



**Alcohol consumption in black and minority ethnic groups and recent immigrants in Scotland: current situation on available information**

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# 1 Introduction

The report reviews the current available information on alcohol consumption in black and minority ethnic (BME) groups in Scotland and makes recommendations for future data collection. Understanding alcohol consumption and its consequences in certain population groups, particularly those which may not be adequately represented in national data sources and which may have differing health needs, is important. It is a precursor to effective and informed decision making regarding the most appropriate services and interventions to address those needs.

## 2 The size and distribution of the black and minority ethnic (BME) population in Scotland

The 2001 Census provides the most recent published information on ethnicity in Scotland (Scottish Executive, 2004)

- In 2001, the minority ethnic population was just over 100,000 or 2% of the total Scottish population.
- Over 70% of the total ethnic minority population were Asian (Indian, Pakistani, Bangladeshi, Chinese or other South Asian).
- Pakistanis were the largest minority ethnic group in Scotland, followed by Chinese, Indians and those of mixed ethnic backgrounds.
- Over 12% of the minority ethnic population described their ethnic group as Mixed.
- The total population of Scotland increased by 1.3% between 1991 and 2001. In this same period, the minority ethnic population increased by 62.3%.
- Glasgow City is the local authority with the highest percentage of minority ethnic inhabitants with 31% of the total minority ethnic population of Scotland living in the city. This is followed by Edinburgh City with 18% of Scotland's minority ethnic population.
- Other cities for comparison include Aberdeen with 6% of the total minority ethnic population and Dundee with 5.2%.

The 2001 Census also showed some demographic and social differences between minority ethnic groups:

- BME groups had a younger age profile than white groups.
- Pakistani and Indian people had the highest rate of home ownership. African and black Scottish people had the lowest rate.
- Overall, white people reported poorer health than people from other ethnic groups, although this varied by age.

Estimating the number of recent migrants from other parts of Europe to Scotland is more difficult. Ethnic groupings used in the Census forms have so far not been specific enough to identify people in any more detail than 'white – other'. In July 2008, the Scottish Government's new ethnicity classifications were published (Scottish Government, 2008), with recommendations for the 2011 Census to include the option 'Polish' since this was the most common nationality for migrants from the A8 countries (the eight countries that joined the European Union in 2004: Czech Republic, Estonia, Latvia, Lithuania, Hungary, Poland, Slovakia and Slovenia). It is followed by the category 'any other white ethnic group' with a free text box to capture other nationalities. Testing has shown that people from the A8 countries tend to use nationality or country of birth to record their ethnicity.

According to the General Register Office for Scotland in their 2006 mid-year population estimates, 'migration is the most difficult component of population change to estimate'. There are a large number of routes through which people may come to Scotland, for example to work or study, but there is no single complete source of information on migrants. Estimates can be drawn from other data sources. Three commonly cited sources of information are:

- International Passenger Survey
- NHS GP Registrations
- National Insurance Number registrations

Some local areas have estimated numbers of migrants based on National Insurance Number registrations although this includes those who are no longer in the country and excludes those who registered elsewhere in the UK and then moved to Scotland. However, this information is useful to allow some idea of trends in migration. Publications by individual councils or other local level organisations have provided some information.

Local studies have been carried out by individual councils or other local level organisations utilising national data. A selection of such studies are summarised below.

#### Grampian

The report 'A Study of Migrant Workers in Grampian; published in February 2007 (University of the Highlands and Islands, 2007) used National Insurance Number registrations as a measure of numbers of migrant workers moving to the area. A significant increase was observed in registrations from migrants from the A8 countries between 2002/03 and 2005/06, with people from these countries making up 50% of NI registrations in Grampian.

#### Tayside

From research carried out into the migrant labour population in Tayside (Communities Scotland, 2005) it was estimated that there were around 4000 migrant workers living in the area during the summer of 2005, based on NI registrations, with a significant increase reported during 2004/05. The majority of new migrants came from the A8 countries.

#### Highland & Islands

A study carried out on behalf of Highlands and Islands Enterprise (HIE) (University of Highlands and Islands, 2005) provided some information on migrant populations in the HIE area as well as Scotland, again with estimates based on NI registrations. Registrations of A8 country nationals increased from 115 in 2003/04 to 1320 in 2004/05 in the HIE area.

