

**ALCOHOL ISSUES AND THE SOUTH ASIAN & AFRICAN
CARIBBEAN COMMUNITIES**

**-IMPROVING EDUCATION, RESEARCH AND SERVICE
DEVELOPMENT**

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Andy Stonard-Rugby House

The authors are grateful to Andy for writing about his personal and professional experiences as a white manager involved in the development of BME alcohol services.

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 Much needs analysis was based on poorly conducted research, small samples and outdated studies, and there were significant gaps in the knowledge base.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was no possibility that the recommendations of the Alcohol Concern report were themselves based on an inadequate or outdated view of the field, and to contribute to the debate surrounding the national strategy on alcohol.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.

This document will aim to investigate current knowledge about alcohol use and misuse in the South Asian and African-Caribbean communities and, in particular to:

- explore specific needs in relation to education and service provision;
- review current service planning and provision in the light of any identified needs;
- review current research initiatives and their relevance to the South Asian and African-Caribbean communities and to identify gaps;
- consider the appropriateness of current research frameworks;
- an overview of the capacity for research within these communities.

Once this overview is apparent, gaps can be identified with clear preliminary recommendations for future policy and practice.

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.

The report starts with a policy overview which contextualises the findings of the survey and this takes on added emphasis, given the 'flurry' of activity over the last two years at the national level, instigated both by Alcohol Concern and the government.

1. Alcohol & Black and Minority Ethnic (BME) communities

-A Policy Overview

(Juliette Hough, Alcohol Concern)

Introduction and a historical context

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. Alcohol Concern had been lobbying for over 20 years for a coherent approach to alcohol problems based on clear standards and care pathways, and a significant increase in resources to ensure that alcohol treatment services were able to cater to demand. One of the key points stressed was the need for appropriate understanding of, and provision for, the needs of people from BME groups.

Commission on the Future of Alcohol Services

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', and it stated that 'one measure of the success of a national alcohol strategy will be its ability to respond to this challenge'.

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 Development of a National Strategy

The Alcohol Strategy was informed by the Cabinet Office's Interim Analytical Report, which gathered a range of facts about alcohol. This report 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

The Strategy 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.

Education and communication

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 is to be hoped that this research includes consideration of which interventions are most effective for young people from different community groups.

Identification and treatment

There are two commitments in the 'Identification and Treatment' section of the Strategy which are key to meeting the needs of problem drinkers from BME communities:

- i. The audit of treatment provision and need.

This, the Government says,

'will provide information on gaps between demand and provision of treatment services and will be used as a basis for the Department of Health to develop a programme of improvement to treatment services'
(p.47).

It is to be hoped that the gap between provision and need for BME groups is identified in the process, and, once identified, will be addressed – and, crucially, funded.

ii. Models of Care for Alcohol Misuse (MOCAM).

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.

Alcohol Policy – Looking Forward

Unfortunately, more than a year on from publication, there is still no sign of the Strategy resulting in investment in alcohol treatment services, which is much needed. 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 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. The next year will be critical in showing how far the Government will meet its commitments to improve alcohol education and treatment, and how far these will address the needs of people from BME groups.

2. Search Strategy

An inclusive approach was taken to searching for relevant information. We were particularly concerned to ensure that in addition to all 'peer reviewed' reports in established academic and clinical journals being located through traditional techniques, we should also locate as far as possible other sources of reliable evidence from the so-called 'grey' literature; of practice and unpublished research studies, notably those coming from community and alcohol service project bases. Using standard searching tools, all articles relating to black and minority ethnic groups ('ethnic') and alcohol use or services to deal with problems relating to misuse of alcohol, and health educational activities relating to alcohol, were identified in the major electronic databases: - Medline, Cinahl, and social science databases such as ASSIA, as well as the King's Fund Library. We also had access to a number of specialised research bibliographies - notably that of Dr Asesha Morjaria (Mary Seacole Research Centre); previous studies by team members and their personal collections. We also visited and accessed research reports in the libraries of Alcohol Concern, Alcohol Education Research Council (AERC) and Aquarius alcohol agency in Birmingham. Internet searching proved to provide little UK relevant materials, but we did access some data from major national surveys in this manner, including that in the 1999 Health Survey for England, which included some questions on use of alcohol.

Waller and colleagues (2002) have compiled a meta-review of reviews relating to the prevention and reduction of alcohol misuse for the Health Development Agency's 'Evidence Briefing' series. This lists the harms related to alcohol use and abuse, and evidence relating to trends in alcohol consumption in Britain, but was essentially confined to an overview of existing review articles. It makes the point 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 echo this statement 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)

These findings also echo those of Subhra's review for the Alcohol Research Forum in evaluating the gaps in research relating to black and minority ethnic groups. (A summary of this review is included later in this report).

Recommendations for future research made by Subhra include:

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

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 :22 - see also the combined recommendations of Alcohol Concern 2002 :143)

We would not disagree with any of these comments, and would note that during the search for materials undertaken for this review, we have not identified any papers which would enable either of the two reviews proposed by Waller and colleagues to be undertaken. There is clearly a need for more, and better, primary research, as Waller and colleagues as well as the Alcohol Research Forum also suggest. We would also comment that the 'mainstream agencies' needs to become more alert to the needs of an increasingly diverse society. Through this it may discover new models of greater applicability to the majority community. One weakness of the Alcohol Research Forum report (Alcohol Concern 2002) was the virtual absence of 'diversity' from any of the chapters other than that by Subhra, dealing explicitly with this population at risk. More recently, a strong criticism was reported of all alcohol-related health promotion interventions, in a review of the national alcohol harm reduction strategy Prof. Martin Plant observing that he also sees most 'generic' interventions as being poorly grounded in evidence-based practice: at best most are 'purely experimental'

..." such initiatives need to be carefully evaluated ..."
(Plant 2004: 905)

A search of the National Research Register (the main index of currently-funded health service research maintained by the NHS: issue 2, 2003) conducted for this review located only one study that appeared to relate to these needs - and this (in the name of

Prof. Beevers of Birmingham) was a re-analysis of data from Birmingham based studies, including those which had formed the basis of some of the work reported in McKeigue and Karmi's 1993 paper. The principal aim of that study was to examine the relationship between alcohol intake and blood pressure, and mortality, but not to examine other aspects of lifestyle, or to undertake new primary data collection. Nearly all of the other 17 studies located using the standard key-word search items (Ethnic and Alcohol) related to mental health or substance misuse (three were linked projects related to the Beevers INTERMAP/INTERSALT factory screening study). Others, if they mentioned ethnic minorities at all, were more likely to be concerned with the Irish community, a group explicitly excluded from the terms of reference of this study. From this we conclude that there is no major activity being centrally funded that relates to, or answers the needs expressed by, the Waller et al 2002, or this, review.

3. Black and minority ethnic (BME) communities in the UK

Institutional racism has led to entrenched inequalities being experienced by BME communities in accessing health and social care services in Britain (Atkin and Ahmad, 1996). Existing services have often been culturally inappropriate in terms of a lack of BME staff, knowledge of cultural, religious and language needs, activities and policy. If this is combined with service users lacking awareness of what services offer, then the low take up in services by the BME communities is the inevitable outcome.

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. These provide more robust estimates than those obtained from the 2000 Labour Force Survey (still using 1991 census group categories). This suggested there were just over 4 million people living in Britain who considered they are from a minority ethnic group, or 7.1 % of the UK population. Best current estimates, for midyear 2001, are that 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. Examples of these facts can be easily drawn from the most recent national census of population: and a variety of other publications:

- The Pakistani and Bangladeshi communities show much lower employment rates and higher unemployment rates (Census 2001)
- Drug misuse is more prevalent amongst those experiencing disadvantaged circumstances/ social exclusion (Smart & Osborne 1994)
- Black Caribbean people report poorer health than average. (Census 2001)
- BME prisoners form 20% of inmates in England & Wales, yet only 6% of the population is from the BME community. (Minority Ethnic Issues in Social Exclusion and Neighbourhood Renewal 2000)

Geographical distribution

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 Vietnamese population, many of whom had been refugees in the 1960s and 1970s, have mostly moved to live in London, with smaller numbers in towns such as Nottingham and Derby. Similarly, Leicester has become known as a town whose economy has grown since the resettlement of Asian people (many of them, Gujerati speakers) seeking asylum from events in east Africa in the 1970s, and the 2001 census shows that over a quarter of the population is of 'Asian-Indian' origin.

Birmingham has large populations of Punjabi, Pakistani (and/or Kashmiri) background, as well as a significant population of Caribbean background. The largest numbers of people of West African background are found in southeast London. 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.

Language

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. Recent estimates suggest over three hundred languages are used as 'mother tongues' in London speaking a language, however, does not always imply literacy in it, nor lack of English. This is likely to have increased as a result of recent settlement of refugees and people seeking asylum. Levels of skills in English also vary, both between people speaking different languages, and also from town to town between people who appear to be of similar ethnic origin. On current data, (Asian) minority ethnic women especially in Muslim cultural groups, are the least likely to speak or read English: they may also not be literate in their 'mother tongue'. Some languages, notably the Sylheti dialect of Bangladesh, do not have an agreed written form. Those who can speak Punjabi or a dialect variety of it, including Kashmiri forms such as Pahari and Mirpuri, may not be able to read it, or only to read in either Urdu or the 'Gurmukhi' (Devanagiri) script.

Religion 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.

When one considers the South Asian and African Caribbean communities and their relationship to alcohol, then religion and its impact must be given serious consideration. Some of the earlier studies are helpful in gaining insight into what these diverse communities think, feel, believe about alcohol, its use, misuse, promotion and to what extent it matters, and in considering the question 'for whom and where would you go for help?'. Religious texts and scriptures are interesting here as Ghosh (1984) highlights, in that all the major faith groups, (i.e. Buddhism, Christianity, Hinduism, Islam and Sikhism) are generally, if not totally, prohibitive of the use of alcohol and in some cases other intoxicants.

Adherence to religious values should be discussed further as these do appear to have a strong impact on drinking behaviours. Early work by Nayak (1985) indicates that class and accessibility to alcohol were factors in drinking patterns among higher-class families and those in the armed services, a profession which in India even today is considered as having merit in terms of status. Some areas of Indian life were traditionally organised culturally and structurally around alcohol use. A visit to an Indian barracks at Philluar in the Punjab some years ago demonstrated this fact starkly in the nature of the canteen. It was constructed with two separate entrances and buildings, one catering for strict vegetarians and the other for those who ate meat (but not beef) and drank alcohol.

In contrast the rural poor of India were seen according to Ghosh (1984) as mainly abstainers from alcohol. This appears to be in contrast to the situation in the UK at the turn of the century. Dickensian London is portrayed as awash with alcohol among the poorer classes, and certainly the Salvation Army and its anti-drinking campaigns had its roots in the east end of London where many low-income families lived (at that time: local populations have changed in many ways).

Cochrane and Bal's (1990) study and Cochrane (1999) looked at male drinking patterns of South Asian and African Caribbean men and found that increased religious attendance resulted in lower levels of alcohol consumption and therefore less problematic use. 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..."

In a review of alcohol services for the Asian and African Caribbean communities for Alcohol Concern (1995) one of the present authors wrote about the provision of mother tongue counselling at the community alcohol service in Coventry in 1991. This resulted in an increase of referrals to the service from 9 in 1991 to 55 in 1992/3. 80% of those referred wanted to see a mother tongue speaking alcohol counsellor (Dhillon, 1994). What was not mentioned in that report at the time, as it did not directly relate to the point being made, was that of the two workers in post, one was a on the board of the local Hindu temple and the other was the daughter of a prominent local Sikh family. Their status within the community was an important element in their impact.

An individual's religious affiliation and adherence to religious values can have links with alcohol use, even though the research is limited in demonstrating this. Hay et al (2001) cite the research conducted by Cochrane and Bal (1990) which only interviewed Asian men in the West Midlands. They note that of the Sikh and Hindu men that attended a Gurdwara or Mandir (temple) at least once a week some still reported drinking between 20-23 units per week, whereas none of the Muslim men who attended the mosque regularly reported any drinking. Hay et al (2001) note that the sample sizes in these studies are quite small for any meaningful comparisons. These ideas will be taken up in the case studies later in this report, describing South West Hertfordshire Alcohol Advisory Centre, Aquarius, New Roots (Rugby House Project), Choices (ARP) and Drug and Alcohol Service for London (DASL formerly Alcohol East).

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. This is a fascinating area for discussion which was recently considered by the Centre for Ethnicity and Health at University of Central Lancashire (2003) on behalf of the Department of Health. Their research around BME Drug Misuse Needs Assessment found that substance misuse (including alcohol) was perceived by many as a departure from religious, family and community values. One person interviewed in East Birmingham stated that

"It is common at least that parents usually would send their children to their own homeland of Pakistan or Kashmir if there was a drug problem..."

We can see how alcohol abuse may be a substitute activity for religious observance, and thus understand Morjaria's observation that there is strong evidence that for many Asian people recovering from abuse (or heavy use) of alcohol, rediscovery of their religious roots has been a major support factor. The practice of rituals, the reminding of duty, and participation in activities (including 'sewa' or service) all contribute to positive reinforcement against alcohol use and abuse. Many South Asian people are reported to

have been able 'spontaneously' to remit from being alcohol-dependent, through this means (Manik 1997) .

Indeed we understand that Iqbal Hyare of the Manchester Alcohol Service is close to agreeing the establishment of an alcohol clinic in the Punjab, India with the co-operation of partners both in India and the United Kingdom offering tier 3 and 4 services, structured and residential treatment for alcohol problems. The emphasis perhaps is on the offering of alcohol treatment in a context of what constitutes 'home', that is with a perceived closeness to religious and cultural values. This has been significant in recent debates around the possible establishment of a residential treatment facility in West London, East London or the West Midlands targeted specifically for the Asian communities around detoxification from alcohol and drugs.

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.

The Health Education Authority survey of 'health and lifestyles' of black and minority ethnic groups conducted in 1994, and analysed by Johnson et al (2000), did not ask a specific question on alcohol use. Instead, it asked whether there were any foods which were avoided on religious or cultural grounds, and also asked about causes of various forms of ill-health (notably, blood pressure) and whether respondents knew of health problems associated with excess use of alcohol, as a means of assessing perceptions of alcohol-related harms. As the authors comment, this may minimise the reporting of use of, or knowledge about, alcohol since in the form the questions were asked, many respondents replied 'don't know', or indicated that the question might be inappropriate. It is clear that since the choice was not forced, it was possible that people would not mention not drinking alcohol, which in many cases might not have been regarded as a 'food'. Even so, around half of all Bengali men and women aged under 50, and two thirds of those over 50, said that they chose not to drink alcohol - compared to virtually none of the African-Caribbean sample, and one in eight Indian men and women. Only about a quarter of Pakistani women (especially, more so among the younger age groups) and nearly half the men said that they did not drink alcohol for religious reasons, but since between two thirds and three quarters stated that they only ate halal meat, which is a more expected response, this is likely to reflect explicit recollection, rather than actual avoidance levels. Certainly, in other questions where the use of alcohol was a possible response to the causes of disease, hardly any Pakistani and Bengali Muslims did suggest it, although other groups sometimes did.

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. 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. Interestingly, those aged 30-49 were more likely to suggest liver disease, possibly reflecting a popular stereotype or 'common knowledge' fact about cirrhosis, while those aged 50-74 were more likely to talk about heart disease, to which they themselves were more likely to be at risk. Overall, however, there was a poor level of knowledge about the risks of alcohol in all these groups at all ages.

Curiously, given the response to the question on the risks of alcohol use, which did not highlight blood pressure, when asked explicitly what advice they thought should be given to a person to avoid high blood pressure, around half of all African-Caribbean, Indian and Pakistani respondents suggested 'cutting down' on alcohol. This advice was given by less than a third of Bengali females and a quarter of Bengali men - but as no Bengali woman aged over 50 mentioned this, we may suggest that this indicates not lack of awareness, but lack of perceived relevance to their situation. The fact that 40% of Pakistani men and women aged 50-74 mentioned it, however, suggests that there may be a slightly higher level of alcohol use in this community than is usually reported!

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 presumed to reflect greater 'acculturation' among younger generations of migrant minorities. Among those aged 16-34, however, consumption levels were no higher for African-Caribbean (Black Caribbean, in the HSE survey classification) men, and substantially lower among African-Caribbean women than those aged 35-54. There was some suggestion that women who gave their ethnic origin as Indian and were aged under 35 might be more likely to drink more than 14 units / week, but this was based on a small number. Males of this ethnic origin showed no age differences in their propensity to consume over 21 units/week. Men and women aged over 54 of Pakistani and Bangladeshi origin were very unlikely to report any drinking.

Social class was no guide to likelihood of drinking or levels of drinking, but a table analysing 'usual weekly alcohol consumption' by household income, (See below) shows that while African-Caribbean men in better-off households appear to drink slightly more, it is African-Caribbean women in the poorest households who report highest consumption. For Indian groups, there is a slight increase in levels of consumption as income levels rise, for both men and women. It is, however, possible that among those people of minority ethnic origin who do drink, there is less likelihood of drinking every day or even every week, and a rather larger number of them who may drink occasionally, perhaps at major social events, compared to general population patterns. Younger people (particularly Indian women) were also somewhat more likely to drink more frequently, as in the general population, except among African-Caribbean men, where frequency is considerably lower among the youngest age group. (See below)

Table: Reported Frequency of Drinking Alcohol, by Age - Of those drinking alcohol (Proportion saying they drank 'at least once in 2 months')

	Men			Women		
	16-34	35-54	Over 54	16-34	35-54	Over 54
Black Caribbean	81	90	78	79	78	52
Indian	64	60	56	36	26	7
Pakistani	7	8	9	2	3	-
Bangladeshi #	5	4	-	0	2	-
General Population	92	92	83	86	83	68

Based on very small numbers

Table adapted from data reported in Erens & Laiho 2001, Table 5.6

The data from the Health Survey for England also shows that even when drinking heavily, or on every day, (as an indicator of problem or risky drinking) rates are very much lower in all minority ethnic groups (except Irish), but no specific questions were reported relating to alcohol-related harms, or other indications of risk.

Cochrane (1999) presents data from a GP-practice based survey of approximately 600 men (200 from each of the White, Black and Sikh populations in Birmingham). He shows that while admission to mental health (as opposed to alcohol-treatment) services for alcohol-related mental health is much higher among Asian-born people, this does not reflect rates of alcohol use. Rates of harmful or risky behaviour were much lower among Sikhs - and even lower among African-Caribbean men, and 'second generation' (UK born) Sikhs were drinking at more moderate levels than the older migrant generation. African-Caribbean men were more likely to attend a variety of Christian churches and much less likely to drink alcohol at risky levels, although more likely than Sikhs (contrary to some reports) to drink spirits. Both minority groups were relatively unlikely to drink with family, and both groups felt more than white respondents that they wished to reduce their drinking. They were also very much less likely to know about or refer to community-based and voluntary sector sources of advice and support such as Alcoholics Anonymous.

Another one of the few major community survey-based studies to present detailed recent data relating to 'problematic drinking' and reported harms or risks is that by Purser and colleagues in Birmingham and Leicester, looking specifically at UK-born (or educated) people of minority Asian or African-Caribbean background (Purser et al 1999; Orford et al 2004). Although the majority of those interviewed for this study were relatively young (60% aged under 30) very high numbers were found to be non-drinkers, except among Sikh men and African & Caribbean men and women. Even in these groups, only among Black men were the proportions drinking at rates regarded as 'fairly or very heavy' similar to those in White community samples. While at least half of the drinkers in the survey reported committing at least one risky behaviour or act (such as drinking and driving, involvement in violent incidents) after drinking, very small proportions of drinkers reported levels reaching the survey's definition of 'risky drinking' or showed signs which might be of concern. However, there was in all ethnic groups, a small number of individuals who were clearly drinking at risky or unsafe levels, according to current recommendations, and a number who recognised that there might be a need for them to modify their behaviour.

('Contemplation of Change' in the Prochaska & DiClemente 1986 model)

A recent paper by Douds et al (2003) reviewed the patients attending a hospital in Birmingham, for treatment of liver cirrhosis - the majority of which was alcohol-related. African-Caribbean males were less frequently found in the caseload than anticipated by local population data, but younger South Asian non-Muslim males were over-represented in those treated, developing the disease younger than the white patients, and more often the disease was linked to alcohol rather than viral causes. They do not report levels of alcohol use, but suggest that patterns of drinking, and possibly some genetic factors, may predispose to causing disease in this population. This mirrors earlier findings by Wickramasinghe and colleagues (1995), who found that among admitted patients, those of South Asian origin had more advanced disease and damage than White Europeans, despite having reported shorter duration of career as a (heavy) drinker. We have not so far been able to locate any explanation of this pattern.

Young People

A school-based set of two surveys in the East Midlands examined smoking and drinking behaviour among pupils in 1990 and 1997, and concluded that while Muslim Asians remained very unlikely to use alcohol, Sikh and Hindu pupils at school were closing the gap with their white peers in self-reported levels of drinking. In 1997, however, alcohol

consumption rates among South Asians (aged 15-16, and hence below the legal limit) were still nearly one tenth of the rates among white peers. Denscombe & Druquer 2000 call for more detailed studies of the mechanisms of change paying attention to issues of detailed ethnic identity (including religion).

Rather similar conclusions were drawn by Rogers et al (1997) following their study of Black African, Black (Caribbean) and Bangladeshi young people in London: they note that significant numbers of the Black African young people were also Muslim, or said that drinking was against their religion. Karlsen et al's (1998) analysis of a later phase of the same study showed a slight increase in the likelihood of having tasted alcohol among the African group over time but no evidence of regular drinking. Best et al's later (2001) paper, however, does not disaggregate the minority groups beyond 'Asian, Black, White and Mixed/Other' but suggests that Asian and Black children are least likely to progress from 'trying' alcohol to being regular drinkers. Similarly, Arora & Khatun's (1998) survey of 203 young people in Bradford aged 12-18 noted that four out of five had not tried alcohol, and attributed this to the problems of accessing alcohol in a largely Muslim community - but their report does not provide any further breakdown of the data, and prefers to concentrate on what is seen as a more pressing problem of misuse of illegal substances.

History, Migration and Alcohol Use

It may still need to be stated that alcohol use is not new for the South Asian and African Caribbean traditions, although this has been observed before. Certainly Ghosh's (1984) early study gives useful detail about the historical context of alcohol use on the Indian Sub-continent even during the Mughal Period when Islam was the faith of the rulers of India. Any reading of African Caribbean history reveals that well before the triangular slave trade and the growing of sugar in the Caribbean, for import into England and elsewhere to the colonies, alcohol was fermented and associated with celebrations and rituals such as libations. We can deduce that the South Asian and African Caribbean communities brought some traditions including use and perceptions of alcohol to this country when they migrated here. This then encountered a pervasive situation in Britain in relation to alcohol promotion and use, as Subhra (1999) notes

"The ease of availability of alcohol, its legality and the advertising messages highlighting social and material benefits means that alcohol use by the Black (and Asian) communities is here to stay and likely to increase".

We may usefully compare this with Plant's recent observations on the national strategy for alcohol harm reduction:

'The complex relation people have with alcohol, and how deeply embedded the use of alcohol is in our (sic) culture is not sufficiently acknowledged in the report'
(Plant 2004 :905)

Early anthropological studies looking at the settlement patterns and other behaviours of minority groups are illuminating when they consider habits around alcohol use. An example is Helweg's (1979) study of the Sikh community in Gravesend in London. It notes the significance of the local pub as a place to make contact with other men, find out about work and accommodation and of course to drink and be social. This picture is probably not too dissimilar to many new migrant communities where the early migrants

are mainly men seeking employment (economic migrants) and where the pub is more than just a place to drink alcohol: it was and is also a place to do business.

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).

