“Keep it to yourself”.
Supporting solutions for South Asian women:
Developing models for alcohol support

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Contents

Executive Summary

- This study focussed on the lived experiences of South Asian (SA) women who use(d) alcohol (and other drugs), exploring their trajectories into problematic use, and their engagement with support.
- Its three core aims were to:
  i. explore their lived experiences of alcohol use and help-seeking
  ii. understand how non-alcohol-using women from SA communities respond to women's problematic alcohol use
  iii. explore if and how alcohol practitioners offer support to SA communities, particularly women.
- A comprehensive literature review and search of grey literature provided the foundations for the study.
- Three groups of people participated: i) SA women in recovery, ii) SA women in the communities, and iii) practitioners from specialist ethnic minority alcohol services or from specialist projects within wider services.
- A range of qualitative methods were used to collect and record new data including focus groups, semi-structured interviews, and narrative portraits.
- 18 South Asian women in recovery participated in interviews revealing experiences of trauma, conflict, abuse, and histories of familial alcohol use among male relatives.
  - Experiences of domestic and sexual violence and abuse were common as was controlling behaviour from male partners, fathers, brothers and in-laws.
  - The shame and stigma they experienced resulting from their alcohol use was often worsened by family fears of community disapprobation.
  - The women were careful about where they drank, with whom, and often would hide their drinking.
  - Family support was mixed – some had positive experiences, others experienced family rejection – but family ignorance of alcohol and how to support or seek help for the woman was common.
  - The women were often the only SA woman in the treatment services or groups they attended. They had accessed a range of services from self-help literature to periods of significant inpatient rehabilitation.
  - The women had varying experiences of help from faith groups or faith-based alcohol support networks.
- 29 women took part in five community focus groups with over half of them stating they knew people who drank heavily or had problems relating to their alcohol use.
  - There was a strong message about the cultural disparity and double standards between men and women's drinking and the tolerance of men's drinking and the intolerance of women's drinking.
  - Women were viewed as being judged more harshly on every level, including their alcohol use, driving women to drink in secret.
  - Women were seen as keepers of the family image and needed permission to do many day-to-day tasks. Women drinking alcohol, therefore, was seen as 'another level' and subject to stigma and community gossip.
  - There were mixed views about generational differences in drinking with some discussion reflecting the greater pressures on younger women, particularly at university or socially, to drink alcohol.

    - None of the women were aware of services for SA women in their communities and recognised the challenges this presented for women seeking help.
- Seven practitioners were interviewed who worked for specialist alcohol services or projects for ethnic minority people.
    - Only one of the services was set up to provide services to women and this is now subsumed within the agency's wider remit. Six of the seven agencies provided services other than alcohol support.
    - All the practitioners described a complete lack of service provision for both men and women from minority or migrant communities in the wider alcohol service landscape.
    - Culturally-specific features of the specialist services were considered responsible for attracting people from those communities.
    - Four of the seven practitioners spoke of the difficulties engaging SA women in their services and made considerable efforts to do so in terms of outreach and partnership work, often over a long period of time.
    - The key difference between mainstream and specialist services was the nuanced cultural understanding held by specialist services negating the need for people to explain repeatedly the cultural expectations and challenges they faced.
    - Specialist services also understood the risks women took and fears they faced if they were identified within the community.
- Future alcohol service needs identified for SA women included:
    - Discrete, separate, services are needed for SA women seeking alcohol support. This should be in the local communities and would be best placed within a service that women would frequent for a range of reasons, for example, a women's centre or health centre.
    - Improved knowledge and education about alcohol (and other drugs) for the SA communities is needed, particularly where to go to seek help for themselves or a relative.
    - Greater outreach to ethnic minority communities is needed to build relationships and trust. This would take time.
    - Services need to evidence the safety and trust of the service and not assume that the organisation's confidentiality policy would address the risks and fears they faced.
    - Faith leaders and faith groups need to play a role in educating the communities and providing individual support.
- A new model of alcohol support that meets the needs of SA women has been developed around the four 'S's – Setting, Structure, Skills and knowledge, and Staffing. It is a model that is SA woman-centric and reflects the cultural sensitivities required to enable SA women to access services more readily.
- A tool for the improvement of existing alcohol services poses questions in five areas of service: i) environment, ii) service, iii) staffing, iv) training and v) assessment & interventions, enabling existing services to maximise their reach to, and support of, SA women in need of alcohol support.
- Finally, a process map has been developed that offers a pathway to developing service provision while seeking to maximise its chances of success for SA women in need of alcohol support.

Chapter 1 – Introduction

1.1 The culture and context of South Asian women's alcohol use

Cultural scripts are never rigid; they are fluid and easily disrupted. Gendered roles and experiences mean that male and female drinking are treated differently in all societies. A greater stigmatization of women drinking (heavily) is not uncommon in western cultures (Dawson et al., 2005), but it is even more harshly judged in South Asian cultures, which struggle to retain tradition against the demands of new circumstances and cultures.

South Asian cultures are characteristically marked by patriarchal structures. The women's world is marked by domesticity, marriage, modesty, and safeguarding the 'izzat' or honour of the family (Wilson, 2023). The social interaction of women and their public demeanour is therefore heavily monitored and policed (and self-policed).

Behaviours that deviate from exhibitions of izzat and domesticity (e.g. pre-marital sex, clubbing, using drugs and alcohol) are heavily deterred within South Asian families. These acts are believed to taint the family image and reflect badly upon the family's upbringing. Such acts of deviance are also frowned upon with the communities because they may damage the marital prospect of the girls in the family.

This honour, modesty and chastity is entrenched and represented in the rules of comportment, e.g. in women's gait and gaze, and in deportment, e.g. in attire and the style in which clothes are worn (Pandian, 2020; Bradby, 2006; Guru, 2003; Ghuman, 2001; Liddle and Joshi, 1986). Women who abide by, and adhere to, traditional roles are praised, and those who defy them are actually or potentially rejected (Pandian, 2020: Hill and Marshall, 2018). The fear of such rejection is an important disciplinary technique/correction which women internalise and by which they self-police or are policed (Guru, 2003; 2009; Wilson, 1978 and 2006; Ratna, 2013).

The instilment of the above 'virtues' has led to western perceptions of South Asian women as largely 'passive' and 'timid' (Saifullah Khan, 1977; Shaw, 1994, Ballard, 1994[1]), however, such interpretations have been contested. Although not publicised in the West, there is a long history of South Asian women's public protests, e.g. in the anti-colonial movement and in the Chipko movement against deforestation (Petruzzello, 2022). In the UK, the Imperial Workers and the Grunwick strikes were significant moments in the labour movement history of women's struggles against employers (Mixed Museum, undated). Further challenges by South Asian feminist movements have been documented by Anitha and Dhaliwal (2019) who summarised the histories of SA women's struggle in the UK at the intersection of gender, class and race. Perhaps as a result of these battles South Asian women in the UK and among the wider diaspora today are more likely to challenge traditional gender roles.

This is partly attributed to the adoption of more liberal attitudes reflective of the longer period of migration, the relatively greater economic participation and upward mobility facilitated by better education and stronger role models (Wilson, 2006).

[1] Such notions have more recently been echoed in addressing women from other ethnicities, e.g. government initiatives to 'free' and 'liberate' women of Iraq and Afghanistan in the 'war against terror'.

South Asian people traditionally subscribe to strong intergenerational family and community bonds, i.e. a collective orientation (Cohen, et al., 2016). The individual holds secondary significance to the family and community and the individual's life is deeply shaped by the involvement of the family. Individual aspirations and desires may be supported by the collective family group, but if not, sacrifices are expected from the individual. These values are inculcated through socialisation from the beginning of the child's life, just as, in the West, values of individualism are embedded from childhood. Women, in particular, are taught to be attentive to the feelings of others and expected to sacrifice their own aspirations (Sivakumar, 2021; Pandian, 2020; Krishan, 2019).

These familial and gendered values are reflective of most of Asia and as such, the South Asian worldview is related more to interdependence and the extended family/communities or the 'familial self', as opposed to the western conceptions of 'individual self' and, individual liberty, which override individual considerations (Roland, 1988 quoted in Rastogi and Wadhwa, 2006; Cohen, et al., 2016).

The safeguarding of one's good reputation within the wider family and community is of the utmost importance and individuals are constantly conscious of how their own behaviour reflects on their family and the communities to which they belong (Bradby, 2007).

The breaking of cultural precepts and taboos is highly sanctioned, especially for women perceived as bearers or custodians of culture. Stigma, a blemish upon one's own family and community, is strongly associated with tight-knit, collective cultures with blurred distinctions between the individual and the community (Bhopal, 1998; Wilson 2006). Individuals within these communities are expected to abide by strong codes of conduct and social norms, a breach of which may bring shame and sanctions against the individual, the family, and the wider communities.

There is a tension between continuity (tradition) and change (modernity, the present), particularly in migrant communities. This tension is deeply felt by women and second and subsequent generations of migrants who are required to maintain both the past and its memory, as well as to adapt and change to the current circumstances of the new communities of settlement.

Women and young people especially, have felt the pressure to subsume individual success, characteristic of modern societies (Bradby, 2007), to the greater good of the family and communities (Jeffrey, 1976; Werbner, 1990). Such trends are not unique to western societies as they are also being felt in the Indian sub-continent where western cultural influences are flourishing.

Moreover, social norms do not apply equally to all sections of the communities, often more liberally applied to men, whose activities may be disregarded or dismissed with greater ease than when women breach such norms. Women's ability to challenge patriarchal forms (such as limitations to education, physical movement and space, marriage arrangement, and dress) is greater in middle- and upper-class families which may display more liberal attitudes than poorer, rural communities to some extent. Taboos against alcohol, as with other cultural restrictions, may become less restrictive for women who can exercise greater autonomy.

Stigma against alcohol and drug use is strong in South Asian communities and is attached to not only the person using them but also their families. Given that the use of alcohol and drug use is

proscribed in most South Asian religions and communities, deviations are often hidden. This influences the way families react, most often resulting in a denial of the problem.

The taboo about women's drinking, and its association with promiscuity, disregarding izzat, family shame, and stigma in their communities, prevents conversations about alcohol with women and any subsequent acknowledgement of problems related to it. Yet women, as caretakers, are often the first to seek help for other family members experiencing problems (Galvani et al. 2013; Gleeson et al., 2019).

It is against this backdrop of South Asian women's stigmatization, marginalisation, approbation, and judgement about their alcohol use, that this research set out to answer the following research questions:

1. What do we already know about the alcohol consumption of South Asian women? What are the knowledge gaps about their needs, and what service provision already exists for this group?
2. What role does identity, belonging and stigma play in women's use of alcohol and their access to support? And what is the role of family and the wider community?
3. Among non-substance using South Asian women, what are their views of South Asian women who use alcohol? What do they know about alcohol support and where would they seek support for someone using alcohol?
4. What enables South Asian women to identify problematic alcohol use and where do they seek help?
5. What support would alcohol-using South Asian women like to see offered to them and by whom?
6. What good practice exists for supporting South Asian women who use alcohol and what could be improved?

To address these questions, this report will present a summary of the existing evidence. It will outline the methodology chosen to explore the research questions above before setting out the key findings from this research. It will conclude by presenting a model of support drawn from the voices of South Asian women and the small number of specialist alcohol service providers for minority communities, albeit not gender specific services.

Chapter 2 – Headline review of the existing literature

This chapter summarises the key messages from the existing evidence base while demonstrating the paucity of knowledge and understanding of South Asian (SA) women's alcohol use. Where research has taken place there has been a tendency to homogenise communities. It can present a siloed approach which results in an inability to recognise differences in, and trends of, alcohol use both within and between men and women, and in terms of age and geographical origins. Such information is crucial for effective interventions. The headlines should be read with some caution given the limited research on which they are based.

2.1 Key messages – South Asian communities' alcohol use

i. Prevalence and incidence of alcohol data among SA communities are limited due to difficulties of ethnic categorisation of data

One of the difficulties with available data is that it either does not report data by ethnicity or it homogenises ethnicity into fixed groupings and does not account for heterogeneity within these different groups e.g. Black Caribbean, Black African.

ii. Generational changes in alcohol use are rarely acknowledged, researched and documented providing a very limited picture

Orford et al.'s study (2004) of South Asian and African-Caribbean communities in the UK showed high levels of alcohol use among men from Sikh communities. Whilst an old study, its significance lies in the fact that it attempted to look at the impact of migration and generational changes in alcohol use across South Asian communities. They found that the previous research pointing to high levels of alcohol abstinence among Black and Asian communities was no longer applicable to those born or educated in Britain. Results varied by ethnic groups and by gender in some instances, with mostly Black men and women as well as Sikh men, being amongst the heavy drinkers with their drinking rates matching the general population.

iii. Higher rates of alcohol morbidity and mortality among SA men might be explained by biological factors

In 2009, Pannu, et al. found that lower alcohol-related mortality rates were observed among men born in the Middle East, North Africa, West Africa, Bangladesh, Pakistan, West Indies, and China. However, while men born in India drank less than the general population their alcohol-related admission rates were higher in England than White British men. Pannu et al., (2009) pointed to biological factors (e.g. greater proneness to liver cirrhosis) that may help to explain why, despite having a shorter history of heavy drinking compared to White British people, South Asian men had higher alcohol-related mortality rates. The evidence suggests that Sikh men, in particular, have higher rates of alcohol-related morbidity and mortality, and that while Pakistani-Muslim men have higher abstinence rates, when they do drink, they drink heavily (Hurcombe et al. 2010).

iv. Intersectionality for SA communities must be considered to understand drinking patterns and responses fully

An effective understanding of drinking patterns among South Asian communities must consider the complexity presented by the intersectionality of different factors. Drinking levels are mediated by a range of factors including religion, culture, geographical location, historical patterns, socio-

economic inequalities/class, discrimination, generational and biological differences as well as being complicated by acculturation (Bradby et al. 2006).

v. Religious affiliation for people accessing alcohol treatment needs to be recorded

Despite proscriptions against alcohol in the religions practised by South Asian communities, NTDMS (PHE, 2022) data shows that in the last five years, there has been an increase in the number of people identifying as Muslim, Sikh and Hindu when accessing treatment, with 3182 Muslims, 963 Sikhs, and 624 Hindus in treatment in England and Wales in 2020/21. Furthermore, NTDMS data also indicated that 3496 people declined to share their religion and 11275 people classified as 'unknown' religion when engaged in treatment in 2020/21, which could indicate the likelihood of a higher proportion of Muslims, Sikhs and Hindus accessing treatment.

vi. Religious practice and adherence do not shield against alcohol use and its associated problems

Adherence to, and belief in, religious edicts do not shield against risky drinking; income, social status, socio-cultural norms, migration, acculturation, beliefs and expectations about alcohol use also have an effect. Religion can be a protective factor against the harms of excessive alcohol use. However, Tuck, et al. (2017) argue that socio-demographic and cultural factors also have an impact. Hence, religious practice and adherence do not shield against alcohol use and its associated problems. While an important contextual factor, religion must be placed alongside the impact of other factors, particularly the wider culture and the social/power relations in which it is practised. Cultural practices may endorse consumption and this presents varying levels of contradiction among different SA communities and may result in weaker adherence to religious proscriptions. Religion and culture are intertwined and differences between the two aspects may be blurred (Morjaria and Orford, 2002).

vii. The challenges and stresses of acculturation are risk factors for increased alcohol intake.

There is increasing evidence of how acculturation to new ways of life and the pressures and stresses of such adaptations combined with managing racism and other forms of discrimination, simultaneously lead to increased alcohol intake across the western world (Mulia, et al., 2008 and 2009; Martin, et al. 2003). Alcohol misuse seems to have grown in the Indian diaspora and the stress of migration and managing discrimination is a significant factor in their use of substances according to a number of US and Canadian studies (Rostogi and Wadhwa, 2006; Tuck et al., 2017). In a quantitative study employing an online survey of immigrants in Australia, Arli et al. (2019) found that cultural adaptation/acculturation led immigrants towards excessive drinking as they adopted liberal norms and attitudes. It also revealed that migrants consume alcohol as a way to gain social acceptance, which racism denies them.

2.2 Key messages - South Asian women's alcohol use

i. Overall, there is an evidence void relating to alcohol and other drug use by women from minority or migrant communities

There is little prevalence and incidence data relating to SA women's alcohol consumption. Public Health England (PHE) reported alcohol consumption increasing among young South Asian women since 2014/15 (PHE, 2021). But for women, the environment remains restrictive (Hurcombe, et al. 2010) because their femininity is constructed by notions of modesty, 'izzat', respectability and honour which alcohol consumption is perceived to contravene.

ii. A small number of studies have commented on the perceived increase in drinking by SA women but these are limited in generalisability and consistency of focus

Although the reporting of women's drinking remains low, due to greater stigmatisation and the assumption of abstinence among them (Bhala et al. 2010), anecdotal evidence suggests that alcohol consumption has increased among Indian women and personal accounts of women's experiences have begun to emerge (Singh, 2018; Kumar, et al., 2018; Randev, 2019; Rai, 2019; Kaur, 2021):

- Bayley and Hurcombe (2010) concluded that since the 1990s, reports of alcohol use among Sikh girls had increased, with heavy drinking increasing in line with growth in income and lifestyle change among Indian, Pakistani, and Chinese communities in the UK.
- Galvani et al. (2013) in their qualitative exploration of alcohol support needs in a Midland's based Punjabi Sikh community in the UK, found older South Asian women believed that younger generations of South Asian women were drinking more frequently and becoming more westernised compared to previous generations. They also found mixed views about whether there were generational differences in drinking patterns, but there were concerns in the communities about increased drinking among younger women.

iii. Religion and cultural expectations of SA women may have some impact on some SA women's drinking

Bradby and William's longitudinal study (2006) of 824 young people of Asian (selected based on their South Asian names) and non-Asian origin, in Glasgow, Scotland, found that religious proscription against alcohol was more salient among Muslims, and among Asian women generally. However, they concluded that religious effects varied; the broader Punjabi cultural scripts, or the 'restrictive disciplines' that the Asians in their study shared, were more important, particularly among women and children.

iv. The stresses of acculturation may have a greater impact on SA women's drinking

Beccerra et al. (2013) used data from the California Health Interview Survey to examine the impact of acculturation and socio-economic factors on binge drinking among six Asian American subgroups (South Asians, Vietnamese, Chinese, Filipino, Korean and Japanese). They found that among first-generation immigrants, monolingual (English only) Vietnamese, Chinese women and South Asian single women were more likely to be binge drinkers, indicating the high levels of stress associated with migration, acculturation, and the struggle to maintain an economic standing.

