

# *Treatment and Recovery: Black and Minority Ethnic Communities*

## 1. Introduction

This briefing follows a discussion which took place at a Recovery Partnership roundtable discussion held under the Chatham House Rule in Birmingham in July 2015. The event was attended by substance misuse commissioners, drug and alcohol service managers, frontline workers and volunteers from the West Midlands, as well as representatives from related sectors such as criminal justice. This paper draws also upon published research and statistics. It considers how the systems and services involved in substance misuse can better address the needs of people from Black and Minority Ethnic (BME) communities, and ensure that the values of equality and diversity are upheld and enacted in drug and alcohol treatment and recovery. The definitions of equality and diversity used in this paper are borrowed from the Department of Health, which summarises equality as equal access, equal treatment, equal outcomes and equal opportunity, and diversity as the ‘recognition and valuing of difference.’<sup>1</sup>

The term ‘BME’ is used in this report to describe people who are not from a white British background, however it is acknowledged that this term is a catch-all<sup>2</sup>, one that masks a great deal of diversity. Not only are there great cultural differences between the many different BME communities in England, but participants at the roundtable emphasised that within those communities there are often cultural differences between different

By Adfam on behalf of the Recovery Partnership

generations, genders, and religions. The authors of this briefing are mindful of this diversity and of the limitations of the terminology used.

This briefing is limited in its scope to treatment and recovery; it does not focus on prevention in and of itself. Neither does its scope permit an in-depth consideration of services for young BME people. It is acknowledged that this briefing captures only a snapshot of perspectives and practice shared at a single event, which focussed on one region. However, a number of clear messages emerged from the event which may have relevance for the sector beyond the West Midlands, as well as related sectors, including mental health and housing/homelessness. These include the importance of choice in treatment, the benefits of a culturally competent system and the value of well-established links with the community. This paper will consider these themes in greater detail, using case studies to explore their positive potential for the recovery journey of people from BME communities.

## Background

### Facts and Figures

Statistics from recent censuses indicate that the White British population in England and Wales<sup>3</sup> has decreased from 91.3% in 2001 to 80.5% in 2011,<sup>4</sup>. After London, the population of the West Midlands has the greatest proportion of non-White residents of any region in England.<sup>5</sup> The call in the coalition government's 2010 *Drug Strategy*<sup>6</sup> for substance misuse services 'to be responsive to the needs of specific groups such as black and ethnic minority people' is therefore especially pertinent in regions such as the West Midlands. Under the Equality Act 2010<sup>7</sup>, public services are legally required to ensure they do not discriminate against people on the basis of race, religion or belief. The existence of national guidance and policy on BME groups in substance use treatment and recovery specifically, along with recent research in this area, is however limited; the 2012 *Alcohol Strategy*<sup>8</sup> offers no national guidance on engaging BME groups for instance, and instead devolves the responsibility to 'meet the needs of specific groups' and 'provide mechanisms to ensure that the needs of all populations, and all issues, are considered' to local authorities. These mechanisms include the use of Joint Strategic Needs Assessments (JSNAs) to understand local needs and priorities, as recommended by Public

Health England's (PHE) JSNA support packs for alcohol and drug prevention, treatment and recovery.<sup>9</sup>

According to National Drug Treatment Monitoring System (NDTMS) data<sup>10</sup>, people identifying as white British were over-represented in treatment in England in 2013-14. The majority of service users (83%, compared to 80% of the English population) were white British, the next most common group being 'white - other' (4%, compared to 5% in the general population). No other ethnic group accounted for over 2% of the treatment population, and certain ethnic groups were under-represented in the treatment system compared to the general population: people reporting their ethnicity as Pakistani, Indian, and black African, for instance, each made up only 1% of the treatment population, compared to 2.1%, 2.6%, and 1.8% of the English population respectively.

### What do the statistics tell us?

Drawing conclusions from these statistics is challenging, requiring an understanding of the factors underlying these apparent disparities – factors which both the existing literature and the discussion's participants suggest are complex and wide-ranging. One explanation is simply that drug and alcohol misuse is more prevalent in some ethnic groups than in others. The combined dataset from the Crime Survey for England and Wales 2011 - 2014<sup>11</sup> to an extent supports this, indicating that adults from mixed ethnic backgrounds were more likely to have consumed an illicit drug in the year preceding the survey than adults from any other ethnic group, followed by those who identified as 'White British' or 'Other White' (it should be noted that the survey does not cover certain groups, including homeless people and people in prison<sup>12</sup>). Adults identifying as Asian or Asian British reported the lowest levels of illicit drug use. Standardising the drug use rates by age, however, reduces many of the differences between ethnic groups, suggesting that age, rather than ethnicity, is the primary driver of differences between groups.<sup>13</sup>

Another possible reason for the under-representation of some BME groups in treatment is the varying perception of drugs and alcohol in different communities. There is a small body of evidence to suggest that certain substances are seen as more or less acceptable in different communities<sup>14</sup> – drinking among older men in Punjabi culture, for example, being 'the norm'<sup>15</sup>,

as it is arguably for a large section of the White British population, or khat being perceived as socially acceptable, a part of culture and tradition, by some Somali and Yemeni people<sup>16</sup> (although this attitude is not universal, and the perception of khat may have shifted since it became a controlled substance under the Misuse of Drugs Act in 2014). Such perceived acceptance could, participants suggested, reduce engagement with treatment services.

