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Alcohol drinking among Black and minority ethnic communities (BME) in the United Kingdom

Introduction

Alcohol is a socially acceptable and legal drug within the UK. Today it plays a focal role in people's socialising and to a certain extent excessive drinking is accepted and tolerated as a flip side to the pleasure it brings. Subhra and Chauhan (1999)[1] point to the fact that although certain of the BME communities place restrictions on the (mis)use of alcohol (for religious or cultural reasons) there already exist complex patterns of alcohol use within these communities. Furthermore members of these communities are members of the British society as a whole and sensitive to the mores of that society.

"*The ease of availability of alcohol, its legality and the advertising messages highlighting social and material benefits mean that alcohol use by the Black communities is here to stay and likely to increase*".[2] (The same can be said of other ethnic groups such as the Irish community and other newly arrived migrant groups such those from the Balkans.

Alcohol mis(use) puts members of these communities at risk of a whole range of problems both for the drinker themselves and for their relatives and friends, compounded, in many cases, by a community culture which discourages open discussion of alcohol issues.

This factsheet aims to provide an overview of alcohol use and misuse within different communities and the problems they experience as a result of excess drinking based on findings from key studies/surveys of the last twenty years. It also looks briefly at the difficulties these groups have found in trying to access help for substance misuse problems and points to a model for future development to support these communities.

The factsheet will focus on the Afro-Caribbean and various South Asian communities living in the UK. These communities have been the most visible migrant groups of the last forty years and have experienced a high degree of racism and discrimination resulting in social and economic disadvantage - all factors found to be associated with increased risk of alcohol misuse. The dearth of available data makes it extremely difficult to examine other communities. However, there is a clear need to develop research across a range of communities to help understand the problems experienced by newer arrivals.

Note that the quality of the data in the area of alcohol use in BME communities varies greatly. Subhra (2002) in his introduction to this research advises that "*factors such as sample size and composition, transferability of patterns of drinking from specific areas of the UK and factors such as the class, rural or urban origins, gender and age*"[3] make it difficult to draw firm conclusions and extrapolate from these findings. Currency of data is another major problem that has an impact on the ability of service providers and commissioners alcohol agencies to gauge accurately the levels of hazardous drinking and alcohol-related harm in their communities. Paucity of evidence is one strand feeding into the whole debate surrounding the failure of many alcohol agencies to respond to the needs of members of the BME communities. This issue needs further examination when looking at ways agencies can develop "culturally sensitive" services to reach diverse communities.

However, a review of existing data can usefully point to where more research is needed in future.

Background

Demographic breakdown

The minority ethnic population has increased from 3 million in 1991 to 4.6 million in 2001 and accounts for 8.1% of the total population (excl. Northern Ireland). The majority of people in ethnic minority groups live in conurbations with 45% of all ethnic groups living in London.[4] Geographical distribution of different groups across England varies widely. For example, 2% of the population of England and Wales are Indian, with Leicester having the highest proportion (25.7%) and Black Caribbean account for 1.1% of the total population but form more than 10% of certain London boroughs.[5] The uneven distribution of ethnic groups across the country needs to be borne in mind when considering proportions of groups using or misusing alcohol. Although certain percentages appear small, in some areas the actual numbers of people affected could be high.

Defining ethnicity

The concept of ethnicity has no universal or fixed definition, it has different meanings across time, place and people. A consideration particularly relevant to research and to service provision is the distinction between ethnicity as an identity and ethnicity as a category.

As an identity, ethnicity is described as a process by which people create an identity to distinguish themselves

Figure 1a Weekly alcohol consumption : men[7]

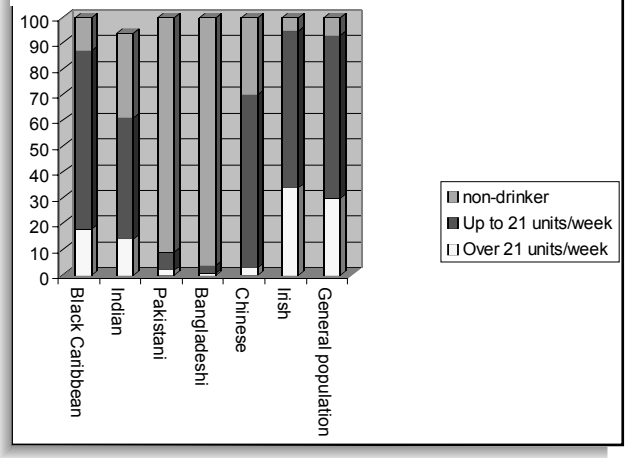
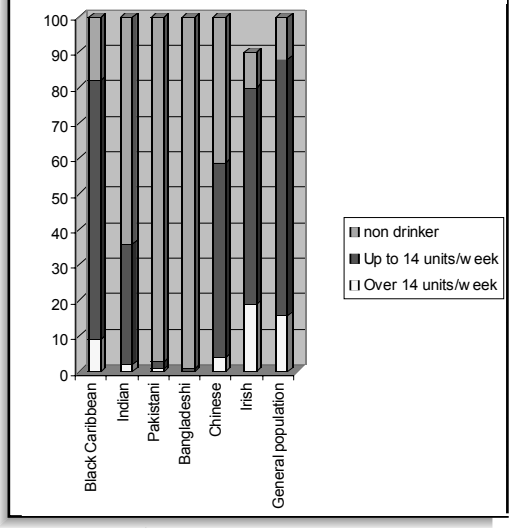