#### Scotland

The Highlands & Islands report also included estimates at Scotland level, with registrations increasing from 495 in 2003/04 to 7040 in 2004/05.

Reports listed above are examples of the information found published on websites. There may be more covering other areas and using different methods and measures.

### **3 Data sources**

Two types of data source can be examined for alcohol consumption in BME groups; surveys and routine data collection from health services. Each has strengths but also limitations. With these limitations in mind, surveys remain one of the best ways to undertake comparisons between different social groups within the population.

a) Population surveys are used to collect information on self-reported alcohol consumption in the general population. They can be carried out at national or local level. It is well documented that surveys tend to underestimate consumption for a number of reasons including recall and social acceptance of drinking (WHO, 2000; Catto & Gibbs, 2008). Survey questions often require the respondent to average out consumption, possibly leading to under reporting of less frequent heavier drinking (for example on special occasions).

Underestimating consumption may be particularly relevant when respondents are from religious or ethnic groups for whom drinking alcohol is prohibited or not considered socially acceptable.

Small sample sizes are a significant issue for many surveys of BME groups in Scotland. Some national surveys have used booster samples of BME groups (for example the Scottish Crime Survey in 2000 and the Health Survey for England in 1999) in order to facilitate analyses by ethnic group and enable comparisons between different groups. Also, care must be taken with translations to ensure the questions are not interpreted differently by non-English speakers and that translations do not change the meaning or tone of a question, causing results between groups to be incomparable.

Population surveys are however useful in showing drinking patterns, illustrating which groups of individuals are drinking and allowing comparisons between groups and also between time periods.

b) Information collected during contact with public sector agencies. Many public sector agencies, particularly health care services, gather information routinely during contact with their clients. General practice and hospital contacts tend to be driven by clinical demand and are therefore arguably less susceptible to social processes. That said, presentation rates are affected by individuals' decisions regarding whether or not to seek treatment. Less positively, the level of compliance in recording of ethnicity varies significantly across data collection systems and areas.

## **3.1 Surveys**

### **3.1.1 National Surveys**

#### **Scottish Health Survey**

The Scottish Health Survey currently provides information on alcohol consumption although detailed data on ethnicity is not reported. In the most recent published survey, carried out in 2003, 97% of respondents were white Scottish, white other British or white Irish.

Prior to the most recent survey in 2008, a review was conducted and one of the recommendations was that there should be an option to boost the sample for specific groups or geographical areas. Specifically, it was recommended that the survey should '*consider different, more efficient sample designs for collecting information on Ethnic Minorities and other subgroups of the population*'. The stratification available from the 2008 survey will be 'white' and 'non-white' but any further breakdown will not be available. It is possible that there may be a more detailed BME breakdown at the end of the four-year sweep (2008 – 2011).

#### **Scottish Schools Adolescent Lifestyle and Substance Use Survey**

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) collects information every two years on smoking, drinking and drug use among 13 and 15 year olds. It has collected data on ethnicity since the 2002 survey. The most recent information is available for 2006 for which around 6% described their ethnicity as something other than 'white'. The question on ethnicity used categories similar to those in the Census and included a self-defined 'other' category.

### 3.1.2 Local surveys

There have been a number of local surveys in recent years which have collected information on alcohol consumption in ethnic minority groups, primarily in the Glasgow area.

*(a) Greater Glasgow & Clyde Health Board surveys:*

NHS Greater Glasgow & Clyde carried out two relatively recent surveys: *The African & Caribbean; Pakistani and Indian Survey* and *The Chinese Healthy Living Survey* (NHS Greater Glasgow, 2006) to collect information on these groups, which had not been possible previously due to small numbers in the General Population Survey 2002. The sample sizes for each group were: general population: 1802, Chinese: 350, African & Caribbean: 244, Pakistani: 210 and Indian: 155. The surveys included questions on health behaviours, including whether or not respondents drank alcohol. The report published by Greater Glasgow NHS board in 2006 entitled "Black and Minority Ethnic Health in Glasgow" (NHS Greater Glasgow, 2006) compared results from General Population Survey and the two other surveys mentioned above, where questions were comparable between surveys. It was found that self-reported consumption of alcohol was much lower in participants from black and minority ethnic groups in comparison to the general population in Greater Glasgow (see Table 1). Also, only a small number of BME respondents reported drinking in the last week, which meant that further analysis of number of units of alcohol consumed could not be carried out.

