Patterns of alcohol consumption and problems among the Irish in London: A preliminary comparison of pub drinkers in London and Dublin

Published in *Addiction Research & Theory* (2004) 12(4), 373-384

Jim McCambridge, Paul Conlon, Francis Keaney,

Shamil Wanigaratne, John Strang

National Addiction Centre
(The Maudsley/Institute of Psychiatry)
Addiction Sciences Building
4 Windsor Walk
Denmark Hill
London SE5 8AF

Correspondence by e-mail: J.McCambridge@iop.kcl.ac.uk

Acknowledgements
The data which enabled this study to be undertaken were originally collected during the studentship of the second author (PC) on the MSc in Clinical and Public Health Aspects of the Addictions, University of London. We are also grateful to the management, staff and participating customers of the four pubs in which this study took place.

Abstract

Alcohol related morbidity and mortality rates among the Irish in England and Wales are higher than both other ethnic minorities and the general population. Higher consumption per episode of drinking is responsible for higher overall mean consumption levels among the Irish. Patterns of consumption and problems among the Irish were investigated in two samples recruited in pubs in London and Dublin. Mean alcohol consumption was found to be higher - by approximately 50% - in the London sample with more high risk drinking a result of more frequent drinking patterns. Hazardous drinking was strongly normative among young Irish people in both London and Dublin. The distinct Irish style of drinking - greater quantities per episode – and the English pattern of more frequent drinking combine to produce elevated risk among the Irish in London. Irish drinking patterns in general, and the alcohol related needs of the young Irish in Britain in particular, require further study to better understand the nature of risk and to prevent harm.

Introduction

Alcohol Consumption & Problems among the Irish in Britain

Alcohol-related mortality in England & Wales among those born in Ireland is substantially higher - both by comparison with other ethnic minorities and with the general population (Harrison, Sutton & Gardiner, 1997). General and psychiatric hospital admissions data also provide evidence of elevated alcohol-related morbidity (Cochrane, 1977; Cochrane & Bal, 1979; Dean, Downing & Shelley, 1981; Taylor et al., 1986; Commander et al., 1999; Canning et al., 1999).

These patterns of differential morbidity and mortality can be seen to have a relationship to some measures of elevated consumption in nationally representative survey data. The Health Survey for England in 1999 compared the health of the Irish with five other ethnic minorities and with the general population (http://archive.official-documents.co.uk/document/doh/survey99). This survey found that all other ethnic minorities were less likely to drink alcohol, drank less frequently and consumed smaller amounts than the general population. By contrast, the Irish were either found to be similar to the general population or to be at higher risk. Whilst having similar frequencies of drinking, greater amounts of alcohol consumed per episode of drinking are largely responsible for higher mean consumption levels among the Irish in Britain.

Although not specifically related to alcohol consumption, health inequalities in the form of elevated mortality rates have been found to extend into second and third generation Irish in Britain (Harding & Balarajan, 1996; Harding & Balarajan, 2001). These health inequalities reflect, but are not solely explained by, socio-economic inequalities experienced by the Irish (Wild & McKeigue, 1997; Hickman & Walter, 1997; Abbots et al., 2001).

Various explanations have been offered for these data. Greenslade, Pearson & Madden (1995) argue that the influence of stereotypical views of Irish drinking patterns has inhibited serious research and policy attention to this area, in Ireland as well as elsewhere. Cochrane (1977) identifies three hypotheses drawn from wider work on the mental health of migrant populations, which may explain higher levels of drinking problems. These direct attention to (1) levels of alcohol consumption and problems in Ireland (hypothesised rates higher than the host country), (2) the process of migration itself (hypothesised to promote alcohol involvement), and (3) the characteristics of the migrants themselves (migrant selection hypothesis).

Studies of drinking among migrant Irish populations have been undertaken since the 1940s. For example, Stivers (1976) describes the ways in which specific 'hard-drinking' characteristics of the Irish combined with the initially hostile stereotypical view held by American society of the 'habitual drunkard' to produce a convergent positive and accepted identity of the 'happy

drunk'. This acceptance of Irish drinking practices in the U.S. was associated with broader social inclusion and access to political power.

