Ethnicity and alcohol

A review of the UK literature

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This literature review draws together recorded drinking patterns among minority ethnic groups in the UK over the last 15 years and considers the evidence for service provision and support.

A recommendation in implementing the Government's alcohol strategy, Safe. Sensible. Social. is to assess the need for and develop provision for black and minority ethnic groups. This need is heightened by the growing minority ethnic population and changes in consumption levels that may emerge over generations. The review explores differences in drinking patterns by ethnicity and the cultural and social contexts around which the use of alcohol is established and maintained.

This review:

- describes drinking levels as reported in national surveys and local research;
- considers processes and influences that help to explain why drinking rates among ethnic groups in a new country may change over time;
- examines help-seeking, support and service provision for minority ethnic groups;
- examines the extent to which services are equipped to respond to the needs of minority ethnic groups.

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Executive summary

This literature review explores the research on abstinence and drinking patterns among minority ethnic groups in the UK over the last 15 years. It considers whether rates of alcohol use are changing among ethnic groups and the possible impact of changes in drinking behaviour on the support and services needed. The report is based on a review of English-language publications focusing on alcohol and ethnicity that have been produced in the UK since 1995.

Background

Historically people from certain minority ethnic groups report lower levels of drinking, and fewer minority ethnic individuals present to alcohol services with problems related to alcohol misuse. Some research shows that drinking patterns in second-generation minority ethnic groups may start to resemble the drinking habits of the general population. At the same time, drinking patterns among some first-generation minority ethnic groups resemble those from their country of origin. Changes in the ethnic composition of local populations along with changes in drinking rates present challenges to services in providing accessible and culturally sensitive interventions that meet service users' needs. Consequently, an understanding of drinking patterns among minority ethnic groups, and their preferences for support and service provision, is required.

Summary of findings for different ethnic groups

Most minority ethnic groups have higher rates of abstinence and lower levels of frequent and heavy drinking when compared with the British population as a whole and to people from white backgrounds. Drinking patterns vary both between and within minority ethnic groups.

Mixed ethnicities

People from mixed ethnic backgrounds have high rates of current use and are less likely to abstain than people from non-white minority ethnic groups. People from mixed ethnicities also report relatively high rates of heavy and very heavy drinking compared with other non-white ethnicities. Differences between men and women for abstinence and frequent drinking are also less marked than for other minority ethnic groups.

White ethnicities

Irish people are less likely to abstain compared with other ethnic groups and with the general population. Deaths related to alcohol are higher for Irish men and women compared with the general population in England and Wales, and adults in higher income brackets are more likely to exceed recommended alcohol limits. Abstinence decreased among Irish girls between 1999 and 2004.

Deaths related to alcohol are higher for Scottish men and women in England and Wales compared with the general population.

South Asian ethnicities

Alcohol-related deaths are higher among Indian men compared with the general population, and between 1999 and 2004 Indian women showed an increase in drinking frequently and heavily. Indian women in higher income brackets are more likely to exceed recommended guidelines for alcohol consumption.

Sikh men show high rates of heavy drinking, and are over-represented for liver cirrhosis. However, second-generation male Sikhs are less likely to drink or drink heavily than first-generation male Sikhs. Conversely, reports of Sikh girls having ever drunk and drinking frequently increased in the 1990s.

Although abstinence levels dropped for Hindu boys in the 1990s, and second-generation men drink slightly more regularly than first-generation men, heavy drinking among this group has not

shown an increase. Hindus are less likely to drink if they report that religion is important to them.

People from Bangladesh are less likely to consume alcohol than other ethnic groups, and drinking rates are low amongst the group.

Drinking is polarised for people from Pakistan. Drinking rates remain low among Pakistani men and women, but Pakistani men who do drink consume more units of alcohol compared with those from other minority ethnic groups. A similar pattern emerges for Muslims; Muslim men and women are both likely to abstain, but, among drinkers, rates tend to be high compared with other religious groups.

Chinese ethnicity

Despite low levels of drinking among Chinese men and women, frequent and heavy drinking rose significantly for Chinese men between 1999 and 2004.

Black ethnicities

Black Caribbean people have higher levels of drinking than people from South Asian and Chinese ethnicities, but lower levels compared to people from white backgrounds and with the general population. They also have lower rates of alcohol-related mortality compared with people from white and South Asian backgrounds in the UK.

Black African people have higher levels of drinking compared with most South Asian ethnicities,but lower rates of alcohol use than the general population and people from white backgrounds. They also tend to report rates lower than Black Caribbean people.

Why drinking rates may be changing

Over time, minority ethnic groups who have settled in a new country may start to adopt new attitudes and behaviours, and their drinking rates may start to reflect the rates found in the general population of that country. Researchers suggest that these processes of acculturation help to explain changes in drinking rates observed in some ethnic groups. Stress associated with migration has also been linked with increases in levels of drinking among certain minority ethnic groups. The experience of moving to a new country can be affected by factors such as people's access to education and employment opportunities, socioeconomic status, and peer influences and lifestyle choices. For example, changes in socioeconomic status among some minority ethnic groups may help to account for changes in consumption levels. Indian, Pakistani, Chinese and Irish men, and Indian, Chinese and Irish women are less likely to abstain and more likely to drink occasionally if they are in the highest income brackets. Irish men and women, and Indian women, are also more likely to exceed recommended limits and drink heavily if they earn higher incomes.

In general, studies suggest that abstinence and low levels of drinking among non-white ethnic groups are associated with a strong ethnic identity, strong family and local community ties, continuing links with the host country, and maintaining religious values.

Qualitative research has identified sources of tension between generations in some minority ethnic groups. Young people from minority ethnic groups with strong religious ties that forbid drinking, or that are less tolerant of drinking among women, may hide their drinking for fear of repercussions and bringing shame on their families. This is evident among some young people belonging to the Muslim, Sikh and Hindu religions.

Support and service provision

Minority ethnic groups are under-represented proportionately among those seeking treatment and advice for drinking problems; they may not be aware of how they can be supported, or of specialist or mainstream services. In particular, Muslim men and those on lower incomes from minority ethnic groups have reported being unsure about where to go for advice. Reluctance to approach outside agencies can lead to underestimating the need among different ethnic groups.

Women and young people from South Asian ethnic groups, who are expected to be abstinent, may hide their drinking. For people who are socially excluded because of their drinking and are drinking at harmful levels, some research suggests that new approaches should be explored

to raise awareness and discussion of alcohol and related issues within these communities. Community engagement is advised as a way of reaching and representing socially excluded people, such as hidden drinkers, both in research and in guiding service development. Involving local agencies and stakeholders in consultations with those who are socially excluded, or their representatives, is key in developing service responses for such communities.

Preferences for approaches to support and intervention vary by gender and age for different ethnic groups. Many males and younger people would rather consult a GP about alcohol issues, with specialist alcohol services a less preferred alternative. Some individuals prefer the support or interventions that take place within a family or community context. For example, the family context is often preferred among black and Christian women. Viewing the drinker in isolation may not be sufficient, as problem drinking may have a negative impact on other family members, for example through violence or withdrawal from their community.

Research emphasises a lack of cultural sensitivity to the religious and cultural backgrounds of people from minority ethnic backgrounds within mainstream service provision. For alcohol services to become more accessible, the development of cultural competence within both mainstream and specialist services is advocated. Cultural competence can be realised through developing individual and organisational competence. Staff selection, education and training are highlighted as important for enhancing cultural sensitivity. Awareness of the many different ways in which racism can occur is a resounding theme, and tackling racism, which can be embedded within the systems of organisations, should be a key objective.

There is a case to be made for the development of specialist alcohol services that target minority ethnic populations, more particularly as the needs of targeted groups can become the focus of professional training, and understanding of cultural issues can be enhanced in such settings. Nevertheless, there are some reservations about developing specialist services. Individuals may have both special and more general shared identities that embrace characteristics other than their ethnicity, for example, gender, religion and sexuality. A focus on one aspect of their, often, complex identities and lives may deny other opportunities for engagement. One combined approach suggests that services should be developed in response to the needs of the population at the local level, with mainstream services continually adapting to ensure culturally sensitive provision, while targeted services are developed where required.

The research evidence suggests that, within mainstream and specialist alcohol services, opportunities need to be explored to integrate the preferences of minority group individuals. Furthermore, service provision in mainstream and specialist services needs to be flexible to adapt to socio-demographic changes in local populations, and to changes in drinking patterns and attitudes among some different ethnic groups.

1 Introduction

Background

The portrayal of drinking in the UK as excessive and problematic, particularly among young people, is a continuing focus of social, political and media attention. Yet historically, people from certain minority ethnic groups report lower rates of drinking and fewer minority ethnic individuals present to alcohol services for problems related to alcohol misuse. Research examining alcohol consumption among people from minority ethnic groups has not been approached consistently. Certain groups remain the focus of much research activity, for example people from the Indian subcontinent, while information on others such as Irish and Chinese people is lacking. This is not unique to the field of alcohol studies but has been evident in research into chronic condition illnesses in general, as Ahmad and Bradby (2007) point out: 'The excessive focus on South Asians and the record of measuring, analysing, but not necessarily tackling health disadvantage, are problems that remain to be addressed' (p. 1).

However, some key issues do emerge from existing studies. Notably, research indicates that patterns of drinking in second-generation minority ethnic groups may start to resemble the drinking habits of the general population, while rates resembling those from their country of origin are seen in people from first-generation minority ethnic groups (Hjern and Allebeck, 2004). Indeed, relatively recent research in Britain has revealed evidence that the drinking patterns of some minority ethnic young people are changing, and that young Asians are now drinking more than previous generations (Newburn and Shiner, 2001).

This review seeks to examine the existing research on drinking behaviours among minority ethnic groups. How and why these patterns might be changing, for some ethnic groups particularly over several generations of residence in the UK, will be addressed. To fully understand drinking behaviours, we need to explore the meaning of alcohol consumption in people's lives and in the context of their cultural background. While this may be pertinent among populations where alcohol is socially sanctioned, research among people from ethnic groups for whom alcohol is proscribed presents significant challenges, not least among young people whose drinking is hidden. To reveal the extent of problems, how they are perceived and the impact they have on the individual's and others' lives, representations of drinking behaviour among minority ethnic groups need to be explored. If drinking rates are changing, then this has implications for the provision of health care for minority ethnic groups, who traditionally face greater barriers to health service access than white British people (Drummond *et al.*, 2005). How support and services need to develop, and the challenges of breaking down the barriers to health service access will also be addressed.

Structure of the review

The first part of this review is concerned with establishing the recorded drinking rates of different ethnic groups in the UK over the past 15 years, and whether there is any evidence to suggest that these rates may be changing. The methodological difficulties inherent in conducting research on alcohol and minority ethnic groups are highlighted, along with the challenges in ascertaining whether drinking rates may be changing. The second part of the review discusses why there are differences in drinking rates and what factors may lead to changes in consumption patterns for people from different ethnicities. The cultural and social contexts in which attitudes and behaviours around alcohol are established and embodied are considered, along with possible tensions arising from conflicting cultural norms. In particular, theories of acculturation and bi-acculturation (see pp. 38 and 39 for definition) are drawn on as explanations for changes in the drinking habits of both the majority ethnic and the minority ethnic populations. Finally, the review reports on the service provision that is reportedly available for

different ethnic groups, with attention focusing on whether there are any gaps in services and barriers to access facing members of black and minority ethnic populations. The review concludes with recommendations for further research and the role of current research into attitudes and behaviours towards alcohol in different ethnic groups.

Location of relevant studies

The first stage of the review involved carrying out a literature search to identify relevant studies and information focusing on alcohol and ethnicity conducted in the UK since 1995. The electronic databases, search terms used, and results of the literature search for the UK are shown in Appendix 1. In addition, we chain-searched the bibliographies of initial articles. To try to identify any 'grey' literature and new studies we contacted 23 of the main authors in the UK and carried out an online search of the Alcohol Concern library and the NHS grey literature search engine, the Fade Library.

Our search then extended to the international literature to identify relevant studies. We attempted to identify literature from a range of other countries, despite the possibility that cultural differences might mean that the findings were not directly relevant to the UK. Appendix 2 shows the search terms and databases used in international searches. The references for all articles are included at the end of this report.

A next step involved discussions between the two main authors in deciding on the relevance of studies for the review. Mostly these were self-evidently relevant but, where there was doubt, a strategy for inclusion and exclusion was adopted. As the focus of our review is on the sociocultural and age-related context of drinking in minority ethnic groups, we did not include articles which were physiologically focused (e.g. genetic predispositions) or concerned biological markers of alcohol-related disorders. Neither were overviews or reviews used in which the data was considered to be too out of date. Despite this, studies able to illuminate trend data were retained. Official surveys on alcohol consumption, such as the General Household Survey 2005 (Goddard, 2006) and Health Survey for England 1999 and 2004 (Becker *et al.*, 2006; Erens and Laiho, 2001) have been included. The most up-to-date data on ethnicity from the General Household Survey is the 2005 report, which – due to low numbers of minority ethnic people – comprises combined data from the 2001 to 2005 surveys. Some surveys, such as the Health Survey for Wales and Health Survey for Scotland do not analyse results by ethnicity due to low numbers, for example in the Scottish Health Survey (2003), 97 per cent of respondents were White Scottish, White Other British or White Irish (Jarvis, 2009). The Smoking, Drinking and Drug Use survey among Young People in England reports information on drinking among young people annually (Fuller, 2009). Data from the

Criteria for inclusion

Only studies in which alcohol was a main focus were included, although, in a small number of cases, the use of other substances such as drugs, tobacco and *paan* (South Asian chew containing betel leaf) were also a focus of enquiry. However, the review reports on findings from alcohol only and does not address variations in substance use. A requirement for the ethnicity component of our search was that sufficient detail should be given regarding the ethnic groups sampled and also consideration of ethnic differences given in any findings and discussion. Most of the studies explored aspects of drinking and related issues such as associated harm, prevalence, service access and provision, and so on, with ethnicity as a focal issue. Studies were also included, however, which did not set out to test ethnicity as a variable, but where findings emerged subsequently involving links between ethnicity and alcohol-related behaviours or issues.

Some of the articles identified for this review also explore the religious background or affiliation of participants, as well as their ethnic background. Although religion was not included as a search term during the literature search, the importance of religion warrants consideration, and findings on alcohol consumption among religious groups from identified articles are included in the review.

2002–4 surveys were combined due to low numbers of minority ethnic people (Information Centre, 2007).

Some survey findings are reported in numerous publications and, to avoid replication, publications that draw on findings already included in the review, such as the General Household Survey, are not included.

In the international literature, even though some ethnic and indigenous populations such as Mexican Americans may not be represented within the UK in sufficient numbers, or even at all, we chose to include them when they provided consideration of theoretical issues relevant to the UK context, and when there was sufficient exploration of key issues to aid our understanding of drinking and ethnicity and lessons to be learned from the findings of such research. However, as countries in Western society vary considerably in terms of culture and drinking cultures, and the ethnic composition of the population differs between nations, comparing drinking rates among minority ethnic groups from the UK with drinking rates of minority ethnic groups in other Western countries was not deemed appropriate. In particular, it has been argued that direct comparisons with the United States are not straightforward, as the US is exceptional in a number of ways (Lipset, 1996). An important focus of the review is on young people and acculturation processes, so articles discussing and critiquing this dimension were included. For example, articles examining some of the minority ethnic groups found in the UK were considered, despite differing contexts, for example, Punjabis living in Canada. If cross-cultural or multicultural perspectives were being examined and issues raised thought relevant to the UK context, these were included. Therefore, international studies were used to provide insights into theories of acculturation and the experiences faced by migrants in new societies.

Although most of the studies reviewed date from 1995 onwards, some of the research studies analyse data that is now more than 15 years old. Consequently, these findings will not reflect current consumption patterns and may not be appropriate for considering current service provision and treatment. For a review of older studies on drinking among black and minority ethnic communities, see Harrison and colleagues (1996).

Britain's multicultural population

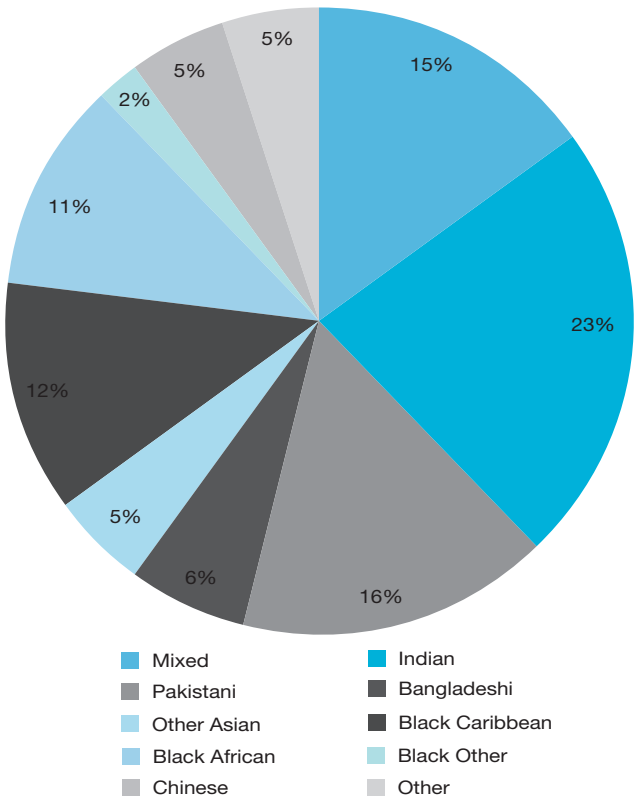
The first time that official data on the ethnic composition of the UK population was collected

Table 1. The UK population by ethnic group, April 2001

Ethnicity	Percentage of total population
White	92.1
Mixed	1.2
Asian or Asian British	
Indian	1.8
Pakistani	1.3
Bangladeshi	0.5
Other Asian	0.4
Black or Black British	
Black Caribbean	1.0
Black African	0.8
Black Other	0.2
Chinese	0.4
Other	0.4
All minority ethnic population	7.9

Source: Census 2001, Office for National Statistics; Census 2001, General Register Office for Scotland

Figure 1. Minority ethnic population in the UK 2001



was during the 1991 Census, where people were asked to which ethnic group they felt they belonged. The figures collected estimated the minority ethnic population to be 3.1 million, but these numbers are believed to have underestimated the actual minority ethnic population at the time (Hay *et al.*, 2001). The numbers of minority ethnic people have been increasing since; from the 2001 Census data the size of the minority ethnic population in Britain was estimated at 7.9 per cent or 4.6 million, an increase of 53 per cent since 1991 (Office for National Statistics, 2001). Table 1 on the previous page shows the breakdown of ethnic groups, and Figure 1 represents the composition of the minority ethnic population from the 2001 Census (data from Office for National Statistics, 2001).

Table 1 and Figure 1 show that Indian people comprise the largest non-white minority ethnic group, followed by Pakistani, Black Caribbean and Black African. Approximately 1 per cent of the white population are White Irish. The term 'White' includes British, Scottish, Irish, Other British and Other White. 'Mixed' ethnicity comprises White and Black Caribbean, White and Black African, White and Asian and Other Mixed.

It is estimated that the majority of the UK's minority ethnic population live in England (96.8 per cent) and that they are concentrated in urban areas, with nearly half living in London (Scott *et al.*, 2001).

Table 2. The UK population by religious group, April 2001

Religion	Percentage of total population
Christian	71.82
Buddhist	0.26
Hindu	0.98
Jewish	0.47
Muslim	2.78
Sikh	0.59
Any other religion	0.28
No religion	15.05
Religion not stated	7.76
All religious groups	***100.00***

Source: Census 2001, Office for National Statistics; Census 2001, General Register Office for Scotland

The 2001 Census also showed the diversity of religious affiliation in England and Wales (Table 2). A majority of respondents, more than seven out of ten, describe their religion as Christian. Fifteen per cent of the population report 'no religion'. The second largest religious group is Muslim, comprising nearly 3 per cent of the population (Office for National Statistics, 2001).

Since 1999, migration has been the biggest contributor to population growth in the UK, and is in part a consequence of EU enlargement. Between 2001 and 2004, almost two-thirds of the increase in population in England and the UK was due to people migrating into the UK (Office for National Statistics, 2001).

Definition of groups under study

'Minority ethnic' is sometimes considered to be a pejorative term, as it has connotations of 'less important' or 'marginal' (Parekh, 2000). It can also be numerically inaccurate in some contexts, where ethnic groups do not comprise a minority of the community. However, the term 'minority ethnic' is commonly used within the literature, and is used within this study to refer only to the collective population of people who have community backgrounds outside Britain. Different authors use different ethnic terms to describe the groups under study, and some terms that were previously deemed appropriate have later been deemed inappropriate (Bradby, 2003). For the purposes of this review, the terms are applied as they are used by the authors of the studies.

Within the UK, the term 'Asian' is most frequently applied to those coming from the Indian subcontinent, most commonly India, Bangladesh and Pakistan, but also Sri Lanka and Nepal. This contrasts with America where the term 'Asian' also includes Chinese, Taiwanese and Korean (Dar, 2002). In line with McKeigue and Karmi (1993), where the term 'Asian' or 'South Asian' is used in this review, it refers to people from the Indian subcontinent, unless otherwise stated.

Within studies, the term 'Black' often refers

to those of Black Caribbean or Black African origin, and also those who identify themselves as Black British or Black Other. 'White' is used to refer to those who are White British, but may also include Irish respondents and those from White European backgrounds. Appendix 3 provides a breakdown of how ethnic terms are defined by the authors of each study. Where terms for ethnic groups come from research studies and surveys, they are capitalised. Otherwise they are lower case.

Religious terms are used to describe a person's faith or their religious origins. Religious origins do not necessarily mean an individual is currently practising their faith (McKeigue and Karmi, 1993).

Describing people by ethnicity

Until the mid-1990s, research in the UK on drinking habits in adolescence failed to focus on the differences in consumption between ethnic groups (Denscombe, 1995). Additionally, not all studies that determine the ethnicity of their participants also record religious affiliation. Failure to do so risks ignoring the important influence of religion on drinking attitudes and behaviours. Categorising people into ethnic and religious groups as part of the research process can be problematic, but may be necessary for the purposes of analysing statistical data. There is considerable variation in the means by which people are categorised, often reflecting the emergence of new and more appropriate systems of classification. A full discussion of the problems encountered in classifying respondents by ethnicity is described in Appendix 4 and summarised below.

Inherent problems tend to arise from broad ethnic categorisations, for example, 'South Asian' and 'Black', which may fail to uncover differences within groups that are often more revealing than differences across groups (Denscombe & Drucquer, 2000). Broad categorisations may also be applied to the ethnic majority group; for example, 'White' groups tend to be classed together within the UK, which fails to account for the growth in populations from Eastern European countries. Within surveys there is often a 'Mixed' ethnicity option for people from more than one ethnic background, but there is rarely an option to expand on the nature of mixed ethnicity, which can vary considerably according to which ethnic groups the person belongs to. Broad categorisations occur most frequently in quantitative analysis, where researchers often collapse minority ethnic groups together, or remove them entirely from the sample due to small numbers, making it difficult to derive meaningful conclusions from the data.

The differences that become apparent when the diversity of groups are explored point to the inadequacy of the usual umbrella ethnic categories. If exploring this diversity is considered an important part of the research aim, then it brings into question the validity of making comparisons between groups within studies, and even comparisons across studies that apply the same ethnic terms in a fairly consistent way (Bradby, 2003).

Associations between alcohol and religion

Religion is closely linked to ethnicity and culture, and plays a role in influencing attitudes to alcohol use and levels of consumption. The influence of religion on drinking cultures is apparent both through the rates of lower consumption and higher levels of abstinence among the population as a whole in Muslim countries, and through lower levels of consumption in certain populations within Western societies (Ahlstrom and Osterberg, 2004). However, religions vary considerably in their toleration and sanction of alcohol use. A continuum of alcohol acceptance has been suggested for the way in which alcohol is regarded and used in South Asian religious groups in the UK (Cochrane, 1989 in Newburn and Shiner, 2001) ranging from being less socially acceptable among Muslims, with Hindus occupying a central position, then Sikhs, among whom alcohol is more socially acceptable. Acceptability can be linked to traditional religious views. Muslims are influenced by the Koran which prohibits alcohol use. The Sikh religion has also traditionally condemned use, but men in the Punjab drink recreationally and there is a belief among Sikhs that consuming an alcoholic drink helps a man to work harder and longer. For Hindus,

views are complex, with drinking being common throughout India's history, although drinking by members of higher castes is condemned in many religious books (Alcohol Concern, 1995).

In addition to variation in associations between religion and sanction of alcohol use, the importance of religion, how it is practised, and the meaning ascribed to it will vary for individuals and be mediated by other factors such as ethnicity, gender and age. Therefore, exploring the significance of 'religion' alone is problematic, without considering how the term is applied and how it may vary in significance for research participants. Identifiable differences in drinking behaviour according to 'religion' may help to distinguish one group from another, but may do little to further our understanding of the processes involved in maintaining or changing a group's practices.

The question arises of how such findings might be used to advance our understanding of the meanings and attitudes people themselves hold towards the different aspects of religion and alcohol use. This is relevant not only for further research but particularly for developing intervention and prevention programmes, and perhaps points to using more of a 'bottom-up' approach, encouraging greater involvement among participants themselves in early developmental work.

Data from the 2001 Census shows that White, Mixed, Black Caribbean and Black African people are most likely to report their religion as Christian. The Indian group reported a mix of religious backgrounds: 45 per cent of Indian people were Hindu, 29 per cent Sikh and 13 per cent Muslim. In contrast, 92 per cent of people from the Pakistani and Bangladeshi groups were Muslims. Just over half of all Chinese people in the Census stated they had no religion. One-quarter of people from Mixed ethnic backgrounds and 15 per cent of the English and Welsh population also reported having no religion.

Measuring alcohol use and trends in consumption

Government guidelines for daily maximum drinking levels in the UK are currently no more than three units per day for women and no more than four units per day for men (Department of Health, 2007: p. 13). Drinking over these levels is likely to lead to health risks. References in this review to drinking above the recommended levels mean exceeding these guidelines. Official surveys tend to use these guidelines as a measure of consumption levels, but comparing levels across research studies is challenging due to the range of measurements used to record drinking frequency, and the varying definitions applied to problematic or heavy drinking. These limitations are highlighted where appropriate in the review. In terms of determining whether drinking patterns are changing for different ethnic groups, trends are almost impossible to ascertain given the small numbers of ethnic groups present in studies on alcohol use and the variation in ethnic categories and drinking rates used within surveys and questionnaires. Apparent variation in drinking rates over time from cross-sectional surveys may be due to differences in sampling or methodology and changes in the minority ethnic population in the UK, and need to be interpreted with caution. Smith *et al.* (2009) highlight the problem in their recent review of drinking trends in the UK. However, where possible this review utilises longitudinal studies (e.g. Denscombe and Drucquer, 2000; Health Survey for England in Becker *et al.*, 2006); follow-up studies (Bradby and Williams 2006; Karlsen *et al.*, 1998) and comparisons between first- and second-generation minority ethnic groups (Nazroo, 1997; Vora *et al.*, 2000) to ascertain whether changes that can be observed in the drinking habits of the general population also apply to minority ethnic groups.

Drinking trends in the general population

In the general population in England, large-scale survey data suggests the proportion of adults who reported drinking in the week prior to interview and drinking on five or more days in the previous week has remained relatively stable since 1998. In terms of heavy drinking, the proportion of men averaging more than 21 units per week fell from 28 per cent to 23 per cent between 1998 and 2006, and the proportion of women exceeding 14 units per week fell from 15 per cent to 13 per cent over the same time period (Information Centre,

2009). The amount of weekly alcohol consumed by women fell between 2007 and 2008 from 9.9 units to 7.7 units (Information Centre, 2009). The number of men exceeding recommended limits also fell in the period between 2001 and 2007 in Scotland, with women's consumption remaining fairly stable (Bassett and Gilby, 2008). However, the authors relate the decreases in men's drinking to increases in the strength and size of some drinks. Conversely, in Northern Ireland, drinking prevalence and exceeding the recommended amount has increased for men and women between the periods 1986 to 2007 (Northern Ireland Statistics and Research Agency, 2007). Data from Wales shows little change in proportions of men and women who exceed recommended guidelines (Dolman *et al.,* 2007, in Smith, 2009).

Changes in drinking patterns are more noticeable among adolescents, however. Survey data show that the numbers of students aged 11–15 years having ever had a drink, drinking in the last week, and drinking at least once a week has been declining since 2001 (Fuller, 2009). Yes the amount of alcohol consumed by those who drank in the last week among the 11–13 age groups rose between 2001 and 2006 (Information Centre, 2007). In Scotland, young people's frequency and mean consumption of alcohol has remained fairly stable, though the mean alcohol consumption of 15 year olds has increased (Bromley *et al.*, 2005). Prevalence of alcohol consumption appears to have decreased recently for young people in Northern Ireland, but apparent trends may be due to measurement and methodology (Smith *et al.*, 2009).

Regional variation in drinking rates in the UK

Drinking patterns in the UK have been shown to vary by region. The General Household Survey carried out in 2005 found that adults in the south-east and south-west were most likely to drink on five days or more in the previous week, with adults in the north-east and London being least likely to do this. However, drinking over the daily recommended amount, and binge drinking, were more common in the north-east and north-west, and least common in London (Information Centre, 2007). Drinking patterns also vary between England, Wales, Scotland and Northern Ireland (see Table 3 below for a comparison of rates).