**Table 1: Percentage of respondents in Greater Glasgow reporting that they did not drink alcohol, by BME group:**

<b>Ethnic group</b>	<b>% reporting that they did not drink alcohol</b>
Pakistani	91
African & Caribbean	64
Chinese	63
Indian	57
General population	30

*Source: NHS Greater Glasgow, 2006*

*(b) Review of prevalence data, Bhopal et al, 2004:*

A literature review carried out by Bhopal et al (2004) collated the results of a number of local surveys undertaken throughout the United Kingdom on tobacco and alcohol use among BME groups. Although the surveys were not consistent in how respondents were categorised (e.g. sometimes by nationality, sometimes by religion or grouped together into categories such as 'South Asian') and the questions asked varied, there was some agreement among them in terms of ethnicity and reported alcohol consumption. In the surveys, more European respondents reported current alcohol consumption than those in minority ethnic groups such as 'Indian', 'Bangladeshi', 'Pakistani' and 'Chinese' and in surveys which looked at religion, fewer Muslim participants reported drinking alcohol than other groups.

*(c) Alcohol consumption, perceptions of community responses and attitudes to service provision, Heim et al, 2004*

In this study, Chinese, Indian and Pakistani young people (16 to 25 years) living in Greater Glasgow were surveyed. The sample they obtained included 174 respondents (73 Pakistani, 47 Indian and 54 Chinese) and was considered to be of sufficient size to report statistically significant differences between groups.

Table 2 shows respondents reported alcohol consumption. The sample sizes used are very small, therefore results should be treated with caution. Muslim participants had the lowest level of reported alcohol consumption. However, amongst Muslims who did drink alcohol

(19%), a higher level of consumption was reported than in other religious groups although this was only statistically significant when compared to the non-religious participants. A similar observation was made in a survey carried out amongst men in the West Midlands (Cochrane & Bal, 1990) in which a community survey of random samples of 200 each of Sikh, Muslim and Hindu men and 200 white English-born men, matched for age, were interviewed using a structured questionnaire containing a retrospective drinking diary. Sikhs were most likely to be regular drinkers followed by white and Hindu respondents. The very few Muslim men who reported drinking consumed the most alcohol on average, although again, the very small sample sizes should be taken into account.

**Table 2: Alcohol consumption by BME group, religion and gender in Greater Glasgow:**

	Gender	Number (%) reporting alcohol consumption	Units of Alcohol Per Week in those who drink
<i>Ethnicity</i>			
Indian	Male	13 (50%)	8.8
	Female	10 (48%)	6.3
Pakistani	Male	9 (30%)	16.3
	Female	5 (12%)	7.6
Chinese	Male	18 (75%)	6.3
	Female	20 (71%)	3.1

<i>Religion</i>			
Muslim		13 (19%)	13.7
Sikh		11 (50%)	7.6
Christian		9 (82%)	3.9
Hindu		12 (50%)	8.4
Buddhist		5 (63%)	4.1
None		22 (67%)	5.0

Source: Heim et al, 2004

The survey found that self reported importance of religion was negatively associated with alcohol consumption, whereas having friends outside their own ethnic community and having friends within their own ethnic community who drank alcohol were both positively associated with alcohol consumption.

### 3.1.3 Wider UK studies

In the report 'Ethnicity and Health in Scotland: can we fill the information gap?' (Bhopal et al, 2005) it is suggested that information on health and ethnicity in England can be applicable to Scotland if standardised for age and social class. It is a reasonable assumption that BME groups in Scotland behave similarly to those in England in terms of alcohol consumption and it is worth looking at some of the research which has been carried out in other parts of the UK in order to identify issues which may help to improve the information available in Scotland.

