision of services appropriate for the diverse communities in this country'

The Commission identified a range of needs for BME service provision. In areas with large BME communities, it recommended investment in open access and outreach services specifically targeting these communities. In areas with dispersed BME communities, it suggested small outreach teams, targeted literature and community development approaches to build awareness, accessibility and trust. It also stressed that developing the capacity of services to engage with families was important when working with those BME groups, which tend to solve problems as communities or within families.

Another finding of the Commission was the need to evaluate various models of service delivery to BME communities – and for this kind of research to be repeated every few years, as the demography and values of BME communities will change over time.

The national Alcohol Strategy was informed by the Cabinet Office's Interim Analytical Report, which acknowledges that

'some groups such as ethnic minorities ... can have difficulties in accessing services' (p.142).
It also states that, although on average ethnic minorities drink less than their white counterparts, this is not necessarily true for all groups on a local level (p.101). It does not investigate the needs of BME groups in any more depth.

Prior to the writing of the Strategy a national consultation took place and again, access to adequate treatment for BME groups was stressed as a key priority for a national strategy by those responding. Amongst treatment services, Turning Point identified

'a need to develop separate information for different groups. Services need to be structured to meet the needs of black and minority ethnic groups and to be sensitive to cultural diversity'.

Likewise, Drug and Alcohol Service for London (DASL) highlighted the need to provide services for

'those BME groups not accessing services'.

The Alcohol Recovery Project (ARP) stressed the need for separate services for people from BME communities, as well as for generalist services which are able to work with diverse groups.

The Alcohol Harm Reduction Strategy for England tackles four key policy areas:

- education and communication;
- identification and treatment;
- alcohol-related crime and disorder;
- and supply and industry responsibility.

The most pertinent areas for BME groups are the first two areas: education and communication; and identification and treatment.

Disappointingly, BME groups are not specifically mentioned in the 100 page Alcohol Strategy document. Many of the Strategy's action points are high-level commitments involving research into need, provision, and its effectiveness, and it will take some time to see how far these prove to take into account, and meet, the needs of BME groups.

Strategies around public information focus primarily on the 'going out to get drunk' culture, neglecting our other diverse cultures, which can require very different messages about drinking. When tackling the education of young people, the strategy commits to research the effectiveness of interventions on alcohol prevention for children and young people, both inside and outside the school setting (p. 35). It has yet to be demonstrated that such research includes consideration of which interventions are most effective for young people from different community groups.

Similarly, there are commitments in the 'Identification and Treatment' section of the Strategy which are key to meeting the needs of problem drinkers from BME communities: namely, more attention to the audit of treatment provision and need. However, the review to date has not been able to find effective demonstration of this having any concern for, or impact on, the needs of minority ethnic groups.

Another commitment in the national strategy concerns the "Models of Care for Alcohol Misuse" (MOCAM) approach. The National Treatment Agency is to develop this framework for the commissioning and provision of treatment services, which will incorporate a review of the appropriateness and effectiveness of different types of

treatment. MOCAM potentially provides a place to acknowledge the difficulties of BME groups in accessing services, and encourage alcohol treatment services to provide appropriate treatment for people from diverse cultures.

Unfortunately, several of the Strategy's key commitments have not yet been met, including the audit of treatment services, the publication of Government targets for harm reduction, and investment for help-giving treatment agencies. However, the development of Models of Care, the evidence base review evaluating the effectiveness of treatment services, and the audit of provision and need, are much needed steps towards an improved alcohol treatment system. The improved services which should result will (it is hoped) inevitably benefit members of BME communities.

In policy terms, Alcohol Concern continues to lobby Government for relevant, targeted information; improved access including the availability of services in different languages; and culturally appropriate treatment for people from BME communities.

Black and minority ethnic (BME) communities in the UK

The latest estimates of the size of the Black and minority ethnic population of Britain can be derived from the 2001 census, which asked a specific question of ethnic origins, and another on religion. BME groups make up 7.9% (one in twelve) of the UK population - 4.6 million people. When confined to the population of England, the proportion of minority ethnic origin rises to 9.1% (one in eleven), of whom just over half (4.6 of the population) are of south Asian (Indian, Pakistani, Bangladeshi, and 'other') origins. People of Caribbean and African origin ('Black') made up 2.3% of the English population: the remainder were of various origins including Chinese, 'Mixed' (i.e. dual heritage) backgrounds, and Others (including Arab and other groups which are not separately identified). Around 1-2 % of the population in England are estimated to be of Irish origin.

As a general rule, it is the case that most people of the BME communities are living in areas of relative deprivation, and that overall, people belonging to these ethnic groups are relatively disadvantaged in social and economic terms, as a result of historical and structural factors, even if individuals have been able to overcome these problems.