Table 3. Regional drinking rates in the UK

Study	Age	Measurement	Rates (%) by region		
Goddard, 2006	16+			Male	Female
		Drank last week	England Scotland Wales Great Britain	**73%** **75%** **68%** **72%**	**58%** **55%** **51%** **57%**
		Drank on 5 or more days last week	England Scotland Wales Great Britain	**22%** **21%** **16%** **22%**	**13%** **11%** **9%** **13%**
		Drank 4 or more (men)/3 or more (women) units in past week on typical day	England Scotland Wales Great Britain	**34%** **34%** **38%** **35%**	**20%** **18%** **21%** **20%**
		Drank 8 or more (men)/6 or more (women) units in past week on typical day	England Scotland Wales Great Britain	**18%** **18%** **22%** **19%**	**8%** **8%** **9%** **8%**
Northern Ireland Statistics and Research Agency, 2007 (data from 2006–7)	18+			Male	Female
		Drinks below sensible levels	Irish	**52%**	**62%**
		Drinks above recommended levels/below dangerous	Irish	**20%**	**10%**
		Drinks above dangerous levels	Irish	**8%**	**1%**

Caution is required when interpreting data from large-scale surveys, as some regions have small populations, leaving the research open to potential sampling error (Goddard, 2006).

As drinking patterns differ by region, it is plausible that drinking among minority ethnic groups may also differ by region. The majority of studies identified for this review took place in England, with the few Scottish studies taking place in Glasgow only. Many of the studies in England focus on either London or the Midlands. This highlights the need for further studies to explore local drinking patterns of minority ethnic groups in Wales, Scotland, Ireland and in other parts of England, to capture geographical differences.

Many regional surveys, such as the Health Survey for Scotland, the Health Survey for Wales, and Continuous Household Survey for Northern Ireland, do not break results down by ethnic group, so cannot be used to compare rates among ethnic groups. Large-scale surveys that do make ethnic comparisons are the General Household Survey covering Great Britain, and the Health Survey for England, covering England only. These surveys provide useful comparisons, but are not fully representative; data from the General Household Survey (data from Goddard, 2006 and Information Centre, 2007) is limited insofar as it omits those who live in hostels and insecure accommodation (Harrison *et al.*, 1996). It is among disadvantaged groups such as these that the highest levels of problems are found (Harrison *et al.,* 1993). Furthermore, surveys that use random sampling do not pick up concentrations of minority ethnic populations.

2 Drinking patterns

Abstention from alcohol

Measuring abstinence

Definitions of abstinence vary within the literature on alcohol. Some research defines abstinence as lifetime abstinence (e.g. Bradby and Williams, 2006), whereas other studies classify abstinence as not currently drinking (e.g. Erens and Laiho, 2001), or drinking very rarely (e.g. Denscombe and Drucquer, 2000).

Abstention from alcohol by ethnicity

Abstention varies considerably between ethnic groups, though most minority ethnic groups have higher rates of abstention than the general population, and South Asians, particularly Pakistani and Bangladeshi people, have much higher rates of abstention than all other minority ethnic groups. Irish respondents are less likely to abstain than the general population. People from mixed ethnicity backgrounds are more likely to drink than respondents from other non-white minority ethnic groups.

Appendix 5 shows the breakdown of abstention from alcohol by ethnic group.

The research shows that White respondents are more likely to have ever had a drink than South Asians (Best *et al.*, 2001; Cochrane, 1999; Denscombe, 1995; Denscombe and Drucquer, 2000; Fuller, 2009; Goddard, 2006; Karlsen *et al.*, 1998) and, with the exception of one comparison within one study (Karlsen *et al.*, 1998), are more likely to have consumed alcohol than respondents from Black African and Black Caribbean backgrounds (Best *et al.*, 2001; Cochrane, 1999; Fuller, 2009; Goddard, 2006; Karlsen *et al.*, 1998; Stillwell *et al.*, 2004). White participants sometimes comprise those from White British, White Irish and White European backgrounds, even though studies show that Irish respondents report slightly lower rates of abstinence compared with the general population (Becker *et al.*, 2006; Erens and Laiho, 2001). Furthermore, an earlier study also reveals differences in the self-reported levels of alcohol use among adolescents in Northern Ireland and Scotland, with Scottish young people more likely to have consumed alcohol (Loretto, 1994). This highlights the need to distinguish between white ethnic groups, and consider regional variations in drinking patterns.

Studies also show that respondents from Black Caribbean, Black African and Black British backgrounds are more likely to drink than South Asians (Best *et al.*, 2001; Erens and Laiho, 2001; Goddard, 2006; Karlsen *et al.*, 1998; Purser *et al.*, 2001). Black Caribbean participants also report higher rates of ever having drunk alcohol than Black African participants (Goddard, 2006; Karlsen *et al.*, 1998; Stillwell *et al.,* 2004).

Chinese people also have high rates of abstention; Chinese respondents are less likely to have had a drink than Europeans (White, *et al.*, 2001) and than the general population (Erens and Laiho, 2001; Goddard, 2006; Heim, *et al.*, 2004).

A study carried out in Glasgow, Scotland, found similar differences in drinking rates between Pakistani, African and Caribbean, Chinese, and Indian participants compared to the general population (Heim and MacAskill, 2006). All minority ethnic groups were less likely to drink than the general population, with Pakistani people being least likely to report this.

Within the South Asian population, research shows that abstention rates for Bangladeshi and Pakistani participants are higher than for Indian respondents (Erens and Laiho, 2001; Goddard, 2006; Heim *et al.*, 2004; Purser *et al.*, 2001). In particular, Purser *et al.* (2001) found that Indian Hindu, Pakistani and Bengali men and Indian Hindu, Pakistani, Bengali and Indian Sikh women were least likely to be drinkers out of the South Asian sample. However, Indian Sikh men were likely to be drinkers. Low numbers

of Pakistani and Bangladeshi drinkers is largely due to the prevalence of Muslims within this group (see religion and abstention below).

Very few studies have respondents who classify themselves according to Mixed ethnicity. However, the available research shows that people from Mixed ethnicity backgrounds are more likely to drink than respondents from other non-white minority ethnic groups (Goddard, 2006). For example, Mixed White and Black African people show a greater likelihood of drinking than Black African respondents, though they are less likely to drink than White British people. Similarly, respondents who are White and Asian are more likely to drink than respondents from Pakistani, Bangladeshi, Indian and Other Asian backgrounds, and have abstinence rates not much lower than White British respondents.

Some studies use samples that are not randomly selected and are consequently not a reliable indicator of prevalence in the general population. Data collected from hospitals or general medical settings are known to be biased, with an increased likelihood of alcohol dependence (Harrison *et al.*, 1996). However, results from studies with special populations still reveal similar patterns of abstinence between ethnic groups. For example, Dar *et al.* (2002) found that among patients attending a Community Drug Team, Asian patients (Indian, Pakistani, Bangladeshi) were less likely than White patients to drink. It must be noted that differences may be a function of service provision and organisation, rather than actual differences between the populations (Dar *et al.*, 2002).

The different ways of measuring abstention, and the different populations sampled, coupled with numbers for quantitative analysis sometimes being too small, mean that comparisons should be made with caution, but studies show similar patterns of abstention across ethnic groups, even though absolute rates vary.

Religious affiliation and abstention

Higher rates of abstention have been consistently associated with religion, with higher rates of abstinence among South Asian religions, and lower rates among Christian religions and those with no religion.

Although some religions prohibit alcohol use, perception of religious proscription has not been associated with higher levels of abstinence.

Appendix 6 shows the breakdown of religious groups who abstain.

In some studies, over 90 per cent of Muslims report abstaining (Denscombe and Drucquer, 2000; Nazroo, 1997; Vora *et al.*, 2000). Purser *et al.*, (2001) found that Muslim groups are the least likely to drink, with Hindus also reporting low rates.

Some studies indicate that Sikhs and Hindus are equally likely to report drinking (Heim *et al.*, 2004; Nazroo, 1997). When broken down by gender, however, some research finds relatively high rates of drinking (around 70 per cent) reported among Sikh men (Cochrane, 1999; Purser *et al.*, 2001) compared to rates typically reported for Muslim and Hindu men.

The majority of Christians and those who have no religion show the lowest rates of abstinence (Denscombe, 1995; Northern Ireland Statistics and Research Agency, 2007; Purser *et al.*, 2001). Rates of abstinence between Protestants and Catholics are similar in Northern Ireland (Northern Ireland Statistics and Research Agency, 2007).

Similarities between ethnic groups, perhaps arising as a consequence of similar cultures can be found, even though there are differences in religion. For example, Denscombe (1995) found that there was no significant relationship between perception of religious proscription and drinking among their South Asian sample. Patterns of consumption found within the group remained even after taking into account religion and proscription, in that Hindus and Sikhs were largely non-drinkers, even though smaller numbers than Muslims felt that drinking was against their religion. The authors also found no real differences between religions in the white ethnic group.

Religious importance and abstention

The influence of religion on drinking rates has been shown to vary according to the importance attached to religion. Perceiving religion as important, and having strong religious beliefs, is associated with lower levels of reported drinking for Christians and Hindus, but not always for Muslims.

Religious importance has been shown to vary by ethnicity; Karlsen *et al.* (1998) did not specify religious affiliation in their study, but found that Bangladeshi participants had significantly higher levels of abstention from alcohol, and reported strong religious influence measured by active religious involvement compared with Black African, Black Caribbean and White participants. Conversely, White young people had the highest levels of use, and low levels of religious influence. Bradby and Williams (2006) also found that young South Asian (mostly Punjabi) people often gave religion as a reason for abstention from drugs, whereas religion was not a cited factor for non-South Asians.

Identifying strongly with religion has been linked to higher rates of abstinence; for example, even though Pederson and Kolstad (2000) found that young people in Norway who identified themselves as Christian were not more likely to abstain from alcohol use than those with no religion, young people who felt that religion is 'very important' to their way of life were five times more likely to abstain than young people who felt that religion was not important at all. The authors argue that when analysing the role of religion in alcohol consumption, it is important to test for strength of belief and participation in religious practices.

In the UK literature, Purser *et al.* (2001) also found a direct relationship between identifying strongly with religion and the probability of drinking. Christians and Hindus who identified strongly with their faith were considerably less likely to drink, with strong identification also being a protective factor for Sikhs, though to a lesser extent. Conversely, Heim *et al.* (2004) in their study of alcohol consumption in Chinese, Indian and Pakistani populations, found that importance of religion was associated with less drinking across the sample. However, self-reported importance of religion, and self-reported religious activity, did not distinguish drinking Muslims from non-drinking Muslims. They conclude that levels of alcohol consumption may not be related to the strength and importance of religious beliefs among all religious groups.

These findings may suggest that the degree of attachment to religion differentiates between drinkers and non-drinkers in religions where some drinking is seen as socially acceptable, such as Hindu and Christian religions. This is particularly noticeable in some ethnic groups, such as people from white backgrounds, where Christians may not have markedly different rates to those with no religion, but Christians who are strongly attached to their religion are less likely to drink than those who do not report strong attachment. For Muslims however, strength of belief has less effect, perhaps as a consequence of the prohibition against alcohol in Islam, which means that alcohol is not part of social and cultural life, even for non-religious Muslims.

Abstinence by gender and ethnicity

A comparison of abstention rates in males and females by ethnicity shows that females are generally more likely to abstain than males across most ethnic groups. However, recent research among young people suggests that the gender gap between males and females may be closing among Irish, Indian, Pakistani and Bangladeshi ethnicities.

Results also vary by religion, with very high rates of abstinence regularly reported for Muslim men and women, with more variation among Sikh and Hindu men and women.

Within the general population in England, women are approximately twice as likely as men to have never drunk (Erens and Laiho, 2001), or to have abstained in the past year (Becker *et al.*, 2006). Results by ethnicity show that females are significantly more likely to abstain than men among Irish and Indian respondents,

and abstinence is also higher among Chinese females and Black Caribbean females compared with their male counterparts (Erens and Laiho, 2001). Another study also found that Chinese females are significantly more likely than Chinese males to abstain from drinking, whereas the difference between male and female rates in the White European population was not found to be significant (White *et al.*, 2001).

Comparing young people in Northern Ireland and Scotland, Loretto (1994) found that girls were more likely to report that they had not consumed a whole alcoholic drink than boys. However, the gender disparity in drinking rates was greater in Northern Ireland than in Scotland, with girls in the Northern Irish study group being the most likely to abstain from alcohol.

More recent research on younger people indicates that the gender gap may be closing; in a study of 8–15 year olds, Irish, Indian, Pakistani and Bangladeshi females were slightly less likely to report abstinence compared with their male counterparts (Becker *et al.*, 2006). Another study of 14–16 year olds also found White Irish females were more likely to have consumed alcohol than White Irish males (Stillwell *et al.*, 2004).

Gender differences by religion show that Muslim men and women both report high rates of abstention (Denscombe and Druquer, 2000; Purser *et al.*, 2001). Sikh men show lower rates of abstinence than Sikh women (71 per cent and 24 per cent respectively), and Hindu men also have slightly lower rates than Hindu women (33 per cent and 20 per cent) (Purser *et al.*, 2001). Females from Christian backgrounds report slightly higher rates of abstention than males (Northern Ireland Statistics and Research Agency, 2007).

Changes in abstinence rates among ethnic groups

One of the studies indicated that young people from White and South Asian backgrounds were drinking more in the late 1990s than the early 1990s. Research also suggests that Caribbean, Indian/African Asian, and Pakistani/Bangladeshi non-migrants are more likely to drink than migrants. However, although methodological issues make comparisons tenuous, an overview of abstinence rates across the reviewed studies suggests that there has been no discernible shift from abstinence to drinking among South Asians and most other minority ethnic groups. Irish girls, however, showed a decrease in abstinence rates between 1999 and 2004.

Abstinence rates for the South Asian population in the UK are of particular interest for researchers, as they provide an insight into whether some South Asians are being influenced by White British drinking cultures. In a longitudinal study, Denscombe and Drucquer (2000) compared the drinking patterns of young people aged 15–16 years in 1990, with the drinking patterns of 15–16 year olds in 1997 in the East Midlands (see Appendix 5). They found that the percentage of both White and South Asian young people abstaining decreased significantly during the period. The disparity between the groups also decreased, suggesting that differences between the (broadly defined) ethnic groups may be narrowing. Nevertheless, South Asians still remained significantly less likely than the White young people to drink.

In a nationally representative survey of minority ethnic groups in Britain, Nazroo found that Caribbean, Indian/African Asian, and Pakistani/Bangladeshi people who had migrated to Britain were less likely to be drinkers than those who were born in Britain or had migrated before the age of 11 years old (Nazroo, 1997). The results were statistically significant for all ethnic groups.

More recent research suggests that there is little indication that drinking among young people from minority ethnic groups may be increasing. In a comparison of cross-sectional surveys exploring young people's drinking rates in 1999 and 2004, differences in drinking rates between the two surveys were not significant for any of the ethnic groups, except for the number of Irish girls who had ever had a drink rising significantly during the period (40 per cent to 54 per cent), (Becker *et al.*, 2006).

Changes in abstinence among religious groups

Research shows that abstinence rates for Muslims remain high; second-generation Hindus may be more likely to drink than first-generations; and consumption increased among Sikh girls in the 1990s.

Ascertaining changes in drinking patterns for different religious groups over time poses the same methodological limitations as it does for ethnic groups. However, abstinence rates among people who continue to identify closely with a religion may be expected to show a greater degree of consistency over time, than among people who abstain because of cultural and social norms. A comparison of abstinence rates for Muslims during the period 1990 to 2004 (see Appendix 6) shows that they maintained high rates of abstinence overall. In particular, Denscombe and Drucquer (2000) found that between 1990 and 1997 abstinence rates fell for Sikhs and Hindus but Muslims maintained the same level of complete abstinence, suggesting the importance of religion for this group. A study by Vora *et al.* (2000) suggests that second-generation male Muslims in the UK are abstaining as much as first-generation male Muslims. Stilwell *et al.* (2004) also found that ten out of the twelve Black Muslims in their study had never tried alcohol. Conversely, some studies indicate that Muslims are possibly experimenting with alcohol more (e.g. Heim *et al.*, 2004).

Studies exploring the drinking patterns of Sikhs show more varied results. Data collected in the early 1990s (Denscombe, 1995) suggested that Sikhs had high rates of abstinence, although these rates had dropped by 1997 (Denscombe and Drucquer, 2000). The number of Sikhs in the study was too small for reliable comparison, though the data suggests that female consumption was increasing, particularly compared to male Sikh consumption. Conversely, a comparison of abstention rates for first- and second-generation Sikh males indicates that second-generation Sikhs are more likely to abstain than first-generation Sikhs (Cochrane, 1999). A study by Vora *et al.* (2000) reported similar patterns of drinking in first- and second-generation Sikhs, though abstinence rates were slightly higher among second generations.

There is less data available for comparative purposes on changes in abstinence rates for Hindus, but evidence from one study suggests that second-generation Hindus are slightly more likely to drink alcohol than first-generation Hindus (Vora *et al.*, 2000).

Summary points: abstention

- Minority ethnic groups, except Irish people, are less likely than the general population to have ever consumed an alcoholic drink.
- South Asians, notably Pakistani and Bangladeshi respondents, are the least likely ethnic group to report ever drinking.
- Muslims are the religious group most likely to report abstinence, with Christians and those reporting 'no religion' the least likely.
- Identifying strongly with religion, and strength of belief, are associated with abstinence among Christians, but not among Muslims.
- Second-generation Sikh males may be less likely to drink than first generations.
- Historical gender differences are not being observed in recent studies on young people and abstention, and the closing of the gender gap includes minority ethnic groups.

Frequent and current use of alcohol

Measuring frequent use of alcohol

Studies vary in how they define frequent drinking levels. Such variation can lead to individuals being classed as regular drinkers in some studies, whereas they may be defined as irregular or infrequent drinkers according to a different classification. Other studies however, prefer to explore current use of alcohol, for example in the

past week or year. This contrasts with frequency, insofar as respondents will be requested to report on recent behaviour rather than typical behaviour over a longer time period. Comparing these studies is therefore open to potential error, as recent alcohol consumption may contrast significantly with typical consumption (Rodham *et al.*, 2005). In addition, recording alcohol consumption in a recent period can be misleading if it does not differentiate between frequency and quantity. Drinking a small amount every day will have different health consequences and indicate a difference in drinking habits from drinking a large amount once a week, although the total quantity consumed may be the same.

Ethnicity and drinking frequency

Research shows that white respondents, particularly those from Irish backgrounds, are more likely to report current alcohol use and have higher rates of frequent use than those from Black Caribbean, Black African, and South Asian ethnicities. South Asians are least likely to report frequent alcohol use, primarily Pakistani and Bangladeshi respondents. Frequent use has been reported among drinkers from Sikh and Asian backgrounds, however. Young people from mixed ethnicities report comparatively high rates of current use.

Appendix 7 shows the differences in drinking frequency and recent use of alcohol by ethnic groups.

Differences in drinking frequency among ethnic groups tend to mirror the differences observed for abstinence. In comparison to the general population, Irish people report higher rates of weekly drinking. Their consumption frequency is also higher than other minority ethnic groups such as Pakistani, Bangladeshi, Indian, Black Caribbean, Black African and Chinese, who tend to report rates lower than the general population (Becker *et al.*, 2006; Erens and Laiho, 2001). Irish women are more likely than the general population and all other ethnic groups to report drinking on at least one day in the past week (Becker *et al.*, 2006). In another study, McCambridge *et al.* (2004) found that Irish participants living in London drank more frequently, and were more likely to drink on a daily basis than Irish participants situated in Dublin. The authors suggest that stresses from migration may be a factor.

Conversely, one study found that differences in drinking frequency between White Irish, White English, Black Caribbean and Black African males were not significant (Stillwell *et al.*, 2004). The same study found that White English girls were significantly more likely to drink regularly than the other groups combined, but the difference between White English and White Irish females was not significant.

In many studies, Black Caribbean participants report higher rates of regular drinking than Black African participants (Becker *et al.*, 2006; Goddard, 2006; Karlsen *et al.* 1998). An exception to this was found in one study with young people, where Black Caribbeans were less likely than Black African, White British and White Irish young people to report frequent drinking (Stillwell *et al.*, 2004). Such differences suggest the importance of looking at differences in drinking patterns for those from black ethnicities where possible, as rates do differ.

Very low rates of regular use are recorded for Pakistani and Bangladeshi respondents compared to all other ethnic groups (Becker *et al.*, 2006; Erens and Laiho, 2001; Goddard, 2006). The same surveys also report low rates for Indian people, though rates for Indian respondents are closer to people from Black African and Asian Other backgrounds than Pakistani and Bangladeshi backgrounds (Goddard, 2006).

Although studies generally point to South Asian respondents drinking the least frequently when compared to other ethnic groups, there are some exceptions. For example, Best *et al.* (2001) found that although Asian young people had a lower prevalence of regular use than White and Black young people, of those who have consumed alcohol, 13 per cent reported that they do so regularly. This compares to 8 per cent of Black young people who have ever drunk, doing so regularly. Another (non-representative) study also found similar results for Sikhs; although abstention rates were higher for Sikhs than for White English and Black African-Caribbean

respondents, among drinkers, frequency of consumption rates were higher for Sikhs than for the other two groups (Cochrane, 1999). These findings reiterate the importance of highlighting whether drinking frequency is calculated for the sample overall, or for drinkers only, as they can indicate very different patterns of consumption. Measures of frequency that are applied to the total sample may mask the drinking patterns among the small number of respondents who do drink.

Research also indicates that young people from mixed ethnicities may report higher rates of current alcohol use. Data from the Smoking, Drinking and Drug Use among Young People in England (SDD) reveals that those most likely to report drinking in the last week were from White or Mixed ethnicity backgrounds (Information Centre, 2007).

Religion and drinking frequency

Drinking regularly is less common among religious followers, particularly those from South Asian religions. However, drinking patterns do vary by religion, with Muslims reporting less frequency than other religious groups, and Christians reporting the highest frequency. People with no religion have similar rates to Christians.

Appendix 8 shows the breakdown of drinking frequency by religion.

Consistent with findings on abstention rates, research shows that young people from Church of England, Catholic and Other Christian religions are more likely to report drinking occasionally and regularly than young people from Muslim, Sikh and Hindu religions. Young people with no religion are similar to those affiliated with Church of England (Denscombe, 1995).

In a study tracking the drinking patterns of young people aged 14–15, followed up at 18–20 years, Bradby and Williams (2006) found that Muslims were less likely to be regular or current drinkers than Sikhs/Hindus (one category). By the ages of 18–20 years, the numbers of Sikhs and Hindus reporting to be current drinkers had increased in contrast to the consistently low numbers of Muslims, reflecting the stronger prohibitive influence of Islam.

One study found that Sikh men were more likely to be regular drinkers (three times or more a week) than White English or Black African-Caribbean men (Cochrane, 1999). Lower levels of drinking were associated with attendance at religious services for all three groups, but 29 per cent of Sikhs attending temple every week still drank regularly, similar to the proportion who never attended temple (30 per cent).

Gender and drinking frequency

Most studies suggest that across ethnic groups men drink more frequently than women and are more likely to be current drinkers. Other research, however, suggests that the gender gap may be closing for White English, White Irish, Black Caribbean and Black African young people.

Within the general population, men drink more frequently than women, and are more likely to have had a drink in the last week, and to have drunk on more days in the past week (Goddard, 2006). Across ethnic groups similar patterns emerge as males drink more frequently than females and are more likely to be current drinkers (Becker *et al.*, 2006; Denscombe and Drucquer, 2000; Erens and Laiho, 2001; Goddard, 2006; Rodham *et al.*, 2005; White *et al.*, 2001).

However, one study suggests that a narrowing of the gender gap in drinking frequency can be observed among some ethnic groups (Stillwell *et al.*, 2004). The study found that no results were statistically significantly different by gender for White English, White Irish, Black Caribbean and Black African respondents. However, males tended to drink more frequently than females, with the exception of White English females who drank more frequently than White English males.

Gender differences may vary with age; Bradby and Williams (2006) found that non-Asian girls were trying out alcohol more than boys at 14–15 years, but that this disparity had

disappeared by the time the respondents were 18–20 years old.

Changes in drinking frequency by ethnicity

Some research indicates that young people from White and South Asian groups were drinking more regularly by the late 1990s compared with the early 1990s. Research on Black Caribbean people suggests that the frequency of their drinking has not changed in recent years. Chinese men and Indian women showed an increase in drinking between 1999 and 2004.

Research showed that abstention rates from White and South Asian young people decreased during the 1990s (Denscombe and Drucquer, 2000). The same study showed that the numbers of White and South Asian young people reporting regular alcohol use rose during the same period. For South Asians, the proportions doubled. Although they were still less likely to drink than White young people, the increase in the number of young South Asian people drinking is a notable finding and again suggests that their behaviour was altering along with the changes observed among their white peers.

There is less data available on people from black populations regarding frequent alcohol use, making it difficult to ascertain whether their drinking habits are changing. However, the Health Survey for England found no change in drinking rates for Black Caribbean people between 1999 and 2004 (Black African was not included as a category in the 1999 data collection, so comparisons could not be made) (Becker *et al.*, 2006). Research in the 1990s also found no difference between first- and second-generation drinking patterns for Black African-Caribbean men who generally reported little involvement with alcohol (Cochrane, 1999).

Data from the Health Survey for England 2004 found little change in frequent drinking in the past year among minority ethnic groups compared to 1999 results from (Becker *et al.*, 2006). The largest change was seen in the proportion of Chinese men who do not drink or only drink very occasionally, which dropped from 43 per cent to 31 per cent over the period. The change was most noticeable among older Chinese men. Drinking on at least one day in the last week showed an increase among Chinese men (39 per cent to 48 per cent) and among Indian women (15 per cent to 21 per cent).

Changes in drinking frequency by religion

Research has shown that regular consumption among Sikh girls has shown an increase. Conversely, second-generation Sikh men and Sikh boys are reporting less regular drinking. Second-generation Jains and Hindus, on the other hand, are more likely to drink regularly than first generations.

Studies have shown that second-generation Sikh men are less likely to be regular drinkers than first generations (Cochrane, 1999). A study in the 1990s also showed that the percentage of Sikh boys drinking occasionally or regularly between 1990 and 1997 decreased, whereas the percentage of Sikh girls drinking occasionally or regularly in the same period increased (Denscombe and Drucquer, 2000). Low numbers mean findings should be interpreted with caution, but this finding relates back to similar patterns observed in abstinence levels among Sikh boys and girls in the same study.

For Hindus, drinking occasionally or regularly rose steeply during the period 1990–7, with males three times more likely to drink in 1997, and females 1.5 times more likely (Denscombe and Drucquer, 2000). Another study showed that second-generation Hindus show similar patterns of occasional drinking to first generations, albeit with slightly higher levels of occasional drinking (Vora *et al.*, 2000). These findings are consistent with the earlier reported finding that second-generation Hindus are slightly less likely to abstain. However, these findings contrast with earlier research where Hindus born in India were more likely to be regular drinkers than those born in the UK (Cochrane and Bal, 1990, in Alcohol Concern, 1995).

The number of second-generation Jains drinking regularly is significantly higher than first generations (Vora *et al.*, 2000).

Summary points: frequent and current use of alcohol

- White people tend to drink the most frequently, followed by Black Caribbean, Black African and South Asian people.
- Irish respondents report the highest rates of weekly drinking.
- Young people from mixed backgrounds are also likely to report drinking frequently.
- In the 1990s white and Asian young people showed an increase in frequent drinking.
- Second-generation Sikhs are less likely to drink regularly than first generations.
- The numbers of Jains and Hindus drinking regularly rose in the 1990s.
- Females drink less frequently than males across ethnic groups, though gender differences in White British and Irish, and Black Caribbean and African groups seem to be converging.

Drinking intensity

Measuring intensity

The amount of alcohol consumed in a single session, or over the course of a given time period can be an important indicator of potential health risks caused by drinking. Intensity is variously measured according to the average amount consumed typically or recently. To ascertain problem drinking levels, measurements again vary considerably, to include exceeding the weekly recommendations on an average week (Erens and Laiho, 2001), consuming 20 units or more in a week (Cochrane, 1999), more than ten episodes of drunkenness within the past year (Heim *et al.*, 2004), and frequency of drunkenness (Rodham *et al.*, 2005). What is classed as heavy drinking in one study could be determined to be moderate in another. Measures of usual or typical alcohol consumption are unlikely to capture heavy drinking occasions or bingeing (Erens and Laiho, 2001). Government guidelines advise not exceeding four units per day for men and three units per day for women (Department of Health, 2007).

A further consideration is that participants may under- or over-estimate how much they drink. The drinking context in particular, is likely to affect recall. People who drink at home will potentially under-estimate the amount they consume because the quantities are not measured and are likely to be larger than those dispensed in licensed premises (Goddard, 2006). Recall may also be difficult for young people who share drink with their peers and are unable to keep track of the amount consumed.