Figure 1b Weekly alcohol consumption: women[8]



from others. Ethnicity is frequently associated with country of origin and/or skin colour. However, individual ethnic identities may be informed by a range of factors including country of origin, religious and political belief systems, language, skin colour, social circumstances and so on.

As a category, ethnicity is described as the process by which external categories are created and imposed by others and with which people so categorised may not necessarily identify. Ethnic categories, such as those used in the Census and other datasets, do not provide information about the range factors that inform individual identity. As such, they are not in themselves useful if the data required needs to take account of the broader range of factors. For example, the category South Asian encompasses three different countries, numerous languages, a diversity of belief systems and so on. Ethnic categories are most frequently used in research and in datasets that inform planning, provision and monitoring of services. It is important therefore, to be aware of their limitations and the extent to which they provide the required information. Note that there is a lack of consistency in the various descriptors used across many of the existing studies of drinking in BME communities.

Patterns of drinking

Current situation

The 1999 report "*Health of minority ethnic groups*" provides the most current national set of data on drinking among ethnic groups, based on self-report questionnaire interviews. Key findings are as follows:

- Men and women from all minority ethnic groups, apart from the Irish, are less likely to drink alcohol than the general population. Overall they drink smaller quantities and all minority groups report drinking less frequently than the general population except for the Irish, who drink as frequently.
- 7% of men in the general population are non-drinkers compared to 5% Irish, 13% Black Caribbean, 30% Chinese, 33% Indian, 91% Pakistani, and 96% Bangladeshi
- 12% of women in the general population where non-drinkers and similarly among most ethnic groups, higher proportions of women than men were non-drinkers, 10% Irish, 18% Black Caribbean, 41% Chinese, 64% Indian, 99% Bangladeshi.
- The age-adjusted risk ratio for proportions of men drinking over 21 units per week were all below 1 (risk ratio for the general population) being .59 for Black Caribbean, 0.44 for Indian men and less than 0.1 for other groups (except the Irish men, 1.13). Age adjusted ratios for women drinking over 14 units per week were all below 0.5 (except Irish women, 1.17).
- Figure 1 a and b provide a picture of excess drinking across different ethnic groups.
- On the heaviest drinking day in the last week 59% of the general population drank over 4 units compared to 74% of Irish drinkers, 50% Indian, 43% Black Caribbean, 21% Chinese (no figures are available for Pakistani and Bangladeshi men as so few drank in the past week). For women the proportion of women drinking over 3 units was 47% for the general population, 56% for Irish women, 36% Indian women, 35% Black Caribbean women and 30% Chinese women.
- In common with the general population, weekly levels of alcohol consumption decrease with age with the exception of Black Caribbean and Indian men.[6]

The figures show that despite the overall picture of lower levels of consumption among most minority ethnic groups a significant proportion of the Indian and Black Caribbean communities exceed weekly limits and among those who do drink, both men and women report exceeding the daily limits.

- Alcohol dependence is less prevalent in Black and Asian minority groups than in the general White population, with 60 per 1,000 of Black

adults dependent and of these both men and women experiencing mild dependence. Among Asian groups 25 per 1,000 are mildly dependent with the majority of these being men. This compares with 75 per 1,000 of white adults being dependent.[9]

- Among 11 to 15 year old adolescents from ethnic groups 82% from Asian communities said they never drank, as did 56% of those from Black communities, compared to 33% from White groups. However, 18% of Asian and 44% of Black adolescents did say they had tried alcohol compared to 66% of White adolescents. [10] (No other questions were posed around drinking among adolescents in different ethnic groups).