Abbots et al. (2001) observe that continuing socio-economic disadvantage among Irish migrants in Britain contrasts sharply with the U.S.A., and propose that attention needs to be drawn to particular national contexts. Hickman & Walter (1997) identify pervasive ongoing anti-Irish discrimination throughout British society, and Harrison et al. (1997) suggest that the racism experienced by the Irish in Britain may be responsible for elevated levels of alcohol-related mortality.

Comparisons of Alcohol Consumption & Problems in Ireland & Britain

Levels of alcohol consumption in Ireland have increased rapidly over the last fifteen years, during which time Ireland has become the fastest growing economy in Europe. Per capita consumption was equivalent to that of Britain in 1989, at 7.6 litres of pure alcohol in both countries. Whilst Britain was one of the few countries in the European Union (E.U.) in which per capita consumption increased between 1989 - 2000 (to 8.4 litres), this increase was dwarfed by the increase in Ireland to 11.1 litres over the same period (Strategic Task Force on Alcohol Interim Report, 2002). Ireland, from being the second lowest in the E.U. in 1989, had the second highest rate of per capita alcohol consumption in the E.U. by the year 2000 (Strategic Task Force on Alcohol Interim Report, 2002).

Comparisons of general population data between the two countries (regular General Household Survey in Britain and specially commissioned survey in Ireland in 1999) reveal broad similarities in consumption patterns (Friel, NicGabhainn & Kelleher, 1999; Walker et al., 2001; Strategic Task Force on Alcohol Interim Report, 2002). For example, in both countries younger people are more likely to drink higher quantities per occasion of consumption and for there to be similar patterns among both young women and men. Older age groups, on the other hand, are more likely to be more frequent drinkers at lower quantities of consumption, with men drinking more heavily than women, in both countries.

Harrison, Carr-Hill & Sutton (1993) found a higher proportion of men reporting two or more physical or psychological problems resulting from alcohol consumption in Ireland compared to England & Wales in data collected during the 1980s. O'Connor (1978) examined patterns of consumption, attitudes and problems among young people in Ireland and England, including among second-generation Irish i.e. those born in England of parents born in Ireland. This group (along with their parents) were found to be substantially heavier drinkers than either the Irish (in Ireland) or the English. Detailed comparisons of patterns of consumption and problems between the two countries are otherwise limited.

Cross-national comparisons between Britain and Ireland are evidently subject to substantial influence by change over time, and are characterised broadly

by similarity in patterning. Any contribution of the first hypothesis advanced by Cochrane (hypothesised rates higher than the host country) is thus thought to be both difficult to evaluate, but likely to be modest.

Other Possible Explanations for Elevated Consumption & Problems among the Irish in Britain

Harrison & Carr-Hill (1992), in an investigation of the Irish in England, found that majorities of both men and women with alcohol-related problems reported the onset of these problems as occurring after migration. The migration strain hypothesis (2) and the migrant selection hypothesis (3) may both be investigated by examining the drinking patterns and psychosocial characteristics of migrants with comparable non-migrants. Detailed comparison of patterns of consumption and problems between the Irish in Britain and those remaining in Ireland are unknown to the authors. The basic rationale for making such comparisons may be summarised as having the potential to increase understanding of the distinct alcohol-related needs of the Irish in Britain i.e. those arising out of migration to and living in Britain, thereby permitting consideration of the second and third hypotheses identified by Cochrane - migration as a source of increased risk and high-risk people being more likely to migrate.

In the absence of prior study, it was decided to conduct a preliminary investigation of patterns of consumption and problems between the Irish in the two countries. In addition to this main focus of the study, it was decided

also to consider the extent to which the views of the Irish migrants relating to alcohol were similar to those held by non-migrants. It may be that acculturation leads the migrant to view alcohol in a way distinct from that held by the non-migrant, and that these views have implications for patterns of consumption and problems including definitions of problem drinking. These preliminary investigations are necessarily conducted for the purpose of more detailed hypothesis generation.