The majority of people of BME origin live in the Greater London area or the West Midlands, with smaller numbers in West Yorkshire and Greater Manchester, and other major metropolitan centres such as Liverpool and Cardiff. Relatively few live in rural areas. According to the 2001 Census, 45% (nearly half) of the 'minority ethnic' population lives in the Greater London area, where they form 29% of the population overall. A further 13% of the BME population is resident in the West Midlands region, while they form only about 2% of the population of the North-East and South-West regions, where it may be suggested that services will be least likely to be attuned to their needs. Other major urban areas show the proportion of people of minority origin to be roughly comparable with the national average. Certain minorities are even more concentrated in London - 78% of the population giving their origin as 'Black African' live

in London (largely in four boroughs, south of the river Thames) while nearly two thirds of the Caribbean origin population (61%) is also located in London. Some towns or metropolitan boroughs have become known for local concentrations of people from particular ethnic origins. Relatively large numbers of people from Somali backgrounds live in Liverpool, Sheffield, Cardiff and Birmingham and also Leicester. More than half the UK population of Bangladeshi origin live in the 'East End' of London, mostly in Tower Hamlets. The majority of people of south Asian origin in the northern towns of Yorkshire and Lancashire are of Pakistani origin, many deriving from the Mirpur area of Kashmir.

Best current estimates are that there are more than three million speakers of other languages in England and Wales, but probably only one per cent (300,000) of these have no ability in English. The remainder, however, may only have a very basic understanding of spoken English. Many refugees and asylum seekers have very high levels of education, but their children's education will have been interrupted. The census does not provide data on languages (other than Gaelic and Welsh in Scotland and Wales) and there are few reliable data on language needs among minorities. There is a constantly changing picture with the migration of new groups, including refugees, and the learning process undergone by settlers. At the same time, those who have acquired English as a second language do get older, and often lose this 'learned' ability.

Religion, Culture and Alcohol Use

The 2001 Census was the first modern one to ask a question about religion in England, Wales and Scotland. 37.3 million in England and Wales stated that their religion was Christian, but 3.1% of the population in England were Muslims, and a further 1.1% were Hindu, 0.7% Sikh, 0.5% Jewish, and 0.3 Buddhist. Numbers of Muslims in Britain have been estimated variously at 1 million and two million, compared to the Census estimate of 1.54 million: many of these, however, may not be members of minority ethnic groups. On the other hand, less than five per cent of 'Asian' groups surveyed recently said they had 'no religion', compared to about a third of the white population (Modood et al 1997). About half of the 'Indian' group interviewed in a national survey said they were Sikhs, while a further third were Hindu (Modood et al 1997). Many Vietnamese are members of the Roman Catholic faith, while others are Buddhist (as are many Indians and Chinese, and some Pakistanis). Religion is clearly very important to many people from a minority background, and may be a key part of their ethnic identity. It should be remembered that there are Christians of Pakistani , Bangladeshi and Indian origin.

Adherence to religious values should be discussed further as these do appear to have a strong impact on drinking behaviours. This is further supported by Orford, Johnson and Purser (2003) who also state that

> "*Religious identification appears to be a significant factor in whether second generation ethnic minority group members in England drink or not. For men this is more important than other social or cultural factors. Religious identity is also*

associated with less risky drinking among those who do drink. For women drinking and risky drinking were strongly related to a number of cultural and religious variables, especially identifying less strongly with one's religion and ethnic group…"

Morjaria's work (unpublished, 2003) and with Orford (2002) around spirituality raises significant findings following interviews with men around their drinking and recovery. Morjaria found that most respondents had made use of traditional modes of alcohol treatment such as groups including Alcoholics Anonymous and counselling and that rediscovery of faith and spirituality aided recovery and treatment. For instance, *Amrit*, taking a blessing as a symbolic ritual in Sikhism is seen as a way of joining the 'brotherhood of Sikhism', and *Sewa* or service to the community is particularly noted as being important for some of the male respondents.

Epidemiology of alcohol use and abuse among BME groups.

There is a fairly generally accepted understanding that the level of alcohol use, and misuse, is lower among black and minority ethnic groups (particularly those of south Asian origin) than among the general ('White') population. Insofar as modern lifestyle survey data exist, this pattern is substantiated and repeated. The major sources of modern data are the Policy Studies Institute's 'Fourth National Study' of minorities (Nazroo 1997a, 1997b), the Health Education Authority's second Health & Lifestyles Survey of black and minority ethnic groups (Johnson et al 2000) and the 'Ethnic Minority-booster' study in the national Health Survey for England (Ehrens et al 2001). All of these repeat the finding of relatively low use among most South Asian, and African-Caribbean groups of men, and very much lower use of alcohol among women of all minority ethnic groups, especially females of Asian background and Muslims. Only two studies have considered the Chinese population (White et al 2001; Sproston et al 1999). There are other communities whose needs are even less studied, such as the Cypriots (Theodorou 1992), and we found no references to studies of alcohol among such groups as the Vietnamese, and more recent refugee groups.