2.3 Key messages: Treatment

i. There is a gap in the evidence about treatment for alcohol-related problems among minority ethnic groups

From the small body of evidence that exists (Gleeson, et al., 2019; Galvani, et al., 2013; Hurcombe, et al., 2010) South Asian communities appear to have little access to culturally tailored substance use treatment services. Fountain (2009), Gleeson et al., (2019) and Uddin et al. (2008) found that there was a lack of cultural and religious competence in service provision, and this contributed to the poor access to treatment.

ii. There appears to be an underrepresentation of young people from minority ethnic groups in treatment

Ralphs, et al. (2014) in their formative assessment of Early Break, an outreach programme for young people from minority ethnic groups in North-East Lancashire, found underrepresentation of Pakistani and Bangladeshi young people. They emphasised the need for services to maintain visibility, consistency of staff, trust and confidentiality, relationship building, patience, ease and flexibility and versatility of access as important factors in providing an effective service. Females, in particular, remained underrepresented and they called for greater outreach work creating female-only spaces.

iii. The hidden nature of drinking among SA women is likely to negatively impact their treatment seeking

Gleeson et al., (2019) reported specific problems associated with women's drinking within BME communities, noting that the hidden nature of problematic drinking among women in all cultures could prevent the associated harms from being addressed. They reported evidence from mainstream practitioners who gave examples of families refusing to discuss the problematic drinking among their family members because it's 'just easier not to talk about it' (Gleeson et al., 2019:23). Bayley, and Hurcombe (2010) also argued that where abstinence from drink was expected, due to strong taboos against it and cultural or religious proscriptions, people who drink were more likely to fear exclusion and to hide their drink and be reluctant to seek help. Galvani et al.'s (2013) study showed that awareness of alcohol harm was high among the Sikh communities but notions of stigma and shame about problematic drinking prevented help seeking. These findings are reflected in other diasporic studies identifying the need for recognition of shame, honour, and privacy in treatment, (Rastogi and Wadhwa, 2006; Gleeson, et al., 2019; Puri et al., 2020. Galvani et al. also found that Punjabi Sikh women and the Punjabi communities generally had a good level of awareness about the detrimental effects of alcohol on health and family relations and on financial resources, but a similar knowledge did not exist in relation to the availability of services. Orford, et al. (2004) argue that large proportions of South Asian men and women who drank believed their parents did not know about their drinking and they preferred this scenario. The pressure to hide alcohol consumption contributes to the obstacles in seeking help to alleviate problematic use.

iv. Where services recognise the need for improvement, a lack of resources can prevent them from taking action

Gleeson, et al.'s 2019 study of provision on drug interventions for BAME young people in youth justice found that practitioners recognised the need to increase engagement with minority groups and were willing to provide culturally appropriate services. However, their efforts were hampered by lack of training, cuts in funding and a reduced workforce that prevented the delivery of more effective provision.

v. Religion can play an important role in helping people undergoing substance use treatment

Morjaria-Keval's (2006) study of 13 Sikh men in the Midlands found that religion played a key role in recovering from addiction because it provided a meaning system and a sense of control to provide the impetus for a 'commitment to change'.

vi. Family and communities are important components in alcohol interventions and need to be considered in future planning

Beddoes, et al. (2010), in their study examining the impact of drug use on different communities, found that community-based venues were preferred by minority ethnic groups for the

dissemination of alcohol-related information. Their preference was for written, multilingual, oral and visual media. Anonymity was also important as were positive role models and messages from people in recovery from their own communities, mentoring and buddying schemes were also acceptable forms of support. Galvani et al.'s study (2013) suggested that family and friends were the first port of call for help, followed by the wider communities and that alcohol services outside their communities, often perceived as 'white' services, were a last resort. They also found that family members (usually wives) would often seek help for their drinking husbands from their GP. In the absence of research on how ethnic minority families could best offer support, Orford et al., (2004) suggests that mainstream and specialist services must provide cultural sensitivity, with opportunities for families to be engaged, since they too were affected by the problematic use of alcohol by their older or younger family members.

2.4 Chapter summary

There is a serious dearth in research addressing the experiences of substance use among South Asian communities generally and particularly for women. Limited evidence suggests that some groups (e.g. Sikh men and women, young women) are consuming higher levels of alcohol than other minority ethnic cohorts, hence the recognition of diversity in treatment settings is an essential plank of appropriate intervention (Hussain and Cochrane, 2002; Lee, et al., 2008; Gleeson, et al., 2019). A greater focus on the variation of, and different patterns of, consumption among ethnic minority communities is warranted. Current treatment interventions are considered inadequate in addressing cultural and religious aspects of SA populations in need of alcohol and substance-related treatment (Fountain, 2009) and of women in particular.

This research sought to understand better SA women's alcohol use and their treatment needs, and for this understanding to be used for the development of tailored alcohol interventions for SA women. The following chapter outlines the approach taken.

Chapter 3 – Methodology

3.1 Aims of the study

This study sought to explore the lived experiences of South Asian women who use(d) substances, understanding their trajectories into problematic use, and their engagement with support. Its three central aims were to:

1. explore the lived experiences of alcohol use and help-seeking from the perspectives of South Asian women
2. understand how non-alcohol-using women from South Asian communities respond to women's problematic alcohol use
3. explore if and how alcohol practitioners offer support to South Asian communities, particularly women.

More detailed objectives relating to these aims are presented in table 1 below.

3.2 Community involvement

From the outset, the research was shaped by the inclusion of South Asian women who had experienced problematic use, as well as alcohol services set up to support people from South Asian backgrounds. Two researchers of South Asian origin (Pakistani-Muslim and Punjabi-Sikh) were employed on the project, reflecting the research population, and helping to overcome potential language barriers.

Two substance use charities who worked with South Asian women using substances (alcohol or other drugs) formed part of the research partnership: Kikit Pathways to Recovery – Birmingham, and Each Counselling and Support – London. An additional woman's charity – Against Violence and Abuse (AVA) – London, was included in the initial partnership, owing to their experience of working with women who experience multiple disadvantage (substance use, violence against women, mental-ill health, and other forms adversities and traumas experience by women).

Initially, two geographical locations with high populations of South Asian communities were selected: Birmingham and London. However, as the project progressed, participant recruitment expanded across England. This was largely due to the difficulties identifying and engaging with women, perhaps because of the stigma surrounding women and substance use.

3.3 Methods – data collection and analysis

Each research question was operationalised with objectives and explored through specific research methods. The research question explored issues in specific ways by using a range of methods such as interviews, focus groups, and narratives.

The table below (table 1) lists the research questions, objectives and the predominant research methods used in gathering data.

Table 1 – Mapping research questions with objectives and methods

	Research Questions	Research Objectives	Research Methods
1.	What do we already know about the alcohol consumption of South Asian women? What are the knowledge gaps about their needs, and what service provision already exists for this group?	Collate and analyse existing research evidence focussing on alcohol use among South Asian women.	• Comprehensive literature review • Review of grey literature
2.	What role does identity, belonging and stigma play in women's use of alcohol and their access to support? And what is the role of family and the wider communities?	• Explore first-hand lived experiences of problematic alcohol use among South Asian women and the role identity, belonging and stigma play in helping or hindering their access to alcohol support. • Represent the lived experiences of problematic alcohol use among South Asian women through narrative and creative methods.	• Semi-structured interviews with South Asian women who use(d) substances problematically • Narrative portraits
3.	Among non-substance using South Asian women, what are their views of South Asian women who use alcohol? What do they know about alcohol support and where would they seek support for someone using alcohol?	Explore how South Asian women who do not use alcohol, view alcohol use among women from their communities, and explore their knowledge of support services for alcohol use.	Focus groups with South Asian women who do not have problematic use
4.	What enables South Asian women to identify problematic alcohol use and where do they seek help?	Explore first-hand lived experiences of problematic alcohol use among South Asian women and the role identity, belonging and stigma play in helping or hindering their access to alcohol support.	Semi-structured interviews with South Asian women who use(d) substances problematically
5.	What support would alcohol-using South Asian women like to see offered to them and by whom?	Explore first-hand lived experiences of problematic alcohol use among South Asian women and the role identity, belonging and stigma play in helping or hindering their access to alcohol support.	Semi-structured interviews with South Asian women who use(d) substances problematically
6.	What good practice exists for supporting South Asian women who use alcohol and what could be improved?	Document practitioners' experiences of supporting women from South Asian communities who use alcohol, including the challenges they face and the solutions they've found.	Semi-structured interviews with substance use practitioners

3.3.1 Women in recovery interviews

Research aim: To explore the lived experiences of alcohol use and help-seeking from the perspectives of South Asian women

The interview questions (Appendix 1) were drawn from i) the themes emerging from the literature review , ii) in collaboration with partner agencies and iii) based on initial conversations with South Asian women in recovery.

The initial target sample for the study was 40 women (age 18+) with experiences of their own problematic substance use. Recruitment began in Spring 2022, using a flyer developed by the research team (Appendix 2) that was distributed in various locations around Birmingham and London including women's centres, Gurdwara's, Mosques, pharmacists and various health and social care organisations. The flyer and participant information sheet (Appendix 3) was shared with partner organisations, who shared it with women who used their service, as well as their own organisational networks. This recruitment information was also emailed to professional contacts and mailing lists available to the research team and shared on social media sites.

After seven months of recruiting, it was apparent that the target sample of 40 was overly ambitious. Eighteen women took part in the one-to-one interviews, and these women were recruited through the partner organisations, email networks and snowball sampling via the women themselves. Due to the ongoing impact of the coronavirus pandemic, the most convenient way to speak to women was via Zoom interviews. All women received the information sheet and consent form (Appendix 4) prior to agreeing to take part.

The open-ended, semi-structured interview method used provided a topic focus for participants but also enabled them to talk about themselves more freely and naturalistically without imposing specific restrictions.

The interviews lasted between 40-90 minutes, and while some women became upset during the interview while sharing personal stories or reflections, none of the women wanted to stop or withdraw from the interview. The women were also sent a £20 voucher for a shop of their choice as a gratuity payment. The interviews were recorded and fully transcribed and anonymised by a member of the research team.

Analysis 1: Developing the narrative portraits

In seeking to portray South Asian women's lived experiences of alcohol use, pen portraits gave space for their story to be heard in its entirety. Narrative portraiture/ portraits, "offers a means to enhance the presentation of research findings and honour participants' stories" (Rodríguez-Dorans and Jacobs 2020:611). To develop the narrative portrait, each woman's narrative was developed one at a time by one member of the research team (SF), the transcription was checked and reread a second and third time, using a coding framework where sentences relating to characters, time, space, key-events and their substance use, were copied into a new word document and formatted in a chronological order. This reordering of the woman's transcript, enabled a coherent narrative to be formed, using the women's own words to tell their story (Rodríguez-Dorans and Jacobs, 2020). A second member of the research team read through these narratives for sense-making, before

sending them to the women for their feedback. All the women wanted to read their narrative portrait and while some women returned their narratives with minor comments regarding sentence-structure or sense-making, none of the women wanted to withdraw their narrative or make any major changes to their words. Importantly, it also ensured they had an element of control over how their portraits would appear, an important factor for this group of women because their life course often existed in a context of not having control. (The full narratives are available in a supplementary document.)

In addition, an illustrated book with 600-word excerpts from the women's narratives has been developed to educate and inform treatment services, families, communities and other women who may be in need of support around their alcohol use (Galvani et al, 2023).

Analysis 2: Thematic analysis

Braun and Clarke's (2012) thematic analysis was used to interpret the empirical data as it allowed explicit and implicit (manifest/latent) patterns of meaning to emerge from the data sets and to highlight the most important and relevant links between meanings within the datasets (Joffe, 2012; Javadi and Zarea, 2016). Their six steps are as follows:

1. Familiarizing yourself with your data: Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes: Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes: Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes: Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes: Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report: The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis (Braun and Clarke, 2012: 87)

NVivo software was used to facilitate the analytical process. The analytic method adopted is particularly suited to ethnographic questions concerned with explorations of representations of social phenomenon and the ways in which people conceptualise their thoughts and actions (Aronson, 1995; Joffe, 2012). This approach resulted in a clear description, clarification and refinement of the coded data which, in turn, increased the transparency of the coding process. The relevance and the prevalence of the codes within and between the data sets contributed towards the reliability of the themes developed.

3.3.2 - Focus groups with South Asian women from the wider communities

Research aim: To understand how non-alcohol-using women from the South Asian communities respond to women's problematic alcohol use

Previous research by Galvani et al. (2013) highlighted how older SA women believed that younger generations of SA women were drinking more frequently and becoming more westernised compared to previous generations. This was an important finding to explore in this study as it would help clarify the potential impact of stigma and shame on women's substance use and access to support. Hence, this study sought to explore the views of SA women who do not use alcohol (or do not use problematically) on SA women's alcohol use, and their knowledge of support and services available for women in their communities.

Sampling and recruitment

Target recruitment was 20 SA women to take part in 2-4 focus groups in Birmingham and London, however, we lifted the geographical restrictions and opened recruitment up across England due to the challenges of identifying women to take part. Women were recruited using a flyer (Appendix 5), available in alternative languages on request, and was shared with women's organisations, women's groups, women's centres, across social media, and with peers. The flyer was also shared with the partner organisations and was emailed to professional contacts and mailing lists available to the research team.

Recruitment began in Summer 2022. Some women were initially hesitant to participate but following discussion with members of the research team they decided to take part. By September 2022 five focus groups with a total of 29 women took place, two focus groups took place online and three took place in person. Nine of the women were recruited through snowball sampling from a partner organisation, four were recruited through a women's service, six women shared a support network with one of the research assistants, and the remaining ten women were recruited from an Asian women's social group identified through social media. The women lived in the Midlands and Northwest of England, and the focus groups lasted between 40 minutes and two hours. While the initial focus was on non-alcohol using women, some of the women in the groups drank but reported this was not problematically.

Focus group – data collection and analysis

The topic schedule (Appendix 6) for the focus group included an exploration of the 'rules' regarding substance use and its relationship with religion, culture and gender, changes in substance use among their communities over the years, and their understanding of support for women with problematic use in their communities. Following Galvani et al.'s (2020) example, a vignette was used to stimulate discussion (Appendix 6). Vignettes are "short stories about a hypothetical person, presented to participants during qualitative research" (Gourlay et al., 2014). The vignette was developed by the research team and presented a scenario of a South Asian woman who was worried about her daughters' alcohol use, and fear of others finding out about this. This scenario was developed to explore notions of stigma and shame relating to women's substance use, and to enable the women to think about the advice they would give if the woman in the vignette was their friend. At the end of the focus group, women were thanked for their time, reminded what would happen with the recording, and a £20 per person voucher was sent to them. The women were not contacted again following their participation.

Analysis for the focus group data followed the same process of thematic analysis (Braun and Clarke, 2006) as identified in section 3.3.1 above.

3.3.3 - Interviews with practitioners from specialist alcohol services for minority communities

Research aim: to explore if and how alcohol practitioners offer support to South Asian communities, particularly women.

Recruitment

The original plan was to recruit 20 practitioners who worked in organisations offering support to people from South Asian communities. However, the team found only a small number of services who offer alcohol support for people from minority or migrant communities and only one that, historically, focussed on women directly. Following email contact with potential participants, and the network knowledge of project partners, as well promotion through social media, seven specialist providers from five different agencies were recruited.

Interviews - Data collection and analysis

Focus groups were initially proposed for data collection but the pragmatics of coordinating the diaries of agency leaders and small numbers of specialist staff made this approach untenable. The method was changed to semi-structured interviews enabling people to participate at a time that suited them. The interview schedule (Appendix 7) for the interviews was developed from themes identified in interviews with women in recovery and the focus groups of women in the communities, as well as pre-determined questions. The interviews lasted between 30-60 minutes and were conducted via Zoom, Microsoft Teams or telephone.

Analysis for the focus group data followed the same process of thematic analysis (Braun and Clarke, 2012) as identified in section 3.3.1 above.

3.4 Ethical considerations

Ethical approval was granted by the Faculty of Arts and Humanities Ethics Committee at Manchester Metropolitan University in Spring 2022. All potential participants received a Participant Information Sheet with details of the study, who to contact if they were unhappy with the research process, and what would and would not be done with any information they shared. Informed consent was gained by informing participants about the nature of the research and the nature of their role in participating. Debriefing was carried out by ensuring that women were emotionally well and had the necessary information about where they could gain assistance if they required further support after the interview.

3.4.1 Renumeration

Women in recovery and the women from the wider communities were offered a £20 voucher to acknowledge their time and for sharing their experience. Two women refused the voucher stating they were happy to engage in the research because they wanted to talk about their experiences.

3.4.2 Supporting women who took part

While the Zoom format of interviews with individual women did not allow the personal reassurance that face-to-face contact would have permitted, efforts were made to maximise their feelings of safety and comfort. Research protocols were followed in terms of ensuring confidentiality, space to stop or rest during the interview, and debriefing at the end. During the interview, when women became upset, they were asked if they were happy to continue the interview and told that the interview could be paused or stopped, however, this did not prove necessary.

While participants consented to for their quotations to be used in various research outputs, we understood that the women may be worried about being identified or shamed within the communities or wider society. We therefore reminded and assured the women that any identifying information such as the names of the people they mention, place names, geographical areas, and other identifying information would be removed from the transcripts, and subsequent outputs.

3.5 Chapter summary

This chapter has set out the aims at the core of this research and the involvement of women from SA communities. It has mapped the research questions, against the objectives and methods and set out the methods of data collection and analysis for the three groups of participants. The following chapter presents the findings from the women in recovery group before moving on to women in the communities and the professionals' responses.

Chapter 4 - Findings: Women in recovery

4.1 Key messages

- 18 South Asian women in recovery participated in interviews revealing experiences of trauma, conflict and abuse and histories of familial alcohol use among male relatives.
- Experiences of domestic and sexual violence and abuse were common as was controlling behaviour from male partners, fathers, brothers and in-laws.
- The shame and stigma they experienced resulting from their alcohol use was often worsened by family fears of community disapprobation.
- The women were careful about where they drank, who with and often would hide their drinking.
- Family support was mixed – some had positive experiences, others experienced family rejection – but family ignorance of alcohol and how to support or seek help the woman was common.
- The women were often the only SA woman in the treatment services or groups they attended. They had accessed a range of services from self-help literature to periods of significant inpatient rehabilitation.
- The women had varying experiences of help from faith groups or faith-based alcohol support networks.