Ethnicity and typical intensity

The majority of research shows that White British and Irish respondents are likely to drink more units on average than other ethnicities, with South Asian respondents drinking least, and Black Caribbean and Black African respondents falling somewhere in between. Rates are also low for Chinese people. Among drinkers, however, some studies find relatively high rates of use for South Asian respondents.

Appendix 9 shows the breakdown of results.

Research has shown that Irish people consume on average more than the general population (Becker *et al.*, 2006). This disparity may be a reflection of heavier drinking cultures in Ireland, or they may be a consequence of changes in drinking rates among migrant Irish groups. Drinking has increased in Northern Ireland over the past couple of decades, with the proportion of people exceeding recommended limits for consumption rising between 1986 and 2007 (Northern Ireland Statistics and Research Agency, 2007). However, in their research study, McCambridge *et al.* (2004) found that Irish participants in London consumed a higher number of average units in the week prior to interview, and were more likely to be classified as having high consumption levels (64 per cent) compared with Irish participants in Dublin (43 per cent). As mentioned previously,

this may be due to stresses from migration or exposure to drinking cultures in London, but the finding reinforces the need for research to consider Irish people's experiences in the UK.

Large-scale surveys among adults report that Black Caribbean people have higher drinking rates than Black African people (Becker *et al.*, 2006; Goddard, 2006). Conversely, a study with young people found that Black Caribbean participants reported lower consumption in units than Black African participants (Stillwell *et al.*, 2004). The study found that Black Caribbean males drank less than Black African and White respondents, and were significantly likely to drink less alcohol than White English and White Irish males. For girls, White English and White Irish females are significantly more likely to drink more units than either Black Caribbean or Black African females.

Findings from special populations report similar patterns; Dar *et al.*, (2002) found that Asians attending a drug treatment unit drank fewer units per week compared to White participants. McCambridge and Strang (2005) in their sample of illegal drug users found that White young people drank a higher number of units per week than Black and Asian young people, and reported more frequent pub-going.

Not all studies find that South Asian drinkers consume less alcohol than other ethnic groups, however; McCambridge and Strang (2005) found that, although fewer Asians in their study were current drinkers, those who did drink consumed more units on average per week than Black respondents. Similarly, Cochrane (1999) found that Sikh men consumed more units than White English and Black African-Caribbean men, which is related to the fact that Sikh men also drank more frequently. Heim *et al.* (2004) found that among drinkers, people from Pakistan consumed the most units in a week, compared with Indian and Chinese respondents, even though they were also the group most likely to abstain. The difference between Pakistani and Chinese respondents was statistically significant. These differences only become apparent when units are calculated for the proportion of drinkers in the sample, rather than the sample as a whole.

Studies have shown that Chinese populations in the UK have low rates of alcohol consumption compared with Europeans, with Chinese respondents being more likely to drink safely, and consume fewer units per week (White *et al.*, 2001). Similarly, another study has shown that Chinese men have a lower than average weekly consumption rate at 4.2 units compared with 17.5 for the male general population, with Chinese women consuming 2.0 units per week, compared to an average of 7.2 for the female general population (Erens and Laiho, 2001).

Ethnicity and heavy drinking

Rates for heavy drinking follow a similar pattern for typical intensity, with records of drunkenness or drinking beyond safe limits being most common among White English and Irish respondents, with those from South Asian backgrounds least likely to report this. Sikh men, however, do report high rates of heavy drinking. People from mixed ethnicities report relatively high rates of heavy and very heavy drinking compared to minority ethnic groups.

Research indicates that in comparison to the general population, Irish respondents report higher rates of heavy drinking (Becker *et al.*, 2006; Erens and Laiho, 2001). Conversely, McCambridge *et al.* (2004) found that there were no significant differences between Irish participants and the general population samples on hazardous drinking, measured as exceeding the AUDIT (Alcohol Use Disorders Identification Test) threshold for hazardous drinking (see Conigrave *et al.*, 1995 in McCambridge *et al.*, 2004 for AUDIT threshold).

Rodham *et al.* (2005) found that White males were significantly more likely to have been drunk than Black, Asian or Other males, and that White females were significantly more likely to have been drunk than Black females.

In a sample of women in prison and on remand, Borrill *et al.* (2003) reported that White women had slightly higher rates of harmful drinking than Black/Mixed race women and higher mean AUDIT scores, but there was no significant overall association between ethnicity and drinking status.

Stillwell *et al.* (2004) found that Black Caribbean males were significantly less likely to report drunkenness in the last 90 days compared to Black African and White British and White Irish respondents. Black Caribbean and Black African females were significantly less likely to report drunkenness compared to their White counterparts. Furthermore, the study showed that the average typical quantities of alcohol consumed by male and female Black Caribbean and female Black African young people were within the recommended limits for adults. However, Black African males, White British and Irish males and White British and Irish females drank in excess of recommendations on a typical day. White Irish males in particular drank double the recommended three–four unit limit. This study suggests that Black African respondents are more at risk of heavy drinking than Black Caribbean respondents. Conversely, other research finds the opposite and indicates that Black Caribbean people are more likely to exceed safe drinking limits and drink heavily than Black African people (Becker *et al.*, 2006; Goddard, 2006).

Purser *et al.* (2004) report that young Black men had higher rates of both fairly heavy and very heavy drinking, compared with the other groups (Indian Sikh, Indian Hindu, Pakistani and Bengali) in the sample. However, the sample did not include respondents from White backgrounds.

Data from the General Household Survey (Goddard, 2006) carried out in 2005 also revealed that respondents of Pakistani or Bangladeshi origin were the least likely to exceed the recommended daily limits or binge drink in the week prior to interview. Dar *et al.* (2002) similarly found that Asians were less likely to drink heavily (exceed 50 units per week) than White respondents.

Purser *et al.* (2004) found that females from minority ethnic groups were not very likely to report drinking regularly (fewer than 1 per cent), but a substantial minority reported consuming large amounts occasionally (4 per cent). This indicates that a small number of women from minority ethnic backgrounds may not be using alcohol sensibly and may be at risk for binge drinking or harm related consumption.

One study found that Sikh men were likely to report drinking heavily (Cochrane, 1999). The research found that similar rates of White English and Sikh men reported that they exceed the recommended weekly limit (24.5 per cent and 27 per cent respectively) and that they get drunk at least once a week (9 per cent and 10 per cent respectively). By comparison, Black African-Caribbean respondents were far less likely to exceed the weekly limit and did not report drunkenness on a weekly basis.

One study found that the differences by ethnicity for alcohol consumption disappeared when looking at very heavy drinking. Rodham *et al.* (2005) found that when analysing respondents who drank more than eleven drinks per week the differences between White, Black and Other males and females disappeared, but Asian respondents remained significantly less likely to drink. Very heavy drinking is more of an indicator for concern than light or moderate consumption, and the finding suggests that protective factors associated with some ethnic groups may be less relevant in cases of very heavy drinking.

Other research suggests that heavy consumption is low among the Chinese population with very low rates of Chinese men and women exceeding the recommended weekly intake compared to European men and women (White, *et al.*, 2001). The differences between the males were significant. Furthermore, there were no reported hazardous drinkers among Chinese respondents.

Although very few of the studies identified through the literature search classify respondents according to mixed ethnicity, findings from the General Household Survey suggest that this group may be at risk for heavy and binge drinking (Goddard, 2006). The survey found that adults most likely to exceed the recommended daily limits in the previous week were those of Mixed ethnicity, particularly White and Asian Mixed, and White and Black Caribbean Mixed, along with White British and Other White respondents. The same pattern was identified for very heavy drinking. These findings can be linked to findings reported earlier in the review that people from mixed ethnicities are more likely to drink, and drink frequently, than other ethnic groups.

Young people from mixed ethnicities may be exposed to different cultural influences around alcohol use. These experiences may influence

drinking levels directly or indirectly, making the experiences of those from mixed backgrounds of interest for further research. In addition, research has revealed that young people from mixed ethnicities have a higher prevalence of drug use (Ramsey *et al.*, 2001 in McCambridge and Strang, 2005) and are more likely than other ethnic groups to be a victim of crime in England and Wales (Research Development and Statistics Directorate, 2004). They are also more at risk of criminal prosecution than young white males with similar characteristics, perhaps a reflection of the discrimination they may face in society (Feilzer and Hood, 2004). Consumption rates among people from mixed ethnic backgrounds should therefore be considered in the context of other factors that are linked to increased risks of alcohol consumption.

Religion and drinking intensity

People who are not religious and those from Christian backgrounds report higher consumption rates than other religious groups. Muslims tend to report the lowest rates, although among drinkers only, they show relatively high rates compared with other religious groups.

Appendix 10 shows the breakdown of drinking intensity by religious group.

Consistent with rates of frequent drinking and abstention, respondents of no religion and Christians tend to report heavier consumption than other religious groups, with Muslims and Hindus reporting the lowest rates, and Sikhs falling in between, although their rates are closer to Christians than the South Asian religions (Purser *et al.*, 2001). Another study showed that first-generation Sikhs drank more than Muslims, Hindus and Jains (Vora *et al.*, 2000).

Among drinkers only, however, a different pattern emerges for Muslims. Heim *et al.*, (2004) found that Muslim drinkers had higher reported rates of use per week than other religious groups, although not significantly so. They were significantly likely to drink more than those with no religion, however. Christians drank the least number of units per week. Similarly, Purser *et al.*, (2001) found that in comparison to the total sample, Muslims overall had low rates of risky drinking (4 per cent), but the percentage of Muslim drinkers who exceeded guideline amounts formed a much higher proportion (26 per cent). Similar results are evident from earlier studies with Muslims, where average consumption levels among the small number who consumed alcohol were high (Cochrane and Bal, 1990, in McKeigue and Karmi, 1993).

This suggests that, although practising Islam may be a protective factor against the likelihood of being a drinker, it may not serve such a protective role regarding consumption levels among drinkers. This finding supports the theory that despite strong associations between certain ethnic and religious groups and low rates of consumption, drinking problems among the members of the group who do drink tend to be higher.

Gender and drinking intensity

Studies indicate that gender differences can be observed within ethnic groups, with men from Irish, Indian, Pakistani and Chinese backgrounds drinking more than their female counterparts. However, some studies indicate that the gender gap may be closing for young people from White British, Irish, Black Caribbean and Black African backgrounds.

Recent research from the General Health Survey suggest that gender differences in alcohol consumption in the general population are still prevalent, with men more likely to exceed daily limits in the last week and twice as likely to have drunk heavily (Goddard, 2006).

Comparing Irish participants in Dublin and London, McCambridge *et al.* (2004) found that being male was associated with an increased risk of heavier drinking and problem drinking.

Heim *et al.* (2004) found that Indian, Pakistani and Chinese men drank significantly more alcohol per week than their female counterparts. However, the authors note that the gender disparity is not as great as that observed in

the Health Survey for England (Erens and Laiho, 2001), leading them to speculate that the discrepancy between male and female rates may be closing.

Supporting this view, Stillwell *et al.* (2004) found that within White and Black ethnic groups, no results were significantly different by gender. Males on average tended to report slightly higher amounts of alcohol consumption on a typical day, while females in both Black Caribbean and Black African groups reported slightly higher levels of frequency of drunkenness than their male counterparts. Though results were not statistically significant, 2.3 per cent of Black Caribbean females, and 4.5 per cent of Black African females reported being drunk once a week or more in the last three months, compared to none of the Black male participants (Stillwell *et al.*, 2004).

Similarly, McCambridge and Strang (2005) found no significant differences by gender in patterns of alcohol consumption for White, Black or Asian participants.

Changes in drinking intensity by ethnicity

There is little evidence that minority ethnic groups are consuming more alcohol than previously. However, results from the Health Survey for England show that consumption rose significantly for Chinese men and Indian women between 1999 and 2004.

The Health Survey for England 2004 found that men in the general population showed no real change in heavy consumption between 1999 and 2004 (Becker *et al.*, 2006). However, although drinking frequency among Chinese respondents remained low, there was some evidence that Chinese men were drinking at increased rates than previous generations. The survey showed that the percentage of Chinese men (whole sample) exceeding four units in a session showed a significant increase from 8 per cent to 19 per cent between 1999 and 2004. Those exceeding eight units in a session also rose from 2 per cent to 10 per cent. However, the small sample size and sampling methods mean that the findings must be interpreted with caution, as they may be an anomaly rather than reflecting a real increase.

The same survey showed that between 1999 and 2004, women in the general population showed an increase in binge drinking from 12 per cent to 14 per cent. Among women in minority ethnic groups, the only significant increase was an increase in the number of Indian women drinking more than three units in a session (from 5 per cent to 8 per cent).

Changes in drinking intensity by religion

For religious groups, there is some evidence that second-generation Muslims and Jains are drinking more than first generations. Conversely, second-generation male Sikhs, and Hindus born in the UK, consume less alcohol than first generations.

One study found that although second-generation Muslim men are as likely to abstain as first generations, the average number of units consumed per week by second-generation Muslims who do drink was 18 units, compared to 4.3 units a week for first-generation Muslim drinkers (Vora *et al.*, 2000). The number of units was also higher than those reported by Sikh, Hindu and Jain men. The same study found that consumption levels of second-generation Jain men were significantly higher than first generations (Vora *et al.*, 2000).

Conversely, studies have shown that second-generation male Sikhs who drink consume on average less alcohol, and are less likely to drink heavily than first generations (Cochrane, 1999). Vora *et al.* (2000) found that the average number of units consumed by first-generation Sikh men was similar to second generations (12.8 and 13.3 respectively).

Older research indicates that first generation Hindu men are likely to consume more than Hindus born in the UK (Cochrane and Bal, 1990 in Alcohol Concern, 1995). Vora *et al.* (2000) also found that the average number of units consumed by Hindu men fell slightly from 10.3 units in first generations to 7.8 units in second generations. Therefore,

although research suggests that Hindus are less likely to abstain, and more likely to report frequent drinking than previously (Denscombe and Druquer, 2000; Vora *et al.*, 2000), their consumption rates are not reported to have increased.

As much of the research has focused on the drinking habits of first- and second-generation men from South Asian religions, it would be useful for further research to consider if the drinking habits of second-generation minority ethnic women are changing, particularly given the increase in consumption among Indian women, and the lower levels of abstinence and higher levels of drinking frequency reported among Sikh girls. While it must be remembered that any differences or apparent changes in drinking behaviour among minority ethnic groups may be down to sampling differences and variation in research methods, these findings do warrant further consideration.

Summary points: drinking intensity

- White people tend to consume the most units per week, followed by black and Asian people.
- Men still tend to consume more alcohol than women across ethnic groups, but differences no longer show the same amount of disparity.
- Participants from mixed ethnicities are showing a comparative likelihood of heavy drinking.
- Pakistani people have high rates of abstinence and do not drink frequently, but there are high rates of consumption among some drinkers.
- Muslims are less likely to drink, but among drinkers only they show comparatively high levels of heavy or risky drinking.
- Chinese men and Indian women have shown an increase in heavy drinking.
- Second-generation Jain and Muslim men are consuming more alcohol than first generations.

Health problems and mortality

Measuring health problems

Health problems can be related to physical and mental problems associated with use, and are often revealed through alcohol-related disorders and mortality, alcohol dependence and the impact of drinking on the lives of individuals. Calculation of risk in terms of alcohol consumption is not standard across ethnic groups. With regard to the health implications of consumption, tolerance can vary according to individual characteristics such as age, gender and genetic disposition.

Ethnicity and health problems

Research shows that South Asian men, particularly those from the Sikh population are over-represented for liver cirrhosis. White and Sikh men are more likely to score highly on the Alcohol Problems Scale than black men. However, some research indicates that although black and minority ethnic people have lower rates of harmful and hazardous drinking, they have similar rates of alcohol dependence to the white population. Irish and Scottish men and women, and Indian men, have higher rates of alcohol-related mortality than the general population.

Studies indicate that as Black men appear to drink less alcohol than White men, they pose a much lower risk for developing alcohol-related problems (Cochrane, 1999). Black African-Caribbean men are less likely than White English or Sikh men to have sought professional help for drink problems, and score lower on the Alcohol Problems Scale (see Table 4). Studies carried out in the 1980s

Table 4. Differences in alcohol-related problems by ethnic group

	White English	Black African-Caribbean	Sikh
Medical advice to stop drinking	8%	3%	0%
Ever sought professional help for drink problems	4%	0%	4%
Score >3 on Alcohol Problems Scale	16%	4%	12%

Source: Cochrane, 1999

reported that Afro-Caribbean men had a 50 per cent lower prevalence of alcohol-related problems compared with the general population (McKeigue and Karmi, 1993) and research also suggests that there were fewer Afro-Caribbean men presenting with liver cirrhosis in the late 1980s and 1990s than would be expected from their prevalence in the local population (Douds *et al.*, 2003).

By contrast, some sources indicate that South Asian men are over-represented as patients for liver cirrhosis caused by alcohol use, in comparison to other ethnic groups and the general population (Douds *et al.*, 2003; McKeigue and Karmi, 1993). Many of the South Asians seeking help for alcohol-related liver damage are non-Muslim, often from the Sikh population (Douds *et al.*, 2003; McKeigue and Karmi, 1993). This is likely to be a consequence of high rates of abstinence and low levels of consumption among the Muslim community. Most South Asian men with liver cirrhosis tend to be younger when diagnosed with the condition than White men. This is despite the fact that alcohol use tends to decrease in age in White men, but shows less variation in Indian and Sikh men (Cochrane, 1999; Erens and Laiho, 2001).

Although drinking levels are higher among Sikhs than among other South Asian groups, their drinking levels fail to account for the high numbers of alcohol-related hospital admissions for the Sikh community in the UK (Cochrane, 1999). The reasons for ethnic differences in the prevalence of liver cirrhosis, despite South Asian men consuming the same or less than men in the white population, could be down to a number of factors, including genetic differences in how alcohol is metabolised and affects the body, and differences in type and amount of alcohol consumed (Douds *et al.*, 2003). Cultural and social differences in attitudes to alcohol, such as preferences for spirits, binge drinking, or drinking alcohol with a meal may have an effect. Furthermore, some cases of liver cirrhosis may be attributable to causes other than alcohol, such as viral hepatitis. In the Indian subcontinent, Hepatitis B is widespread and could help to explain the higher rates of liver disease and cirrhosis in South Asians (Harrison *et al.*, 1997). However, the higher rates among men suggest a link with alcohol. More needs to be understood about the causes of the high prevalence of this disease among South Asians, particularly within the Sikh community.

Women with liver cirrhosis tend to be predominantly White (Douds *et al.*, 2003), reflecting higher rates of consumption among women from white ethnicities compared to other ethnic groups.

A national needs assessment study on alcohol in England found that black and minority ethnic groups have lower rates of hazardous and harmful drinking, but have a similar prevalence of alcohol dependence compared with the white population (Drummond *et al.*, 2005; Raistrick *et al.*, 2006). The similar prevalence of alcohol dependence for white and black and minority ethnic groups has implications for service provision. Surveys that measure drinking above sensible levels only may lead researchers to conclude that the service needs of black and minority ethnic drinkers are lower than for the white population, whereas the above findings indicate that this is not the case. The findings also point to the need to consider the impact of alcohol use on the individual and how dependence affects quality of life, as impact may vary by ethnicity and will not be captured purely by measuring heavy rates of use.

Ethnicity and alcohol-related mortality

Some ethnic groups show an increased likelihood of alcohol-related deaths; men born in Ireland, Scotland and India, and women born in Ireland and Scotland have higher than national average alcohol-related deaths in England and Wales (Bhala *et al.*, 2009). One study found that Irish people have over twice the rates of 'alcohol use

and related mortality' than the general population in England and Wales (Harrison *et al.*, 1997). Their mortality rates remained consistently higher than average over the period 1979–91 and there is some evidence that they have worsened slightly since the 1970s. The same study showed that people born in the Indian subcontinent also have high rates of alcohol-use-related mortality (Harrison *et al.*, 1997). However, the increase appears to be in line with the trend observed in the general population. Recent research also reports that in Scotland there was an exponential increase in cirrhosis mortality rates between 1950 and 2002, giving cause for concern (Bassett and Gilby, 2008).

Alcohol-use-related mortality was believed to have increased during the 1980s and early 1990s for Caribbean migrants, which in the 1970s was lower than the general population (Harrison *et al.*, 1997).

Men and women born in Bangladesh, Middle East, West Africa, Pakistan, China and Hong Kong, the West Indies and East Africa and women born in North Africa and India have lower than national average rates of alcohol-related mortality (Bhala *et al.*, 2009).

Mortality from hepatocullular cancer (HCC), a complication of liver cirrhosis, is above the national average for men and women born in Bangladesh, China and Hong Kong, West Africa and Pakistan (Bhala *et al.*, 2009). To deal with the higher rates of HCC among some ethnic groups, authors have recommended a case finding approach by ethnicity to identify patients for screening and treatment of the disease (Bhala *et al.*, 2009).

Summary points: health problems and mortality

- South Asian men, particularly Sikh men, have a higher prevalence of alcohol-related liver damage and liver cirrhosis than other ethnic groups.
- More research is required into the causes of the high rates of liver damage evident among South Asians.
- Black and minority ethnic people have similar rates of alcohol dependence to white people.
- Irish, Scottish and Indian men, and Irish and Scottish women have higher rates of alcohol-related mortality than the general population.

Alcohol use over the lifespan

Measuring lifetime use of alcohol

Cross-sectional surveys can provide useful information on current drinking levels among the adult and adolescent population and can demonstrate how drinking behaviour and attitudes tend to change with age for different ethnic groups. However, longitudinal surveys are needed to explore how attitudes and behaviours change over the lifespan for individuals and how ethnicity, religion and culture may be linked to these changes.

Lifetime use of alcohol and ethnicity

Studies suggest that South Asian young people are likely to be older than young people from white and black backgrounds when they first consume alcohol. During adolescence, frequency of consumption and intensity of use start to increase. However, these changes are not as pronounced among South Asians compared with other ethnic groups. Also during adolescence, alcohol use starts to reflect consumption patterns in the adult population. Among adults, frequency of consumption tends to increase with age and intensity decreases. These patterns are not observed, however, among Sikh and Black Caribbean men, where drinking shows less variation with age, reflecting cultural differences in the use of alcohol.

Appendix 11 shows age of first consumption for different ethnic groups.

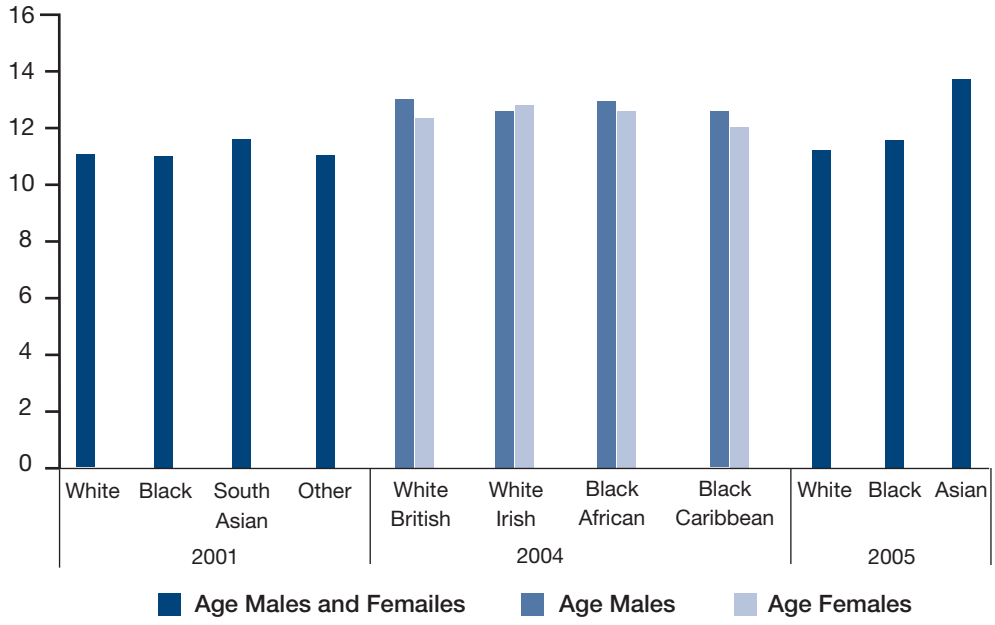
Initiation of alcohol use

Variation in the age at which young people first start drinking can lead to different trajectories of use. For example, chronic heavy drinkers can be distinguished from late-onset heavy drinkers by the age at which heavy use starts (Maggs and Schulenberg, 2004). Best and colleagues (2001) found that South Asian young people had the highest age for initiation of alcohol use, and age of first use was younger for Black young people than for White young people. Stillwell *et al.* (2004) found that among females, Black Caribbean females had the lowest average age and, among males, Irish boys had the lowest average age of first use. Although males reported to be slightly older than females at first initiation of drinking, differences were not statistically significant. McCambridge and Strang (2005) found that White respondents had the lowest age for initiation, followed by Black and Asian. They also found that the younger respondents in the sample were significantly younger at reported age of first consumption than the older respondents. This may reflect a generational difference in the age at which young people start to drink, or could be a consequence of differences in recall by age. Figure 2 shows age of first consumption for different ethnic groups. Best *et al.* (2001) found that age of initiation did not seem to be related to frequency of drinking in their sample, where the higher rate of regular drinking among young White people seemed to be a consequence of the fact that they were more likely to have ever drunk, and those who have consumed alcohol are more likely to progress to regular use. Although the research was cross-sectional, the authors tentatively suggest that cultural and racial factors may have an influence on trajectories of use.

Alcohol use during adolescence

As young people start to experiment with alcohol during the adolescent years, data from participants at different stages of adolescence can offer an indication of how alcohol use changes during this period. Approval of alcohol use increases with age during adolescence, and patterns of consumption tend to show the likelihood of ever having had a drink, frequency of drinking, recent drinking, and levels of consumption, increasing with age (Fuller, 2009). The same pattern can be observed in different ethnic groups. For example, a comparison of Irish and Scottish young people revealed that young people are more likely to have ever had a drink at 14–16 years than at 11–12 years (Loretto, 1994). However, the effect was greater

Figure 2. Age of first consumption by ethnicity



Sources: Best *et al.*, 2001, Stillwell *et al.*, 2004, McCambridge and Strang, 2005

for females than for males. McCambridge and Strang (2005) found that the Black, White and Asian young people in their study aged 18–20 years drank more alcohol than young people aged 16 or 17 years, averaging 2.5 units per week more for each year above the age of 16 years.

Longitudinal studies can give an indication of how drinking behaviour changes for individuals from different ethnic groups during the adolescent years. In a study exploring drinking in young people at 14–15 years, followed up at 18–20 years, Bradby and Williams (2006) found that abstinence rates decreased for both males and females over the period. However, the changes were insignificant and smaller for South Asians than those observed among the non-Asians in the study. In particular, Muslims maintained fairly high abstinence rates, reflecting how attitudes to alcohol that are influenced by religion, particularly Islam, are less likely to change with age. Sikh/Hindu women's drinking also increased a fair amount during the period; although they still drank less than Christians and those from Other religions, they drank significantly more than Muslim women at age 18–20 years.

A different follow-up study found that Black African young people showed a statistically significant increase in the numbers who had had a drink between the ages of 12-13 years and 14–15 years (Karlsen *et al.*, 1998). Bangladeshi, Black Caribbean and White young people did not show a significant increase during this time frame. However, although the numbers of White young people who had ever drunk rose only by 3 per cent, the numbers of White young people drinking regularly rose from 27 per cent to 63 per cent. White young people were the only group from the sample whose frequency rates increased significantly during this period. This suggests that these years are important for changes in drinking habits for White young people, and would be an appropriate age to target prevention efforts.

Although young people tend to drink less than adults, there is some indication that young people's drinking broadly reflects the norms and patterns in the adult population (Karlsen *et al.*, 1998), and that by mid-adolescence young people's drinking patterns are adult in nature (Stillwell *et al.*, 2004).

Alcohol use during adulthood

Among the adult population, drinking frequency tends to increase over the lifespan; older adults are more likely to report drinking during the last week, and drinking on at least five days in the last week. However, drinking intensity, such as consuming more than the recommended daily amount, and binge drinking, tends to decrease with age (Becker *et al.*, 2006; Goddard, 2006; Information Centre, 2007).

The Health Survey for England in 2004 (Becker *et al.*, 2006) showed that reported daily drinking increases with age in the general population and similar patterns emerge among Irish, Chinese and Indian men, and to a lesser degree among Black Caribbean and Black African men. However, being a non-drinker or very occasional drinker is also most common among older men in the general population, and among Irish, Chinese, Indian, and Black Caribbean men. Similarly among women, older women are more likely to drink daily but among minority ethnic groups the same pattern is true for Irish women only. Being a non-drinker or occasional drinker increases with age for women in the general population and among Irish, Chinese, Indian and Black Caribbean women.

Drinking heavily and binge drinking is less common with age in the general population and for all minority ethnic groups except Black African men and women who do not show a clear pattern (Becker *et al.*, 2006).

Other studies also suggest that similar drinking patterns over the lifespan are often observed in different ethnic groups, except for studies that have shown that Black Caribbean and Indian men (Erens and Laiho, 2001), and Sikh men (Cochrane, 1999), show less variation in consumption by age.