Many of the papers reviewed relied heavily on the evidence presented in McKeigue and Karmi's invited review for Alcohol and Alcoholism (1993). This appears to have confirmed, or created, the general impression that average alcohol consumption rates among African-Caribbean men and women were lower than for the national population, as was the proportion of 'heavy drinkers', and that South Asian populations display, if anything, even lower rates of alcohol use, and alcohol-related harms - although for some South Asian communities 'alcohol-related morbidity' was reported to be higher than for the general population. The paper also comments that Sikhs drink more heavily, particularly, spirits, than either Hindu or Muslim men. Nearly all the consumption data was based on studies conducted in the 1980s, beginning with the work of Ghosh (1984) and Nayak (1985), was in a period before the majority of the present population of UK-born people of minority ethnic origin had reached school-leaving or working age, and possibly also including some early migrants before their families had joined them.

Consequently we would not regard these data as being of great relevance to present-day patterns. Further, the 'excess mortality and morbidity ' referred to, relates largely to liver damage (cirrhosis or cancer, mostly) much of which might be related to other 'ethnic-specific' risk factors such as the higher prevalence of Hepatitis B in South Asians. Their data on alcohol-related admission to psychiatric care is even older, and does not appear to be repeated in more modern sources of evidence.

When asked in the HEA survey 'what serious health problems are linked to drinking too much alcohol', virtually no-one said 'none', but a very substantial proportion of Muslims - three out of four Bengali women and over half the Bengali men, 'did not know' - even among the age-group 18-29. 45% of Pakistani women and 30% of Pakistani men gave the same response (Johnson et al 2000). On the other hand, substantial numbers of Pakistani and Indian men and women, and a majority of African-Caribbean respondents noted either liver or kidney disease and heart disease as sequelae (i.e. consequences) of alcohol over-use. Hardly any of the minority group respondents, however, referred to diabetes, blood pressure or cancer, and very few either suggested addiction or mental health problems. Overall, however, there was a poor level of knowledge about the risks of alcohol in all these groups at all ages.

The most reliable large-scale data available on alcohol use among minority ethnic groups are reported in the specially extended round of the health survey for England held in 1999, which included a substantial 'booster' sample of black and minority ethnic respondents and asked a number of questions on alcohol use (Erens & Laiho 2001). This also confirmed that both men and women from all minority ethnic groups (except the Irish) were less likely to drink alcohol: those who did drink, tended to drink less frequently, and smaller quantities on average. As many as one in eight (13%) of African-Caribbean men, one third of those of Indian origin (33%) and nearly all Pakistanis (91%) and Bangladeshis (96%) did not drink alcohol, compared to only 7% in the 'general population'. Among women, slightly more in all ethnic groups, and two thirds of Indian women (64%) were non-drinkers. Drinking levels fell with age - which was presumed to reflect greater 'acculturation' among younger generations of migrant minorities.

Use of other intoxicants, stimulants and drugs

This review has explicitly excluded major consideration of literature relating solely to use and abuse of drugs other than alcohol, and the provision of services, treatment and educational facilities relating to these. There is a considerable body of such literature, probably greater than that devoted to alcohol-related issues, but often coming to similar conclusions (Fountain et al 2003). Use of drugs is (or has historically been) lower among nearly all groups of minority ethnic origin, at all ages, compared to white populations. Services are also less used, although it is difficult to relate the level of service use to that of potential need, and historically, drug treatment and drug education services avoided (or failed to) work with minority ethnic groups, whether because they felt that there was 'no need', or because they felt unable to offer a suitable and sensitive service to those groups (Johnson & Carroll 1995).

Services for BME people related to alcohol use and problems

It is a commonplace for reports on alcohol and ethnicity, as in other studies of minority ethnic groups and health promotion, to note that there are low levels of uptake by, or penetration of, minority ethnic groups in all preventive and supportive services. Orford et al (2003) comment that despite growing levels of alcohol use among 'second generation' migrant populations, among whom language barriers are less of an issue, there remain very low levels of awareness, or perceived accessibility, of sources of advice relating to drinking. Most of their respondents appeared to believe that they might seek help through health centres and GPs, and were unwilling to discuss the matter otherwise outside their immediate family (and generation) or close friendship network.