Conventionally, among the majority population, it is assumed that the use of most illegal drugs is associated with higher than usual levels of alcohol consumption. However, there is some evidence that among minority ethnic groups, there may be some differences. In a study of alcohol use among younger people of African-Caribbean origin (Johnson and Powell 1997), for example, the researchers were advised that this group 'did not need' to use alcohol, since they 'had our own' ways of self-intoxication (it was assumed that this referred to ganja/cannabis!). Muslims, on the other hand, may regard certain drugs as being more acceptable than alcohol and one paper reports that a significant proportion of young Asian drug users were teetotalers (11.8% rather than 1.5% in the white population studied) or drank alcohol only within recommended limits (Dar et al 2002). This report on the development of (drug-related) services for minority ethnic groups also makes the point that the introduction of ethnic monitoring, recruitment of minority-origin staff, cultural awareness and translation of service information into minority languages have led to a marked increase in service uptake by Asian patients. The paper by Vora et al (2000) was the only one which combined alcohol with consideration of the use of an Asian-community-specific 'drug' - the use of chewing paan (Areca nut), and also draws attention to the differences between the settler (migrant) generation and those born, or educated in Britain.

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.

Virtually the only quantitative survey, which is able to assess the degree to which people in need of alcohol services are obtaining them, is a small and complex study in a deprived area of Birmingham by Commander and colleagues (1999). This shows that, despite high levels of consultation, 'Asian' men are less likely than whites, to have a need for referral to alcohol treatment services recognised and appropriate referral made by health professionals: this also applies to young people and women. Black people make less use of primary care so are also likely to miss out on being referred at need. The study relies heavily on secondary or indirect measures, rather than direct measurement of alcohol consumption, and since non-English speakers were excluded from assessment using the CAGE questionnaire, is likely to underestimate need. It is however clear, they state, that the national strategy for alcohol services needs to reflect the ethnic and cultural diversity of the populations at risk and ensure that all those in need of support by the addictions services are identified and referred appropriately, although this conclusion is not confined to the minority ethnic population, who are merely in a worse situation, relative to a generally low level of case recognition and referral.

Health promotion (Tier 0)

Insofar as papers and reports reviewed have concerned interventions, as opposed to epidemiological and descriptive studies, most have related to short reports on alcohol education, or analysed (and sometimes described) the development of materials for primary health education. Few, if any, met the normal quality standards of evaluation studies, with details of population sample sizes, methods and objectives, or detailed analysis of the impact in terms of meaningful descriptions of population sub-groups. Vora et al's paper (2000) was designed to inform health education, and draws attention to the need to deal with religion and generation as independent factors, commenting on the relatively low level of awareness of risks associated with alcohol.

Treatment (Tier 1-4)

There is general agreement that the world-wide 'Alcoholics Anonymous' or 'Twelve Steps' model for alcohol recovery is fundamentally based on (Protestant Christian) notions of spirituality, with language and procedures linked to recognition of a transcendent entity or power. In this respect, it is perhaps well placed to attract and serve members of minority ethnic groups located in Britain who develop problematic alcohol usage, compared with some of the other models adopted by practitioners. In

particular, Morjaria and Orford (2002, Morjaria unpublished) and others have been critical of the so-called Transtheoretical Model (TTM, also known as the Stages of Change approach) which is very clearly a-spiritual in its approach. The observed high level of salience of religion in most minority ethnic communities does suggest that a spirituality-based approach such as the Twelve Steps model would be best attuned to their needs, but none of the research papers reviewed describes an evaluation or indeed, significant use of this approach among minority ethnic groups in the UK. (We may note in passing that Morjaria reports that one of her interviewees had attended an Alcoholics Anonymous meeting on a few occasions). There is, however, some evidence that the approach has been accepted in India (and Pakistan and Sri Lanka, if not Bangladesh: Makela 1991; Ranganathan 1994; Cherian 1986). There remains some doubt as to whether UK Asian (or African-Caribbean) people would feel happy at the lack of confidentiality in such a public event, especially if not fluent in English, and conscious of cultural differences.

One paper (Dhillon 1994) presents a series of case studies and an analysis or reflection on the counselling delivered to these five south Asian clients. It is clear that these clients were different from the 'usual' (i.e. majority white) clients in their needs and the way they used the service. There was a much higher apparent level of relationship (dependence?) on the counsellor, and a strong feeling that while culture and recognition of this and of spirituality was important, that a 'physical' or clinical, 'medical model' was being sought.

Other research into issues associated with stigma in the Asian community has shown, that a more clinical, less social model of disease, may have its merits in overcoming stigma and encouraging users to seek help. There may also be some increasing evidence that there genuinely is a different clinical (genetic) picture associated with alcohol-related problems in patients of south Asian ethnic origin, at least (Douds et al 2003).

4. Findings from the Survey of Alcohol Services

The survey questionnaire (see Appendix 1) was circulated by Alcohol Concern to its full mailing list as a special issue of Alcohol Concern News; and also publicised via other networks available to us. Through Alcohol Concern it was also sent to the regional network of Drug and Alcohol Teams, some of whom replied that they would pass this on to local agencies in their area but no replies that can be traced to this source have been returned to the team. The project suffered considerably from the lack of an up-to-date national database or index of relevant alcohol-related agencies. Many of those circulated replied that their primary interest was in drugs, and we are aware that there are some agencies from whom we have not received responses - but since we were unable to access the mailing list, we are not certain to whom it was actually sent. Where agencies known to us have not replied, we have contacted them directly with requests for information, and added materials from them to the database.

Agencies replying to the Survey:

This provides a reasonable coverage of the regions as well as London and includes input from Scotland, and Northern Ireland.

Respondent	Location #	Tier *	Good Practice Enclosures <input type="checkbox"/>	Interview (Part 3)
<i>Croydon Alcohol Counselling Service</i>	S London	0 1 3		
<i>Turning Point - Davies Alcohol Services Battersea</i>	S London	3 4	Leaflet	
<i>Options CDA, Worthing</i>	SE	3 4		
<i>Womens Alcohol Centre</i>	London	2 3 4		
<i>Rugby House Herbert St Project</i>	N London	4		
<i>Cara Irish HA</i>	London #	0 1		
<i>Equinox ASPSL Stairways</i>	S London	3		
<i>NORCAS</i>	East Anglia	0 1 2 3		
<i>Aberdeenshire Community Substance Misuse Service</i>	Scotland	0 1 3 4		
<i>Farm Place, Surrey</i>	SE	4		
<i>Essex Young Peoples DAS</i>	E Anglia	0 1 2 3		
<i>Focus, Bury St Edmunds</i>	E Anglia	3		
<i>Framework ADS Nottingham</i>	Midlands	0 1 2 3 4		
<i>Barking Havering & Brentwood AAS</i>	E London	0 2 3		
<i>First Step</i>	(01642?)	0 1 2 3 4		
<i>Turning Point Court Arrest Scheme, Sunderland</i>	North	2		
<i>Alcohol Services South London</i>	S London	3	Ann Rep/Leaflet	
<i>Turning Point, W Yorkshire</i>	North	3		
<i>Mount Carmel Treatment</i>	S London	\$		

<i>Centre</i>				
<i>Stevenage CAT</i>	Home Counties	0 1 3 4		
<i>AAC Herts (SW Herts AAC)</i>	Home Counties #	2 3	Leaflets	&
<i>QALB Centre</i>	E London #	0 1 2 3	Leaflet	&
<i>Aquarius Sahaita Birmingham</i>	Midlands	2	Leaflets, HPE booklet	&
<i>Aquarius CAT South Birmingham</i>	Midlands	0 1 3 4		
<i>Alcohol Services CIC St Helens</i>	North	0 1 2 3		
<i>Project 6, Airedale VDAS</i>	North #	0 1 2 3	Leaflets and project report	
<i>City & Hackney AS</i>	E London	0 1 2 3		
<i>The Barn, BADAS, Barnsley</i>	North	1 2 3	Equal Opps monitoring survey	
<i>Equinox</i>	London #	2 3 4		
<i>James Kingman Project, Luton</i>	Home Counties	2 3		&
<i>East Kent CAS, Canterbury</i>	SE	3		
<i>The Foyle Haven</i>	N Ireland	2		
<i>Drug Care St Albans</i>	Home Counties	2 3		
<i>One North East</i>	E London	0 1 2 3		
<i>CAN Northampton</i>	Midlands #	2 3		
<i>New Roots Rugby House</i>	N London #	1 2 3	Leaflets, posters, newsletter etc.	&
<i>Drug & Alcohol Services for London (DASL formerly Alcohol East),</i>	E London #		Diwali calendar cards; Eid prayer-time calendar cards	&
<i>Options (Southampton),</i>	#			&
<i>Alcohol Services Camden & Islington (London)</i>				&
<i>EACH (London),</i>	#		Various reports (see bibliography)	&
<i>ARP Choices (London).</i>	#			&
<i>Saaf Dil (Rotherham)</i>	#			&

NB:

Has specific ethnic minority focus project / funding

* For explanation of 'Tiers', see text. In brief, Tier 0 is Health Promotion; Tier 1 Personal Education; Tier 2 Open Access; Tier 3 Appointment based; Tier 4 Residential

□ Items listed in final column have been added to the Project Archive, held at the MSRC in Leicester.

& Interviewed for Part 3 (Tiers 3-4) of this report.

- Tier 0 refers to general health promotion activity 'below' the level of the commissioning framework for Drug & Alcohol Teams in England. This is commonly carried out by a wide variety of agencies.
- Tier 1 refers to work with clients including drug and alcohol mis-users, whose sole or main purpose is not treatment, and which are not specific to substance misuse. These may include, crucially, referral to specific services.
- Tier 2 refers to 'open access' drug and alcohol treatment services, accessible either by referral or by personal 'walk-in' and mainly engaging in harm-reduction activity and ad hoc work, often as a pathway to more specialised help.
- Tier 3 refers to structured community- based alcohol treatment services where the alcohol mis-user can receive a comprehensive assessment and have a care plan agreed between the provider and client
- Tier 4 services are residential services specifically for drug and alcohol substance mis-users, including rehabilitation units and crisis intervention centres. (NTA 2002).

In the following section, all 'written-in' comments taken from the survey questionnaires are reproduced '*verbatim*' in italic script.

Q1: Which types of service do you provide:

	Service	Tier	Please add detailed comment if you wish
Y / N	General Health Promotion	Tier 0	
Y / N	Personal Health Education	Tier 1	
Y / N	Specialist Open Access Support	Tier 2	
Y / N	Appointment Based Treatment	Tier 3	
Y / N	Residential Treatment	Tier 4	

The Tiers referred to here use the classification of alcohol services outlined in the Alcohol Concern Commissions report on the future of alcohol services (June 2003): appendix IV provides a more detailed description of Tiers 1-4. We have added a notional 'Tier 0' to reflect the large number of agencies who provide 'general' health promotion materials as well as an individual personalised (Tier 1) service (see Box, above).

From the responses returned to us, five indicated that they provided a specialised BME service, four offered 'both', and there was one for which the response was compiled by a specific ethnic-service worker within a generic service. The remainder were generic, though one Asian-led agency said it was not specifically funded although it offered a specialised service. One of the specialised services was in the process of being reorganised into an integrated service.

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.

One mainstream generic service that was clearly reaching a substantial minority ethnic clientele was not now funded specifically to do so. However, in the past it had two 'minority-targeted' projects, which seem to have had an effect on present provision funded out of generic revenues. We may observe that this is a rare example of institutional learning and development: in more cases, the cessation of specialist funding has led to the closure of specialised services and a failure to incorporate or 'mainstream' the developments arising from those project.

Q4: Please give us some details of your users if you have any ethnicity data:

While 21 agencies were able to complete the table with numeric data:

Five agencies gave no details of their users at all, and most of the remainder gave estimated proportions.

Eight supplied only percentage data - including

- Two which were 100% white
- One agency: 77% white (5% Black and Other; rest not stated, total not stated)
- One agency stated 99% White and handling 'over 1000' clients in a year:
- One agency in London saw 90% white, 4% Black (groups) and 3% Asian clients and 4% 'other' not stated; (total not stated).
- One Asian-specific project reported that 93% of clients were Indian, 5% Pakistani and 2% Other (and as with several others, no Bengali users),
- One BME project had 5% White British users (and 15% Bangladeshi)
- One generic agency noted that its profile *'roughly reflects the borough'* (58% White British) and included a significant proportion of Turkish users.

It is interesting to note that these proportions are relatively close to the figures reported by Luce et al (2000), in their national census of UK alcohol treatment agencies. They also noted that around 6% were 'White -Other or Irish' but had a slightly higher rate of BME users (5.4%) - they also had a relatively low response rate (41%) but were not concerned that under-representation of BME users was occurring.

- Please supply data for the most recent full year you have

	Number of Clients	Percentage
White 'British' #	5982	89%
White (Other)	399	6%
Black / British: African/ Caribbean	143	2%
Asian / British Indian/ Pakistani/ Bangladeshi	130	2%
Other Please State:	52	<1%
TOTAL	6706	

One agency reported 'White English' and allocated White Scots, Welsh & Irish to White Other.

Most other agencies were able to supply a breakdown of the ethnic composition of their clientele, although few used the same categories and very few indeed had significant numbers of minority users. Five agencies, including some in towns or boroughs with large multi-ethnic populations, did not supply any such data. The table shows the total numbers reported by the 19 'generic' agencies in England who were able to provide ethnic monitoring data, in aggregate, and combining groups to 2001 census categories. Only two of the 'ethnic minority' oriented agencies provided data in this numeric format, so we are unable to combine the totals for 'generic' and 'specialist' and attempt an estimate of the overall levels of service use. However, it seems clear that without the input of those specialist agencies, there would be very few people from black and minority ethnic groups receiving any alcohol services, especially outside the central London and Birmingham areas which supplied the majority of non-White-British users in the following table.

(We have also excluded from this table, the one service specifically targeting Irish users).

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.

"Please note BME issues are not targeted: Less than 0.02 (%) of population is BME in our area. We rather target isolated rural communities who could also be a particular cultural group."

- **Q5: Which languages can you offer to your service users: are these 'in-house' or do you use paid interpreters?**

The majority of respondents used and offered only English: a few gave the languages spoken by members of staff - these included:

Dutch (2), Farsi (via a colleague in mental health), Greek (2), German (3), Italian, Portuguese, Croatian, Spanish (3) French (4), and Bulgarian. Only four services could apparently offer staff able to work in Urdu, Sylheti/Bengali, Hindi, Punjabi or Gujarati and Turkish.

One agency, which was relatively well supplied with multi-lingual staff, had been requested for (and supplied) two interpreters in the previous three years: one Russian, one BSL. Another had been requested for, and offered, a French interpreter for a West African client, which was not taken up. None were able to provide data on the number of times a language-specific service, or interpreter, had been provided, even including those who indicated that they had access to paid-for services such as Language Line or the local authority service. 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. One identified the need for (West Indian) dialect speaking staff.

It is quite clear that speakers of European languages are much more likely to find their need for a speaker of their home language, than British citizens speaking a language of Asian, African or Middle-Eastern origin. Even where these could be obtained through 'paid-for' support, no-one was collecting or monitoring either demand or use of it, or the use of translated information. Provision of interpretation, and translated materials, are heavily tied to the employment of staff with appropriate language skills.

A project with a specialist remit (and some funding) to meet minority ethnic needs, offered Volunteer interpreters with Bengali and Gujarati, had staff speaking Urdu, Hindi, Pahari and Punjabi, and could offer leaflets or other material translated into all of these except Pahari (which does not have a formal written form). They could also offer, and had used extensively, an interpreting service for 'most other Asian and Middle Eastern languages.

Virtually no other agencies reported offering, or using language support.
Typical responses were:

- * *A 'language plate' in the Family Fact File handbook provides for alternative language versions (by calling a phone number) but in six months there have been no calls*
- * *Police interpreters could be used if the workers visit (to the cells) coincides with their availability*
- * *"Very very rarely"*
- * *We developed an Asian phone line many years ago with leaflets in four languages and did not get one call in nine months (S London)*
- * *We have access to 'paid for' interpreters - we have never used this service*

• **Q6: How does your service target / ensure access to BME communities:**

Most services left this question unticked and unanswered. Responses included:

- * Advertising (no examples included)
- * We go out into the community
- * Referral via staff of the specialist (EM) housing agency

- * We do employ a BME substance misuse worker (a positive action decision in recruitment) (One of 99 users in the previous year did come from the same BME origin)
- * We try to build relationships with ethnic minority GPs and community leaders (this group reported a 4% uptake by BME users)
- * We have recruited counsellors from BME communities
- * Leaflets in four languages, radio/media appearances, outreach work, culturally-sensitive service offered

One 'all-white' (or so-called generic) service was in the process of developing an outreach programme, writing to all community groups locally with an 'Equal Opportunities' monitoring questionnaire to find out how well known they were but six months later there is no data or analysis yet available.

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.

- **Q10: What is the normal pathway by which users come to your service (i.e. referral route) - Is there any difference in access pathway or referral route for BME (Black and Minority Ethnic) users – have you had to make changes to meet their needs?**

In virtually all cases, the answer to this question was No - with the exception of one which received all its referrals via staff of the specialist (ethnic minority) housing agency which was part of.

Another - again, one of the few agencies to report high rates of take-up of services, but which was in receipt of special additional funding, noted that
'(It has) been important for the worker to establish herself with the community, have them get to know her. Usually approach her directly as few enter through the traditional route referral routes. Many clients are not recorded in the statistics shown as we only detail those who enter formal counselling. Very many more receive general information, leaflets, passing advice.

Another specialist service, which works closely with local primary care providers, reported that 'few professionals refer - we have had to make sure everyone knows about the service, provide more home visits, be more flexible, have an understanding of the help-seeking process and culture and religion'. They added, 'We have to understand the effects of racism on help-seeking'.

Interestingly, one respondent reported that *'The BME clients, if they wish to see a black counsellor do not have to wait on the waiting list for up to 8 weeks, like the white clients'*.

There are clearly some advantages to having access to an under-utilised service.

- **Q11: What is the assessment process and criteria for acceptance? Is there any difference in criteria / assessment for BME (Black and Minority Ethnic) users – have you had to make changes to accommodate their needs?**

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.

One written response simply stated 'NO'.

Only one noted: *Aim to work as far as we can in mother tongues: Staff must have a range of languages that suit the local population. Occasionally use interpreters (volunteers) to give information and some support*

- **Q12: Do you feel you have had to make any major changes to your service provision to accommodate the needs of BME clients?**

Again, there was little evidence in mainstream or 'generic' services of any affirmative action or development of services to meet specific needs, all groups except two responding 'NO'. Those two, however, made the same point:

Yes - the outreach work is very important, we would not reach any BME clients without it. Treatment and outreach are frequently funded and categorised as separate services: with BME groups they must be integrated to be effective

More outreach (e.g. GP surgery, home visits) and telephone counselling, less formal communication

- **Q13: Do you attempt to match service users and workers by 'race'/ethnic group and gender?**

Typically, NO, or in a few cases, it was stated that efforts were made to match by gender, sometimes noting that this was for personal safety reasons. Commonly, it was also noted that agencies had found it hard or impossible to recruit male staff. An Asian-only service noted that they did match 'as necessary' and a few stated that matching would depend on client preference. One (generic) service noted that they would match *'only on request, which to my knowledge has only occurred once. Such attempts to match do not seem successful'*.

In general, it proved difficult to obtain statistics on the ethnic profiling of staff. One agency declined to give details because of the risk of identifying individuals in a small agency: they estimated that 10% of staff (including volunteers) were from BME origins but noted that the management committee also included members of white/European and religious minorities including Jewish. In another, the 'sole worker' was identified as a

female of white/Asian dual heritage - the manager (Male) did not give his details. Another had 14 white UK staff and 'a Spanish cook'.

- **Q15: It would be helpful if you could give us details of your staff by ethnic group:**

	Male Staff	Female Staff
White 'British'	86	162
White (Other)	7	5
Black / British: African/ Caribbean	8	6
Asian / British Indian/ Pakistani/ Bangladeshi	2	3
Other Please State:	1	1
TOTAL	104	171

(Note: these categories are based on the 2001 census groups)

If these responses from 20 agencies are taken to be a reasonable cross-section of alcohol agencies, it can be seen that there are fewer male than female workers, as more than one respondent commented, but that this does not necessarily apply for all minority ethnic groups. Black and Minority workers (other than Irish or other White Europeans) made up one in ten of the male workers (roughly proportionate to the national population) but around half that proportion of the female workforce. Further, most of these were of African or Caribbean origin, and it is clear that there are relatively few staff with ethnic origins (and, it is assumed, language competence) in South Asian cultures. As few of the replies to the survey identified the role or status of staff in much detail, we cannot say whether these reflect a true integration of staff of minority origin in the service. It seems clear that many of the Black and Asian staff were in fact specialist workers, or working in projects specifically targeted at minority users. The typical response to the next question was therefore not surprising:

- **Q16: In developing your work with BME communities, have you encountered any staffing-related issues? (Please give details – and how you face them, if possible)**

Getting interpreters and workers to match clients (SE)

Staff recruitment

Advertising has not attracted BME applicants on the whole

... in the next round of recruitment we shall advertise in the black press ...

Inevitably all staff recruited are white British/European and female: small numbers of candidates from BME although I've seen 4-5 in the last 12 months which is a dramatic increase in numbers.

Problems in recruiting {ethnically matched} workers since changes in the home economy

Staff supervision

It is very important to permit the worker to develop their own work plan to work in their own community

One agency noted that they provided external supervision from an outside consultant in Asian community development for their one (Asian) member of staff, and another employed external BME clinical supervisors.

Staff retention

Not having security (project funding) is disconcerting and led to staff turnover in the past

No pension scheme - this makes it difficult to retain experienced staff

Average turnover of counsellors is about 2 years

Staff Training

(No replies were seen in response to this prompt within the survey: we have to assume that no agency felt there were any major training issues arising).

- **Q17: Which of the following specific issues relating to service delivery do you feel arise when working with the BME communities: (Please give details – and how you face them, if possible)**

BME is a new issue for this area - we are beginning to see a few asylum seekers ...

Provision of a culturally sensitive service is an essential factor in success - we can deliver (Irish) cultural awareness training...

Language

Counselling in mother tongue is the minimum standard we should meet.

Essential to be able to offer counseling in a wide range of languages. We could usefully employ (another) worker with Indian Punjabi skills as well as Pakistani Punjabi skills, and also Eastern European languages to reflect new immigrant needs

Group discussion on the Minnesota model requires reasonable English (T4 service) ...

Gender

Services are heavily under-represented by male workers

Ideally would have another 2 BME workers male, Indian, Bosnian

(we) need more male counselors as majority of clients are male

Age

And aged 45+ (this followed on from the previous comment about the need for male staff)

Older staff do attract older BME users. It was very apparent that when we recruited an older BME worker our stats showed an increase of older women using the service ...

Religion

Religious taboos surrounding the use of alcohol in Muslim communities and the shame and dishonour felt by the relatives of substance users (mean a) need to give detailed information about our confidentiality policy

We see approx. 2-5 Jewish users a year - there is approx. 7000 Jewish population: we have never successfully reached this group

We network and support faith groups who are concerned about drinking and drug use. BME peoples are spiritual people in an organised religious way and to ignore this is to miss the point. Some clients see re-engaging with their religion as part of the solution to their problems.

An interesting observation was made by one pro-active agency:

The unacceptability of alcohol to Muslims means that the pattern of substance misuse is found in inverse proportions to the general population: start with drugs and descend into alcohol, which is expressly forbidden by the Koran. There is much secrecy and shame surrounding alcohol use, less so with drug use. Penalties with the latter are mainly associated with offending behaviour in consequence of drug use, not simply because it occurs.

Culture

Staff are trained and continue to be trained to be aware of differences and adapt and be sensitive to a non-discriminatory stance

Clients expect and require at least a basic understanding of their cultural systems and practices. This is the foundation of their whole being

It appears the significance of culture is never raised by majority white staff unless to say they're to be referred on, or a problem client (generic agency)

Other

We struggle to understand the implications of culture, religion and language difficulties but we do our best to meet their needs

Perception of ethnic barriers to access: Agency perceived as white, 'no empathy' therefore for BME (alcohol) dependent people

Isolation - very much feeling the minority in a small project

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.