There are some significant limitations to the information provided by the 1999 Health Survey:

- It fails to distinguish between ethnic subgroups, particularly the South Asian groups, though community surveys have shown clear differences between the drinking patterns of the diverse communities which make up these populations eg of Sikh and Hindu men.
- Most of the data is age-adjusted so the figures do not show varying patterns across age groups, though it is clear from figures provided by the General Household Survey that there are distinct patterns across different age groups within the general population. Nor does it show any differences between first and subsequent generations of people from different ethnic groups who might be expected to engage in different patterns of drinking behaviour.
- The data is based on self-report. Malseed (1990), in a study of young Asian and African Caribbean men in Preston, criticised the use of conventional questionnaires as being unsuitable when assessing people's private attitudes towards alcohol, with responses tending to present 'public' rather than 'private' accounts.[11] For those in Muslim communities in which alcohol consumption is forbidden, it would be very difficult for an interviewee to admit to drinking. Even among Asian communities that accept some levels of alcohol consumption, admitting to excess drinking or drunkenness would compromise respect for an individual or their family. [12]

One recent large community survey of second and subsequent generation people in BME communities in Birmingham and Leicester provides interesting comparative findings to this national survey (see fig. 3) [13]. It overcomes some of the shortcomings outlined above by using interviewers drawn from a wider range of ethnic groups, a modified set of questions combined with confidential interviewee settings outside the home. This survey focuses on a younger age group with 93% of the sample being aged less than 40 years.

In terms of non-drinking, it shows that:

- 5 in 6 Pakistani men do not drink, 3 in 4 Bengali men and 2 in 3 Hindu men do not drink.
- 4 in 5 Hindu women, 3 out of 4 Sikh women, 9 out of 10 Pakistani women and 5 in 6 Bengali women choose not to drink.

Figure 3 Drinking among second and subsequent generation Black and Asian communities

Sometimes drink	Black*	Indian Hindu	Indian Sikh	Pakistani	Bengali
Men	136 (87%)	57 (34%)	116 (71%)	24 (15%)	23 (24%)
Women	113 (80%)	45 (22%)	52 (25)	10 (8%)	19 (15%)
Drank at least fairly heavily last week					
Men (>21 units)	54 (34%)	6 (4%)	39 (24%)	6 (4%)	5 (5%)
Women (>14 units)	26 (18%)	7 (3%)	10 (5%)	2 (2%)	5 (4%)
Drank very heavily last week					
Men (>50 units)	23 (15%)	3 (2%)	10 (6%)	0 (0%)	2 (2%)
Women (>35 units)	6 (4%)	2 (1%)	1 (<1%)	0 (0%)	1 (1%)

*The term 'Black' includes Black Caribbean, Black African and Black British

However, it also shows:

- higher proportions of men and women from each groups admitting to drinking alcohol occasionally.
- across the survey as a whole, heavy drinking days are not unusual and Black men in particular reported a high rate of very heavy drinking.

Another recent 2002 survey of 16-25-year olds from Pakistani, Indian and Chinese communities commissioned by the Greater Glasgow NHS Board [14]shows that higher proportions of the younger members of Asian communities do drink, with 19% of Pakistanis saying they drink, as do 49% of Indians and 73% of Chinese. Interestingly this study also shows that although young Pakistanis are less likely to drink, those that do drink consume the highest number of alcohol units on average (13.8 units per week compared to 7.94 for young Indians and 4.76 for young Chinese.

These are both community studies focusing on younger members of BME communities and neither includes samples of white contemporaries for comparison. However, they do help to develop a picture of alcohol use and potentially problematic misuse at a local level, which contrasts with the national image of alcohol misuse as not being a major problem for minority ethnic communities.

Trends

Establishing trends in drinking in BME communities is particularly difficult. The last national survey carried out by the Policy Studies Institute in 1994 [15] showed:

- Low levels of drinking among Muslim and Pakistani and Bangladeshi groups with 1 in 12 admitting to drinking occasionally.
- 1 in 3 African Caribbean people (50% men and 23% women) reporting drinking once or twice a week - much less than the white members of the sample.
- Clear gender differences among South Asians with 40% of Indian men and 32% of East African

Asian men drinking compared to 6% and 8% of women in these groups.

These findings are similar to the 1999 survey. However, unlike the General Household Survey which uses similar sample structures and sets of questions, these surveys do not chart gradual year-on-year changes. Only one study by Denscome and Drucquer,[16] of drinking among 15-16-year old Asian adolescents charts change over a seven year period between 1990 and 1997, showing that although there was a greater increase in drinking among white males and females than among their South Asian contemporaries, the gap was reducing, with South Asians being more likely to drink in 1997 than in 1990.