Additional obstacles to accessing treatment services might also include higher than average levels of shame and stigma experienced by BME individuals. In some cases (for instance South Asian and Chinese communities) high levels of stigma are also directed at the families of drug users, causing concerns that the whole family and not just the individual could be alienated from the community. This could lead not only to a reluctance on behalf of the individual to seek support or disclose their drug or alcohol problem to family members, but also to the concealment, denial and underreporting of substance misuse,<sup>17</sup> as well as a need for dedicated family support services.<sup>18</sup> Language and cultural barriers, concerns surrounding confidentiality and anonymity, and the unfamiliarity of treatment (in particular talking therapies) were also cited at the roundtable event as obstacles which treatment and recovery services must address in order to ensure their accessibility to people from all of the communities they serve, and these themes will be explored in this briefing.

It has also been suggested that people from BME groups living in England can have greater difficulty with access to health care services in general,<sup>19</sup> experiences which could discourage engagement with other services including substance use services. 43% of respondents to a recent survey on alcohol treatment (which targeted service providers, service users and commissioners) felt that BME communities are underserved in the alcohol treatment system,<sup>20</sup> and the issues of access to and suitability of substance misuse services will be considered in greater depth in this paper.

That the factors behind the underrepresentation of BME groups in drug and alcohol treatment are complex, multifaceted, considerably between communities and individuals, and change across generations, demands a flexible and dynamic approach to service provision.<sup>21</sup> This briefing focuses on some of the ways in which treatment and recovery systems and services in the West Midlands are operating in order to become more accessible and culturally appropriate for BME people in need of support for their substance use problems.

## 2. A whole system approach?

### Mainstream or specialist BME services?

Representatives from both specialist BME drug and alcohol services and mainstream treatment providers were present at the roundtable event. There was some discussion as to whether a specialist BME service is better equipped to support service users from the BME community than mainstream services are, with the suggestion that they can offer an initial engagement, providing what one participant referred to as a “soft landing”, from which BME service users could then integrate more easily into the mainstream treatment system once trust has been established.

It was, felt by many of the participants that the two types of services work most productively alongside one another, as parts of a single larger system. For instance, a larger provider might have greater capacity and infrastructure to enhance the reach of smaller specialist services, while local, specialist services can offer an in-depth knowledge of and relationships with the community and cultural context.

It is acknowledged that larger, mainstream providers can certainly develop expertise around the local, cultural environment. However, a key benefit of having specialist BME services running alongside mainstream drug and alcohol services, it was proposed, is that both have assets that the other can draw on to produce an overall system that is stronger as a result. This has been the experience of mainstream services working together with a grassroots, specialist BME service in Birmingham. An additional advantage of both types of services running alongside one another is that it enables service users to exercise choice over how they engage with treatment. This choice, it was

## Case Study: A whole system approach

Reach Out Recovery provided by CRI is an integrated service commissioned by Birmingham City Council to offer support to anyone experiencing difficulties with drugs or alcohol in the city. CRI have sub-contracted KIKIT Pathways to Recovery to deliver a specialist, culturally sensitive service as part of the Reach Out Recovery model.

KIKIT Pathways to Recovery is a BME specialist community based health and social care enterprise that works with individuals, families and communities that are affected by drugs and alcohol. KIKIT projects and services are developed and designed to meet the needs of hard to reach and marginalised communities. KIKIT uses an integrated and culturally competent approach, which offers a diverse range of services designed to maximise transformative recovery and support individuals to take personal responsibility so that they may achieve freedom from addiction and become productive individuals within their communities

As a community-based organisation for over ten years, KIKIT has established strong links with community groups, mosques, churches, synagogues, local charities and neighbourhood forums. It uses these local links to help service users reintegrate into their communities, which KIKIT considers an important part of recovery.

The KIKIT staff team has an intimate knowledge of the cultural environment in which it operates and the patterns of substance use prevalent in the community's different BME groups. KIKIT identified one area of the city as a hot spot for the dealing and use of khat, particularly among Somalian and Yemeni communities. It was commissioned to design and deliver a pilot project, working in partnership with local pharmacists to improve knowledge around khat use. The project aimed to equip pharmacists to provide information, harm reduction advice and brief interventions to khat users and carers of users, and developed a referral pathway into KIKIT for those who required further support. KIKIT also runs regular khat workshops with the Somalian and Yemeni communities, providing harm minimisation advice and education around the legal status of khat.

KIKIT has developed a BME recovery forum and the Muslim Recovery Network, adapting the 12-step programme with the Islamic faith.

KIKIT recognises that women from BME communities face additional barriers to reaching out to services for support, whether around their own substance or that of a loved one. These obstacles can include isolation, culture and language barriers. As part of their BME Women's Support provision, KIKIT employs female recovery workers who provide multilingual support to women in discreet locations which have included libraries, colleges, coffee shops, and homes,

and also offer a separate drop-in service for women. As well as addressing substance use, the KIKIT service offers support around a wider set of issues which may affect women from hard to reach BME communities, including domestic violence, female genital mutilation, and forced marriage.

Working in partnership with CRI as part of the Reach Out Recovery system has been advantageous for KIKIT. CRI has supported KIKIT by providing additional training and development support for its staff team and helped KIKIT to build its capacity, enabling the organisation to access more vulnerable people in Birmingham than was previously possible. KIKIT has seen an increased number of referrals from across the city since it began working within the Reach Out Recovery service.

For more information on KIKIT Pathways to Recovery visit: [www.kikitproject.org](http://www.kikitproject.org)

For more information on CRI Reach Out Recovery visit [www.cri.org.uk/content/reach-out-recovery-birmingham](http://www.cri.org.uk/content/reach-out-recovery-birmingham)

suggested, is fundamental, given the varying needs and wishes of individuals across and within different BME communities.

Based on this case as well as experiences of other roundtable attendees, it was concluded that debating the relative value of mainstream service versus specialist services can create a false dichotomy which masks the value of the two types of services working closely together.