Methods

Sampling, Setting & Participants

A non-probability sampling method was used. A probabilistic sampling strategy, providing in many ways the most appropriate means of making intended comparisons, was precluded on grounds of cost and time available in which to undertake the study. Additionally, we specifically wished to over-sample heavier drinkers, in order to explore in depth the relationships between patterns of consumption, and different types of risk and problems in the two countries. To this end, we recruited convenience samples in two locations – two pubs each in London and Dublin, matched on a number of variables. London and Dublin were deemed to be urban locations as equivalent as possible in the circumstances of the study.

This sampling method is biased in the way required, with heavier pub consumers, by definition, spending more time on licensed premises than lighter consumers. It was understood at the outset that this sampling method

excluded those populations with most severe and complex alcohol problems, by virtue of their exclusion from this setting. Street drinkers in both cities, including those who are chronically intoxicated, or who may be homeless, or have significant dual diagnoses involving alcohol, were understood to be less likely to be found in pubs for a variety of reasons. In some respects, exclusion from pubs may be one component of their broader social exclusion.

Pubs have previously been used as settings for ethnographic and other qualitative studies of drinking patterns and consequences. Epidemiological or other quantitative studies that have opportunistically sampled pub drinkers are rare and have usually been concerned with the pub itself as a risk environment (see Miller & Williams, 1981 for example). Pubs are self-evidently settings in which large numbers of drinkers may be recruited quickly. They potentially offer a low cost, easy to access, setting in which quantitative alcohol data may be rapidly collected. Satisfactory procedures are needed to ensure that intoxication does not undermine the reliability of data obtained.

Opportunistic sampling of targeted drinking populations has been previously used to explore in-depth patterns of consumption and risk (see for example Harnett et al., 1999). Whilst there may be inherent problems in determining the representativeness of pub samples, these are certainly not insurmountable. For example, it may be possible to collect data on sociodemographic, drinking and other characteristics in order to compare

with available local or general population data (as was done by Cosper, Okraku & Neumann, 1988).

In the present study, cross-national comparison was identified as being the primary object of interest. This study was thus designed to recruit equivalent populations, with identical procedures being used in each location. The potential exists, however, for hidden sampling bias, undermining the validity of the comparison, and this may be difficult to evaluate. Therefore, given the limitations of the sampling method, post-hoc consideration of unanticipated sources of sampling bias in respect of the achieved sample is needed, and will precede any consideration of the generalisability of the findings.

Study participants were recruited from two well-known pubs on the Holloway Road in north London and two equivalents on Dorset Street in north Dublin. This area of London has a longstanding reputation for having a large Irish population. These locations were also selected on the basis of similarities in proximities to; city centres; retail and shopping facilities; educational establishments; major hospitals; and having a mix of social housing, owner occupied and private rented property in each area (Conlon, 2001). All four establishments were also understood to have a wide range of customers, and to be reasonably busy throughout the day: - which matched the time available for fieldwork in circumstances most conducive to reliable data collection.

Participants were required to be Irish (i.e. born on the island of Ireland), over eighteen years old, resident in either Dublin or London for more than one year, never to have attended a treatment agency in relation to their alcohol use and to have literacy sufficient for questionnaire completion. Additionally, prior to approach as soon as possible after entry to the pub, participants were informally assessed for signs of prior intoxication, and potential study participants who were judged already to be intoxicated were not approached.

Data Collection & Measures

The second author (PC) attended both sites in Dublin and both sites in London at different times of the day and on all days of the week. A typical field session averaged four hours in duration. Data was collected from the Dublin sample first, over a 12-day period. Data collection from the London sample took 15 days to complete, with all data collection in both cities taking place in the month of July 2001.