As risky drinking increases, but cultural ties and barriers remain strong, it is important to consider the degree to which services for BME people with alcohol-related needs are sensitive and accessible to their specific needs. This needs to be at all levels from basic education and health promotion advice, to residential rehabilitation and recovery care. There is, however, surprisingly little attention to this issue to be found in the published literature, in comparison to the levels of research into drinking and harms, although a number of community and practitioner based reports (not necessarily research-based) do criticise the lack of cultural sensitivity and appropriateness of the majority of 'mainstream' services on offer (e.g. Ahmed 1989). As Midgley & Peterson (2002) observe, this is effectively 'Institutional Discrimination' - and as such, illegal under the terms of the UK Race Relations Amendment Act 2000.

It is also important to note that Hyare's (1996) study found community health and welfare professionals had very low levels of knowledge and awareness about alcohol-related issues. This could mean that their clients might be unable to access suitable support and referrals to services, even if there were any that were culturally and linguistically appropriate. Language and literacy were an issue, as was the use of a 'medical model' in the minds of community members, which would render the idea of using a counselling service of less utility or value.

Findings from the Survey of Alcohol Services

We circulated a structured survey to all known services using Alcohol Concern's database: there is no central comprehensive register of alcohol services. From the responses received we are able to state that there are relatively few services which are able to say that they offer a comprehensive service to the whole community. Few 'mainstream' or 'generic' service providers have much competence in dealing with minority ethnic group needs, and very few conduct adequate 'ethnic monitoring' or collect data on the religious, linguistic or cultural backgrounds of their users. As a result, it is almost impossible to state that an adequate level of service is being provided, to establish levels of unmet need, or to be convinced that the requirements of the Race Relations Amendment Act are being observed.

Very few projects reported that they received specific funding for BME work, and none provided budget details although one noted that this amounted to 7% of their budget,

from PCT and a local charitable trust. The majority appeared to obtain their specific funds from 'joint funding' (between health and social care) and several 'BME' projects did not report that they had any specific income for their BME work, or else suggested that they were funded generally, or with difficulty. A number of mainstream, generic services had, on the other hand, made explicit steps to reach and serve BME clients. This indicated that funding was not immediately obviously directly linked to service - although several noted that they would not be able to sustain or undertake outreach and specific project work or employ workers with specialist knowledge without obtaining funds.

A small number of agencies appeared to have compared their data with the current (2001) census data for their region, mostly in areas where there were extremely small numbers of BME users, and they were able to comment that *'as you can see, this reflects the local population'*. Most London respondents did not attempt this comparison.

The majority of respondents used and offered only English: and very few were able to provide health promotion or more advanced information which was translated or could be said to have been assessed as culturally appropriate for minority users. None were able to provide data on the number of times a language-specific service, or interpreter, had been provided. From inspection, it does not appear that the provision (or absence) of a service necessarily relates to the linguistic diversity of the catchment. Similarly, excepting those centres where an 'ethnic-specific' service was offered, very few agencies had stocks of, or access to, materials in languages other than English. Provision of interpretation, and translated materials, are heavily tied to the employment of staff with appropriate language skills. The same could be said of outreach to address the needs of under-served populations and minority cultural communities.

One of the fullest and most successful responses noted that they were able to employ a specialist outreach worker who
'Targets BME groups, community groups, special events, access points, works through established networks and organisations and also holds drop in sessions at various BME-friendly locations'

A similarly active Centre recorded
'Outreach, community engagement programmes, workshops, meetings, we hold forums, invite communities to our team meetings, talks, events - mela, carnival etc. We base our services in the community'.

Exceptionally, one agency noted that targets had been set in their three-year business plan to increase the proportion of BME service use. This had resulted in the securing of additional funds and recruiting an Asian Development Worker.

It does not seem that any groups have yet felt the need to adapt their admission or inclusion criteria: none suggested that they would use different protocols to assess risk or need for a service, or had developed alternative or culturally specific assessment procedures.

A number of issues were raised in relation to training, both in terms of the funding available to recruit and train staff, and in respect of locating adequate and appropriate training: most specialist agencies had to develop their own training programmes, and were then offering these to other groups.

It does not appear that there was any active hostility to ethnic diversity, and many agencies seemed to be making positive efforts to break down barriers and make themselves open to users from minority groups. Some of the most positive responses came from areas which were not customarily associated with multi-cultural, multi-ethnic populations, especially when considering the lack of responses from some major cities where we know there to be alcohol services and minority ethnic communities who are not accessing them.

`All of these issues arise and we are seeking communication and training in cultural diversity to enable us to respond as effectively as possible to the needs of the BME community. In short, we want to be a 'culturally competent" service.`

The following comments were also recorded and are self-explanatory!