### Engaging the whole system

For BME communities to have access to culturally appropriate treatment and recovery services, engagement of the whole system is required. This includes cultural competence running through the whole system, including commissioning. JSNAs which assess the local population and its needs, including the BME populations and any trends of substance use in those populations, can represent the first step in this process. Consultation with local community organisations and BME service users about their needs and experiences could also make a valuable contribution to this process. Where

need relating to the substance use of BME communities is identified investment may be required – for outreach activities, the training of staff and for interpreting and translation services, for instance.<sup>22</sup> Questions about the resourcing of these activities may arise. The majority of respondents involved in the Recovery Partnership’s State of the Sector 2014-15<sup>23</sup> project, which surveyed adult community and residential treatment providers in England, reported reductions in funding over the year preceding the survey. While commissioned local authority funding for substance use interventions doubtless remains a vital resource, drawing on and investing in the assets that exist within the community and in community-based organisations could be one way of helping to ensure treatment and recovery services are accessible to BME groups.

### 3. Addressing the barriers around access

Improving access to information about services and facilitating access to treatment was a key challenge discussed at the roundtable.

#### Information about drugs and alcohol, and the available services

The challenge of providing information around drugs, alcohol and substance misuse in the range of languages spoken within a local area, and delivering that information in a targeted and culturally appropriate way, is a common thread in much of the literature on the accessibility of substance misuse treatment services to BME communities.<sup>24</sup>

Roundtable participants emphasised that the translation of information into the relevant community-specific languages remains essential. However, it was noted also that many people identifying as BME are second or third generation migrants whose mother tongue is English. It should not be assumed therefore that language is the only or most significant barrier to accessing treatment, and developing an accessible and culturally competent treatment system entails much more than providing information in multiple languages. It was suggested that the way in which services are presented and the means through which they are publicised is equally important.

In a series of reports published in 2009, involving consultation with Black African, Black Caribbean, Chinese and Vietnamese, South Asian, and Turkish, Kurdish and Cypriot community organisations, many reported a lack of targeted and

widely available information on drugs and drug services in their communities. Commonly cited sources of information included friends and family, religious organisations, and community groups.<sup>25</sup> Approaches to outreach advocated at the roundtable indicate that these sources of information remain vital.

One service responding to Alcohol Concern's 2006 Survey of Alcohol Services, which asked about provision of alcohol treatment for BME communities, noted for example that 'Religious taboos surrounding the use of alcohol in Muslim communities and the shame and dishonour felt by the relatives of substance users [mean there is a] need to give detailed information about our confidentiality policy'<sup>26</sup>. Confidentiality was also put forward as a priority at the roundtable, and participants suggested that discreetly branded literature about services should be made available in spaces used by the local community, such as schools, colleges, GPs surgeries, libraries and places of worship. Promoting drug and alcohol services over South Asian TV and radio has been recommended in research on this issue,<sup>27,28</sup> and the use of digital and particularly social media were also encouraged at the roundtable to provide information about substance misuse and services in an easily accessible form to many people from their own home. The use of telephone helplines has likewise been advocated by BME communities on the grounds of their usability for those with poor literacy and their anonymity, which can help to combat fears of stigma and social isolation that might otherwise deter individuals from seeking advice and support.<sup>29</sup>

## Outreach

Owing to the additional barriers to accessing services that people from BME communities can still experience, roundtable participants emphasised that drug and alcohol services should proactively reach out to community organisations in order to make themselves more visible and accessible, ensuring that community leaders are informed of the substance misuse support available locally, and are able to direct those experiencing drug or alcohol problems to relevant services. This might, it was suggested, include women's groups and youth groups, as well as religious leaders and faith-based organisations. It was also acknowledged that communicating messages about drugs and alcohol to community leaders and religious leaders can be challenging, but if successful getting them on board to provide advice and signposting can be extremely valuable. Positive links and relationships with local communities, it was proposed, are essential to this process.

## Case Study: Working with religious leaders

As part of its outreach work, KIKIT Pathways to Recovery works closely with mosques and imams in Birmingham. KIKIT has trained imams on safeguarding, harm reduction advice, and has established a referral pathway between the mosques and KIKIT / CRI.

Should a vulnerable individual or a family approach the mosque, the imam is now able to contact KIKIT and arrange an appointment with a recovery coordinator.

For more information on KIKIT Pathways to Recovery visit: [www.kikitproject.org](http://www.kikitproject.org)

## 4. Migrants and People with No Recourse to Public Funds

Participants acknowledged that BME migrants who are subject to immigration controls frequently face additional barriers in accessing substance use support because of their no recourse to public funds (NRPF) status. People with NRPF are not entitled to certain welfare benefits and local authority housing provision.<sup>30</sup> It was suggested that difficulties experienced accessing other public services may deter people with NRPF from engaging with drug and alcohol treatment. These concerns may not be entirely unfounded. Findings from The Recovery Partnership's *State of the Sector* survey 2014-15 show that 25% of services are unable to work with undocumented migrants and only 15% and 5% of drug and alcohol services are commissioned to meet the needs of EU migrants and undocumented migrants respectively.<sup>31</sup> The survey findings indicate that a much greater proportion of services do however work with these groups regardless of the absence of specific funding, and this reflects the experiences of a number of the services represented at the roundtable event. Attendees suggested that for drug and alcohol services that are able to provide services to people with NRPF, it is particularly important to make explicit that their services are confidential and free of charge.