- **Q18: Do you have particular resources for use with BME communities (e.g. information packs, posters) - why have these been particularly useful (could we have a copy?) We would welcome comments on any culturally-specific educational materials or campaigns that you have experience of.**
- A very few services, mostly those offering a specialised service, supplied copies of their leaflets. It did not appear that most of the rest actually possessed any, although some made reference to local authority services having access to these.
(see Appendix Two)

We can get them! Alcohol Concern, Health Education Council (sic) and local PCT (Note: HEC no longer exists and its successor, the Health Education Authority has become 'Health Promotion England').

Where there was a supply, however, it was rarely seen as of value, and one stated that 'all information' was in 'differing languages' and reported that there was 'poor uptake' of these.

(We have) Multi-lingual leaflets - very rarely taken or requested

We have the old HEA (Health Education Authority) guides for parents in alternative languages (but these are) now out of date (e.g. no reference to current street drugs, alcopops etc)

We used language specific leaflets but this doesn't work when we cannot offer language specific services ...

All the agencies who provided leaflets or flyers describing their service in specific languages or otherwise adapted to enhance rapport with BME users are listed in the appendix.

- **Q19: What has been the most helpful step you have taken, or 'best practice' advice you have found, in relation to working with BME communities?**

There were very few detailed answers to this question. The majority clearly relate to the recruitment of staff from minority backgrounds.

- * *Mother tongue counselling*
- * *Working with ethnic minority GPs and community leaders*
- * *Employment of BME worker to attract, develop and monitor our service is relevant to BME issues*
- * *Accessing community groups directly*
- * *To work with BME clients within their own community where possible, e.g. premises, manpower*

Against which, another group noted that *"if in a community-based centre the client may feel uncomfortable to see a counsellor for fear of others knowing they or someone they know have a problem, especially if alcohol is against their religion"*

- * *Listening and learning about the BME communities: Humility*
- * *'Grasp the nettle'*
- * *recruiting highly motivated BME staff who have the skills to approach local community leaders/ communities ...*

One respondent noted that they had been the 'race equality' lead in a previous post with a health trust, and was clearly using this experience as a basis for work now.

Another, black, worker in a white-led generic agency, noted that their major strategy had been

'not getting overtly worried by low attendance. Counselling and addiction services are not how the community handles problems'

• **Q20: What obstacles or problems have you met in seeking to deliver a service to BME communities**

The responses to this question, on the other hand, reveal a multitude of problems perceived and experienced:

- * *Finding interpreters/ workers that match the clients*
- * *Would appreciate resources to pro-actively use outreach worker in the community to link with our service (i.e. have not got one...)*
- * *Lack of funding, resources, training to enable outreach*
- * *Fear of being judged, not understood, repercussions from their families and friends, ridicule.*
- * *Culture, shame, community knowing who clients are*
- * *Service location - may be better location & closer to target population.*
- * *Lack of organisational will / commitment / interest - other staff too busy to think/plan and work towards working with Black communities*
- * *Denial that the problem exists*
- * *Crossing the barrier of appearing to label the community as having a problem (see final comment). It can take months to get a community to accept us as being there to help.*
- * *Much awareness raising work yet to do re: service availability*
- * *Low take-up of an Asian Outreach Service (it was not clear from the response whether this was still in operation, or why and when it had been run and subsequently abandoned).*

In some cases, it was perceived that there were no clients locally to deliver such a service to!

- * *'lack of BME groups in sleepy (rural county)'*

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: therefore it was encouraging to read comments like the following, from a Northern city:

'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.'

- **Q21: Has QUADS or the Race Relations Amendment Act had any impact on your service (to date) – please give details:**

Again, few replies were given to this question - some ticked it, or said 'No'; one said 'positive' and a small number commented that this had set a target or an example, which was provoking some change. Others noted that they had undertaken the QUADS audit and had passed' it - several noted that this had drawn attention to certain issues such as the RRAA and user involvement or provoked some reflection.

Made us more aware of our statutory obligations under the RRAA

One noted that *'We have been positively assessed by QUADS and all staff have annual race awareness'*. (training)

Service user involvement high on the agenda

- **Q22: Please add any comments or advice that could be incorporated in future alcohol service development guidance or the national alcohol strategy, and give your thoughts on any investment that needs to be made to develop services for these communities (overleaf or on extra sheets!).**

- * *Outreach work*
- * *BME User involvement*
- * *Staff training in cultural competence*
- * *'needs assessment' research in the community*
- * *Training for non-Asian practitioners (in a variety of professions)*
- * *A great help to our service would be to have trainee posts. If we could take people from the local community and provide good quality training to diploma level, offer them access to professional qualification ... would increase the number of skilled workers available ...*

Appended at the end of this report is a list of the 'good practice' materials, mostly copies of leaflets and posters, that we were sent accompanying responses to the survey. It can be seen that the majority of these were fairly straightforward translations of English-language 'generic' materials (guides to 'safe drinking', information leaflets about Units and diseases etc.) Some of the better examples had artwork which had been designed to be appropriate to the target readership, or which carried the 'logo' of the sponsoring agencies. However there was little attempt to make these differ between (say) translations into Urdu and Punjabi, to fit possible differences in culture associated with

these scripts. We were not sent any details of the uptake, or the processes of translation, checking and validation of the leaflets and posters, and cannot comment on their impact or accuracy.

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

Comment by one South-Eastern provider:

'There are specific needs in the (nearby urban area) area which are distinctly Asian and you may wish to contact the PCT who manage the health needs in that locality for a view of the BME provision. The DAT is responsible for commissioning all current drug and alcohol services and although it has a pooled budget for alcohol this is historical spend and they are awaiting the National Alcohol Strategy and the money! The Drug strategy is keeping them occupied!'

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?'

This final comment could lead into a major discussion of the morality and appropriateness of many kinds of service delivery relating to 'health promotion' and to issues perceived as being 'less prevalent' among minority groups. We have taken the view that if a service is available to the majority community and that it can be made

available to members of minority communities having the same needs, without disproportionate effort to adapt them, it would be appropriate and probably legally required (under the Race Relations Amendment Act 2000), to do so. Nor do we believe that BME staff necessarily have to abandon their identity within a 'white-led' agency, or to betray their community roots. We do not believe that the provision of a service implies that any particular community has a 'problem', but we do recognise that all communities (and sub-groups within communities) have different styles and attitudes or needs, which should be reflected in services which are provided out of taxation and public funding to which they may contribute. This is as true in services dealing with potentially addictive and damaging substances as it is in any others relating to personal welfare, and does not seek to insist that any one lifestyle or belief is superior or inferior to others.

5. Availability and effectiveness of alcohol related health promotion activity- Practice Survey: Tiers 0, 1-2) (Harrinder Singh Dhillon)

In developing this overview the author of this section has also drawn on his own knowledge and experience as a

- community development worker for the South Asian communities since 1991
- community development outreach team manager since 1999
- current service director for a community based alcohol and drug service in East London: the Drug and Alcohol Service for London (DASL – formerly Alcohol East).

DASL would consider itself to be a reasonably well informed about the major national and local influences, that have impacted on the provision of health promotion, early interventions and community action as it pertains to the South Asian and African Caribbean communities. Both of these communities reside in significant numbers in the boroughs that the agency serves (Newham, Tower Hamlets and Redbridge).

The following analysis will utilise

- literature related to the research and evaluation of health promotion activity specific to alcohol and related issues,
- an unpublished piece of work conducted by Civis Trust for Alcohol Concern focusing on dispersed communities
- strategy, guidance and other documents from Alcohol Concern and the National Treatment Agency for Substance Misuse
- the survey conducted for this report by Professor Mark Johnson of the Mary Seacole Research Centre at De Montfort University and circulated by Alcohol Concern to its membership
- interviews conducted with alcohol providers of health promotion, early interventions and community action with these respective communities.

As concluded in the literature review earlier in this report, the lack of a comprehensive research base makes it difficult to get a sense of not only the drinking habits and treatment needs of BME communities. For this analysis, it is also problematic to clarify the community's experiences and views about alcohol interventions such as health promotion, education, brief interventions, public health campaigns and all things in-between before a person actually seeks help. Despite this lack of an overall perspective, there has been an increasing interest in the BME communities and alcohol in the UK since the mid 1980's.

A disproportionate number of studies have focused their attention on the prevalence of drinking in the South Asian and African Caribbean communities and only make passing references to the analysis of tiers 1 and 2 of the models of care for the treatment of adult drug misusers as outlined by the National Treatment Agency for Substance Misuse (2002).

These specifically focus on the areas of 'non-substance misuse specific services' (tier 1) and what is referred to as 'open access drug and alcohol treatment services' (tier2), (i.e.

low threshold services with easier access). In setting out the scope of this chapter the elements of tier 1 and 2 that will be addressed are

- health promotion advice and information (tier 1)
- drug- and alcohol-related advice, information and referral services for misusers (and their families), including easy access or drop-in facilities
- services that minimise the risk of overdose and other drug- and alcohol-related harm
- outreach services (detached, peripatetic and domiciliary) targeting high-risk and local priority groups (tier 2)
(NTA, 2002)

In other words, we are concerned with activities targeted at the general public including the South Asian and African Caribbean communities that include an alcohol element (health promotion, alcohol education, brief interventions) and those activities that specifically target these populations for this purpose solely. Anything that takes place before appointment based 'structured community-based drug (in this case alcohol) treatment services' (tier 3) is of importance.

Alcohol as a Taboo impacting upon help-seeking behaviour

Time and again alcohol use, especially problematic use, is viewed as something that should not be disclosed to others within and outside the South Asian and African Caribbean communities. Bakshi et al (2002) in a study looking at South Asian community's note that the use of services (i.e. treatment) carries with it a stigma. This appears to be supported by Commander et al (1999) who state that the Black (African Caribbean) communities under-consult primary care services (GPs), whereas South Asians over-consult at primary care services but are less likely to be referred on to treatment services. This referring on may be indicative of the reported behaviours associated with such self-presentation and help-seeking behaviour:

"Belligerence in one form or other was the commonest harmful effect reported for both sexes, but women were more likely than men to report more personal forms of harm"

(Civis Trust, 2003).

This is quite damning but perhaps not unusual when we consider the sensitive nature of alcohol problems in the population generally and the South Asian and African Caribbean population more specifically. What may be evident within the above quote is that individuals may not consider themselves as having difficulties with alcohol despite the contradictory evidence which may be physical in nature when consulting GP's at primary care.

The taboo associated with heavy drinking and disclosure is considered by Hyare (1996), Manik et al (1997) and Bashford et al (2003). Comments from young people are cited in the last study

"You can't talk to the community openly" (Bengali female)

“his mother is adamant that he seeks help for his addiction in North West London, away from members of the community who may recognise him” (African Community Involvement Association – London).

Shame is a powerful motivating (and de-motivating) force and at EACH the Ethnic Alcohol Counselling in Hounslow service (Shaikh and Naz, 2000) have spoken in detail about its implications in relation to seeking help around alcohol problems.

“(‘izzat’) within Asian communities influences people to hide problems or avoid help-seeking. Loss of ‘izzat’ through excessive drinking could potentially damage an individual’s or a family’s reputation leading to feelings of shame that might perpetuate drinking problems”.

This is supported by the Bashford et al (2003) study quoting an African respondent

“African culture is a culture of silence. Silence is part and parcel of the culture. Therefore, when one’s child or relative is into drugs, denial is not the only defence used but withholding of this information too. People do not share information”.

Research and analysis about how people with alcohol problems from the South Asian and African Caribbean communities go to seek help is under-developed. What is clear from studies in the alcohol field is that they do not traditionally refer themselves to the local alcohol advisory service. Two reviews by Alcohol Concern (2001 and 2002) which looked at the nature of alcohol services and their achievements found that among the 65% of agencies able to provide the ethnicity of clients worked with collectively, only 5.5% of clients seen came from the South Asian and African Caribbean communities. When considering the location of the Asian, African and Caribbean communities in the UK in mainly urban areas this figure is considerably below their representation in the population overall.

The wider picture is echoed by the Bashford et al (2003) study where respondents around the country spoke about not knowing where to go or about those (substance misuse) services that specifically could meet their needs. For example,

“Most people didn’t know where to go for help...” (Wakefield);

“Many respondents could not name any local specific service...” (Tameside);

“The group felt that in order for Black and Ethnic Minority communities to access services that there should be more Black and Ethnic Minority (BEM) people working in drug services” (Sheffield).

This is in stark contrast to the experience of those agencies in the alcohol field that have taken a targeted approach to working with South Asian and African Caribbean communities.

Examples of this work are well documented, for instance, by

EACH (1999 & 2000) in Hounslow, West London, who have produced two reports: ‘Between Two Cultures – effective counselling for Asian people with mental health and addiction problems’

'A Cultural Cocktail – Asian women and alcohol misuse', (Shaikh, Z)

Aquarius with three studies (1993, 1995 & 1996) in the West Midlands.

'Alcohol Education in the Asian Communities of Dudley',

'Increasing the accessibility of Alcohol Services to the South Asian Communities of Birmingham'

'Alcohol and the South Asian population of East Birmingham', (Hyare, I)

SAAS (1989) in Southall, West London.

'Service provisions for ethnic minority problem drinkers from an Asian background', (Ahmed, N)

ARP Choices (1996) in South London.

'Black Advisory Services on Alcohol Related Concerns: An evaluation of three years work'.

DASL in East London (formerly Alcohol East, 1994 & 1995).

'Counselling Asian Men with Alcohol-related Problems', (Dhillon, H) and 'Alcohol and the Asian, African and Caribbean Communities: Research and Practice', (Alcohol Concern).

Additional analysis of tier 1 and 2 work of these agencies will be considered later within the case studies but it is revealing that agencies such as EACH in Hounslow saw some 2000 BME clients for treatment over their first 8 years as an alcohol service provider. This equates to approximately 250 clients per annum actually worked with (not just referred), which by any measure is a substantial number. This is in direct contrast to the relatively small number of black minority ethnic clients being seen by the agencies within the Bashford (Op cit) study. EACH has been able to combine a number of key strategic elements over a number of years to establish itself as a community based alcohol service initially serving Hounslow but now also as a provider to the London Boroughs of Harrow and Brent, serving diverse populations.

Some of the key ingredients within these initiatives include;

- having an innovative charismatic pioneer leader in Zaibby Shaikh,
- a strong emphasis and priority on an active outreach strategy to engage the local communities at various venues and locations from sauna to temple,
- utilising mother-tongue speaking counsellors and staff to help with communication and accessibility
- maintaining a high profile both in the alcohol field for this work but more importantly with the local population.

An agency is required to be more than just a specific service to generate this level of client throughput and presence in the community it services and EACH's experience offers some insight into what is required. This is where activities under tiers 1 and 2 are crucial in establishing a provider of a credible service for the South Asian and African Caribbean population. The later material in this report focussing on tier 3 work explores these issues more fully, but will confirm that a successful tier 3 provider must have solid foundations at tiers 1 and 2.

Are Alcohol services a priority?

The provision of services relating to alcohol appears not to be a main consideration for those that make decisions about national strategies in the area of health and social care, at least for local commissioners of services, as no such requirements are made by central government. These observations are made before the publication of the government's national strategy on reducing the harm of alcohol, however, this view is supported by the Commission on the Future of Alcohol Services

"...current planning structures for alcohol services are as uncoordinated as the provision. No one agency has the lead on developing alcohol services; The absence of national targets and consequent resources has further delayed the development of services" (Alcohol Concern, 2003).

The Alcohol Harm Reduction Strategy for the England (2004) states that most people obtain alcohol-related information from the following sources

- public health information and government campaigns
- information provided by the alcohol industry
- education in schools
- the workplace and
- advertising

Bhopal and Donaldson (1988) and Bhopal (1991) found that among postgraduate (health) students and health professionals who would be responsible for delivering public health messages such as "sensible drinking", when specifically considering the health of the South Asian communities, alcohol came in joint 21st alongside tobacco in importance. This was seen as significantly less of a priority than mental health (8th); diet and food (6th) and even rickets (10th). The same respondents were asked to rank in order of priority health concerns that warranted spend; preventative care and nutrition came 1st and 2nd with alcohol a lowly 20th.

A strong contrast can be drawn with the priority afforded to substance misuse of (illegal) drugs with the advent of the National Treatment Agency (NTA) for Substance Misuse. In July of 2003 the NTA circulated to all Drug Action Teams in the United Kingdom the key performance indicators (KPIs) for treatment, number 7 reads

"Improve demographic composition of problem drug users entering treatment so that access by BME groups is improved"

While this target is not one of four main targets that are measured against Government (PSA Department of Health) baseline data, increases are required by 2004 and 2008 in the region of 55 to 100%. Nonetheless it is collected and required by local commissioners and ultimately the NTA. The four main targets that are measured concern drug treatment (tier 3) and workforce development and consist of

1. Increase the number of problem drug users in treatment by 100% by 2008
2. Increase year on year the proportion of problem drug users sustaining or successfully completing treatment programmes
3. by April 2004 reduce average waiting times by modality to 2 weeks for inpatient Detox, 3 weeks for residential rehabilitation, 3 weeks for specialist prescribing, 2 weeks for GP prescribing, 2 weeks for counselling and 3 weeks for day care
4. Increase the drug treatment workforce by 3,000 extra workers by 2008 (NTA, 2003)

The alcohol field has been lobbying for the expansion of services and policies for sometime and the Commission on the Future of Alcohol Services(2003) Executive Summary recommends that government

“Review the needs of particular groups in their community such as women drinkers, black and minority ethnic populations and young drinkers, in order to ensure the provision of appropriate responses”
(Alcohol Concern, 2003)

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.

With newer communities arriving from around the world, the situation is becoming ever more complex and the analysis of the Research Unit in Health and Behavioural Change (RUHBC, 1989) is still very relevant to today's circumstances. They argued that both 'host' and 'arriving' communities need to change and develop better mutual understanding:

Firstly, for BME groups to understand the majority culture (acculturation) can enable them to better grasp the changes that are taking place in their own communities and to better control them

Secondly, mutual understanding from the deliverers of health promotion and the receiving communities can lead to greater success.

This may be illustrated by the “No to Nasha” (intoxication) research project conducted in Bradford's Asian communities in 1998 which may offer some illustrations of such mutuality may consist of in its recommendations for general and educational work:

- messages to young people need to be more relevant to them, and more participative and interactive. Young people should play a part in their learning
- role models should be used - i.e. community members should be trained to offer help and advice in a 'friendly setting'
- peer education models need to be adopted in youth and community centres. Many young people have said they would talk to friends about drugs. It is therefore logical to have as many informed friends as possible
(Arora and Khatun, 1998).

The challenge for alcohol education and health promotion specialists is that some of the evidence above suggests that messages such as promoting “sensible drinking” may be more favourably received if delivered by peers from within the BME communities. However, this could be seen to be in conflict with the evidence cited by EACH (Shaikh and Naz 2000), or Bashford et al (2003), where 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. The research conducted by Arora and Khatun (1998) questioned 2003 men and women from the Asian communities in Bradford between the ages of 12 to 40 years. They found that when respondents were asked the question

“people who take drugs are...”

59.9% of the respondents said they were bad and had made a negative assumption. This picture was balanced with 61.8% saying that they also needed help.

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).

The complexity of the situation with regards to language and culture is further illustrated by Bashford et al (2003) who cite the following comments from the respondents in their study

“Furthermore, the Zimbabwean population shows linguistic differences (Shona, Ndebele, Tonga, Kalanga, Venda and Nyanja)” (London)

Another respondent notes of the Pakistani population,

“The main language spoken is a Mirpuri dialect of Punjabi. This is an unwritten language. The main written language used, other than English is Urdu” (Sheffield)

Analysis of the literature conducted by Hay et al (2001) at the Centre for Drug Misuse Research in Glasgow looked at the drug and alcohol issues affecting BME communities and considered the issues of language and culture in alcohol education and health promotion. They note that:

- 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

The use of audio-visual resources has also been positively mentioned in a study of alcohol use in the Punjabi community of Toronto in Canada by Kunz and Giesbrecht (1999). They state that

“since their survey interventions have been made, such as video tapes (both in English and Punjabi languages), covering topics relating to alcohol use prevention and treatment. At the end of the tape, viewers are given the address

*of community agencies from which they can get more information. Response to these tapes have been favourable”
(Cheung et al, 1996).*

The recommendation of using audio-visual materials in community languages is common to research into health promotion among South Asian populations in the UK. It will be taken up again when discussing Aquarius as a good practice example of the development of such resources.

Key Issues in communicating messages to BME communities

The National Picture

The Drinkwise elephant is dead, long live the Drinkwise elephant! This strategy was always lost on the authors of this report, and perhaps many other people both inside and outside the alcohol field. For a number of years in the early 1990's the Health Education Authority (HEA) of the Department of Health used the symbol of an elephant to promote safer drinking and the notion of using units as way of calculating safe limits for men and women. The only BME material available at this time was produced by the forerunner of EACH's and Accept, both London agencies. They developed translations of the Drinkwise material into a number of mother tongue languages (mostly from the Indian sub-continent). This was not especially helpful as it gave no other additional information and just looked like a complicated equation not really suitable for public consumption.

Our impressions are reinforced by Dijkshoorn (1994) and Hyare (1996) who note very low levels of knowledge about the unit concept of counting alcohol consumption especially among women. The Health Education Authority before it became Health Promotion England produced two leaflets targeted at the South Asian and African Caribbean communities. The first titled 'Alcohol the Facts' (1999) was translated into Bengali, Gujarati, Hindi, Punjabi and Urdu. It covers myths about alcohol, daily benchmarks, the effects of alcohol and where to seek help. It unfortunately only lists EACH and Alcohol East (now DASL) both London agencies as contacts. It was developed in consultation with EACH and Alcohol East (DASL). The second titled 'Your Drink and You' (1998) was only produced in English and is targeted at the African Caribbean communities. It too covers the above but includes information about Sickle Cell Disorder. It had limited scope in that it was not produced in a range of mother-tongue languages.

The 'Think Drink' material of the Health Education Authority produced in 1999 is clear about daily benchmark drinking but makes no attempt at being BME friendly or focussed. This was despite the HEA's investigation into the "sensible drinking" message and to make any recommendations in 1993. The Alcohol Concern (1993) publication which analysed effective alcohol education messages in working with the Asian communities, notes that there is no such concept as "sensible drinking" for Muslims and that other more appropriate messages should be considered. It also argues that the communities themselves should be involved in the development of such messages.

The Government in its recent harm reduction strategy (2004) have realised the limited success of the "sensible drinking" message and state that they will overhaul the way they present messages about alcohol. They advocate the development of a strategic approach based on

- a co-ordinated communications effort, with input from non-governmental stakeholders where necessary;
- a revised “sensible drinking” message; and
- additional targeted messages, which focus on particular groups of people or behaviours, and which support but do not contradict the universal message.

We would commend the Government’s decision to review the national alcohol education and health promotion message and to consult a wide group of stakeholders including the BME communities to develop more targeted messages.

Another approach worthy of consideration comes from within the drinks industry itself. The Portman Group was established in 1989 and has developed the unit counter. It is behind the ‘DES’ (designated driver) campaign promoting the ‘don’t drink and drive message’. Again no attempt is made at being BME specific in any of the material or literature. The message has also shifted from consumption per se to driving and alcohol and is backed by the alcohol industry. The chosen medium for both of the above has been written material and as two respondents note from the Bashford (2003) et al study,

“Most people can’t read and write Bengali..”

“The fact that African culture was described as mainly an ‘oral society’ means that information which was provided verbally at social gatherings and in focus group settings was a better way of communication the ‘drug’ message rather than through leaflets and literature...”

These last observations are telling when the case study examples are considered which highlight innovative tier 1 and 2 work around alcohol and the BME communities.

It is encouraging that over the last few years, Alcohol Concern’s commitment to BME work can be evidenced by a number of initiatives. For instance:

- Alcohol education: an introduction to working with the South Asian communities (1993) developed by the training team in partnership with Aquarius, SAAS and DASL (formerly Alcohol East)
- Alcohol and the Asian, African and Caribbean Communities: research and practise (1995) developed by Alcohol Concern and DASL (formerly Alcohol East and Newham Alcohol Advisory Service)
- Evaluation of Alcohol Concern’s grants programme for Black projects (1994) by the Confederation of Indian Organisations (first phase)
- Developing Black services: an evaluation of the African, Caribbean and Asian services funded by the Alcohol Concern grants programme (1999) by Chauhan and Subhra (second phase).