The first aim of this study was to explore the lived experiences of alcohol use and help-seeking from the perspectives of South Asian women. Through hearing their experiences, it sought to clarify the role identity, belonging and stigma played in helping or hindering their access to alcohol support.

4.2 Themes and clusters

As a result of the analytic process (see s. 3.3.1), 1591 codes were identified initially from the transcripts. These were organised into 13 primary thematic clusters containing 63 sub themes.

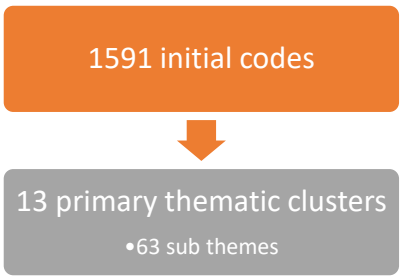


Figure 1 – Initial coding to primary thematic clusters

The final thematic clusters are listed in figure 2 below, starting with the codes with the highest number of references to the fewest number of references. The themes highlighted in orange are those most closely linked to the aim and objectives of this research strand and will be the focus of the findings presented here following a brief summary of the women's backgrounds:

Primary thematic clusters (n=13)	Nature and extent of drinking and/or substance use
	Help seeking
	Participant background and profile
	Family response to women's substance use
	Domestic violence and sexual abuse
	Future service needs - see chapter 7
	Family background and history
	Women's hopes for the future
	Family and friends' substance use
	Cultural control and expectations
	Shame and stigma
	Role of faith
	Miscellaneous

Figure 2 – List of 13 thematic clusters following the coding process[2]

4.3 Women's background

The women who participated in this research needed to meet three criteria; i) to have a problematic relationship with alcohol – current or past, ii) be a woman from Indian, Pakistani or Bangladeshi heritage, and iii) be over 18 years of age. No detailed demographic data was collected given the known sensitivity of this topic and the need for strict anonymity. However, 18 women were interviewed ranging from 24 to 68 years in age. Some women chose to disclose their identity in terms of age, ethnicity and religion, while others did not. Of those who identified their ethnicity (n=16), 13 defined themselves as Indian, two had mixed Indian combined with other ethnicities, and one woman identified as Bangladeshi. In terms of religion (n=15), six women identified as Sikh or from a Sikh background, four as Hindu or from a Hindu background, one as from a Muslim background and four specifically said they were not practising any religion.

Twelve of the women mentioned the role of faith in relation to their alcohol use, for positive or negative reasons. While some women found their involvement with their faith through prayer, study, or music helpful in maintaining their recovery, others spoke clearly of the judgement their religion placed on people who used, and had problems with alcohol, and the need for their places of worship to be more supportive and educational.

> I would like to share my experience, if I wouldn't be judged by them in any Indian religious places. I would love to do that. I would love to stand in a Gurdwara or a Mandir and tell them. Being in recovery is nothing bad. It's not bad. It's your daily life (Biro).

[2] The findings from the theme 'Women's hopes for the future' have contributed to the final pages of the book stemming from this research, *Alcohol, izzat and me: South Asian women in recovery* (Galvani, et al. 2023)

The majority of the women came from family backgrounds where either fathers, grandfathers, 'uncles' or brothers had a history of problematic alcohol use while mothers were more likely to be abstinent. Many of the women had siblings and friendship groups who drank but only one woman spoke of a female family member who died as a result of alcohol use.

The alcohol backgrounds of the women ranged from one woman who reported drinking still but at non-problematic levels to those who had between three months and 41 years abstinent[3]. The women spoke of key points that started and/or increased their drinking to problematic levels. These were commonly points of low or poor mental health, including anxiety, depression, loneliness, drinking to cope with grief, sexual abuse and domestic abuse as well as feelings of social exclusion as a result of their ethnicity and trying to fit in at University. Seven women spoke of suicide attempts or suicidal thoughts.

Experiences of domestic and sexual violence and abuse were common with many women experiencing violence and abuse in a number of partner or family relationships. Four women disclosed sexual abuse, seven parental abuse including physical and emotional abuse, seven partner abuse and three witnessing, or hearing about, father to mother or grandfather to grandmother physical and sexual violence.

In sum, this was a group of women who had faced trauma and conflict on many levels and for whom alcohol consumption had become part of the problem and solution. However, their gender and the cultural expectations placed upon them added complexity to their experiences. The following section will explore this further.

4.4 Cultural control and expectations

Through the narratives it was clear that gender differences around behaviour in general and drinking behaviour in particular were deeply culturally ingrained as were wider expectations of women's role in the family and community. One woman said that "pride and shame" were bred into Asian women and she saw it as the "basis of all my problems" (Leena). Another woman (4) talked of the many taboos in the family and community including how women looked or what they wore while one woman spoke about having all the housework and domestic chores "dumped" on her by her parents as a child and needing to defend her siblings from her parents (18). Another was allowed to go to University but was expected to go home every weekend and if she did not meet their expectations "the emotional abuse was heavy" (Sukhi). One woman was taken out of school aged 13 by her father who said she could not be near boys:

> Dad always kept saying his 'Izzat' [honour] means everything. Um and that he couldn't have me being seen walking with a boy, or talking to a boy. Um so he said it was easier if I just didn't go to school. So (nervous laugh)…(Ajit)

For some women 'going out' [socialising] was not acceptable particularly without a male family escort:

[3] This woman reported she'd been in AA for 41 years with abstinence implied.

> I think I noticed it more when I was a teenager. So, I'd gone to secondary school. And then when it's, you know you get to 13-14 and your friends are going after school, they're hanging out with each other, and that was just not allowed for me. You know, for me it was come home, do your homework and that's it. … (Ravi)

Some women also faced the pressure of staying with their husbands even when he was violent and abusive due to notions of family honour or 'izzat'. One woman tried to leave but her parents would not take her, "…I knew that if I left [my husband], my family wouldn't have anything to do with me" (Ajit). She eventually ran away and has not had contact with her family for more than 20 years and has kept moving so they cannot find her.

While many of the women shared examples of male family members who drank alcohol, some of whom drank problematically, they also highlighted the double standards and judgement from family and communities when they drank:

> The wider community didn't know about our drug problem, or us drinking alcohol. The wider community just knew oh these girls keep going out. They keep doing this. They're hanging around with these people and that people. They're going bad. They're gonna ruin [their] reputation, and [give a] bad name to your family. Your reputation's on the line, but yeah. They wasn't saying nothing about the boys, - my brother, they were constantly focusing on us, the sisters. (Robina)

The sense of community disapprobation and shame women carried as a result of their drinking, while men did not, was clear in the narratives of many of the women. Their downfall and inability to maintain their "picture-perfect image" led to women being "silenced" or being forced to "keep it to yourself" (Rosie).

For women it was clear that drinking and particularly drunkenness was wholly shameful among most families and communities and this is the focus of the next section.

4.5 Shame and stigma

While shame and stigma are felt by many people who use alcohol and other drugs problematically, for women in the South Asian communities this is escalated due to cultural gender inequality, expectations of appropriate behaviour for women, and the culturally ingrained belief that their poor behaviour brings shame and stigma to the family and community.

> … all that anyone sees is the alcohol. Our communities, all they see is 'you drink' and that – you're weak. And the judgement. Well, that's not gonna solve [anything]. (Daljinder)

> Erm, [my parents] were like "you know people are seeing? We're like respected people." My parents are both teachers. … And it was all about everyone else at that point. You know, "what you're doing is bringing

> shame to us." She would lock me out the house. She would kick me out. Erm, they would lock me in the house. (Rosie)

> And I've seen that, being ostracised by my own community. My own family. Feeling like the black sheep – I'm talking about, I should be shut down, um you know, dismissed sort of thing. And I feel like I've never been able to be heard by our communities. …once you become bad, you are labelled, you're tarnished, you are ostracised, you are isolated. You are literally, you know, an outsider, an outcast. (Kuli)

> Well before I was sober I always felt that there was too many of us who never came forward due to probably shame or the stigma attached. … And, it's sad because I am a proud Indian. I speak my mother tongue. I love my food. I love the culture. The people not so much…. I'd rather stay clear of them. (Sukhi)

This judgement and shame led women to attempt to hide their alcohol use even when people around them knew:

> … there's so much judgement around women drinking, and how they should be as a wife and a mother. Still, I think there's still a lot of stigma and taboo and judgement. And that pushed my drinking and mental health into more, I took to hiding it, hiding it, and the shame attached. And the secrets, and the lies. (Daljinder)

> I was hiding it, but like there were a few occasions when my dad was like 'I know you're drinking why you keep lying about it'. And it's just this weird thing where you've been caught out and you still deny it? (Ravi)

Some women felt they had avoided much of the stigma attached to their drinking through controlling where they drank and who with and by doing so outside their community:

> …probably I didn't notice it much because I didn't hang around in places where there were Indian communities. So, the pubs I went to, the clubs I went to, happened to be with English people (Raj)

> I mean, I think if I was in an area where a lot of my cultural, you know, group were from, I think I probably would get a lot of stigma for drinking. But I'm not. I'm in a very predominantly white area. There is a scattering of Asian individuals around, and all of them drink. (Raakhi)

Other women spoke of having more 'liberal' parents, mindful that it was not the norm, or living in an environment where drinking was accepted within the family and where people did not judge them, but for this group of women it was a minority view:

> My family's always been very liberal. They'd be very easy going. Very flexible, it's not a typical Asian family that I grew up in. … I, you know a lot

> of Asian girls aren't allowed to do x, y, z. I was allowed to do everything. I was let free, kind of thing. Um and I think I just abused that to be honest. And I think in my DNA, in our genes, there is an addictive trait. (Suman)

> …because it was only my family, like literally my parents and my sister that knew of the issue, I didn't feel that [stigma] from any of them, because that wasn't a thing in our family. It wasn't you know. (Ravi)

However, even the women who had grown up with families who were more accepting of their drinking often spoke of not drinking outside of the immediate family:

> …it's one thing having your family knowing and your closest friends. When you have two of your neighbours who - we've lived in this street since I was seven - they've seen me grow up. And they had to come round, to check if I was basically alive or not. (Ravi)

Others spoke of not drinking in front of in-laws or when they went out for community events preferring to wait until they got home.

For some women their abusive partners used their drinking as a way to shame them and abuse them further:

> …[he] threatened to distribute photos of me when I was drunk on the sofa. And I think that, that, that really frightened me. That really frightened me. And he would, and he would shame me in front of our daughter a lot. (Daljinder)

Through all the interviews with the women the shame and stigma associated with their drinking (and other drug use) was a key point of discussion. However, there was variation in terms of family responses to their use and the following section will explore this further.

4.7 Family response to woman's substance use

The family's responses to the women's substance use ranged from harsh criticism, abuse and rejection to acceptance and support. They also demonstrated genuine ignorance of alcohol problems and, as a result, made inappropriate attempts to help their relative without any knowledge of what to do or the extent of the problem she had.

Some women had supportive families, from parents and grandparents to children and siblings who attempted to intervene and get help:

> You know there is a programme on our Sikh channel...My daughter got the mobile number. … She came to my room, 'Mum, would you like to speak to this guy?' I rejected [it] there and then, I said 'No, I'm not alcoholic. I drink after finishing all my work duties'. After two or three days I said I'm not recovering… I was denying it…I agreed to speak to the guy. (Banto)

> …my older brothers, three of them, they intervened. They said we're here to support you, we're here to look after you. We want the best for you… And then my sister - she's a mental health [professional] - and she was making me recognise that it is a problem…she worked me up to the stage where I actually admitted to myself, oh yeah, it is a problem. (Robina)

Others had families that were not supportive initially until they realised the seriousness of their relative's situation and then they tried to help. One woman collapsed in the street and was rushed to hospital with life-threatening organ failure:

> … it became real to them at that point. And it was at that stage that they dropped all the ego and all the pride and they tried, you know, especially my mom. She tried to get me, she fought to get me the help really, that I desperately needed. (Rosie)

Another had been isolated by her family but had a friend who made contact with her family to seek financial help:

> … I had a friend … from Uni who was contacting my sister. It was all, it was all done behind my back. He said he was going to help me. Turned out that … my sister told my parents to give him the money to put me through the first rehab. I found out a year later it was my parents who put me through. (Sukhi)

Some support came in the form of advice but was inadequate or inappropriate at best, or unhelpful and critical at worst:

> Y'know my dad said to me many times 'oh right stop drinking the Vodka and have some wine' or 'have a couple of ciders.' They didn't know the extent that I needed it. I actually needed it, it was like medication. (Leena)

> I remember all the statements of my Mum and Dad. …Like, 'do you really think drink's going to solve your problems?' No Mum, I know that. I know that it isn't. 'Why can't you just stop then? Why are you so weak?' (Daljinder)

Many women faced threats and criticism from family members relating to their drinking – some because of their own anger and frustration at the woman, others because the woman was seen to be failing in her role as mother, daughter, sister:

> So even when I was, when I threw the towel in after I relapsed, after leaving the addiction unit. Even my son at that time, when he was sixteen, he's thirty-five now. He said to me 'Mom, Mom, I wish you was dead. Look what Dad's done for you'. (Sita)

> I have noticed a pattern with my mother and, and it was almost like she was using me to get the sympathy that *she* required. But it was almost like

> laying me, when I already feel shit about myself, you're already laying me bare. And then my Grandma was like 'no wonder he couldn't cope with her. No wonder he used to hit her because if she behaves like this.' You know just vile things like that really. (Rosie)

> My brother cut me off. My sister's with a man who's cut his family off. She couldn't take it, so she's cut me off. Because her husband, she said that she had promises to keep with her husband. Which I know the guy. He's probably said you know, you need to focus on me and your kids, and not her. So, they all just cut me off! (Sukhi)

A common thread in the women's narratives was that their families did not know where to go for help or what advice to offer particularly when talking, shouting and arguing failed:

> There is only so much you can talk to someone, and they didn't know where to turn, where the help was. (Leena)

> I don't know why I didn't ask for help. I think I did to my Mum and Dad and I think they kind of just dismissed it. And I don't think they knew how to help me and the situation. (Daljinder)

> [My parents] would just think 'oh why [are]you doing that? What's happened? What wrong? Why are you, you know, drinking too much? Just stop, you know. Just have that one drink in the evening, at the weekend and then put the bottle down.' You know they just wasn't getting it, they just didn't. (Kuli)

In many South Asian communities, families are the first port of call for help, followed by the communities and, only then, will people turn to 'external' agencies in the wider geographical area (Galvani et al. 2013). However, many women spoke about how families have limited to no knowledge of alcohol problems, let alone service provision. With this in mind, the following section explores how the women sought help and what their barriers and successes were.

4.6 Help seeking

Some women spoke of being the only, or one of few, 'Indian' or 'Asian' women in the places they eventually accessed for help. As a result, they found the experience 'of limited value' because people wouldn't be able to understand or relate to the cultural dimensions of their drinking experience:

> …I went to AA [Alcoholics Anonymous]. And, like I said, I tried it, but didn't, didn't think much of it. And there was nobody in there I could identify with. I was the only Indian in there. … There was one Muslim girl that came in, but she didn't stay. (Raj)

> I was the only, tryna think, the only Asian woman in that service. … Oh, one girl. One girl. She was there for a very short period of time. … I just

> wondered like what the hell's going on? Where's all the, where's everyone? Where's all the other people? … You know, if I'm goin through this, I know loads of other people that must be goin through it – and hiding it as well. (Bina)

> Every rehab, I've been to 3 rehabs. I'm the only brown girl there. I'm the only Indian ever there. Any NA, AA meeting I've been to, I'm the only Indian girl there. …It was okay. … being the only Indian girl there. … But there are certain things that you, I didn't really wanna talk about, because they just weren't gonna get it. Imagine telling them that my parents don't actually give a shit and it's hard for me to tell them that I'm an addict. (Sukhi)

For some women, being the only Asian woman in the service was not a problem as they were desperate to get support of some kind:

> …it didn't bother me. … I wasn't worried about it, it was a question of life or death. I was not interested in what people would think. You know, I was more interested really, in how I would get my child back or what would happen to me. My problem was, was I going to be able to not drink a day at a time. That was my problem. (Biro)

> I found that for me it was about getting well from addiction. For me, all I wanted to do was get well. As a human being I wanted to get well. Because I couldn't find a way out. I could stop but I couldn't stay stopped. So, at that point, when I went in, it was just about getting well. I didn't care who I was with. Then, Asian people started appearing in the rehab… So, it became like a family within a family. And that felt really, really, nice because I connected with those people on a different level to English people. (Ajit)

Some women had found support through online communities which offered some anonymity and also some out of service support:

> So, this Sober School that I went to [online], it was very, it was predominantly… actually it was white. Everyone was white. But you could show up without a camera and without a microphone even. You know, you didn't have to contribute. You didn't have to show your face. You didn't even have to share your real name. (Raakhi)

> So yes, there's a couple of Asian women in the Sober Ninjas. Um, she's kind of a bit more silent now. Um but I'm still friends with her on Facebook. And she's doing really well. Um and then another lady as well. (Suman)

Some women found services with Asian staff, one in AA, and one in a service that is primarily BAME staffed, that helped them to 'open up'. Another found a multi-cultural

service but it was mainly male clients and staff but they had female only groups that she attended as she 'didn't want to mix with the guys'.