## Case Study: EU Migrants in Birmingham

Sifa Fireside is a Birmingham based charity which seeks to improve health and inclusion for homeless people. Sifa Fireside has seen a growing number of East European service users accessing its drop-in over the years. Many of these individuals come to the UK for work but employment contracts can be short term, exploitation is not uncommon and work-based contributions, such as tax and National Insurance, are often not made. As a result, many discover they are prevented from accessing benefit support during periods of unemployment.

Without entitlement to benefit support many East European service users are homeless. Alcohol or other substances are sometimes used to cope with homelessness, which may exacerbate the difficulties they already experience, reducing, for example, the chances of securing or maintaining employment. Thus they can be trapped in a cycle of homelessness, substance use and unemployment.

Residential rehabilitation may not be available to service users who are not eligible for public funding. That said, there are other avenues of support available, and East European service users at Sifa Fireside are encouraged to engage with the key provider of support to those with substance misuse problems in Birmingham, who work with clients from all cultural and ethnic backgrounds.

Sifa Fireside endeavours to deliver a service that maintains dignity and provides for many of the service users' basic requirements, including two meals a day, showers and laundry. In addition, clients with no access to benefits are provided with clean clothing and food parcels. A key support service for many of the East European clients is helping them back into employment. For many this is a vital step in their recovery.

As well as the support they will receive to tackle their substance use problems from the treatment provider, Sifa Fireside runs courses and activities to help East European service users develop the confidence and skills necessary to improve their training and employment prospects and their English skills. Sifa Fireside also provides welfare and benefit advice with the help of paid and voluntary translators. By providing a comprehensive service Sifa Fireside aims to support the East European service users to maintain health and dignity achieve greater self-confidence and independence, and thus facilitate their journey towards recovery.

For more information on Sifa Fireside, visit [www.sifafireside.co.uk](http://www.sifafireside.co.uk)

## 5. Developing culturally appropriate services

### Culturally appropriate support

Roundtable attendees raised concerns about the suitability of certain central elements of treatment for some BME service users. One US study found that mental health services targeted to a specific cultural group were several times more effective than those provided to clients from a range of backgrounds.<sup>32</sup> Although substance use services were not a focus of this study, research and anecdotal evidence from the roundtable event suggest that certain elements of substance misuse treatment may also be more or less appropriate for some BME groups.

Research in the Punjabi Sikh community in Birmingham indicates that middle aged and older men often find psychosocial talking therapies uncomfortable, proposing that current approaches should be adapted or re-designed to meet the needs of this population. It has been suggested that clinical approaches and direct advice may be a more suitable way to engage with this group.<sup>33</sup> Where talking therapies are used, it has been proposed that time should be dedicated to introducing service users to this new way of working,<sup>34</sup> although we acknowledge that psychosocial therapies are unfamiliar to a large part of the population and so this may apply equally to non-BME service users.

### Cultural competence in the workforce

Participants at the discussion agreed that one of the most important elements in developing culturally appropriate services is a culturally competent workforce. As one manager put it “it’s about the worker’s ability to connect with the other person in the room, human to human”. But at the same time it was suggested that service managers should not assume that all staff are confident supporting people from a range of cultural and linguistic backgrounds with equal efficacy. 30% of respondents to Alcohol Concern’s recent review of alcohol treatment identified working with people from non-White British communities as a priority training need.<sup>35</sup> In discussing this subject, participants recommended that drug and alcohol workers should be offered specific cultural competence training, though the evidence base around the potential of cultural competence training to improve service user motivation and their relationship with the drug/alcohol worker is currently weak.<sup>36</sup>

The values associated with cultural competence underpin effective and sensitive work with all individuals regardless of their ethnicity or background, but may be of particular importance when working with BME groups. Cultural competence 'goes beyond cultural awareness as it refers to the capacity of effectively operating in different cultural contexts. Cultural competence is an ongoing process of self-reflection of one's own (or organisation's) values, beliefs and professional practice'.<sup>37</sup> It requires that a culturally sensitive attitude, principles of equal access and non-discrimination are translated into behaviours and action in service delivery.<sup>38</sup>

Key elements of cultural competence include:

- Recognition of the influence of culture on people's beliefs and behaviours, including those surrounding illness, drug and alcohol use, and addiction. Assessing and taking into account any differences in perspective that may exist between the service user and the worker
- An understanding of cultural diversity and difference
- An awareness of the influence of culture whilst ensuring the individual remains at the forefront
- Effective communication, to mitigate against the problems caused by linguistic and cultural misunderstandings
- An awareness of the practitioner's own prejudices and biases.

Knowledge of different cultures can have a positive impact on the capacity of workers to operate in a culturally competent way, however it has also been proposed<sup>39</sup> that it is possible to be culturally competent without a comprehensive knowledge of a particular culture, and that knowledge alone is insufficient to guarantee culturally competent practice. For training around cultural competence to be successful in the long term and have a positive impact on the treatment of all service users, organisations should embed their training activities into a strategic model of cultural change, to promote organisational, rather than individual, cultural competence.<sup>40</sup>

Some debate occurred at the roundtable event as to whether a drug/alcohol worker from the same ethnic background as the service user is better positioned to support that person than someone from outside their community. It was conjectured that a drug or alcohol worker from the same ethnic background

could enable a “soft landing” much like a BME specialist service could: someone the service user could identify with at the initial point of engagement, speaking a community language if appropriate/possible, and introducing the individual into the culture of the service. Once the individual is familiar with the service they may be more comfortable engaging with other staff members. Research with Chinese and Vietnamese community organisations has produced a similar suggestion – that the presence of staff from the Chinese and Vietnamese communities might encourage other community members to approach the service, and these staff members could explain relevant cultures and traditions to their co-workers to equip them to better support this group of service users.<sup>41</sup>