Different trajectories of use have implications for the planning of service provision for different ethnic groups. Cross-sectional studies can provide a snapshot of drinking practices at particular life stages, but more needs to be understood through longitudinal studies about how drinking patterns manifest over the life course in order to plan appropriate service provision.

Summary points: alcohol use over the lifespan

- Young people's drinking tends to reflect the norms in the adult population.
- Frequency of alcohol use increases over the lifespan for most ethnic groups.
- Heavy and binge drinking tends to decrease with age for most ethnic groups, though some Black and Indian respondents show less variation with age.
- More research is needed into how ethnicity and culture influence trajectories of use.

Drinking consequences by ethnicity

Research shows that White English and Irish respondents are more likely to report negative experiences associated with drinking, including law breaking and trouble with the police, than Black Caribbean, Black African and Sikh respondents. Among drinkers, however, Pakistani, Black, Sikh and Bengali men, and Pakistani women are likely to exhibit signs that their drinking may be a cause for concern. Hindus have lower levels of risk-taking behaviour associated with alcohol use compared to Christians, Muslims, Sikhs and those with no religion.

Appendix 12 shows drinking consequences by ethnic group.

Drinking consequences and antisocial behaviour

Measuring drinking consequences

As drinking rates vary, so it may be assumed that ethnic groups with higher consumption levels may experience a higher proportion of adverse consequences. Health problems are one possible consequence of heavy or excessive consumption (see pp. 28–30). Other negative consequences can include getting into trouble with the police, being involved in fights, or being a victim of crime. However, establishing causal links between drinking and negative or risky behaviours is problematic as the relationship can be bi-directional (Stillwell *et al.*, 2004). Consideration should also be given to the fact that there may be cultural, gender and age differences in people's perspectives of what constitutes a negative consequence. For example, perceptions of what comprises 'aggressive' behaviour and interpretations of when this behaviour is deemed problematic may well vary by gender and ethnicity. It is often therefore people's perceptions of their own experiences, with their subjective interpretations of whether a particular behaviour is problematic, that are reported.

Stillwell *et al.* (2004) looked at young people's negative experiences arising from their drinking (see Appendix 12). Problems included being unwell, poor school performance, having an accident, and relationship difficulties with family and boy/girlfriend. The authors found that White English and Irish young people were more likely to report negative consequences associated with alcohol use, although nearly 20 per cent of Black African and Caribbean respondents also reported some negative experiences in the last year. Black Caribbean males were less likely to experience a negative consequence than Black African, White Irish and White British males, with the difference between the Black respondents approaching significance. For females however, there was a similar likelihood of Black African and Black Caribbean females experiencing a negative consequence, though both groups were less likely than White Irish and White British females to experience this. These findings are consistent with the higher rates of reported drinking among White British and Irish respondents.

People from white backgrounds seem to have a higher incidence of problems with the law, or antisocial behaviour when drinking (see Table 5). Stillwell *et al.* (2004) found that White Irish males were the most likely to report lawbreaking as a consequence of alcohol use, followed by

White English and Black Caribbean males. Black African young people did not report this. White respondents also reported higher rates of being aggressive when drunk, and driving a vehicle in an unsafe manner. Corroborating this finding is a study showing that White English men are more likely than Black African-Caribbean men or Sikhs to get into trouble with the police while drinking (Cochrane, 1999). The authors note that this is a surprising finding, given the perception that police are more likely to identify problem behaviour in minority groups. These results may be explained in part by the context in which drinking occurs; Black African-Caribbean and Sikh respondents were more likely to drink alone, and twice as likely to drink at home than White English respondents, reducing the likelihood that they would attract attention from police.

Purser *et al.* (2001) calculated the likelihood that respondent's drinking may be of concern due to the risks they experienced (see breakdown in Appendix 12). Relatively heavy, frequent and risky

Table 5. Antisocial behaviour/law-breaking when drunk by ethnic and/or religious group

Study	Age	Measurement	Rates by ethnicity and gender		
Cochrane, 1999	17–65			Male	Female
		Trouble with police while drinking	White English Black African-Caribbean Sikh	10% 2% 3%	N/A
Purser *et al.*, 2001	18+			Male	Female
		Aggressiveness	Pakistani Bengali Muslim Sikh Hindu Christian No religion	64% 68% 49% 36% 26% 50% 43%	20% 21% 17% 15% 17% 20% 21%
		Been in fight	Pakistani Bengali Muslim Sikh Hindu Christian No religion	52% 57% 49% 33% 26% 46% 38%	20% 16% 10% 6% 17% 15% 19%
		Stopped by police	Pakistani Bengali Muslim Sikh Hindu Christian No religion	28% 22% 26% 19% 9% 19% 35%	10% 0% 7% 0% 2% 5% 10%
		Been convicted	Pakistani Bengali Muslim Sikh Hindu Christian No religion	20% 7% 10% 7% 0% 7% 16%	0% 0% 3% 0% 2% 0% 5%
Stillwell *et al.*, 2004	14–16			Male	Female
		Being aggressive	White English White Irish Black Caribbean Black African	18% 31% 13% 12%	16% 5% 7% 5%
		Breaking the law	White English White Irish Black Caribbean Black African	18% 28% 8% 0%	11% 11% 2% 0%

drinking, and drinking patterns in need of change were used to measure signs of concern. Out of all participants, the results showed that a third of Black men had two or more signs for concern, followed by about a fifth of Indian Sikh men. Just over a tenth of Black women were likely to be drinking in a way that could lead to concern. However, out of the drinkers only, Pakistani men were the most likely group to exhibit two or more signs that their drinking might be a cause for concern. Other groups with two or more signs were Black men, Sikh men, Pakistani women and Bengali men.

One study found that Hindus had lower levels of risk-taking behaviour associated with alcohol use compared to Muslim, Sikh and Christian respondents and those with no religion (Purser *et al.*, 2001, see breakdown in Appendix 12).

Summary points: drinking consequences and antisocial behaviour

- Problems from drinking or concerns over drinking habits tend to be higher among White respondents than other ethnic groups.
- White respondents have higher rates of trouble with the police and antisocial behaviour when drunk than Black or Sikh respondents.
- Among drinkers, Pakistani men show signs that their drinking may be a cause for concern compared to other minority ethnic groups.

Socioeconomic status, ethnicity and drinking

Measuring socioeconomic status, ethnicity and drinking

The need to consider the importance of ethnicity in the context of other factors such as socioeconomic status shows the complexity entailed for researchers (Bradby, 2003). Few of the identified studies explored the socioeconomic status of the participants as a potential explanatory factor in differences in drinking rates among ethnic groups. This is despite the fact that socioeconomic status is linked to both drinking patterns and to minority ethnic status. Bradby (2003) argues that the link between socioeconomic status and minority ethnic status means that it is imperative that an exploration of ethnicity must also consider socioeconomic status as a linked, and not an independent, variable. Yet the small numbers of minority ethnic groups that comprise most samples within research can make further exploration by socioeconomic status very difficult, if not impossible.

Links between ethnicity, socioeconomic status and drinking

Social class does not appear to be reliably related to drinking levels for most ethnic groups. However, people earning higher wages are less likely to abstain and more likely to drink heavily. Irish men and women and Indian women are more likely to exceed limits and drink heavily if they earn higher incomes.

The 1999 Health Survey for England showed that consumption levels for women in the general population tend to be higher in the non-manual classes than in the manual classes (Erens and Laiho, 2001). A similar trend was observed for Irish and, to a lesser extent, Chinese and Indian women. However, after age standardisation, social class differences in drinking rates disappeared for women in the general population and for all minority ethnic groups. For men there was little difference in drinking rates between the manual and non-manual classes, either within the general population, or within minority ethnic groups.

Other studies also found little difference in drinking rates by ethnicity and social class. One study found that Black African-Caribbean respondents had lower levels of consumption than White English and Sikh men, and that the Black African-Caribbean participants were also more likely to be unmarried, unemployed and in manual jobs, though these factors were not sufficiently related to drinking to be able to explain their much lower drinking rates (Cochrane, 1999). In a study

exploring the drinking of Chinese participants in contrast to Europeans, White *et al.* (2001) found that there was a greater likelihood of people in a higher social class drinking alcohol than those in the lower classes, but the difference was not significant due to the low number of non-drinkers. However, the average amount of units of alcohol consumed per week was not found to vary significantly by social class for either group.

Research does, however, suggest that income has been linked with alcohol consumption, with higher earners showing an increased propensity for drinking. For example, the Health Survey for England 2004 (Becker *et al.*, 2006) showed that men and women whose income is in the highest tertile (third of the population) are least likely to abstain, or be very occasional drinkers. The same was true for Indian, Pakistani, Chinese and Irish men, and Indian, Chinese and Irish women. Irish women are also more likely to drink three or more times a week if they are in the highest income tertile. The same survey showed that Irish men, and Irish and Indian women, are most likely to drink more than eight and more than three units respectively in a session, if they are in the highest income tertile. Irish men in the highest income tertile are also more likely to binge drink.

The findings suggest that income may be a better predictor of drinking than social class among minority ethnic groups and the population as a whole. Patterns of consumption found among some groups, for example the increase in frequent and heavy drinking among Indian women (Becker *et al.*, 2006), may be related to income, lifestyle, education and employment opportunities. Ideally, drinking behaviour needs to be understood within the social and economic context in which it takes place.

Summary points: socioeconomic status, ethnicity and drinking

- Few studies link drinking to ethnicity and socioeconomic status.
- Social class does not reliably predict drinking patterns.
- In the general population and in some ethnic groups, higher income is linked to lower abstinence rates.
- Irish men, and Irish and Indian women with higher incomes consume more alcohol.
- Changes in consumption rates should be considered in parallel with changes in economic status, education and employment opportunities.

3 Drinking cultures

This section of the review considers different cultural attitudes and norms around alcohol use that help to explain differences in drinking rates, and the factors that may lead to changes in consumption patterns for people from different ethnicities. The cultural and social contexts in which attitudes and behaviours around alcohol are established and embodied are discussed, along with possible tensions arising from conflicting cultural norms. In particular, theories of acculturation and bi-acculturation are drawn on as explanations for changes in the drinking habits of both the majority ethnic, and minority ethnic populations.

Attitudes towards drinking and alcohol expectations

The review so far has identified differences in drinking rates between ethnic groups, with differences often being linked to religious beliefs. However, differences in drinking rates between and within ethnic groups also reflect diversity in attitudes and expectations about the enjoyment and purposes of alcohol. Attitudes towards alcohol arise in part from the cultural context, and are passed on through social relationships via the family, peers, local community and the work and school environment. Cultural and social norms help to shape attitudes and beliefs, which are then mediated by individual experiences and expectations. As people model their drinking behaviour to an extent on the wider culture, their drinking patterns are a reflection of the drinking norms and expectations of the larger population. Galvan and Caetano (2003) suggest that liberal norms and attitudes predict both current drinking and greater likelihood of heavy drinking than more conservative ones. There is some evidence that drinking motives are culturally embedded, with different motives found between different countries, but not between different ethnicities within a country. For example, social motives are most often cited as a reason for drinking in countries where there are a great deal of social activities or pressure to drink in social settings (Kuntsche *et al.*, 2006). Associations between ethnicity and alcohol consumption are, however, often inconsistent, in part a reflection of changes in culture and attitude towards drinking, particularly among migrant groups (Pederson and Kolstad, 2000).

Ethnic and gender differences in the perceived benefits and drawbacks of alcohol consumption are evident in the literature. Table 6 shows that South Asians are more likely to say that they would prefer to reduce their consumption or not drink at all, and to disagree that drinking is enjoyable. Chinese respondents, particularly Chinese women, have cited dislike of alcohol as a reason for abstention, with those who do drink doing so only occasionally, and using alcohol for medicinal purposes or special occasions (Sproston *et al.*, 1999). Health reasons are also a concern for some groups; Chinese men report that they abstain for health reasons (Sproston *et al.*, 1999) and London-based Irish men and women are significantly more likely than Irish inhabitants in Dublin to cite the adverse consequences on health caused by consumption as a reason to alter drinking behaviour (McCambridge *et al.*, 2004). Sikh males have reported that they drink to forget their problems, which can be an indication of unhealthy use of alcohol (Cochrane, 1999). Sikh men have also reported that they see benefits from drinking in their work life, indicating alcohol may serve a function when conducting business or socialising with colleagues and business partners (Purser *et al.*, 2001). Conversely, Pakistani men have reported that they believe that low levels of drinking have a positive impact on their work (Heim *et al.*, 2004). In the US, Black and Hispanic people report more conservative views on drinking and drunkenness compared with White people, with more polarised attitudes to alcohol (Caetano and Clark, 1999; Caetano and Medina Mora, 1990).

How attitudes are passed on through the generations, and how new attitudes and behaviours are adopted, is an important aspect

Table 6. Attitudes to drinking by ethnicity

Study	Age	Measurement	Rates by ethnicity and gender		
Cochrane, 1999	17–65			All participants	
		Felt should reduce consumption	White English Black African-Caribbean Sikh	35% 23% 40%	
Denscombe, 1995	15–16			Male	Female
		Agree: 'Drinking alcohol is enjoyable'	White South Asian	87% 28%	84% 34%
		Disagree: 'Drinking alcohol is enjoyable'	White South Asian	7% 34%	8% 29%
		Don't know: 'Drinking alcohol is enjoyable'	White South Asian	7% 39%	8% 37%
Heim *et al.*, 2004	16–25			All participants	
		Would like to reduce consumption	Indian Pakistani Chinese	8% 21% 2%	
		Would prefer to not drink	Indian Pakistani Chinese	16% 14% 5%	
Sproston *et al.*, 1999	16–49			Male	Female
		'Don't like alcohol' (non-drinkers)	Chinese	64%	76%

of explaining why drinking rates change for some minority ethnic groups; or why they do not change to fall in line with the general population, as people retain their traditional cultural beliefs and practices. The relationship between attitudes and behaviour still remains a tenuous one and research has shown that it is possible to uphold strong beliefs about abstention and restrictive drinking practices while still drinking (Bradby, 2007; De Visser and Smith, 2007). Acculturation theory helps to explain changes in drinking patterns for minority ethnic groups, while cultural retention describes how people retain their traditional values and practices. These theories are the focus of the following section.

Summary points: attitudes towards drinking and alcohol expectations

- People from different ethnic backgrounds vary in their approval and expectations of alcohol use, with South Asians reporting less approval, and people from white backgrounds perceiving alcohol consumption as enjoyable.
- Sikh men positively associate drinking with work life, whereas Pakistani men express the opposite view.
- Wider cultural norms need to be considered as influences on drinking attitudes; liberal cultural drinking norms predict current drinking behaviour and heavier drinking.
- Over time, attitudes and behaviours around alcohol use can change.

Acculturation theory

Acculturation theories help to explain changes in drinking patterns that occur in migrant groups over a period of time. Acculturation was originally defined within the field of anthropology as 'those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups' (Redfield *et al.*, 1936, p. 149, in Salant and Lauderdale, 2003). However, sociologists have subsequently focused primarily on 'assimilation'

to describe the effects of Western culture on minority ethnic groups, suggesting a unidirectional influence (Salant and Lauderdale, 2003). This approach has been criticised for its assumption that adopting new behaviours automatically leads to the loss of old behaviours, and that ethnic identity is one's place on the spectrum between two different cultures. Consequently, more recent theories have come to regard acculturation as a multidimensional process, where identification with one culture does not necessarily mean reduced identification with another culture. The bidimensional model of acculturation describes four possible emerging types of identity for migrant groups, with processes seen as orthogonal and independent. Different labels have been suggested for the different outcomes, though the process is the same. Hutnik (1991) describes identifying with the host culture while retaining one's own ethnic identity as 'acculturation'. 'Assimilation' refers to those who identify with the host country but identify less with the culture of one's origins. 'Dissociative' individuals retain their ethnic identity without developing an affiliation with the host country. Individuals who identify with neither culture are 'marginal'. Other authors have described identifying with more than one culture as 'bicultural', fully adopting the new culture as 'assimilative/acculturated', remaining immersed in traditional culture as 'separated/traditional', and associating with neither culture as 'marginalised' (Landrine and Klonoff, 2004). The labels described by Hutnik (1991) are adopted for this review in order to retain a distinction between acculturation and assimilation.

Bi-acculturation

Despite recent recognition within the sociological literature of the complexity of acculturation and its processes, a one-way process of acculturation is implicit in much of the research agenda both internationally and in the UK. It is rare for researchers to explore how drinking and abstention by the migrant group might affect the host group's consumption and that a two-way process of acculturation might be at play. Furthermore, processes of bi-acculturation precede the arrival of new migrants. Due to globalisation leading to cultural influences being transmitted across nations, different ethnic groups will have experienced different levels of westernisation within their own countries prior to moving to the UK, and will encounter certain aspects of their own culture within British mainstream society. Consequently, a consideration of acculturation also depends on taking into account how different the individual's indigenous culture is to the new host culture. Gureje *et al.* (1997) at the time of carrying out their study, reported that drinking wine – sometimes large amounts of wine – with meals was seen as the cultural norm in parts of Spain, while drinking spirits by young people in pubs was considered 'culturally deviant'. It would be interesting to see the extent to which these views are upheld today, especially in cities and other regions more frequently visited by tourists, whose drinking habits are likely to influence local drinking patterns (Room, 2005). Acculturation is bidirectional and, as there is entry into the mainstream population of new migrant groups, then mainstream cultural norms will be likely to alter.

Indeed, Gutmann (1998) argues that within the literature there is an implicit assumption of cultural homogeneity rather than diversity in the migrants' home country and lack of recognition of any changes that may be taking place. This assumption risks stereotyping the cultural background of migrants and subsequent generations, by failing to recognise that temporal shifts in culture and regional diversity in their country of origin will differentiate their experiences in a new country. For example, recent research has revealed that India has increasing rates of alcohol consumption and alcohol-related disease (Prasad, 2009). This has been attributed to a proliferation of bars and nightclubs and marketing campaigns aimed at young people. In particular, young people are drinking more, and consuming their first alcoholic drink at a younger age. Heavy and frequent drinking has also increased among Indian women, who are now consuming amounts similar to their male counterparts. Worryingly, although the proportion who drink remains low, more than half of drinkers are described as hazardous, characterised by binge drinking and solitary drinking, and a fifth of drinkers are dependent, requiring 'help' (Prasad, 2009). Consequently, the high levels of alcohol consumption reported among Sikh men, and the increase in levels reported among Sikh girls and Indian women identified in this review, need

to be considered in the context of changes in drinking rates in India. Indian people in Britain who are now drinking more may be influenced by the changes in consumption patterns in India, as well as being influenced by exposure to white British drinking cultures in the UK.

Room (2005), from an alternative perspective, considers the symbolic role of substance use and the acting out of ethnic identity as a performance. Both use and abstinence become a way of symbolically demarcating ethnic boundaries and point to the social changes that are occurring across generations, religious groups, and among men and women of different ethnicities (Bradby, 2007; Room, 2005). Room argues against a theory of acculturation in which transmission of substance use flows from mainstream culture in one direction only, suggesting that there are a number of trajectories, one of which is the 'construction of a new synthesis distinct from patterns in both the immigrant culture and the receiving society, or the alternative of divergence and differentiation as a marker of an ethnic identity' (p. 329).

Summary points: acculturation theory

- Acculturation is the process of retaining one's ethnic identity and also identifying with the host culture.
- Mainstream cultural norms may change with the arrival of new migrant groups, with neither mainstream cultural norms nor minority ethnic norms being fixed.
- Stereotyping of minority ethnic groups may occur through widespread ethnocentric approaches in the literature, which fail to acknowledge diversity and temporal changes in an individual's home country.

Measuring acculturation

Operationalising the concept of acculturation is problematic, as acculturation is a complex process. Consequently, research may tend to reduce the concept into one or two signifiers of change or cultural retention in migrant groups. Measurements of acculturation typically include language proficiency and use, participation in cultural practices, social relationships, perceived discrimination, sense of belonging, and importance of honouring cultural traditions (Salant and Lauderdale, 2003). However, both acculturation and non-acculturation have been associated with increases in drinking behaviour in the literature.

Historically, much emphasis has been placed on non-acculturation as a consequence of the stresses that can occur before, during and after migration as playing a causal role in problematic substance use (Room, 2005). A number of studies have suggested that not feeling accepted or acculturated into a society may result in drinking being used as a coping mechanism for dealing with stress; for example, Dotinga *et al.* (2006) found higher drinking rates were reported among Turks and Moroccans who did not feel accepted into Dutch society.

Other theories perceive acculturation through integration into the new culture, along with peer pressures and exposure to social drinking practices as a risk factor for increases in consumption (Dar, 2002). Length of time determines how long new groups will have been exposed to new cultures, with studies often measuring the amount of time, or number of generations spent in a new country as an indicator of integration. Research indicates that an increased length of time does lead to an increase in drinking behaviours among some groups. A study carried out among Punjabis in Canada revealed that the vast majority (87 per cent) of those who currently drank (40 per cent) reported not drinking alcohol before migrating to Canada (Kunz and Giesbrecht, 1999). Drinkers in this group had lived in Canada longer than non-drinkers and were more likely to describe themselves as Punjabi-Canadian or Canadian than non-drinkers, suggesting greater integration into mainstream Canadian culture. Additionally, higher rates of abstention have been reported among Mexican women migrating to the US than among women in general in the US and among their Mexican counterparts (Collins and McNair, 2002). But over the course of three generations the drinking profiles of Mexican American women and women in the general US population become indistinguishable.

Abstention rates among Mexican American women decline and they are more likely to drink at light to moderate levels and show increases in heavy drinking (Gilbert and Collins, 1997, in Collins and McNair, 2002). These findings support a model of acculturation that point to increases in alcohol consumption as a result of time spent in the host country, rather than as a consequence of the stressors associated with migration.

Although both stress and integration as risk factors may apply, they represent different models, and can predict opposite effects. The former model suggests that residence in Western society will, after a period of time, reduce the risk of substance use if initial pressures are resolved. The second model indicates that increased time spent in Western society will have a corresponding increase in the risk of substance use, as people gradually adopt the norms and values of the host country. The first model may seem readily applicable to 'dissociative' or 'marginal' individuals according to the bi-dimensional model of acculturation. The second model may appear more suited to 'assimilated' or 'acculturated' individuals, but will only put people at increased risk if the norms in their country of origin have lower rates of drinking and substance use.

Supporting the view that integration may increase risk for some groups, Adrian (2002) suggests that individuals moving from a high consumption area to a low one will be likely to alter their usage over time to fall in line with the level of their new destination. Such individuals would be less vulnerable than individuals moving from a low consumption area to a high one, which would place them at greater risk. As most minority ethnic groups historically have lower consumption rates than White British people, they will be at risk of adapting their behaviour in line with the general population. Indeed, studies have generally shown that differences in health behaviours are most apparent between groups who maintain traditional habits and groups who are most acculturated. Consequently, higher levels of acculturation are associated with significant changes in health behaviours (Landrine and Klonoff, 2004).

One mediator of acculturation will be the ethnic density of the local population. Maintaining traditional cultural behaviours will be easier for minority ethnic people living in close proximity to people from the same or similar ethnic and religious backgrounds. Recent research in the UK suggests that the ethnic density of the local area is associated with differences in drinking behaviour (Becares, 2009). The research showed that respondents from all ethnic groups who reside in areas defined as predominantly non-White had lower odds of current drinking compared to counterparts living in White area types. White respondents living in non-White areas were less likely to drink, though only significantly less likely in Mixed and Black area types, and they were more likely to drink as co-ethnic density increased. Minority ethnic people residing in a predominantly White area are similar to people moving into a high consumption area as described by Adrian (2002) and may be considered to be high risk for increases in alcohol consumption, whereas minority ethnic people residing in areas with high co-ethnic density may be considered lower risk.

Learning theory and acculturation

Landrine and Klonoff (2004) have developed a theoretical model of acculturation using learning theory. This model predicts that recent migrants with a low prevalence of risky behaviours (which would include low alcohol consumption) are *most* at risk with acculturation to a host country such as the US. Conversely, those migrants with more risky behaviours are predicted to show *declines* in these behaviours with acculturation. The most at-risk group for increased drinking would thus be women who have migrated recently and who still maintain their culturally traditional behaviours. They are likely to display few health-aversive behaviours and a cluster of health-affirming behaviours while non-acculturated. With the proviso that this model requires empirical testing, Landrine and Klonoff suggest that it has implications for prevention programmes, which should focus on helping to maintain cultural traditions that promote health-reinforcing behaviours.

Although successive generations may become more acculturated, acculturation processes will differentially affect ethnic groups. Galvan and Caetano (2003) report considerable variation across ethnic groups and for subgroups within the same ethnicity. High rates of stability among white people of various nationalities are evident despite many generations of acculturation e.g. people of Irish heritage in the US have higher rates of frequent heavy drinking than do other white US people; those of Italian, Austrian, English/Scottish, Greek heritage. Amundsen and colleagues (2005) examined drinking patterns and acculturation in Norway among second-generation students from Pakistan and Vietnam, both with low levels of recorded drinking. The proportion of Vietnamese second generation drinkers matched that of the general population; however, the proportion of Pakistani drinkers was still at a lower level, particularly for women, reflecting ethnic and gender differences in acculturation processes and the continuing influence of religious background.

In a UK study, minority ethnic respondents were asked to reveal how closely they identified with a British and 'ethnic' identity, using the orthogonal model (Purser *et al.*, 2001). Respondents were more likely to report that they strongly identified with their cultural origins than with feeling British. Among the Black, Pakistani and Bengali groups Muslims, Christians and non-religious people were most likely to feel strongly attached to their ethnic culture. Indian Hindus and Sikhs were mostly likely to identify with both cultures. However, the usefulness of the model in explaining drinking patterns is questionable. Although the findings indicated that 'dissociative' females were less likely to drink, and 'assimilative' males and females were more likely to drink, ethnic identity was not strongly associated with drinking behaviour. Gender, religion and age had much stronger associations. Other authors have also pointed to the limits of the bi-dimensional model, as it is descriptive and does not help to explain why people adopt some behaviours and not others; why there are inter-group differences; and why there are intra-group differences (Landrine and Klonoff, 2004).

Summary points: measuring acculturation

- Individuals moving from a low consumption area/country to a high one will be at increased risk as their drinking behaviour adapts to higher general population drinking levels.
- Non-acculturation can result in drinking being used to cope with the stress of non-acceptance.
- There are cultural influences unique to some minority ethnic groups that affect their drinking patterns.
- Acculturation and non-acculturation may be risk factors for increases in consumption levels, but risk will depend on the functions of alcohol use, which will vary between individuals and between ethnic groups.
- A bidimensional model of acculturation is limited, failing to explain the take-up of some behaviours and not others, and within-group and between-group differences in drinking behaviours.

Socioeconomic status, gender and acculturation

Acculturation processes for individuals and ethnic groups will be influenced by the socioeconomic context. The ability of some groups to access social resources will affect their ability to prosper and benefit from the host country and may affect a sense of belonging. As previously discussed, socioeconomic status has been linked to differences in drinking habits, with earners in the higher income tertile more likely to drink (Becker *et al*, 2006). Research has shown that over the course of time (three generations) the drinking profiles of Mexican American women and women in the general US population become indistinguishable (Gilbert and Collins, 1997, in Collins and McNair, 2002). Collins and McNair suggest that

socioeconomic changes and how they relate to alcohol consumption are responsible for these changes. Increases in education and income, coupled with living alone or being divorced, predict heavier consumption among Mexican American women as they do for the population in general. Working women are initiated into new social contexts of drinking in public environments, with work colleagues. Collins and McNair conclude that the benefits acquired through acculturation may also act as risk factors for heavy drinking.

Socioeconomic status can also help to explain gender differences in drinking rates. A study carried out among Punjabis in Canada revealed that most of them started drinking after migrating to Canada (Kunz and Giesbrecht, 1999). However, drinking was reported by fewer than 10 per cent of Punjabi women compared with 62 per cent of Punjabi men. Higher socioeconomic status is linked with greater alcohol consumption, but Punjabi women are disadvantaged educationally, economically and in their employment in comparison with men. The difference in socioeconomic status could therefore explain some of the gender difference in drinking.

Conversely, Room (2005) considers how low socioeconomic status may be linked to drinking for some migrants. The idea of the '*Gastarbeiter*'– the male working migrant, who is likely to be at the bottom end of the socioeconomic ladder, as he is both comparatively poorly paid and likely to be sending money home, ties in with Leao *et al.*'s (2006) hypothesis that the social network of migrants may be weaker and that this could act as a mediator for problem substance use.

Summary points: socioeconomic status, gender and acculturation

- The benefits of increased education and income acquired through acculturation may, over time, act as risk factors for heavy drinking.
- New drinking contexts, especially for some male migrant workers, may lead to increases in drinking occasions, but poor networks may mediate problem drinking.
- Higher socioeconomic status is associated with greater alcohol consumption, but some minority ethnic groups of women may still remain disadvantaged educationally, economically and in the workplace.

Social drinking cultures

Learning theory (see page 41) is often used as a framework to help explain the adoption of new norms and behaviours in new contexts. One of the strongest influences on the adoption of drinking patterns in the UK is the social aspect of alcohol consumption. In the UK drinking is often a social activity among some members of the population, and alcohol is available in social contexts. People who participate in social events where drinking is prevalent will be exposed to drinking establishments and will be introduced to drinking cultures through work and friends.