More recently the Networking Distant Neighbours initiative has facilitated the development of a steering group to consider the setting-up of a national forum for organisations working with BME communities. The Civis Trust have been commissioned by Alcohol Concern to provide a strategy to work with small and dispersed BME communities in the UK. The work looks at the BME communities of Reading in Berkshire and Southampton in Hampshire, both with relatively small and dispersed BME

communities. Hopefully the learning from this will have applicability to other parts in the UK.

'Achieving Cultural or Individual Behavioural Change via the classroom is a tall order'

The above is taken from an AERC publication, Alcohol Insights (2000), a brief summary of alcohol education materials in schools. When considering the views of the National Drug Education Forum founded in 1995 and that of Tacade, a consensus begins to appear. The forum note that

-alcohol education is responsive to children and young people's needs, views and opinions; that educators should identify children and young people's knowledge and experience and use as a starting point for further learning. Alcohol education should be a continuous part of the learning process beginning in childhood and going on right through to adulthood

Tacade states the importance of beginning alcohol education in primary schools when attitudes are being developed and affirmed and observes:

-Tacade believes that different messages must target different groups, and that funding must be made available for organisations such as Tacade (not-for-profit) to action this based upon appropriate research.

The Government appears to grasp some of the ideas proposed above, that is, that alcohol education should be a continuous process and that different messages should target different groups. Unfortunately, they appear not to seize the opportunity to introduce alcohol education at primary school level, and only advocate it as part of PHSE and Citizenship at secondary level, This appears to be a missed opportunity as against strategies recommended by both the National Forum and Tacade.

In the absence of nationally produced 'good quality' alcohol health promotion and education material for the South Asian and African Caribbean communities, local services have taken it upon themselves to fill the void.

Examples of Good Practice initiatives in the development of BME services

The aim here is to provide a range of case studies that can highlight good practice in each of the following areas of work with BME communities;

- promoting a clinical (tier 3) service
- utilising local/personal networks
- working at a primary care level
- engaging a community via a community development model
- developing needs-led resources around alcohol and the South Asian communities
- a 'holistic approach' in providing a service
- a creative solution to a recruitment problem.

The case studies emerged from semi-structured interviews with key personnel in each of the following services with the exception of EACH and Coventry where the material was supplied in written form.

Choices – Promoting Treatment (Tier 3) Services to the BME Communities

Choices is one of the projects within the London based Alcohol Recovery Project (ARP), a large alcohol service provider serving Greater London. They were established 9 years ago and are based in Stockwell in South London serving the alcohol treatment needs of the BME communities in Lambeth, Lewisham and Southwark. The aim of the service is to overcome some of the barriers facing members of the BME communities in seeking an alcohol treatment service.

Choices are almost exclusively a tier 3 treatment provider and as such their tier 1 and 2 work mainly consists of promoting this service. A range of methods have proved successful in this regard. Examples include;

- creating an atmosphere that is friendly, warm and engaging so that sensitive issues can be dealt with;
- actively engaging with local, mainly voluntary sector projects in the community serving some of main BME communities (African, Caribbean, Portuguese, Somali, Indian, Albanians) such as those serving older people, women and young people;
- liaising closely with primary care services (GP practices) and tenancy support services and the probation service.

The presentations to staff in the above settings (community and statutory) include an explanation of the ARP philosophy which like many service providers in the field has its roots in social learning theory. This approach is captured by the Government's Alcohol Harm Reduction Strategy for England (2004) which states that alcohol misuse does lead to increased risk of harm depending on the following both individual and situational factors;

- the amount drunk on a particular occasion
- an individual's genes, life experiences and personal circumstances
- the extent to which an individual has other substance misuse problems and
- the environment in which the alcohol is drunk

With the communities facing entrenched inequalities these factors themselves could potentially compound the above situation with the introduction of alcohol misuse leading to an increased risk of harm.

It was emphasised that the staff of Choices 'reflect' the local population that it serves in terms of ethnicity and that these particular staff members do go out into the communities they serve.

Other methods of promoting the service have included;

- community radio broadcasts
- articles for local newspapers
- distribution of Choices leaflets with an accurate follow-up of who has received them and a courtesy call
- an open morning so that professionals can pop-in and look at the service once a week

- presenting the 'ARP video' to staff teams.

Adequate funding was mentioned as a concern to secure future tier 1, 2 and 3 services by Choices. Specific hope was placed upon the Government national harm reduction strategy for alcohol and it was observed that while local need was vast, current funding levels did not permit an increased level of tier 1, 2 and 3 services and activities. Areas of current unmet need included a concern about street drinkers in Brixton.

To summarise the key elements of good practice when considering the above case study appear to be;

- for a service to reflect the local BME communities that they serve
- meeting people in the community 'face to face' is important as according to the manager

"people like to see you"

as it enables the building of trust

- for an outreach strategy to encompass a range of methods to promote the tier 3 service to access BME individuals who previously would or could not access mainstream alcohol services

Choices appears to be a service that has consolidated its activities and remit since its inception and the impact of its outreach strategy seems to be clearly evident. It has moved away from being the 'black alcohol centre' to a BME provider, with a consequent move to work with a wider group of minority ethnic communities.

South West Hertfordshire Alcohol Advice Centre

– Utilising local and personal networks to increase accessibility to BME communities

Located in Watford town centre, the Alcohol Advice Centre serving this part of Hertfordshire houses the second phase of the Ethnic Services Project. The first phase (3 years) established a project to develop services to the BME communities of South-West Herts. with the second phase building, enhancing and consolidating this work with further development (3 years). The Alcohol Advice Centre is a well established voluntary sector provider providing mainly tier 3 treatment services (structured counselling) with some tier 1 and 2 work including education programmes targeted at drink drivers.

This case study will aim to illustrate the significance of utilising local and personal networks to establish a tier 2 project for the BME communities around alcohol in Watford. The Project Manager is a well known Pakistani woman whose family, (especially father) is very well regarded in the local Pakistani community of Watford, which is numerically the most substantial BME community. The project serves all of the BME communities, yet the project manager's personal and local networks have been influential in the path the project has taken. The manager explained her sensitivity to the pros and cons of being well known. On the one hand she is known and considered to be a 'good woman' from a 'good family' doing good 'charitable work'. However, this is also a challenge to the concerns that people have about (perceived) confidentiality especially as she is both a counsellor for the very communities she is doing development work

with! People known to her are curious about her need to do such work and when they ask her directly about this they receive a polite but firm response,

“this is my job and I must respect others confidentiality just as you would expect it from me”.

The Project Manager has developed an approach to manage the sensitivities of the mainly Muslim population of Watford around the sensitive and (forbidden) subject of alcohol use and misuse. Some elements of this approach can be explained by the following guiding principles;

- in meeting with individuals and community groups the Project Manager waits to see and hear what is being communicated by them before responding. This is given particular importance, as alcohol education messages such as “sensible drinking” are not considered appropriate when working with communities where Islam is the major faith.
- the Project Manager is able to be flexible, which appears to be determined by the degree of tolerance she encounters around the issues of alcohol consumption within the community and the responses they require from her to that drinking.
- she approaches the work with an appreciation of its importance to the communities she serves. The reality of this is that her work may potentially result in a better-informed community around the effects of alcohol misuse and possibly even result in referrals for help.
- she interacts with members of the BME communities in such a way that she is able to handle a multiplicity of views around the issues, some of which indeed may be quite strong, whilst not being side-lined from her task of increasing the awareness of knowledge around alcohol misuse in these communities.
- a technical skill that the Project manager has utilised in working with the BME community groups in Watford is that of taking a ‘third party position’ to the issue of alcohol misuse. So rather than saying:

“do you or has someone in your family have an alcohol problem?”

which may appear quite direct and confrontational, she has taken a less direct less contentious approach by saying,

“you may know of someone in the community or someone may have mentioned a relative in their family who has a problem with alcohol”

The impact of such an indirect and anonymous approach when working with a sensitive issue such as alcohol use and problems in the mainly Muslim community of Watford, is that it does not personalise the issue without closing down the potential discussion. The key conclusion that can be taken from the Project Manager’s approach to her work is that the consumption of alcohol and alcohol misuse in the BME communities where Islam is the major faith cannot be avoided or colluded with. The evidence from around the UK, Cochrane and Bal (1990), Cochrane and Howell (1995), Hay et al (2001) and Arora and Khatun (1998) confirm that alcohol is used and misused within these communities.

Taking into account the sensitivities of working with the Muslim community, it is to her credit that she has accessed in significant numbers, the Pakistani community and to a

lesser extent the Indian, Bangladeshi and other communities. The Project Manager's network of personal contacts including friends and local colleagues has facilitated the work with these other communities. In Watford and for that matter in other places it is crucial to the success of a tier 2 project for it to be embedded in the community in which it serves. This enables the building of trust and can add to its grass-roots credibility. Indeed a number of studies have advocated training community members to carry out tier 2 activities such as education, prevention and health promotion around alcohol and substance misuse, most notably Arora and Khatun (1998) and Bashford et al (2003).

The work to engage the community has involved a broad strategy of outreach;

- contacting primary care (GP practices)
- community gatherings
- a conference on domestic violence
- post natal and mother and toddler groups
- luncheon clubs and work with young people.

'Word of mouth' seems to be important in this tier 1-3 project establishing itself in Watford and the surrounding area. The inevitable difficulty of this projects approach which utilises a specific workers personal and local networks/credibility is that this resource goes if the individual leaves the post. Such points of access to the BME communities are then more difficult to access or worse still, closed to a newcomer. This perhaps is an all too familiar scenario for community development projects reliant on one specific, well connected and trusted BME worker. Subhra and Chauhan (1999) discuss the concept of the 'super-Black' worker who carries a multiplicity of roles including being the 'bridge' into hard to access BME communities.

New Roots – Primary Care Interventions to the BME Communities

New Roots is a BME Project located in Islington North London and is a part of the Rugby House Project, a medium sized drug and alcohol provider (tiers 1-4). With a 6-year history of working in a dedicated way with BME communities, New Roots have developed an approach focussing attention at a primary care (GP practice) level. This case study will outline how this strategy has resulted in the establishment of satellite services in the communities of Camden and Islington particularly within health centres.

Clients can access the 5-6 session brief intervention at such a setting with the possibility of being referred onto tier 3 treatment services if required and appropriate. The sessions cover;

- health needs
- assessment of substance use including alcohol
- agreeing a care plan of the clients needs (in line with NTA Models of Care criteria, 2003)
- completing diaries of substance use and assessing a persons motivation to change
- information about substances and services available from New Roots.

The staff of New Roots are trained in delivering brief interventions and the underlying philosophy of the approach is one of harm minimisation. Over the past 2 years the project has worked with the South Asian and African Caribbean communities specifically including Bengali, Caribbean, Somali, Eritrean and African groups. Resources used by the workers of New Roots are drawn from:

- established material around the 'cycle of change' focussed around the work of Prochaska and DiClemente's (1982), looking at the elements of change behaviour among smokers. The key importance of this work for alcohol misuse is that people are most likely to respond to feedback and education as sources of information around 'addictive behaviours' when they are in the contemplation stage.
- material from William Cross around 'black identity' (1991) in his classic text 'Shades of Black'
- Clinical Psychologist Naim Akbar's work 'community of self' (1985) offers an African-centred approach to modern psychology with a re-focus on the community within.

The above resources acknowledge the impact of racism on an individual but are written with the specific experience of the Black American community in mind. The influence of Prochaska and DiClemente (1982) has been widespread with many approaches to work with substance misuse, alcohol problems and other addictive behaviours incorporating such ideas. There is no reason to believe that the ideas put forward by the likes of Cross and Akbar will not have a more lasting impact over time in relation to work with the BME communities in the UK.

The key learning point for the alcohol field about the work of New Roots in a primary care setting is that BME communities do, generally trust and use their GP for serious, acute or chronic conditions (see also Johnson & Verma 1998). Purser et al (2001) note that in some cases the GP is the 'most trusted' source of such information. There is agreement with this view in the national strategy (2004) where the Government notes that many people use their local GP surgery as a first port of call for access for alcohol misuse problems. The same section (5.1 Identification and referral of those with alcohol problems) in the strategy document also mentions that consumption can reduce by as much as 20% among drinkers who receive brief interventions at primary care level than those who do not receive such interventions.

The Project Manager at New Roots felt that more money could potentially mean a greater impact for the BME communities in the boroughs they work, and as with the Choices case study earlier, the BME communities needs are greater than the resources available to tackle them. The national strategy (2004) does acknowledge this situation on a national scale and recommends action to address this issue.

Aquarius, Birmingham

– Developing Needs-Led Resources for Working with the South Asian Communities

Aquarius is a large drug and alcohol agency based in Birmingham but with projects located across the West Midlands region. The focus of this case study will be an AERC funded project which looked at alcohol education in the South Asian communities in Brierley Hill near Dudley. The Co-ordinator adapted the ideas of Geisbrecht et al (1990) when considering the model and approach to take with the South Asian communities in establishing and engaging stakeholders.

Following consultations with the various (religious) communities of Brierley Hill several relatively clear needs were expressed about how to raise awareness of the issues raised in relation to the various minority communities. The key ideas that emerged from this consultation exercise were:

- the message around harm minimisation around alcohol needed to be delivered before problems with alcohol perhaps had developed
- using everyday language and a medium that was community friendly
- It was decided that a trigger video would be developed accompanied by a comprehensive training manual and health education leaflets all in a number of languages. It was agreed to produce the trigger video and leaflets in Bengali, Hindi, Punjabi and Urdu.

The 'Sharaab' (i.e. 'intoxicated') video was developed, and along with 'Big Night Out' (the video targeting younger people), and both are now well established in the field for practitioners working with the South Asian communities in tier 2 work. The time and the costs for any agency developing something similar would be considerable and 'Sharaab' took 18 months in production from script to finished product and cost £35K in the early 1990's. It is estimated that the actual cost could have been £100K had it not been for the Co-ordinator and project reducing the expenses by utilising community networks. The community, the project steering group, the production company, the Co-ordinators family and even the actors who star in the video accepted basic Equity rates as they all felt that the project was a good cause.

The results are a polished soap opera style trigger video tackling various issues of the day in addition to just alcohol use, gender roles, violence and sexual health. The videos have received awards throughout Europe and in the UK.

The awards recognised the innovative approach taken by this particular format of alcohol and health promotion. The appeal is wider than just a literature based promotional tool such as a leaflet or a booklet. A video can be viewed and heard and does not just depend on the written word to communicate its potential message. This was further enhanced by placing 'the issues' of alcohol misuse and related issues in an interesting story board where potential viewers could be encouraged to engage and identify with particular characters as the story unfolded. The vignettes were used as prompts to discussion rather than as an end in themselves and there was a comprehensive manual and series of leaflets that accompanied the video to guide professionals using the resource.

The positive recommendations of using video as an education tool for alcohol education with the BME communities are further discussed by Arora and Khatun (1998) and Hay et al (2001).

Drug and Alcohol Service for London (formerly Alcohol East)
– A Community Development Approach to the establishing BME services

DASL is a well established alcohol and recently drug provider based in East London. The agency has been working with the South Asian and African Caribbean communities in a targeted way since 1988 in relation to tier 2 and 3 provision. The approach with tier 2 work has meant working with the young and old, men and women, those individuals who have multiple problems, those who are hard to reach (in this case young Bengali men in Tower Hamlets) and of course professionals in health, social care and other sectors.

The aim of this case study will be to set out how work with BME communities and alcohol misuse has been developed. DASL's experience of working with the Bengali community in Tower Hamlets initially involved working for approximately 3 years almost exclusively with women in the community experiencing domestic violence and/or mental health problems. It was only through detailed and intensive work with these women and the establishment of a facilitated women's group in a community centre and a drop-in surgery, that the Project Worker became aware of the background issues of problematic alcohol and or drug misuse among men in the family.

The Bengali Alcohol Project now works with over 1,000 individuals per annum which is probably the most numerically significant project in the country working with this community at tier 2.

Last year the project piloted the first brief interventions programme in mother tongue at a GP practice close to the City of London. The patients that attended came from this particular practice and from two other local practices with large Bengali patient lists. The programme included:

- health issues in general
- substance and alcohol use
- diet
- diabetes management
- and healthy heart issues

The material has been developed in-house using the Executive Bengali word processing package provided by Gate Seven Computers Ltd.

The younger age range; specifically young Bengali girls have been reached via the 'Girls Talk' project offered at Swanlea and Oakland Schools in Tower Hamlets. Young girls have found it liberating to talk about things following an eight-session programme covering:

- Me – exploring my identity
- My body & me – body, emotional and physical
- My body – how to look after my body
- Drugs, Tower Hamlets & me – how I cope
- Alcohol, domestic violence & me – things that happen that aren't talked about
- Love, relationships and marriage – feelings and fears
- Marriage – love, arranged marriage, forced and sexual health
- Me – my dreams and aspirations

This type of work with young Asian women takes on added urgency when considering that

“Young Asian women are three times more likely to commit suicide than the rest of the population.”

Raleigh and Balarajan (1992);

The key learning from DASL’s experience is that the ‘designated client’ may not be the ‘alcohol misuser’ themselves in the first instance in tier 2 work, although with work with the BME communities they may appear at some later point seeking treatment or support. The girls themselves said how important it was to talk;

“I wish I could talk to someone that will understand. Am I the only one?!...”

“Sometimes I feel like I live a double life, why is there so much pressure to be ‘perfect’? I am scared, I am confused, I am scared to tell someone.”

EACH (Ethnic Counselling in Hounslow)

– A Holistic approach to providing services to BME communities

EACH (Ethnic Alcohol Counselling in Hounslow) is a specialist service targeting the black and minority ethnic communities and providing culturally appropriate support relating to alcohol, drugs and mental health issues. Established in 1991 in the London Borough of Hounslow, it also has centres in the London Boroughs of Brent and Harrow, and operates across the West London area, providing a package of tiers 2 and 3 services comprising advice, information, outreach, structured counselling and a day care programme.

During 2002-2003, EACH overall supported 1,385 people from a variety of ethnic background, but predominantly Asian, reflecting both the ethnic profile of the locality as well as EACH’s own area of expertise.

EACH’s success of engaging BME communities has been its community development approach, based on the premise that in order to be relevant and accessible, it has to enter into a meaningful dialogue not only with professionals and other services but with the community itself. Thus:

- EACH’s services are provided within a cultural framework that acknowledges alcohol problems as being self-defined on the basis of an individual’s cultural, familial, social or religious point of reference.
- Services are provided in a number of languages by workers who are representative of the local ethnic communities, thus helping to establish a common ground and relevance.
- Outreach activities to raise awareness of alcohol issues within the community. This work is carried out through community events and via community based, religious and social organisations, thus helping to gain acceptance and trust.

- Outreach provision that establishes and provides multiple access points, including within community organisations, GPs and in various local neighbourhoods to reduce stigma and shame and improve access.
- A flexible response that takes into account hard-to-reach groups, such as a home-visiting service to Asian women which helps to address social isolation as well as engage them into services
- A holistic approach that involves work to access and support family members, carers and relatives through user/carers groups and individual support within community settings. Family systemic work is provided that acknowledges the cultural emphasis on the collective as much as the individual. The holistic approach also takes into account the help-seeking behaviour of ethnic communities and addresses the multiple problems and concerns an individual may bring, such as issues of immigration, racism, domestic violence, housing, inter-generational gaps and cultural conflict.

The key learning from this approach being pioneered by EACH is:

- There is the need to have a continuum of support that starts from and is embedded within the community itself in order to engage people from the ethnic community to address alcohol problems
- A long-term approach is required to build up trust, awareness and acceptance, which needs to be taken into account when planning services
- Help-seeking behaviour of members of the community, in particular women, needs to be taken into account when locating and providing services
- A holistic approach that encompasses a broad remit to working with the ethnic community is effective as a means to explore and address alcohol problems
- There is the need to undertake extensive outreach work to raise awareness within the ethnic community, utilising a number of mediums but in particular word of mouth, as well as that of professionals and organisations with whom members of the community may be in contact
- Language and linguistic understanding is vital as is having an appropriate staff mix but will only be effective where organisations have developed the cultural competency to work with ethnic communities

EACH continues to be a diversified provider and has also written extensively on their work over the years; Shaikh and Naz (2000), and Shaikh and Reading (1999).

Coventry Community Alcohol Service:
Asian Trainee Post - A creative solution to a recruitment problem.

Following unsuccessful attempts to recruit suitable candidates for Primary Care Worker positions from the South Asian communities in Coventry, it was decided to create a "Traineeship" post. This decision was informed by other recruitment processes that had succeeded in attracting Asian candidates with obvious potential, but who had insufficient experience and qualifications to meet the person specification. The purpose was to recruit someone with potential and to recognise that discrimination may have affected the capacity of Asian people to gain the relevant experience in such a specialist area and may have affected their educational opportunities.

The agency was seeking to ensure that it was genuinely representative of the communities it seeks to serve and was addressing issues of disadvantage and social exclusion. The post was widely advertised, attracting 7 completed applications of which 6 were invited for interview. The successful candidate began work in September 2001.

Considerable care was taken to design a work programme that would offer the new recruit the optimum chance of success. With no prior experience of employing a Trainee worker there was a need to be cautious and judicious.

Senior managers planned the process for the Traineeship and invested significant efforts into the design of the package. The key features of the post were:

- Job Description virtually identical to that of a Primary Care Worker;
- Emphasis on the existing agency Core Competences and those specific to the role;
- Extending the period during which competences need to be demonstrated from six months to one year;
- Very detailed Work Plan with target dates for achieving all competences;
- Successful completion of the Traineeship to result in automatic transfer to the Primary Care Worker grade;
- Additional training to be made available;
- Additional regular supervision to be made available;
- Provision of a Mentor in addition to supervision.

The target date for the completion of all the competences was set at nine months as compared to the Probationary period for new staff which is six months. It was expressly intended that any competences not met at the nine-month mark could still be addressed during the remaining three months of the Traineeship and as long as they were met within the year then progression to Primary Care Worker grade would still occur.

The pilot project proved to be a success. The appointed candidate successfully achieved all of the goals set within the target dates. In addition to anticipated work in the Coventry service she also agreed to assist the Trust through a temporary attachment to its Nuneaton office. This enabled her to gain a wider experience of delivering community alcohol services.

In addition to successfully recruiting and deploying a specialist Asian Communities alcohol worker, the benefits included the experience of detailed work planning which has informed the development of all work plans. The mentoring role has also been replicated elsewhere in the organisation. The experience of working with a detailed competence based work-planning programme will have definite benefits in the transition to incorporating DANOS standards into job descriptions and planning.

The wider benefits of offering Traineeships are that they may

- Attract new people into the field thus addressing the issue of workforce development at a time when there is likely to be a further increase in addictions posts;
- Demonstrating the agencies commitment to equal opportunities and diversity by enabling wider participation of under-represented and disadvantaged groups;

- offering greater choice for service users;
- Increase the tiers of staffing within services and thus offering a career path that may increase levels of staff retention;
- Increase opportunities for staff development through involvement in management and support of trainees.

The model was an ad hoc response to a specific recruitment difficulty and there is no continuing programme of offering alcohol traineeships in this service. Adapting a substantive post into a Trainee post automatically reduces the capacity and output of the agency because of the necessarily different pace of development and the requirement for enhanced supervision and support. The model has not yet been repeated in the alcohol service.

The Swanswell Charitable Trust (the parent body of Coventry Community Alcohol Service) also runs a significant Primary Care drug service: Drug Solutions Birmingham. This service has introduced a structured programme of Traineeships and the first intake completed their training during 2004. The trainees were recruited from a large field of applicants and further intakes are planned. Drug Solutions Birmingham has successfully recruited a diverse first intake and confidently anticipates that the enterprise will successfully deliver well prepared and inducted new drugs workers into the field.