Nonetheless, there was a strong feeling at the event that (language barriers aside) with appropriate training and support, culturally competent drug and alcohol workers are capable of supporting service users from any ethnic background. Where the service user does not speak the same language as staff, the provision of independent interpreting services (someone not known to the service user) is recommended by the National Institute for Health and Care Excellence (NICE) guidelines.<sup>42</sup> It has likewise been pointed out that services cannot assume that matching a practitioner with a service user on the basis of ethnicity will create a strong therapeutic relationship, and in general far more important is the worker’s sensitivity to the individual’s concerns<sup>43</sup> and their empathy towards the service user.<sup>44</sup>

### Residential rehabilitation

Participants at the roundtable largely represented community drug and alcohol treatment services, and as a result there was a focus in the discussion on community-based treatment services over residential rehabilitation. It is likely, however, that the residential rehabilitation sector will face some similar challenges in providing equality of access and developing culturally appropriate support for BME individuals. It is possible that residential rehabilitation may face some additional challenges in ensuring that it is appropriate for service users from all cultures, religions and ethnic backgrounds. Respondents to Alcohol Concern’s Survey of Alcohol Services in 2006 noted that the high level of social interaction involved in residential treatment (both in formal, group work sessions, and informal contexts such as eating and social activities) can result in some BME service users feeling isolated, particularly if they are not

confident speaking English.<sup>46</sup> Culturally conscious service design and the cultural competence of staff may be even more crucial in this context to create an inclusive environment for BME service users.

## Case Study: Engaging BME Communities—Cultural Competence

Wolverhampton Service User Involvement Team (SUIT) works with volunteers who are currently receiving drug or alcohol treatment or who have received drug or alcohol treatment in the last six months. This group also makes up 75% of the SUIT workforce. Volunteers take part in a comprehensive training package including on vocational topics. They provide a wide range of activities and supports to people experiencing drug and alcohol issues in the Wolverhampton area, from advocacy and peer support, to advice and guidance, to social activities.

SUIT works with service users from all cultures and ethnic backgrounds, and despite not operating as a specialist BME organisation, has been successful in engaging service users from the BME community. SUIT attributes its success in this area to a number of factors, not least that a number of community specific languages are spoken by staff and volunteers. Although they do not intentionally represent themselves as such, staff and volunteers have been perceived as BME recovery champions: members of BME communities have approached the service because they feel that they will be able to identify with the experiences of SUIT's team. Other vulnerable individuals are also attracted to the service, not only those solely with substance use needs, but people with immigration, mental health, employment and domestic violence needs, to mention a few.

SUIT volunteers are encouraged to develop cross-sectoral competence, for instance in obtaining a basic knowledge of immigration laws and where to seek further advice when necessary. SUIT considers social integration to be an important part of the recovery journey, and it therefore connects BME service users who struggle with English to classes in English as a second language, and plans and tracks their journey towards financial independence and social well-being.

For more information on Wolverhampton SUIT, visit [www.suiteam.com](http://www.suiteam.com)

## 6. Conclusions

BME communities can face additional barriers in accessing health services, including drug and alcohol treatment and recovery services for a wide range of reasons, ranging from language barriers to stigma. This may be especially true for particular groups, including women and people with NRPF. Whatever the obstacles are, there was a consensus that the substance misuse sector should be fully equipped to respond to the needs of all BME individuals and groups, providing services which are both accessible and which offer culturally appropriate support.

Language remains a crucial part of this response. Breaking down the language barrier is only one of a number of strategies that can be used to increase the engagement of BME communities in drug and alcohol treatment and recovery. Also key is the presentation and marketing of services in a discreet way and an emphasis on confidentiality. Perhaps most crucially, those participating in the discussion highlighted the value of proactively reaching out to local community and religious organisations, building positive relationships, establishing referral pathways and empowering community leaders to deliver basic harm reduction advice. The importance of developing a culturally competent workforce, and the need for training in this area, was likewise highlighted.

Specialist BME services which are community-based are well-positioned to develop these relationships and pathways and can act as a 'soft landing' for BME service users. However it was proposed that specialist services can work productively together with mainstream drug and alcohol services. Debating the merits of one type of service versus the other could, therefore, create a false dichotomy. Both bring different assets to the table, producing a system that is stronger overall as a result of the partnership, with the added advantage of offering service users choice when accessing support.

Moreover, the difference between and within different BME groups was emphasised at the roundtable discussion – generation, age, gender, religion, immigration status, a range of cultural influences and not least individual experience should also remain at the fore of both the commissioning of services and their delivery.

## Further Reading

### Research and Reports

Issues surrounding drug use and drug services among ethnic communities in England. Fountain, J. 2009.

*In-depth investigation into knowledge about drugs and drug services in a range of BME groups in England. Five separate reports on:*

[South Asian communities](#) (pdf)

[Black African communities](#) (pdf)

[Black Caribbean communities](#) (pdf)

[Kurdish, Turkish and Cypriot communities](#) (pdf)

[Chinese and Vietnamese communities](#) (pdf)

**[Drugs and Diversity: ethnic minority groups. Learning from the evidence.](#) UKDPC 2010**

*Part of a wider programme of work undertaken by the UKDPC to provide an overview of the differing needs and challenges associated with drug use among diverse minority communities within the UK. Explores the extent and nature of drug use among BME groups, and considers treatment and prevention programmes for these group, as well as interaction with the criminal justice system.*

**[The Impact of Drugs on Different Minority Groups: A Review of the UK Literature. Part 1: Ethnic groups.](#) Beddoes, D. et al. UKDPC 2010.**