Potential participants who appeared to meet study criteria were approached shortly after they entered the pub. Written consent was obtained following invitation to participate in the study and the asking of screening questions. Participants were given both verbal and written information about the study. No information involving personal identification was requested and appropriate assurances of confidentiality were given. A self-completion questionnaire was used, which took approximately 20

minutes, after which time the completed questionnaire was collected by the researcher.

A data collection target of 140 questionnaires was set - 70 each for Dublin and London. In Dublin, 76 questionnaires were initially collected, with 12 refusals. In London, 65 were completed with 5 refusals. A total of 10 questionnaires were later excluded for reasons of inadequate completion or information indicating ineligibility. This resulted in a total sample size of 131 participants, comprising 70 from Dublin and 61 from London.

In addition to sociodemographic data, participants were invited to categorize their current drinking pattern by frequency and to describe their drinking over the previous week and month. Data were collected on both the quantities and types of alcohol, as well as the context of drinking.

Two distinct standardised self-report measures of alcohol-related problems were also incorporated. The first of these measures hazardous drinking, comprised of components of consumption, problems and dependence (the Alcohol Use Disorder Identification Test [AUDIT]; Babor et al., 1992). The second measure used was a dedicated measure of dependence, specifically developed to be sensitive to dependence in non-treatment populations (Short Alcohol Dependence Data [SADD]; Davidson & Raistrick, 1986).

In addition to these consumption and problems data, participants were asked if they had experienced any of a listed series of consequences of drinking over the last year. They were also asked for their views on whether a series of alcohol-related negative consequences constituted a problem, and whether they believed these consequences were sufficient reasons for personal behaviour change.

Expectancies have proven to be predictive of consumption patterns in adults (Lee, Greely & Oei, 1999) and to be variable cross-culturally, with distinctly Irish patterns having previously been described in a treatment population (Teahan, 1998). Expectancies, as manifestations of Irish cultural beliefs about alcohol, were measured using the Drinking Expectancy Questionnaire (Young & Knight, 1988). This instrument yields a total score and six sub-scale scores representing assertiveness, negative affective change, dependence, sexual enhancement, cognitive enhancement and tension reduction respectively.

Data Analyses

In addition to the presentation of data straightforwardly comparing London and Dublin, a series of multiple regression analyses were undertaken to examine whether any univariate relationships between London/Dublin location and consumption and problem variables were robust to potential confounding by other variables. These analyses all considered the following variables as potential confounders: age, sex, relationship status (single/non-single), educational attainment (higher education or not), any family alcohol

problem history (yes/no) and total expectancy score. Stepwise backward elimination procedures were employed with a criterion of p=0.1. All analyses were performed using SPSS Version 11.

Results

The Sample

The overall sample comprised 75 (57%) males and 56 (43%) females. The mean age of the total sample was 32 years, with the youngest participant being 18 years old and the oldest 65 years old. Fifty-eight people (42%) reported being married or cohabiting, 12 (9%) being divorced or separated and the remainder (n=64, 49%) of the sample reported being single. The majority (n=72, 59%) had attained some form of higher education qualification ranging from diploma through to postgraduate degree. Only 3 (2%) individuals reported being unemployed, 10 (8%) were students and the remainder were in part or full-time employment.

Table 1: Basic Sociodemographic Characteristics of London & Dublin Samples

	London	*Dublin*
Mean Age (in years)	36	30
% Female Gender	41	44
% Single*	56	61
% Higher Education	64	47
% Current Employment	96	90
% Family History of Alcohol Problems	48	48

* incl. separated/divorced/widowed

The London and Dublin samples are compared in Table 1. There was one statistically significant difference between the samples recruited in London and Dublin: The London sample was older (see Table 1; t=3.99, p<0.001). The London sample was also more likely to have a higher education qualification (see Table 1), though this was not statistically significant (chi-sq.=3.7, 2 df, p=0.054).

