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Alcohol misuse and ethnicity

Hidden populations need specific services—and more research

The development and implementation of clinically effective interventions for alcohol misuse remains a priority for developed countries with high levels of harmful alcohol consumption.^{w1} Such interventions rely on individuals recognising that they need help and then seeking it, but ethnic minorities may have particular problems with alcohol use yet may be constrained from seeking help.

In the United Kingdom several ethnic minorities have higher levels of alcohol use and resulting health problems than the general population. For example, 34% of Irish men drink above the weekly recommended limit of 21 units of alcohol,^{w2} compared with 29% of the general Irish population and 27% of the general British population. A similar problem exists in south Asian (Sikh) male migrants to the UK, where problem drinking is higher than in the Sikh population in South Asia and similar to that of the UK general population.^{w3} Irish and Sikh groups in the UK also have higher rates of morbidity and mortality than the general population.^{w4} In the United States, similar patterns have been observed in Hispanic men, whose prevalence of alcohol misuse has remained static while it has fallen among white (non-Irish) men, and whose prevalence of alcohol related health problems has more than doubled over 10 years.^{w5}

Both alcohol misuse and ethnicity are bound to social disadvantage. In the United Kingdom the clustering of first generation Irish people in areas of socio-economic deprivation may explain their higher prevalence of alcohol use.^{w6} A similar observation has been noted in Mexican Indians in the United States. They have higher rates of alcohol dependence and misuse than other Mexicans in the US, but these differences disappear when adjusted for socioeconomic factors.^{w7}

Considerable stigma surrounds alcohol misuse in minority ethnic groups. This is particularly so for Asian communities in the UK, where people from an older generation are unwilling to recognise alcohol misuse within their communities. The second generation may share this view and perceive their actions as reflecting on the behaviour of the whole family. As a result people with alcohol problems may try to cope on their

own rather than use local alcohol services.^{w8} Moreover, they may be unaware of alcohol services.^{w9} A different set of influences may operate in Irish communities, where perceived negative stereotyping from health professionals might explain the low rates of primary care consultation for alcohol related problems.^{w10}

In turn health providers may avoid developing services for ethnic minorities at greatest risk of alcohol misuse for fear of being seen as racist or because they think they will be ineffective for communities that do not readily access alcohol services. Nevertheless, some progress has been made in developing culturally appropriate services over the past 10 years. One avenue is through generic mental health services, which some ethnic minorities may access in preference to specialist services.^{w11} Several examples of good practice now exist in the UK, with the development of both statutory and voluntary organisations for alcohol related problems in Asian and Irish communities. A further initiative has been the formation of the Federation of Black and Asian Drug and Alcohol Professionals (www.thefederation.org.uk). The Centre for Ethnicity and Health based at the University of Central Lancashire (www.uclan.ac.uk) has complemented these advances with its pioneering research into community engagement with minority groups.

Alcohol misuse cannot simply be tackled using a broad population approach without culturally appropriate services to meet the needs of minority ethnic groups. This in turn cannot be achieved without a knowledge base drawn from high quality ethnographic research within specific populations. At present, such knowledge remains patchy.^{w12}

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Competing interests: None declared.

References w1-w12 are on bmj.com

BMJ 2006;332:682