*A review of the literature on factors relating to drug use among black and minority ethnic (BME) communities.*

**[Developing a Community Alcohol Support Package: An exploratory study with a Punjabi Sikh Community.](#) Galvani S. et al 2013.**

*Final report on a project which sought to determine the feasibility of developing a community alcohol support package (CASP), which identified the support needs of communities and families, within a Punjabi Sikh Community in Birmingham.*

### IAPT Black and Minority Ethnic (BME) Positive Practice Guide. NHS 2009.

*Includes recommendations for the provision of mental health services to BME communities. Proposes that services should be provided in non-stigmatising and culturally sensitive settings in which:*

*Equality, diversity awareness and competency training is given to all staff*

*Advocates and/or interpreters are available*

*Information is provided in a variety of formats and languages*

*Services in a culturally-relevant format are accessible to local people*

## Websites

### KIKIT Pathways to recovery

*A BME specialist drug and alcohol service in Birmingham. KIKIT's services include:*

- *Drug and alcohol support*
- *Khat training*
- *Women's service*
- *BME recovery forum*
- *Muslim Recovery Network (faith-based, 12 step recovery support programme)*

### PHE Alcohol Learning Resources - BME

*Houses a set of resources and reports around BME groups and alcohol, including guidance on treatment pathways, and links to guidance on the Equality Act 2010 and the [Equality Act Impact Assessment](#).*

## Appendix

The roundtable discussion to inform this briefing took place on 22<sup>nd</sup> July 2015 at the Bond Company in Birmingham, with a regional focus on the West Midlands. Other roundtables in this series focus on learning from London, North West England, and South East England. We would like to thank the participants of the roundtable for their valuable contribution to this briefing.

### Attendees :

Mohammed Ashfaq, KIKIT Pathways to Recovery  
Bushra Ali, Birmingham City Council  
Jo Barber, Office of the Police & Crime Commissioner - West Midlands  
Jodie Beckett, Wolverhampton SUIT  
Ricky Bhandal, Sikh to Recover  
Malcom Clayton, Swanswell Drug and Alcohol Service, Sandwell  
David Coombes, Sifa Fireside  
Ed Corles, Aquarius Birmingham  
Sunny Dhadley, Wolverhampton SUIT  
Vivienne Evans OBE, Adfam (chair)  
Lauren Garland, Adfam  
Alana Gooden, Birmingham Changing Futures Together  
Kevan Hellewell, Swanswell Worcestershire  
Anna Kasmir, Adfam  
George Kelly, Sandwell IRiS  
Nicola McAlister, CRI Reach Out Recovery  
Shelton Mhlanga, Aquarius Wolverhampton  
Nicola Morris, Recovery Near You  
Sharon Reavey, Sifa Fireside  
Chris Saunders, Recovery Partnership Coventry and Warwickshire  
Paul Urmston, ESH Works  
Max Vaughan, Birmingham City Council  
Sian Warmer, CRI Reach Out Recovery