A white worker in an all-white service noted:

`For our service to develop in order to reach out to BME communities we would need funding to research the need in our catchment area. We would need funding to recruit and train specialist workers from BME communities. There would need to be investment in interpreters, translation and staff awareness as we are currently 100% white British and therefore by definition (sic) not sufficiently racially aware to effectively retain staff or work with BME communities. In other words, it would require substantial investment … and therefore substantial investment in alcohol services`

`Asian, and Indian communities in particular are highly individualised. The stress is therefore on personal knowledge of the worker delivering the service ….`.

A Black worker in a generic service expressed a very disillusioned position, which may merit consideration:

`BME communities have enough challenges in their day to day lives, such as employment, mental health etc. Alcohol, though problematic for some individuals in the community as for their white counterparts, may actually be very low on their agenda as a problem that can be resolved through counselling. Such a model of helping is strongly Eurocentric and smacks of ... interference. It can seem like an opportunity to further embarrass, judge and shame them by 'white services'. Equally, black counsellors and helpers in white services may never be trusted even if it was known they existed and could offer help. In order to be in this field, a black counsellor has to adopt a Eurocentric language and perspective - others in the BME can see this. Also there always seems to be

the implication that some of our BME have a problem with alcohol. The research suggests a different attitude, style of consumption than that of white society. Is there a problem? Does it show itself in mental health and the criminal justice system or in Black religion and family support networks?`

Issues of Language and Culture in Alcohol Education and Health Promotion

Developing Health promotion and health education strategies in the alcohol field with BME communities is a challenging task. This may be illustrated, for instance, in Newham, East London where over 40 languages are spoken and where, if the Local Authority translates anything for public consumption it does so in a minimum of 9 languages. The 'Basic Skills Unit' offers a best estimate of some 3 million speakers of other languages in England and Wales with 300,000 with no ability to speak English.

The challenge for alcohol education and health promotion specialists is that some of the evidence suggests that messages such as promoting "sensible drinking" may be more favourably received if delivered by peers from within the BME communities. However, concepts such as "izzat" (shame) and silence around alcohol (and drug) problems may potentially be a hindrance to speaking to someone from within one's BME community for fear of being exposed and/or negatively labelled. Many health promotion messages (including alcohol education/promotion) are deeply rooted in Western ideologies, such as the pursuit of individual needs and choice, rather than consideration for family and religious duties. In some cases the messages heard by the BME communities can be lost or even wrongly interpreted (Bhopal and White, 1993).

- there is a clear need for culture-sensitive health promotion material for members of the BME communities
- health promotion material about alcohol use should be available in community languages
- although language may not be such an issue for younger drug (*and alcohol*) users, material in community languages is needed to inform parents.
- the use of audio-visual materials such as community language videos should be considered

Developing Cultural Competence within alcohol services

Culturally competent services embrace the principles of equal access and anti-discriminatory practices in the delivery of their services. Culture is not just about ethnicity. A narrow definition of culture focusing just on ethnicity limits its usefulness in practice. A useful description of this complex concept comes from nursing practice in America:

"Culture refers to the learned values, beliefs, norms and way of life that influence an individual's thinking, decisions and actions in certain ways"
(Leininger, 1991).

This formula, however, risks becoming restricted to a view that 'learning about' the cultures of individuals or groups is sufficient, rather than a commitment to exploring and examining the ability of the organization and its staff to meet the needs of a diverse community, and examining its own internal culture. From this, we may proceed to a definition of Cultural Competence, while noting that culture is dynamic, that it changes and evolves over time and that everyone has a culture.

Cultural competence occurs when

'Knowledge, information and data about individuals and groups is integrated and transformed into clinical standards, skills, service approaches, techniques and marketing programmes to match the individuals' culture and increase both quality and appropriateness of health and health outcomes.'
(Davis 1997).

It is argued that all mainstream services should be culturally competent in dealing with all sections of the community. In areas where it is difficult to introduce a specific BME service it becomes even more important for services to embrace cultural competence.

The principle of cultural competence was cited as important by agencies as it enabled them to respond to the needs of the communities and affect change. Cultural competence seeks to identify and understand the needs and help-seeking behaviours of individuals. Practice is driven by delivery systems and by culturally preferred choices not by culturally blind or culturally free interventions.

Legislative Frameworks, Quality Standards and Guidance

There are a number of laws and guidance documents or other forms of regulation which affect the general and specific duties and obligations for agencies to develop their cultural competence:

QUADS Quality in Alcohol and Drug Services

The QUADS organisational standards manual provides alcohol and drug services with an assessment tool to help them develop quality systems within services. QUADS are a set of "comprehensive standards which services can and should meet" (QUADS 1999).
In particular Section 2: Core service user charter standards: Standard 19 Equal Opportunities specifically addresses equality in terms of workforce development and service delivery.