A picture of alcohol use and particularly misuse in BME communities in the 1980s and 1990s is more clearly drawn from local or community studies. Key findings showed:

- 62% of Hindu men drinking within weekly guidelines (<21 units per week) but 11% drinking above recommended levels (>21 units per week) [17]
- of all South Asian groups, Sikh men were most likely to be regular drinkers and drink over recommended levels [18]
- White males were 3 times as likely compared to Black men to drink more than 20 units per week and no Black men reported getting drunk weekly compared to 6.5% whites [19]
- 10% of Muslim men in Birmingham reported drinking in the previous year, of those who did drink, the average consumption was high. [20]

Although the levels of misuse among members of BME groups in national and local surveys appear small in comparison to White people, these drinking patterns indicate that certain members of these communities are at risk of harm from their drinking.

Alcohol-related problems

The prevalence of alcohol-related problems in these communities can be measured by a number of indicators including:

- indicators of physical harm - such as hospital admission rates for known alcohol-related disorders and mortality rates for causes likely to be alcohol-related.
- assessment of people's engagement in risky behaviour related to drinking.

(Another indicator of harm is analysis of people's attitudes to their drinking. Cochrane and Bal in their 1990 study carried out such an analysis but given the age of the study and limitations on space in this article, their findings will not be examined in detail)

Physical harm

Despite low reported levels of drinking across BME communities, reviews such as the one carried out by McKeigue and Karmi in 1993 show that people in these communities have experienced harm as a result of their drinking. Key studies show:

- A survey of alcohol-related psychiatric admission to hospitals in 1981 showed surprisingly high rates for men born in India of 75 per 100,000 compared to 49 per 100,000 for native-born admissions. In addition the rate of admission had increased by 121% for Indian men between 1971 and 1981 compared to a 75% increase for native born admissions. Although the rate for Black Caribbean men was considerably lower (27 per 100,000 in 1981) this group had also experienced a 75% increase since 1971. [21]
- A survey of Asian GPs in Coventry in 1985 noted that a significant proportion of their male patients had alcohol-related problems. Of an estimated 3,500 male Punjabi Sikhs on their lists 370 (11%) were reported to be at risk and of 2,500 male patients from Muslim, Gujerati and 'other' groups, 195 (8%) were drinking problematically. [22]
- A survey of mortality from likely alcohol-related causes from 1979 to 1983 showed that for South Asian men death from chronic liver disease and cirrhosis was more than 2.5 times the national average. Asian women and both Caribbean men and women were closer to the national average. [23]
- A West Midlands study of deaths resulting from alcoholic liver disease (ICD codes 571.0 - 571.3) showed that deaths increase almost threefold from 2.8 per 100,000 deaths in 1993 to 8 per 100,000 in 2000. Rates of increase were similar for white men, white women and Asian men (with Sikh men making up 80% of the Asian group). However, Asian men had a standardised mortality ratio 3.79 times that of white men, based on the 46 deaths among Asian men compared to 12.4 deaths expected by extrapolation from the white male population. [24]
- A study by Harrison, Sutton and Gardiner of standardised mortality rates (SMR) for disorders known to be alcohol related for members from different ethnic groups born in Ireland, South Asia and the Caribbean from 1979 to 1991 suggests a changing pattern in alcohol-related mortality for these groups. This statistical analysis of deaths from causes known to be alcohol-related suggests that the Irish and South Asian born groups had higher rates of alcohol-related mortality than the general population during this period. However, where the SMR for the Asian has stayed fairly stable, in contrast the SMR for the Caribbean has risen by 1.768 times (1991 SMR for people from the Caribbean was 115.2 and SMR for people from South Asia 157.7) [25]

McKeigue's and Karmi's review contains numerous references to small studies that highlight the vulnerability of South Asian groups to the physical ill-effects of alcohol with Sikh men in particular experiencing alcohol-related health problems. There are fewer studies of African or Caribbean groups and those that exist suggest their experience is closer to the native-born population. A variety of reasons have been put forward for this increased vulnerability, ranging from different drinking patterns, different physiological make-up and stress caused by migration. Significantly Harrison et al. point to pressure of socio-economic disadvantage experienced by many members of these groups in terms of low

occupational status, low pay and poor housing on their arrival in the UK.

Unfortunately many of these studies are around 15 to 20 years old. They deal mostly with first generation migrants and are heavily orientated towards men. There is a pressing need to update findings about the physical harm alcohol causes within different ethnic groups and particularly among different generations and different sexes.

Risky behaviour

This section of the paper is drawn exclusively from Purser et al.'s 1999 study of second and subsequent generation members of ethnic minorities. It is based on questions from the Birmingham Untreated Heavy Drinkers Project (BUHD [26]) looking at drinking and related behaviour in the last week rather than a 'usual week'. The survey asked 22 questions about the extent to which interviewees engaged in different behaviours after drinking or while drunk. See fig 4 for a breakdown of activities by different ethnic groups.