Research on ethnicity and drinking practices reveals that spending time with friends is often linked with an increased likelihood of drinking. Karlsen *et al.* (1998) found that White and Black Caribbean young people had the highest rates of alcohol use and frequency, and were also the groups most likely to spend spare time with friends and be involved in after-school activities, compared to Black African and Bangladeshi young people. Additionally, Black African participants' likelihood of drinking increased significantly between the ages of 12 and 13 years, and 14 and 15 years, and this coincided with an increased likelihood of spending spare time with friends and less time with family. A study carried out with White English, Black African-Caribbean and Sikh adults found that all three groups were most likely to report drinking with friends or workmates (Cochrane, 1999). Table 7 shows the drinking preferences of these groups, and reveals that White English respondents are more sociable in their drinking habits, are less likely to report drinking alone and are considerably more likely to report drinking with family.

Preferences about where alcohol is consumed and with whom can therefore vary by ethnicity. In the US, Treno *et al.* (2000) found that Black people

Table 7. Drinking preferences by ethnicity

Measurement		Rates by ethnicity		
		White English	Black African-Caribbean	Sikh
Where	Pub Club Home Elsewhere	55% 24% 15% 6%	43% 20% 30% 7%	61% 3% 31% 4%
Who with	Alone Friends/workmates Family	6% 62% 42%	25% 40% 28%	24% 51% 26%

Source: Cochrane, 1999

and Hispanics were more likely to drink at home and less likely to use public drinking establishments such as pubs and restaurants. They were more likely to drink at parties and special events with friends and relatives. White people, in contrast, preferred to drink in bars and restaurants. Treno and colleagues argue that these differences are so persistent, after having controlled for other determinants of venue choice, as to suggest that they are culturally embedded. Environmental factors may play an important role in the choice of drinking venue, they suggest. Areas with high densities of minority ethnic communities often have greater densities of alcohol outlets and there are both social and economic gains from buying there.

The likelihood of drinking will be influenced by the perceived benefits or drawbacks alcohol has for social integration. In the UK literature, many minority ethnic groups have reported that alcohol helps them to relax and improves their social life (see Purser *et al.*, 2001). They report an improvement in friendships, though less so for Christian and Hindu women and Pakistani men. South Asians also reveal that drinking gives them more self-confidence. Conversely, a different study found that Indian, Pakistani and Chinese respondents did not report that drinking has any significant effect on their friendships or social life (Heim *et al.*, 2004).

While drinking may facilitate social integration in some contexts, it can also lead to some ethnic groups being alienated from their local community. Purser *et al.* (2001) report that Sikh and Christian males described improved participation in their community as a consequence of drinking. However, Muslims and Hindus, and women in general, were less likely to see benefits in this regard. Pakistani men and Bengali women in particular were most likely to associate drinking with less community activity. Negative community responses can also lead to drinking being 'hidden' from the community. In Heim *et al.* (2004), 31 per cent of Pakistani respondents felt that their community ignores or hides drinking among its members, compared to 6 per cent of Indian and 6 per cent of Chinese respondents. A small number of Pakistani people also indicated that problem drinking may be dealt with through violence or drinkers being sent back to Pakistan. Chinese respondents reported the most positive response, with the majority feeling that their community is informed about alcohol consumption and that it is not an area for concern within the community.

Peer-group influences on drinking patterns

Research has shown that people who have more inter-ethnic relationships are thought to acquire new behaviours more readily than those who associate mainly with people from their traditional culture (Landrine and Klonoff, 2004). In a study of second-generation minority ethnic people in Britain Purser *et al.* (2001) found that four out of ten minority ethnic people reported that most or all of their friends were from the same ethnic background as their own, with one in twenty reporting that less than a quarter of their friends were from the same ethnic group. People with inter-ethnic friendships were more likely to drink; in particular women aged 25–34 years showed a greater likelihood of drinking if half or fewer than half of their friends were from their own ethnic group. However, age mediated the association; younger women who drank tended to do so regardless of who their friends were.

Another study showed that Indian, Pakistani and Chinese young people were more likely to drink if they had friends outside their ethnic group and/or friends within their ethnic community who drank (Heim *et al.*, 2004). Hence, acculturation through association with peers forms an important part of understanding changes in drinking behaviour.

Supporting these findings from the UK literature are international studies carried out in schools that have identified some correlation between the ethnic composition of schools and the drinking patterns of the students. A Norwegian study found that schools with a higher percentage of Muslim students were associated with less drinking among the student population, in particular among those with an ethnic Norwegian background (the majority group) and among migrant girls (Amundsen *et al.*, 2005). In a study looking at the relationship between episodic heavy drinking and ethnic composition in Dutch schools, Monshouwer *et al.* (2007) found that a relatively high percentage of ethnic minorities in a school was associated with a lower probability of episodic heavy drinking, but only among the minority ethnic students. These findings seem to suggest that young people from predominantly white ethnic schools, or forming friendships with predominantly white peers, may be more at risk of frequent or heavy drinking. They also suggest that if schools have a higher rate of minority ethnic students, this may sometimes result in less drinking among the ethnic majority population. These findings reinforce bi-acculturation theory by demonstrating how drinking behaviour can follow a 'bi-directional acculturation process', where ethnic minorities may be influenced by the drinking habits of the majority, and vice versa (Amundsen *et al.*, 2005).

Young people from different ethnic backgrounds will be differentially affected by peer-group influences. For example, research has shown that peer effects are not as strong for Black young people (Kawaguchi, 2004) and a study in Sweden revealed that young people from outside Sweden were more susceptible to peer influence than young people born in Sweden (Lundborg, 2006). In the Norwegian study (Amundsen *et al.*, 2005) described above, the influence of bi-acculturation was evident for the ethnic majority students and minority ethnic females. Conversely, the Dutch study (Monshouwer *et al.*, 2007) found that only the minority ethnic students seemed to be influenced by the ethnic composition of the school. Bi-acculturation through peer groups is therefore not a uniform process by any means, but will depend in part on the structure and inter-ethnicity of friendships, which will vary by country, region and ethnic group.

Summary points: social drinking cultures

- Drinking socially is important for a number of minority ethnic groups but different groups report different social benefits and problems associated with drinking.
- Choice of drinking venues and occasions appear to be persistent and therefore culturally embedded for some groups.
- Friendship groups in the UK with high inter-ethnicity are more likely to lead to the take-up of new behaviours, including alcohol use, than having friends from the same cultural background.
- Alcohol consumption can be affected by bi-acculturation processes, with people from white backgrounds being influenced by low rates of drinking among minority ethnic people and vice versa.
- Bi-acculturation through the peer group will be influenced by the structure and inter-ethnicity of friendship groups.

Ethnic resilience and cultural retention

Despite the pressures of living in a 'wet' culture, some ethnic groups maintain lower rates of consumption compared to the general population, often by retaining traditional customs and norms. This retention may even deepen overtime; Gutmann (1998) argues that it is assumed that there is a unilinear relationship with length of time spent in

the host country and being acculturated. In reality, intensifying ethnic identity may be minority ethnic people's response to racism or a way of preserving cultural traditions when contact with their country of origin is minimal. Indeed, within some of the literature on acculturation, attention has shifted to focus on the manner in which ethnic groups hold on to their ethnic identities and negotiate new identities. Ethnic resilience refers to the awareness of differences between different ethnicities and how social solidarity is based on them (Portes, 1984).

Some studies measure cultural retention through language spoken at home. For example, Chen *et al.*, (2000) attempted to classify adolescents living in Australia into two groups, those speaking English at home and those speaking a language other than English. Language spoken was proposed to overcome problems in defining ethnicity and as an indicator of acculturation; although no overall assessment of acculturation was made. They found the prevalence of all substances, legal and illegal, to be lower among young people who did not speak English at home. Although language spoken at home is an indication that the research subject practises one aspect of their traditional culture within the home environment, it is not also an indicator of lack of integration into mainstream society, unless an 'assimilation' approach to acculturation is adopted.

Few qualitative studies were identified which explore how cultural retention operates within ethnic groups, but they offer valuable insight into how minority ethnic people deal with conflicting values and attitudes towards alcohol consumption. The retention of traditional cultural beliefs and norms may enable some to resist the pressures of mainstream values that normalise alcohol use in 'wet' cultures. Which traditional beliefs and norms are influential will indeed vary across cultures, and more needs to be understood about how active cultural retention operates in ethnic groups.

The family

The family forms an essential part of cultural retention for some minority ethnic groups, passing on cultural practices through generations. Young people from cultures where drinking is not a part of family life or traditional culture are less likely to be initiated into drinking practices and may face expectations from family members that they do not consume alcohol. Pakistani men have reported that they believe that low levels of drinking have a positive impact on parental relationships. These findings suggest that Pakistani men may be sensitive to the impact their drinking has on those around them, and may be an indication of how attitudes are passed on through generations (Heim *et al.*, 2004).

Research has shown that minority ethnic people who do drink are more likely to hide their drinking from their family than from their friends. Purser *et al.* (2001) found that most of their minority ethnic respondents reported that their friends knew about their drinking, but less than half reported that their parents and siblings knew, and even fewer reported that their grandparents knew. Concealing use may stem from fear of punishment or disapproval from family; South Asian young people are more likely to fear parental retribution for drinking compared to white young people, believing that parents would punish them severely (Denscombe, 1995). In a study examining young Asians and drug use, Patel and Wibberley (2002) also report young people's fear of rejection and being sent 'back home' (p. 57) as their family's possible reaction to the discovery of their substance use.

If family members drink, then this increases the likelihood that young people will also try alcohol and adopt drinking habits. Purser *et al.* (2001) found that Hindu men are four times more likely to drink if their father drinks. Paternal drinking also increases the odds that Muslim men will drink, although numbers were very small, so the finding should be interpreted with caution. Maternal drinking was very uncommon among the Asian community, but where it did take place, daughters were highly likely to follow their mother's example.

Young people who spend more time with the family will not be as exposed to social influences from outside the home. Furthermore, young people with close family attachments may gain less benefit from imitating their peers, and more benefit from adopting the behaviours expected from them in their family environment. Attachment to family varies according to culture and ethnicity; a study carried out in the UK revealed that Bangladeshi youth showed less peer involvement

and higher levels of familial involvement with lower levels of alcohol and substance abuse. These patterns were reversed for the White youth in the study, with Black African and Black Caribbean youth falling somewhere in between (Karlsen *et al.*, 1998). In a study in Norway it was found that the influence of the family, particularly time spent with family, weakened the association between being a migrant and being an abstainer for girls (Pederson and Kolstad, 2000). Gender roles and expectations are clearly a factor here, as girls are more likely than boys in some cultures to be required to participate in family activities.

In a qualitative study, Bradby (2007) explores how Asian young people discuss their consumption of, and abstention from, alcohol. As future guardians of family honour and morals, and because of gender role expectations of responsibility for the care of family and dependents, the behaviour of Asian young women is under constant scrutiny by older generations of women. But many young Asians, while paying lip service to traditional values, view them as being too restrictive. An erosion of these values may create a tension in how Asian women negotiate their identities, particularly in the pressure to adapt to the more permissive drinking practices of student life when they enter further and higher education, and also in the workplace. Drinking was expected to rise particularly among non-Muslim women with greater integration into mainstream society (Bradby, 2007).

Young people from mixed ethnicities may be exposed to different drinking cultures within their own family, from parents and grandparents. The number of people from mixed ethnic backgrounds is growing in the UK, comprising 1.2 per cent of the population in the 2001 Census. People from mixed ethnicities are more likely than any other ethnic group besides White British to describe their identity as British, with nine out of ten people of mixed ethnicity describing themselves this way (Office for National Statistics, 2001). Given the association between being of mixed ethnicity and frequent drinking (Information Centre, 2007), current and heavy drinking (Goddard, 2006) identified in recent surveys, the cultural identity and drinking experiences of young people from mixed ethnicities are of particular interest for further research.

Marriage and relationships

Minority ethnic research participants are generally more likely to report drinking if their spouse or partner also drinks. However, Purser *et al.* (2001) report that being married, living with a large number of people in the same household, and not working outside the home, has been linked to not drinking among women. In particular, Muslim and Hindu men rarely reported that their wives drank, with Sikh men being the most likely to report this, though numbers were still low. The authors found that although women were more likely to report drinking if their husband drank, the association between an individual's drinking and spousal drinking was not very strong. Bangladeshi men were also likely to report that alcohol was not beneficial to their married life. Other research has also shown that White English and Black African-Caribbean men are less likely to drink if they are married (Cochrane, 1999).

Reporting alcohol problems in a spouse or partner has also been shown to vary by ethnicity. Research on women in prison or on remand found that white women were more likely than minority ethnic women to report that their partners had a problem with alcohol; 26 per cent of white women and 9 per cent of black/mixed race women with partners reported that their partner had alcohol problems (Borrill *et al.*, 2003). The same study found that no ethnic minority (Black, Asian and Mixed race) men in prison reported that their partners had problems with alcohol.

Summary points: ethnic resilience and cultural retention

- Lower rates of drinking may be maintained by upholding traditional cultural practices.
- In cultures where drinking is not part of family life, young people are more likely to conceal their drinking from their family because of disapproval or fear of punishment.

- Close family attachments and family involvement can protect against raised drinking levels, but gender role expectations mediate ethnicity and abstention for girls.
- Although both partners in a couple are likely to drink if a spouse drinks, factors such as working outside the home living in a large household, and being married is linked to abstinence among women.
- White women are more likely than Black/Mixed race women to report that their partner has alcohol problems.
- Muslim and Hindu men are not likely to report that their wives drink.
- Black, Asian and Mixed race men are not likely to report that their partners have alcohol problems.

Religion and cultural retention

Acculturation will vary according to whether groups and individuals' customs and practices are sacred or secular, and traditional theories of acculturation have been criticised for neglecting this distinction when they consider acculturation processes (Stodolska and Livengood, 2006). Acculturation will be different for groups in the UK who continue to practise religion, compared with groups whose cultural traditions are not directly informed by religious beliefs. It is believed that the latter group will assimilate the practices and behaviours of the host culture faster than the former. Consequently, it has been argued that ethnic and religious acculturation should be treated separately (Gans, 1994). This proposition is supported by the findings in the UK literature that there is less reported change in drinking rates for religious groups, especially where proscription is the norm. Continuing religious practice is very important for some ethnic groups and helps to explain the continuing disparity in drinking rates between groups within the population.

Alcohol and the Muslim community

As discussed previously, alcohol use within Islam is prohibited. Bradby (2007) reports that not only drinking but even the serving of alcohol is forbidden among Muslims and that abstention is therefore strongly tied to an Islamic identity. Contravening this religious proscription would throw into question an essential element of what it means to be Muslim. Despite this, gradations of adherence to this religious proscription can be seen among young Muslim men.

While being a devout Muslim is synonymous with abstinence, the influence of Muslim faith as a constraint on drinking is evident in qualitative research on young male Muslims who drink. For these young men it is possible to be less devout and to drink in moderation in order to avoid the harmful effects of excessive drinking (De Visser and Smith, 2007). Indeed, all Asian groups in this particular study frowned upon drunkenness. It should be noted, however, that these findings contrast with some of the quantitative data that indicate that alcohol consumption is comparatively heavy among Pakistani and Muslim drinkers (Cochrane and Bal, 1990, in McKeigue and Karmi, 1993; Heim *et al.*, 2004; Purser *et al.*, 2001).

The findings from research exploring drug issues among different ethnic groups in Glasgow echo the importance of religion acting as a barrier both to actual use but also to disclosure of drug use among Pakistani people, most of whom were Muslims (Ross *et al.*, 2004). In the same study drug use was felt to be widespread and on the rise among young people of different ethnic groups, and participants in the survey provided lower estimates of drug use than those taking part in the possibly less formal and more confiding atmosphere of discussion groups. Similarly lower estimates of drug use among young Asians are reported in a quantitative survey compared with findings of more widespread use in a qualitative study (Patel and Wibberley, 2002). Young Pakistani people born in Britain, whose parents were born in Pakistan and were Muslim, felt pressurised to hide drug use from their families because of the shame that discovery would unleash on their family and community. Wanigaratne *et al.* (2003) similarly describe the same reasons for concealing drug use. Tension

was evident in the accounts of some young people through the conflicting pressures of their ethnic religious and cultural norms and the need to integrate into the wider community in their daily life at home in Britain. While some young people wanted to take part in some of the social practices of being young in Britain, such as visiting clubs, pubs and engaging in substance use, legal and illegal, and to break away from traditional attitudes, others felt alienated, finding themselves belonging neither to their ethnic community nor to the mainstream white society. These young Muslims were fearful of threats, rumoured to involve prohibiting continued relations with friends and being sent away to live elsewhere. Even though there was little evidence to support these threats, they are firmly embedded in the drug discourse of Pakistani young people (Ross *et al.*, 2004).

Alcohol and the Sikh/Hindu community

In the case of Asian young people of Sikh and Hindu religions, sanctions in the use of alcohol are found to be highly gendered. Officially, religious proscriptions on alcohol are equal for men and women, but in the case of Sikhs and Hindus, concerns about marriage prospects being tainted by poor reputation are manifested through greater constraints on women's substance use than on their male counterparts (Bradby, 2007). Ross *et al.*, (2004) similarly describe parental worries regarding the jeopardising of their daughter's marriage prospects if they should be found to engage in mainstream British substance-use practices. Young women who drink run the risk of having their morality thrown into question, and protecting family honour and reputation means that they must avoid drinking, at least in public. Strong gender discrimination and fear of reprisals within their community also suggests that the extent of disclosure of drinking must be treated with some caution; indeed, studies exploring illicit drug use suggest that some groups of Asian women constitute hidden populations for these reasons (Cottew and Oyefeso, 2005; Wanigaratne *et al.*, 2003).

Cultural practices rather than religion play a far more important role in this respect when contrasting drinking tolerance for male Sikhs and Hindus in comparison with women's obligatory abstinence. While conforming to tradition may offer protective health benefits for young women in particular, tradition and religion are felt to be much more important influences than concerns about health.

Gender and religion

The interaction between gender, religion and acculturation is apparent in the research which reveals how men and women are differentially influenced by religion and acculturation processes. For women, although drinking rates are lower than men's across religious groups, religion does not appear to play an explanatory role in their lower consumption rates. Purser *et al.* (2001) found that even women with 'no religion' have lower rates of heavy and very heavy drinking. The same study also found that, for men, religion was more important than social or cultural factors for predicting drinking behaviour, and that religious identity was associated with less risky drinking. However, although religion was also an important factor for women, their drinking was predicted by a more complex set of variables than men's. One interpretation of these findings is the marked cultural differences women from some backgrounds face in the UK around employment, friendships and new freedoms that are not available to them in their country of origin. These freedoms will be dependent on individual circumstances; women who are married or spend a lot of time in the family home are less likely to be exposed to influences that contrast with the cultural norms of their home country.

The importance of religion for men is further conveyed in the work of Bradby (2007) and De Visser and Smith (2007), where the tension between maintaining an Asian – and in particular a Muslim identity – and a British identity, is explored through drinking practices. While masculinity is strongly equated with high levels of drinking among white ethnic groups, this is not the case for the majority of Asian young men. For them, the independence to make appropriate choices that do not compromise their integrity, and being able to resist peer pressure to conform to drinking norms, are seen as vital to masculine identity, particularly so for young Muslims (De Visser and

Smith, 2007). In contrast, drinking was found to equate with manliness among non-Muslim men, that is, Sikh and Hindu (Bradby, 2007) and also some Asian men in general (De Visser and Smith, 2007). Attitudinally there is greater receptivity to alcohol consumption among young Sikh and Hindu men than there is, for example, among young Muslim males. This, coupled with increasing integration into mainstream young drinking cultures, might predict a rise in alcohol consumption.

Summary points: religion and cultural retention

- A distinction needs to be made between ethnic or secular acculturation and religious or sacred acculturation.
- Less change is reported in drinking rates for religious groups, especially where alcohol is proscribed.
- Abstinence is strongly linked to Islamic identity, although some young men drink in moderation but still remain devout Muslims.
- Muslim faith constrains drinking, and drunkenness is frowned upon and considered harmful.
- For young Sikh and Hindu women who drink, gender role expectations of abstinence and fear of reprisals indicate that disclosure of drinking may be under-reported.
- Concerns about health are perceived to be less important among young women than cultural traditions and pressures, and this has implications for preventative measures.
- Many young Asian men, particularly Muslims, associate masculinity with resisting pressures to drink; among Sikh and Hindu men, drinking is more likely to equate with masculine identity.

Understanding different cultural attitudes to problem drinking

Research into acculturation and ethnic resilience indicate that there are influences unique to the ethnic group that affect differences in drinking patterns. The challenge remains to tease out the nature of these influences. Whether increases in alcohol use are associated with acculturation or non-acculturation depends on the functions that alcohol use has for individuals and for ethnic groups. More needs to be known about the functions of drinking and the inter-relationships of culture, religion and socioeconomic status both within a culture and across different cultures.

Inherent in much research into alcohol use is an attempt to capture heavy or problem drinking, in order to minimise harm and develop support services. Problem drinking within the research literature has been variously defined and is often derived from concerns around health problems and antisocial behaviour associated with excessive consumption. Deviation from social drinking norms, including the context in which drinking takes place and motivations for consuming alcohol have also been used to flag up potential problem use. Consequently, definitions of problem drinking tend to vary over time within cultures, as well as varying across cultures. Problem drinking defined by researchers may contrast with problem drinking as defined by the ethnic groups being studied. For example, people from Islamic backgrounds may view any drinking by Muslims as problematic, including drinking that falls within guidelines for sensible use. A study carried out among Punjabis in Canada revealed that most (70 per cent) believed that problems with alcohol were widespread in their community, even though rates of drinking were considerably lower than in the Canadian mainstream population (Kunz and Giesbrecht, 1999). The authors suggest a need for greater understanding of attitudes to drinking and how problem drinking is viewed within the Punjabi culture.

In other cases, rates perceived as problematic by researchers may not be deemed inappropriate by the ethnic group being studied. Adrian (2002) notes the underlying and continued tendency to present a problematic view of an ethnic group's

experiences. For example, the use of alcohol as a coping strategy to deal with the stresses of migration and acculturation is often presented for Irish migrants, rather than alcohol acting as a mechanism of social integration and reinforcing of group identity. Socioeconomic pressures due to lack of power because of money shortages and lack of social standing, together with racial tension, may be added to the list of stressors (Al-Issa, 1997, in Caetano *et al.*, 1998). According to Adrian (2002) such discourses can endorse the status of minority ethnic groups as being problematic. More recently, Room (2005) has suggested that dimensions of status and power play a role in characterising how substance-use behaviour in certain ethnic groups is identified as problematic.

A tendency within the literature is to pre-define 'problematic' without due consideration of the norms that shape drinking behaviour. These norms are in turn shaped by the context within which drinking occurs. Gureje *et al.* (1997) argue that problem drinking needs to be seen within its environmental context together with the type of drink being consumed. This is more meaningful than, for example, only measures of quantity consumed. Adrian (2002) contrasts an ethnographic approach, drawn from anthropological studies, in which the substance use of one ethnic group is closely observed within its naturalistic setting, with more recent comparative studies. These are concerned with the substance use of migrant groups compared with use in the mainstream population. She explains that historically, drinking and drinking to get drunk in anthropological literature was often identified as having a ritualistic function to promote social integration within a particular group, serving to reinforce the group's identity (e.g. Gordon, 1978, in Adrian, 2002). Neither drunkenness nor the individuals involved were portrayed as problematic in this kind of account. This contrasts with a more recent view in which substance use among minority groups was perceived as deviating from the majority population norms (Adrian, 2002).

Minority ethnic groups may define problem drinking according to their traditional cultural views on consumption, and regard rates lower than the general population as problematic. This has implications for service provision, where most services will define problem drinking according to the levels in the general population and government guidelines. If services are to be culturally sensitive, there needs to be recognition of how different cultures view problematic drinking, rather than a blanket approach which derives definitions of need from the habits and attitudes of the ethnic majority. The following section focuses on the service needs of different ethnic groups.

Summary points: understanding different cultural attitudes to problem drinking

- A definition of problem drinking based solely on measures of consumption is inadequate; it fails to reflect different cultural norms that shape drinking behaviour and is defined according to the normative rates of the host country.
- A focus on the stresses of migration as an explanation for problem drinking risks 'problematising' a group's experiences and fails to acknowledge diversity of experience. The status of a minority ethnic group may thus be uniformly cast as problematic.
- Cultural variation in perceptions of problem drinking needs to be better understood in order to understand minority ethnic groups' experiences, and to plan appropriate service provision.

4 Service provision and access

Policy context

By way of the policy context, a Commission on the Future of Alcohol Services, set up by Alcohol Concern in 2002, emphasised a lack of commitment to the development of appropriate services for black and minority ethnic communities. It recommended a set of different strategies in areas with high concentrations of people from black and minority ethnic communities compared with areas in which minority ethnic communities are more scattered (Johnson *et al.*, 2006). Importantly, it recognised a key preference among minority ethnic groups to approach problem solving within a community or family context. The need for continuous evaluation of models of service provision was similarly stressed to reflect the changing values and demographics of the various minority ethnic groups (Johnson *et al.*, 2006).

The Alcohol Recovery Project, building on this recommendation, has emphasised the development of separate services for people from black and minority ethnic groups together with more general services designed to work with diverse groups. But Johnson *et al.* (2006) found that services comprehensive enough to serve the wider community were rarely in evidence, nor had much expertise been developed in dealing with the needs of minority ethnic groups. They concluded that adequate service provision for minority ethnic groups was largely absent; that the level of need was impossible to establish and that the Race Relations Amendment Act requirements were not always upheld.

The most recent opportunity to address these gaps in provision was presented in Safe. Sensible. Social (2007), the latest government alcohol strategy but, disappointingly, this failed to consider the needs of problem drinkers among different minority ethnic groups. The Safe. Sensible. Social. Toolkit (2008) was developed as a resource to deliver the strategy at local level and, although it does recommend addressing the needs of black and minority ethnic groups, advice is generic. It suggests that an assessment of needs and development of appropriate services for diverse groups, including minority ethnic groups, could improve treatment provision. Nevertheless, lack of consideration of these groups within the strategy points to a gap between policy and practice, and implementation guidance that covers minority ethnic groups generically suggests that research is not fully reflected in practice.

A necessary part of this review is to highlight findings that are relevant to developing services among minority ethnic groups and a good foundation for this already exists in the comprehensive work of a number of key authors in the field, notably, Johnson *et al.* (2006) and the work of the Alcohol Education Research Council; Orford *et al.* (2004); Subhra (2003); Hay *et al.* (2001); Purser *et al.* (2001); Chauhan and Subhra (1999); and Hyare (1999). This section focuses on findings from the review which have implications for the identification of needs and the development of appropriate service provision among minority ethnic groups.

Assessing need

The National Needs Assessment Research Project (ANARP) for England in 2004 (Drummond *et al.*, 2005) provides a comprehensive assessment of needs and a survey of alcohol treatment services. Detailed estimates of harmful drinking prevalence are given in Section 2 and indicate little difference in prevalence between minority ethnic groups and the white population for alcohol dependence. Part of the project involved research among Drug and Alcohol Teams professionals (DAT) and agencies providing specialist alcohol interventions. Among DAT professionals, minority ethnic groups were perceived to be the most disadvantaged for accessing alcohol treatment and refugees/

asylum seekers were also considered to be disadvantaged. While agency staff believed all clients with alcohol problems to be poorly served by alcohol treatment services, ethnic minorities were among client groups thought to be particularly poorly served (Drummond *et al.*, 2005).

The ANARP survey provides estimates of harmful and dependent drinking in the population in England as a whole, but it is important to examine the drinking patterns of special populations likely to be more at risk for harmful levels of alcohol consumption. The findings from studies by Borrill (2003) carried out among prison populations, for example, reveal much higher rates of harmful and hazardous drinking among people from minority ethnic groups in the year before they entered prison, compared with the population as a whole as described in the ANARP survey. However prevalence of harmful/hazardous drinking was approximately double that estimated in the ANARP study for both White and Black/Mixed race groups. Of the women, only 3 per cent of the Black/Mixed race group received help for alcohol related problems in prison compared with 9 per cent of the White sample. Among the male minority ethnic sample, about a third had received help. Borrill (2003) points out the need for developing services that address alcohol misuse for both men and women of minority ethnic groups in prison populations.