Race Relations (Amendment) Act 2000 (RRAA)

The Race Relations (Amendment) Act 2000 placed a general duty on public authorities, and lays down the government's expectations for public authorities to pursue race equality within all their processes and outcomes:

It is therefore unlawful for public sector organisations to discriminate by:

- Refusing their services to people on the basis of ethnicity;
- Giving services on less favorable terms or conditions that offered to people of other racial groups
  (Diversity Manual Home Office 2003)

The DAT strategy and service delivery are included in this act.

The general duty requires due regard to the following 3 factors: the duty to -

- Eliminate unlawful racial discrimination;
- Promote equality of opportunity between persons of different racial groups;
- Promote good relations between persons of different racial groups

National Service Framework/s (NSF)

The mental health NSF states that mental health services need to develop and demonstrate cultural competence. It also states that services must be planned and implemented in partnership with local communities and must involve service users and carers. Consultation with BME communities is essential, but must be linked to implementation so the learning is not lost.

DANOS - Drug & Alcohol National Occupational Standards

DANOS are specific standards of performance that people in the drug and alcohol field should work to. They cover three areas:

1. The Delivery of services
2. The Management of services
3. The Commissioning of services

They also describe the knowledge and skills workers need to perform to the required standard (Unit AA4: Promote people's equality, diversity and rights). This standard recognises that these areas often have a number of competing tensions; with people themselves; between people and between people and organisations.

<u>Implementation in Practice: Good Practice case studies</u>

Most of the services stressed that they endeavour to avoid making assumptions about client's cultural identity as there are many factors influencing this, including generational, gender, where they live, and level of integration within British society. The nature of past and current racism within generic but predominantly white service delivery agencies has been to over-categorise and simplify the identity and needs of BME

communities. Avoiding this is a key starting point to an accurate assessment of needs and issues facing BME communities and clients.

Agencies providing higher level services who were interviewed for the study offer a range of interventions. From their experience they have found great value in the following model:

- Take every opportunity to present ourselves to the community
- Have staff from the same communities enabling linguistic understanding.
- Good relations and trust of the local community has been build over the years
- We have a cultural understanding of our clients
- Having an understanding of the political, social and cultural lives of their clients, “The culture and ethos of the organisation is not white, we understand the power, cultural structures, political structures of the community and take a systemic view.”
- Quarterly user consultation event
- Understand that there can be a lot of tension between family members and that family can be a barrier to treatment, so working with them is essential.
- Offer complementary therapies

“ You have to be flexible and creative, you work on the edge of counselling practice sometimes, you can’t be rigid” Clients come to us having been labelled, any rejection by us is reinforcing”

Key issues in developing services for BME communities:

i. Gender

Women maybe experiencing cultural conflict, mental health problems, intergenerational conflict, arranged marriage and domestic and sexual abuse. For drinking mothers the fear of losing their children if they involve professionals in their lives is great. This is compounded by their everyday experience of racism and inequality and leaves them feeling powerless.

ii. Language

One of the main barriers to accessing the service for all services was the ability to offer a provision in the mother–tongue of the client. This was especially important if the client was not confident in their use of English or didn’t speak English at all. The use of interpreters has its limits and in some cases workers stated it hindered the process. The gender of the interpreter was an important factor as was their attitude towards drug and alcohol use and misuse. Avoiding the interpreting process becoming `contaminated` by judgmental attitudes is very difficult and raises the issue of the selection and training of translators. This was especially important when considering the needs of newly established BME communities Generally the survey showed that there is a lack of

instruction or training for workers within the field to learn how to use translators and get the most out of this intervention for the client and themselves.

iii. Working with family members

All services cited the need to work with family members and were offering some level of family support including individual brief solution-focused work, couple work, open support group, telephone help–line and Systemic Family Therapy. They also indicated the need for alcohol services to be aware of the key differences between the different BME clients and their family structures compared to that of white clients. There was a need to understand the tensions that drinking can have upon the members of an Asian family and how the family can also hinder help-seeking, the retention in and outcome of the treatment.

iv. Working with communities

There was a lot of evidence from the agencies interviewed of the networking (and outreach) being done within the BME communities. Indeed, all stated that without this element to their work that they would struggle to get clients to the service. Raising the visibility of the agency and the services available was seen as essential. The service needed to be valued by the stakeholders (service users, local communities, other service providers and commissioners). The building of the trust takes time and most services had been working in this way for years.

The key components of the strategies being utilised by the agencies interviewed were:

- Inform the community about the service

Workers stated that within many BME communities there is a lack of knowledge about alcohol dependence and related problems and the range of services available. This led providers to be proactive and to attend locality forums, meetings and visits to BME groups, stalls at events and fairs such as, carnival, Mela, health fairs and Saturday school prize giving etc. Being visible was seen as important.