Given the gender inequality in many of the South Asian communities and the gendered dimensions of shame, women wanted services for women but were not able to find them:

> …as an Indian person, where d'you go? Because again, like you said, the shame of it, you know. Because again Indian men being alcoholics is one thing, but a female is, right, that's even worse! So, you feel even more isolated. (Raj)

One woman who accessed services observed poor treatment of women by Asian doctors:

> I've noticed that. I've noticed that professionally as well. Like from doctors, as well. When they're from the South Asian community and they see a girl come in to get detox, they just basically ignore her. I've seen the stigma in the healthcare as well, like setting, and it's not nice. (Robina)

However, the women did report positive experiences. Many of the women had attended and stayed in AA and NA (Narcotics Anonymous) – some had attended SMART peer support groups too. For many of them the combination of AA's fit with their religious beliefs was helpful:

> Yeah, [AA] 100% changed my life. 100% changed my life. And I think having a faith changed my life as well. Because the two went hand in hand. …So I'm a Sikh yeah. So I go to the Gurdwara. Because what I follow is quite a spiritual programme. A Sikhi is quite spiritual, so you know you're given suggestions and in order for me to stay sober I follow these suggestions … (Leena)

> You have saved me God, to recognise myself, that who I am. Coming into this AA, yes, it is our primary purpose to stay sober. However, [so too is] dealing with family, accepting people as they are and not, not being cunning. (Banto)

> So, when I joined AA I felt that I'd come back to my religion really. Because in terms of Hinduism, I can believe whatever I want to believe really. In Hinduism, I think is a way of life. And, and, practising, you know, love, tolerance, compassion, kindness and so on, are not just Hinduism traits, but also other religions have that too, but so does AA. So does AA. (Biro)

For those women their faith became a significant support for them to establish and maintain their recovery. Others turned to their faith communities for help but the response was ignorant and not helpful or the woman's lack of religious beliefs meant religious-based interventions were a non-starter:

> … accessing help was my biggest [challenge] – I ended up going to the Sikh Temple, to the Gurdwara to ask for help. And they said, - I remember them saying 'Stop drinking and then we'll get you help'. The love being – stop drinking and drugs and whatever you and other people are taking. I says I'm not doing anything else you know. And they said stop doing that and then, you know, we can help you. But again, I didn't say it was me. I remember saying do you have any help for people who have drink problems? I don't remember it, me saying I need help. (Daljinder)

> No I don't do the Twelve Steps. It never resonated with me. The whole concept of God, as I told you earlier, I don't believe in religion. I have a big issue with the concept of God. … I did try to go to two AA meetings but I quickly ran away from those. (Rosie)

Overall, the women had accessed a range of services, some repeatedly, before finding the right fit for them. These ranged from GP appointments, detoxification and rehabilitation inpatient stays to local community-based drug and alcohol services in the UK, to yoga hospitals in India, to independent therapists and self-help groups like SMART and AA/NA. One woman found social services to be helpful in motivating her to stop as the option was losing custody of her child, a GP of another woman referred her to a day centre which was helpful for her, and another had a hospital inpatient stay that included an alcohol worker visit. As previously mentioned, two women found online support communities very helpful. Two women found self-help through focussed reading helpful initially before moving on to additional support.

What did not work for the women was also a focus of discussion. Two women mentioned services that asked them to keep drink diaries and they knew they would lie or wouldn't do them. One service suggested things like 'every time you buy a bottle, spill the first cap and then after a week spill the second cap' (Leena) which only served to irritate the woman and she bought more. One woman was put on anti-depressants by her GP which didn't work for her drinking. Women also described particular triggers to drink more such as abuse, loss, grief and conflict. Three women stated that things got worse for them during the Covid pandemic in that it exacerbated their drinking as well as diminishing service availability.

4.7 Chapter summary

This chapter has set out some of the findings from the 18 women in recovery who spoke to us during the course of this research. The cultural expectations of maintaining 'izzat' and the control from male members of the family in particular, added to their sense of shame and stigma when their alcohol use became problematic. While some had family support to seek help, others were rejected and abused, or a combination of both. Their help seeking attempts were varied and creative yet often lonely and fearful.

Chapter 5 - Findings: Women in the communities

5.1 Key messages

- Twenty-nine women took part in five community focus groups with over half of them stating they knew people who drank heavily or had problems relating to their alcohol use.
- There was a strong message about the cultural disparity and double standards between men and women's drinking and the tolerance of men's drinking and the intolerance of women's drinking.
- Women were viewed as being judged more harshly on every level, including their alcohol use, driving women to drink in secret.
- Women were seen as keepers of the family image and needed permission to do many day-to-day tasks. Women drinking alcohol, therefore, was seen as 'another level' and subject to community gossip.
- There were mixed views about generational differences in drinking with some discussion reflecting the greater pressures on younger women, particularly at university or socially, to drink alcohol.
- None of the women were aware of services for SA women in the communities and recognised the challenges this presented for women seeking help.

The second main aim of this research was to understand how women from the South Asian communities who do not use alcohol problematically respond to women's problematic alcohol use. It sought to explore how they viewed alcohol use among women from their communities and to explore their knowledge of support services for alcohol use. To facilitate discussion, a vignette was used of a mother worried about her daughter's drinking (see section 3.3.2) followed by a topic guide to prompt a wider discussion related to alcohol consumption among SA women.

5.2 Themes and clusters

As a result of the analytic process (see s. 3.3.1), 534 codes were identified initially from the transcripts. These were organised into 12 primary thematic clusters containing a further 12 sub themes.

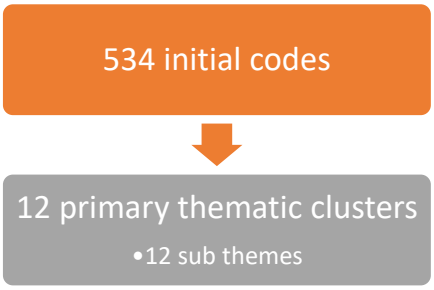


Figure 3 – Initial coding to primary thematic clusters

The final thematic clusters are listed in figure 4 below starting with the codes with the highest number of references to the fewest number of references. The themes highlighted

in orange are those most closely linked to the aim and objectives of this research strand and will be the focus of the findings presented.

Primary thematic clusters (n=12)	Gender divide and differences in alcohol consumption
	Tension between religion and culture
	Focus group profile
	Cultural responsibilites for, and pressure on, women
	Vignette responses
	Culturally appropriate service needs for SA women - see chapter 7
	Drinking in family and friendship groups
	Generation differences in women's drinking
	Alcohol service knowledge and access
	Diversity of experience
	Parental role and parenting
	Miscellaneous

Figure 4 – List of thematic clusters following the coding process

A total of 29 women took part in five focus groups. Demographic data were not collected routinely but of those who disclosed their age, this ranged from 18-60 years of age. In terms of religious affiliation, 13 women were Muslim, nine were Hindu, five were Sikh although one said she was not practising, and one woman was Christian. In terms of ethnicity, 13 identified as Indian, 10 as Pakistani or British Pakistani or Pakistani-Kasmiri, four as Bangladeshi and one as UK. Seventeen of the women shared that they knew people who drank alcohol/drank heavily.

5.3 Gender divide and differences in alcohol consumption

There was a strong message about the cultural disparity and double standards between South Asian men and women's drinking. For men it is accepted, for women it is not, regardless of religious doctrine. For women, not only is their reputation at risk but their family's honour and, potentially, their own safety:

> …it's just not talked about because the families would, metaphorically and potentially literally, strangle the life out of them if they found out, because it's still more taboo for an Asian female to be caught having drugs or drinking than a male. (FG1, woman 6)

> I think there's a lot of double standards (group agreement) because they do it themselves but they're the same type of people that if someone says to them 'yeah I drunk' mention it casually they would attack you for it, they'd go into vicious mode, but it's like they shouldn't be because like if you done it yourself you shouldn't judge other people. (FG1, woman 5)

One woman recalled an incident of being seen by someone she knew in a Weatherspoon's pub having coffee with her sister and was fearful of the consequences despite just drinking coffee.

The gender bias in alcohol consumption was discussed by the women as being "taught generationally" with norms handed down from parent to child. While one woman saw the differences as another way of "policing and controlling female bodies", another saw it as 'protecting' them. The women also spoke of needing permission from husbands or family members to drink alcohol:

> Yeah as long as you have your husbands validation and people around you are aware that your husband have given you his validation then we don't have a problem. (FG5, woman 6)

There were mixed views about the role of religion in SA women's drinking. One woman felt religion had nothing to do with it and stated that while men's and women's roles were defined differently it didn't equate to one being superior to the other. However, this appeared to be a minority view:

> I think in our religion, everything is a lot deeper where the women are concerned, so for a woman to drink it's frowned upon a lot more. I mean in general, it goes for anything for dating, drinking, drugs, anything, smoking anything, I think it's a lot worse when it comes to women, but these are just my experiences. (FG2, woman 2)

The sense that women were judged more harshly than men on every level was a majority view:

> …people are more judgemental about women. I think we should take this for anything [group laughs], everything you do you'll be judged, so alcohol is one of them as well, it's anything that you do, even in the workplace, if you do a thing a certain way and a man does it a certain way you will get a different views on that. (FG4, woman 6)

> … people comment on whatever they do more than men, so like I feel like, when women drink it's seen as more irresponsible because its seen as like they're supposed to be the mother, they're supposed to take care of the children, but like when the men do it it's 'O he's having a hard day'. (FG3, woman 3)

This resulted in hidden drinking behaviour for women and barriers to service access. While some of this was secretive drinking, others chose to hide it in certain contexts. They either drank away from home only or drank only in the home and not outside of it. Some women spoke of not drinking in front of in-laws or parents out of respect, while others conducted a risk assessment before buying a drink:

> In the UK, so the thing is if I am going out with my colleagues and my friends I am absolutely okay drinking but if I am going out with my husband [and his] South Asian colleagues I will take a look around the room, I will take a look at what the other women are doing, I will make sure that in this set-up it is okay for me to grab a drink, before I order a drink, so I will do that. (FG5, woman 4)

Some women believed there'd been some changes in attitudes to women's drinking and women caring less about the consequences or seeing it as a liberating move:

> …whereas before it was normal but hidden, now it's becoming a bit more accepted but people just aren't caring anymore about the culture that much. (FG2, woman 1)

> W5: I think some people see drinking as like a trend now as well like you have to drink to fit in and be cool
> W6: Yeah and some people are seeing it as synonymous with women's liberation but it's not.
> W2: It's having the choice. But I would say that from having this conversation today, it's made me think actually, that it must be very hidden, the degree to which there are women who have issues with alcohol, who are not getting help, who don't know how to get help, because of the shame and embarrassment, it must be a very hidden problem that must then have an impact on the rest of their lives. (FG4)

To summarise, while there was agreement about a gender divide and differences in relation to alcohol use, there were mixed feelings about whether or not this was changing.

5.4 Cultural responsibilities for, and pressure on, women

The pressure on SA women to remain honourable, chaste, and "a good woman" at all times was reflected in some focus group discussions about male family members' surveillance of them. One woman described how strict her father and grandfather were:

> … I wasn't even allowed to put my bin out sometimes y'know he'd be saying 'boys gonna watch you so you're not allowed to put a bin out, your mum and I will do it' … even when I used to go to school y'know he was outside with his racing dogs and I'd be like 'why does he come and pick me up, why does he does this', he was very strict with me. … but now that I've got my own children and I know he was only doing it because he wanted to protect me. (FG1, woman 2)

Another spoke about one brother who didn't like her talking to male classmates on the walk home from school:

> … I had one brother who was a lot stricter [than the others] … my brother the third one down, he'd come up and if I was talking to a boy going over some homework … [he'd say] ' come on go, get away from my sister you're

> not allowed talk to my sister' but, I never took it to heart we just got on with it, but I think it's just the way we were brought up, just to be quiet… (FG1, woman 3)

While these women were slightly older in the group, woman 3 said she was the same with her own girls who "wouldn't even go out the front door to play on the drive or in the garden". This suggests that the intergenerational transmission of such norms is still powerful for some families. What is noticeable is the acceptance of these two women to such surveillance and to the role of being a quiet woman (or girl) who needed male protection. There was a fear of being "marked" as dishonouring the family that worried some women and this extended to alcohol consumption. Despite more relaxed attitudes many of the women express towards their daughters some cultural practices remained. One woman said she was mindful of the "absolutely painstaking heart-breaking" situations their daughters and children had to go through if they were married to "husbands from back home…" (FG1, woman 3).

Another felt the concept of honour being upheld by the girls in the family had not changed:

> And with the honour thing, it still goes on as much as it did when I was young. I mean because I know many families that would say just for drinking, 'I would take my daughter to Pakistan and marry her off if I found that she was getting out of hand, if she ever drank or went with boys' I mean it is still much, very much goes on, like how it did when I was young. (FG2, woman 2)

She went on to say that even if there were alcohol services in the communities, she would not be able to approach them for risk of exposing herself to greater abuse:

> … as a Muslim woman … even in my desperation I would not be able to approach it because I know how frowned upon it is, … if they catch your vulnerability, you're open to more abuse and y'know, so I don't think, I think it would have to be in a place where, where you know you are safe to talk. (FG2, woman 2)

The women spoke of the damage to marriage prospects if there is an 'alcoholic problem' in the family whereby they'd be avoided by others. However, after marriage it was different as the woman was no longer her parent's responsibility.

One group spoke about women being responsible for "what happens to them" in Indian culture:

> …so if you're teased it's because you're not wearing the right clothes, if something goes wrong, it was because you were drunk, if your husband is drunk and is hitting you it's because you are not cordial enough or y'know whatever, or you are not available enough for his needs. So maybe that is why the stigma of drinking is more for women than for men, is because they're responsible for what happens to them. (FG5, woman 4)

Some had the attitude of paying no attention to the gossip although noted that daughters-in-law were prime targets for gossip, and this often meant they had to control their behaviour for their own protection:

> W6: … people like to talk about the daughter-in-laws in the house, and … there are basically no inhibitions when people start talking about daughter-in-laws, and that is when you yourself are responsible for protecting your own image and controlling what people are saying about you, so the less opportunity you give them to talk about you the more you're protecting yourself.
> W5: Every small thing they will pick up on and they will gossip
> W4: It's the fear of what others will say (FG5)

There was agreement among the women that they were viewed as the keepers of the family image:

> W6: There is a term that literally translates to 'the homes reputation', and it is a label you assign to women of the household whether you're a daughter or daughter-in-law and you are literally carrying the home's reputation on your shoulders. So whatever you do might destroy the reputation of the household, which includes drinking. …
> W9: Indian woman has to be like pure white, white by character, she cannot drink, she cannot smoke, she cannot talk loudly, she has to have a certain 'yes yes' y'know if you say anything other than yes you are a bad woman
> W6: She can't have an opinion (FG5, woman 6 & 9)

The women spoke further about even needing permission to work from family and in-laws therefore "alcohol is another level" (FG5, woman 9)

The cultural expectations of women's behaviour and the judgements associated with it were dominant in this discussion. While much of the discussion focussed on the disparity and tension this created for women, other parts of the discussion suggested that these were deeply ingrained. This was reflected in responses that highlighted how some of the women in the group held similar expectations of their own daughters.

5.5 Generation differences in women's drinking

Generational differences in drinking were mentioned by the women. There were mixed views about whether or not but this was often framed as the younger generations needing help rather than the 'aunties' or older women for whom religious norms and cultural expectations were more 'embedded':

> W7: So myself, I don't drink, but I do know several people from the younger generation and I do believe as the third generation in this country, it's getting more liberal so, the first generation, second generation they embedded religion in us, as much as culture, and I think that's why we

> didn't drink, but the fourth generation in the country, they're very lenient and liberal. (FG1, woman 7)

> W2: I think it is hard, it's very hard for the young generation now because they are being encouraged by their, it's the peer pressure and everything. And, then they're stuck between their families, their friends, but the outside is, y'know they see a different world. Inside the house is different so, I feel there should be a, especially now, there should be some sort of support where they can go and talk about their problems because it is a lot of, a lot to take in (FG1, woman 2)

Clearly the more embedded and stigmatised alcohol is, the more chances of it being hidden and denied.

College or university were cited as environments where there was pressure to fit in and where young people could live a life separate to expectations at home with family. However, not all women agreed – one suggested there was a risk of people idealising the past and that older generations had also done things they hid from family:

> I'm just thinking of some of the stories my cousins my older cousins and my aunties have taught me and even my mum, about how my uncles or someone did something and their parents never found out, that generation didn't find out but everyone else knew, so I do think there's an idealisation that South Asian kids or this third or fourth generation now are doing things their parents never would do. (FG1, woman 6)

One woman said that times were changing and norms were much more liberal all round compared with previous generations, for example, marrying outside of your caste or ethnic group was more common. Another gave an example of people being shocked that she didn't drink:

> I can remember once I had a discussion with someone and they asked me if I drink and I said no and they were kind of shocked about it, because it's so common to see people like as soon as you turn 18 you drink, like two of my friends drink, but sometimes they get really surprised that you don't drink. Obviously, before, they'd be more surprised if you did [drink] especially as a woman but now they're kind of more surprised if you don't, because like people are moving with society that 'O now it's fine to drink' like becoming more modern in a way, so it's like the complete opposite a little bit. (FG 4, woman 5)

Nevertheless, education about alcohol was still an expressed need:

> W9: Women and alcohol it's about educating women that alcohol is not bad, and I think female society now is very different to what it was ten years ago.
> W5: Yeah, now it's totally different. (FG5)

Women's knowledge of alcohol and related services was another theme identified in the focus groups as needing attention.

5.6 Alcohol service knowledge and access

None of the women knew of any group specifically for women from the communities. A clear message from all focus groups was that they thought women would not know what support was available and where to start looking:

> … they don't have an avenue to turn to, so they're struggling on their own and the only option they have is to go away in a quiet corner and just drink it off, which is not good for their health, it's not healthy for the family. (FG1, woman 3)

> I mean for me, if I became, (which I haven't, I don't drink), if I had a drinking problem I wouldn't know where to begin. I wouldn't want to google search because you don't know how reliable or what it's for. And at the same time, I wouldn't know where to begin to be honest, to ask for help. (FG2, woman 2)

> …these Asian youngsters or families they don't know where to go, y'know there is not many, I know about alcohol anonymous because we had training here, that's why we found where to go for support, but most of these are hidden, most of the families or youngsters, they don't know where to go. (FG3, woman 4)

One woman stated that due to her being in a social care profession she would know where to go as she'd had training while another commented that at least in the UK there was a GP to ask if help was needed and therefore access was much easier than "back home" in India. However, the overwhelming message was not knowing where to go and any thoughts about seeking help would be further problematised because of the taboo and stigma about women's drinking.

Most of the women knew of Alcoholics Anonymous although there was some confusion about what it offered, with one woman suggesting they gave out a "small amount" of drugs and alcohol. She appeared to be confusing AA with a harm reduction or detoxification process:

> W4: Yes, there's alcoholics anonymous centre … everytime they go, they give them small amount of drug in a safe place, they can take the drug and then gradually they coming out. It's not like one go you can actually stop alcohol or drug, it has to go through slowly slowly. And they have professionals who will actually check that. Professionals they keep the data, and they give drug small amount, and what the person was telling, in a safe place they use the alcohol or drug they safely have their needles or whatever how to dispose, they learn all over there. (FG3, woman 4)

Another spoke of suspicion from women about how anonymous AA actually was:

> W6: And then the next step of getting the counselling and getting [to] Alcohol Anonymous, that might also be difficult in society here, because then people will find out. If you go to alcohol anonymous people will find it out so that will have practical problems here, because 'what are my relatives going to think, can you not just stop it' (FG4, woman 6)

This was supported by another woman who spoke of the mistrust within certain communities towards health and care services:

> W2: The thing is there is a mistrust within certain communities, and didn't that become apparent during the pandemic that y'know certain communities don't have trust in the system, so there's that layer of sort of reducing access as well isn't there, that results in access being reduced in those services where people feel that there's a mistrust, of the treatment that they would receive because of the colour of their skin or their religious or cultural identity. (FG4, woman 2)

The women also mentioned family responses as a barrier to help seeking and the risk of being disowned by both family and communities.