Barriers to accessing services

Along with health services in general, it is obligatory for alcohol services to be accessible to all sectors of the community (Subhra, 2003). Nevertheless, a finding resonating throughout many studies is that clients from black and minority ethnic groups are under-represented in seeking treatment, help and advice for drinking problems. Subhra (2003) presents the findings from an analysis of clients attending services in 2002 (taken from Alcohol Concern, 2002) in which the overwhelming majority (95 per cent) of clients were White (Alcohol Concern, 2002 in Subhra, 2003). Luger and Sookhoo (2005) highlight the debate about whether the real need for services is indicated by the low uptake among minority ethnic groups or that people are prevented from accessing services because of particular barriers. Among people considering changing their drinking behaviour, Black and South Asian people, for example, are under-represented in accessing specialist services (Purser *et al.*, 2001). South Asian respondents are as likely to seek help as Black or Black British respondents but Muslim men in particular, have reported that they are unsure about where to go for advice (Purser *et al.*, 2001). This suggests that agencies are currently less successful than they might be in making their services accessible to Black and South Asian people. Treatment take-up data from a study conducted by Luger and Sookhoo (2005) in London indicated that people from minority ethnic groups are accessing drug and alcohol services but proportionally to a lesser extent than the White British population, although the study does not take into account drinking trends among different groups. They found that some participants in their study mentioned that community members often ignored problems and lacked any idea of what to do and where to go in relation to drug and alcohol problems. Heim *et al.* (2004) similarly revealed a lack of awareness of any specialist alcohol service provision among their sample of Chinese, Indian and Pakistani respondents who were unlikely to contact services in the event of any alcohol-related problems. Low take-up of services creates difficulties in estimating the prevalence of problem drinking and the nature of the problems. There is clearly then a need for better understanding of the barriers to access and take-up among different minority ethnic groups and the different attitudes towards seeking help among them (Subhra, 2003).

Distributions of minority ethnic groups within the population

It has been suggested that one of the reasons for low take-up of services may be a reflection of the particular distribution of a minority ethnic group within the population (Luger and Sookhoo, 2005). While it might follow that the more scattered, or fewer in number, members of an ethnic group are within the population, the less the corresponding likelihood that they will present to services, it cannot be assumed that patterns of consumption will be uniform for ethnic groups across the UK. Some regional differences would be expected among

the drinking patterns of minority ethnic groups – as indeed they are found for the population in general – but to date no research has systematically explored either regional differences or help-seeking behaviour in areas with high or low concentrations of different minority ethnic populations.

There is a case to be argued that in cultures where drinking is hidden and there is a *high* concentration of the ethnic group within the population, take-up of services may be even *lower* than expected. Greater numbers of members of an ethnic group mean a greater likelihood of problematic use being exposed within that community and this alone may prevent people with problem drinking from using services, especially in communities where there are proscriptions on alcohol.

Representing and engaging minority ethnic groups in research

Findings from this review suggest that some minority ethnic groups are more frequently the subject of research than others; for example, Irish, Chinese, Scottish and people of mixed ethnic backgrounds are unlikely to be included as subgroups and are rarely the focus of specific research investigations. This may in part be a function of the low concentration of a particular minority ethnic group within the population, but may also be a result of subsuming a minority ethnic group within a broader classification; for example, a broad 'white' category is likely to include Irish people. Such groups continue to remain largely invisible and yet findings suggest that some people within these groups may be at risk (see Section 2). For service providers to identify and respond to needs, more comprehensive surveying of minority ethnic groups is required, along with ethnographic research conducted from within groups to present more accurate indications of drinking patterns and the cultures within which they arise. Chauhan and Subhra (1999) consider involvement of the community, researchers and different stakeholders among practitioners vital, especially from within minority ethnic groups. More recently a model of community engagement has been developed by Fountain *et al.* (2007) which seeks to address the representation of community groups that are socially excluded, with a view to meeting their health and service needs. The authors argue that to maximise access and involvement of a particular group, environments need to be created in which the community being researched, together with the different relevant agencies, are engaged in issues of shared concern. A key feature of the model is the recruitment of 'insiders' from within the community to access members and to represent community diversity. Such individuals will receive training and support and so the community not only benefits from the research itself but also from capacity building of its members.

Categorisation and self-identity within ethnic groups

As discussed earlier in this review, cultural diversity can be lost by classifying groups of people into broad ethnic categories, especially in drinking prevalence studies and this has implications for the planning of appropriate service provision (Dar *et al.*, 2002). Ethnic categories may vary across treatment centres and broad categories may hide certain ethnic groups, for example, a 'white' category may include people from Iran and Poland who are likely to have different drinking patterns (Luger and Sookhoo, 2005). Irish people are a case in point as they are often subsumed within the broader 'white' ethnicity and therefore remain hidden. Yet the review has found lower abstinence rates and higher consumption levels among Irish people and higher rates of alcohol related mortality compared with the population at large. While some authors have highlighted the service needs of Irish people (Foster, 2003; Tilki, 2006) they are very rarely discussed in service provision literature that considers different ethnicities.

Not only is there a need to specify ethnic subgroups within broader classifications, but it is important to recognise cultural diversity within ethnic groups (Luger and Sookhoo, 2005). Minority ethnic groups are not homogenous; indeed considerable variation has been found between and within groups across different generations, gender and age (Subhra, 2003).

A problem related to classifying people into formal ethnic group categories is how people think of and identify themselves. This is especially relevant for second and subsequent generations of young people. Ross *et al.* (2004) suggest

that sensitivity to the needs of young people is particularly important and that assumptions about ethnicity, community and other issues may not be relevant for some groups, especially for those who do not see themselves as migrants but part of mainstream society. This highlights issues in creating culturally specific services, which may not attract a young clientele because they identify more with mainstream society. As already noted, this may be particularly relevant for people of mixed ethnicities who drink frequently and heavily compared with other ethnic groups, but to date little is known about how they identify themselves.

Socio-economic status

The interplay between ethnicity and socioeconomic status needs to be acknowledged as a potential barrier to service access for some minority ethnic groups and presenting difficulties in seeking help. In a Canadian study examining trends in various addictions including alcohol, drugs and gambling among Afghan, Pakistani and Russian minority groups (Ethnoracial coalition, 2003), low-income status was found to be a barrier to accessing services; for example, time and financial constraints made attending prevention and treatment programmes more stressful among those already overworking. The picture is likely to be similar in the UK. Subhra (2003) reports on findings from UK surveys that indicate greater awareness of services including helplines, charities, self-help groups, and so on, among UK-born, more qualified men and women. If services are to be culturally sensitive and appropriate, then more creative ways of developing services and pathways to access for those on low incomes need to be explored, for example, via support in the workplace. Notwithstanding this, there are significant challenges for developing services or access in environments where particular ethnic groups might cluster; for example, maintenance of confidentiality and time off work.

Lack of awareness of problems

While it is the case that problem drinking is at its highest among the white population, some subgroups of different minority groups show increased levels of heavy drinking in recent years. This is, for example, evident among Indian women and Chinese men (Becker *et al.*, 2006). What remains unknown is the extent of awareness of the health risks associated with heavy drinking among various ethnic groups. Luger and Sookhoo (2005), for example, found that participants from a wide range of different minority ethnic backgrounds in their study were unaware of problems and lacked any idea of what to do and where to go in relation to drug and alcohol problems.

The implications from these findings suggest that health-related messages about drinking are not reaching minority ethnic groups, or they may be perceived as irrelevant to different groups, especially among those in which drinking is proscribed. As noted by Johnson *et al.* (2006) the notion of 'sensible' drinking may be irrelevant to those from non-drinking cultures. Health messages may reach groups differentially but the pathways for support may be poorly defined or inaccessible.

Dealing with problem drinking and hidden alcohol/substance use

Considerable variation can be observed in the way problem drinking is perceived and dealt with in different minority ethnic communities. Findings from this review highlight the perceived need to conceal not just problem drinking but drinking in general among some ethnic groups, particularly on the grounds of religion. Heim *et al.* (2004) found that the ways in which a community would respond to alcohol use differed across a number of ethnic groups. Most Chinese and Indian people (70 per cent) suggested that they were no different from the population in general in the ways in which they approached drinking alcohol, but Pakistani respondents were more likely to indicate that their community would hide or ignore alcohol use (31 per cent compared with 6 per cent among Chinese and Indian respondents).

Cottew and Oyefeso (2005), exploring drug use among Bengali women, observed that Benagali women do not access services because they are confronted by tremendous pressures. The concept of shame permeates every aspect of their lives and drug use would present a source of shame to the family's standing within their community, such that both users and families will endeavour to conceal a family member's drug use. These authors argue for the need to recognise diversity within minority ethnic groups,

particularly across generations. They found that second-generation Bengali women assigned less importance to strict religious practices and cultural values than their parents. However, the processes through which they attempt to cope with inter-generational differences in values and practices are poorly understood. Although concerned with drug use, these findings are likely to be of significance to understanding problematic alcohol use in different cultural contexts.

The likelihood that problem use is under-reported is of course much higher in a community where use is concealed. Findings from this review suggest that disclosure of drinking may be under-reported among young Sikh and Hindu women drinkers because of gender role expectations of abstinence and fear of reprisals. Gharial (2007) draws attention to the difficulties individuals have in discussing problems of *any* kind within South Asian communities in attempts to uphold the status of the family name, and this in itself has implications for the need to address the issues underlying problem alcohol use.

There are other reported variations across different communities in the ways in which they deal with problem drinking. In attempts to conceal their problems, Pakistani men and Bengali women may withdraw more from their communities with increased drinking, thereby further concealing problem use. Violence may accompany problem drinking among Pakistani people, together with threats of expulsion to Pakistan (Heim *et al.*, 2004). Similar measures are reported by Luger and Sookhoo (2005) and involve sending drug users 'back home to the subcontinent' (p. 172) by South Asian families as a way of changing their behaviour. For service development this suggests that it is not sufficient to view the drinker in isolation, but that the impact of problem drinking on other family members and their needs should be considered.

The concealment of problem alcohol use within a minority ethnic community needs to be properly understood within its cultural context and the function that it serves within that community. This is not easy for those outside these communities to grasp, particularly when the value systems are different; for example, the more individualistic nature of mainstream white culture compared with the community and family focus of South Asian minority ethnic groups. As Johnson *et al.* (2006) point out, the shame and silence surrounding problem alcohol use may inhibit help-seeking for fear of exposure and being ostracised by the community. There follow a number of implications for developing appropriate services and support. The cultural context of the problem user needs to be fully understood especially in the case of women. Different gender role expectations around substance use and the maintaining of honour can pressurise women into hiding their substance use; for some women the risk would mean being ostracised by their family and community. Assurances of confidentiality and a need for discretion on the part of service providers are essential. While an understanding of the cultural context suggests that services should be staffed by Asian women, Cottew and Oyefoso (2005) found the opposite to be the case, for fears that Asian staff might judge them. While greater exploration is needed of appropriate pathways to help-seeking behaviour and service use among different members of different minority ethnic groups, perhaps the most important recommendation is offered by Chauhan and Subhra (1999) who suggest that: 'The community thinking that discourages a discussion of alcohol issues may therefore need to be challenged and new approaches to dialogue and awareness raising developed' (p. 5).

Help-seeking preferences

The help-seeking behaviour of different minority ethnic men and women differs, along with variation in preferences about where to seek help with problem drinking, from GPs or health centres. In line with the low levels of take-up of services, a high level of reluctance to approach outside agencies for help with drinking problems is found among many minority ethnic groups, and a greater inclination to try to cope on one's own (Purser *et al.*, 2001).

Notwithstanding this, a comprehensive study by Purser *et al.* (2001) found gender differences in the kind of support different groups prefer. About a third of Black and Christian men are as likely to consult a GP as they are family and friends, while Black and Christian women prefer to find support from within their families. Sikh and Hindu men and women are more likely to consult friends, but male

Hindus would also talk to a GP. Finding support from within the family was the least preferred option among all South Asian women; similarly for Bengali men but less pronounced among Pakistani men. Women from Pakistan were the most likely to seek help from the GP. It is a cause for concern that in response to questions on external advice sources, Pakistani and Sikh men were the most likely to state that they did not find them anywhere (Purser *et al.*, 2001). In cultures where alcohol problems may be concealed, the findings from this review that South Asian men have a higher prevalence of alcohol-related liver damage and liver cirrhosis than other groups is worrying and needs to be addressed. Sikh men have been found to have higher rates of liver cirrhosis (McKeigue and Karmi, 1993), and Pakistani drinkers show higher rates of unit consumption compared to Indian and Chinese people (Heim *et al.*, 2004).

There is some suggestion that younger people from different minority ethnic groups are more likely to prefer alcohol services to be included in mainstream health services versus specialist alcohol services (Heim *et al.*, 2004). Over half (54 per cent) preferred mainstream services compared with 41 per cent opting for specialist services, irrespective of ethnicity; however, Chinese and Indian people did not want to be treated differently, implying a preference for mainstream service provision (Heim *et al.*, 2004). That many people from different ethnic groups may feel more comfortable discussing their alcohol problems within a mainstream health setting indicates that pathways to facilitate this need to be developed. While males may prefer discussing their own problems with a GP, there may be a lack of awareness of the needs of other family members affected by the problem drinker. The GP setting should provide an environment in which the needs of others within the family context could be assessed.

Although there appears to be a need for both mainstream and specialist service provision, the family context also offers the potential for support, but little research has been conducted into how families from different minority ethnic groups cope with alcohol problems. One exception to this is a study by Ahuja *et al.* (2003), who explored how families cope with alcohol problems in the Sikh community, finding that female members in a family with a male problem drinker were very willing to be supportive in their treatment. There is clearly great potential for the family as a source of support to be examined and developed.

Some minority ethnic groups have tended to access or have been referred to mental health services for problem drinking rather than specialist alcohol services. Foster (2003), for example, identifies the need for evaluating treatment services aimed at problem drinking among Irish people in acute psychiatric settings. He observes that while problem drinking among Irish people continues to be treated in mental health settings, poor outcomes are likely to be expected. Luger and Sookhoo (2005) similarly draw attention to the practice of mainstream health services referring black clients to mental health units and that this may result from misdiagnosis, stereotyping or prejudice by medical staff directed at clients from minority ethnic groups.

Summary points: barriers to accessing services

- Minority ethnic groups are under-represented in seeking treatment, health and advice for drinking problems. Muslim men in particular report being unsure of where to go for advice. Lack of awareness and low take-up of services creates problems for estimating the nature and prevalence of problem drinking.

- Comprehensive surveys coupled with ethnographic research are required to provide more accurate indications of drinking patterns and the drinking cultures within which they arise, especially in communities in which drinking is proscribed. The community engagement model (Fountain *et al.*, 2007) is outlined as a way of researching socially excluded communities in order to meet their health and service needs.

- Little research exists on awareness of risks associated with drinking among

minority ethnic groups, suggesting that more needs to be known about the communication of health messages and interventions targeting problem drinking; these are either not reaching minority ethnic groups or are perceived as irrelevant.

- There are likely to be discrepancies between formal classification systems for minority ethnic groups and perceptions of self-identity. This is relevant for all individuals from minority ethnic groups but especially so among those of mixed ethnic backgrounds who may remain hidden but who have relatively high rates of frequent and heavy drinking compared with other ethnic groups.

- There may be lower awareness of services among people of low socioeconomic status and appropriate pathways to promoting and accessing services and support need to be developed.

- Gender role expectations of abstinence may inhibit disclosure of drinking among women from South Asian ethnic groups, and pathways to seeking help need to be explored to address their needs. Most importantly innovative approaches need to be developed that encourage raising awareness and discussion of alcohol issues within the community.

- The family context of the problem drinker is of twofold importance in cultures with strong familial bonds and needs to be considered when problem drinking is evident. Problem drinking may impact negatively on other family members, for example through violence. Conversely, the family context may present opportunities for supporting problem drinkers.

- There is considerable variation in the kind of support different members of different ethnic groups prefer for help with their drinking problems, pointing to the need for alcohol problems to be addressed within mainstream services and via specialist alcohol services. Family context is among the preferred options for offering support to Black and Christian women and, to a lesser extent, their male counterparts.

- Mental health services need to be alerted to and able to deal with referrals from people from minority ethnic groups, in particular Irish and black clients who present with problem drinking.

Developing culturally competent services

Permeating virtually all the studies investigating service use and provision is the need to develop cultural competence and cultural sensitivity in addressing the needs of minority ethnic groups. Mainstream services and the provision of information often fail to acknowledge the cultural and religious contexts of black and minority ethnic clients (Ross *et al.*, 2004). This raises the question of how appropriate and accessible existing services are in catering for the needs of minority ethnic groups. Workers in the field suggest that services at every level of education, health advice and treatment need to be culturally sensitive, but this expertise is not evident among many mainstream service providers; neither is there often sufficient specific knowledge and awareness of alcohol issues among community health and welfare professionals (Gharial, 2007; Subhra, 2003).

A number of factors that contribute to developing culturally competent services have been identified. Staff selection, education and training are significant in enhancing cultural sensitivity, as alcohol services can be seen as irrelevant for the needs of minority ethnic men and women, who may perceive them to be run by white people for white clients (Dar *et al.*, 2002; Hyare, 1999; Subhra, 2003). Failure to address the stigma attached to alcohol problems coupled with the experience of discrimination and lack of sensitivity can dissuade people from seeking help (Hyare,

1999). The need for confidentiality and awareness of the stigma particularly among those for whom alcohol use is proscribed is therefore key (Dar *et al.*, 2002). Services often do not offer counselling in a range of appropriate languages and Subhra (2003) notes that the counselling that exists is often Eurocentric and deemed irrelevant. This view is not only held by clients at the receiving end of services but by practitioners themselves. Luger and Sookhoo (2005) reported that most staff from a White British background, although aware of the different needs of clients from minority ethnic groups, found difficulties in discussing cultural issues and needs with them. Staff from a minority ethnic background, having been socialised into a multicultural environment, felt more comfortable attending to clients from cultures other than their own. Dar *et al.* (2002) suggest that staff should be represented from a range of backgrounds, be trained in cultural awareness and that information should be provided in a range of languages.

The conclusions from a recent rapid needs assessment of drug and alcohol services for minority ethnic groups (Luger and Sookhoo, 2005) suggested that greater support was needed from alcohol services. Problems remain hidden because of low rates of access, shame, lack of awareness of services and inappropriateness of service provision. There is an urgent need to develop awareness of alcohol misuse factors among minority ethnic groups, but service providers have low understanding of minority ethnic group cultures. Time constraints and lack of resources present difficulties in providing a culturally competent service. The requirement for relevant training, development of skilled staff, training for educators and key minority ethnic group workers, communication between staff and clients are also highlighted. Policies should be designed to reduce inequalities and social exclusion across all public authorities, and partnership work between different cultures is required to develop openness, trust and mutual respect.

Tackling racism

The Race Relations (Amendment) Act of 2000 states how public authorities must, through their processes and outcomes, pursue the principle of racial equality. How this should guide agencies in developing their cultural competence is noted by Johnson *et al.* (2006). As pointed out by Ahmad and Bradby (2007), who do acknowledge that this is a contested view, the act reinforces the idea that racism and racial disadvantage are ingrained into the very fabric of British life. A resounding theme in discussions of cultural competence is awareness of the many different ways in which racism can occur. How it is manifested throughout service provision has been highlighted in the work of Samje (1995) in Wanigaratne (2003), namely through direct racism, institutional racism and Eurocentrism. Indeed, it has been suggested that institutionalised racism may be the most important reason for low accessing of services among black and minority ethnic groups (Wanigaratne *et al.*, 2003). Some service providers have purposefully employed ethnic minority staff in a bid to address racist issues, but Wanigaratne *et al.* (2003) point out that racism is often institutionalised within an organisation and that addressing these problems that are embedded systemically within the organisation should be the primary focus. A number of initiatives are suggested, for example to devise equal opportunity policies and to implement them through monitoring by the management. A commitment to overhaul general working practices to ensure an accessible service, free of institutionalised racism, is needed. The practice of employing workers to match client groups is a debatable issue and may suggest issues of tokenism (Hay *et al.*, 2001). For such employees working within such an environment can be limiting for the worker's career prospects, as staff are subject to scrutiny by white management, risk their voice being lost as they lack influence, and are assigned their caseload according to the ethnicity of clients alone (Hay *et al.*, 2006; Wanigaratne *et al.*, 2003).

Culturally specific versus mainstream services

Some authors have argued for the development of culturally specific services to cater for the needs of minority ethnic groups, mainly because of enhancing understanding of culturally related issues; others have suggested, however, that there should be provision for these clients within mainstream services largely to minimise the racial and social tensions that might arise if

minority ethnic groups were seen to be having specialist treatment (Ross *et al.*, 2004).

There is some evidence that black and minority ethnic individuals feel more comfortable approaching a specialist organisation run by black and minority ethnic staff when they are in need of support (see Harrison *et al.*, 1996). Consequently, strong arguments have been voiced in favour of developing separate organisations for black and minority ethnic groups with drinking and substance misuse problems. In particular, advantages lie in the provision of services that are culturally competent, can plan around the needs of the targeted group and bring about service change that benefits those from minority ethnic communities. Training for professionals working within these organisations would take the needs of these groups as a focus, rather than an adjunct of a training programme.

Despite this, there is some resistance to the idea that specialist services should be developed as an alternative to black and minority ethnic people accessing mainstream services. Raistrick *et al.* (2006) argue the case that individuals may have both special and more general shared identities; their special identities may be drawn from their gender, sexual orientation, professional group, homelessness, age, religion and ethnicity among others, and their lives may be too complex for supporting them via 'a single special population service' (p. 50). As minority ethnic groups appear to differ according to their strength of religious affiliation, this may provide innovative ways of engaging them in preference to providing separate services. Indeed religious affiliation, along with family honour, were often given as reasons for stopping drinking in a population of Asian problem drinkers (Cameron *et al.*, 2002). Harrison *et al.* (1996) argue that it is not an either/or situation, but a decision that should be taken in response to the needs of the local population. Mainstream services should adapt continually to ensure culturally sensitive provision, and to reflect the needs of the changing composition of the population and indeed their changing drinking trends, while targeted services are developed where required.

The framework and guidelines in the box opposite (Fountain, 2009) have been suggested in the context of developing cultural competence within drug services for different minority ethnic groups. Developing competence at the level of the individual and within the organisation are key elements. Through an inter-dependent and mutually reinforcing relationship between these two elements the framework offers a cohesive and co-ordinated approach for assessing and developing cultural competence. This could usefully be considered as a model of good practice for alcohol service development generally, and not only specifically for black and minority ethnic groups. Some authors, notably Johnson *et al.* (2006) and Wanigaratne *et al.* (2003) advise of the importance of cultural competence to be encompassed by *all* mainstream services when dealing with *all* sectors of the community, and that this is particularly essential when there are problems in developing separate services for black and minority ethnic groups. Examples of such training already exist in the Race and Culture Module developed by the British Psychological Society in their clinical psychology training course (Patel *et al.*, 2000 in Wanigaratne *et al.*, 2003).

Cultural competence

adapted from Fountain (2009)

Cultural competency is a term widely used within the public sector, but there is little agreement over its meaning and how it can be implemented. Moreover, the diverse meanings of 'cultural competence' are often highly dependent on local contexts and no nationally recognised standards of measuring or defining the term exist. However, a basic framework for assessing cultural competence can still be developed.

The following framework is intended as a guide and contains examples of the skills, processes and abilities involved. It is based on both individual and organisational competence. Individual competence is skills-based and relates to individual practitioner's professional practice in working with diverse communities and individuals. Organisational competence is defined by the level of maturity in the organisation for

addressing equality and diversity across the full range of its functions and policies.

Individual competence is based on the skills of acknowledging, accepting and valuing cultural difference in others – that is, between and among culturally diverse groups and individuals. It is built up through a developmental process that includes:

- **Improving knowledge of local communities**, such as demographics, religious beliefs, sects and practices, common languages, migration and settlement patterns, health and social care needs, diet and cultural norms.
- **Developing skills** in reflective practice including empathy, the ability to challenge assumptions and prejudices in self and others, and the ability to work through communication difficulties and differences with a sensitive aptitude and attitude.
- **Developing communication skills** in working with people whose first language is not English and the ability to work sensitively and competently with interpreters.

Organisational competence is demonstrated through a clear commitment to recognising diversity and the development of proactive policies that embed equality and skills in working with diverse communities throughout the organisation. This process includes:

- **A clear commitment to equality**, valuing diversity and human rights, articulated in the aims and objectives of the organisation.
- **Provision of staff training programmes** that meet the needs of a range of personnel, from basic induction through to higher-level learning.
- **A system for engaging and consulting with local communities** and ensuring that services take account of local diversity.
- **Leadership and management** of equality and diversity through performance and monitoring systems.

It should be recognised that individual and organisational cultural competence are inter-dependent. No matter how skilled or competent the individual, they require the support of the organisation in order to achieve effective cultural competence. Similarly, however well developed an organisation's policies and procedures are, it will fail to meet the needs of a culturally diverse population without skilled and competent staff to carry them out. Taking a maturity approach to cultural competence recognises that there are various levels through which individuals and organisation might pass as they move towards a fully developed level of competence. This is also in keeping with models of lifelong learning and organisational development.

These recommendations focus on developing mainstream service provision but, despite preferences among some groups for seeking advice within health settings, a medical model of advice and treatment may be inappropriate for the needs of many minority ethnic groups. An alternative approach such as complementary therapies may be more appropriate for different cultural approaches to the meaning and understandings of health and the treatment of problems. At best these therapies should form part of service provision (Johnson *et al.*, 2006; Subhra and Chauhan, 1999). Acknowledging the problems that may contribute to or result in problem drinking is also key and Wanigaratne *et al.* (2003) suggest that practical help with housing, social services, etc. may often be required, together with help for psychosocial problems.

Addressing the needs of young people

Alcohol services were historically designed to address the needs of adults with problem use

and only in recent years have young people become a focus with changing patterns of alcohol consumption. Patel and Wibberley (2002) found that young Asian people experienced other sources of tension connected to usage. This was in part a result of the Asian community's refusal to admit to substance misuse and the subsequent need for young people to conceal their drug use; and also because of young Asian people's association with the more permissive British youth drug culture. Reconciling the two conflicting positions creates considerable tension and can also lead to feelings of isolation because the problems cannot be aired within their minority ethnic community, particularly in the case of South Asian groups (Gharial, 2007). This may result in a preference to deal with problems themselves rather than access specialist services (Rao, 2006).

This is a key issue to be addressed in the provision of services for young people of ethnic minority groups. Differences in drinking rates and cultural practices, between and within ethnic groups, calls for the provision of culturally competent services that reflect an understanding of the conflicting pressures that young people face. While some researchers have argued that there is little call for the provision of different services for different groups (Ellickson *et al.*, 1999), cultural sensitivity to the dual cultural context in which substance use and misuse occurs among young people is important generically for child health professionals (Patel and Wibberley, 2002). These findings suggest that preferences for help-seeking behaviour need to be explored in depth among young people themselves to fully inform the development of appropriate service provision.

Summary points: developing culturally competent services

- Expertise in developing culturally competent services is required both in mainstream and more specialist services. A framework for cultural competence in service provision is outlined. Cultural competence can be realised through developing individual and organisational competence via a relationship that is both inter-dependent and mutually reinforcing.
- Resources should be directed at staff training and enhancing understanding of different minority ethnic group cultures.
- Addressing racism and systems within organisations that support it are required.
- Continuous monitoring of services is needed to ensure adaptation to changing population needs, changing drinking trends and appropriate targeting of services where most needed.
- Young people from minority ethnic groups face additional challenges of reconciling drinking behaviour with cultural and gender expectations. Their preferences for support need to be explored.
- Well-conceptualised and theoretically underpinned ethnographic research approaches can usefully guide culturally appropriate service development, as they locate the research question within the context of the underlying values and attitudes of the group(s) being researched. A clear rationale is given for the approach and issues have emerged from among the researched 'community' itself. Findings will be directly relevant and benefit individuals.

Examples of research approaches that can guide culturally appropriate service development

Rao (2006), in a *British Medical Journal* editorial, concludes that alcohol misuse must be tackled using culturally appropriate services to meet the needs of the diverse ethnic groups and that this will only be achieved with evidence from high-quality ethnographic research within specific groups. There follow a number of examples of studies, mostly using ethnographic research approaches which have been identified from

the literature. A clear rationale for the approach is provided for each study and the issues researched have emerged from within the cultural context and needs of the individuals being researched. These issues are directly relevant to the particular participants involved and emergent findings will potentially benefit them. The studies also tend to use theoretically underpinned approaches and illustrate how well-conceptualised research can be used to inform the development of culturally specific services.

This study by Ahuja *et al.*, (2003) identifies the ways in which different family members attempt to cope with alcohol problems within their families in the Sikh community and is the only UK study found to address coping with drinking in the family context. It uses a combined qualitative and quantitative approach and questions are based on psychological constructs with interviews conducted in the participant's preferred language.

Significantly, the effect of problem drinking on the drinker's immediate family has rarely been addressed, yet the female members of a family in which there is a male problem drinker are usually very willing to be supportive in their treatment (Ahuja *et al.*, 2003). The study revealed a number of important findings. One was the difference in perceptions of the male problem drinker and female family members on the effects of their drinking, with male drinkers not recognising their excessive drinking as a problem affecting their family and believing it to be under their control. Sikh women were, however, affected by their husband/father's drinking in many aspects of their daily lives – social, economic, personal and emotional – and the stereotype of the Sikh wife quietly tolerating her husband's drinking was neither accurate, nor reflected the complexity of different ways in which mothers and daughters sought to cope with his behaviour. Wives felt duty bound to be supportive but isolated from their community as attempting to conceal the husband/father's behaviour from public knowledge denied them the very support that they needed.

Differences in how the problem drinker and female family members cope with problem drinking point to a range of needs when they are accessing services. To this end, Ahuja *et al.* (2003) note that detachment from family members' drinking problems by others in the family is encouraged by many professional treatment services, and they call for professionals to be conscious of the ways in which Sikh women try to cope with their husband's problem drinking and to recognise their difficulties in attaining any degree of independence. Professionals need to recognise the links between masculine identity and drinking in Sikh culture, and that men may play down both the problems around their drinking and the concern of female family members, in attempts to preserve their masculine identity.