## References

1. Department of Health (2011) *No Health without Mental Health: A cross-Government mental health outcomes strategy for people of all ages Analysis of the Impact on Equality (AIE)*. Accessed online at [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213763/dh\\_123989.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213763/dh_123989.pdf)
2. Universities Scotland Race Equality Toolkit <http://www.universities-scotland.ac.uk/raceequalitytoolkit/terminology.htm>
3. Office for National Statistics (2012) *Ethnicity and national identity in England and Wales 2011*. Accessed online at [http://www.ons.gov.uk/ons/dcp171776\\_290558.pdf](http://www.ons.gov.uk/ons/dcp171776_290558.pdf)
4. Office for National Statistics (2012) *2011 Census, Key Statistics for Local Authorities in England and Wales*. Accessed online at [http://www.ons.gov.uk/ons/publications/re-reference-tables.html?newquery=\\*&newoffset=0&pageSize=25&edition=cm%3A77-286262](http://www.ons.gov.uk/ons/publications/re-reference-tables.html?newquery=*&newoffset=0&pageSize=25&edition=cm%3A77-286262)
5. *Ibid*
6. Home Office (2010) *Drug Strategy 2010: Reducing demand, restricting supply, building recovery*. Accessed online at [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/118336/drugstrategy-2010.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118336/drugstrategy-2010.pdf)
7. Equality Act 2010. Accessed online at [http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga\\_20100015\\_en.pdf](http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf)
8. Home Office (2012) *The Government's Alcohol Strategy*. Accessed online at [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/224075/alcohol-strategy.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf)
9. Public Health England (2015) *Alcohol, Drugs and Tobacco Joint Strategic Needs Assessment Support Pack*. Accessed online at <http://www.nta.nhs.uk/healthcare-JSNA.aspx>
10. Public Health England (2014) *Adult Drug Statistics from the National Drug Treatment Monitoring System (NDTMS)*. Accessed online at <http://www.population-health.manchester.ac.uk/epidemiology/NDEC/factsandfigures/statisticsfromndtms201314.pdf>
11. Home Office (2014) *Drug Misuse: Findings from the 2013/14 Crime Survey for England and Wales*. Accessed online at [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/335989/drug\\_misuse\\_201314.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/335989/drug_misuse_201314.pdf)
12. Office for National Statistics (2014) *User Guide to Crime Statistics for England and Wales*.
13. Home Office (2014) *Drug Misuse: Findings from the 2013/14 Crime Survey for England and Wales*. Accessed online at [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/335989/drug\\_misuse\\_201314.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/335989/drug_misuse_201314.pdf)
14. Beddoes D., Sheikh S., Khanna M. and Francis R. (2010) *The impact of drugs on different minority groups: A review of the literature*. UK Drug Policy Commission. Accessed online at [http://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20The%20impact%20of%20drugs%20on%20different%20minority%20groups\\_%20ethnic%20groups.pdf](http://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20The%20impact%20of%20drugs%20on%20different%20minority%20groups_%20ethnic%20groups.pdf)
15. Galvani S., Manders G., Wadd S. and Chaudhry S. (2013) *Developing a Community Alcohol Support Package: An exploratory study with a Punjabi Sikh Community*. Accessed online at [http://www.beds.ac.uk/\\_data/assets/pdf\\_file/0006/296394/CASP-Final-Report-December-2013.pdf](http://www.beds.ac.uk/_data/assets/pdf_file/0006/296394/CASP-Final-Report-December-2013.pdf)
16. Beddoes D., Sheikh S., Khanna M. and Francis R. (2010) *The impact of drugs on different minority groups: A review of the literature*. UK Drug Policy Commission. Accessed online at [http://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20The%20impact%20of%20drugs%20on%20different%20minority%20groups\\_%20ethnic%20groups.pdf](http://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20The%20impact%20of%20drugs%20on%20different%20minority%20groups_%20ethnic%20groups.pdf)
17. *Ibid*
18. Galvani S., Manders G., Wadd S. and Chaudhry S. (2013) *Developing a Community Alcohol Support Package: An exploratory study with a Punjabi Sikh Community*. Accessed online at [http://www.beds.ac.uk/\\_data/assets/pdf\\_file/0006/296394/CASP-Final-Report-December-2013.pdf](http://www.beds.ac.uk/_data/assets/pdf_file/0006/296394/CASP-Final-Report-December-2013.pdf)
19. Department of Health (2003) *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*. Accessed online at [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4019452.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019452.pdf)
20. Ward M., Holmes M. and Booker L. (2015) *Final Report: The Recovery Partnership Review of Alcohol Treatment Services* [http://www.recovery-partnership.org/uploads/5/1/8/2/51822429/alcohol\\_treatment\\_review\\_-\\_final\\_draft.pdf](http://www.recovery-partnership.org/uploads/5/1/8/2/51822429/alcohol_treatment_review_-_final_draft.pdf) Alcohol Concern and the Recovery Partnership
21. Galvani S., Manders G., Wadd S. and Chaudhry S. (2013) *Developing a Community Alcohol Support Package: An exploratory study with a Punjabi Sikh Community*. Accessed online at [http://www.beds.ac.uk/\\_data/assets/pdf\\_file/0006/296394/CASP-Final-Report-December-2013.pdf](http://www.beds.ac.uk/_data/assets/pdf_file/0006/296394/CASP-Final-Report-December-2013.pdf)
22. Banton P. M., Dhillon H., Johnson M. R. D. and Subhra G. (2006) *Alcohol Issues and the South Asian and African Caribbean Communities - Improving education, research and service development*. Commissioned by the Alcohol Education Research Council. Accessed online at [http://alcoholresearchuk.org/downloads/finalReports/AERC\\_FinalReport\\_0029.pdf](http://alcoholresearchuk.org/downloads/finalReports/AERC_FinalReport_0029.pdf)
23. Recovery Partnership (2015) *State of the Sector 2014-15*. Accessed online at <http://www.recovery-partnership.org/state-of-the-sector.html>