Alcohol Consumption Patterns

In the week prior to data collection, mean alcohol consumption level was 63 units in the London sample (SD=42), compared to 43 units in Dublin (SD=30, t=2.98, p=0.01). A similar difference was observed in the previous month, with the mean number of days on which alcohol was consumed being 14 days in Dublin (SD=7), compared to 20 days in London (SD=8, t=4.26, p=0.001). However, in a typical day drinking in the previous month, the two samples were very similar in quantity consumed – 13.3 units in Dublin (SD=5.7) and 13.1 units in London (SD=5.5). Also there was no significant difference in the number of times participants reported being drunk in the previous month – 6 times in Dublin (SD=6.5) and 8 times in London (SD=6.5) respectively. Table 2 presents data on how participants categorised their current consumption pattern by frequency of drinking. These categorical differences in drinking frequency were also statistically significant (Linear chi.sq=24.7, 3 df, p<0.001).

Table 2: Current Drinking Frequency Categories

Drinking Frequency	*Dublin*	*London*	*Total*
Less than weekly	10 (14%)	1 (2%)	11 (8%)
1-3 times weekly	41 (59%)	20 (33%)	61 (47%)
4-6 times weekly	18 (26%)	29 (48%)	47 (36%)
Daily	1 (1%)	11 (18%)	12 (9%)
Total	70 (100%)	61 (100%)	131 (100%)

Finally, in respect of consumption level, participants were categorised as being low, medium and high consumption according to whether they exceeded previously recommended weekly thresholds of 21 units and 50 units for men, and 14 units and 35 units for women respectively in the previous week (1 unit being a half-pint of ordinary strength beer). Sixty-four per cent of the London sample were categorised as high consumption, compared to 43% of the Dublin sample. Twenty-one per cent of the Dublin sample fell into the low consumption category, whereas only 5% of the London sample fell into this low consumption category (Linear chi-sq.=8.0, 1 df, p=0.004).

Are London–Dublin Consumption Differences Explained by Associations With Other Variables?

Each of the four consumption variables (number of days drinking, number of times drunk and quantity consumed per drinking day all in the previous month, and amount consumed in the previous week) was separately

considered in multiple regression analyses to examine the robustness of any London-Dublin differences. In addition to location (B=0.34, p<0.001), only gender (B=0.24, p=0.004) was associated with frequency of drinking in the previous month. After controlling for the influence of gender, those in London were drinking on 5.5 days more in the past month than those in Dublin.

There was no London-Dublin difference in quantity consumed per drinking day in the previous month, with only gender (B=0.39, p<0.001) and expectancies (B=0.24, p=0.018) being associated with this variable. Although the London-Dublin difference was not significant in the univariate analysis of number of times drunk in the previous month (see previous section), this difference did become significant in the multivariate analysis, partly as a result of the influence of age, which was non-equivalent in the two samples. In addition to location (B=0.20, p=0.029) and age (B=0.29, p=0.002), gender (B=0.26, p=0.004) and expectancies (B=0.19, p=0.029) were also associated with frequency of being drunk.

The difference in total consumption in the previous week between London and Dublin also remained significant (B=0.25, p=0.003). The mean consumption level in the London sample was approximately 19 units higher than the Dublin sample after controlling for gender (B=0.31, p<0.001) and expectancies (B=0.16, p=0.06).

Expectancies & Other Views on Alcohol

There were no differences between the London and Dublin samples in expectancies, neither in total scores nor subscale-scores for assertiveness, negative affective change, dependence, sexual enhancement, cognitive enhancement and tension reduction respectively (all p>0.1). Of 32 negative consequences, on six items there were statistically significant differences between the London and Dublin samples as to whether the consequence constituted a problem.

The London sample were more likely to see having a hangover (chi-sq.=5.5, 1 df, p=0.019), vomiting (chi-sq.=6.2, 1 df, p=0.013) and diarrhoea (chi-sq.=8.3, 1 df, p=0.004) as problematic. The Dublin sample were more likely to see drinking in the morning (chi-sq.=5.3, 1 df, p=0.022), drinking every day (chi-sq.=10.9, 1 df, p=0.001) and spending most of leisure time drinking (chi-sq.=7.0, 1 df, p=0.008) as being problematic. When controlling for consumption using the previous week measure in logistic regressions, only this last difference remained statistically significant.

