Summary of Findings

Black and Minority Ethnic Groups and Alcohol
A scoping and consultation study

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Summary of Findings

The main aim of this scoping and consultation project was to describe and explore the issues relating to drinking, related harms and service provision among Black and Minority Ethnic (BME) groups in England.

In particular the study focused on
- The national picture
- Cultural, social and economic factors relating to Polish migrants, Traveller and Gypsy groups and South Asians.
- Regional differences
- Equality Impact Assessments
- Service provision
- Good practice

Methods included review of the literature, analysis of regional statistics, interviews with Regional Alcohol Managers and interviews with service commissioners, project workers and PCT leads, mainly in London, East Midlands, Yorkshire and The Humber and West Midlands.

The National picture

Research and statistics have consistently shown that people from most minority ethnic groups have higher rates of abstention and lower rates of consumption than the majority white ethnic group. However, drinking varies greatly both between and within minority ethnic groups and across gender and socio-economic group, resulting in a very complex national picture of alcohol consumption and alcohol-related harm across ethnicity.

The report provides examples of diversity between and within ethnic groups and emphasises the importance of taking heterogeneity into account when conducting research and planning strategy and service provision.

Cultural, social and economic factors relating to drinking among Polish migrants, Traveller and Gypsy groups and South Asians.

These groups were chosen to illustrate the range of factors which influence drinking patterns, the needs for help and services, the responses of different ethnic groups to identification of alcohol-related problems and service use, and the responses of professionals to the identification and management of drinking problems among ethnic minority groups. Polish people were chosen to look at the problems affecting ‘new migrants’; Traveller and Gypsy groups have always occupied a ‘marginalised’ status in society but are generally not included in discussions on alcohol consumption in BME groups; South Asian groups comprise very different communities but are often placed in the same category and, as members of these groups have been in the UK for many generations, their experiences illustrate the changes which can occur over time.

The limited information available suggests that Polish migrants are more likely to drink spirits in heavy drinking sessions and more likely to drink at home or in public
spaces. Drinking to excess tends to be culturally acceptable in the Polish migrant culture and not seen as problematic. Homelessness is a compounding difficulty among Polish migrants as is their restricted access to social benefits and health care.

While information is, again, scarce, there also appears to be heavy drinking among the Travelling population. Heavy drinking – particularly among men - is common at celebrations but may also be used as a coping mechanism to deal with the stresses associated with the travelling life-style. Access to services is low and this group is reported as encountering considerable prejudice from service providers.

South Asian groups vary greatly in their tolerance and use of alcohol. Heavy drinking – particularly of spirits - is generally culturally accepted among men in the Sikh community and associated with hospitality. Because of the cultural acceptance, there appears to be a lack of awareness of drinking problems. While use of alcohol is prohibited in Muslim cultures, there may be problems with hidden drinking among some of the diverse Muslim communities across the UK. There are reports of hidden drinking among young women and older men and social drinking among young men in particular communities.

Service provision therefore needs to take account of social, religious and cultural differences such as belief systems, social exclusion, health status and stigma as well as other aspects of diversity such as gender, age and socio-economic status.

**Regional differences in BME populations and alcohol-related hospital admissions**

There is an uneven scatter of BME groups across the country and, because of the mobility of different groups and the changing nature of the BME population, regular review of local profiles is needed. Alcohol-related hospital admissions should be considered in relation to the number and types of BME groups in each Region and figures at Regional level can provide only a crude estimation of the extent of alcohol-related harm among different groups.

The North East has the highest alcohol-related hospital admission rate (per head of population) among the White British population but the lowest proportion of BME groups. The West Midlands has the highest admissions rate for White Other, Indian and Mixed (White and Asian) groups. The London region has the highest admission rate for White Irish people. However, there is a need for better data of this sort at the regional – and perhaps local – level.

**The use and utility of Equality Impact Assessments**

All new policies and services must be subject to an EqIA Part 1 which requires consideration of whether the new policy or service will have a negative or positive impact on equality. 62 replies were received to a survey sent to all PCTs to enquire about the implementation of EqIAs in relation to BME issues. The replies indicated that EqIAs are carried out at both strategic and service levels, leading to considerable variation in how they are undertaken and used. A number of explanations were given for delay or failure to carry out an EqIA. These included:

- EqIA not required / already integrated into other processes/ cover similar ground to other processes (e.g. needs assessments)
• Preparatory work underway or needed before EqIA can be carried out
• Workforce issues (resources, manpower etc.)
• Nature of the BME population (e.g. small numbers, scattered, affluent)
• Practical problems (e.g. need for appropriate information and partnership working)
• Problems gathering personal data (e.g. people are suspicious about providing personal data)
• EqIAs are not prioritised at the top
• They are forgotten about once completed (not part of a continuing drive towards inclusive services, and are not being revisited and revised as required)
• Low awareness of benefits of EqIAs and of how to use them effectively

There was a willingness to incorporate EqIAs into development processes and staff training. However, drinking among BME groups was not seen as a priority in some areas and some respondents stressed that this fact had to be acknowledged.