5.7 Chapter summary

This chapter reported on findings from five communities groups of SA women who reported that they did not drink alcohol or did not do so at problematic levels. It highlighted the gendered bias in attitudes towards alcohol consumption among SA women and the dual standards they faced in response to their drinking compared with SA men. Discussion about women bringing dishonour to the communities through alcohol consumption also loomed large in the focus groups as did their sense of not knowing where to turn to if they, or a woman they knew, needed help with their alcohol use.

Chapter 6 - Findings: Specialist service providers

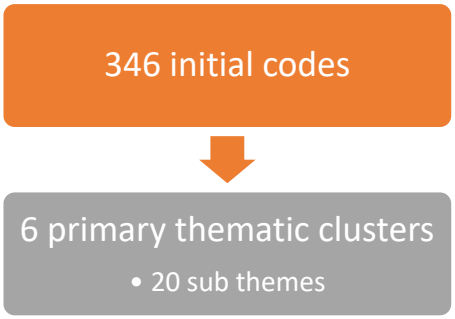
6.1 Key messages

- Seven practitioners were interviewed who worked for specialist alcohol services for ethnic minority people.
- Only one of the services was set up to provide services to women and this is now subsumed within the agency's wider remit. Six of the seven agencies provided services other than alcohol support.
- Apart from their own services, all the practitioners described a complete lack of service provision for both men and women from minority or migrant communities in their local area.
- Culturally specific features of those services were considered responsible for attracting people from those communities.
- Four of the seven practitioners spoke of the difficulties engaging SA women in their services and made considerable efforts to do so in terms of outreach and partnership work often over many months.
- The key difference between mainstream and specialist services was the nuanced cultural understanding held by specialist services negating the need for people to explain the cultural expectations and challenges they faced.
- Specialist services also understood the risks women took and fears they faced if they were identified within the communities.

The third aim of this study was to explore if, and how, alcohol practitioners offer support to South Asian communities, particularly women. In particular, this research strand sought to document practitioners' experiences of the challenges they faced and the solutions they found to engaging South Asian women. Seven practitioners were interviewed from five agencies or projects specialising in support for ethnic minority people with alcohol and other drug problems[4].

6.2 Themes and clusters

As a result of the analytic process (see s. 3.3.1), 346 codes were identified initially from the six transcripts from specialist minority service providers for people with alcohol problems. These were organised into six primary thematic clusters containing 20 sub themes.



[4] There was one joint interview with two practitioners and separate interviews with two people working for different projects within the same organisation.

Figure 5 – Initial coding to primary thematic clusters

The final thematic clusters are listed in figure 7 below starting with the codes with the highest number of references to the fewest number of references. The themes highlighted in orange are those most closely linked to the aim and objectives of this research strand and will be the focus of the findings presented here.

Primary thematic clusters (n=6)	Current service features
	Challenge of specialist service provision for SA women
	Mainstream vs specialist services
	Future service needs - see chapter 7
	Miscellaneous
	Practitioners' personal experiences

Figure 6 – List of 7 thematic clusters following the coding process

6.3 Current service features

Alcohol more than other drugs was seen as the drug of choice for women (and men) from the Asian communities with the exception of one practitioner who said in the 28 years she'd been working for the organisation she'd met more women using illicit drugs than alcohol. The seven alcohol and drug practitioners interviewed described their organisations as offering a range of support for people using substances. Only one of the services was set up specifically for women and this was a project within the wider organisation.

More broadly, the services described the lack of service provision for men and women from minority or migrant ethnic communities. Three of the specialist services were set up originally by individual men with lived experience of substance use who were attempting to fill such gaps in service provision:

> … so [I] created that organisation to be able to work with service providers, local authorities, commissioners, to help them start building more culturally appropriate services, and taking the lessons learned from approaches that we've taken to be built into that, but also connecting them with others from the community so they can make sure that lived experience is really at the heart of anything they build out for other communities. (Specialist practitioner 1)

Of those three, two were abstinence-based and worked alongside the AA and NA fellowships. Two providers were from different projects within the same organisation but based in different geographical areas. Their approach was harm reduction and harm minimisation. One provider was set up specifically to provide alcohol support to the Asian

communities more than 30 years ago and had expanded their work to include projects that focussed on mental ill health, women's projects, domestic abuse and employment support.

Only one of the seven practitioners interviewed delivered substance use services only. The remainder described a range of additional support services including family and community work and engagement/awareness raising, housing and employment support, outreach into communities to support engagement of those communities, support for weekly 'recovery' plans or structures, assessments, medical assessment, detox, and psychological/psycho-social therapies:

> We look at mental health, we look at physical health. We look at women's health, we look at family background, family history. What they're using drugs wise, what they're using alcohol wise. We look at historic, we look at fits. What they want to do, how they want to do it, children, social services – everything. (Specialist practitioner 3)

The organisation focussing specifically on minority ethnic or migrant substance use was AA specific and had grown rapidly both nationally and internationally (including India and Canada) during Covid, attracting people from the Punjabi communities in particular. It currently delivers two weekly meetings by zoom and one physical meeting – a Punjabi/English language meeting.

The culturally-specific features identified ranged from language-specific literature or culturally-specific food, to the broader understanding of the culture resulting in people not having to explain how it was different for them:

> …these are places where you can share about your culture, your context and your lived experience without having to explain it, and then also you still have other meetings (Specialist practitioner 1)

> They feel that we understand the cultural values. That we understand the cultural barriers and difficulties they go through. And they feel that we kind of like spend more time with them because we're community based (Specialist practitioner 5)

All practitioners spoke of the hurdles and obstacles that people from minority ethnic communities faced in accessing services. Some undertook joint work and partnerships with local community specific organisations or social services to try to overcome those barriers. Coming from the community was also seen as an advantage for one male service provider:

> I was able to be say successful in this area because I was from that community, you have a lot of people from the service providers who have the best will in the world but they just don't have that access into the community (Specialist practitioner 1)

However, given the concerns about 'gossip' in the communities identified by the women in chapters 4 and 5, this may not have been the case for women in the communities. The following section focusses on the challenges of specialist service provision for SA women.

6.4 Challenge of specialist service provision for SA women

Four of the practitioners spoke of difficulties engaging SA women within the service. A range of examples were provided to explain the difficulties including women being pregnant, having resident in-laws, or trying to avoid husbands finding out, fearing her attendance would get back to the community, unstable housing, lack of knowledge of, and trust in, the service, and just not understanding what the service will provide:

> There is a gap, sometimes a longer gap of actually getting them to engage. Because I think it's because they don't have that concept. What is, how is this stranger going to help me, how? … You know, and I see it even in myself, like I have this internal dialogue going on where I'm like, I'm just going to waste four or five hours of my time and not get anywhere. (Specialist practitioner 4)

To overcome the barriers to engagement practitioners made a range of efforts including texting the woman occasionally to remind them they were there if she wanted support, avoiding wearing ID tags when outreaching into the communities, running relaxation classes, contacting local family support workers, outreach into women centric services:

> So for women we'll go out into cafés, libraries, community centres, them sort of things. (Specialist practitioner 3)

One specialist practitioner spoke of 'challenging them a little' as a way of overcoming barriers about fear of being known:

> …a big part of the community thing where that, people always say 'what if someone knows me there' and I always say to people 'they're there for the same reason', nobody goes there for fun, we all go there for the same reason. (Specialist practitioner 1)

However, for women the risk of being known could be greater than for men. Unfortunately, such attempts often resulted in limited success and became a frustration for project staff. One practitioner reflected on the reasons why women were not attending suggesting it could be that some women would not seek help for their own drinking, particularly if they were more recent arrivals to the UK and were not integrated into the local community:

> Like I put energy and time into [developing the service for women], but really nothing much came of it. We didn't get any referrals for example. So, it's a little bit, sometimes you think oh God, it is pointless? … I think the main barrier is because it's not in their culture. Especially if they're, if they're so, if they're still not as integrated. (Specialist practitioner 4)

Several practitioners mentioned how, once they had become established and known, the barriers were not as significant. However, in spite of this view, they largely spoke of small numbers of women accessing their services. One service stated that almost half of their clients were women but pointed out that they were supporting family members, "a wife of someone who is drinking problematically" (Specialist practitioner 2).

Understanding gender differences required some reflection by the male specialist practitioners in particular. As one put it:

> It's great saying 'we've got this South Asian meeting yeah, look at all this stuff we've done' but what does it feel like for an Asian woman to walk into a room full of Asian men, it's horrifying I can only imagine, … and we have to all look at our own privilege, y'know just that example of me as a Punjabi male, … ladies know what it's like to walk into a room and feel 'ohh' and you have to amplify that with a typical alcoholic walking in full of fear, feeling different, so these are things on top of that as well (Specialist practitioner 1)

A common thread appeared to be the amount of time required to put into reaching SA women, the lack of funding and resource to do that, and the need to keep trying however frustrating it felt. One example was given of a woman who took 13 months and involvement of the police before she moved to a place of safety. In supporting her the agency was very aware of the potential life-threatening situation if they acted in the wrong way:

> …you've really got to be careful, because that's, that's you completely exposed. And her life could then be at huge risk. … we're very aware that, actually, if they [the family] get any wind of that she's being supported by somebody else, again her life could be threatened… (Specialist practitioner 2)

This also demonstrated the family pressures and fears about family that some women faced. It was common to hear of familial abuse of the woman, resulting in isolation and fear of going out into the communities.

> … these three [women] that I'm talking about have been disowned unfortunately. Because it came out that they, well they had alcohol problems. And it's not the thing to do when you've bought shame on the family. And you're out and you're on your own. (Specialist practitioner 3)

It was clear that the specialist practitioners were respectful of more mainstream services but were aware that these culturally-specific and challenging features of providing services to SA women were minimally understood.

6.5 Mainstream vs specialist services

The core message about the difference between mainstream services and specialist alcohol services for minority ethnic and migrant communities was one of cultural understanding – an understanding that meant SA women did not have to repeatedly explain the cultural

expectations around alcohol, gender roles and family honour, for example. One practitioner spoke of people facing the need to forever explain the cultural differences in their drinking and the consequences and impact of it. Specialist services offer both an instant and nuanced understanding of the challenges South Asian people may face; for example, knowing that some third or fourth generations of South Asians may feel that they don't fit in either the British culture or their parent's culture.

Specialist services also understood intergenerational trauma based on inherited histories of racism and inequality, 'normalised' familial domestic abuse, and family and community relationships. One provider said that mainstream providers liked to think that they offered what specialist services did but, in reality, they did not. They spoke of a lack of:

> …empathy, connection, the warmth, the love – that family feel…we'll have food on Fridays and things. And that just, all of that makes a big difference to experience [of] the service. (Specialist practitioner 2)

Mainstream services were criticised for their "cultural blindness" and not understanding that there was a lack of trust in mainstream services. One practitioner suggested that the mainstream services were often delivered in sterile environments that failed to address cultural identity (Specialist practitioner 2). Another who offered training in cultural literacy stated:

> I get bored of saying we have cultural barriers so I break down what the barriers are, so that's the whole presentation around intergeneration conflict, intergeneration trauma, hierarchical families, extended families y'know family relationships, how in Punjabi communities it's not about the blood relationship it's about the relationship you have, I have people that I call uncle who live in the same village as my parents but there's no blood relation … So it's about really giving them that understanding of actually for culture this is what it is, and for Punjabi communities, there's no such thing as the Punjabi community y'know, it's actually loads of loosely coupled communities that are kind of adhere around different things, it could be geography, y'know it could be what temple you go to y'know, it's under the covers it's just an umbrella term but there's just so much under it (Specialist practitioner 1)

Another practitioner said because she was an Asian woman it opened people up more:

> …with me they were quite open cause I was Asian. And they were saying like, well you're alright you, cause you're educated and you understand. Cause 1. you're the professional and 2. you're Asian, so, you know what it's like (Specialist practitioner 3)

Several specialist providers point out that it took a long time to build up trust with the communities giving examples of people's fears:

> Are we linked to the police? Are we local authority? Who would know about me? Competence transparency and also you know, is this person connected to my doctor or with my doctor? Will the doctor tell my family; confidentiality? So, there's a lot of factors people don't take into consideration when you're trying to break into communities, trying to spread awareness and trying to get people help and access to treatment. So, people take all these factors into consideration. But when you ask service users like, why did you come here? 'Oh, cause I know you're not linked to the police or the NHS. And my doctor's not gonna find out. And this is why I've come to you. It's because I've heard that this service has been set up by somebody who knows. They've been through it'. (Specialist practitioner 5)

One specialist practitioner said that the specialist services should collaborate more, rather than compete, to better inform and support the communities.

6.6 Chapter Summary

The specialist practitioners interviewed reinforced the lack of alcohol (and other drug) services for minority ethnic or migrant communities generally. The implication was that the specialist alcohol service provision for women from minority ethnic communities was a step too far under current commissioning conditions. Views on mainstream services responses to supporting people from minority ethnic groups ranged from accusations of 'cultural blindness' to an acknowledgement of the genuine ignorance mainstream services had of the context and challenges people from minority ethnic communities faced in seeking alcohol support. The number of women attending the services for their own alcohol use was low in spite of significant efforts at outreach, engagement and embedding themselves within the communities. They were more likely to present as family members.

Chapter 7 – Future Service Needs

7.1 Key messages

- Discrete, separate, services are needed for SA women seeking alcohol support. This should be in the local communities and would be best placed within a service that women would frequent for a range of reasons, for example, a women's centre or health centre.
- Improved knowledge and education about alcohol (and other drugs) for South Asian communities is needed, particularly where to go to seek help for themselves or a relative.
- Greater outreach to ethnic minority communities is needed to build relationships and trust. This would take time.
- Services need to evidence the safety and trust of the service and not assume that the organisation's confidentiality policy would address the risks and fears they faced.
- Faith leaders and faith groups need to play a role in educating the South Asian communities and providing individual support.

This study was keen to explore what the service needs might be for SA women with alcohol problems from the perspective of the three groups of participants. This was in addition to finding out what specialist services already existed, their service features, and their added value compared to mainstream services.

7.2 Future service needs for SA women: participants' responses

Table 2 below sets out the participants' responses to questions about the future service needs for South Asian women with problematic alcohol use. Six service needs were identified by some individuals in all three participant groups, four service needs were identified by two groups of participants, with a further five suggestions from individuals within one participant group[5].

Table 2 - Future service needs by participant group

Future service need	Women in recovery	Women in communities	Specialist practitioners
1. Discrete service specifically for SA women – community based	X	X	X
2. Public information and awareness campaigns for South Asian communities – open dialogue – including shops and beauticians, yoga centre, GP practices, NHS, family centres	X	X	X
3. More outreach - for women and families	X	X	X
4. Staff from cultural or religious background	X	X	X

[5] For the purposes of this exercise, participant responses have been aggregated at a group level. Not all participants in each group will have mentioned the future service need identified here.

5. Involvement of people with lived experience in services	X	X	X
6. Gurdwara, Imams, Priests involved in education and support	X	X	X
7. Holistic service including range of therapies	X		X
8. Confidentiality reassurance – safety and trust	X	X	
9. Online support service	X	X	
10. Tackle taboo - role for social media, films, documentaries to educate and break taboo	X		X
11. Worker to bridge communities and service for mutual education	X		
12. Family support groups	X		
13. Range of language skills for service and literature	X		
14. Education for children	X		
15. 1-1 sessions for SA women		X	

Chief among the service needs identified was the need for separate service specifically for South Asian women. Suggestions ranged from specialist AA groups to suggestions of a service within a space commonly used by women.

> W2: I think that services for Asian women might draw more, better response because I think the fact that it's a service specifically for Asian women might set people's mind at ease, might help them to feel that this is somewhere where their cultural beliefs might be respected or taken account of. (Focus group 4)

As in previous research (Galvani et al., 2013) there was a clear view that the service should be located in the communities but set within a health service, or a women's or community centre – a location that women could frequent for a range of reasons. The service would be discreet and would not be an obvious alcohol service thus avoiding the shame, stigma and subsequent reticence that the women would have about attending:

> And I think having an organisation is really good but how do you make it anonymous, and where would you situate it so the community don't judge, because the community know 'okay those women are going there because they have an addiction or they drink alcohol or have drugs' those women won't turn up because the community know. (Focus group 1)

One specialist practitioner who had longevity in providing alcohol services to SA women suggested several considerations in offering a discreet service including considering the school and mosque timing:

> So, we try to, what we've learnt is – try to do it in a place where it's accessible. Where you're not seen, so they don't know where you're from and who you are. And [not get in] the way the times of the school timing or the mosque timing. That's what we've learnt (Specialist practitioner 3)

The need for much improved knowledge and education about alcohol and other substances for women, their children, parents and wider family, was also a common request. The ignorance of people about services and where to go and what to expect was frequently mentioned, as was a general ignorance of alcohol and other substance problems, leading to shame and stigma. Greater knowledge and information were related to help-seeking by the woman or her family.

> The fact that the Asian community have so much stigma and pride, means that they don't ever educate themselves on the information out there on services to begin with. That's one problem. Because they, they like to deal with everything behind closed doors. They don't, they're not aware of their services because they never ever make themselves aware. (Rosie)

There were many suggestions about ways to increase SA communities' knowledge of services, including leaflets in shops and beauty parlours where women frequent to GP practices, family centres and other health and wellbeing settings. Many participants stressed the need for a far more open dialogue about drinking within the SA communities more widely as a way of countering the taboo it holds.

Engaging SA women in existing services was a challenge even for the specialist minority ethnic service providers. Numbers of women were low overall except for one service that had a larger number of women family members attending for support. All three groups said more outreach into the SA communities was needed – both to inform women and their families about the service available and to educate them about alcohol and other substances. One participant cited success in a similar project when employing women of the same cultural background to reach into people's homes and communities.

All participant groups mentioned the need for services to have staff from the cultural or religious backgrounds of the women they served whether that was new services or existing mainstream services.