24. Banton P. M., Dhillon H., Johnson M. R. D. and Subhra G. (2006) *Alcohol Issues and the South Asian and African Caribbean Communities – Improving education, research and service development*. Commissioned by the Alcohol Education Research Council. Accessed online at [http://alcoholresearchuk.org/downloads/finalReports/AERC\\_FinalReport\\_0029.pdf](http://alcoholresearchuk.org/downloads/finalReports/AERC_FinalReport_0029.pdf)
25. Fountain, J. (2009) *A series of reports on issues surrounding drug use and drug services among various Black and minority ethnic communities in England*, *Drugs and Alcohol Today*, Vol. 9 Iss: 4, pp.41 – 42
26. Alcohol Concern (2006) *Survey of Alcohol Services* cited in Banton P. M., Dhillon H., Johnson M. R. D. and Subhra G. (2006) *Alcohol Issues and the South Asian and African Caribbean Communities – Improving education, research and service development*. Commissioned by the Alcohol Education Research Council. Accessed online at [http://alcoholresearchuk.org/downloads/finalReports/AERC\\_FinalReport\\_0029.pdf](http://alcoholresearchuk.org/downloads/finalReports/AERC_FinalReport_0029.pdf)
27. Fountain J., Bashford J., Winters M. and Patel, K. (2003) *Black and minority ethnic communities in England: a review of the literature on drug use and related service provision*. National Treatment Agency for Substance Misuse and the Centre for Ethnicity and Health (University of Central Lancashire). Accessed online at <http://www.better-health.org.uk/sites/default/files/consultations/responses/Black%20and%20minority%20ethnic%20communities%20in%20England.pdf>
28. Galvani S., Manders G., Wadd S. and Chaudhry S. (2013) *Developing a Community Alcohol Support Package: An exploratory study with a Punjabi Sikh Community*. Accessed online at [http://www.beds.ac.uk/\\_data/assets/pdf\\_file/0006/296394/CASP-Final-Report-December-2013.pdf](http://www.beds.ac.uk/_data/assets/pdf_file/0006/296394/CASP-Final-Report-December-2013.pdf)
29. Beddoes D., Sheikh S., Khanna M. and Francis R. (2010) *The impact of drugs on different minority groups: A review of the literature*. UK Drug Policy Commission. Accessed online at <http://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20The%20impact%20of%20drugs%20on%20different%20minority%20groups%20ethnic%20groups.pdf>
30. No Recourse to Public Funds Network (2015) *Practice Guidance for Local Authorities (England) Accessing and Supporting Adults who have No Recourse to Public Funds (NRPF)*. Accessed online at <http://www.nrpfnetwork.org.uk/Documents/Practice-Guidance-Adults-England.pdf>
31. Recovery Partnership (2015) *State of the Sector 2014-15*. Accessed online at <http://www.recovery-partnership.org/state-of-the-sector.html>
32. Smith, T. B., Rodríguez, M. D. and Bernal, G. (2011) *Adapting psychotherapy to the individual patient: Culture*. *J. Clin. Psychol.*, 67: 166–175. doi: 10.1002/jclp.20757
33. Galvani S., Manders G., Wadd S. and Chaudhry S. (2013) *Developing a Community Alcohol Support Package: An exploratory study with a Punjabi Sikh Community*. Accessed online at [http://www.beds.ac.uk/\\_data/assets/pdf\\_file/0006/296394/CASP-Final-Report-December-2013.pdf](http://www.beds.ac.uk/_data/assets/pdf_file/0006/296394/CASP-Final-Report-December-2013.pdf)
34. Banton P. M., Dhillon H., Johnson M. R. D. and Subhra G. (2006) *Alcohol Issues and the South Asian and African Caribbean Communities – Improving education, research and service development*. Commissioned by the Alcohol Education Research Council. Accessed online at [http://alcoholresearchuk.org/downloads/finalReports/AERC\\_FinalReport\\_0029.pdf](http://alcoholresearchuk.org/downloads/finalReports/AERC_FinalReport_0029.pdf)
35. Ward M., Holmes M. and Booker L. (2015) *Final Report: The Recovery Partnership Review of Alcohol Treatment Services* [http://www.recovery-partnership.org/uploads/5/1/8/2/51822429/alcohol\\_treatment\\_review\\_-\\_final\\_draft.pdf](http://www.recovery-partnership.org/uploads/5/1/8/2/51822429/alcohol_treatment_review_-_final_draft.pdf) Alcohol Concern and the Recovery Partnership
36. Drug and Alcohol Findings (2003) *Notes: Race and gender in the delivery of drug services* Accessed online at [http://findings.org.uk/docs/Ashton\\_M\\_2.pdf](http://findings.org.uk/docs/Ashton_M_2.pdf)
37. Luger, Lisa (2009) *Enhancing cultural competence in staff dealing with people with drug and alcohol problems*. Doctoral thesis, University of West London.
38. Banton P. M., Dhillon H., Johnson M. R. D. and Subhra G. (2006) *Alcohol Issues and the South Asian and African Caribbean Communities – Improving education, research and service development*. Commissioned by the Alcohol Education Research Council. Accessed online at [http://alcoholresearchuk.org/downloads/finalReports/AERC\\_FinalReport\\_0029.pdf](http://alcoholresearchuk.org/downloads/finalReports/AERC_FinalReport_0029.pdf)
39. O’ Hagan K. (2001) *Cultural Competence in the caring professions*. Jessica Kingsley, London
40. Luger, Lisa (2009) *Enhancing cultural competence in staff dealing with people with drug and alcohol problems*. Doctoral thesis, University of West London
41. Fountain, J. (2009) *Issues surrounding drug use and drug services among the Chinese and Vietnamese communities in England*. National Treatment Agency for Substance Misuse. ([http://www.nta.nhs.uk/publications/documents/5\\_chinese\\_vietnamese\\_final.pdf](http://www.nta.nhs.uk/publications/documents/5_chinese_vietnamese_final.pdf))
42. National Collaborating Centre for Mental Health (2011) *Alcohol-Use Disorders. The NICE Guideline on Diagnosis, Assessment, and Management of Harmful Drinking and Alcohol Dependence*. The Royal College of Psychiatrists. Accessed online at <http://www.nice.org.uk/guidance/cg115/evidence>
43. Drug and Alcohol Findings (2002) *Still little evidence for matching client with same-gender or same-race therapist*. Accessed online at [http://findings.org.uk/docs/nug\\_7\\_4.pdf](http://findings.org.uk/docs/nug_7_4.pdf)
44. Drug and Alcohol Findings (2000) *Client-receptive treatment more important than treatment-receptive clients*. Accessed online at [http://findings.org.uk/docs/nug\\_3\\_7.pdf?s=eb](http://findings.org.uk/docs/nug_3_7.pdf?s=eb)

## About Adfam and the Recovery Partnership

Adfam is the national charity working to improve life for families affected by drugs and alcohol. Adfam provide information and training to practitioners and local authorities and our work also concentrates on piloting and disseminating good practice, representing the views of family members to decision makers and influencing local and national policy. Adfam is a registered charity (number 1067428).

More information on Adfam's work may be found at [www.adfam.org.uk](http://www.adfam.org.uk)

DrugScope, the Recovery Group UK (RGUK) and the Substance Misuse Skills Consortium formed the Recovery Partnership in May 2011 to provide a new collective voice and channel for communication to ministers and officials on the achievement of the ambitions set out in the 2010 Drug Strategy. Following the closure of DrugScope, Adfam joined RGUK as a lead delivery organisation of the Recovery Partnership's programme of work. The Recovery Partnership is able to draw on the expertise of a broad range of organisations, interest groups as well as service user groups and voices.

Further information is available at: [www.recovery-partnership.org](http://www.recovery-partnership.org)

### **For further information about this briefing please contact:**

Lauren Garland

Policy Officer (Recovery Partnership)

[L.garland@adfam.org.uk](mailto:L.garland@adfam.org.uk)