In the light of findings such as these, Orford *et al.* (in press), have developed a two-component model that focuses firstly on understanding the experiences of different family members and, secondly, introduces flexible ways of working with them. Research has been carried out among two different minority ethnic groups in the Midlands and, despite referring largely to the treatment of drug problems, it strives to offer examples of good practice and a model for future development of service provision in which the impact of the problem on the family is addressed.

Two further examples are provided of how culturally sensitive research can be used to guide the development of culturally specific services with a focus on recovery from problem drinking. Factors enabling people with drink problems to recover without outside help are surveyed in the first study, and the dimensions of spirituality and religion are explored in the second. The emphasis in both studies is on the exploration of the processes and mechanisms underlying recovery within the broader context of the attitudes and beliefs of the groups being researched.

Minority ethnic usage of local community-based alcohol services is often found to be underused, even in areas where community penetration of a specialist service is well developed (Cameron, 1995 in Cameron *et al.*, 2002). One reason for this may be that a significant change in drinking practice can occur among people who have drunk excessively in early adulthood

but who in their later years cut down on their consumption or become abstinent.

Cameron *et al.*, (2002) examined the reasons why the patterns of problem drinking among Asians and White males might change over their lifecycles and how those changes then stabilise. While health, self esteem and being able to cope and work were mutual concerns for motivating Asian and White groups to stop or reduce their alcohol intake, there were striking differences. Compared with the White population, who were found to be more isolated, less concerned with their public image and more interested in psychological and domestic problems around their alcohol use, the Asian population had a stronger sense of community, more coherent social networks of extended families and a readily available, often abstinent and religion-based culture, within which they could re-establish links more easily. Cameron *et al.* (2002) conclude that goals and treatment within services should reflect the attitudes and beliefs of the communities of origin of their clients.

The exploratory work of Morjaria and Orford, 2002, among men recovering from problem drinking, points to different models of recovery for South Asian men and White members of Alcoholics Anonymous (AA). South Asian men already had a pre-existing foundation of beliefs embedded in their cultural values and underwent a process of reaffirmation of their beliefs. White AA members, in contrast, mostly lacked any spiritual beliefs and needed to develop a faith by undergoing a process of conversion. For South Asians, recovery itself was the goal; for White AA members it was lifelong abstinence. Morjaria and Orford suggest that among South Asian people there is great potential in further exploring more culturally embedded processes of recovery, about which little is known, to further our understanding and to develop culturally appropriate services that can incorporate the spiritual aspect of recovery.

5 Conclusions and further research

Conclusions

This review has highlighted the variable patterns of alcohol consumption both within and between ethnic minority groups in the UK. The limitations of official data on alcohol use and ethnicity and the problems of measuring ethnicity both in population level surveys and in smaller research studies have been noted as important factors which obscure understanding of the use and problem use of alcohol and the need for culturally sensitive responses and service provision. However, despite the limitations of the available information, the literature provides a broad picture of drinking patterns, alcohol-related harm, and need for services across a range of ethnic groups. The most important findings and recommendations stemming from the review are outlined briefly below. But the review also raises issues regarding how knowledge is constructed and how this influences perceptions of appropriate policy and service responses to different minority ethnic groups.

In the UK, until the 1990s limited research consideration was given to drinking among minority ethnic groups. There was also a lack of concern regarding the targeting of service provision and alcohol harm prevention at the white majority population. The more recent inclusion of ethnic categories into research on alcohol was a welcome and needed addition, which has resulted in more visibility being given to the previously unidentified needs of minority ethnic populations. However, Adrian (2002) points out two assumptions underlying the choice of particular ethnic groups for study. On the one hand, belonging to a particular ethnic group is perceived as being at increased risk of alcohol use and possible problems arising from usage – with the danger that the group becomes stigmatised or marginalised; on the other hand, and more implicitly, both use and problem use point to the possibility that there are aspects of group membership itself which give rise to problems. As previous sections have shown, gender and age differences, for instance, are often sources of tension within groups as generational shifts in the strength of religious adherence, the degree of 'acculturation' or processes of adjustment to the host culture may be perceived as a threat to traditional beliefs, values and behaviours regarding alcohol use. Such tensions are likely to result in underestimations of use and under-reporting of alcohol-related problems, and issues of guilt, stigma, family shame and fears of repercussions may prevent early intervention or service use.

The importance of recognising the heterogeneity within different ethnic groups and the implications for changes in drinking behaviour and attitudes should not be underestimated. How to tackle sensitively the tensions likely to be experienced by young people, women or families and relatives remains a challenge to practitioners in the field. It also emphasises the importance of seeing service provision as possibly only one element in addressing the needs of different ethnic groups. Engaging minority ethnic clients in services is likely to require a wider range of supportive and alternative options to provide adequate and acceptable forms of awareness and assistance. In particular, innovative ways (such as the model suggested by Fountain *et al.*, 2007) of engaging individuals who may be socially excluded, such as drinkers from ethnic groups in which alcohol is proscribed, need to be sought.

Issues of heterogeneity and inter-ethnic tensions also have implications for mounting research that attempts to improve knowledge and understanding of the use of alcohol, and the possible needs for services among ethnic groups. A clear rationale is needed for the research methods and approaches adopted; wherever possible, qualitative research using 'insider' ethnographic methods may be advisable to complement findings from survey data. This would help elucidate the context in which alcohol use takes place, the functions that

alcohol has for individuals and different ethnic groups, and the approaches and initiatives that are likely to prove acceptable and effective.

Main findings

Summary of findings for different ethnic groups

Overall, most minority ethnic groups have higher rates of abstinence, and lower levels of frequent drinking and heavy drinking compared with the British population as a whole and to people from white backgrounds. There is considerable variation between and within different minority ethnic group populations in their drinking behaviours.

Irish ethnicity
Irish people are less likely to abstain compared with other ethnic groups and the general population. Irish girls showed a decrease in abstinence rates between 1999 and 2004, and there are recent signs that the gender gap may be closing. Men and women in this group have higher rates of alcohol-related mortality compared with the general population in England and Wales and are more likely to exceed recommended limits if they are in higher income brackets.

Scottish ethnicity
Men and women born in Scotland are over-represented for alcohol-related mortality compared with the general population in England and Wales.

South Asian ethnicities
Drinking patterns are changing for Indian people in general. Indian men have higher rates of alcohol-related mortality compared with the general population, and Indian women also showed an increase in drinking frequently and heavily between 1999 and 2004. Indian women in higher income brackets are more likely to exceed recommended guidelines for alcohol consumption.

Sikh men show high rates of heavy drinking, and are over-represented for liver cirrhosis. Second-generation male Sikhs are less likely to drink and drink heavily than first generation male Sikhs. Conversely, having ever drunk, and drinking frequency increased among Sikh girls during the 1990s.

Although abstinence levels dropped for Hindu boys in the 1990s, and second generations may drink slightly more regularly than first generations, heavy drinking among the group has not shown an increase. Hindus are less likely to drink if they report that religion is important to them.

People from Bangladesh are less likely to consume alcohol than other ethnic groups, and drinking rates are low among the group.

Drinking is polarised among people from Pakistan. Drinking remains low among Pakistani men and women, but Pakistani men who drink consume more alcohol in units compared with other minority ethnic groups. A similar pattern emerges for Muslims; Muslim men and women are both likely to abstain but, among drinkers, rates tend to be high compared with other religious groups.

Chinese ethnicity
Rates of consumption are low among Chinese men and women. However, frequent and heavy drinking rose significantly for Chinese men between 1999 and 2004.

Black Caribbean ethnicity
Black Caribbean people have higher levels of drinking than people from South Asian and Chinese ethnicities, but lower rates compared with people from white backgrounds and the general population. They also have lower levels of alcohol-related mortality compared to people from white and South Asian backgrounds in the UK.

Black African ethnicity
Black African people have lower rates of alcohol use than the general population,

and also tend to report rates lower than Black Caribbean people.

Mixed ethnicities
People from mixed ethnic backgrounds are less likely to abstain than people from non-white minority ethnic groups, and have high rates of current use. People from mixed ethnicities also report relatively high rates of heavy and very heavy drinking compared with other minority ethnic groups. Differences between the genders for abstention and frequent drinking are also less pronounced than for other minority ethnic groups.

Further research suggestions

Areas for further research have been mentioned throughout the review. The summaries below draw together the various findings, and suggest topics for future research to focus on:

- the drinking habits of Indian women and girls, particularly Sikhs, which has shown some increase in recent years;

Research would help to ascertain if trends indicating frequent drinking among Sikh girls and heavy and frequent drinking among Indian women are continuing and, if so, the extent to which trends are influenced by changes in the country of origin and/or interaction with the host culture.

- the drinking patterns of people from mixed ethnicity;

These should be researched in the context of other factors related to alcohol use, such as substance misuse and experiences of crime. Issues such as potential conflict between different cultural attitudes to alcohol (because of mixed backgrounds), and the development of new identities and norms are worthy of consideration.

- drinking patterns of new migrants into the UK, particularly those from Eastern European backgrounds;

The different drinking cultures of these ethnic groups should be explored to establish potential service needs both for migrants coming for short periods and for those staying longer. In terms of acculturation, the impact of British drinking cultures on new migrants should be considered in conjunction with the influence migrants from Europe might have on British culture.

- alcohol expectations and functions for Irish people in the UK;

Research could focus on alcohol expectations and functions among Irish people living in Britain and the social contexts within which drinking occurs, in order to encourage drinking within sensible limits. Importantly, mental health services need to be alert to referrals of Irish people who may have related alcohol problems.

- alcohol consumption and attitudes towards health among Chinese men;

Further research could help to establish if the trend towards increasing heavy drinking by Chinese men is continuing, and why. Gender differences in attitudes to health in the Chinese community may also be informative as Chinese women are more likely to abstain than Chinese men.

- the socioeconomic status of minority ethnic groups as a linked factor helping to explain differences in drinking rates and changes in consumption levels;

The socioeconomic status of minority ethnic groups should be considered when looking at drinking rates – in particular, the possible relationship between heavy drinking among individuals or ethnic groups and higher incomes and employment opportunities. In addition, exploration of gender differences in consumption for different migrant groups and the association with socioeconomic background merits further attention.

- service access for drinkers from Pakistani and Muslim backgrounds.

Further research is needed into hidden drinking in communities where alcohol use is proscribed. Research is needed to develop and evaluate innovative approaches that encourage awareness-raising and dialogue about alcohol and related issues within the community context of socially excluded minority ethnic groups of people.

Service development

At the policy level, lack of consideration of minority ethnic groups within the Safe. Sensible. Social. alcohol strategy (2007) points to a gap that needs addressing in order to guide practice at the local level. Implementation guidance that considers minority ethnic groups generically suggests that research evidence is also failing to inform practice.

Alcohol problems among minority ethnic groups need to be addressed within both mainstream services and specialist alcohol services as there is considerable variation in support and service preferences among different minority ethnic groups. Local population demographic profiles in the UK are evolving, along with trends in drinking behaviours, and continuous monitoring of demographic changes, assessments of needs and preferences for treatment are needed within the local context.

The family context of people with strong familial bonds who are drinking problematically is important. Families may need support but the family itself may offer potential support for problem drinkers and families may be a preferred option for some ethnic groups. Ways of integrating such preferences into responses and service systems deserves consideration.

Perhaps the most important barriers to help-seeking for problem drinking is failure to address the stigma attached to alcohol problems together with the experience of discrimination. To address racism and systems within organisations that support it, a comprehensive framework that assesses cultural competence has been developed (Fountain, 2009). This approach is seen as essential where there are problems in developing separate services for people from minority ethnic groups, and is also needed more generally within mainstream services.

Notes

1 Alcohol Use Disorders Identification Test (Saunders *et al.*, 1993). AUDIT is a screening instrument for hazardous and harmful alcohol consumption.

2 Hazardous drinking: people drinking above recognised 'sensible' levels but not yet experiencing harm.

3 Harmful drinking: people drinking above 'sensible' levels and experiencing harm.

4 Alcohol dependence: people drinking above 'sensible' levels and experiencing harm and symptoms of dependence.

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Appendix I: UK literature search results

Database/Search engine	Search terms	Identified articles	Relevant articles
Alcohol Concern	Ethnic group UK 1999–2008	9	8
As above	Minority ethnic Ethnic group 1995–2008	6	1 new
As above	Alcohol Ethnic group Minority ethnic 1995–2008	5	1 new
As above	Drinking Ethnic group Minority ethnic 1995–2008	0	
Social Science Citation Index Web of Knowledge	Alcohol Ethnic* England 1995–2008	142	20 new
As above	Alcohol Ethnic* Abstinence	0	
Cochrane database	Alcohol Ethnic*	0	
ERIC online	Alcohol Ethnic groups 1995–2008	19	0
NHS National Library for Health: Ethnicity and Health	Alcohol	9	1 new
NHS Information Centre for Health and Social Care			1 new
AERC report website		1	1 new
Addiction Abstracts		1	0
Centre for Research in Ethnic Relations at University of Warwick 'Ethnicity and Migration' collection	Alcohol	12	0
As above	Drinking	0	0
Institute Alcohol Studies			1
Chain search			10 new
Proquest (media)	Alcohol Ethnic* 1998–2008	107	10
Sent via grey/new literature request			1 new 1*

*One article recently submitted was also sent but in confidence

Appendix 2: International literature search results

Database/Search engine	Search terms	Identified articles	Relevant articles
Social Science Citation Index Web of Knowledge	Alcohol Ethnic*, refined by review US, 1998–2008	36	5
As above	Alcohol Ethnic* Review US, 1998–2008	43	4
As above	Drink Ethnic* refined by review US, 1998–2008	6	1
As above	Drink Ethnic* Review US, 1998–2008	15	1
As above	Immigration Alcohol US, 1998–2008	50	7
As above	Immigration Drink* US, 1998–2008	17	3 new
NIAAA ETOH	Review Ethnic*	31	0
International ERIC online	Alcohol Ethnic groups (thesaurus term) 1995–2008	19	0
As above	Drinking Ethnic groups 1995–2008	28	1 new
Social Science Citation Index Web of Knowledge	Alcohol Ethnic* refined by Canada, Australia, New Zealand, Germany, Sweden, Netherlands, Taiwan, China 1995–2008	302	18
International bibliography of social sciences	Alcohol Ethnic* 1998–2008	27	5 new
Journal hand search: Addiction, Alcohol and Alcoholism, Journal Studies Alcohol	Jan 1998–July 2008		3 new
Sent via grey/new literature request	Alcohol	3	2

Appendix 3: Research samples and ethnic groups

Study	Sample	Ethnic groups (numbers or %)	Location
Becker *et al.*, 2006	Health Survey for England 2004: 6,704 adults aged 16+ and 1,650 children	Adults **General population** (6,704) **Irish** (1,153) **Black Caribbean** (1,067) **Black African** (859) **Indian** (1184) **Pakistani** (941) **Bangladeshi** (889) **Chinese** (723) Children **General population** (1,650) **Irish** (466) **Black Caribbean** (485) **Black African** (519) **Indian** (426) **Pakistani** (600) **Bangladeshi** (567) **Chinese** (235)	England
Best, 2001	1,777 secondary school pupils, 11–14 years	**Asian** (13.4%) **Black** (9%) **White** (73.2%) **Other:** Mixed race or other ethnic origin (4.4%)	Merton, Sutton and Wandsworth, South London
Borrill *et al.*, 2003	301 women on remand or serving a prison sentence from ten establishments in England 40 men from three prisons	Women: **White** (190) **Black/mixed race** (111) Men: **Black** (32) **Asian** (5) **Mixed race** (3)	England
Bradby and Williams, 2006	824 British-born 14–15 year olds, 492 followed up at 18–20 years resulting in a weighted sample of 389 young people	**South Asians**: mainly Punjabi (202): **Muslim** (79%) **Sikh/Hindu** (14%) **Christian** (3%) **Others** (4%) **Non-Asians** (187): **Muslim** (1%) **Sikh/Hindu** (1%) **Christian** (78%) **Others** (20%)	Glasgow
Cochrane, 1999	600 males, 17–65 years, from GP practices	**African-Caribbean** (200) **Sikh** (200) **White English** (200)	West Midlands
Dar *et al.*, 2002	200 attendees at Community Drug Treatment Unit, 12 removed from analysis	**White** (120) **Asian:** Indian, Pakistani, Bangladeshi (68)	Outer Borough of London

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Denscombe, 1995	1,009 15–16 year old pupils	**White:** Males (73.2%) Females (69.6%) **South Asian:** Hindu, Sikh and Muslim: Males (23.2%) Females (27.4%) **Black** (2.7%) and **Other** (3.9%) excluded from analysis	East Midlands
Denscombe and Drucquer, 2000	2 surveys: 15–16 year old pupils 1990 N = 1,009 1997 N = 1,648	1990 – see Denscombe above 1997 – **White:** Males (72.2%) Females (70.4%) **South Asian:** Hindu, Muslim, Sikh: Males (23.7%) Females (26.4%) **Black** (3.1%) and **Other** (4.3%) excluded from analysis	East Midlands
Douds *et al.*, 2003	381 hospital inpatients and outpatients with cirrhosis attending hospital over 14 years (1987–2000)	**White** (64%) **South Asian** (29.3%) **Afro-Caribbean** (4.7%) **Other** (2%)	Birmingham
Erens and Laiho, 2001	Health Survey for England 1999 7,798 adults 16+ years 1,842 children 2–15 years	Adults **General population** (7,798) **Irish** (1,245) **Black Caribbean** (1,295) **Chinese** (662) **Indian** (1,283) **Pakistani** (1,263) **Bangladeshi** (1,096) Children **General population** (1,842) **Irish** (535) **Black Caribbean** (612) **Chinese** (142) **Indian** (264) **Pakistani** (790) **Bangladeshi** (743)	England
Harrison *et al.*, 1997	Office of population censuses and surveys, 1979–91, data on causes of death by country of birth	Grouped by country of birth – **Caribbean:** Belize, Barbados, Guyana, Jamaica, Trinidad, and the other former British West Indian islands (72) **South Asian:** Bangladesh, India, Pakistan (208) **Irish:** Irish Republic (372)	England and Wales
Heim and MacAskell, 2006	The African and Caribbean; Pakistani and Indian Survey The Chinese and Healthy Living Survey	**Pakistani** (211) **African & Caribbean** (244) **Indian** (155) **Chinese** (350) **General population** (1,802)	Greater Glasgow and Clyde
Heim *et al.*, 2004	Survey of 174 young people aged 16–25 years	**Pakistani** (73) **Indian** (47) **Chinese** (54)	Greater Glasgow

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Information Centre, 2007	Taken from Smoking Drinking and Drug Use survey with 11–15 year olds, 2002–4	**White** (25,487) **Black or Black British** (843) **Asian or Asian Britis**h (1,702) **Mixed** (1,055) **Other:** includes Chinese (596)	England
Karlsen *et al.*, 1998	158 12–13 year olds, followed up at 17 months; 132 (83%) 14–15 year olds completed follow up. Study based on 132	**Black African** (27%) **Black Caribbean** (16%) **Bangladeshi** (27%) **White** (30%)	Inner London
McCambridge and Strang, 2005	200 users of illegal drugs aged 16–20yrs	**White:** White British, White non-British (77) **Black:** Black African, Black Caribbean, Black other (plus small number of participants who identified themselves as being 'mixed race/ethnicity') (96) **Asian:** Indian, Pakistani, Bangladeshi (plus small number of Turkish, North African and other non-White, non-Black ethnicities) (27)	Inner London
McCambridge *et al.*, 2004	131 Irish pub goers (mean age 32 years) living in Dublin or London	**Irish:** Living in Dublin (70) Living in London (61)	London Dublin
Nazroo, 1997	National, randomly sampled representative survey of Britain's ethnic minorities	**Caribbean** (1,205) **Indian African Asian** (1,947) **Pakistani** (1,232) **Bangladeshi** (598) **Chinese** (214) **White** (2,867)	Britain
Purser *et al.*, 2001	1,684 second and subsequent generation minority ethnic adults	**Black:** African, African Caribbean, Black British (297) **Indian Hindu** (377) **Indian Sikh** (370) **Indian Muslim:** Indian Muslim and East African Asians of Muslim background (77) **Bengali** (225) **Pakistani** (288) **Other:** British Asian and Mixed Race (50)	Leicester, Birmingham/The Black Country
Rodham *et al.*, 2005	6,020 secondary school pupils, mostly 15 and 16 years old	**White:** Males (81.7%) Females (83.6%) **Asian:** Males (12.5%) Females (9.6%) **Black:** Males (1.9%) Females (3.4%) **Other:** mixed race 60%, also Mexican, Egyptian, Jamaican: Males (2.5%) Females (2.7%)	England
Sproston *et al.*, 1999	Chinese aged 16–74 years in 643 households	**Chinese** (1,022)	England

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Stillwell *et al.*, 2004	609 pupils 14–16 years old	**White English** (26.7%) **White Irish** (26.7%) **Black Caribbean** (26%) **Black African** (20.5%)	London Borough of Brent
Vora, 2000	Participants from GPs surgeries, sixth-form colleges and places of worship Asian males aged 16 years and over N = 233 first generation N = 291 second generation	First generation: **Hindu** (105) **Sikh** (40) **Muslim** (48) **Jain** (39) **Buddhist** (1) **Parsi** (0) **Christia**n (0) Second generation: **Hindu** (157) **Sikh** (61) **Muslim** (53) **Jain** (16) **Buddhist** (1) **Parsi** (2) **Christian** (1)	Leicester
White *et al.*, 2001	380 Chinese and 625 Europeans all aged 25–64 years	**Chinese** (380) **European** (625)	Newcastle upon Tyne

Appendix 4: Categorising ethnicity within the literature

The difficulties inherent within research in describing complexity through ethnicity, socioeconomic status and gender mean that research studies have to be interpreted in the context in which they took place, with categories being understood as proxy measures, which cannot completely capture the diversity of the populations being researched. The UK has been officially collecting data on different ethnic groups only since the 1991 Census. The categorisations used in the 1991 Census are now recognised as limited, with the 2001 Census offering a wider range of options and requesting information on religion in England, Wales and Scotland (Bradby, 2003). Classifications used by the government not only reflect the diversity of the population, but also help to construct the categories that are used to define ethnic diversity, making it imperative that they do not reproduce racialised notions of difference (Bradby, 2003). Any research using fixed classifications runs this risk. Subhra (2003) distinguishes between 'ethnic categories' and 'ethnic identity' as means of describing ethnicity. The former are categories imposed by others to create an external category that is often quite broad, while the latter is understood as a process through which people identify themselves, and is often linked to country of origin.

There has been some debate over whether classifications are most appropriate when identifying people by race or by ethnicity. Although both are generally agreed to be social constructions, it is widely held that ethnicity is a more appropriate means of reflecting this (Bradby, 2003). However, many studies in the UK frequently classify people according to the following categories for quantitative analysis: 'White', 'Black', 'South Asian', 'Chinese' and so forth. Whereas the first two classifications point more towards a racial distinction according to skin colour, the latter two categories reflect the country of origin of the participant. This inconsistency matters, as the terms 'White' and 'Black' reinforce racial difference, but neglect the cultural differences in individuals who are classified in this way. Conversely, the terms 'South Asian' and 'Chinese' seem to take cultural differences arising from different countries of origin as a starting point. Although researchers may refer to the ethnicity of respondents, it is often a combination of ethnic and racial terms that are utilised. Some terms blur the boundaries between ethnic and racial categories; the term 'Hispanic' is considered to describe both race and ethnicity (Bradby, 2003), whereas the term 'Jew' is considered as both an ethnic and religious term.

Inherent problems arise from broad ethnic categorisations, for example, 'South Asian' and 'Black', which may fail to uncover differences within groups that are often more revealing than differences across groups (Denscombe & Drucquer, 2000). The term 'South Asian' tends to refer to people from the Indian subcontinent, but this area is populated by people with a wide range of cultural and religious influences, and comprises individuals from a range of social, economic and educational backgrounds. Contrasting South Asian participants with British participants therefore masks the differences in experience and attitudes held by people from the Indian subcontinent. Findings from the US that tend to make more of a distinction between different groups show marked differences in the drinking behaviours of people from different ethnicities (Bergeson *et al*., 1998, in Rodham *et al*., 2005). However, capturing a broad range of diversity through a large number of categories for minority ethnic groups, while grouping together the ethnic majority, also risks a prejudiced approach to analysis. The ethnic majority population are often cited as the normative groups against which other populations are compared. Exploring difference can then become a process of attempting to explain why certain groups deviate from the norms in the majority population. Differences within the majority group may consequently be hidden; for example, 'White' groups tend to be classed together within the UK, which fails to account for the growth in populations from Eastern European countries. Within surveys there is often a 'mixed' option that comprises people who identify with more than one cultural background, but there is rarely an option to expand on the nature of mixed

ethnicity, which can vary considerably, depending on which ethnic groups the person belongs to. In addition, identifying oneself as mixed does not mean that one will identify equally with both backgrounds. Some authors argue that an all-encompassing category of 'mixed' has racist overtones by distinguishing those of 'mixed' origin from those who are 'pure' (Bradby, 2003).

Other challenges when conducting research with minority ethnic groups include confidentiality and language barriers. Identifying people from cultural groups who comprise a very small percentage within the local community risks compromising anonymity, and this may hinder people's honesty when responding to questions. This consideration therefore has to be balanced against the importance of exploring the full diversity of the sample. For people whose first language is not English, understanding the questions in surveys may be a challenge, and may lead to inaccuracy in estimations of consumption. First-generation minority ethnic migrants could be particularly at risk for this, including those from the Asian community, and recent migrants from Eastern Europe (Harrison *et al.*, 1997).