The survey found that 38% of male drinkers and 18% of female drinkers reported experiencing 7 or more drink-related risks in the last year. The proportion of men experiencing risks exceeds women in most cases. Analysis of the behaviour shows men tending towards aggressive actions, arguments and involvement with police, and women more concerned about working below par, getting involved with strangers and feeling ashamed of their drinking. The first group activities could be described as those directed at other people and the second group are those harmful to oneself.

The issue of how alcohol-related behaviour affects other people is a significant one for members of different ethnic groups, particularly South Asian groups, where proportions of married men engaging in risky behaviour are likely to be higher than in the general population. Shaikh and Naz in their account of Asian women's experience of alcohol problems describe how of Asian women accessing EACH's support services between 1991 and 2000, 35% have sought help for their own drinking and a further 27% have sought help for dealing with a partner's drinking. [27] In particular women are at potential risk of physical harm from their partners where alcohol plays a role in domestic violence.

One area that needs further investigation is the role alcohol plays in crime within BME communities, particularly as the above findings suggest for men in these communities, drinking is a precursor to being involved in fights or being stopped by police. One recent study of substance misuse and criminality among White and Asian youths in West London in 1996/97 found that although Asian youths were more likely to use opiates than white youths, there was also an association with excess drinking. Of young Asians youths 8.8% drank between 28-50 units a week (10.8% of White youths drank at this level) and 5.9% of Asian youths drank over 50 units a week compared to 21% of White youths. [28]

Figure 4 Percentages of drinkers reporting risky drink-related activities

Black*	Hindu	Sikh	Muslim	Risky action	Black*	Hindu	Sikh	Muslim
136	57	116	50	N =	113	45	62	29
32	16	14	34	Gone with strangers	15	9	27	21
57	35	32	42	Walked alone	25	24	35	45
30	23	38	28	Gambled	3	9	2	3
43	14	25	20	Unsafe sex	20	11	8	14
18	7	11	14	Taken drugs	10	11	12	14
38	25	32	48	Argued with bouncers	16	7	14	10
43	26	35	32	Other risks	31	20	29	31
22	9	23	20	Had an accident	7	7	10	10
48	25	37	48	Aggressivene ss	20	13	17	17
40	25	35	50	Been in a fight	13	13	8	10
19	16	23	34	Damaged things	8	2	0	3
2	9	4	10	Neglected a child	4	2	2	10
25	21	30	30	10	10	7	6	14
22	11	25	36	Been thrown out of a pub or club	4	9	4	7
26	9	20	26	Police stop	5	2	0	7
10	0	8	10	Been convicted	1	2	0	3
29	26	27	24	Other	20	20	14	10
24	23	22	26	Lost days work	19	27	31	28
35	32	31	30	Worked poorly	28	24	33	21
7	7	10	8	Been warned at work	2	2	2	3
18	19	22	16	Family criticism	12	4	10	3
14	19	12	16	Felt ashamed	14	22	8	14

*The term 'Black' includes Black Caribbean, Black African and Black British

Reasons for drinking and factors that predict alcohol use and misuse

Some of the most common reasons given for drinking by members of different ethnic groups include: providing self-confidence, improving social relationships, relaxation and improving health or wellbeing. Most of these are also reported in surveys of White people's motivation for drinking. However, given that drinking alcohol is not an accepted norm for both men and women in many ethnic groups, factors that predict alcohol use or misuse are of some significance.

Cochrane in a 1995 survey of White, Black and Sikh men in the West Midlands found that regular attendance at a church or temple was a clear indicator of frequency and level of drinking among Black and Sikh men. Those attending on a weekly basis drank less frequently and had lower levels of consumption. For the men in this study there was no clear correlation between factors such as marital status or occupational status.

Purser et al. in their 1999 study provide a much more comprehensive analysis of predictors of drinking for both men and women, showing clear gender differences. For men the one clear predictor was identification with religion. For women there were a number of significant predictors include

- being more qualified
- being employed
- being single
- fewer people living at home

Figure 5 Variables indicative of social cultural and religious position and their relationship with signs that drinking might be of concern[33]

	Men (2 or more signs of concern)	Women (1 or more signs of concern)	Signs of concern associated with being:
Age	ns	**	Younger
Education	ns	**	More qualified
Employment	ns	**	Employed
Marital status	ns	***	Single
No of people in the home	***	***	Fewer living at home
Identifying with religion	***	***	Less closely identifying with their religion
Identify as British	ns	*	Stronger identity as British
Identify as ethnic groups	ns	*	Weaker identity with ethnic group
Close friends from ethnic group	ns	***	Fewer friends from ethnic group

Ns = no significance
* = just significant
** = moderately significant
*** = highly significant

- being less closely identified with their religion
- weaker identify with ethnic group
- fewer friends from own ethnic group.