> If your research demonstrated we need staff who look like us, then, then we're going to get people through the door. … People like me aren't going to come through the door because the staff doesn't look like me, … so the existing services need to make provision by recruiting the right staff. So that their staff can the go into the mosques, the Gurdwaras, the Hindu samajs to go and talk about it. Cause that's gonna be more welcome and open. Because that's somebody from their background going in and talking about it…Yeah. It was only when they saw an Asian face talking about it, they decided to come forward. (Ajit)

> …need to start having more champions in this space where actually you've got positive examples (Specialist practitioner 1)

One woman, however, said she'd found the anonymity of white services helpful but then she had to explain the cultural elements in order for the staff to understand how it played a role in her drinking journey:

> …I felt able to be myself. But then when I would talk about certain specific issues, cultural – they wouldn't get it. But I'd have to explain it a bit more. And it almost would look like I was making an excuse for my drinking. By saying how hard it was in my, in the culture. And I didn't want, I didn't want it to be an excuse, but at the same time I did want them to acknowledge it was a factor. That it was a factor. (Daljinder)

In addition to staff being from similar cultural backgrounds, two of the three groups of participants spoke about the service needing to do more than address alcohol. The need for a more holistic service was seen as more appropriate for SA women, particularly a service that addressed trauma experiences and intergenerational patterns of drinking. One woman felt this was a particular gap in services:

> There's three trauma-informed rehabs in the country. There's endless 12 Step rehabs. But there's only three trauma-informed rehabs, when the majority of people who are in active addiction are in active addiction because they've experienced trauma. … Yeah, I just find it a bit bizarre really. (Rosie)

Other women mentioned a range of therapies and activities that were able to address co-existing problems including mental ill health and family pressures. Both groups of women also expressed the need for SA women with lived experience of alcohol problems to be involved in service provision so women felt there was someone who understands preferring someone with lived experience:

> It's all well and good to have trained professionals, who've never had an alcohol problem in their life…. they're coming from a place of fix. I want to fix you…not I want to listen to you. (Raj)

The two groups of women stressed the need for confidentiality, for feeling safe within a service and trusting those within it. The fear of people finding out was significant given its potential impact on her and her family. For this reason, a woman in the community group suggested offering 1-1 sessions for SA women rather than group work. It is perhaps interesting to note that the specialist practitioners did not mention issues of safety and trust. It is possible they considered them a 'given' feature of services or perhaps there was less understanding about the additional importance of safety and trust for SA women in alcohol services compared with men. Gleeson et al., (2019) also noted that facilitating factors for accessing services included confidential services, awareness raising, peer-led support, flexibility to changing needs, dissemination of multilingual literature in community languages and minority ethnic media.

Online support options were also mentioned by the women as a way of providing anonymity by not needing a camera on or not giving your real name. Several of the women had found online support helpful to them through online AA meetings or other forms of online help, while one woman ended up running online groups in her area:

> …I went online and started looking for, I'd actually made some sober contacts on Instagram, cause there's a big sober community on Instagram. …. And I got fully stuck in with that community for about a year- and, well I left then in March-April this year. So nearly two years I was with them, and I was running online drop-ins, I was hosting meet-ups in person and brunches. I became one of their coaches. (Ravi)

The role of religion in future services was mentioned by both specialist practitioners and women in recovery. They suggested various roles for faith leaders and for the faith communities and temples including education for the communities and individual support. They were mentioned as places that had not always engaged with efforts to involve them in supporting people with alcohol problems although they were welcoming to those who sought out their faith as part of their recovery. One woman wanted a SA women's alcohol service to be located within the Gurdwara to "break down this shame and stigma" (Daljinder).

The taboo of drinking and SA women's drinking was also a priority for women in recovery and the specialist practitioners. It had resulted in women being isolated from friends and family and being unable to speak openly to others as well as denial from the communities that drinking takes place within it. One specialist practitioner spoke of the efforts to educate the local SA communities to try to break down the taboo about drinking:

> So, it took us a few years to build that trust in the community. So, we were out pretty much regular in the week, going out and spreading awareness. … creating content in different languages. Telling people that this issue exists, it's not a taboo subject. It is happening in our community, talking through lived experience, telling people 'Look, I've been on this journey.' It is an issue in our community. My family has suffered this. You don't have to hide it under the carpet, there is help available, it is free'. (Specialist practitioner 5)

The final five suggestions were primarily made by the women in recovery group. Support groups for families were identified as a gap in services as was literature that was available in a range of languages. The women also felt education for children about alcohol was important from an early age to try to prevent later problems. Earlier studies have also identified the need for more family support as one of the key features of addressing problematic alcohol consumption (Galvani, et al. 2013; Kumar et al., 2018).

The specialist services were often small charities and minimally funded. They wanted future services to be better funded allowing greater capacity for support for minority ethnic

communities in general. One service was concerned that they didn't "let the floodgates open" without the resources to provide the service.

7.3 Chapter summary

This chapter summarised the findings relating to future service requirements for SA women needing support for their alcohol use. The key finding is simple – provide services for SA women as they currently do not exist. Further, ensure that the location, context and staffing is considered with SA women's needs front and centre. Beyond service provision there is a need for education and knowledge within the families and communities they live in that will counter the taboo of alcohol use and enable people to seek support for themselves or others when needed.

Chapter 8 - Model(s) of support

This chapter draws together the learning from across the existing evidence base and combines it with the new data from this research. In an attempt to support both new and existing services, it presents a model of support for new services, a self-assessment tool for existing services and a process map.

8.1 Overcoming barriers to support

A clear message from this research has been the lack of services that meet the needs of SA women with alcohol problems. In addition, while anecdotal evidence suggests there are women in the communities in need of alcohol support, even the limited number of specialist alcohol services face the challenge of finding and engaging women in those communities. There are clearly physical, psychological, emotional, and cultural barriers within the family and communities that prevent SA women from accessing the support and services they need. Access is further hindered by a lack of recognition of their needs within wider service commissioning. This is undoubtedly due, at least in part, to the inadequate and inaccessible data available to underpin commissioning decisions – a likely consequence of the colour- and culture-blind approach to data collection from policy makers and researchers. In part it may also be a consequence of the potentially devastating impact of familial and individual shame and stigma, and the secrecy and denial of alcohol problems within the SA communities. The result is a vicious circle depicting no evidence of need therefore no resource for services, and with no appropriate service, SA women's alcohol use will remain hidden and stigmatised (see figure 8 below), therefore, no evidence of need.

Figure 7 – Vicious cycle resulting in gaps in services

However, in this research, what the women in recovery highlighted was the difference in SA women's drinking compared to women from white cultures due to the cultural and gender expectations placed upon them by their family, their religion, and their communities; differences that are not understood within mainstream services:

> … I don't want to use [my ethnicity] as an excuse but being an Indian woman needs to be acknowledged at the same time. My drinking is different to your drinking, in a sense that it's just, if I could sum up my alcoholism and my problem with drinking in a few words – shame, guilt, isolation, scared, judged, lonely. And amplified by a million with the aspect of being a mother. (Daljinder)

This research sought to explore SA women's alcohol use and their support needs. It has resulted in a model of support for new services and a tool of self-assessment for existing services. Galvani et al.'s (2013) study among a Punjabi Sikh community recommended two models based on differences between generations rather than genders. They suggested younger people may be more open to the westernized 'talking therapies' than older generations with older generations preferring medical advice. This study found nothing to suggest South Asian women were averse to talking therapies, more that a separate service would provide the safety, trust and cultural competence required to support them.

Bayley and Hurcombe (2010) also suggested that help-seeking preferences for drinking problems varied between and within groups, suggesting that alcohol problems need to be addressed within both mainstream and specialist services. They stated that the issue of providing only mainstream services and/or specialist services is a contested one. While specialist services are desirable and offer cultural specificity the proponents of more mainstream services argue that since identities are complex and intersected with gender, religion, and sexuality, etc. an overemphasis on one aspect may deny the relevance of others. Kumar et al. (2018) pointed out that service users among the Sikh communities were sometimes reluctant to use BME specialist services due to issues of confidentiality, while others preferred the cultural sensitivity offered by specialist provision. Whatever the rationale, what is key to this research is the need for separate services to meet the needs of women, and South Asian women in particular, something that both specialist and mainstream services appear to find challenging.

8.2 New model of alcohol support for South Asian women

The new model of alcohol support services for SA women (see figure 9 below) incorporates the features identified in section 7.2 above. It is a model that is woman-centric and reflects the cultural sensitivities required to enable SA women to access services more readily.

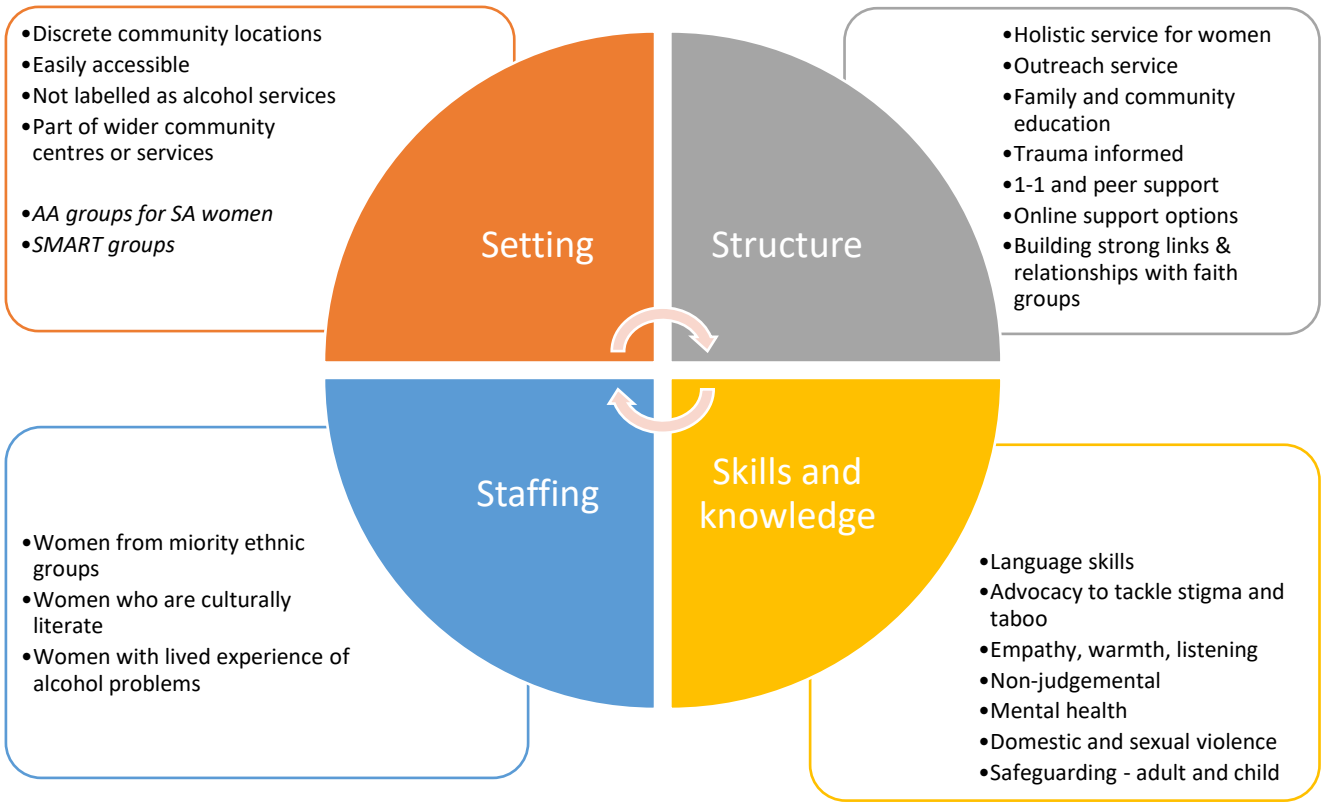


Figure 8 – Model of alcohol support for SA women

While explicit mention of women-specific staff for future services was limited in the SA women's responses, they did call for SA women with lived experience to be involved in service development. Some women also spoke about difficult experiences in services being the only SA woman in services dominated by men. However, the need for women staff was widely implied given the participants called for an understanding of the cultural and gendered expectations placed on women, services that provided trust and safety, an understanding of trauma and abuse, and staff who 'looked like me'. The high levels of abuse reported suggest women staff would be far more appropriate in the same way that women staff run women's groups and domestic abuse refuges.

This research did not explore in detail any mechanics or processes of service development, however, the need for services to be community-based and culturally literate indicate that new services are best developed within the communities they serve. Galvani et al. (2013) recommended that services needed to be developed with the communities from the outset as equal partners if instigated by a mainstream service provider.

Services must be mindful of not only the cultural and religious requirements but also be responsive in terms of providing security, confidentiality and easy accessibility, away from the public gaze so that the feared dishonour for women is kept at bay.

8.3 Model for improvement of existing services

The model for existing services emerging from this research is designed to support further development of cultural literacy and gender competence. The research raised some critical

opinions of 'white', mainstream services and a peer support organisation, for their lack of cultural competence or representation from people within their communities. These services include community-based alcohol services, rehab and detox facilities, residential programmes, and peer support.

One of the stated outputs of this research was to develop a self-assessment tool for current services based on the findings of this research. This tool is not intended to be definitive and can be adapted to service needs. However, it is intended to stimulate discussion and prompt potential improvements to existing services as well as a checklist to underpin the development of new services. It comprises a list of questions relating to five areas of service provision: i) environment, ii) service, iii) staffing, iv) training and v) assessment & interventions (see table 3 below).

In addition to the self-assessment tool (table 3), figure 9 (below) offers a process by which existing services could build a more culturally literate and gender responsive service in partnership with local communities. As with findings by Galvani et al. (2013), existing services need to be open to changing their models and approaches to service development to be culturally responsive.

Table 3– Self-assessment tool: providing alcohol services to SA women

Environment	▪ What does your service do to show your commitment to the needs of SA women (and ethnically diverse communities) when people enter your service?
	▪ Does your advertising and marketing resources include pictures of SA women?
	▪ Is the information on your service available in local languages?
Service	▪ To what extent are you offering a safe, discrete, women's focussed service?
	▪ Does your agency have the ability to offer women only spaces and/or private entrances and exits to women who may need it?
	▪ Does your service offer any services to family members in the various communities?
	▪ Is it obvious that you are providing alcohol services? If so, are there options for outreach in settings that are not obviously alcohol focussed?
	▪ How are you providing a) outreach and b) satellite services within the local minority communities?
	▪ Are you currently providing information on peer support for women from SA communities?
	▪ What services do you offer that address women's wider needs?
	▪ What education and knowledge events are you running within the local minority ethnic communities? In partnership with whom?
	▪ How is your service engaging with local religious groups, faith centres and other community groups?
	▪ To what extent are you delivering some services online and can they be developed for different minority ethnic communities?
	▪ What services are you offering to families from minority ethnic communities and how are these promoted to the communities?
Staffing	▪ How many of your staff speak minority languages and do you know what they are?

	▪ How many of your staff are from minority ethnic groups and does this reflect the local population?
	▪ How many of your staff are women?
	▪ How many of your staff or volunteers are people with lived experience?
Training	▪ Do you have a mandatory, rolling programme of cultural competence/literacy training?
	▪ How many of your staff have completed the training and is a refresher course available?
	▪ To what extent are gender differences in alcohol use and impact part of your cultural competence training?
	▪ To what extent does your training also address common issues faced by SA women who drink alcohol, for example, abuse, coercive control, marginalisation and isolation, family and community rejection, motherhood?
Assessment & interventions	▪ Do your assessment procedures ask about ethnicity and religion in adequately detailed categories? Are all your staff asking the questions or is there missing data?
	▪ Do your assessments and interventions include discussion about religious beliefs and their relevance (for good or bad) to the person's motivation to change their substance use? How is this monitored?
	▪ Do your assessments and interventions ask about cultural norms and pressures around (women's) alcohol and other drug use?
	▪ Do your assessments and interventions routinely ask about coercive control and domestic abuse from partners, parents, children, extended family members?
	▪ How do your assessments and interventions establish levels of personal safety for women at home and in the communities?

In a qualitative, longitudinal study by Bashir et al. (2019), they found that, in order to be relevant and effective, intervention programmes needed to go beyond approaches that sought to 'fix' people and to focus on developing 'a sense of connection, belonging, identification and understanding which recognises humanity' (2019:4). Holistic approaches investing in comprehensive analysis and provision may be better situated to provide effective services.

8.4 Chapter summary

The model, tool and process presented in this chapter have been built on the limited evidence base to date and the additional evidence this research project has collated. The vicious circle that starts and ends with a lack of evidence exposes the inadequacies of current data collection. The new model of support structures the alcohol support needs of SA women around the four 'S's – Setting, Structure, Skills and knowledge, and Staffing. Importantly such a model needs to be developed with or by the communities from the outset. The chapter also presented a tool for the improvement of existing alcohol services. It poses questions in five areas of service: i) environment, ii) service, iii) staffing, iv) training and v) assessment & interventions, enabling existing services to maximise their reach to, and support of, SA women in need of alcohol support. Finally, it has offered a process map that offers a pathway to service provision that will maximise its chance of success.

Figure 9 – Process of building a more culturally literature and gendered response for existing services

Chapter 9 – Conclusion

This research set out with three central aims:

1. To explore the lived experiences of alcohol use and help-seeking from the perspectives of South Asian women
2. To understand how non-alcohol-using women from the South Asian communities respond to women's problematic alcohol use
3. To explore if and how alcohol practitioners offer support to South Asian communities, particularly women.

The clearest message emerging from the review of existing literature and through listening to all three participant groups, is the lack of informed and specific service provision for South Asian women with problematic alcohol use.

This research was limited by the same challenges facing South Asian women who want help with their alcohol use. There are very few services available and those that are available have a mixed gender demographic. Different experiences could be reflected in a larger sample size of services although recent work looking for specialist alcohol services for ethnic minority communities (Hulmes and Galvani, 2023) suggests there are few services nationally with none focussing on women from SA communities. There may be more specialist alcohol projects targeting SA women or wider communities attached to broader mainstream organisations that were difficult to find online.

Recruitment of the women in the community to the focus groups relied heavily on networks and partner agencies – in other words, trusted intermediaries. Again a wider range of women may have resulted in different or additional findings. However, the range of women who participated in the groups suggests a reasonable spread of women from different backgrounds, educationally, religiously and culturally.

Finally, given the reported hidden nature of SA women's drinking, women were reluctant to take part resulting in a smaller sample than hoped. A national scale recruitment campaign in services women frequent, in addition to partner agencies, may result in a bigger sample. However, there was such a great deal of homogeneity across the groups in terms of their experiences, it is difficult to imagine very different results even with a larger sample.