6. Availability and effectiveness of treatment and higher-order intervention related to alcohol misuse amongst BME communities (Practice Survey: Tiers 3-4) (Pam Menzies Banton)

Introduction

The author has drawn on her knowledge and experience:

- Working in the alcohol field since 1985 in a range of services
- Undertaking a community consultation & outreach programme to the Black & ethnic minority communities on alcohol related issues
- Developing and managing the New Roots service (Rugby House)
- Developing a tier 3 abstinent substance misuse day programme

Rugby House is a substance misuse organisation providing residential, community based rehabilitation services also training and education to both communities and professionals. Since 1992, Rugby House has striven to address the issue of access to services for the BME community. Their experience is captured in the case study provided by Andy Stonard later in this report.

Methodology

In gaining the overview of service provision the following analysis was undertaken by using data from a number of sources including:

- the survey conducted for this report by Professor Mark Johnson of the Mary Seacole Research Centre at De Montford University.
- Alcohol Concern Services directory
- Interviews with alcohol services using a topic guide prepared for the project
- Published literature studying service provision to BME communities, Community Care, Commissioning, counseling psychology and legislation.

Methodological constraints had an adverse impact on the production of this overview. Although 24 tier 3 and tier 4 services in England and Wales were contacted, a number of these declined interview as they did not feel they could contribute or were struggling with the issues of access and engagement. A number of agencies agreed to a telephone interview or scheduled visit. The topic guide was sent in advance. Many of the interviews were cancelled upon telephoning or arriving and the interviewee had either forgotten and double booked. This work was not seen as either a priority or the workers were too busy. There were a couple of services who were unable to participate as they had to gain permission from clinical governance structures within their organization and we had missed the meetings cycle.

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).

From this, we may proceed to a definition of Cultural Competence.

Cultural competence makes the assumption 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.

Cultural competence requires that organisations :

- *Have a defined set of values and principles, demonstrate behaviours, attitudes, policies and structures that enable them to work effectively cross-culturally.*
- *Have the capacity to (1) value diversity, (2) conduct a self assessment, (3) manage the dynamics of difference, (4) acquire and institutionalise cultural knowledge and (5) adapt to the diversity and cultural contexts of the communities they serve.*
- *Incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systemically consumers, key stakeholders and communities.*

(Cross et al, 1989)

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. To design and implement services that are tailored or matched to unique needs of the organization and community. Practice is driven by delivery systems by culturally preferred choices not by culturally blind or culturally free interventions .

(Cross T. et al 1989)

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 - beyond the 'basic' moral one that is often taken for granted. It is helpful to review these:

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 (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.

Delivering services to Black and minority communities (DPAS Paper 16 2002)

This Home Office study was commissioned to support the Government's 10-year drug strategy. The research was taken from 6 Drug Action Team areas and existing literature. This study is an important document on issues surrounding the delivery of drug prevention and drug service to Black and minority ethnic communities. It identifies priority areas and issues.

Relationships between drug agencies and BME community groups were problematic. These failings were to do with:

- The image of the services
- The isolation of the services from the community
- An inability to respond to distinct patterns of drug use shown by BME communities
- A more general inability to respond to different needs

Failings appeared to be acute in residential services. Considerable emphasis was placed on “cultural competence”. This cultural competence was identified as resting on:

- Cultural ownership and leadership
- Symbols of accessibility (something that shows members of BME communities that they are welcome)
- Familiarity with, and ability to meet, the distinct needs of communities.
- Holistic, therapeutic and social help
- A range of services
- BME workers
- Community attachment and ownership and capacity building

Implementation in Practice: Good Practice case studies

We now turn to the findings of the survey of practice and interviews with workers in agencies:

“Tier 3 refers to structured community-based alcohol treatment services where the alcohol misuser can receive a comprehensive assessment and have a care plan agreed between the provider and client “

National Treatment Agency 2002.

The specialist services interviewed have gone some way to make their services culturally competent. These services have actively sought to integrate knowledge, skills and dialogue in order to demonstrate their cultural competence.

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.

Sahaita, New Roots, EACH, and Choices all voiced the need for flexibility in referral routes into tier 3 services. By having more open and flexible protocols a wider net is cast in being able to reach potential clients. This is also illustrated in the dialogue with tier 4 services. Closer working with tier 2 and 4 services was felt to be crucial.

EACH (Ethnic Alcohol Counselling Hounslow)

EACH is a voluntary sector organisation that was set up in 1991. EACH works mainly with people from the ethnic minority communities, but is also working with white clients. Sixty-five percent of their clients are from the Asian community. The aim of the service is to work with individuals, family members and carers primarily from the minority ethnic communities affected by alcohol and mental health problems to help them make beneficial and positive changes in their lives (EACH Annual Report 2000).

They offer a range of interventions both structured counselling and day programme as well as a service for carers. 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 built 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
- They 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 complimentary therapies

EACH incorporates a “cultural and self” awareness group within its structured day programme. This is open to all participants and acknowledges as stated earlier that culture is not just an “ethnic” issue and that everyone has one. Some of the group work is conducted in mother tongue where group numbers and composition allow.

Their work with the local statutory substance misuse team and community mental health team is an example of how they have worked to ensure that the “best interests” of their clients are represented. EACH took the lead in informing the local protocols and principles to ensure the needs of BME clients were incorporated.

The Qalb Centre

Qalb is a BME voluntary sector organisation. They offer structured counselling and group work to alcohol using clients. They employ an Asian speaking worker and an African Caribbean worker. A “Black centric” approach which accepts the client’s worldview and this approach draws from the work undertaken in the mental health field, especially Fernando (1995). This perspective argues for an embracing of the client’s worldview, spiritual, religious ideas and thoughts and to accept that some clients will bring God into the therapy.

“ 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”

This worker was highlighted the dilemma of engaging with clients who are not used to the rigidity of counselling practice. Adapting in order to offer flexibility of time-keeping and timing, and providing less rigid interventions such as, taking a client for coffee to enable introduction of the service and engagement process in some cases operating with “looser” counselling boundaries. The Qalb worker uses this period of engagement to induct the client into the expectations and principles of counselling. This was also highlighted by the work of Alcohol Concern (1993) *An Introduction to Working with Asian Communities*.

Sahaita Project

Sahaita, which is part of the Aquarius project in the West Midlands works primarily with the South East Asian community and have taken this approach a step further and work within a methodology, which states the ability and willingness to appreciate, understand and work with:

- Religious beliefs
- Family dynamics and power hierarchies, due to gender, age and generation
- Caste
- Spirituality

Miller (1998) states “The history of alcohol and other substance use is intertwined with spirituality and religion. The use of specific psychoactive agents is proscribed in certain religious traditions, and proscribed in others”. In the twelve steps tradition of Alcoholics Anonymous sees sobriety as far more than just abstinence and incorporates spirituality into its programme. Sahaita acknowledges that to work with the Asian community, where religiosity and spirituality are important, any programme methodology needs to incorporate this, even down to the day and time of groups allowing for prayer or attendance at the a place of worship. Asking direct questions about religiosity and if the client had thought about the role of religion in their recovery was seen as part of the process as much as asking about the amount of alcohol consumed.

This is then combined with an approach, which includes an understanding that Asian people may:

- Value a more directive approach
- Be more fatalistic
- Believe in or know more about a “disease/ medical model”
- Not understand or misunderstand what counselling is
- Individuals place more importance on the group/ community than the individual.
- Appreciate “looser” counselling boundaries
- Attend a course of counselling in a more chaotic manner
- Sporadic attendance, less formal contact
- Appreciate more directive “advice”

- Appreciate or request adhoc support/ advice on wider but potentially related matters such as legal issues, welfare benefits and housing.

Sahaita is staffed by 4 Asian workers from the Sikh and Hindu religion and have mother tongue languages in Punjabi and Hindi.

New Roots

New Roots is a Rugby House scheme established in 1996 and working with a range of BME communities in central London. The New Roots model utilizes community engagement and counselling. New Roots sees the value of integrating traditional models such as the cycle of change model, Motivational Interviewing and Cognitive Behaviour techniques with other world view models. It has drawn on a wide variety of perspectives in shaping their own approach to the work:

- The Black identity model (Cross 1995), which sensitise workers to appreciate the impact that racism and oppression plays in the clients' life and identity
- The Community of Self-model developed by Akbar (1985).
- Nugozo Saba: Seven elements of healthy living as described by Karenga (1965) This model governs how the team work together
- Learning from other providers within the alcohol field
- Learning from the mental health field.

The service also looks to include readings and affirmations from BME writers and philosophers enabling the client to look to their own culture for solutions, strength and build self- esteem. As mentioned earlier, cultural and religious adherence are key factors and this was found in two studies by Cochrane and Bal (1990) and Cochrane (1999). The grounding of staff and services in this material has been a key part of the shaping of the identity and working approach of staff and the overall New Roots project.

The model operates from satellite venues within local services and community organisations enabling easy access and choice of venue and location for those unwilling or unable to access other substance misuse services. Group work and structured counselling operates from these venues. There is an acknowledgement that the client's experience of racism in everyday life and in other services may affect their help-seeking behaviour. BME groups tend to be less aware of services and treatment options, so utilising a community engagement model helps to break down this barrier.

The community engagement model takes the service out into the community offering a range of interventions tailored to meet the needs of the distinct communities, from training and workshops for community groups and allied services though to care planning and counselling and group work.

Clients referred into tier 4 services (residential detox. or rehabilitation) can receive visits or support upon admission. Clients have stated they find this beneficial and it has helped them stay focused. Some clients are referred back after treatment.

In the ethnic and gender matching study by Fiorentine et al (1999), they found that engagement and outcomes in counselling were strongly related to empathy and that matching by gender and ethnicity helps engender the perception of empathy. Miller (2000) found these variables are also important and the ability of the therapist to empathise with the client seems to predict success.

The importance of this ethnic and cultural matching is evident within the New Roots service, which is run by workers from the BME communities, and the impact is tangible.

Drug and Alcohol Services in London

DASL have found that by locating and offering a service within primary care that they are able to access African Caribbean clients into their main services. The primary care setting also offers to opportunity to address health problems such as, diabetes and high blood pressure, giving the service a wider health perspective. Research has found that both diabetes and high blood pressure affect the African Caribbean communities at higher rates than the white British community. A person of African Caribbean origin is twice more likely to suffer from a stroke than white people. They tend also to suffer a first stroke at a younger age and it is more likely to be fatal (The Stroke Association 2002).

Within the DASL structured group work programme, the service has strived to be culturally competent. They provide 16 groups per week. New clients are assessed against the criteria for the programme. Where available the assessment is completed in mother tongue and if the clients English is below the requirements of the programme they are referred to an English as a second language course before being given a place on the programme. This was seen as empowering the client. The service has English classes available on site, "English with Confidence" which are open to all.

The service has an ethnically diverse workforce, which they see as essential and representative of the local community.

ARP Choices

Choices are an alcohol treatment centre established to meet the needs of the BME community in south London, an area with a high population of people from Africa and the Caribbean. Choices are part of the Alcohol Recovery Project, a large service provider in London. It has its roots in the social learning theory of dependence and identifies the value in outreach and counselling working "side by side". with the client. Their tier 2 service enables information to reach the community by "breaking down barriers" and helps individuals engage especially in the early stages of contact. The concept of counselling is "alien" to most of their clients and taking time to aid understanding of the process and structure is important. In their experience ARP Choices finds the following as positive elements of their programme:

- Service User stakeholder meetings
- Employing multi-cultural staff group
- Employing sessional counsellors with community languages
- Welcoming and warm environment with BME images, information and art
- Complimentary therapies such as acupuncture, Indian head massage and shiatsu

- Information in a range of community languages
- Drop-in facility where people can get information on the programme
- Education, employment and training services on site

Choices also offers a group-work programme which is both educational and therapeutic.

Options Alcohol & Drug Counselling & Information Service

Options is based in Southampton. It is a generic voluntary sector agency working across Hampshire. Options operates a structured counselling and day programme. Options state that 6% of the local population is from the BME community and mainly, Sikh, African Caribbean and African. They have been faced with many challenges in widening access to their service. They saw the need to establish a tier 2 service to work alongside the tier 3 programme which opened up access and aided engagement. This led them to set up satellite venues within local districts, to give clients anonymity. Building trust and confidence in the service by outreaching into local BME communities, establishing a steering group chaired by a local community member.

All staff have undertaken trans-cultural counselling and Options have actively recruited volunteers to train as alcohol counsellors to work alongside paid staff. Their service literature has been translated into local languages.

Key issues in developing services for BME communities:

i. Gender

EACH has pioneered work with women and provides an Asian women's group in recognition of the need for women to be able to express themselves outside of the gender power structure and roles.

"Drinking women and women of drinking partners maybe ostracized and she may be expected to for go her happiness for the sake of the honor of her family"
(Shaikh & Naz 2000).

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. Those interviewed highlighted the importance of information sharing and a deeper understanding of the client's situation in formulating a care plan and developing a therapeutic alliance. 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 such as the Bengali and Horn of Africa communities. New Roots has started to address this and is training translators from one of the local PCT's translation service. This training covers alcohol and drug awareness, attitudes to its use and an understanding the terminology and language of the field.

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.

Project workers interviewed stressed the importance of mutual understanding and information sharing. As one interviewee put it

"It is not only speaking the same language that is important but the way the language is expressed"

(worker at EACH)

EACH reviewed their first 300 service users and found that 75% of them expressed a preference for mother tongue intervention. Of course in running a group work programme this can be problematic in catering for the needs of all participants, but aspects of the service can be reinforced or explored in greater depth outside of the group programme.

"Having workers who are able to understand the street language and pataios (Caribbean dialect) of the Caribbean community has been of great value, not only for the client but for the teams understanding"

(New Roots)

Another service highlighted that they were able to support Bangladeshi people going through home detoxification by employing Sylheti speaking workers, without whom clients would not receive a service and/or compliance with the regime would be hindered. (DASL)

All services stated that being able to provide counselling and group work in mother tongue was an essential strategy and component of their work. The alternative is to encounter the challenges of accessing interpreting services. One service described the process they and the client have to go through to access interpreters from the local authority

"If we don't have counsellors who speak the language, we are required to go to the statutory team for an assessment before an interpreter is agreed. This creates another barrier to treatment for BME clients"

The translation of paper tools commonly used and taken for granted in alcohol work such as drink diaries, service information leaflets, alcohol education materials etc. was also highlighted as essential.

Agencies argued against family members being used as interpreters and thus respecting/maintaining the client's confidentiality. It is important that work with families does turn into a situation where family members are being used as interpreters. Alcohol

and especially problematic alcohol use brings with it shame and stigma and is grounded in the culture, religious values and norms of many BME communities.

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.

This was also highlighted as a key recommendation in a report for the Home Office: Delivering Drug Services to Black and minority communities (Sangster et al 2002).

“An ability for services to work appropriately with family members was identified as an important issue by South Asian drug workers and community members. Drug workers cited the need for family work as a key difference between South Asian and white clients.”

(Sangster et al 2002)

As one service put it:

“ Pakistani Families in this country are very close and one member of the family will usually know what is going on with regards to the next member. Also families are wide-spread and include your uncles, aunts & cousins etc. not just parents and brothers and sisters. The most influential member in a household is the father and what he says will be accepted by the family.

In the case of alcohol if someone is drinking and the family found out then they would see this as shameful and degrading for the whole family not just the individual involved. The family would generally get together and come to some sort of decision regarding the individual”.

(Saaf Dil worker).

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. One way of dealing with this was to offer the significant family members support in their own right. The concept of particular family members being the `gate-keepers` or `shepherds` is worth considering in that their role in enabling you to access their family or play a role in helping a relative to maintain contact with treatment maybe critical. Parental problem drinking has an impact on family functioning and by working with the family and influential others, it enables the family to work towards cohesive relationships and functioning. As mentioned earlier it is possible to build in protective factors to help guide behavior change. Velleman(1996).

As mentioned earlier in this document “izzat” in the Asian culture can be either a motivating factor or demotivating and therefore needs to be acknowledged and worked with.

Within the African and Caribbean cultures the role of the parents is crucial as they are often the main provider of child care and support to the grandchildren.

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.

“When providing a service to the Asian community you can’t be complacent, you have to be proactive and take the opportunity to present ourselves”
(Worker at EACH)

Building networks with community groups, leaders and grass roots people who have an interest in the subject or community was actually as valid as providing the actual counselling. Most local authorities have networks or forums aimed at focusing on the health & social care needs of the BME community and these were cited as a good starting point to meet key players. Some services such as New Roots and Sahaita have established their own forums focusing on alcohol-related issues and BME communities. These are attended by local BME groups and providers. These forums not only inform the community and the service providers but also feed into local service planning and strategy processes.

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.

A willingness and ability to listen.

A willingness to take action and represent the concerns of the BME community.
Providers have access to commissioners and other decision-makers.

Provide translated information on services and alcohol.

Feed this into service provision

Services also felt it was important not only to acknowledge the Christian celebrations such as Christmas, but also to send out for e.g. Eid and Diwali cards to clients and community groups and have an event within the programme for all clients to celebrate. ARP Choices hold an event for service-users which is more of a cultural celebration. This simple action was very much appreciated and well attended.

v. The use of satellite venues

Some services have taken their services out into community venues and see much value in this. New Roots operates solely from satellite venues based within health and community settings. They also provide on-site alcohol input to Black and minority ethnic mental health services. This model was established as a result of consultation and discussion with BME community groups. The model has enabled the service to provide a flexible and anonymous option.

vi. Trans -cultural Counselling

D'Ardenne and Mahtani (1989) define it thus

“ 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.”

It should come as no revelation that the profession inherently reflects white cultural values and can be mis-matched with the values of BME clients. 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 from primarily individual focus to one that also includes family and environmental variables.

Management and Leadership

Recognition of the inequalities in service provision led some professionals to take specific local action. Some services were operating within culturally diverse neighborhoods but not having anyone from these communities accessing their service. For most services the decision-making processes about whether to undertake BME work was made at senior management level or management committee. Only one service stated that it was the counsellors who raised the issue with management. The following statements highlight the need for leadership:

“The director was a motivating force”

“The service manager took the initiative and leadership”

“The manager helps keep the focus and leads the culture of the team”

“The management committee voiced their concern 11 years ago”

“The centre was for Asian people and they felt there was a need to address both the needs of the Asian and African Caribbean community”

“Board is from the BME community and don’t lose sight, their leadership is very important to us”

Having management take the lead helps to shape the culture of the services. There needed to be clear aims of what is to take place, to whom, by whom and what was being offered. Those questioned expressed the need for outreach workers to be able to feedback from the communities. This guidance informed services of the needs of both their service and the community.

In all of the interviews no workers stated that their service came about as a result of local commissioning strategies, none were approached by commissioners to address local need from the outset of the services development. However, two services stated that as a result of their service being established, local commissioners have had a “shift in thinking” about the needs of the BME community in particular and are now commissioning with the needs of this community in mind. One service experienced a great deal of support and investment from their commissioners with good lines of communication between them. This has helped develop a responsive service. Services reported that once commissioners are ‘on-board’ they have been supportive and aided capacity.

viii. Funding of services

Involving communities in service planning and development is not only good practice but now a requirement of the government’s modernisation agenda. The National Health Service Framework (NSF) states that all services must be planned and implemented in partnership with local communities and must involve service users and carers (Drugscope and Alcohol Concern 2002).

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.

One commissioner was interviewed for this report, and were chosen because of their track record and experience of commissioning substance misuse services and in particular BME services. They are also have a good knowledge and interest in the substance misuse field. They stated that commissioning has become

“more political than before (Community Care.) Needing greater co operation between health and social services departments. There is now the willingness to give longer term investment in services that offers real resources. As a commissioner there is a need to

know what the traditional services have done to try and access BME community. It is important to have an interest in the field and a belief in treatment.

It crucial that the right people sit on the right forums and can make decisions. Investment in “development work or needs assessments of the local community as there can be a lot of assumptions made and an imbalance of service delivery “less deprived doesn’t mean less damaged, nor does not taking up services mean there is no problem. Capacity building initiatives need to go hand in hand with service delivery. Taking a lead from the NSF as it is a fact that consultation is less evident within the drug & alcohol field than anywhere else and this needs to change. “

Most of those interviewed 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, it took time and a lot of effort.

Commissioning standards, Drug and Alcohol Treatment and Care (SMAS 1999) provide important guidance in the commissioning of drug and alcohol treatment services. Integration of BME needs at every stage of the commissioning process is recommended. Improved services for the BME communities will only come about when the commissioning cycle reflects this.

Tier 4 services

“Specialist, residential and high intensity treatment services. These are high threshold services, with access by referral from local authority social services substance misuse teams. Typical services running tier 4 interventions including residential rehabilitation and inpatient detoxification services”.

(NTA 2002)

There is a broad range of substance misuse residential rehabilitation services in Britain. They are of differing levels of therapeutic intensity, programme structure and duration. There are over 100 programmes operating in England (DrugScope 2002). Residential services are usually registered under the Care Standards Act (2000), as a registered nursing or care home. Treatment is paid for out of community care budgets and supplemented by other funding.

All services questioned were generic services, to our knowledge there is no specific BME residential rehabilitation or detoxification service in the United Kingdom.

The inpatient/ residential detoxification treatment units are aimed at those who have difficulties achieving abstinence in the community. These programmes provide supervision in a controlled environment, with supervised withdrawal (detoxification) and most programmes provide psychosocial counseling and support aimed at relapse prevention. People are referred onto residential treatment programmes or after care in the community. (Models of Care NTA 2003).

There are 4 types of provision:

- Therapeutic communities
- 12 step programmes based on the Minnesota Model
- Faith based programmes usually Christian
- Cognitive Behavioral and Motivational Interviewing programmes

BME clients were less visible in residential services. Providers stated that they were reliant upon referrals from mostly statutory services who “gate keep” the contracts and funding. Service providers felt that this was a barrier. However, those who had good links with GP’s and local services and protocols to aid referral, such as the Max Glatt Unit in west London, saw a significant number of mainly South East Asian (Indian) men accessing treatment. It is widely acknowledged that that residential rehabilitation services are generally poor at meeting the needs of the BME substance misuse’s (Sangster et al 2002).

Residential services stated they are limited in the marketing of their service to communities due to staffing and relied on mail-outs and tier 2 services to promote them in the community. The referral pathways come mainly from statutory services that traditionally see very few BME clients.

The complexities of residential rehabilitation programmes

Respondees stated that it was important for their programmes to have a high level of social interaction both formal (group work) and informal (communal eating and social gatherings). This element of the programme they felt can leave BME clients feeling isolated especially if they are the sole BME client or if they have limited English, which excludes them from participating fully in the programme.

Clients undertaking residential rehabilitation may well require a programme outside of their local area, sometimes outside of their county because of lack of provision locally or their need to change their environment.

Respondents from tier 3 services stated that parents and partners who have not known about treatment services send the problem drinker home usually to South East Asia for treatment or to family to rest and “get better”. In some cases the families were unaware of treatment services and the funding structures and processes, and paying for the treatment from the family budget or savings. There is clearly a lack of information in the community about social services and how to access them.

Brook Drive – Equinox

Brook Drive is a substance misuse detoxification and assessment residential services. It is part of Equinox, a voluntary sector social care agency based in London. There are 27 beds and the length of stay is up to 31 days. 10 days are spent in detox and 21 days in assessment.

Brook Drive has contracts with several local authorities; most of the referrals come via substance misuse teams. Equinox has beds specifically allocated for the needs of the

homeless population, who are referred via its homeless outreach team. In this respect they have little control of who is referred and who is not. However, they do promote the service outside in the community to the BME population.

The philosophy of the service is to provide a good quality service, as the manager put it, *"If someone has a good experience of detox their sobriety will be enhanced. Treating people with respect"*.

Brook Drive provides:

- Diet cards, which are completed upon admission to identify dietary preferences and religious needs
- Separate fridges, work surfaces and kitchen tools to minimize contamination of food products such as, pork or beef or meat.
- Nutritious and varied meals provided which includes ethnic dishes
- Offer detox to anyone who has limited English, using translators and getting staff to be around the person as much as possible to minimize isolation
- Each client receives an exit interview
- Each client is given a copy of the complaints procedure
- A clean, safe and nice environment
- Diverse staff teams, out of 26 staff, 11 are from the BME community.