#### National

Each year, the Health Survey for England focuses on a different demographic group. In 1999 and 2004, the health of minority ethnic groups was analysed in greater detail with the help of booster samples. The Health Survey for England for these two years incorporated booster samples for the most populous minority ethnic groups: black Caribbean, Indian, Pakistani, Bangladeshi, Chinese and Irish. For the 2004 survey, numbers of black African respondents were also increased. The booster sample allowed further analysis by age and gender, and also by income (and social class in the case of the 1999 survey).

In both the 1999 and 2004 surveys, men and women from all ethnic minority groups (except Irish) were more likely to report being non-drinkers. All minority ethnic groups who did report drinking, drank less frequently than the general population. The surveys also found that levels of alcohol consumption, including weekly estimates and amount consumed on the heaviest drinking day of the week, were lower among all minority ethnic groups, again, except Irish.

## **Local**

There are a number of local surveys carried out in other parts of the UK and although this report is concerned with information for Scotland, it is useful to look at these for possible lessons in methodology, previously unconsidered issues and future suggestions

A survey carried out in Leicestershire (Denscombe, 1995) illustrated the possibilities of aggregating groups together. The study suggested that without analysing by ethnic group the extent of alcohol consumption amongst white 15-16 year olds would have been significantly underestimated. The study also suggested that combining groups to create a larger 'South Asian' category was suitable for the analysis since the group did not vary a great deal in terms of results, particularly in comparison with results for white 15–16 year-olds. Although as mentioned previously, there are concerns about creating a larger 'South Asian' group as it would include a diverse range of people in terms of religion and culture.

Douds et al, (2003) examined diagnoses of alcoholic cirrhosis by ethnicity in a hospital in Birmingham over a period of 14 years. The study revealed that a significantly greater proportion of South Asian males had a diagnosis of alcoholic cirrhosis than would be expected if the sample of people with the disease reflected the ethnic composition of the local population. This may illustrate potential under reporting of consumption in surveys. Also, the observation was made that the majority of South Asian males with the disease were non-Muslim and were younger than white patients at first diagnosis (although this may just reflect the difference in the demographics of this population). It was suggested that along with possible cultural reasons for these observations, there might also be physiological reasons, with possible genetic differences between groups in terms of ability to metabolise alcohol and possible susceptibility to alcoholic cirrhosis. It may also be the case that those who do drink, drink more heavily. If this is the case, it reinforces the need for more research into alcohol consumption and its consequences among BME groups.

## **3.2 Routine data collection**

Health service data collection systems which cover the whole of Scotland could potentially be sources of information on harm caused by alcohol consumption in BME groups, although currently where information is collected, data on ethnicity is very incomplete.

### **3.2.1 Scottish Morbidity Records: SMR01 / SMR00 / SMR04**

The datasets collected from acute inpatient and daycase (SMR01), outpatient (SMR00) and psychiatric inpatient (SMR04) hospital episodes have the facility to allow the collection of ethnic group information but it is often not recorded. Around 17% of SMR01 and 11% of SMR00 records in the quarter July - September 2008 had an ethnic group assigned, although these figures vary considerably between NHS Boards so there may be an opportunity to analyse the information at local level for boards with better completion rates. There has been some improvement in recording throughout Scotland. Diagnostic data on alcohol related conditions are recorded by ICD10 codes.

For psychiatric inpatient information, it may be possible to analyse information on alcohol related diagnoses by ethnicity as there are about 5 NHS Boards in Scotland who use PiMS (Patient Information Management System) for their mental health service. This is not routinely reported. NHS Greater Glasgow & Clyde have been trying to establish the collection of ethnic group from this system.

The Equality and Diversity Information Development Programme within ISD deals with the collection of information to ensure quality and diversity are considered in healthcare settings. Current developments within the programme include improvements to how ethnicity is collected from SMR datasets. The Scottish Health Council 2007/08 set a target for the 14 Territorial NHS Boards to report the percentage of SMR00 (outpatient) and SMR01 (inpatient and daycase) records with ethnicity completed. ISD is providing support to NHS Boards by providing them with quarterly reports. Completeness data is available on the programme's webpage on the ISD site (<http://www.isdscotland.org/isd/5826.html>).