Despite these limitations, the need for culturally literate and gender sensitive services was highlighted – services where women do not have to explain the additional cultural pressures and expectations placed upon them, services that are safe, confidential, and trauma informed, and services that can both educate and support through a range of formats. In particular, services must respond to the shared experiences of domestic and sexual abuse, mental ill health, and family conflict that is so prevalent in the lives of the women in this research. Further, services must be located discretely in the communities, in places women will frequent for reasons other than alcohol support. However, services must also be aware of diversity: not all women will require clandestine locations, for instance, some may be at ease in using mainstream services. Their cultural needs, therefore, must also be addressed within mainstream services.

To address our second aim, we held focus groups with South Asian women from the communities who did not drink alcohol, or did not drink problematically, to gather their views of alcohol use among other women within their communities and responses to it. They spoke strongly of the gendered double standards that SA women need to navigate in relation to their alcohol consumption. They voiced concerns about the perceived generational differences in relation to alcohol use, particularly the pressure younger women may feel as they are caught between traditional expectations and modern social pressures around drinking. Importantly, they stressed the weight of cultural pressures and expectations on women that serves to push their drinking to secrecy out of fear and retribution. These are key considerations for services to understand and address as they result in an expectation of judgement, guilt, shame and late presentation to services for help.

To meet aim 3, we heard from specialist alcohol services or specialist projects for minority and migrant communities. They exist in very small number and often with minimal funding. They also found accessing women from the SA communities difficult. The barriers to women accessing alcohol services are many and deeply embedded. Even those services that had attempted outreach to women in the local communities found it a time consuming and ongoing process. A woman from the community focus groups summarised the size of the task well:

> So how do you work on that as a society? I think, y'know, people need educating don't they. And it's years of, I suppose that kind of, I wouldn't say brainwashing, but it's how you learn. It's the values that are enshrined within us as we grow up isn't it? Honour and izzat and what people think and all of that, so it's not something that you can undo overnight. (FG4, woman 2)

The dearth of research available on all aspects of SA women's alcohol or other drug use needs to be addressed. There cannot continue to be a gender-blind or colour-blind approach unless the intention is to ignore sections of the population. The challenge is where to start given the void that currently exists. This research suggests that more evidence needs to be gathered, in a culturally acceptable way, that identifies the needs, prevalence and incidence, of SA women using alcohol and other drugs, as well as developing responses and evaluating them for effectiveness. And all this must be done in partnership with the communities being researched.

The cultural environment of SA women is steeped in restrictive practices of izzat (honour, humility, modesty) which place them as guardians of family honour. Their overwhelming burden of safeguarding this honour means that while their male counterparts might freely breach cultural norms with impunity, any such deviations on the part of women are feared to result in exclusion and ostracisation. Whether or not it actually culminates in such a position is almost irrelevant; it is the *fear* of potentially ruinous reputations that helps to police and regulate women's behaviour (Bradby, 2006; 2007).

However, cultures are not static; women have agency and everyday practices negotiate cultural imperatives and contradictions and present fluidity resulting in continuity and change (Gill, 2015; Bradby 2006;2007). Given the clandestine consumption of alcohol for many SA women, the need for confidentiality and trust are foremost in them being able to share their experiences.

Lack of knowledge about available services, appropriate language provision in existing services, and the inability of provisions to reach out to SA communities in culturally appropriate ways are serious barriers to access. Holistic services, able to address cultural, gendered, physical, spiritual, economic, and social needs, and offering communities and family support, are likely to be more effective (Bashir, et al. 2019; Gleeson, et al., 2019; Kumar, et al., 2018; Gill, 2015, Bradby 2006, 2007; Galvani at al., 2013; Morjaria-Keval's, 2006; McKeigue and Karmi, 1993).

While class has been considered in mainstream studies of alcohol use (Bailey, et al., 2015; Lennox, et al., 2018), an appreciation of this among minority populations is seriously absent. The diversity and the intersectionality between the various factors need to be recognised (Anitha and Dhaliwal, 2019) if more responsive services are to be developed. Hence, understanding the diverse needs of SA communities in all its forms (culture, gender, religion, geography, age, class, language) and ensuring a comprehensive, well-funded, provision, is likely to form a sound stepping stone to effective treatment.

References

Anitha, S and Dhaliwal, S.(2019) South Asian feminisms in Britain: Traversing gender, race, class and religion. *Economic and Political Weekly*, 54(17), online. Available online at: https://www.epw.in/journal/2019/17/review-womens-studies/south-asian-feminisms-britain.html (accessed 14th August 2023)

Arli, D., Kim, J., Rundle-Thiele, S., Tkaczynski, A. (2019) Australian migrant's social cultural adaptation and consumption behaviour towards food and alcohol, *International Journal of Consumer Studies*, 43, 2-13.

Aronson, J. (1995) A pragmatic view of thematic analysis, *The qualitative report*, *2*(1), 1-3.

Bailey, L., Griffin, C., and Shankar, A. (2015) "Not a good look", *Substance Use Misuse*, 50(6), 747-758.

Ballard, R. (1994) *Desh Pardesh: The South Asian Presence in Britain*. London: Hurst & Company.

Bashir, N., Ameyaw, N., Sahota, S., Bajwa, M., and Dayson, C. (2019) *Culture, connection and belonging: a study of addiction and recovery in Nottingham's BAME community.* Available at: https://www.shu.ac.uk/centre-regional-economic-social-research/publications/culture-connection-and-belonging-a-study-of-addiction-and-recovery-in-nottinghams-bame-community

Bayley, M., and Hurcombe, R. (2010) Drinking patterns and alcohol service provision for different ethnic groups in the UK: a review of the literature, *Ethnicity and Inequalities in Health and Social Care*, 3(4), 6-17.

Becerra, M.B., Herring, P., Marshak, H.H., and Banta, J.E. (2013) Association between Acculturation and Binge Drinking among Asian-Americans: Results from the California Health Interview Survey. *Journal of Addiction*, https://doi.org/10.1155/2013/248196

Beddoes, D., Sheikh, S., Khanna, M., and Francis, R. (2010) *The impact of drugs on different minority groups: A review of the UK literature,* UK Drug Policy Commission. Available at: https://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20The%20impact%20of%20drugs%20on%20different%20minority%20groups_%20ethnic%20groups.pdf

Bhala, N., Fishbacher, C. & Bhopal, R. (2010). Mortality for alcohol related harm by country of birth in Scotland, 2000-2004: Potential lessons for prevention. *Alcohol and Alcoholism*, 45(6), 552-556. DOI: 10.1093/alcalc/agq056

Bhopal, K. (1998) How gender and ethnicity intersect: the significance of education, employment and marital status, *Sociological Research Online*, 3, 1–16

Bradby, H. (2006). Understanding Honour and Religion as resource and constraint for Young British Asians. In Beckford, J.A., and Walliss, J. (eds), *Theorising Religion: Classical and Contemporary Debates*. Aldershot: Ashgate Publishing Ltd.

Bradby, H. (2007). Watch out for the Aunties! Young British Asians' accounts of identity and substance use, *Sociology of Health and Illness*, 29(5), 656 – 672. DOI: 10.1111/j.1467-9566.2007.01011.x

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57–71). American Psychological Association. https://doi.org/10.1037/13620-004

Cohen, A. B., Wu, M.S., and Miller, J. (2016) Religion and Culture: Individualism and Collectivism in the East and West, *Journal of Cross-Cultural Psychology*, 47(9), 1236-1249.

Dawson, D.A., Grant, B.F., and Ruan, W.J. (2005) The Association Between Stress and Drinking: Modifying Effects of Gender and Vulnerability, *Alcohol & Alcoholism*, 40(5), 453-460.

Fountain, J. (2009) Issues surrounding drug use and drug services among the South Asian communities in England, NHS National Treatment Agency for Misuse. Available at: https://www.bl.uk/collection-items/issues-surrounding-drug-use-and-drug-services-among-the-south-asian-communities-in-england

Galvani, S., Fox, S., Guru, S. and Khan, N. (2023) *Alcohol, izzat and me: South Asian women in recovery*. Manchester: Manchester Metropolitan University

Galvani, S., Manders, G., Wadd, S., and Chaudhry, S. (2013) *Developing a Community alcohol Support Package (CASP): An exploratory study with a Punjabi Sikh Community*. Available at: https://uobrep.openrepository.com/handle/10547/603551 .

Ghuman, P. A. S. (2001) Asian girls in secondary schools: A British perspective, *Intercultural Education,* 12:2, 197-207, DOI: 10.1080/1467598012006483

Gill, Ravinder (2015) "Don't let them see a drink in my hand": an interpretative phenomenological analysis of British Sikh women's experiences of alcohol. Doctoral thesis, London Metropolitan University.

Gleeson, H., Thom, B., Bayley, M., and McQuarrie, T. (2019) Rapid evidence Review: Drinking problems and interventions in Black and minority ethnic communities. Available at: https://alcoholchange.org.uk/publication/rapid-evidence-review-drinking-problems-and-interventions-in-black-and-minority-ethnic-communities

Gleeson, H., Duke, K. and Thom, B. (2019), Challenges to providing culturally sensitive drug interventions for black and Asian minority ethnic (BAME) groups within UK youth justice systems, *Drugs and Alcohol Today*, 19(3), 172-181.

Gourlay, A., Mshana, G., Birdthistle, I., Bulugu, G., Zaba, B., and Ueassa, M. (2014) Using vignettes in qualitative research to explore barriers and facilitating factors to the uptake of prevention of mother-to-child transmission services in rural Tanzania: a critical analysis. *BMC Medical Research Methodology,* 14(21), https://doi.org/10.1186/1471-2288-14-21

Guru, S. (2003). *Working Paper for the Pavis Centre for Social and Cultural Research: Transmission of Femininity - a study of British-Asian women across three generations*. Open University.

Guru, S. (2009): 'Divorce: Obstacles & Opportunities, South Asian Women in Britain', *The Sociological Review*, 57(2), 285-305.

Hill, S., and Marshall, T.C. (2018) Beliefs about Sexual Assault in India and Britain are Explained by Attitudes Towards Women and Hostile Sexism, *Sex Roles*, 79, 4210-30.

Hulmes, O. and Galvani, S. (2023) Compendium of specialist alcohol support services for people from minority ethnic and migrant communities. Available online at: https://e-space.mmu.ac.uk/631609/ (accessed 14th August 2023)

Hurcombe, R., Bayley, M., & Goodman, A. (2010). Ethnicity and alcohol: A review of the UK literature. *Joseph Rowntree Foundation*: York, UK.

Hussain, F., and Cochrane, R. (2002) Depression in South Asian women: Asian women's beliefs on causes and cures, *Mental Health, Religion and Culture* 5(3), 285-311, DOI:10.1080/13674670210130036

Javadi, M., and Zarea, K. (2016) Understanding thematic analysis and its pitfall. *Journal of client care*, *1*(1), 33-39.

Jeffrey, P. (1976) *Migrants and Refugees: Muslim and Christian Pakistani Families in Bristol*. Cambridge: Cambridge University Press.

Joffe, H. (2012). Thematic analysis. *Qualitative research methods in mental health and psychotherapy*, *1*, 210-223.

Kaur, R. (2021) *'How 'Drink Spiking' is Impacting British Asian Women'*. Available at: https://www.desiblitz.com/content/how-drink-spiking-is-impacting-british-asian-women

Krishan, K. (2019) Changing Role of Women in Indian Society, *Scholarly Research Journal for Humanity Science & English Language*, 7(36), 9560-9565.

Kumar, A., Castelli, A., and Syal, C. (2018) *The unspoken alcohol problem among UK Punjabis*. Available at: https://www.bbc.co.uk/news/uk-43505784

Lee, P., Robyn, S.B., Antin, T.M.J., and Lipton, R. (2008) Alcohol use among two generations of Southeast Asians in the U.S., *Journal of Ethnicity in Substance Abuse,* 7(4), 357-375.

Lennox, J., Emslie, C., Sweeting, H., and Lyons, A. (2018) The role of alcohol in constructing gender and class identities among women in the age of social media, International *Journal of Drug Policy*, 58, 13-21.

Liddle, J., and Joshi, R. (1986). *Daughters of Independence: Gender, Caste and Class in India.* New Brunswick: Rutgers University Press

McKeigue, P. M., and Karmi, G. (1993). Alcohol consumption and alcohol-related problems in Afro-Caribbeans and South Asians in the United Kingdom. *Alcohol and Alcoholism, 28*(1), 1–10.

Mixed Museum (undated) 'The Grunswick Strikes.' Available online at: https://mixedmuseum.org.uk/btcotc/the-grunwick-strike/ [accessed 28th Jul 2023]

Morjaria, A., and Orford, J. (2002) The Role of Religion and Spirituality in Recovery from Drink Problems: A Qualitative Study of Alcoholics Anonymous Members and South Asian men, *Addiction Research & Theory*, 10(3), 225-256, DOI: 10.1080/16066350211864

Morjaria-Keval, A. (2006) Religious and Spiritual Elements of Change in Sikh Men with Alcohol Problems, *Journal of Ethnicity in Substance Abuse*, 5(2), 91-118, DOI: 10.1300/J233v05n02_06

Martin, J. K., Tuch, S. A., and Roman, P. M. (2003). Problem drinking patterns among African Americans: the impacts of reports of discrimination, perceptions of prejudice, and "risky" coping strategies. *Journal of health and social behavior*, *44*(3), 408–425.

Mulia, N., Ye, Y., Zemore, S. E., & Greenfield, T. K. (2008). Social disadvantage, stress, and alcohol use among black, Hispanic, and white Americans: findings from the 2005 U.S. National Alcohol Survey. *Journal of studies on alcohol and drugs*, *69*(6), 824–833. https://doi.org/10.15288/jsad.2008.69.824

Mulia, N., Ye, Y., Greenfield, T. K., & Zemore, S. E. (2009). Disparities in alcohol-related problems among white, black, and Hispanic Americans. *Alcoholism, clinical and experimental research*, *33*(4), 654–662. https://doi.org/10.1111/j.1530-0277.2008.00880.x

Orford, J., Johnson, M. and Purser, B. (2004) Drinking in second generation Black and Asian Communities in the English Midlands, *Addiction Research & Theory*, 12(1), 11-30, DOI: 10.1080/1606635021000059493

Pandian, L.V.K. (2020) Patriarchy and Beauty: The Power Over Indian Women, *Journal of the Anthropological Survey of India*, 69(1), 117-123.

Pannu, G., Zaman, S., Bhala, N., and Zaman, R. (2009) Alcohol use in South Asians in the UK, *British Medical Journal*, 2009, 339(7729), 11-1044.

Public Health England (PHE) (2021) M*onitoring alcohol consumption and harm during the COVID-19 pandemic: summary*. Available at: https://www.gov.uk/government/publications/alcohol-consumption-and-harm-during-the-covid-19-pandemic/monitoring-alcohol-consumption-and-harm-during-the-covid-19-pandemic-summary

Public Health England (2022) Local Alcohol Profiles for England – Further resources: https://fingertips.phe.org.uk/profile/local-alcohol-profiles/supporting-information/further-resources

Puri, N., Allen, K., and Rieb, L. (2020) Treatment of alcohol use disorder among people of South Asian ancestry in Canada and the United States: A narrative review, *Journal of Ethnicity in Substance Abuse*, 19(3), 345-357, DOI: 10.1080/15332640.2018.1532855

Petruzzello, M. (2022) "Chipko movement". *Encyclopedia Britannica*, 6 Oct. 2022, https://www.britannica.com/topic/Chipko-movement. Accessed 28 July 2023.

Rai, J. (2019) *Alcoholism and Beyond*, Sikh Recovery Network. Available at: https://sikhrecoverynetwork.org/445-2/

Ralphs, R., Gray, P., and Smyth, G. (2014) *A Formative Evaluation of Early Break East Lancashire Outreach Project.* Available at: https://e-space.mmu.ac.uk/617314/1/Evaluation%20of%20Early%20Break.pdf

Randev, S. (2019) *Sonia's Story : "My addiction will not define me, nor will it beat me"*. Available at: https://alcoholchange.org.uk/story/sonias-story-my-addiction-does-not-define-me-nor-will-it-beat-me

Ratna, A. (2013) Intersectional Plays of Identity: The Experiences of British Asian Female Footballers, *Sociological Research Online*, 18(1), DOI: https://doi.org/10.5153/sro.282

Rastogi, M., and Wadhwa, S. (2006) Substance Abuse Among Asian Indians in the United States: A Consideration of Cultural Factors in Etiology and Treatment, *Substance Use & Misuse*, 41(9), 1239-1249.

Rodríguez-Dorans, E., and Jacobs, P. (2020) 'Making narrative portraits: a methodological approach to analysing qualitative data', *International Journal of Social Research Methodology,* 23(6), 611-623, DOI: 10.1080/13645579.2020.1719609

Roland, A. (1988) *In Search of Self in India and Japan*. New Jersey: Princeton University Press.

Khan, S. (1977) The Pakistanis: Mirpuri villagers at home and in Bradford, in J. L. WATSON (Ed.) *Between Two Cultures: migrants and minorities in Britain*, Oxford: Blackwell.

Shaw, A. (1994) The Pakistani community in Oxford, in: R. BALLARD (Ed.) *Desh Pardesh: the South Asian presence in Britain*, London:Hurst & Company.

Singh, J. (2018) The Rise of Alcohol Addiction Among U.K. South Asian Women. Available at: https://browngirlmagazine.com/2018/06/rise-alcohol-addiction-amongst-u-k-south-asian-women/

Sivakumar, I., and Manimekalai, K. (2021) Masculinity and Challenges for Women in Indian Culture. *Journal of International Women's Studies*, 22(5), 427-436.

Tuck, A., Robinson, M., Agic, B., Ialomiteanu, A.R., and Mann, R.E. (2017) Religion, Alcohol Use and Risk Drinking Among Canadian Adults Living in Ontario, *Journal of Religion Health* 56, 2023-2038.

Uddin, M.S., Bhugra, D., and Johnson, M.R.D. (2008) Perceptions of drug use within a UK Bengali community, *Indian journal of psychiatry*, 50(2), 106-111

Werbner, P. (1990) *The Migration Process: Capital, Gifts and Offerings among British Pakistanis*. New, York: Berg.

Wilson, A. (2006) *Dreams, Questions, Struggles: South Asian Women in Britain*, London:Pluto Press.