It is important that staff make no assumptions about BME clients wanting that same race worker, clients can be allocated a worker on gender or race if they ask.

At Brook Drive clients are expected to participate in a group work programme and interact with both staff and other residents. Those without any or limited English are offered the 10 day detox. Programme.

All staff receive anti- discriminatory training and robust policies to protect clients and act upon discriminatory behavior.

St Augustine's and Agar Grove Residential schemes – Rugby House

Both St Augustine's and Agar Grove are two rehabilitation schemes and are part of Rugby House, a voluntary sector substance misuse agency. Referrals are taken from substance misuse teams within the London local authorities. Residents need to be abstinent or post detoxed and looking towards an alcohol- free lifestyle. The length of the programme is 3 to 6 months. In the interview I was recounted an incident which had occurred to a Black client, as a way of illustrating how important it was for the clients to know that they belong. The Black client had attended his first AA meeting and was directed by a member to the Narcotics Anonymous meeting. When the client reiterated that he wanted the AA meeting he was asked if he was sure! This client never went back to AA. We have to insist that while this was not AA's fault, it illustrates one perception of where black men and women are expected to fit in. This comes across as unwelcoming and isolating. The service has worked hard to address cultural competence issues.

- An external supervisor who is Black has been appointed, and provides a space where the issues can be discussed and explored
- Valuing a person's cultural background
- An understanding of the importance of identity

- An understanding that religion and religiosity may be more important for BME clients
- Clients receive a copy of the complaints procedure
- The resident's handbook contains information on where to buy spices, certain food stuffs and places of worship.
- Ensuring that the programme timetable is structured to allow residents to visit places of worship if they want to. (keeping Friday, Saturday and Sunday less structured)

Long Yard Crisis Centre– Rugby House

Long Yard is a 13 bedded residential care home for men and women to withdraw from alcohol. Residents stay up to 28 days. Residents receive a supervised withdrawal, assessment, stabilization and assisted move on. 90% of the service is contracted through health and social services and as mentioned before, has little control over who is referred into treatment. However, being linked to New Roots and having locally agreed referral protocol agreed with commissioners New Roots can refer BME clients directly.

As the manager put it

“we have a duty to be aware and have knowledge of the issues facing all our clients such as language and how we as staff express ourselves, that intimacy is cultural and that clients can be interpreted as being in denial when they are not”.

” We are striving to have a culture whose principles and practice are embedded in operational policy.”

Long Yard retains BME residents at the same level as non BME residents.

The service works to meet the needs of clients by:

- Establishing the clients dietary needs prior to admission so they can be catered for
- Acknowledge that family contact maybe a more significant element in treatment than for other clients
- Understanding the role of the family and community
- Having New Roots worker visit those they have referred and assist with translation and helping the client settle into the programme
- Allowing family members to visit if the client wishes
- Choice of gender of worker
- Diversity issues are raised and discussed within the team meeting
- Having a robust complaints procedure
- Anti- discriminatory policy
- Give a single room to those for whom prayer is important

Max Glatt Unit In-Patient Service

The Max Glatt Unit is based within the St. Bernards Wing of Ealing Hospital, London. It part of the Central and North West London Mental Health Trust. Max Glatt offers detoxification and is in an area where there is a high Asian population. Alcohol misuse carries a lot of stigma and coming into the unit can be an ordeal for both the client and their family. In order to enable engagement and compliance, clients receive information on the service prior to admission so they are aware of the expectations. The service has good links with GPs in the area and as a result receives a high number of referrals from the Asian community.

The service utilises interpreters where necessary to enable engagement and compliance with the programme.

Conclusions

This sample of Tier 4 services is too small to make any in-depth conclusions as the sample size is small and not representative of the country as a whole.

However key learning does emerge including

- i. having links into the community enabled care pathways into treatment. Feedback from residential services indicated that there is a need for more flexible care pathways into treatment and there was an assumption that those referring (statutory services) to them were not seeing or referring BME clients. Residential services also reported that they were limited in their “marketing” to the community.
- ii. In talking with services who are working with BME communities, what was striking was the flexibility of approach and the range of treatment options made available. They are culturally competent or certainly striving towards it and had identified areas of the service that they had changed to accommodate diversity.
- iii. Nearly, all the services offered a greater holistic care plan, paying particular attention to spiritual and faith beliefs and culture. They were attempting to accommodate the client rather than force the client. There are now a number of guidance documents and services operating to aid the process of becoming culturally competent than before.
- iv. Where local services were working closely with the commissioner, there seemed to a clear local strategy, creativity and emergence of services was not being stifled and services felt supported and secure. Where this was not the case and services were receiving short term funding this led to the loss of staff and a lack of planning.

Recommendations

A. Working with other services

- To 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.
- To 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.
- For an outreach strategy to include the promotion of tier 3 and tier 4 services to the BME communities
- Newly arrived communities such as, asylum seekers and refugees (vulnerable to developing alcohol problems) are excluded from funding which more work on the impact of this on tiers one and two services and communities.

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

7. Alcohol Concern's contribution to developing alcohol services for people from minority ethnic groups in the UK

Background

Between 1990 and 2002 the greater part of Alcohol Concern's work in developing and promoting services for people from UK minority ethnic groups took place in the context of its major Grants Programme, Alcohol Concern's (AC) Services Funding initiative. The Grants Programme offered the opportunity to address the need of those groups, which were traditionally under-represented in alcohol services. During the 1990s the AC Grants Programme dispersed over £10 million of Department of Health (DoH) funding, aimed at increasing the quantity, range and quality of alcohol services.

In the late 1980s and 1990s there were very few services specifically for people from minority ethnic communities. Many services considered their "open to all" view sufficient without analysing whether their services actually met the needs of people from different ethnic groups.

Grants programme Stages I and II

Stage 1 of the Grants programme ran from 1990 to 1994. The aims of the programme were to:

1. Improve the availability of alcohol services to enable more people to receive help
2. Enhance the quality of services so that this help can meet all users' needs more effectively and
3. Dissemination of the lessons learnt

Some key considerations in funding alcohol services included:

- The need to establish a solid funding base so services were able to engage in forward planning in partnership with local funding bodies.
- Ensuring that specific aspects of good practice were implemented by services and that they were in a position to provide concrete evidence of its effectiveness to commissioners and other funders.
- Promoting equal opportunities in service provision so that services could respond appropriately to the need of all potential users.
- Providing a high level of monitoring and support for grant aided services and ensuring dissemination and take up of the lessons on good practice to emerge from the programme.

The programme was targeted at two categories of alcohol services – those that filled a geographical gap in service provision and services for specific groups of people that traditionally under-used alcohol services, including women, people in rural areas and those from minority ethnic groups. For the purpose of Grants Programme, services for ethnic minority groups include those with potential clients from African, Caribbean and South Asian groups. These are now usually referred to as Black Minority Ethnic groups (BME). Special care was taken to promote the Programme with agencies that could service BME communities, with a team of three AC development officers set up to support applications from these agencies.

By the completion of Stage 1 of the Grants programme 13 services for minority ethnic groups had been funded, accounting for one fifth of the available funding. Overall, 92% of the services funded through the programme went on to receive statutory funding. One of the key features of the Programme was the importance of evaluation of the lessons learnt and the dissemination of good practice to the wider alcohol field. To achieve this, an independent evaluation was undertaken of the whole programme together with a separate evaluation of services specifically for BME groups. These were made available as part of a series of published reports:

- 'Evaluation of Alcohol Concern's Grants Programme' (1994)
- 'Evaluation of Alcohol Concern's Grants Programme for Black Projects (December 1994)

Lessons learnt from Stage I of the programme were fed into Stage II. In order to prioritise services to African, Caribbean and South Asian people Alcohol Concern ring-fenced £1 million for this purpose out of a total of £3 million available for the Programme. Nine projects were funded in this way and a further 3 projects were funded from general programme funds, making a total of £1.4 million dedicated to the development of BME communities. Grants were awarded on a cost-share basis with Alcohol Concern covering 75% of costs and local commissioners contributing the remaining 25%. Local commissioners and funders also had to indicate a commitment to fund the project once the grant had expired.

In addition to funding alcohol projects for BME communities, Alcohol Concern put considerable effort into developing and supporting these services. Throughout the second stage of the Grants Programme Alcohol Concern ran training days for grant applicants and a mixture of training sessions and networking days to help workers in the successful agencies, enabling them to share experience and expertise and to develop ideas or guidance on specific organisational issues.

Some additional benefits from Stages I and II of the Grants programme included:

- The publication of the independent evaluation of the Grants Programme "Developing Black Services: *Evaluation of the African, Caribbean and Asian Services funded under Alcohol Concern's Grants Programme*" by Subhra and Chauhan (1999). This report focused on the factors involved in the successful development of sustainable services for BME communities.
- Summaries of key points for commissioners and services were incorporated into two briefing papers – "*Developing Black services – A briefing paper for commissioners and other funders of alcohol services*" and "*Developing Black services: A briefing paper for providers of Alcohol Services*" (2000).
- Funding to commission research into the prevalence of drinking in 2nd and subsequent generations within minority ethnic groups. The report "*Drinking in second and subsequent generation Black and Asian communities in the English Midlands*" was published by Alcohol Concern in 2001. The report aims to provide evidence of drinking levels and alcohol related risk in BME communities to inform commissioners and service providers of levels of need in their areas and a better understanding of the problems people experience with alcohol.

The focus of the third stage of the DoH resourced grants programme in operation from 2000 onward changed to reflect different aspects of alcohol service development and

changing funding structures within the NHS. This meant that Alcohol Concern's work with services for members of minority ethnic groups also had to change direction.

Further initiatives to promote services to minority ethnic groups

From 2000 onwards Alcohol Concern identified additional pieces of work and sources of funding to develop services in this area.

Key initiatives included:

The Black and Minority Ethnic Forum

The forum was set up with funding from the second stage of the Networking Distant Neighbours Project as one of a number of forums for alcohol workers with specific areas of interest. The forum was intended to give members of the field an opportunity to discuss their work, share good practice and take forward issues of importance. Alcohol Concern hosted a number of events and meetings including:

- A seminar on Diversity in 2001 held for workers from alcohol services and representatives from organisations with a specific concern for minority ethnic groups.
- A Conference on the implications of the Race Relations (Amendment) Act 2000 for alcohol services. (2002)

Additional stand-alone publications commissioned by Alcohol Concern include:

- **Good practice in developing local strategies for services to BME groups.** This report was undertaken by the Civis Trust.
- **Organisational Review guidelines for alcohol and drug services in relations to the Race Relations (Amendment) Act 2000.** This amendment to the Act puts a general duty on public authorities to make the promotion of racial equality central to their work and take a lead in promoting equality of opportunity and good race relations, and preventing unlawful discrimination. In this context Quality in Alcohol and Drug Services (QuADS), which sets recognised standards of quality in treatment services, recommended carrying out an organisational review of BME access to services. The QuADS Organisational Standards were jointly published by Alcohol Concern and SCODA. In addition Alcohol and DrugScope commissioned the production of comprehensive, user-friendly guidance for alcohol and drug services on reviewing BME organisational policy and practice in relation to the Race Relations (Amendment) Act. The draft were circulated to members of Alcohol Concerns' BME forum. The comments have been incorporated into the final draft of guidelines.

Recent initiatives

The Alcohol Concern Consultancy Service.

Ethnic Alcohol Counselling in Hounslow (EACH) was set up in 1991 in response to the needs of Asian people in Hounslow experiencing alcohol problems. EACH is a well established respected organisation in the alcohol field. When the three major grants which funded the Brent services came to an end, EACH commissioned consultancy@alcoholconcern to carry out an independent evaluation of their services in 2003. The evaluation has now been completed and it is hoped that this will be one of a series of detailed evaluations that will provide feedback to services on how they perform. Hopefully, the findings from this type of evaluation will be disseminated more widely at a later date.

8. CASE STUDY: NEW ROOTS (RUGBY HOUSE)

Developing Alcohol services for and with BME communities - A white managers perspective and experiences (Andy Stonard)

Introduction

This is a short case-study that summarises the experiences and views of Andy Stonard from Rugby House. The case study highlights the critical role that managers (and in most instances in the alcohol field, they are white) can play in encouraging the development of services for BME communities.

The case study is not intended to take anything away from the critical and obvious role played by BME staff. On the other hand, it is invariably the manager that is in the best strategic position to instigate change and a shift in priorities as well as being the link person with prospective funders. For this reason, Andy was invited to put his thoughts and experiences forward.

What are the current services offered by Rugby House

Rugby House delivers eleven projects in London – New Roots, the Alcohol Resource Centre, Fulcrum (the Drug Day Programme), the Children and Family Alcohol and Drugs Service, and a Community Care Assessment Service in Tower Hamlets, a Criminal Justice Unit with the London Probation Service, the Crisis Centre, four Residential Care Homes and a third stage scheme, and a Volunteer Training Centre.

Background

When Rugby House was established in 1986/87 to develop the Crisis Centre (a 13 bedded residential care home for men and women to withdraw from alcohol), it was in an 'era' of two major social phases:

1. Equal opportunities was a highly political topic.
2. The AIDS/HIV panic was underway.

In London, the equalities issue was enshrined by the London Boroughs Grants Unit. Other public institutions fell in line somewhere behind them. It was also an era with little public dissension; but there was a debate about how much and how far the LBGU and Equality Units in Town Halls were genuinely attempting to improve accessibility across services. What they did was to meet resistance, because it was a tough challenge for many and it was easy to pretend compliance, by fixing statistics, and 'by talking the talk rather than making the walk' by senior managers who did not want to be seen as defensive, nor to be accused of ignoring minority needs.

Perhaps also it was a reluctance to be proactive beyond prescriptive requirements because change or the handing over of power and control was too challenging. In hindsight, it was a bandwagon that literally everyone seemed to climb on without thinking it through and with many examples of people poorly understanding some of the basic principles.

In the Alcohol and Drugs field everyone seemed to be suddenly publishing activity levels which appeared to demonstrate that between 7-13% of their clients were from BME communities without doing anything differently. Clients from these communities suddenly appeared!

In addition, the emergence of the HIV/AIDS panic was articulated by a massive increase in both preventative campaigns and services. Considering the current chronic problem in

Africa and the problems facing Black Africans in Britain, the services in the late 1980's were almost exclusively for white gay men. As a group, they had the economic and political clout to make things happen; to influence health and social services spend. The same level of concern was being expressed as today, and agreed with, but the reality was that the majority of services went to white men.

Key Stages in the development of the New Roots project within Rugby House

The Rugby House Crisis Centre was developed by a consortium of agencies and authorities that would make referrals into the Crisis Centre when it opened. Therefore, it was expected that the Crisis Centre would automatically receive referrals at around 7-13% from BME communities via these agencies!

At this juncture, I have to confess that I was both reasonably anxious and sceptical. My previous employers were quoting the same uptake. I was fairly certain that the service had not seen a flood of new referrals from these communities since I had left. In fact, the only agency I knew who had an uptake of over 10% was the Probation service, part of the criminal justice service where black people are over-represented!

The Mobile Alcohol Service was the forerunner of the Rugby House community services. The whole of the West End of London and great swathes of central London had no alcohol services. It did however have a range of services for homeless people, young people, mental health services, all of whom saw people with alcohol problems but never as the presenting problem. We therefore pioneered a small-scale outreach/satellite service to go into these agencies offering assessment, training, some individual and group-work.

Many of these groups were also claiming a similar uptake of BME clients, yet our staff were not seeing them. The funding for the Mobile Alcohol Service set us certain client targets and we had sought and obtained funding for a Black outreach programme.

We had funding for three posts of which one was to develop the Black Outreach Programme. The other two posts were development posts as well; one with the Irish communities and one with Homeless agencies. I made the post of Manager of the team, the person leading on the Black outreach programme. At the time this felt like the most proactive step I could take. I thought that it was an example of affirmative action - but it may just have been 'positive discrimination'.

The recruitment did not attract a good range of candidates. As the manager I should have balanced my enthusiasm to get the project started with delaying until we were really certain about making the right appointment. I let the pressure of the funding clock (and it was a real pressure) sway us. We appointed someone with little management experience nor alcohol experience but she appeared to have excellent outreach experience. We figured the alcohol training could be given and I would offer significant additional management support. With the power of hindsight this was all wrong. The consequences of this was that insufficient progress was made in reaching many communities and consolidating the project.

This issue applies to BME staff and white staff alike, whether in specialist or generic projects. The consequences and risks seemed to be more significant because of the scarcity of BME services. On reflection this episode taught me to delay if in doubt and re-advertise. ALWAYS.

The reaction to the work was also unhelpful in many places. Many responses claimed that their black clients had a problem with drugs not a problem with alcohol and of

course many argued that all Muslims are non-drinkers! This denial was strong in some Black African-Caribbean community groups as well. We were approaching the problem of alcohol misuse through community leaders in BME services and senior management in voluntary sector agencies, and both of these relatively powerful groups seemed to present more hurdles to overcome than practical assistance.

Learning with humility from BME staff

When the manager left, Pam Menzies, who possessed the alcohol and drugs experience missing in the previous phase, replaced her. The post ceased to be the Manager post, not because of the change of personnel but because in the process the team was reduced to two when the funding on the third post came to an end. My management style was then a mix of support, confident in knowing that the embryonic model of the Mobile Alcohol Service we were developing was a good one; coupled with a good degree of guilt and professional embarrassment at what I had let happen prior to Pam's appointment.

She had the patience to let me talk this through, to learn and listen and to ask questions that with hindsight were clumsy and difficult. As a consequence I gained a better insight to what was needed from me and was able to apply dynamics like the hierarchy of oppression to the work and our roles in trying to develop services. *Again upon reflection it almost seemed that what I was doing was to try to reverse the hierarchy of oppression by making commissioners and agencies ashamed and guilty and therefore act supportively because of fear of exposure or criticism.*

The key point to highlight is the need for white managers like myself to be open to admit mistakes, to learn with humility from BME staff and in particular from staff that we are managing. This affirmation of the experience that BME staff members bring to a project and to at times acknowledge the gaps that managers may have, is critical to making significant progress.

Re-structuring and expansion of Rugby House

At this juncture, Rugby House also re-structured, creating a Director of Services, who was responsible for the clinical supervision and management of Pam and the other service managers (which doubled again in 2001 with a split between community and residential services and two directors of services). Up until early 2002, my role was one of assisting development and organisational dynamics. The two Directors of Services, Satya McBirnie and since early 2002, Sue Clements have provided strong clinical supervision and management.

Under Pam, the Black outreach programme made considerable progress just as Alcohol Concern launched its first BME grant initiative in 1994 through the Department of Health. We focused on the boroughs of Kensington and Chelsea and Westminster. The Alcohol Concern grant offered 75% of the funding for three years. The two boroughs had a significant BME community spread across a wide range of communities. The two boroughs also had no voluntary sector mainstream alcohol service. The funding was for two workers plus running costs. There was little management funding for the costs to pay for Pam. She had some training money but it was insufficient to pay her salary.

The solution was simple. Pam was a key post, everyone would have to pay for her by shaving off their budgets. I was Chief Executive, no-one was going to argue with me (in fact everyone agreed) and anyway, the Management Committee thought it was brilliant. Just never tell the Commissioners!

This to me is an example of how managers can take risks, exercise discretion, shift priorities, bend rules and champion projects (and key members of staff) in order to maintain BME services.

Scrutiny by Commissioners

The service flourished. However, to do this it had to put in an enormous amount of 'leg-work' with the local communities to win trust and confidence. The Commissioners at the time were critical of the lack of clients especially in the first 18 months. They just expected clients to turn up. Or rather, not just turn up but almost to be at a point where they could already recognise that they had a drink problem but did not want to attend a mainstream service. *There was a total lack of awareness that there were no models available that were culturally appropriate for many people from BME communities to even be able to self assess, or come to this recognition through their family or friends.*

By the third year Alcohol Concern were putting pressure on the Commissioning group to pick up the funding. During these negotiations, the team and I experienced the most intense scrutiny of the work and proposed future work that I have ever had to go through. We talked it through with the team; I reiterated the management support. I talked to each of the Commissioners privately, tried to see things from their point of view; tried to show appreciation that they were doing the best that they could (whilst of the view that they could do a hell of a lot more). I think that they knew I was trying to find a compromise but had a fall back position of open criticism if they abandoned New Roots.

By the end of three years the client figures and treatment outcomes were impressive and on a par with, or better than, our other services. The team felt disheartened and their work somehow diminished. What was I able to do? Be angry along with them, accept that it was not fair; tell them that I thought they were doing a good job. *At the same time you start to realise that how I felt was nothing compared with being Black team working with Black clients and having your work undervalued by white commissioners, and other mainstream services hardly jumping to their defence.*

During this time, one person stood out. The Director of the NHS Substance Misuse Service, Robyn Doran, did speak out. She told the Commissioners that New Roots were doing a good job; that they were the only service working effectively with Black clients and that they needed support and trust, not more scrutiny than the rest of the services. She did it in small meetings and conversations, so as not to embarrass the commissioners publicly. This championing role is one that is not played enough by those in key strategic positions.

Gaining mainstream funding:

Compromise was the name of the game. Maintaining a firm and assertive line with the Commissioners when I smelled something more unpleasant was difficult. Give them the public credit for funding New Roots, give them the avenue – lose the battle to win the war. It was back to everyone else within Rugby House to fund the Managers post and for me to try to raise money elsewhere; (shave £2000 here and there on a contract) in order to fund the management costs of New Roots.

It did not really stop there either. Contract review meetings – the Commissioners would always book two hours for the Crisis Centre, ARC and New Roots. We would always start late because one of the commissioners was late. The first hour was spent on the Crisis Centre and the next 40 minutes on ARC, leaving 20 minutes or so for New Roots, except one of them usually had to leave early!

I noticed it, the other managers noticed it. I'm sure it really got to Pam. Challenge them openly? I do not think so. My response was to ask them politely to review New Roots first next time. The first time I asked, they forgot. The second time they didn't and I had to tell them that I did not like the order.

The dynamics of this type of situation are complex – not least for BME staff like Pam and the team. Positively challenging (discriminating?) for New Roots has opened me to accusations of favouritism to New Roots. I have been told that as a white manager these are examples of the affirmative choices that I make in order to redress the imbalance created by historical inequality. What I do remember from my transcultural awareness training was asserting what I did not like, not asserting on others behalf. They are choices I can live with. Sure I showed favouritism. They needed that from me sometimes. This sort of discretion has been exercised in favour of generic (i.e. predominantly white services) for many years. However, by sticking to our guns we were given the mainstream funding and Rugby House picked up the funding for the mainstream alcohol service as well.

The contract was for both the Alcohol Resource Centre and New Roots and it allowed us to continue to run the latter as a discrete separate black service, albeit with no separate management costs. This was extremely aggravating, but in my mind merely clarified the unofficial line I had taken previously about finding the management costs from elsewhere). The rest of the funding had all been small, short term funding and this had taken its toll on Pam and the team. It meant that Pam's time was taken up with the delivery and management of these small initiatives at the expense of managing and developing the team.

The next stage was to enable New Roots to break out of dependence on one commissioning group. The Kensington, Chelsea and Westminster (KCW) commissioning group had all changed and were now extremely supportive of New Roots work, and proud to be funding such a service. New Roots needed a range of statutory funders in order to be visible and a significant BME service in the whole of London. Individual clients were already travelling from all over London to ask for help from what they saw as a culturally sensitive service where they could feel safe and talk openly.

Obtaining the next funding was made very easy by the colour blindness of the rest of the alcohol field. Alcohol Concern (in 1999) were now promoting a primary care grant initiative. We discussed the bid with the 4 Primary Care Trusts (PCTs) across Camden and Islington and submitted a bid. We were awarded the grant. A significant factor in that success was that ours was the only BME led bid out of 64 applications. I found this incredible given the diversity of communities across England, but maybe it should not be so surprising!

Again the negotiations were difficult because PCTs were new and did not really know what they wanted. We just kept on citing the work in KCW, where there were now commissioners on board who liked the work of New Roots. It just needed time, as the client base was not coming forward for services in general, never mind alcohol.