More information on this work can be found in the report "Patient Focus Public Involvement: providing more personal information to the NHS" which was published by ISD in 2007.

### 3.2.2 Scottish Drug Misuse Database (SMR25)

The Scottish Drug Misuse Database records new clients attending services for drug problems. Data on alcohol consumption is collected for those using drug treatment services but only for those in treatment for drug use other than alcohol. Ethnic grouping is recorded but numbers are very small for all groups other than 'white'. In 2007/08, around 1% of new clients reported their ethnicity as something other than white – less than would be expected if this group were representative of the Scottish population.

Table 3, shows the ethnic profile of new individuals reported to the database during 2007/08. This includes individuals reporting misuse of all illicit drugs and also records information on drug users' alcohol consumption. As the numbers for individual BME groups are very small, specific analysis for alcohol misuse would not be robust. Also, as with surveys, underreporting is likely to be an issue.

**Table 3: Ethnicity breakdown amongst clients entering drug misuse treatment for the first time, 2007/08:**

	Numbers	Percentage
<b>New Individual patients/clients</b>	<b>12 560</b>	
<b>Information available</b>	<b>12 224</b>	
White: Scottish	11 711	95.8
White: Other British	296	2.4
White: Irish	19	0.2
White: Any Other Background	110	0.9
Mixed: Any Mixed Background	16	0.1
Asian: Indian	16	0.1
Asian: Pakistani	18	0.1
Asian: Bangladeshi	x	x
Asian: Chinese	x	x
Asian: Any other background	13	0.1
Black: Caribbean	6	0.0
Black: African	9	0.1
Black: Any other black background	x	x
Any other ethnic background	x	x

0 (>0.0 & < 0.5)

x Information not shown to prevent calculation of entries <5.

Source: ISD Scotland (SMR25 Interim Database). Drug Misuse Statistics Scotland 2008.

### 3.2.3 General Practice

The situation regarding ethnicity information collected in primary care was summarised by Bhopal et al, (2005) ('Ethnicity and Health in Scotland: can we fill the information gap?'). There is currently no standard coding for ethnicity in the information collected within primary care.

The only centrally collected source of information from primary care at the moment is Practice Team Information (PTI), collected by ISD on consultations with GPs from a sample of practices in Scotland, mostly using the General Practice Administration System for Scotland (GPASS) system. This sample covers around 5% of the Scottish population and is broadly representative of the Scottish population in terms of age, gender, deprivation and urban/rural mix but not for ethnicity. There is not an option for recording ethnicity other than using a Read code, which would involve the clinician having to ask the patient and record ethnicity at every consultation. The Read code system is used by GP's and general practice nursing staff to record diagnoses, patient characteristics and activities carried out during consultation. Although there are codes available for country of birth, race and family origin, these are not routinely collected. There is no standard agreed coding rule for recording ethnic group and the 2001 Census categories have only been added recently.

General practice is potentially a good source of information for alcohol consumption information as it may be the first point of contact for some people seeking help or advice with their alcohol consumption.

The Quality and Outcomes Framework (QoF) remunerates general practices for providing good quality care to their patients and to help fund work to further improve the quality of health care delivered. Currently, GP's are being encouraged to collect information on patients' ethnicity through the QoF although the data is not extracted for national reporting. There was one QoF point for 2006/2007 for GPs who collect the ethnic group of new registrations. Further information on the QoF system can be found on the General Practice - Quality and Outcomes Framework section of ISD's website: <http://www.isdscotland.org/isd/3305.html>

There is currently a Delivering Enhanced Service (optional with some money attached) where some GP practices are collecting ethnicity and interpreting needs for all its population. Early exploration of the take up of this would suggest that less than 50% practices have taken up this offer.

### 3.2.4 Alcohol related deaths

The General Register Office for Scotland (GROS) collects information on cause of death for deaths registered in Scotland and alcohol related deaths are reported annually. Although different from 'consumption', information on alcohol related deaths is a useful addition to consumption information as an indicator of patterns and trends in harmful drinking.