Wilson, A. (2023) *Finding a Voice: Asian Women in Britain*, Québec: Daraja Press

Appendices

Appendix 1 – Interview questions

Strand 2c: Interviewing South Asian women who use alcohol

Aims of interview:

1. Explore first-hand lived experiences of problematic alcohol use among South Asian women
2. Explore the role identity, belonging and stigma play in helping or hindering their access to alcohol support.
3. Explore the role of family and the wider community in helping or hindering their access to alcohol support.
4. Identify what enables South Asian women to identify problematic alcohol use and where they seek help.
5. Understand what would alcohol-using South Asian women like to see offered to them and by whom.

If the woman becomes upset:

- Pause recording.
- Ask if she is okay and offer some water
- Offer to stop the interview
- Offer contact information for relevant people to talk to

Open with an introduction about yourself and the project. Ensure the woman is comfortable being recorded and take them through the consent form. When consent form has been signed and she has asked any questions, proceed with recording.

1. So (name), I really appreciate you giving me your time today, can you tell me a bit about **why you decided to talk to me about your own experiences of alcohol/drug use**? (A1)

2. We know that women may start using alcohol or drugs in social settings or with their partners, so **can you tell me a bit about your first experiences of using alcohol/drugs? (A1)**
    - Childhood/adolescent experiences

3. We know that women's drinking/drug use is judged differently, and often harsher than men,
   Have you noticed this in your own community? (A2)

4. Often family/friends/community can hold certain views of women's substance use, and as a result, women often feel stigmatised, especially women from certain religious or ethnic communities. Has this been your experience? (A2, A3)
    - Can you tell me more about that?
    - Motherhood

5. We know that for many women, they may try and hide that they're using alcohol/drugs from family or friends, was this your experience? (A3)

- Can you tell me more about that?

6. For many women, they realise that their use may be an issue at different points, such as when their physical health or mental health is impacted, or maybe there was an incident with a family member or friend, **can you tell me a bit about when your use started to become a worry or a concern to you? (A1, A3, A4)**
    - Did you speak to a family member or friend about this?
    - What did they suggest?

7. People who seek help often speak about the shame that they feel, and we've heard this when speaking to women, and those who are mothers, to what extent has that been an issue for you? (A2, A3)

8. What we've learned so far in this research, is that many people from South Asian communities don't access support from traditional alcohol/drug services, often because they can't identify with the people who are there. Did you speak to drug alcohol services, or seek professional support for your use? (A2, A4, A5)
    - Can you tell me a bit more about this?
    - Is there anything you would change about the support you received?

9. We know that most alcohol or drug services don't necessarily meet the needs of people from BAME communities, especially women, **if you could design a service for women like yourself, what would you like to see included in the support offered?** (A5)

10. Can you tell me what place alcohol/drugs has in your life now? (A1)

11. What are your hopes for the future? (A1)

12. Is there anything else about your experience that stands out, or that you feel is important to share?

(Name) Thank you for being so generous with your time today, on behalf of the research team on this project, we really do appreciate you support.

- Give them debrief information
- Give them their voucher
- Tell them what will happen with the interview
    - It will be transcribed
    - The team will analyse it
    - We'll create a pen-portrait/biographical story
- Are they happy for us to contact them through email to share their pen-portrait so they can check they're happy with it, add or amend to it if they want.
- Give them the information about the planned workshop session and ask if they would be interested in taking part, and if we can contact them in the coming months about this.

Alcohol use among women
Can you help us?

Are you a woman with Indian, Pakistani or Bangladeshi background who has a current or previous history of problematic alcohol use? We want to hear your experiences to help inform how support is offered to women like you.

This study is focused on women from South Asian communities who identify as having a problematic relationship with alcohol. As such, we want to have a one-to-one chat with you to understand your experiences of problem alcohol use and support (if you sought it).

The information you share will be kept anonymous and confidential. You will receive a £20 voucher for your time.

If you are interested in taking part, please contact Dr. Surinder Guru (07425631004 or S.Guru@mmu.ac.uk) for more information.

Thank you

ALCOHOL CHANGE UK

Manchester Metropolitan University

SUAB Substance Use and Associated Behaviours Research at Man Met

AVA Against Violence & Abuse

KIK IT

EACH Enabling Change Rebuilding Lives

BAC-IN 2 LIFE CULTURE CONNECTION BELONGING

Appendix 3 – Participant Information Sheet

South Asian women and alcohol use.
Supporting solutions for South Asian women: Developing models for alcohol use support

1. Invitation to research
You are invited to take part in our research which explores South Asian women's experiences of alcohol or drug use where substances had led to difficulties or problems in your life.

Our names are Sarah Fox, Sarah Galvani, Naima Iqbal and Surinder Guru, and we are researchers from Manchester Metropolitan University.

Before you decide to take part in this research, it is important for you to understand why it is being done and what it would involve. Please take time to read the following information carefully, and get in touch with us if you have any questions; contact information can be found at the bottom of this information. Thank you for your interest in this research.

2. Why have I been invited?
This study is focused on women from South Asian communities who identify as having a problematic relationship with alcohol. As such, you have been invited because we want to focus on your experiences of problem alcohol use and support (if you sought it). We want to conduct one-to-one interviews with you to help us understand how your identity as a South Asian woman may impact your alcohol use and help-seeking, and we also want to know, based on your experiences, what support is needed for women who experience problematic alcohol use.

We will also be conducting focus groups with non-alcohol-using women from the South Asian community, and, focus groups with alcohol practitioners to explore how they respond to problematic alcohol use. We hope that the information collected during this study will help to improve and expand the services offered to South Asian women. This research has been funded by Alcohol Change UK (ACUK) as part of their New Horizons 2020 grant focused on groups, communities and alcohol harm.

3. Do I have to take part?
It is up to you to decide. We will describe the study and go through the information sheet, which we will give to you. We will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw at any time, without giving a reason.

4. What will I be asked to do?
If you are happy with the information provided in this information document, and you have asked any questions you may have, we will organise a date, time and location to hold the interview. The interview can be held in person, on the phone or online. If you want to hold the interview online or on the phone, we want to make sure you are in a place where you feel comfortable talking about your experiences, where nobody can hear you. If you want to meet in person, we can host it in an office with our partner organisation.

The length of the interview will depend on what you want to share with us, but we expect it to last between 40minutes and one hour. During the interview, we will ask you questions about your life before you used alcohol, your experiences of alcohol use, the support you may have accessed, your thoughts of support services and your hopes for the future. Overall, these questions will help us understand your experiences of alcohol use and support and will enable us to make recommendations to services.

Before the interview begins, you will be asked to sign a consent form prior to the. This will be stored electronically on a password protected file, or if hard-copy, in a locked cabinet before being uploaded to a password protected file and the hard-copy destroyed. We will record this interview on a digital voice recorder. When you are ready to start the interview, the person interviewing you (Surinder Guru) will press 'record' and begin asking you questions. When the interview is complete, the interviewer will press 'stop'. The interviewer will then give you a £20 voucher for your participation for an outlet of your choice, and debrief information.

After the interview, the recording will be uploaded to a laptop and encrypted with a password. The recordings will be transcribed by a member of the research team. We will then anonymise the transcript, which means we will remove any information that identifies you, your family or friends or the place that you live. Once we have anonymized the transcript, we will delete the recording from the computer.

A member of the research team will then read through your interview and create a pen-portrait (a biographical account of your life based on what you told us). The pen-portrait will then be sent to you by email (or post if you prefer) for you to check for accuracy and you will be asked to send this back to us.

Following the creation of the pen-portrait you will be invited to attend a half-day workshop in your city. This is optional, and you do not have to take part. The workshop will include the research team and other women who have participated in interviews. At the workshop the research team will present the initial findings from the project and have an open discussion about this, including a session where you tell us what your ideal service would look like, and a creative session where you can use arts and crafts to respond to your pen-portraits. You can take these pieces home with you, or you can donate them to the project and we will use them as part of our final outputs to share with services. Following the workshop, you will be given another £20 voucher for an outlet of your choice.

5. Are there any risks if I participate?

We understand the sensitive nature of this study and that it may be hard to discuss some of the issues raised due to their personal nature. You do not have to answer any questions you do not feel comfortable with. You can end the interview at any time without giving a reason.

If you become upset during the one-to-one interview with our research team, we will pause the recording to give you an opportunity to feel ready. If you decide you do not want to continue, or if our researcher feels you are too distressed, they will stop the interview and your recording will be deleted if you wish.

We will provide you with debrief information listing services you can contact if you feel you need support, and we would encourage you to speak to a trusted friend or practitioner after the interview.

You do not have to attend the workshop, but if you do, you are free to leave at any time if it becomes too overwhelming or you change your mind. Because this is a workshop for women who have also taken part in an interview, there is a possibility that you may know each other, however, the workshop will be governed by confidentiality and all participants will be asked not to repeat what they hear outside of the workshop group.

6. Are there any advantages if I participate?
By taking part in this research, we hope that you will feel you have contributed to a project that seeks to create change for other women like you. Through engagement with the workshop, we also hope to foster a sense of shared identity and peer support with the other women who attend, and we hope that this can be carried on beyond this research. You will also receive two £20 vouches for your participation, one following the interview and one following the workshop.

7. What will happen with the data I provide?
When you agree to participate in this research, we will collect from you personally identifiable information.

The Manchester Metropolitan University ('the University') is the Data Controller in respect of this research and any personal data that you provide as a research participant.

The University is registered with the Information Commissioner's Office (ICO), and manages personal data in accordance with the General Data Protection Regulation (GDPR) and the University's Data Protection Policy.

We collect personal data as part of this research (such as name, telephone numbers or age). As a public authority acting in the public interest we rely upon the 'public task' lawful basis. When we collect special category data (such as medical information or ethnicity) we rely upon the research and archiving purposes in the public interest lawful basis.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. After participation you may withdraw your interview data up to one month from the date of interview, and if you participate in the workshop, you may withdraw your artwork up to two weeks from the date of the workshop. After this point, your data cannot be withdrawn as it will be analysed and used in public outputs.

We will not share your personal data collected in this form with any third parties.
If your data is shared this will be under the terms of a Research Collaboration Agreement which defines use, and agrees confidentiality and information security provisions. It is the University's policy to only publish anonymised data unless you have given your explicit written consent to be identified in the research. **The University never sells personal data to third parties.**

We will only retain your personal data for as long as is necessary to achieve the research purpose. Every effort to protect your identity will be made. To respect your privacy and keep your identity hidden, we will use fake names for any information that may identify you. We will replace your name with a fake name and we will use information such as: (name of city) to replace any places you may mention that may show your identity. Your name will only appear on the consent sheet you are asked to fill in if you take part in this research. These consent forms will be kept in a locked cabinet in the university before being scanned and stored on a password protected file, the hardcopy will then be shredded.

There may be exceptional circumstances when confidentiality has to be broken. If the research team feel that what you reveal during the interview means that you are in danger, there is a threat to your wellbeing, health or safety, or that you reveal that someone else's health, wellbeing or safety is in danger, we may have to pass that information on. If confidentiality is to be broken you will be fully informed of this and the processes it will entail.

For further information about use of your personal data and your data protection rights please see the University's Data Protection Pages.

8. What will happen to the results of the research study?
The anonymous transcribed interviews and quotes, information gathered at the workshop, and pen-portraits will be used in a range of outputs including the final project report, academic journals, academic and non-academic events, printed and virtual outputs such as service literature and posters. **Participants would not be identifiable in any report or publication in any way, as explained above**.

9. Who has reviewed this research project?
This project has been reviewed by the research team, colleagues at MMU as part of a peer reviewed process, our funders ACUK and their review panel and the Arts and Humanities ethics committee at MMU.

10. Who do I contact if I have concerns about this study or I wish to complain?
If you would like to take part in this research, or would like to speak to a member of the team to find out more, please contact:

Dr Sarah Fox – Principal Investigator
07795929028
SFox@mmu.ac.uk

Dr Surinder Guru – Research Assistant
07425631004
S.Guru@mmu.ac.uk

If you have any concerns/complaints about the project please contact:
Prof Sue Baines,
313 Geoffrey Manton Building, Rosamond St W, Manchester, M15 6EB
+44 (0)161 247 2511
s.baines@mmu.ac.uk

If you have any concerns regarding the personal data collected from you, our Data Protection Officer can be contacted using the legal@mmu.ac.uk e-mail address, by calling 0161 247 3331 or in writing to: Data Protection Officer, Legal Services, All Saints Building, Manchester Metropolitan University, Manchester, M15 6BH. You also have a right to lodge a complaint in respect of the processing of your personal data with the Information Commissioner's Office as the supervisory authority. Please see: https://ico.org.uk/global/contact-us/

THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

Appendix 4 – Consent form

Interviews
South Asian women and alcohol use.
Supporting solutions for South Asian women: Developing models for alcohol use support

Participant Identification Number:

	Please tick your chosen answer	YES	NO
1.	I confirm that I have read the participant information sheet version ..... , date ..... for the above study.	☐	☐
2	I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐	☐
3	I understand that my participation is voluntary and that I am free to withdraw from the interview at any time without giving any reason and without my legal rights being affected.	☐	☐
4	I agree to participate in the project to the extent of the activities described to me in the above participant information sheet.	☐	☐
5	I agree to my participation being audio recorded for analysis. No audio clips will be published without my express consent (additional media release form).	☐	☐
6	I understand and agree that my words may be quoted anonymously in research outputs.	☐	☐
7	I wish to be informed of the outcomes of this research. I can be contacted at: _____	☐	☐
8	I give permission for the researchers named in the participant information sheet to contact me in the future about this research or other research opportunities.	☐	☐
9	I give permission for a fully anonymised version of the data I provide to be kept on an Open Access Repository (an online archive system) so that it can be used for future research and learning.	☐	☐

Name of participant Date Signature

Name of person taking consent Date Signature

When completed: 1 for researcher, 1 for participant to keep with the PIS

Research about alcohol use among South Asian women

Can you help us?

Are you a woman with Indian, Pakistani or Bangladeshi background?

This study is focusing on alcohol use among women from South Asian communities. Whether you use alcohol yourself or not, we want to hear your views by conducting a group interview with you and other women in your community.

The information you share will be kept anonymous and confidential. You will receive a £20 voucher for your time.

If you are interested in taking part, please contact Dr. Surinder Guru (07425631004 or S.Guru@mmu.ac.uk) for more information.

Thank you

ALCOHOL CHANGE UK

Manchester Metropolitan University

SUAB Substance Use and Associated Behaviours Research at Man Met

AVA Against Violence & Abuse

KIK IT

EACH Enabling Change Rebuilding Lives

BAC-IN 2 LIFE CULTURE CONNECTION BELONGING

Appendix 6 – Focus Group topic schedule and vignette

Introduction
Thank you for taking part in this focus group today, (introduce ourselves) as you are aware we're doing some research around alcohol use and women from different South Asian communities. As part of it we're speaking to women who don't have any problematic use so that we can understand your views on the issue. As the information sheet highlighted, these group will be recorded and used to inform our work, but your identity will remain anonymous. You will receive a £20 voucher for your time which we will discuss and organise after the group. Before we begin has anyone any questions?

1. So, before we get into the questions, would each of your mind just for the purpose of the recording, tell us your name, your ethnicity, and your religion please? And just to remind you, that your name will be taken out when we write this up, it's just to help us identify the different voices. So, I'll begin...
2. Great, thanks for that, so as part of this research I've been learning about the relationship between culture, religion and alcohol use, can you tell us, what you understand regarding the rules around alcohol use in your religion?
    a. Are the same rules reflected in your culture?
    b. And does this apply to men and women or are the rules different for each gender?
    c. Were you raised with these rules in mind/strictly enforced?
    d. Do you think people still follow these rules?
3. Have you seen a change in alcohol use among other members among your community and family/friends in recent years? Can you tell me a bit more about that? Gender? Age?
4. We've read that more and more younger women from varying South Asian communities are taking more drugs and alcohol than before, have you noticed that? What are your thoughts?
5. We've read about the potential consequences for women who have a problem with alcohol, what do you think they may be?
6. We've also heard the word *izzat* mentioned a few times while doing this study, how do you think it may impact and woman who was drinking problematically?

Vignette
Your friend recently confided in you that she's worried about her daughter who is married with three young children. Your friend doesn't drink and neither does her husband, so her daughter was brought up with no alcohol in the house. Your friend's daughter is a stay-at-home mum, and all her children are now in primary school, her husband often works late. Your friend explains that every time she visits her daughter recently, she notices empty wine bottles in the recycling bin, and often she can smell alcohol off her daughter's breath. She is concerned that her daughter may be drinking too much as her grandchild mentioned 'mummy's night juice'. Your friend said she asked about the bottles in the bin, but her daughter said that it must have been the neighbours'. Your friend doesn't know what to do and worries about other people finding out.

What would your thoughts be regarding this scenario? What advice would you give your friend?

1. What do you think are the main reasons that a woman may not seek support, like the scenario above?
2. How do you think religion can play a part in supporting women with alcohol problems?
3. How do you think your community can provide support for women with alcohol problems?
4. Do you know any services or support that exists in your community for women who have problematic alcohol use?
5. What types of support do you think are needed in your area? Where do you think, they should be based to have a chance of making a change?
6. Is there anything else, anyone wants to add about what we've talked about today?

Appendix 7 – Interview questions for practitioners

Practitioner Interview Questions

1. Tell me a bit about your organisation
    a. How did you become involved with it?

2. What are your experiences engaging people from BAME communities in support – as an organisation or in your individual role? What about South Asian communities?

3. What do you do to reach out to BAME women, especially South Asian women?

4. Are there any difficulties or barriers engaging BAME women, especially South Asian women?
    a. How has stigma played a role in women's access?

5. Do you work with other BAME organisations in the community?
    a. How did this come about?
    b. What do you do in collaboration?

6. We know there can be some difficulties gaining access to different community groups, especially those that are influenced by leaders, have you experienced any difficulties or challenges working with different community groups? How have you overcome these challenges?
    a. What about the role of families, have you experienced any difficulties engaging women because of stigma from families?

7. What impact does the current (a) policy landscape and (b) commissioning landscape have on your ability to provide specific services to BAME communities.

8. Since the rise of the BLM movement, have you changed how you offer support or work in the community? Have you seen a change in how people in the community respond to you or engage with you?

9. Obviously covid-19 has had a big impact on service provision, and there's been a big impact on women, especially around domestic abuse, have you seen any notable changes in women's access since the pandemic? What about co-existing issues like domestic abuse, which we know has risen in the past 2 years?

10. Would you like to share anything more on this topic?