However, the clear and distinct model of working at New Roots was clearly evident, i.e.

- community engagement;
- embracing clinical models with cultural ones;
- work with significant others
- taking a holistic approach;

- not embracing the European / American model of disease
- and not being pre-occupied with units

meant that the work evolved, acquired a credibility, and New Roots became seen as a gateway service into mainstream treatment.

Impact of New Roots on Rugby House and in the wider alcohol sector

The influence of an all BME team on a mainstream white organisation and the significant retention of its staff members is a key issue that also needs to be highlighted.

I know that staff at New Roots feel that white staff dump on them, on training issues or with meeting black clients, even with workshops and stalls. We have tried to address this. However the momentum of New Roots, the models that they use and their professionalism, friendliness and success has impacted greatly. There is a greater awareness and appreciation of difference; its strengths and potential. The whole organisation has become more confident in addressing equality issues and has attracted more Black staff, which has furthered that momentum. Rugby House has begun to reflect the London communities that it works in. There are still shortcomings but everyone is aware of them and is trying to address that.

Separate and specialist or integrated-the debate continues!

A number of Black agencies have failed or struggled in London and elsewhere. For instance in 1999, we were invited to try to save the services of a Black agency that had imploded. There were obvious tensions around a generic agency `taking over` a BME led agency. At the end of the day, sadly those who approached us to try to pass the services over, were outnumbered by those who could not bear the idea of Rugby House (a white agency with a black service) running them. Preferring instead to let the agency collapse, they turned their backs on the potential lifeboat (as we saw ourselves), thus bringing an end to important services to black clients.

The model of a specialist BME service with its own identity within a generic agency like Rugby House illustrates a hybrid situation that ought to be worth replicating elsewhere in the country. It is not an `either-or` situation but rather a drawing of strengths from both in order to make progress.

Consolidation and expansion of New Roots

New Roots was founded on the principle of providing quality services to clients, as was Rugby House and this has always remained the absolute priority. New staff are inducted into this belief system by colleagues and the managers. Pam and New Roots are very strong on this ethos and it is reflected in the monitoring and communication with the commissioners.

New Roots now has 4 apprentices that have joined a team of 11. The apprentices are funded through the NTA sponsored Black apprenticeship scheme. The majority of alcohol and drug agencies chose once again not to participate. *Why not?* In London, most services do not begin to deliver services which reflect the needs of local communities. Most commissioners do not seem to push for it. *Why not?* After all, it is now enshrined within the Race Relations Amendment Act.

Would it have been so difficult for the NTA to tell the DATs in London that their services needed to develop a three year programme aimed at ensuring all their drug services were able to become representative and appropriate to their local authority populations?

The role of a white manager

New Roots has been established, has survived and is now flourishing because of the hard work, perseverance and commitment of Pam and the team and the effectiveness of their interventions with the community. This is why the service is important. My role was to provide a similar commitment, both internal and external to the organisation. This dual role is critical and is designed to both buffer and promote the team. Sometimes I am probably seen as the white liberal or paternalistic protector. I did not really analyse it much, I was just aware that I was difficult to argue with. I did what I thought was right and importantly, in the early days, I tried to discuss it all with Pam and her manager.

Why are there not more `New Roots` projects around the country?

Looking back, it has not been all personally difficult supporting the development of New Roots. On the contrary, it has been a particularly rewarding experience. I genuinely do not understand why New Roots is the exception rather than the rule. There should be a New Roots in many London boroughs, especially given the investment in drug services.

It therefore leads me to question my managerial peers in the field and the commissioning personnel above them. No-one ever argues with me or my colleagues at meetings against the idea of Black led provision or lack of such services but there is nevertheless still an inaction, a reluctance to do anything pro-active. However, should a pot of money be made available to fund such services, then those people who lead those self-same colour-blind agencies would deliver mountains of tender documents. *The consistent back-drop since the mid 80's is the gap (or gorge) between the rhetoric and the reality. The imbalance of provision is immoral and for the sector it is a disgrace.*

Our experiences show that progress can be made, consolidated and then integrated into mainstream services and into relatively secure funding. The primary role in this success is that played by the BME staff, but white managers need to recognise that they have an essential and strategic role to play. To undertake this requires them to develop a clarity about the dynamics of the situation and how they can impact upon it.

Closing Notes

New Roots is a good service. I consider myself lucky to have played a part in its development. Trying to write this was difficult. It was difficult because I had never had the proper opportunity to start to unpack it. It was also difficult because the past is always littered with things that could have been done differently or more effectively. However, it is not littered with regrets for my part.

The team played the major role and clients and other professionals still write to me today pointing out how good the service is. Over the last two years my contact with New Roots has greatly lessened while the service is being further developed by Sue Clements with Pam and some Commissioners who are now pro-active and able to tackle cultural diversity and difference.

The hardest part, sadly, has been coming to terms with the intransigence of my peers in the field. Black issues with white people; alcohol with the drug field. No one disagrees but no one does anything unless they are forced or persuaded. The AIDS issue was the same. Why the status quo? What is the problem? In London, where are the Black commissioners? Where are the senior Black managers? Where are the pro-active strategies? Where are the opportunities to answer those questions?

9. Ways Forward & Recommendations

This report has attempted to provide (perhaps too ambitiously!) a broad overview, which focuses on the BME communities and the alcohol field in relation to research, education and services for BME communities. Each of the contributors has been encouraged to include specific ways forward and recommendations within the sections of the report and the underlying theme of the report seems to be

'some good work is happening but much more could be achieved!'

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. This strategy document, by consensus, seems to have been a disappointment, certainly in relation to the needs of BME communities.

So what are the ways forward?

Some of the key underlying themes and ideas that emerged are:

i. Research Priorities

The literature review within this report echoes the point made by Waller and colleagues (2002) 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:

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 inroads 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.

Combining research and the development of alcohol services

Increasing the quality and quantity of evidence-based research, which closely connects to communities and the agencies actually delivering services, is a key priority for the development of the BME alcohol sector.

One of the strategies, which could be pursued, is to consider the experiences of the drugs field and the national project led by the University of Central Lancashire and its Centre for Ethnicity and Health. The Dept. of Health funded the Drugs Misuse Needs Assessment project and involved creating a partnership with 47 local community projects around the country in order to build up a more robust picture of needs relating to drugs misuse. At the heart of this approach were the aims of engagement of communities, encouraging partnerships with local commissioners and drugs agencies and the use of local action-research initiatives. The cumulative effect of this large-scale project was to significantly improve the quality of evidence, services and indeed interest in tackling drugs issues at a local and national level. Winters and Patel (2003) conclude that the work

“details a rich picture adding to an extraordinarily scant evidence base on drug use and BME communities”

This model of enhancing the quality of local community based research would draw together the often separate disciplines and resources of policy makers, researchers, communities and alcohol agencies. There is much for the alcohol sector to learn from this type of approach and is a strong recommendation from this report.

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Note: The following (in the 'grey literature') were identified from cross-referencing in other documents too late to be obtained in time for inclusion in the full review:

Arora R, Khatun A 1998 'No to Nasha: drugs, alcohol and tobacco use in Bradford's Asian community' Bradford: Race Relations Research Unit

Hay G, Kohli H, McKegany N 2001 Drug and Alcohol Issues Affecting Black and Minority Ethnic Communities: Literature review Glasgow: Centre for Drug Misuse research, University of Glasgow

Note: we also identified the following reference from other texts accessed, but were unable to obtain a copy of it from any source.

Clark K (et al) 1997 South Asians and Alcohol Lewisham & Guys Mental Health NHS Trust for Bexley & Greenwich HA {Not found by British Library when requested}

Appendix 1 :

The Survey questionnaire sent to all identified Alcohol Services Agencies

ALCOHOL ISSUES AND SOUTH ASIAN & AFRICAN-CARIBBEAN COMMUNITIES
Improving Education, Research and Service Development

Dear Colleague(s)

We are writing to you with a request that you will spare a few minutes to complete the attached survey. The research has been commissioned by the Alcohol Education & Research Council, to inform future planning and development across all levels of alcohol services. It will feed into the national alcohol strategy, to be announced later this year. The results will help everyone working in the field of alcohol services to meet their obligations under the Race Relations Amendment Act, and we hope that they will be useful to you. All those who help with the study will be sent a report of the findings, and be invited to a workshop or conference to discuss the results.

While we do ask you for contact details, all information will be kept confidential within the research team. This is co-ordinated by Gersh Subhra (University of Derby). The survey is being conducted by the Mary Seacole Research Centre at De Montfort University, working with AlcoholEast and NewRoots/Rugby House. We have tried to combine all the requests for information relating to health promotion, treatment and rehabilitation, prevalence and ethnic diversity into a single document in order to save you work, and hope that you can respond to the questions that refer to the work of your agency – and skip over the others! By BME, we indicate the usually recognised ‘Black and Minority Ethnic’ groups – particularly Asian & African-Caribbean.

We are interested in all aspects of work around alcohol (mis) use – including health promotion and work to prevent future drinking problems, (Tier 1 services), open-access specialist services (Tier 2), community-based treatment services (Tier 3) and specialist high intensity residential services (Tier 4). If your work is entirely based on other drugs of addiction or dependency, please accept our apologies and return the form with a note to explain this – we shall try not to bother you again about this.

We would be very grateful for copies of any reports (including both annual reports, needs assessments, projects and research studies) that you can supply, if they refer to the ethnic diversity of your work. We hope to use some examples of good practice in our final report but will contact you to clear use of your material with you in advance.

If you want to ask any questions, please e-mail Mark Johnson (survey co-ordinator) on mrdj@dmu.ac.uk or call 0116 201 3906.

With thanks for your co-operation

Mark R D Johnson; Pam Menzies-Banton; Harrinder Dhillon; Gersh Subhra
ESRC Centre for Evidence in Ethnicity Health and Diversity, in the Evidence Network
Mary Seacole Research Centre, Charles Frears Campus, 266 London Road, Leicester
LE2 1RQ

Main Office: **+44/0 116 201 3906**: Direct Fax and Answerphone **+44/ 0 116 201 3805**

Alcohol Services and Black and Minority Ethnic Communities

Agency/Organisation

(and Address)

Contact Person: Name

Job Description/ Title

Contact Telephone E-mail

- Q1: Which types of service do you provide:

	Service	Tier	Please add detailed comment if you wish
Y / N	General Health Promotion	Tier 0	
Y / N	Personal Health Education	Tier 1	
Y / N	Specialist Open Access Support	Tier 2	
Y / N	Appointment Based Treatment	Tier 3	
Y / N	Residential Treatment	Tier 4	

- Q2: Do you obtain specific funding to provide services for Asian and African-Caribbean people? (Y / N)
 - (If so, please give basic details: source, proportion of your budget)

- Q3: Is your service for the general population, a BME clientele, or both?

	Tick		Tick	Comment/Which?
Generic		Specialised (BME)		

- Q4: Please give us some details of your users if you have any ethnicity data: Please supply data for the most recent full year you have (indicate dates!)

	Number	Percent	Comment
White ('British')			
White (Other)			
Black / British: Caribbean			
Black / British: African			
Asian / British Indian			
Asian / British Pakistani			
Asian / British Bangladeshi			
Other Please State:			
TOTAL			

(Note: these categories are based on the 2001 census – write in the ones you use!)

- Q5: Which languages can you offer to your service users: are these ‘in-house’ or do you use paid interpreters?

Language (add more as needed)	Staff	Paid-for Interpreter	Translated materials	Comments

Do you have any data on the amount these are used? (please supply if possible)

- Q6: How does your service target / ensure access to BME communities:
If no special efforts made, tick None
- Q7: Do you work with Partners & Families; Yes No
If yes: What services do you offer
- Q8: What Theories or Models of alcohol misuse and treatment underpin your approach to your services?
- Q9: Do you offer or use Complementary Therapies – if so, which and why?
- Q10: What is the normal pathway by which users come to your service (i.e. referral route)

Is there any difference in access pathway or referral route for BME (Black and Minority Ethnic) users – have you had to make changes to meet their needs?

- Q11: What is the assessment process and criteria for acceptance?

Is there any difference in criteria / assessment for BME (Black and Minority Ethnic) users – have you had to make changes to accommodate their needs?

- Q12: Do you feel you have had to make any major changes to your service provision to accommodate the needs of BME clients?
- Q13: Do you attempt to match service users and workers by 'race'/ethnic group and gender?
- Q14: What Evaluation Methods do you use to monitor the success of your work?
- Q15: It would be helpful if you could give us details of your staff by ethnic group:

	Male	Female	Comment (e.g. Role/Status)
White ('British')			
White (Other)			
Black / British: Caribbean			
Black / British: African			
Asian / British Indian			
Asian / British Pakistani			
Asian / British Bangladeshi			
Other Please State:			
TOTAL			

(Note: these categories are based on the 2001 census – write in the ones you use!

- Q16: In developing your work with BME communities, have you encountered any staffing-related issues? (Please give details – and how you face them, if possible)

(for example:)

Staff recruitment

Staff supervision

Staff retention

Staff Training

- Q17: Which of the following specific issues relating to service delivery do you feel arise when working with the BME communities: (Please give details – and how you face them, if possible)

Language

Gender

Age

Religion

Culture

Other

- Q18: Do you have particular resources for use with BME communities (e.g. information packs, posters) - why have these been particularly useful (could we have a copy?) We would welcome comments on any culturally-specific educational materials or campaigns that you have experience of.
- Q19: What has been the most helpful step you have taken, or ‘best practice’ advice you have found, in relation to working with BME communities?
- Q20: What obstacles or problems have you met in seeking to deliver a service to BME communities
- Q21: Has QUADS or the Race Relations Amendment Act had any impact on your service (to date) – please give details:
- Q22: Please add any comments or advice that could be incorporated in future alcohol service development guidance or the national alcohol strategy, and give your thoughts on any investment that needs to be made to develop services for these communities (overleaf or on extra sheets!)

Thank you for your help – please return to the address on the covering letter, **with any copies of relevant documentation that you can add. Thank you very much!**

Reference	Year										
		Theories?	Country	Tier	Ethnic Group(s)	Religion	Non-English Lang.	Socio-demogr Factors	Type of study Quant/Qual	Key findings/ Resources / Interventions	Comments (orientation)

Appendix Two

Summary of data extracted from all articles meeting the primary inclusion criteria for the literature review

Note:

Tier: 0 Health Promotion; 1 Personal Education; 2 Open Access; 3 Appointment based; 4 Residential

Type of Study: Review, Epidemiology; Intervention; KABP Survey (Knowledge/attitude/belief/practice); Theory or Discussion

Orientation: Academic/ Practice/ Policy / Community

Note: Only papers where alcohol was a major focus of the study, and where detailed consideration is given to ethnicity, are included in this grid.

Reference	Year										
		Theories?	Country	Tier	Ethnic Group(s)	Religion	Non-English Lang.	Socio-demogr Factors	Type of study Quant/Qual	Key findings/ Resources / Interventions	Comments (orientation)
Ahmed	1989	-	UK	2	Asian	-	-	-	Descriptive of Intervention	Argues that services for Asian needs are restricted - only two specialist services in 1980s and low uptake of mainstream: Asian men usually accompanied by wives	Community - critical of Eurocentric models of training / counselling; believes Asian women have hidden problems
Albar	1988	Religion	-	-	-	Islam	-	-	Theory/Discussion	Argues Islamic prohibition eliminates problems through adherence to higher aims	Pre-islamic culture had high use of alcohol, overcome in few years through Prophet and Quranic texts cited
Alexander et al	1994	Meditation	-	0-2	-	TM	-	-	Review, Theory discussion	Purportedly Systematic Review dedicated to promoting Maharish Aurveda TM - draws on Jung 1933 to argue spiritual problems are base of self-destructive action, links to 12-step theory: meditators shown to have low levels of substance abuse in all research	Practice oriented, committed to proposing TM but backed up by series of other papers in same issue and has some useful analysis of 12-step programme origins.

Reference	Year	Theories?	Country	Tier	Ethnic Group(s)	Religion	Non-English Lang.	Socio-demogr Factors	Type of study Quant/Qual	Key findings/ Resources / Interventions	Comments (orientation)
Bakshi et al	2002	-	UK Scotland	0	Chinese Indian Pakistani	-	-	SEG	KABP Survey & Focus groups Qt and QI	Pakistani (presumed Muslim) less likely to drink (1/5) than Chinese (3/4) or Indian (1/2) but if do drink, drink more; feel community ignores issue and all felt issue was concealed. Predictors of drinking measured - Not 'identity' or SEG; asked how to influence via health education; note open use of services carries stigma	Acad/Practice - very substantial report: Low awareness of possible services so low uptake - support for school-based targeted education: proportion own-ethnicity friends who drink best predictor
Balarajan & Yuen	1986	-	UK	-	Country of Birth	-	-	-	Qt analysis of GHS survey data	Presents standardised estimates of rates of drinking - Indian subcontinent rates lowest, Irish (not Scots) report higher levels	Brief epidemiological report with little detail and no breakdown of the category Asian
Bhattacharya	1998	Acculturation	USA	-	Asian Americans	-	-	-	Review mainly of theories and USA studies	Focus on generational change (rarely noted in UK) indicating second generation growing problems and usage, due gender role change, weakening family/ cultural loyalties worsened by excessive parental expectations	Academic - no real primary data, concludes more research and training required
Bhopal	1986	-	UK Scotland	0	Asian	Muslim Sikh Hindu	-	'SEG no value'	Quant Survey 65 adults	Rejects 'class' as 26/65 were shopkeepers but varied greatly: notes effects of migration on occupation. Half of men (not Muslims) and 4/35 women used alcohol but few knew risks	Academic - traditional health beliefs not linked to alcohol, smoking or diet in pregnancy (religion affects alcohol use)
Cherian	1986	Stigma AA approach	India	2-3	Indian	-	-	-	Descriptive of Intervention	Discusses high level of stigma attached to alcohol and good reception of treatment centre following AA approaches - majority of users referred by family	Noteworthy for showing that there is an indigenous (Indian) use of this model that is well supported by users!

Reference	Year										
		Theories?	Country	Tier	Ethnic Group(s)	Religion	Non-English Lang.	Socio-demogr Factors	Type of study Quant/Qual	Key findings/ Resources / Interventions	Comments (orientation)
Cochrane	1999	Clinical (Mental health)	UK	-	African-Caribbean Sikh White UK	Sikh Christian, attendance rates	-	-	Quant Survey of GP male patients drinking diary and other data	Three samples of ~200 in each group: Black and Sikh most likely to be Occasional drinker or abstainer: if drink, not with family. Black to drink spirits: whites drank less at home: Sikhs drank more often in both Pub and home Black men reported much less risky/ harmful drinking levels and outcomes: Sikh second-generation drinkers were more moderate than migrants. Religious attendance rates relate to lower usage levels. Higher admission rates to mental hospitals may reflect lack of use of community-based support services	Academic Study
Commander et al	1999	Clinical Pathways	UK Birmingham	2-4	Asian /Black / White	-	-	-	Survey & Case review Quant	Surveys of 773 primary care patens, plus community and inpatients and GP records on 1009 patients: estimates of case rates and referrals - found Black patients under-consult, Asians over-consult but are less likely to be referred to services; under-recording of need	Practice/policy based analysis of audit-type data and survey using CAGE questionnaire case-finding technique locates at-risk groups - young people, women, Asians = undeserved
Denscombe	1995	-	UK Leicestershire	-	South Asian, Black, White	Hindu Sikh Muslim	-	-	Quant Survey KABP of 5 th form pupils in selected towns into drugs and risk taking	1009 15-16 year old pupils (reported again in Denscombe & Drucquer 2000) of which about 70% white, 25% S Asian: 94% all S Asians were non-drinkers ct 38% whites. Asians less likely to know/answer if 'enjoyable' and very much more likely to state parents would punish severely if drunken.	Academic Study

Reference	Year										
		Theories?	Country	Tier	Ethnic Group(s)	Religion	Non-English Lang.	Socio-demogr Factors	Type of study Quant/Qual	Key findings/ Resources / Interventions	Comments (orientation)
Denscombe & Drucquer	2000	Diversity	UK Leicesters hire	-	White S Asian Black	Hindu Muslim Sikh	-	-	Qt survey of school pupils Usage of tobacco and alcohol	Compares survey data for 1990 (1009) and 1997 (1648) and self-reported ethnic origin and drinking behaviours: shows rising trend but strong gap between white and Asian pupils: Small group of Sikhs, but they and Hindus seem to be getting closer to white levels, while Muslims remain non-drinkers	(note that Hindu boys were less likely, and decreasing, in smoking rates: while Hindu girls were taking it up) Need to look at processes of change in groups sensitive to diversity
Dhillon	1994	Counselling Therapy	UK	2-3	Asian	Sikh	Punjabi	-	Qual Case studies and reflection	5 cases reported plus lit review - Asian use of counselling differs from white and physical explanations were often sought: matching user and counsellor wanted but may be problematic in other ways (confidentiality)	Community Practitioner, reflective account with insight into the process of delivering alcohol-related counselling
Dijkshoorn	1994	Health Education	UK	0	Asian African Caribbean	Muslim Hindu Sikh (Christian)	Yes	-	Quant KABP survey of 201 people, and 7 Qual focus groups on HEd posters etc (Drinkers ONLY)	Notes negative views of drinking held among Africans and Muslim Asians - Moderation was 'not showing drunkenness'; awareness of long-term health effects; stereotypes held - Carib/Sikh drinkers 'older'; Afr, Mus, Hindu 'younger' (and largely male)	Practice - Very detailed and insightful understanding; good evidence of lack of awareness of concepts such as 'units', community critical of most of Posters - reasons given
Douds et al	2003	Clinical	UK	- (3-4)	South Asian, Afro-Carib	-	-	-	Epid : Qt record analysis of liver cirrhosis cases	111 South Asian, 244 White & 18 A/C patients: lower than expected rates in A/C, raised in Asians - younger at diagnosis, mostly Sikh some Hindu; rare among BME females; review suggests may be a genetic component, Not due to Hep B levels	Clinical academic suggesting need for more research
Erens & Laiho	2001	-	UK England	-	Black Carib , Chinese, Indian, Pakistani, Bangladesh i, Irish	-	-	SEG class, Income	Quant Survey of levels of drinking	6675 BME and 7700 'general' respondents: Lower than 'General' rates of level and frequency of drinking in all except Irish; females lower levels: broken down by age etc shows some effects. Detailed data available via web-site	Academic Policy-oriented national survey - factual descriptive

Reference	Year	Theories?	Country	Tier	Ethnic Group(s)	Religion	Non-English Lang.	Socio-demogr Factors	Type of study Quant/Qual	Key findings/ Resources / Interventions	Comments (orientation)
Ghosh	1984	Clinical	UK Liverpool / Manchester	-	Asian	Muslim Hindu Sikh others	(Hindi Bengali Urdu or Punjabi)		Quant Survey via GPs	107 people interviewed in homes: descriptive statistics on nationality, social class, religion and level of drinking - small n of female H & S drank wine occasionally. The first reported study, is mostly a pilot but provides early data and good discussion about attitudes to alcohol on the Indian subcontinent at that time.	Academic pilot study and discussion of early religious Indian writings on alcohol and the history of alcohol in India
Harrison et al	1997	Clinical	UK	-	Country of Birth	-	-	-	Quant review Epidemiology	Review of research reports repeats patterns of higher than expected mortality among S Asian men against lower drinking; high Irish rates of both; including psychiatric; calculates SMRs of alcohol-related causes of death by country of birth but unable to ensure cause was alcohol (assumes same ratio as whites) - suggests problem is increasing	Academic epidemiology - accepts that causal linkages may be flawed, as is data, but indicates some clinical evidence of differential effects not related to Hep B alone.
Harrison et al	1996	-	UK	-	'Visible' or 'Black' (all descriptors)	-	-	-	Lit Review	Discussion of the evidence base: prevalence estimates, (weak) and mortality - lack of reliable primary data - discusses selected case studies of service provision and good practice	Academic background discussion of key issues
Hyare	1995	Report	UK Birmingham	0-1 and training	South Asian	-	Punjabi	-	Practice Report - descriptive of intervention	Reports on 18 educational workshops, information distribution event and training needs assessment for welfare providers and other developmental work. Reviews alcohol education video, includes copies of Aquarius leaflets in languages	Practice report - no evaluation or much discussion