Alcohol misuse

Studies suggest a number of trigger factors for problematic drinking that are specific to BME communities.

- The association between social inequality and substance misuse is widely acknowledged. A higher proportion of Black and other ethnic groups experience social inequality in the form of unemployment, poor housing, poor access to decent education and health services. However, more research is needed to find out how the association between social disadvantage and substance misuse operates in practice within different ethnic groups, as inaccurate generalisations could result in inappropriate response to the problem. [29]
- Racism is a significant risk factor. This can take the form of overt racism towards individual members of ethnic communities and debilitating effect of discrimination in all areas of life. Shaikh and Naz also point to the problem of internalised racism affecting succeeding generations resulting in poor self-esteem or self-hatred. These in turn can result in mental distress, poor relationships, self-harm, parasuicide and substance misuse. including excess drinking. [30]
- Intergenerational conflict is another problem that is more acute in minority ethnic groups where it is often a clash of two generations and two cultures. This type of conflict can lead to feelings of isolation for both parents and children. Coupled with internalised racism this can result in resentment that damages relationships and affects the long-term mental health of all concerned.[31]
- The analysis of drinking predictors above shows how differently men and women react to social and cultural influences or pressures. Within some communities, religious restrictions can lead to hidden drinking or heavy drinking sessions at home alone. Also in some Asian sub groups, women in particular are subject to additional pressures. Problems in relationships with partners or families can be compounded by cultural expectations of duties of obedience and loyalty in a woman. In addition Western and Asian expectations of women can lead to confusion and strain.[32]

It is often difficult to see how these various social and cultural factors affect people's drinking on an individual basis. However, Purser et al.'s analysis of men and women whose drinking shows signs for concern, helps to develop a picture of risk factors that predict problem drinking (see fig 5).

This study suggests that for men problem drinking is more likely to be associated with lack of religious identification and living in a smaller household. For women problem drinking appears most closely linked with a reduction in their own cultural network, including religious network and lack of social networks overall. However, various interpretations could be put on these findings. More investigations of this type across a range of cultures would be useful.

Help seeking

It's clear from earlier sections that a significant proportion of those from different ethnic groups are experiencing problems as result of their drinking. However, the picture is fragmented and an appreciation of the scale and nature of the problems is made more difficult by the low uptake of existing alcohol services. A 1999 audit of alcohol services in England and Wales found that of the 543 services only 37 reported making specific provision for different ethnic groups. [34] An analysis of clients attending services in 2002 found that 65% of services were able to provide data on the ethnicity of their clients. These services reported that 94.88% of their clients were White, 2.75% were Black and 2.78% were Asian. The proportion of clients from different ethnic groups varied widely across the country with 7.9% of clients in London services being Black and 3.45% of clients in the West Midlands being Asian.[35] However, with the higher concentration of certain ethnic groups in these areas, it is clear that they are under-represented given the potential level of need for alcohol services.

Alcohol support and treatment services, in common with other health services have a duty to be accessible to all sections of the community, so it is important to understand the factors that hinder access. This is a complex and contentious subject encompassing a number of inter-related themes.

On one hand is the issue of how services function in relation to various ethnic groups. On the whole the evidence indicates that from the 1960s into the 1990s, the majority of existing White-run services have not succeeded in developing accessible 'ethnically sensitive' services appropriate to the developing needs of BME communities.

On the other are a range of issues including:

- how people within minority ethnic communities

view alcohol services

- varying attitudes towards help seeking for alcohol problems and health services in general.

Much of the evidence is anecdotal and the few existing surveys suggest that attitudes vary widely between different ethnic groups, different sexes and different ages or generations. These are some of the main themes to emerge.

Members of these communities have tended to be unaware of the existence of alcohol services as a source of external advice/support. More recent surveys suggest that UK-born, more qualified men and women know more about helplines, charities, internet sites and self-help groups such as Alcoholics Anonymous.[36] Moreover the prominence of the abstinence model as opposed to a harm minimisation approach can make alcohol interventions less appealing/relevant to people within these different communities

Both men and women are inclined to seek help from GPs for alcohol-related problems. Surveys of health-related behaviour in general indicate that people from ethnic minorities make greater use of GPs, despite signs that they quality of consultation they received is less adequate than that received by their white counterparts. They also tend to make less use of other health services such as dentists, psychotherapists, home help etc.[37]

Alcohol services are perceived as being White-run for White clients. This assumption is based on a number of problems they could be expected to encounter. Many services are unable to provide counselling in a range of ethnic languages to match the ethnic make-up of their community, so clients often have to discuss their most intimate problems in a language not their own. Much of the counselling provided could be argued to be eurocentric in design and would have little relevance for the 'Black' psyche. [38]Previous experience of racism in White insitutions could make people from minority ethnic groups wary of letting down their guard, making them feel particularly vulnerable in a help-seeking situation.[39]