Participants were also asked whether they thought the 32 negative consequences provided sufficient reasons to change their drinking behaviour. On only one item – alcohol having an adverse effect on your health – was there a significant difference between the two samples, with those in London more likely to cite this as a reason to change drinking (86%

compared to 56%, chi-sq.=12.9, 1 df, p<0.001). This difference remained significant after controlling for past week consumption.

Alcohol Problems

Participants were invited to report on how often they had experienced each of 20 negative consequences of drinking over the last year. These consequences were described as effects rather than problems. There were no differences between the London and Dublin samples on any item. Similar proportions of the samples in London (80%) and Dublin (73%) exceeded the AUDIT threshold for hazardous drinking (score of eight; Conigrave, Hall & Saunders, 1995). Mean AUDIT scores were also similar – 11.3 in Dublin and 12.5 in London. Similarly with SADD scores, 25% of the Dublin sample and 28% of the London sample exceeded a threshold score of 10, indicating moderate dependence, with mean scores being 6.1 for Dublin and 6.9 for London respectively. None of these differences were statistically significant in these univariate analyses (all p>0.1).

In the multivariate analyses, a statistically significant difference in mean AUDIT scores between the London and Dublin samples was identified and is reported in Table 3. No London-Dublin differences in mean SADD dependence scores were detected.

Table 3: Variables Associated with Hazardous Drinking (Mean AUDIT Scores)

	Beta Values	*P - Values*
London location	0.19	0.012
Younger age	0.27	0.001
Male gender	0.22	0.003
No higher education	0.13	0.069
Expectancy score	0.56	<0.001

Other Variables of Interest

The presentation of results has given most prominence to the central variable under study – differences between the London and Dublin samples. A brief note will be made here of other findings in the preceding analyses. In every instance, gender was identified as being associated with the consumption and problem variables modelled in the multiple regression analyses, with male gender being indicative of heightened risk. For both consumption and hazardous drinking, expectancies favouring alcohol consumption, and younger age are also found to be associated with elevated risk. Younger age was also found to be associated with elevated SADD score and with greater reported frequency of being drunk in the month prior to data collection.

Discussion

In this targeted sample of pub-drinkers in London & Dublin, Irish people in London were found to consume more alcohol than their counterparts in Dublin, with this difference being almost entirely as a result of more frequent

drinking patterns - approximately 50% higher on two different measures. The difference remains statistically significant, and the magnitude of the difference similar, after controlling for other possible factors such as age and gender.

How valid are the comparisons that have been undertaken in light of the limitations of the sampling strategy and thus how generalisable are these findings? In the relatively small number of variables available for assessment of underlying population differences, non-equivalence in age and to a lesser extent higher education was identified. The small sample size entails that differences between the two populations would need to be large to be detected. It would indeed appear plausible that there are other unmeasured differences that will have implications for comparisons between the two populations. The limitations of the sampling method have thus yielded samples for which caution in making population inferences is appropriate.

Taking account of what is known from other sources, along with some striking similarities in alcohol-specific data, these small samples do however exhibit characteristics which are of interest. National survey data (Health Survey for England, 1999) demonstrate that the Irish in England are similar to the general population in respect of frequency of drinking and that it is quantity per episode that differentiates the Irish from the general population. In the London sample, it appears that the Irish have acquired the English pattern of frequency of drinking, whilst retaining the Irish pattern of quantity of

consumption. There is a similarly high rate of reported parental history of alcohol problems in both samples.

One possible explanation for increase in frequency rather than quantity of drinking might be an increase in disposable income – this has previously been observed in the Shetland Islands following the oil boom (Caetano et al., 1983) and among Mexican migrants to the U.S. (Caetano & Medina-Mora, 1988). This possibility highlights a further limitation of this study: - the lack of inclusion of an income measure. Greater levels of Higher Education in the London sample may be indicative of greater affluence. Alternatively, there may be some mechanism of acculturation in the adoption of more frequent drinking. There is also potentially a double-edged nature of the Irish pub in England - providing both a sense of community and engendering alcohol-related risk. It has also been found that maintaining links with home and a relative lack of integration into British society may be protective in relation to alcohol risk (McNicholl, 1992).