The information on deaths from GROS does not include ethnic grouping but it does record country of birth. Country of birth is commonly used where ethnic group is not available. It is considered useful for recent migrants and older people but may be less suitable as a proxy for ethnic group amongst younger people who are more likely to have been born in Scotland, and also older white people who may have been born outside the UK, for example in India pre-independence. Bhopal et al, (2005) reported that around 40-50% of people from ethnic minority groups were born in the UK. This is higher among younger age groups, although alcohol related deaths tend to occur in older age groups so this may not adversely affect current analysis on alcohol related deaths by country of birth. This percentage may vary if

immigration levels vary with time. The country of birth recorded is reliant on the accuracy of the informant and it has been suggested that this might not be as accurate as self-reported information (Gill et al, 2005).

In Bhopal et al's 2005 report, it is described how standardised mortality ratios for coronary heart disease were calculated by country of birth. It may be that this analysis can be replicated for alcohol related deaths although it is possible that numbers would be too small to allow any meaningful interpretation of analysis.

### **3.2.5 Current and future developments**

As well as improving the recording of ethnicity, there is also the possibility of retrospectively adding ethnic group information to already submitted records. Bhopal et al (2005) looked at the reliability of using name search algorithms to assign ethnic group to a database based on surnames. They used SMR01 death records and also the DARTS database (Diabetes Audit and Research in Tayside Scotland). The algorithm was applied to the samples of the data containing South Asian and non-South Asian names. This was followed up with visual inspection by expert observers. It was concluded from this study that the algorithm alone is not sufficient for adding ethnic group to a record and additional visual confirmation by people who have a good knowledge of names from a particular ethnic group is necessary. There are issues with this approach, for example marriage may result in a surname, which does not reflect a respondent's ethnicity. It also does not work well with some ethnic groups who may not be so easily distinguished by name such as Afro-Caribbean groups. Additionally, the method does not support the current recommendation that ethnic group should be self assigned, as it is what people consider themselves to be which may influence behaviours such as alcohol consumption.

Current work at the University of Edinburgh, involving ISD, on the project "Ethnicity and Health in Scotland – making the information desert bloom" – is looking at improving the information available. Proposed work includes linking Census data to the SMR datasets and a report on the confidentiality issues this raises is included in Bhopal et al's 'Ethnicity and Health in Scotland: can we fill the information gap?' paper.

The National Resource Centre for Ethnic Minority Health (NRCEMH) has established an Information Network for Ethnic Minority Health. This was in response to concerns that NHS Scotland was not collecting sufficient information to support the Race Equality Schemes and 'Fair for All' action plans. The group consists of representation from NHS boards, ISD, Edinburgh University and the Social Care Data Standards Project. Work is ongoing to put together policies and develop systems to improve the collection of ethnic group information.

The National Resource Centre for Ethnic Minority Health (NRCEMH) has been integrated into the new Equalities and Planning Directorate with NHS Scotland embracing all the equality strands (age, disability, ethnicity, gender, religion, sexual orientation, transgender). It is providing a centre of expert advice and support to NHS Scotland on delivering equality and diversity, eliminating discrimination and reducing health inequalities.

### **3.3 Recent immigrants (in particular from Central and Eastern Europe)**

This group is being examined separately as quantifiable information on alcohol consumption among recent immigrants, from countries in Central and Eastern Europe, is not available through the previously mentioned data sources. Using the same ethnic groupings used in the 2001 Census in Scotland, they would not be identified any more specifically than as 'any other white background' although respondents who choose this grouping are requested to give more detail. Scottish Morbidity Records also use a classification system that would not be specific enough to identify European immigrants, as the only category available is 'white'.

The same problem with sample size occurs with the groupings used in population surveys mentioned previously. Specific surveys targeting these groups would be necessary to collect information, perhaps using a similar technique to the booster sample.

The report 'Equal Services?' published by NRCEMH as part of the Race Equality Assessment of Mental Health in NHS Boards points out the issue of alcohol problems among short-term and seasonal migrant workers from Eastern Europe and Turkey in NHS Tayside (NHS Health Scotland, 2005). These are mainly young men and a high level of alcohol misuse is reported, along with drug misuse, isolation and depression, which may exacerbate any alcohol problems. No figures are reported and the source is not stated. It is possible that this is also being measured in other parts of Scotland but may not be well documented and the quality and degree of information available may vary between areas.