Cultural attitudes towards the use and misuse of alcohol can constrain an individual's help-seeking behaviour. Previous studies highlight concerns that community pressure and the need to maintain family honour - ('izzat') within Asian communities influences people to hide problems or avoid help-seeking. Loss of 'izzat' through excess drinking could potentially damage an individual's or a family's reputation leading to feelings of shame that might perpetuate drinking problems.[40] However, cultural ideas and attitudes impact in varying ways on different communities and individuals. In a small study of White and Asian men who stopped drinking without external treatment, the importance of family reputation, inclusion in a network of extended families and the existence of accessible abstinent social organisations were all major factors for men from minority ethnic groups, enabling them to stop drinking and reaffiliate themselves to their community. [41] Bakshi et al's study of young Asian drinkers showed that although a third of young Pakistanis thought their community would hide or ignore a person's alcohol problem, over two thirds of Indians and Chinese thought their communities would deal with it in the same way as the general population.[42] Purser et al.'s study showed that while among all the BME groups surveyed, using friends for advice was common, they were at least as likely to seek external advice from their GP as from friends and families. The study concludes that an understanding of the role of social networks both within a religious and family context could help parishioners in working with individuals with identified problems and with community leaders in health promotion work.

The way ahead

This article provides an analysis of drinking patterns and accompanying illnesses and personal difficulties that indicate that the scale of alcohol problems in BME communities is greater than expected and possibly on the increase. The situation is made worse by the fact that many within these communities appear less likely to seek specialist help from alcohol services. Much wider ranging and up-to-date research is needed to improve understanding of the problem. Some priority areas for further investigation include

- drinking patterns in African Caribbean communities
- prevalence of drinking in some of the smaller Asian groups including the Chinese and Vietnamese
- community studies of health problems and risky behaviour resulting from heavy drinking episodes
- research to look at the effectiveness of community safety and public health campaigns
- studies analysing health seeking behaviour, in particular the extent to which members of these communalities are directed towards mental health services and general hospital services, when an alcohol service would be more helpful
- an evaluation of three response that GP's make to people from BMEs that present with alcohol problems.[43]

Clearly it will take years to develop a robust level of evidence in all areas. At the same time there is an urgent priority to look at ways services can be "creatively adapted and innovated". [44] For many working in the field the continuing emphasis on the need for more research has deflected attention away from the reluctance or inability of mainstream services to develop local knowledge of the communities they service and to respond accordingly. Adebowale in a guide for alcohol practitioners speaks of a 'paralysis' which occurs because it cannot be decided whether to prioritise the White majority or minority ethnic groups whose drinking is not visible. [45] If service development for these communities cannot wait for accumulation of evidence in the conventional way, then arguably the role of research in the provision of appropriate services to BME communities needs to be reviewed.

There is a steadily increasing body of information and guidance for practitioners in the field. One major work is Adebowale's "Steps to a perfect Service" (1994) outlines a route by which predominately White-run services can create ethnic-sensitive generic services. Many of the steps suggested such

as assertive outreach, active engagement with local communities and employing Black service workers at multiple levels in an organisation have been used successfully in agencies such as ARP, Choices, and EACH in West London and Aquarius in the Midlands. The practical experience of services such as these can arguably make a valuable contribution to knowledge of alcohol-related issues with minority ethnic communities across the UK.

The Alcohol Education and Research Council (AERC) launched a project in 2002 which aims to produce a strategic framework document which will provide a survey of what is know about both the alcohol-related needs in BME communities and the preventative and treatment services available to them. It will also assess the gaps in knowledge and propose suggestions for future developments.

Research will play a specific role in the project:

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

In this model, research is not remote from practice and the latest findings are made available to inform practice.

(The project is being co-ordinated by Gersh Subhra, Senior Lecturer at the School of Health and Community Studies, University of Derby. The framework document is to be launched at a national seminar in 2003) contact: v.subhra@derby.ac.uk.

References

1 Subhra, G. and Chauhan, V. (1999) *Developing black services: An evaluation of the African, Caribbean and Asian Services* funded by Alcohol Concern's Grants Programme, Alcohol Concern,

2 ibid.

3 Alcohol Concern (2002) *100% Proof: Research for action on alcohol*, London.

4 www.statistics.gov.uk/ethnicityinbrief (2003) *Social focus in brief: ethnicity.*

5 ibid.

6 National Centre for Social Research and Dept. of Epidemiology and Public Health at the Royal Free and University College Medical School (2001) *The Health of Minority Ethnic Groups '99* (Health Survey for England) Office for National Statistics, London.