Apart from these differences, various similarities between the two samples are particularly noteworthy. Quantity consumed per episode of drinking is very similar in the two samples, as are alcohol-related expectancies and a wide range of views on alcohol consumption, risks and problems. The Irish in Britain have thus not acquired different British opinions on alcohol.

Not only are heavier drinkers to be found straightforwardly in pubs in both London and Dublin, but so too are young people with already existing alcohol-related problems. It would appear from the AUDIT data that hazardous drinking is strongly normative among young Irish people, both in London and Dublin, and potentially elsewhere too. Concerns about drinking among the young have been established in Ireland (Department of Health & Children, 2002), but research attention has not previously been drawn to patterns of youthful drinking among the Irish in Britain. The existing literature is primarily focused on the physical and mental health problems consequent on long-term chronic excessive alcohol consumption, and in particular on the sub-population with multiple and severe problems. The logic of earlier intervention is all the more compelling in circumstances in which problems and dependence are already evident among many young people.

Similarities in some aspects of alcohol risk, along with greater levels of participation in higher education in the London sample are suggestive that the migrants in this sample are not more psychosocially or socioeconomically at risk than their non-migrant counterparts (hypothesis 3). The lack of more detailed data on psychosocial risk characteristics prevents further examination of the migrant selection hypothesis in this sample, and points to the need for further study. Identified differences in patterns of consumption and problems between the two samples, subject to appropriate methodological qualification, may thus be interpreted as supportive of

further investigation of hypothesis 2 – arising from the process of migration to (and experience in) England.

This preliminary investigation thus yields more detailed targets for further research investigations. It may be helpful to pursue methodological consideration of pubs as settings for opportunistic sampling of distinct drinking populations. Further data representative of the Irish in England are needed to explain how and why drinking frequency is elevated in England. What is there in the nature of the experience of being Irish in England that leads to the apparent continuation of some aspects of Irish drinking practices but not others? It would appear that the alcohol-related needs of the young Irish in Britain have been overlooked. The existence of distinct Irish styles of drinking involving greater quantities of consumption per episode also requires further study, having implications for interventions in both Britain and Ireland.

References

Abbots J Williams R Ford G (2001) Morbidity and Irish catholic descent in Britain: Relating health disadvantage to socio-economic position. *Social Science & Medicine* 52: 99-1005

Babor TF Ramon de la Fuente J Saunders J Grant M (1992) *The Alcohol Use Disorders Identification Test: Guidelines for use in Primary Health Care.* World Health Organisation

Caetano R Medina-Mora ME (1988) Acculturation and drinking among people of Mexican descent in Mexico and the United States. *Journal of Studies on Alcohol* 49: 462-471

Caetano R Suzman RM Rosen DH Voorhees-Rosen DJ (1983) Shetland Island: Longitudinal changes in alcohol consumption in a changing environment. *British Journal of Addiction* 78: 21-36

Canning UP Kennell-Webb SA Marshall EJ Wessely SC Peters TJ (1999) Substance misuse in acute medical admissions. *Quarterly Journal of Medicine* 92: 319-26.

Cochrane R (1977) Mental illness in immigrants to England and Wales: an analysis of mental hospital admissions 1971. *Social Psychiatry* 12: 25-35

Cochrane R & Bal SS (1989) Mental health admission rates of immigrants to England: a comparison of 1971 and 1981. *Social Psychiatry and Epidemiology* 24: 2-11.

Commander MJ Odell S Sashidharan SP Surtees PG (1999) Psychiatric morbidity in people born in Ireland. *Social Psychiatry and Psychiatric Epidemiology* 34: 565-69.