## **4 Treatment services and access**

Some surveys have examined attitudes to alcohol problems and the willingness to seek treatment and advice.

Heim et al, (2004) looked at community perceptions and attitudes to services available in Glasgow amongst Pakistani, Indian and Chinese young people (aged 16 - 25 years) which, in addition to collecting information on alcohol consumption, also looked at attitudes to service provision for alcohol problems and whether they thought that there should be specialist services for black and minority ethnic service users. Respondents were asked about attitudes within their communities towards dealing with, alcohol. Seventy percent of Chinese and Indian respondents felt that their communities dealt with alcohol no differently from the general population, compared with only 40% of Pakistani respondents. Also, only 6% of Chinese and Indian respondents felt that their community ignored or hid the problem, compared with 31% of Pakistani young people. These results may be useful to consider in service planning and education.

In a similar study carried out by Bakshi et al, (2002), young people were asked whether they thought substance misuse services should be mainstream or specific to minority groups. There was no significant difference between Indian, Pakistani and Chinese communities in opinions on whether services should be specialised, with 54% of respondents believing that alcohol problems should be dealt with by mainstream services. Reasons for this included not wanting to be perceived as being treated differently and concerns about confidentiality in specialised services. However, there were also statements in support of specialist services. For example, it would give a clear message that alcohol problems are not exclusively a problem relating to white people, thus encouraging people to access services and take note of education campaigns. It was also suggested that in terms of language and culture, a specialist service might be better than a generic one. However, variation in attitudes would suggest that, like any other group in society, an ethnic group cannot be treated as homogenous in terms of alcohol-related problems and treatment.

## **5 Discussion and recommendations**

Although there is information available on alcohol consumption among the general population in Scotland, the challenge is to gather information on BME and recent migrant groups that is robust and meaningful.

Much of the information available on alcohol consumption within BME groups in Scotland is in the form of local surveys carried out in the Glasgow area. Scotland-wide information is not currently available from either national surveys or data collection systems. The use of a booster sample nationally has been considered but sample size and geographical variations in BME populations may make this difficult. It may be that survey information from large urban areas cannot be extrapolated to Scotland.

Health service data such as the Scottish Morbidity Record have the potential to be useful sources of information on alcohol related harm as they already have the field available to record ethnic grouping. However, completion rates for ethnicity are very low and improving this should be encouraged.

Information from general practice could be used if ethnic group were to be included. It should be present permanently on the patient record along with other personal details so that it would automatically be included in each consultation record.

With small populations to sample from, even in large urban areas, qualitative analyses may be a valuable addition to the evidence base, to improve awareness of issues such as attitudes towards alcohol and available services. These should include responses from all BME groups and from recent migrants in order to ensure that no issues, for example those relating to accessibility, are missed.

Age and gender are likely to be important factors in any analysis by ethnic grouping – culture changes and the influence of growing up in Scotland may show a difference in behaviours and attitudes to alcohol amongst young people compared to older generations. Again, qualitative research may be useful here, focussing on particular age groups. This is one area where booster samples would be valuable.

With studies consistently showing that BME groups drink less than white groups, the issue to focus on may not be alcohol consumption as such but using consumption information to identify where there may be gaps in health education, prevention and services, ensuring that BME groups are not excluded whether by language or culture.

There is a notable lack of information on recent immigrants. Ethnicity groupings are not specific enough to identify white European immigrants and no surveys have focussed on this group, yet they may face similar problems such as language barriers when accessing services. This is something that should be considered, perhaps by survey method.

Trend information would be very useful to see if alcohol consumption is changing among black and minority ethnic groups in Scotland. Re-running previous surveys and making them a regular occurrence, with booster sample, would be beneficial.

Overall, the currently available research and development work is encouraging and shows that the alcohol consumption in black and ethnic minority groups is an issue that is not being ignored. There is potential to have better information in the future on ethnicity and alcohol consumption as a result of current development work by ISD, the NHS and the Equalities and Planning Directorate. Stakeholders need to be convinced of the benefits of collecting information in order to encourage participation.

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