A number of principles of good practice regarding the development of EqIAs was extracted from the survey:
• Integrate EqIAs into other strategies and processes wherever possible.
• Secure commitment to developing EqIAs ‘from the top’.
• Ensure that adequate, appropriate data is collected and reviewed at intervals to provide a basis for EqIAs.
• Avoid over bureaucratisation and requirements to use ever-changing guidance/toolkits etc.
• Raise awareness of the importance and uses of EqIAs and ensure that staff have the knowledge and competence to use them within their developmental processes and procedures.
• Recognise that for some groups (in this case BME groups) the population composition and ‘scatter’ will influence what can be achieved and the priority which can be given to the group. Recognise that a focus on ethnicity may mask other, more important, cross-cutting factors.

**Service provision**

We do not know the extent to which, on a national or regional level, services are meeting the needs of BME groups. There is no data on identification and early intervention of alcohol problems among BME groups but data supplied by the National Treatment Agency (NTA) provides an indication of tier 3 and 4 service use. In most regions, more than 90% of clients were White. However, in London, Black, Asian and Mixed-race clients accounted for 17% of the total regional population - likely to be a consequence of the higher numbers of minority ethnic people in the London area. It is unlikely that such figures provide an accurate estimate of need.

Interview responses indicated that key factors influencing both the provision and uptake of services included personal, cultural and social factors as well as structural and systems factors. Both the survey and the interviews helped to identify barriers to BME groups accessing services. These were:
• Acknowledging there is a problem
• Identifying a problem (service provider/professional)
• Having knowledge about services and perceiving the service as appropriate/acceptable
• Language barriers especially with older people, new migrants
• Confidence and resilience to approach services
• Misperceptions about alcohol services/approaches
• Hidden drinking often linked to lack of family support/separation from family/fear of rejection by family and community
• Living in a close knit community where confidentiality and anonymity may be difficult
• Lack of knowledge about services and eligibility for services; lack of appropriate documentation
• Systematic factors: institutional and organisational racism, being ‘marginal to the system; lack of service flexibility, location of services.

Examples of good practice

Interviewees were asked to identify projects and approaches which they felt were examples of good practice. The report provides illustrative examples. Conclusions from the examples explored in the report are:
• Few BME specific approaches and services have been well described or evaluated and knowledge about different projects is not easily available
• Local responses are required to meet and keep pace with the needs of changing BME groups
• Approaches specific to BME communities may not always be needed
• Some BME specific approaches are not well received by the communities concerned and may be counter-productive
• There can be a danger of ‘culturalisation’ of groups which masks more important aspects of diversity such as gender, age or deprivation
• Service development needs to consider structural and systemic barriers to engagement and service access as well as personal and cultural characteristics
• There are many innovative projects and approaches but information and learning derived from the successes and failures is not well shared

It is suggested that existing models of cultural competence provide a useful framework for the development of approaches and services for BME groups, for opening up discussions on the need for BME specific services as opposed to incorporating diversity within mainstream services, and for facilitating the review and evaluation of BME projects.

Main conclusions and suggestions

BME groups are not homogenous and, when it comes to drinking, factors such as gender, age and socio-economic status may be more important than cultural and religious factors. Nevertheless, taking account of such cultural and religious factors is key to providing culturally competent services.

Barriers to service use include cultural and other factors relating to BME groups; but they can also involve dismissive attitudes and assumptions among service providers. Continued training and awareness raising among professionals is therefore needed.
Particular attention needs to be paid to new migrant groups, including their legal access to services. This is a moving picture and therefore requires regular review.

Equality Impact Assessments appear to be useful but need to be better integrated within current systems of needs assessment, service audit and review.

Regions vary greatly in the size, nature and scatter of their BME populations and these BME populations may not always be a priority for services. There needs to be on-going profiling of needs within BME populations, taking account of cross-cutting issues such as deprivation and gender. Regional Public Health Observatories might play a role here.

Assessing the need for alcohol services among BME groups can be highly sensitive: especially where data counter prevalent assumptions or where the decision is made not to set up BME specific services. In these situations, open discussion should be encouraged rather than closed down.

There needs to be better sharing of the many examples of good practice around the country through web based systems such as HubCapp and/or the Alcohol Learning Centre.