- Learn about the community

Gain understanding of how the diverse cultural and religious issues affect interventions, providing training and support for BME community groups and services to improve skills, knowledge and confidence and enable discussion and debate inform of services and models of intervention.

v. The use of satellite venues

Some services have taken their services out into community venues and see much value in this.

vi. Trans -cultural Counselling

D'Ardenne and Mahtani (1989) define this in the following terms:

"Transcultural counselling is not about being an expert on any culture, nor does it adhere to a particular school of counselling. Rather, it is a way of thinking about clients, where culture is acknowledged and valued."

A transcultural model assumes and recognises that each culture has strengths and weaknesses. Sue and Sue (1999) identified the components of a culturally skilled counsellor within 3 broad areas:

1. Beliefs/ Attitudes – the counsellor is aware of his/ her own set of values and assumptions and how these may influence their perceptions of members of other cultural groups.

2. Knowledge- the counsellor is aware of the sociopolitical history of the cultural group and has information on the values and characteristics of the group.

3. Skills – A culturally competent counsellor should have a wide set of intervention strategies and means of communicating effectively with culturally different clients. Counselling skills such as empathy need to be changed form primarily individual focus to one that also includes family and environmental variables.

viii. Funding of services

The requirement of good commissioning is to consider BME needs when developing the drug and alcohol treatment strategy as a whole and commissioners are responsible for any purchasing decisions and these decisions need to ensure race equality. They also have responsibility to monitor services and assist them towards meeting local need and from services that have equal opportunities policies and anti-discriminatory practices in place.

Most of those interviewed for our review stated that one of the most de-motivating issues was short–term funding. This made it hard to plan and meant that trained staff often left. This lack of investment was undermining their efforts. Some put this down to (at the time) the lack of local and national alcohol strategy, which has left their services vulnerable. There was also a lack of understanding from their commissioners that reaching the community was a long process.

Recommendations

A. Working with other services

- Build strong operational links and protocols with tier 2 services. These links and protocols need to be more flexible than the Models of Care Pathways.
- Build strong operational links and protocols with community groups, establish learning opportunities from them and to offer capacity building on alcohol & drug related issues.
- Adapt service models from good practice initiatives in the mental health sector.
- Develop and maintain flexible referral procedures, which are client focused.
- An outreach strategy should include the promotion of tier 3 and tier 4 services to the BME communities
- Attention is needed to the needs of newly arrived communities such as asylum seekers, refugees and migrant workers, all of whom are vulnerable to developing alcohol problems and may not be eligible for personal social security funding but create demands on services.

B. Working with communities

- Look to the demographic breakdown of the local DAT area.
- Involve the local BME community groups in the development of the service.
- Offer the community through their groups and organisations the following:
    - i. information on alcohol and alcohol related issues
    - ii. Information on treatment models, local services and how to access them
    - iii. Information on Community Care and Primary Care Trusts
    - iv. Local forums where alcohol related issues can be discussed and solutions found

C. Organisational development

- Develop robust anti-discriminatory practice across the organisation
- To review the Equal Opportunities policy in relation to capacity- building and work force development in terms of:

i) Ethnically balanced staff group
ii) Training requirements and opportunities
iii) Recruitment procedures

- To gain an understanding of other "world views" and counselling models
- Train local translators on alcohol related issues, terminology and attitudes.
- Consider language skills across the organisational context, skills may be available within the workforce but unknown to the team or agency.
- Develop a Mission Statement, Organisational Context, Aims and Values that enshrine all the factors which define Cultural Competence.
- Organisations can benefit from undertaking a self audit or peer audit against the Race Relations Amendment Act 2000.

D. Working with the client, family and carers
- Develop an assessment process that is culturally sensitive, asks about their culture and spiritually and make it relevant to the care plan.
- Understand the family structure, dynamics and gender roles. Use this as a guide.

E. Commissioning and Leadership

- Commissioning within PCT's and Crime Reduction Partnerships that have a responsibility to commission culturally competent services. This can be made explicit in:

i. Tender documents
ii. Contracts and Service Level Agreements

- Commissioners can invest in services becoming culturally competent by providing them with the funds and giving them time to implement changes.
- Demand ethnic monitoring

F. Treatment Programmes

- There is a need for greater evaluation of the effectiveness of "stand alone services" and generic services in relation client outcomes.
- Exploration of mixing Eurocentric approaches with "other world views"
- Incorporating the client's culture references and religious needs within the care plan and programme to increase reintegration into the community and restore self efficacy and self esteem.
- Consider working with families and carers
- Consider more complementary therapies
- Review policies and procedures against cultural competence model and frameworks
- Counselling is a new phenomenon for some BME people; time should be given to induct people into the concept.
- Undertake Trans-cultural counselling training, so that culture can be acknowledged and valued.
- Allow time for clients to undertake religious adherence, keeping important religious days free of essential elements of programmes. Incorporate this into the care plan.
- Develop closer relationships with BME groups and services.
- Seek guidance from local BME groups on elements of the programme to enable it to be appropriate and inclusive

This report has attempted to provide a broad overview, which focuses on the BME communities and the alcohol field in relation to research, education and services for BME communities.