Appendix 5: Abstinence by ethnicity

Study	Age	Measurement	Rates (%) by ethnicity and gender		
Becker *et al.*, 2006	16+			Males	Females
		Abstinence in last year	General population Irish Black Caribbean Black African Indian Pakistani Bangladeshi Chinese	**8%** **10%** **15%** **32%** **33%** **89%** **97%** **19%**	**14%** **11%** **21%** **45%** **59%** **95%** **98%** **33%**
	8–15			Males	Females
		Abstinence in last week	General population Irish Black Caribbean Black African Indian Pakistani Bangladeshi Chinese	**55%** **57%** **62%** **76%** **87%** **99%** **99%** **71%**	**60%** **46%** **65%** **77%** **83%** **96%** **97%** **79%**
Best *et al.*, 2001	11–14			All participants	
		Ever drank	White Other Black South Asian	**56%** **51%** **38%** **24%**	
Bradby and Williams, 2006	14–15			Males	Females
		Ever drank	Non-Asian Asian	**75%** **18%**	**86%** **17%**
	18–20	Ever drank	Non-Asian Asian	**99%** **28%**	**98%** **25%**
Cochrane, 1999	17–65			All participants	
		Abstention (no alcohol in previous year)	White English Black African-Caribbean Sikh	**7%** **20%** **28%**	
Dar *et al.*, 2002	14–56			All participants	
		Abstention (teetotallers)	White Asian	**1.5%** **11.8%**	
Denscombe and Drucquer, 2000	15–16			Males	Females
		Abstention (non-drinker or very rare drinker) (1990)	White South Asian	**34%** **94%**	**43%** **96%**
		Abstention (non-drinker or very rare drinker) (1997)	White South Asian	**27%** **89%**	**37%** **92%**

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Erens and Laiho, 2001	16+			Males	Females
		Abstinence – have never drunk	General population	**3%**	**7%**
			Irish	**1%**	**5%**
			Black Caribbean	**7%**	**13%**
			Indian	**26%**	**60%**
			Pakistani	**86%**	**95%**
			Bangladeshi	**92%**	**98%**
			Chinese	**24%**	**36%**
		Abstinence – ex-drinker	General population	**4%**	**6%**
			Irish	**4%**	**5%**
			Black Caribbean	**6%**	**5%**
			Indian	**7%**	**3%**
			Pakistani	**4%**	**2%**
			Bangladeshi	**4%**	**1%**
			Chinese	**6%**	**5%**
		Ever drank 8–15	General population	**40%**	**32%**
			Irish	**36%**	**36%**
			Black Caribbean	**31%**	**25%**
			Indian	**12%**	**8%**
			Pakistani	**1%**	**2%**
			Bangladeshi	**1%**	**1%**
			Chinese	**18%**	**11%**
Goddard, 2006	16+			Males	Females
		Abstention – non-drinkers	Total population	**9%**	**14%**
			White British	**6%**	**11%**
			Other White	**9%**	**15%**
			Black Caribbean	**10%**	**26%**
			Black African	**44%**	**51%**
			Other Black	**24%**	**31%**
			White and Black Caribbean	**18%**	**15%**
			White and Black African	**22%**	**23%**
			White and Asian	**14%**	**19%**
			Other mixed	**16%**	**8%**
			Indian	**38%**	**60%**
			Pakistani	**85%**	**95%**
			Bangladeshi	**92%**	**92%**
			Other Asian	**41%**	**55%**
			Chinese	**13%**	**35%**
			Other	**30%**	**38%**
Heim and MacAskell, 2006	16+			All participants	
		Do not drink alcohol	Pakistani	**91%**	
			African and Caribbean	**64%**	
			Chinese	**63%**	
			Indian	**57%**	
			General population	**30%**	
Heim *et al.*, 2004	16–25			Males	Females
		Abstention	Indian	**50%**	**52%**
			Pakistani	**70%**	**88%**
			Chinese	**25%**	**29%**
Karlsen *et al.*, 1998	12–13			All participants	
		Ever drank	White	**85%**	
			Black Caribbean	**71%**	
			Black African	**46%**	
			Bangladeshi	**0%**	
	14–15	Ever drank	White	**88%**	
			Black Caribbean	**90%**	
			Black African	**69%**	
			Bangladeshi	**6%**	

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Loretto, 1994	11–16			All participants	
		Percentage never had a whole drink	Northern Irish Scottish	**25%** **20%**	
Nazroo, 1997	16+			Males	Females
		Never drank	All minorities Caribbean All South Asians Indian African Asian Pakistani Bangladeshi Chinese White	**43%** **13%** **58%** **34%** **45%** **92%** **96%** **32%** **8%**	**64%** **26%** **86%** **82%** **74%** **100%** **98%** **49%** **17%**
Purser *et al.*, 2001	18+			Males	Females
		Ever drank (ever drank and sometimes drink are the same measure)	Black Indian Sikh Indian Hindu Pakistani Bengali	**87%** **71%** **34%** **15%** **24%**	**80%** **25%** **22%** **8%** **15%**
Sproston *et al.*, 1999	16–49			Males	Females
		Drinks alcohol	Chinese	**73%**	**56%**
Stillwell *et al.*, 2004	14–16			Males	Females
		Ever drank	White British White Irish Black Caribbean Black African	**89%** **88%** **80%** **50%**	**89%** **95%** **81%** **49%**
White *et al.*, 2001	25–64			Males	Females
		Abstention (never drank)	European Chinese	**1%** **32%**	**4%** **65%**
		Ex-drinker	European Chinese	**6%** **6%**	**7%** **6%**

Note: Shaded figures indicate the estimates are unreliable and any analyses using these figures may be invalid

Appendix 6: Abstinence by religion

Study	Age	Measurement	Rates by religion and gender		
Bradby and Williams, 2006	14–15			Males	Females
		Percentage who have ever drunk	Muslim Sikh/Hindu Christian	**12%** **41%** **71%**	**13%** **27%** **85%**
	18–20	Percentage who have ever drunk	Muslim Sikh/Hindu Christian	**18%** **82%** **98%**	**14%** **54%** **99%**
Cochrane, 1999	17–65			All participants	
		Abstention (no alcohol in previous year)	Sikh	**28%**	**N/A**
Denscombe, 1995	15–16			Males	Females
		Abstention (non-drinker or very rare drinker) (1990)	Church of England Catholic Other Christian	**31%** **29%** **46%**	**42%** **53%** **74%**
Denscombe and Drucquer, 2000	15–16			Males	Females
		Abstention (non-drinker or very rare drinker) (1990)	Muslim Sikh Hindu	**98%** **83%** **92%**	**100%** **100%** **90%**
		Abstention (non-drinker or very rare drinker) (1997)	Muslim Sikh Hindu	**97%** **88%** **76%**	**99%** **79%** **85%**
Heim *et al.*, 2004	16–25			All participants	
		Abstention	Muslim Sikh Hindu Christian	**81%** **50%** **50%** **18%**	
McKeigue and Karmi, 1990	40–69			All participants	
		Abstention	Muslim Sikh (Punjabi) Hindu (South Punjabi) Hindu (Asian Gujarati)	**73%** **23%** **21%** **41%**	
Nazroo, 1997	16+			All participants	
		Reported drinking	Muslim Sikh Hindu	**<10%** **40%** **41%**	
Northern Ireland Statistics and Research Agency, 2007	18+			Males	Females
		Abstention 1996–97	Catholic Protestant	**22%** **22%**	**28%** **33%**
		Abstention 2006–7	Catholic Protestant	**19%** **22%**	**24%** **29%**

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Purser *et al.*, 2001	18+			Males	Females
		Percentage who have drunk (ever drunk and sometimes drink are the same measure)	Muslim Sikh Hindu Christian	**17%** **71%** **33%** **87%**	**10%** **24%** **20%** **82%**
Vora *et al.*, 2000	16+ 1st gen			Males	Females
		Abstention	Muslim Sikh Hindu Christian	**92%** **37%** **41%** **82%**	**N/A**
	16+ 2nd gen	Abstention	Muslim Sikh Hindu Jain	**94%** **46%** **30%** **37%**	**N/A**

Appendix 7: Frequent and current drinking patterns by ethnicity

Study	Age	Measurement	Rates by ethnicity and gender		
Becker *et al.*, 2006	16+			Males	Females
		Frequency: at least once every two months	General population Irish Black Caribbean Black African Indian Pakistani Bangladeshi Chinese	**87%** **87%** **79%** **59%** **61%** **9%** **3%** **69%**	**76%** **83%** **65%** **44%** **33%** **3%** **1%** **48%**
		Frequency: three or more days a week	General population Irish Black Caribbean Black African Indian Pakistani Bangladeshi Chinese	**41%** **51%** **28%** **17%** **18%** **2%** **1%** **18%**	**26%** **30%** **11%** **6%** **30%** **0%** **–** **9%**
		Frequency: drinks almost every day	General population Irish Black Caribbean Black African Indian Pakistani Bangladeshi Chinese	**18%** **20%** **10%** **7%** **7%** **1%** **–** **7%**	**10%** **11%** **4%** **2%** **2%** **–** **–** **4%**
		Current use: drank on at least one day in last week	General population Irish Black Caribbean Black African Indian Pakistani Bangladeshi Chinese	**76%** **80%** **60%** **38%** **47%** **7%** **1%** **48%**	**61%** **67%** **47%** **26%** **21%** **3%** **1%** **32%**
Best *et al.*, 2001	11–14			All participants	
		Regular: at least once a week (total sample)	White Black Asian Other	**14%** **4%** **3%** **8.9%**	
		Regular: at least once a week (as % of those who have ever drunk)	White Black Asian Other	**24%** **8%** **13%** **17.5%**	
Bradby and Williams, 2006	14–15			Males	Females
		Current drinker	Non-Asian Asian	**50%** **6%**	**62%** **7%**
	18–20	Current drinker	Non-Asian Asian	**97%** **22%**	**94%** **12%**

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Cochrane, 1999	17–65			Males	Females
		Occasional: once or twice per week	White English Black African-Caribbean Sikh	**58%** **64%** **32%**	**N/A**
		Regular: at least three times a week	White Black Sikh	**36%** **17%** **41%**	**N/A**
Denscombe, 1995	15–16			All participants	
		Occasional drinking – once a week/fortnight or special night out	White South Asian	**37%** **4%**	
		Regular drinking – two or more times a week	White South Asian	**25%** **2%**	
Denscombe and Drucquer, 2000	15–16			Males	Females
		Occasional and regular drinking category collapsed (1990)	White South Asian	**66%** **6%**	**57%** **4%**
		Occasional and regular drinking category collapsed (1997)	White South Asian	**73%** **11%**	**63%** **8%**
Erens and Laiho, 2001	16+			Males	Females
		Frequency: at least once every two months	General population Irish Black Caribbean Indian Pakistani Bangladeshi Chinese	**89%** **92%** **82%** **61%** **8%** **3%** **57%**	**79%** **83%** **72%** **27%** **2%** **1%** **43%**
		Frequency: three or more days a week	General population Irish Black Caribbean Indian Pakistani Bangladeshi Chinese	**43%** **45%** **28%** **25%** **2%** **1%** **16%**	**27%** **29%** **12%** **3%** **1%** **–** **8%**
		Frequency: drinks almost every day	General population Irish Black Caribbean Indian Pakistani Bangladeshi Chinese	**18%** **18%** **11%** **10%** **1%** **1%** **8%**	**11%** **10%** **4%** **1%** **1%** **–** **2%**
		Current use: drank on at least one day in last week	General population Irish Black Caribbean Indian Pakistani Bangladeshi Chinese	**77%** **79%** **63%** **46%** **5%** **2%** **39%**	**62%** **66%** **50%** **15%** **2%** **1%** **29%**

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Goddard, 2006	16+			Males	Females
		Current use: drank in last week	Total population	**74%**	**59%**
			White British	**77%**	**61%**
			Other White	**75%**	**61%**
			Black Caribbean	**65%**	**42%**
			Black African	**36%**	**18%**
			Other Black	**59%**	**29%**
			White and Black Caribbean	**56%**	**60%**
			White and Black African	**45%**	**44%**
			White and Asian	**63%**	**60%**
			Other mixed	**62%**	**54%**
			Indian	**41%**	**20%**
			Pakistani	**8%**	**2%**
			Bangladeshi	**5%**	**2%**
			Other Asian	**34%**	**20%**
			Chinese	**51%**	**23%**
			Other	**48%**	**31%**
		Current use: drank on 5 or more days last week	Total population	**22%**	**13%**
			White British	**23%**	**14%**
			Other White	**22%**	**12%**
			Black Caribbean	**11%**	**4%**
			Black African	**3%**	**0%**
			Other Black	**11%**	**2%**
			White and Black Caribbean	**9%**	**5%**
			White and Black African	**8%**	**0%**
			White and Asian	**9%**	**15%**
			Other mixed	**16%**	**7%**
			Indian	**8%**	**1%**
			Pakistani	**2%**	**0%**
			Bangladeshi	**2%**	**0%**
			Other Asian	**9%**	**4%**
			Chinese	**5%**	**2%**
			Other	**10%**	**5%**
Information Centre, 2007	16–20			Males	Females
		Current: drinking in week before interview	White	**27%**	**25%**
			Black	**8%**	**11%**
			Asian	**6%**	**6%**
			Mixed	**20%**	**21%**
			Other	**14%**	**11%**
Karlsen *et al.*, 1998	12–13			All participants	
		Regular drinking, not defined	White	**27%**	
			Black Caribbean	**7%**	
			Black African	**6%**	
			Bangladeshi	**0%**	
	14–15	Regular drinking, not defined	White	**63%**	
			Black Caribbean	**21%**	
			Black African	**16%**	
			Bangladeshi	**0%**	

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Nazroo, 1997	16+			Males	Females
		Less than once a week	All minorities Caribbean All South Asians Indian African Asian Pakistani Bangladeshi Chinese White	**25%** **37%** **17%** **26%** **24%** **4%** **1%** **37%** **23%**	**25%** **51%** **10%** **12%** **19%** **<1%** **2%** **40%** **37%**
		Once a week or more	All minorities Caribbean All South Asians Indian African Asian Pakistani Bangladeshi Chinese White	**32%** **50%** **25%** **40%** **32%** **4%** **2%** **32%** **69%**	**11%** **23%** **4%** **6%** **8%** **0%** **0%** **11%** **46%**
McCambridge and Strang, 2005	16–20			All participants	
		Current use	White Black Asian	**97%** **79%** **63%**	
McCambridge, *et al.*, 2004	18–65			All participants	
		Frequency: < weekly	Dublin Irish London Irish	**14%** **2%**	
		1–3 times weekly	Dublin Irish London Irish	**59%** **33%**	
		4–6 times weekly	Dublin Irish London Irish	**26%** **48%**	
		Daily	Dublin Irish London Irish	**1%** **18%**	
Stillwell *et al.*, 2004	14–16			Males	Females
		Regular: once a week or more in last 90 days	White English White Irish Black Caribbean Black African	**34.5%** **41.4%** **22.5%** **29.4%**	**44.7%** **28.1%** **11.4%** **18.2%**
		Mean days' alcohol use in last 90 days	White English White Irish Black Caribbean Black African	**11.1** **14.5** **7.3** **9.6**	**14.9** **11.7** **6.7** **6.8**
		Recent alcohol use	White English White Irish Black Caribbean Black African	**82.9%** **69%** **74.1%** **47.2%**	**82.6%** **86.5%** **74.6%** **41.5%**
White, *et al.*, 2001	25–64			Males	Females
		Current drinking	European Chinese	**93%** **63%**	**89%** **29%**

Note: Shaded figures indicate the estimates are unreliable and any analyses using these figures may be invalid

Appendix 8: Frequent and current drinking patterns by religion

Study	Age	Measurement	Rates by religion and gender		
Bradby and Williams, 2006	14–15			Males	Females
		Current drinker	Muslim Sikh/Hindu All Christians Others	**0%** **21%** **45%** **58%**	**3%** **18%** **60%** **48%**
	18–20	Current drinker	Muslim Sikh/Hindu All Christians Others	**4%** **46%** **92%** **78%**	**4%** **46%** **92%** **78%**
Cochrane, 1999	17–65			Males	Females
		Occasional: once or twice per week	Sikh	**32%**	**N/A**
		Regular: at least three times a week	Sikh	**41%**	**N/A**
Denscombe, 1995	15–16			Males	Females
		Occasional	C of E Catholic Other Christian Muslim Hindu Sikh No religion	**39%** **57%** **23%** **2%** **3%** **11%** **33%**	**38%** **24%** **16%** **0%** **8%** **0%** **39%**
		Regular	C of E Catholic Other Christian Muslim Hindu Sikh No religion	**30%** **14%** **31%** **0%** **5%** **6%** **28%**	**20%** **24%** **10%** **0%** **2%** **0%** **26%**
Denscombe, 2000	15–16			Males	Females
		Occasional or regular (1990)	Muslim Hindu Sikh	**2%** **8%** **17%**	**0%** **10%** **0%**
		Occasional or regular (1997)	Muslim Hindu Sikh	**3%** **24%** **13%**	**1%** **15%** **21%**
Vora *et al.*, 2000	16+ 1st gen			Males	Females
		Occasional drinker	Muslim Sikh Hindu Jain	**4%** **20%** **20%** **5%**	**N/A**
	16+ 2nd gen	Occasional drinker	Muslim Sikh Hindu Jain	**2%** **8%** **25%** **19%**	**N/A**

Appendix 9: Drinking intensity by ethnicity

Study	Age	Measurement	Rates by ethnicity and gender		
Becker *et al.*, 2006	16+			Males	Females
		Drank >4 units (men) / >3 units (women) on heaviest day in last week (drinkers)	General population Irish Black Caribbean Black African Indian Pakistani Bangladeshi Chinese	**60%** **71%** **47%** **44%** **48%** **a** **a** **40%**	**48%** **53%** **40%** **25%** **34%** **a** **a** **37%**
		Drank >8 units (men) / >6 units (women) on heaviest day in last week (drinkers)	General population Irish Black Caribbean Black African Indian Pakistani Bangladeshi Chinese	**33%** **40%** **20%** **19%** **20%** **a** **a** **21%**	**22%** **23%** **13%** **4%** **17%** **a** **a** **14%**
		Drank ≥4 (men) / ≥3 (women) units on heaviest day in past week (whole sample)	General population Irish Black Caribbean Black African Indian Pakistani Bangladeshi Chinese	**45%** **56%** **28%** **17%** **22%** **4%** **1%** **19%**	**30%** **36%** **18%** **7%** **8%** **1%** **1%** **12%**
		Drank ≥8 (men) / ≥6 (women) units on heaviest day in past week (whole sample)	General population Irish Black Caribbean Black African Indian Pakistani Bangladeshi Chinese	**25%** **32%** **12%** **7%** **9%** **3%** **0%** **10%**	**14%** **16%** **6%** **2%** **4%** **1%** **0%** **4%**
Borrill *et al.*, 2003	Adult			Males	Females
		Harmful or hazardous levels of drinking (>8 AUDIT* score)	White Black/Mixed race Black, Asian and Mixed race	**N/A** **N/A** **48%**	**37%** **29%** **N/A**

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Cochrane, 1999	17–65			Males	Females
		Average number units per week: all drinkers	White English Black African-Caribbean Sikh	**15** **8** **17**	**N/A**
		Average number units per week: regular drinkers	White English Black African-Caribbean Sikh	**25** **19** **25**	**N/A**
		Drinks >20 units a week	White English Black African-Caribbean Sikh	**25%** **8%** **27%**	**N/A**
		Drunk occasionally	White English Black African-Caribbean Sikh	**33%** **8%** **31%**	**N/A**
		Drunk at least once a week	White English Black African-Caribbean Sikh	**9%** **0%** **10%**	**N/A**
Dar *et al.*, 2002	14–56			Males	Females
		Drinks <28 units per week	White Asian	**57.5%** **72.1%**	**N/A**
		Drinks 28–50 units per week	White Asian	**10.8%** **8.8%**	**N/A**
		Drinks >50 units per week	White Asian	**20.8%** **5.9%**	**N/A**
Denscombe, 1995	15–16			Males	Females
		Ever been drunk	White South Asian	**73%** **21%**	**67%** **12%**
Erens and Laiho, 2001	16+			Males	Females
		Average number units per week (usual consumption) (whole sample)	General population Irish Black Caribbean Indian Pakistani Bangladeshi Chinese	**17.5** **20.4** **11.5** **8.6** **1.7** **1.5** **4.2**	**7.2** **8.5** **4.3** **1.5** **0.3** **0.0** **2.2**
		Drank >4 units (men) / >3 units (women) on heaviest day in last week (drinkers)	General population Irish Black Caribbean Indian Pakistani Bangladeshi Chinese	**59%** **74%** **43%** **50%** **a** **a** **21%**	**47%** **56%** **35%** **36%** **a** **a** **30%**
		Drinks > 21 (men) / >14 (women) units a week	General population Irish Black Caribbean Indian Pakistani Bangladeshi Chinese	**30%** **34%** **18%** **14%** **2%** **1%** **3%**	**16%** **19%** **9%** **2%** **1%** **–** **4%**

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Goddard, 2006	16+			Males	Females
		Drank ≥ 4 (men) / ≥ 3 (women) units on typical day in past week	Total population	**38%**	**22%**
			White British	**40%**	**23%**
			Other White	**37%**	**20%**
			Black Caribbean	**19%**	**10%**
			Black African	**13%**	**4%**
			Other Black	**19%**	**10%**
			White and Black Caribbean	**38%**	**30%**
			White and Black African	**29%**	**20%**
			White and Asian	**43%**	**26%**
			Other mixed	**32%**	**24%**
			Indian	**14%**	**5%**
			Pakistani	**5%**	**0%**
			Bangladeshi	**2%**	**0%**
			Other Asian	**10%**	**4%**
			Chinese	**17%**	**3%**
			Other	**21%**	**9%**
		Drank≥ 8 (men) / ≥ 6 (women) units on typical day in past week	Total population	**21%**	**9%**
			White British	**23%**	**10%**
			Other White	**19%**	**9%**
			Black Caribbean	**5%**	**3%**
			Black African	**6%**	**1%**
			Other Black	**10%**	**4%**
			White and Black Caribbean	**25%**	**13%**
			White and Black African	**12%**	**8%**
			White and Asian	**26%**	**13%**
			Other mixed	**19%**	**10%**
			Indian	**7%**	**3%**
			Pakistani	**1%**	**0%**
			Bangladeshi	**2%**	**0%**
			Other Asian	**4%**	**2%**
			Chinese	**7%**	**0%**
			Other	**10%**	**4%**
Heim *et al.*, 2004	16–25			Males	Females
		Units of alcohol per week (drinkers)	Indian	**8.83**	**6.25**
			Pakistani	**16.28**	**7.6**
			Chinese	**6.32**	**3.11**
McCambridge and Strang, 2005	16–20			All participants	
		Average consumption last week (units)	White	**23**	
			Black	**7**	
			Asian	**13**	
McCambridge *et al.*, 2004	18–65			All participants	
		Average consumption last week (units)	Dublin Irish	**43**	
			London Irish	**63**	
		Typical drinking day in last month (units)	Dublin Irish	**13.3**	
			London Irish	**13.1**	
		High consumption: >50 (men) / >35 (women) units in last week	Dublin Irish	**43%**	
			London Irish	**64%**	
		Hazardous drinking: % exceeding AUDIT score	Dublin Irish	**73%**	
			London Irish	**80%**	
		Moderate dependence: % exceeding SADD score of 10	Dublin Irish	**25%**	
			London Irish	**28%**	

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Purser *et al.*, 2001	18+			Males	Females
		Fairly heavy drinking: >21 (men) / >14 (women) units last week	Black Indian Sikh Indian Hindu Pakistani Bengali	**34%** **24%** **4%** **4%** **5%**	**18%** **5%** **3%** **2%** **4%**
		Very heavy drinking: >50 (men) / >35 (women) units last week	Black Indian Sikh Indian Hindu Pakistani Bengali	**15%** **6%** **2%** **0%** **2%**	**4%** **<1%** **1%** **0%** **1%**
Rodham *et al.*, 2005	15–16			Males	Females
		Consumes two or more drinks per week	White Black Asian Other	**60%** **42%** **12%** **41%**	**49%** **23%** **7%** **42%**
		Drunk more than once in last year	White Black Asian Other	**59%** **44%** **11%** **39%**	**59%** **30%** **9%** **52%**
Sproston, *et al.*, 1999	16–49			Males	Females
		Drinks hardly at all (daily drinkers)	Chinese	**16%**	**14%**
		Drinks a little (daily drinkers)	Chinese	**48%**	**58%**
		Moderate amount (daily drinkers)	Chinese	**32%**	**28%**
		Quite a lot (daily drinkers)	Chinese	**4%**	**1%**
Stillwell *et al.*, 2004	14–16			Males	Females
		Typical amount consumed (units)	White English White Irish Black Caribbean Black African	**6** **7.2** **3.2** **4.2**	**5.8** **5.1** **2.9** **2.3**
		Drunk in past 90 days	White English White Irish Black Caribbean Black African	**53.4%** **58.6%** **25%** **41.2%**	**65.8%** **48.4%** **20.5%** **22.7%**
		Drunk once a week or more in past 90 days	White English White Irish Black Caribbean Black African	**12.1%** **10.3%** **0%** **0%**	**15.8%** **12.5%** **2.3%** **4.5%**
White *et al.*, 2001	25–64			Males	Females
		Safe drinker: <22 (men) / <15 (women) units per week	European Chinese	**60%** **99%**	**90%** **97%**
		Increasing risk: 22–50 (men) / 15–35 (women) units per week	European Chinese	**33%** **1%**	**9%** **4%**
		Hazardous: >50 (men) / >35 (women) units per week	European Chinese	**6%** **0%**	**1%** **0%**
		Median consumption (units) per week	European Chinese	**16** **2**	**6** **1**

Note: Shaded figures indicate the estimates are unreliable and any analyses using these figures may be invalid
a The bases are too small to provide reliable estimates for these groups
* Alcohol Use Disorders Identification Test (Saunders *et al.*, 1993). This is a screening instrument for hazardous and harmful alcohol consumption

Appendix 10: Drinking intensity by religion

Study	Age	Measurement	Rates by religion and gender		
Cochrane, 1999	17–65			Males	Females
		Average number units per week:drinkers	Sikh	**17**	**N/A**
		Average number units per week: regular drinkers	Sikh	**25**	**N/A**
		Drinks >20 units a week	Sikh	**27%**	**N/A**
		Drunk occasionally	Sikh	**31%**	**N/A**
		Drunk at least once a week	Sikh	**10%**	**N/A**
Heim *et al.*, 2004	16–25			All participants	
		Units alcohol per week (drinkers)	Muslim Sikh Christian Hindu Buddhist None	**13.73** **7.58** **3.88** **8.41** **4.13** **5.02**	
Northern Ireland Statistics and Research Agency 2007 (2006–7)	18+			Males	Females
		Below sensible	Catholic Protestant	**50%** **53%**	**61%** **62%**
		Above sensible/below dangerous	Catholic Protestant	**22%** **18%**	**13%** **7%**
		Above dangerous	Catholic Protestant	**9%** **6%**	**1%** **1%**
Purser *et al.*, 2001	18+			Males	Females
		Fairly heavy drinking: >21 (men) / >14 (women) units last week	Muslim Sikh Christian Hindu None	**4%** **23%** **30%** **3%** **37%**	**1%** **5%** **18%** **3%** **28%**
		Very heavy drinking: >50 (men) / >35 (women) units last week	Muslim Sikh Christian Hindu None	**1%** **6%** **10%** **1%** **18%**	**<1%** **1%** **5%** **<1%** **6%**
Vora *et al.*, 2000	16+ 1st gen			Males	Females
		Average units per week (drinkers)	Muslim Sikh Hindu Jain	**4.3** **12.8** **10.3** **4.8**	**N/A**
	16+ 2nd gen	Average units per week (drinkers)	Muslim Sikh Hindu Jain	**18** **13.3** **7.8** **8.5**	**N/A**

Appendix 11: Age of initiation of alcohol use by ethnicity and gender

Study	Age	Ethnicity	Age of first consumption	
Best *et al.*, 2001	11–14		All participants	
		White Black South Asian Other	**10.9** **10.7** **11.3** **10.7**	
McCambridge and Strang, 2005	16–20		All participants	
		White Black South Asian	**11.1** **12.2** **13.8**	
Stillwell *et al.*, 2004	14–16		Males	Females
		White British White Irish Black African Black Caribbean	**13.1** **12.4** **12.9** **12.6**	**12.2** **12.8** **12.4** **11.9**

Appendix 12: Drinking consequences by ethnicity

Study	Age	Measurement	Rates by ethnicity and gender		
Cochrane, 1999	17–65			Males	Females
		Trouble with police while drinking	White English Black African-Caribbean Sikh	**10%** **2%** **3%**	**N/A**
		Drinks to forget problems	White English Black African-Caribbean Sikh	**22%** **10%** **30%**	**N/A**
Purser *et al.*, 2001	18+			Males	Females
		Zero signs that drinking might be of concern*	Black Indian Sikh Indian Hindu Pakistani Bengali	**45%** **65%** **90%** **90%** **85%**	**74%** **94%** **96%** **97%** **95%**
		One sign that drinking might be of concern*	Black Indian Sikh Indian Hindu Pakistani Bengali	**25%** **14%** **6%** **4%** **9%**	**16%** **4%** **1%** **1%** **3%**
		Two or more signs that drinking might be of concern*	Black Indian Sikh Indian Hindu Pakistani Bengali	**31%** **21%** **5%** **5%** **6%**	**11%** **2%** **3%** **2%** **2%**
		Aggressiveness	Pakistani Bengali Muslim Sikh Hindu Christian No religion	**64%** **68%** **49%** **36%** **26%** **50%** **43%**	**20%** **21%** **17%** **15%** **17%** **20%** **21%**
		Been in fight	Pakistani Bengali Muslim Sikh Hindu Christian No religion	**52%** **57%** **49%** **33%** **26%** **46%** **38%**	**20%** **16%** **10%** **6%** **17%** **15%** **19%**
		Damaged things	Pakistani Bengali Muslim Sikh Hindu Christian No religion	**44%** **39%** **35%** **21%** **16%** **16%** **28%**	**20%** **5%** **3%** **0%** **2%** **8%** **12%**
		Stopped by police	Pakistani Bengali Muslim Sikh Hindu Christian No religion	**28%** **22%** **26%** **19%** **9%** **19%** **35%**	**10%** **0%** **7%** **0%** **2%** **5%** **10%**

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		Been convicted	Pakistani Bengali Muslim Sikh Hindu Christian No religion	**20%** **7%** **10%** **7%** **0%** **7%** **16%**	**0%** **0%** **3%** **0%** **2%** **0%** **5%**
Stillwell *et al.*, 2004	14–16			Males	Females
		Being unwell	White English White Irish Black Caribbean Black African	**53%** **45%** **20%** **35%**	**53%** **50%** **37%** **18%**
		Being aggressive	White English White Irish Black Caribbean Black African	**18%** **31%** **13%** **12%**	**16%** **5%** **7%** **5%**
		Breaking the law	White English White Irish Black Caribbean Black African	**18%** **28%** **8%** **0%**	**11%** **11%** **2%** **0%**
		Had an accident	White English White Irish Black Caribbean Black African	**11%** **14%** **9%** **12%**	**16%** **10%** **9%** **0%**
		Engaging in potentially harmful sexual behaviour	White English White Irish Black Caribbean Black African	**9%** **21%** **5%** **12%**	**16%** **7%** **2%** **0%**
		Driving a vehicle in an unsafe manner	White English White Irish Black Caribbean Black African	**11%** **14%** **5%** **0%**	**3%** **2%** **0%** **0%**
		Family problems	White English White Irish Black Caribbean Black African	**9%** **17%** **3%** **6%**	**16%** **3%** **5%** **0%**
		Relationship difficulties with girl/boyfriend	White English White Irish Black Caribbean Black African	**20%** **0%** **5%** **0%**	**23%** **15%** **2%** **0%**
		Difficulty getting up after drinking the night before	White English White Irish Black Caribbean Black African	**38%** **35%** **18%** **47%**	**29%** **36%** **26%** **23%**
		Poor school performance	White English White Irish Black Caribbean Black African	**9%** **7%** **3%** **0%**	**3%** **3%** **2%** **0%**
		Overspending	White English White Irish Black Caribbean Black African	**24%** **14%** **8%** **6%**	**34%** **16%** **5%** **5%**

* Drinking being of concern was measured by relatively heavy, frequent, risky or in need of change compared with the sample as a whole

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