Reference	Year										
		Theories?	Country	Tier	Ethnic Group(s)	Religion	Non-English Lang.	Socio-demogr Factors	Type of study Quant/Qual	Key findings/ Resources / Interventions	Comments (orientation)
Hyare	1996	Report	UK Birmingham	-	South Asian	Muslim, other	-	-	Semi-Qt survey: myths and facts, awareness (KABP) and of professionals (Qual)	Four womens group, 4 mens (2 youth groups) focus group based surveys & discussions (83 people): welfare service professionals also had low levels of knowledge on alcohol: women did not know about unit; very negative views expressed about all aspects.	Practice-based study: reveals considerable need for training in gateway professionals who might be able to pick up and refer problem cases: heavy burden of stigma associated with drinking affects all.
Hyare & Taylor	1996	-	UK Midlands	0-2	Asian	Muslim (Pak, Bang) Sikh Hindu	-	-	Qt QI survey of community and professionals through focus groups	Elicited worryingly low levels of knowledge among community workers, negative attitudes towards drink among both male and female groups of Muslims & Sikhs. Heavy drinking associated with social isolation	Practice - services should be located away from community to preserve anonymity; need bi-lingual staff and value-free education ('safe' is NOT V-F)
Kunz	1999	Acculturation	Canada	-	Indian Punjabi	(Sikh)	-	SEG control	KABP survey	524 respondents- community has perception of high level of A' problems; strength of religious attachment affects likelihood of drinking: developed videos after survey	Policy & Practice - Link to survey by Weber 1996 Acculturation and/or acculturational stress
Manik et al	1997	Spontaneous cures	UK	-	Asian, White	Yes	-	-	KABP survey Qt QI	Study in Leicester using snowball survey (semi-structured) plus SADQ. Asians did not drink at home; shame, loss of sexual ability, fear of shaming family led to spontaneous cessation, aided by religious re-affiliation > whites had not got peer support	Academic: unpublished, small sample of 20 Asian, 12 white poorly matched respondents
McKeigue & Karmi	1993	-	UK	-	African-Caribbean, South Asian	Gujerati-Hindu, Punjabi - Sikh, Muslim	Gujerati, Punjabi	-	Epid Review	Literature review and some unpublished data suggests African-Caribbean men and women (few studies) show lower rates of drinking and heavy drinking and liver (etc) damage: S Asians possibly higher damage tho much less drinking- Sikhs have higher levels especially of lone drinking and spirits - S Asians have high rates of liver disease ?? not Hep B?? Services seen as under-developed	Academic review with focus on clinical epidemiology. Base of most later reports; drawing on large number of less often cited primary data sources: now dated but probably most comprehensive review to date: many observations still true

Reference	Year										
		Theories?	Country	Tier	Ethnic Group(s)	Religion	Non-English Lang.	Socio-demogr Factors	Type of study Quant/Qual	Key findings/ Resources / Interventions	Comments (orientation)
Miller	1998	Spirituality Models	USA	-	-	Yes	-	-	Review of theories and models for treatment & research	Notes lack of attention to spirituality in most studies, discusses difference from religion: excess use and effects are seen as sinful, not the drug itself : spirituality protects	Academic - no mention of ethnicity; recognises religions differ in the way they act.
Morjaria	n.d.	TTM; 12 Steps; Spiritual	UK	2-3	Indian	Sikh Hindu	-	-	KABP Qual	Alcohol as substitute for spiritual health - rediscovery or identification with new religious meaning system helpful: 18 men in-depth interviews (had been to indiv. Or group counselling) - amrit / sewa helpful.	Academic thesis - discussion exploring self-cure approaches and specific needs and resources of Asian cultures
Morjaria	2003 (u)	TTM 12Steps Spirituality	UK	2-3	Asian	Mostly Sikh	-	-	QI 18 in-depth interviews	Alcohol / Spirit health links - re/discovery of religious meaning system can be helpful. Most had been to group or indiv. Counselling but found religion (Amrit and Sewa) helpful	Academic - Community: based on thesis, pending publication
Morjaria & Orford	2002	Spirituality TTM 12Steps	UK	2-3	South Asian, White	Sikh/Hindu, Catholic	-	-	In-depth QI interviews ten men	Compares 'recovering' Asian and White men - Whites found new spirituality via AA; Asians rediscovered childhood faith. Stages of change (TTM) model ignores spirituality	Academic (Theory) but describes in some detail how two groups differ in ways 'out' of alcohol dependence and gives references to Indian AA
Nayak	1985	-	UK	0	Asian	Sikh Hindu Muslim	Yes	-	Review and QI/QI interviews with key informants	One of earliest reviews of the evidence and early concepts: almost unique in seeking data on related harms, relating to patterns of use in sub-continent - suggests upper class/ army families use widely, rural 'binges', urban poor abstain, while UK under-reporting common	Practice/ Community - How little has changed - Note found data on drink-driving arrests in Coventry: many were Asians and concludes a significant hidden problem exists
O'Connell & Alexander	1994	Spirituality (TM)	USA	-	-	TM	-	-	Review	Literature review (said to be meta-analysis) from committed perspective supporting role of Maharishi Transcendental Meditation and ayurvedic principles: while partial and not so critical of TM, provides strong support for role of spirituality in meeting needs of users	Academic and committed to TM principles but relates to complete issue of journal of linked articles on this topic

Reference	Year										
		Theories?	Country	Tier	Ethnic Group(s)	Religion	Non-English Lang.	Socio-demogr Factors	Type of study Quant/Qual	Key findings/ Resources / Interventions	Comments (orientation)
Orford, Johnson & Purser	2003	Acculturation Risky/Heavy Drinking	UK	-	Black, Indian, Pakistani, Bengali	Muslim, Sikh, Hindu, Christian	-	-	KABP Survey 1684 men and women from minorities in Midlands; QQs from other surveys used	Literature review and non-random sample survey finds bi-cultural strengths: religion protects against risky behaviours; strong identity and lower alcohol usage in all ethnic and religious groups, poor links to sources of support outside family and friend networks	Academic Practitioner with interest in 'protective' factors'
Vora et al	2000	-	UK Leicester	0	Asian	Hindu Sikh Muslim Jain	-	Generation	Quant KABP survey (oral cancer focus)	524 adult males (262 Hindu, 101 Sikh, 101 Muslim, 55 Jain) surveyed on oral health risks including paan and alcohol: 'second generation' Hindus were slightly more likely to drink, Sikhs less likely, Jains much more likely - 1 st gen. Jains (82% non-drinkers) were close to Muslims. Most drank beer, Sikhs drank more spirits but few chewed paan	Academic / practice based study - comments that low awareness of link between alcohol and cancer.
Weber	1996	Acculturation	Canada	-	Indian Punjabi	(Sikh)	-	-	KABP survey	Literature review shows mixed messages but women remain non-users; survey of 404 adults measures acculturation, CAGE, religiosity - - more acculturated drink more but have easier access through using English	Academic/ Policy; finds more problems for less integrated - need to use Punjabi medium media and community organisations
White et al	2001	-	UK Newcastle	-	Chinese, 'European'	-	-	Soc Class, Marital status matched	Quant KABP survey of Chinese residents	380 Chinese people recruited from various sources - attempted whole population survey. White control sample. Fewer Chinese women drank alcohol (29%); men (63%) were also below white rates (93%); gender differences were greater in the Chinese group.	Academic study - mostly tobacco focused, showing some data on alcohol: unique in providing information on Chinese community (but very low rates of risky drinking)
Wickramasinghe et al	1995	Clinical	UK	3-4	South Asian / European	-	-	-	Clinical case series data analysis -Quant	22 SA and 32 European (White) men admitted for DeTox - serum level clinical data and consumption analysed. Suggests damage occurs faster to Asian heavy drinkers	Academic Practitioner epidemiology - descriptive
Williams & Shams	1998	-	UK Scotland	-	Asian, non-Asian Scots	?	?	?	Epid Qt Surveys of 334 (A) + 490 young, 173 mid-age Asian & 344 'general pop' aged 35	Abstract only seen: Lower use of alcohol, drugs etc reported, linked to better health - link alcohol and accidents	Acad / practice (ON ORDER)

Reference	Year										
		Theories?	Country	Tier	Ethnic Group(s)	Religion	Non-English Lang.	Socio-demogr Factors	Type of study Quant/Qual	Key findings/ Resources / Interventions	Comments (orientation)

Appendix 3

Resources sent to the Survey and added to the Project Database of 'Good Practice'

Project leaflets & General publicity materials (see also posters, below) (may contain examples of good presentation, multi-ethnic role models etc)

Davies Alcohol Services (Turning Point) (Residential & Day Centre units)

New Roots (postcards) New Roots Black & Asian Alcohol Advice Service (English)
(Rugby House Project, London)

New Roots (small flyer: 'fancy a drink') (Rugby House Project, London)

Annual Reports etc.

Alcohol Services for South London annual report 2001/2

Aquarius Service Reports 2000-2001 (Birmingham Asian Alcohol Service)

Airedale Voluntary Drug & Alcohol Agency Ltd - Project 6 - Asian Communities
Substance Misuse Support Project report Oct 2002-Dec 2002

New Roots project report (Rugby House Project, London)

Leaflets etc aimed at (potential) Users (recruitment)

Diwali Greeting Card (and annual calendar) - DASL

Eid Greeting Card (and Ramadan prayer Calendar) - DASL

'Is your own or some else's DRINKING causing problems?' (Alcohol Services for South London)

Alcohol Problems? Sharaab Ke Masaail (Ethnic Services Project, Alcohol Advice Centre, SouthWest Hertfordshire)

Ethnic Services Project: Don't suffer alone, Talk to us (Ethnic Services Project, Alcohol Advice Centre, SouthWest Hertfordshire) (lines in Urdu, Bengali, Hindi & Punjabi and English)

Drinking - a problem for you or someone you know? Punjabi/English (Sahaita, Aquarius Birmingham)

Drinking - a problem for you or someone you know? Bengali/English (Sahaita, Aquarius Birmingham)

Drinking - a problem for you or someone you know? Urdu/English (Sahaita, Aquarius Birmingham)

Drinking - a problem for you or someone you know? Gujerati/English (Sahaita, Aquarius Birmingham)

'Are you Asian and concerned about your own or someone else's drug or alcohol use' (also in Urdu & Bengali) (Airedale Voluntary Drug & Alcohol Agency Project 6)

4YP/D2W Alcohol Service for Young People (Rugby House Project, London)
For Young People 4YP (Rugby House Project, London)

New Roots: Working with Doctors & health care professionals in Camden & Islington - Primary Care Alcohol Check-up Service (English & Bengali) (Rugby House Project, London)

New Roots Black & Asian Alcohol Advice Service (English) (Rugby House Project, London)

New Roots Black & Asian Alcohol Advice Service (Bengali) (Rugby House Project, London)

New Roots Black & Asian Alcohol Advice Service (Arabic) (Rugby House Project, London)

New Roots Black & Asian Alcohol Advice Service (Punjabi) (Rugby House Project, London)

Posters

New Roots Black and Asian Alcohol Advice Service ('Talk to us in confidence')

Small posters also in Arabic, Somali, Punjabi, Bengali,

What Alcohol does to your body (English) (Rugby House Project, London)

What Alcohol does to your body (Somali) (Rugby House Project, London)

What Alcohol does to your body (Bengali) (Rugby House Project, London)

What Alcohol does to your body (Arabic) (Rugby House Project, London)

Alcohol Information Leaflets

Alcohol - The Facts - English / Bengali/ Punjabi / Hindi / Urdu / Gujarati (Health Promotion England, 2000) (first published, Health Education Authority 1999)

Keeping a Count on Alcohol - Punjabi/English (Aquarius, Birmingham)

Keeping a Count on Alcohol - Bengali/English (Aquarius, Birmingham)

Keeping a Count on Alcohol - Gujarati/English (Aquarius, Birmingham)

How Alcohol Works - Urdu/English (Aquarius, Birmingham)

Alcohol and the Law - Urdu/English (Aquarius, Birmingham)

Alcohol and the Law - Bengali/English (Aquarius, Birmingham)

Alcohol and You: A guide to alcohol safety for Black and Ethnic Minorities, for Lesbians & Gay Men (Rugby House Project, London)

To all Wannabes 4YP Facts about drinking 4U (New Roots Black & Asian Alcohol Advice Service (English) (Rugby House Project, London))

New Roots Service for Elders (New Roots Black & Asian Alcohol Advice Service (English) (Rugby House Project, London)

What Alcohol does to your body (English) (Rugby House Project, London)

What Alcohol does to your body (Somali) (Rugby House Project, London)

What Alcohol does to your body (Arabic) (Rugby House Project, London)

What Alcohol does to your body (Punjabi) (Rugby House Project, London)

What Alcohol does to your body (Bengali) (Rugby House Project, London)

Other Materials

Newsletter - New Roots (Issue 1,1 Summer 2001; Issue 2,2 Winter 2002)

Clients Rights (English, Bengali) (Rugby House Project, London)

Drugs & Alcohol in your Community Questionnaire - in English, Arabic (bilingual), Somali, Bengali (Rugby House Project, London)

Training Evaluation Form (Somali, English) (Rugby House Project, London)

Drink Diary (Somali, Bengali, English) (Rugby House Project, London)

Confidentiality Document (English, Somali) (Rugby House Project, London)

Non-Alcohol Related materials also supplied:

Ecstasy (Somali/English) (Rugby House Project, London)

Cannabis (Somali/English) (Rugby House Project, London)

Cocaine/Crack (Somali/English) (Rugby House Project, London)

Khat (qaadka) (Somali/English) (Rugby House Project, London)

Dealing with Drugs (invitation to a workshop - Note - 'free food available and space for prayer') (English, Bengali) (Rugby House Project, London)

Older materials retained from previous research activity at MSRC:

New Roots Black & Asian Alcohol Advice Service (Rugby House Project, London)

Saaf-Dil Project (What alcohol can do to your body) English/Urdu (Rotherham HA 1996)

ARP Choices (Black Advisory Services on Alcohol related Concerns):

Complimentary and Natural therapy

Elder Black men and Alcohol

Black Men and Alcohol

Staying Sober the first 30 days

Alcohol and Black awareness

Acupuncture: can it help you

EACH (Ethnic Alcohol Counselling Hounslow/Harrow) Information pack

Harrinder Singh Dhillon 1994 Counselling Asian Men with Alcohol-Related Problems

Newham Alcohol Advisory Service

Appendix 4

(This is adapted from the Alcohol Concern (2002) report: 100% Proof: Research for Action on Alcohol London)

Alcohol and Black & Minority Ethnic (BME) communities: Overview of research and service development issues

(Gersh Subhra)

The link between research, service developments and the Black & Minority Ethnic (BME) communities in the UK has been a complex and at times a controversial one. This centres on perceptions that these communities have faced an over-researching of needs, which at times has pathologised or homogenised their emerging needs. Denscombe (2000) highlights the need for health education research to recognise not only diversity between ethnic groups but also within them. Some of this diversity is also due to age as a key factor in understanding changing attitudes to alcohol and other substance use. Recent studies by Purser et al (2001) extend this call for greater sophistication in research methodology to include gender as a key factor also. A lack of action or change by service providers, despite the research findings has led to further scepticism about the value of research (Johnson & Carroll 1995).

This overview will consider the

- pattern of development of research and culturally appropriate alcohol services
- how this can be mapped using a dynamic model, which illustrates the progress being made towards anti-racist and culturally appropriate research and alcohol services.
- the need for a strategic framework document that takes account of the various developments that have occurred and provides guidance to the alcohol sector about future priorities.

The amount of UK literature covering alcohol issues and the BME communities has been relatively limited but is growing steadily, particularly in the last 10 years. This coincides with a corresponding growth in the number of alcohol agencies developing specific service initiatives for these particular communities.

The material produced by the alcohol field was initially dominated by research which aimed to establish patterns of drinking, attitudinal analysis and comparative work based on variables of religion, race and to a lesser extent gender. Examples of such studies include Cochrane and Bal (1990), Bhopal 1986, Balarajan and Yuen (1986), Mather and Marjot (1989), Ghosh (1984), Burke (1984).

The quality of extrapolations and the firmness of conclusions that could be drawn from such studies varied greatly. The complexity of factors such as sample size and composition, transferability of patterns of drinking from specific areas of the UK, factors such as the class, rural or urban origins, gender and age would suggest that caution be exercised. Even where the large scale studies, such as Cochrane and Bal's (1990), take account of some of these variables, they may generate data that quickly becomes out-dated. Such data is therefore risk-laden for alcohol agencies that are looking for advice or guidance from these sources in order to develop new and targeted services.

The early reluctance by voluntary and/or statutory service providers to establish facilities and services may have been linked to the BME communities needing to 'prove' that there were indeed actual needs that were not being met, before new services could be developed.

This demonstration of proof took the form of small-scale research or anecdotal local studies, both of which are fraught with difficulties and carry with them, the dangers of labeling BME communities with yet another new stereotype. At the same time, Kohli (1989) and Denscombe (op cit) criticise the use of 'common-sense' stereotyping about drinking patterns (or lack of) to overlook the ethnic dimension within larger studies and because of this further research being deemed unnecessary.

The task of research in providing indicators of prevalence, whilst assisting the targeting/adapting of services without reinforcing stereotypes is therefore a delicate balancing act (Johnson and Carroll 1995).

A 1995 review of research literature (Alcohol Concern 1995) into the prevalence and patterns of drinking within African, Caribbean and Asian communities identified significant gaps in knowledge and concluded that not a large amount of research existed and more work was needed to provide a fuller picture. Purser's report (2001) echoed this conclusion, particularly in relation to African-Caribbean communities. Their literature review considers a variety of community-based surveys, general population surveys carried out by OPCS in 1993, Health Education Authority Health & Lifestyle survey (1994), various targeted prevalence studies, as well as studies looking at attitudes and beliefs of self-identified drinkers.

The prevalence and pattern-seeking type of research seems to have been in response to a gap in knowledge that had arisen, partly because of the failure of existing generic services to build up a detailed knowledge base. By being inaccessible or insensitive to the emerging BME needs, these agencies failed to significantly develop their knowledge base through 'organic' or incremental methods such as case work, educational or outreach work (C.I.O. 1994).

The alcohol specific literature on this area is sparse and reflects, perhaps a reluctance to consider how the alcohol agencies themselves, may have been posing barriers to changes by remaining Euro-centric in their approach. This situation contributed to Alcohol Concern developing two grants programmes, both of which included a focus on the development of BME alcohol services from 1991 to 1998. Two independent evaluation reports considered the impact of this work (C.I.O. 1994 and Chauhan & Subhra (1999).

The need for more research and methods that build up a more accurate picture of needs are discussed in a study carried out by Malseed (1990), which focused on young Asian and African Caribbean people in Preston. She criticises the use of traditional survey-type approaches that use questionnaires (often with translations) as being unsuitable in accessing the private, value-laden areas of alcohol issues. The responses that are given, tend to be 'public', rather than 'private accounts'. This is echoed by Denscombe (op cit), who argues that a failure to distinguish between ethnic sub-groups is likely to compromise the sensitivity and validity of the findings.

The need to shift the focus away from research which pathologises through anecdotal snapshots of the BME communities, and towards an approach which looks at ways in which services can be creatively adapted and innovated is an urgent priority.

Adebowale's *Steps to a "perfect service"* (1994) is one of few accounts that focuses specifically on the defects within the predominantly white voluntary sector in providing Black services. He suggests that a range of paradigms exist within these alcohol agencies which act collectively to maintain the status quo or create minimal change. He goes on to map out these paradigms which range from ignoring the issue through to a 'paralysis' which occurs because it cannot be decided who to prioritise.

The focus of early research and literature in the alcohol field can also be critiqued by presenting BME communities as 'passive recipients' rather than 'active generators or providers' of ideas and strategies, able to draw on its community resources (e.g. people, their experiences and community self-help networks) to deal with the issues affecting them. This approach is essentially symptomatic of a lack of a community development perspective to research. (Webster 1998)

What should be key features of research in relation to the BME communities?

The last few years has seen a development in the alcohol field in its approach and analysis of issues relating to the BME communities. The emergence of material on good practice guidelines such as

ARP Choices (1996),

Alcohol Concern: An Introduction to Working with Asian Communities (1993),

EACH: Developing Alcohol Services for Asian Communities (1996),

EACH: A cultural cocktail- Asian women and alcohol misuse (2000),

Awaaz: Asian Young Women and Alcohol (1994),

All are a welcome sign that the diversity and complexity of issues is being recognised. These guidelines offer a way of 'fast forwarding' a back-log of learning within the alcohol field which should be shared by members in different agencies.

It can be seen that the alcohol field and the corresponding research literature, has followed a definite pattern of growth and development in recent years and can be mapped out in the form of a continuum or set of stages. This model was developed within the Chauhan & Subhra's (1999) evaluation of the Alcohol Concern Stage II grants programme and has been adapted to include the research sector:

IGNORE GAPS IN RESEARCH AND SERVICES

- * Development and perpetuation of Euro-centric research projects with little recognition of BME communities or adaptation of research methodologies.

RECOGNISE LACK OF RESEARCH & TAKE-UP OF SERVICES

- * BME communities viewed through a 'deficit' model;
- * Small scale localised research which does not have academic or methodological rigour;
- * Anecdotal evidence leading to stereotypes;
- * Larger scale research into prevalence and patterns of drinking that ignores or minimises the ethnicity of the population.

GENERALISED INITIATIVES -

- * Shift in focus towards looking at the deficits in research & service delivery within the alcohol field;
- * Funding led rather than needs led research projects;
- * More research projects focusing specifically on BME communities;
- * Partnerships (though limited in most cases) with BME communities, agencies & researchers;
- * Funding predominantly for generic/white voluntary sector agencies or researchers to develop services or research.

INCREASED TARGETING -

- * BME communities viewed through a 'resource' model and seen as active providers & generators of ideas, resources & research;
- * Funding targeted much more widely & to a range of organisations including BME led community & research organisations;
- * Enhancing the capacity of BME researchers and practitioners is a core objective;
- * More emphasis on principles within community development and action research traditions
- * Development of Good Practice guidelines;
- * Conferences and specialist training events.

The above model emphasises the role played by research:

- It needs to be relevant and accessible
- It should involve communities, researchers and practitioners, particularly from BME communities;
- findings should be disseminated widely so that they impact on and result in an improvement in services.

It is hoped that new research priorities will emerge from the work to be undertaken in the above three areas. The framework above coincides with Bhopal & Whites (1993) call for research in the area of health promotion to reflect the following three areas

- The impact of social policy and social circumstances on health,
- epidemiological studies of health status
- needs assessments and evaluations that guide the principles and development of interventions for BME communities.

Research priorities in relation to BME communities, currently being highlighted by Purser (op cit) include:

- understanding the factors and processes involved in heavy single episode drinking
- impact and effectiveness of community safety and public health campaigns
- relationship between alcohol use and risky behaviour
- effects on others affected by a persons drinking
- extent to which mental health and other hospital services are being accessed when the person actually requires alcohol services

Denscombe (op cit) recommends more studies associated with the changing use of alcohol by various subgroups of South Asian young people so that interventions can be developed that are more in tune with them.

Other emerging areas include:

- analysis of help-seeking behaviour
- evaluation of the responses being made by GP's to alcohol issues being presented
- researching ways of promoting talking and counselling as routes to tackling an alcohol problem as opposed to seeking a medical solution

Finally, a key issue to be addressed relates to enhancing the collaborative research capacity of the voluntary sector, research bodies and other relevant agencies. A good practice model worth considering is that adopted by the University of Central Lancashire in conjunction with the Dept. of Health and which coordinated over 50 BME community research studies in the drugs misuse field in 2001/02. These studies were collaborations between the above types of agencies and many diverse ethnic groups and have resulted in a number of beneficial outcomes, including a National Summary Report.