There are examples of good practice throughout the alcohol field and these have been achieved with limited and often time restricted resources. Agencies such as new Roots, ARP, CHOICES, Each, DASL, Aquarius and at a national level Alcohol Concern have all demonstrated a pioneering commitment to making innovative progress through the conducting of research, development of services, resources and educational materials. Crucially agencies like these have engaged actively at a policy level in order to push for and then critique the national alcohol strategy.

Research Priorities

The literature review within this report echoes the point made by Waller and colleagues (2002) and every previous review, who argue that there is no systematic review level evidence for many relevant issues, including the effectiveness (or otherwise) of alcohol-prevention programmes targeting younger people 'due to lack of methodologically sound studies and methodological rigour'. We would support this in respect of nearly all aspects of the study of alcohol and black and minority ethnic groups, where much published research is essentially descriptive, or relies on poorly theorised and poorly described constructions of ethnicity and culture. For many of the articles reviewed, much of the evidence is drawn from older studies based on earlier cohorts of migrant populations, at a time when communities had not emerged and evolved into the present-day setting (such as McKeigue & Karmi's 1993 review). Waller's HDA review also notes that:

> *Primary research is needed carry out brief interventions to reduce alcohol misuse and evaluate their effectiveness among minority ethnic groups, particularly among Asians and African-Caribbeans (sic), as well as religious groups*
>
> *The effects of community approaches on different groups of the population needs investigation. It is particularly important to consider the extent to which programmes reach or include identified 'at risk' groups ...*
>
> *A systematic review / meta-analysis is also needed for brief and extended brief interventions relating to minority ethnic groups ...*
>
> *A systematic review is required on the impact of workplace interventions to prevent alcohol misuse among minority ethnic groups ...*
> (Waller, Naidoo, Thorn 2002)

Subhra's review for the Alcohol Research Forum in evaluating the gaps in research relating to black and minority ethnic groups made the following recommendations for future research (which have yet to be improved on or implemented):

> *Studies to further understanding of the factors and processes involved in heavy single-episode drinking within these particular (BME) communities*

Research to examine the impact and effectiveness of community safety and public health campaigns

Exploration of the relationship between alcohol use and risky behaviour

Examination of the effect of a person's drinking on others, in particular women partners

Research to assess the extent to which mental health and other (hospital) services are being considered when a person actually requires alcohol services

Studies analysing help-seeking behaviour

An evaluation of the responses being made by GPs to alcohol issues being presented (to them)

Research (into) ways of promoting talking and counselling as routes to tackling an alcohol problem as opposed to seeking a medical solution

(Subhra G 2002 Alcohol Concern 2002 :143)

A key and ongoing area of research priority is to consider the degree to which services for BME people with alcohol-related needs are sensitive and accessible to their specific needs, at all levels from basic education and health promotion advice, to residential rehabilitation and recovery care. There is, surprisingly little attention to this issue to be found in the published literature, in comparison to the levels of research into drinking and harms, although a number of community and practitioner based reports (not necessarily research-based) do criticise the lack of cultural sensitivity and appropriateness of the majority of 'mainstream' services on offer.

Development of Alcohol Services: Consolidating the work of the `pioneers`

The impact of a number of the pioneering alcohol agencies such as EACH, DASL, Aquarius, New Roots and Tacade has been to provide inspiration and motivation to others with the development of services and resources. Some of these agencies have found the resources or time to write about and disseminate their experiences and ideas. It is, however a reality that a significant proportion of sharing of good practice is `lost` because many agencies operate within a context of insecure funding and this dominates the agenda. To evaluate, write about and disseminate good practice experiences takes time and resources!

The proposal here is to encourage an initiative, perhaps prompted at a national level by an agency such as Alcohol Concern to highlight the innovation in the development of BME services. This national strategy should aim to provide support for :

- the promotion of, what has often been called `Beacon` services in other discipline areas such as Mental Health and Education. The innovation pioneers would be supported to highlight their experiences and strategies in making significant in-roads into the needs and issues facing BME communities
- the highlighting of this work should include for instance, publishing of material, training events and consultancy
- evaluation of the work of these pioneer agencies should be carried out with the intention of identifying the key `ingredients` of their strategies which result in an improvement in services of their own and that of mainstream agencies. This type of evaluation should be seen as being distinct from that which funders often require and aims to secure narrow statistical evidence of impact.

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