7 ibid.

8 ibid.

9 Coulthard, M, Farrell, M., Singleton, N., Meltzer, H. (2002) *Tobacco, alcohol and drug use and mental health*, Office for National Statistics, London.

10 National Centre for Social Research (2002) *Drug use, smoking and drinking among young people in England in 2001*, Office for National Statistics, London.

11 Malseed, J. (1990) *Alcohol in Asian and Afro-Caribbean communities*, School of Independent Studies, Lancaster University.

12 Cameron, D. et al. (2002) *What may be learned from so-called spontaneous remission in ethnic minorities?* New Directions in the Study of Alcohol, no.25, pp37-44.

13 Purser, R., Johnson, M., Orford, J., Davis, P. (1999) *Drinking in second and subsequent generation Black and Asian communities in the English Midlands*, Alcohol Concern, London.

14 Bakshi, N. et al. (2002) *Drug and alcohol issues affecting Pakistani, Indian and Chinese young people and their communities,* Greater Glasgow NHS Board, Glasgow.

15 Modood, T. et al. (1997) *Ethnic minorities in Britain, Diversity and Disadvantage,* Policy Studies Institute, London.

16 Denscombe, M. and Drucquer, N. (1997) *Diversity within ethnic groups: alcohol consumption and tobacco consumption by young people in the East Midlands,* Health Education Journal, vol 59, no. 4, pp340-350.

17 Cochrane, R. and Bal, S. (1990) *The drinking habits of Sikh, Hindu, Muslim and White men in the West Midlands: a community survey,* British Journal of Addiction, 85, pp759-769

18 ibid.

19 Cochrane, R. and Howell, M. (1995) *Drinking patterns of black and white men in the West Midlands,* Social Psychiatry and Psychiatric Epidemiology, vol 30, pp139-146

20 op cit. Cochrane and Bal 1990.

21 Cochrane, R. and Bal, S (1989) *Mental hospital admission rates of immigrants to England: a comparison of 1971 to 1981*, Social Psychiatry and Psychiatric Epidemiology 24, 2-11

22 op. cit. Purser, R., Johnson, M., Orford, J., Davis, P. (1999)

23 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, vol 28, no. 1, pp1-10

24 Fisher, N.C. (2002) *Mortality from liver disease in the West Midlands, 1993-2000: observational study*, British Medical Journal, vol 325, pp312-313.

25 Harrison et al. (1997) *Ethnic differences in substance use and alcohol-related mortality among first generation migrants to England and Wales*, Substance Use and Misuse 32(7&8), pp849-876

26 Orford, J. et al (1998) *The Birmingham untreated heavy drinkers project: Report on the first wave to the Department of Health*.

27 Shaikh, Z and Naz, F. (2000) *A cultural cocktail: Asian women and alcohol misuse,* EACH, London.

28 Dar, K. et al. (2002) *Ethnicity, patterns of substance misuse and criminality: a comparative study of White and Asian patient populations,* Journal of Substance Use, 7, pp244-250.

29 Wanigaratne, S., Unnithan, S. and Strang, J. (2001) *Substance misuse and ethnic minorities: issues for the UK*

30 op cit. Shaikh and Naz.

31 ibid.

32 ibid.

33 op. cit. Purser, R., Johnson, M., Orford, J., Davis, P. (1999)

34 Alcohol Concern (2001) *About alcohol services. How many, where, at what cost and what is achieved?,* London

35 Alcohol Concern (2002) *Report on the mapping of alcohol services in England,* September 2002, London

36 op. cit. Purser, R., Johnson, M., Orford, J., Davis, P. (1999) and Bakshi et al (2002

37 op cit. Madood 1997.

38 Confederation of Indian Organisations (1994) *Evaluation of Alcohol Concern's Grants Programme*, Alcohol Concern, London. NB 'Black' in this context includes Asian groups.

39 Harrison, L., Harrison, M. and Adebowale, V. (1996) *Drinking problems among Balck communities in Alcohol problems in the community,* ed. Harrison, L., London

40 op cit. op cit. Shaikh and Naz.

41 op cit. Cameron et al. (2002)

42 Bakshi et al. (2002)

43 op cit. Alcohol Concern (2002)

44 Subhra, G. and Chauhan, V. (1999)

45 Adebowale, V. (1994) *Steps to a perfect service "in Ethnic dimensions: culture, migration and alcohol and drug issues*" ed. Hyare, I. International Council on Alcohol and Addictions.

References for defining ethnicity

Smaje, C. (1995) *Health, race and ethnicity:making sense of evidence,* Kings Fund Institute, London.

Fenton, S. (1999) *Ethnicity: racisim, class and culture,* Macmillan press, Basingstoke