Conigrave KM Hall WD Saunders JB (1995) The AUDIT questionnaire: choosing a cut-off score. *Addiction*. 90:1349-56

Conlon P (2001) *A comparative analysis of drinking patterns between two non-treatment populations in Dublin and London*. MSc in Clinical and Public Health Aspects of the Addictions, University of London

Cosper RL Okraku IO & Neumann B (1988) A national survey of regulars at public drinking establishments. *Journal of Studies on Alcohol* 48: 252-259

Davidson R & Raistrick D (1986) The validity of the Short Alcohol Dependence Data (SADD) questionnaire: A short self-report questionnaire for the assessment of alcohol dependence. *British Journal of Addiction* 81: 217-222.

Dean, G., Downing, H. & Shelley, E. (1981) First admissions to psychiatric hospitals in south-east England in 1976 among immigrants from Ireland. *British Medical Journal* 282: 1831-1833.

Friel S NicGabhainn S Kelleher C (1999) *The National Health and Lifestyle Surveys* Health Promotion Unit, Department of Health and Children, Dublin.

Greenslade, L. Pearson & Madden (1995) *A good man's fault: alcohol and Irish people living abroad.* Alcohol and Alcoholism: pp407-417 vol.30, no.4.

Harding S & Balarajan R (1996) Patterns of mortality in second generation Irish living in England and wales: Longitudinal study *British Medical Journal*, 312:1389-1392.

Harding, S., and Balarajan, R. (2001) *Mortality of third generation Irish people living in England and Wales: longitudinal study. British Medical Journal* 332:466-467.

Harnett, R., Herring, R., Thom, B., and Kelly, M. (1999) *Exploring Young Mens Drinking Using the AUDIT Questionnaire*. Alcohol and Alcoholism Vol. 34, No 5, pp. 672-677

Harrison L & Carr-Hill R (1992) *Alcohol and Disadvantage amongst the Irish in England* London, Federation of Irish Societies

Harrison, L., Carr-Hill, R. & Sutton, M. (1993) 'Consumption and harm: drinking patterns of the Irish, the English and the Irish in England' *Alcohol and Alcoholism*, 28(6): 715-23.

Harrison L. Sutton M. Gardiner E. (1997) Ethnic differences in substance use and alcohol-use-related mortality among first generation migrants to England and Wales. *Substance Use & Misuse* 32(7-8):849-76

Health Survey for England (1999) http://archive.official-documents.co.uk /document/doh/survey99

Hickman MJ & Walter B (1997) *Discrimination and the Irish Community in Britain* London, Commission for Racial Equality

Lee, N., Greely, J., and Oei, T. (1999) *The relationship of positive and negative alcohol expectancies to patterns of consumption of alcohol in social drinkers.* Addictive Behaviours, Vol. 24. No. 3. pp 359-369

McNicholl D (1992) The extent of problematic drinking among the Irish population in England and associated migration factors. *New Directions in the Study of Alcohol* 18: 29-40

Miller KD & Williams AF (1981) Blood alcohol concentrations of patrons leaving a collge pub. *Journal of Studies on Alcohol* 42: 676-679

O'Connor J (1978) *The Young Drinkers: A Cross-National Study of Social and Cultural Influences.* London, Tavistock

Stivers R (1976) *A Hair of the Dog: Irish Drinking and American Stereotype.* London, Pennsylvania State University Press

Strategic Task Force on Alcohol Interim Report (2002) Dublin, Department of Health and Children

Taylor CL Passmore N Kilbane P Davies R (1986) Prospective study of alcohol-related admissions in an inner-city hospital. Lancet 2: 265-268

Teahan,J.E.(1998). *Alcohol expectancies of Irish and Canadian Alcoholics*. The International Journal of Addiction, 23 (10),1057-1070

Wild S & McKeigue P (1997) Cross sectional analysis of mortality by country of birth in England and Wales, 1970-92. *British Medical Journal* 314: 705-710

Young, R, McD. and Knight, R,G. (1988) *The drinking expectancy questionnaire: A revised measure of alcohol-related beliefs.* Journal of psychopathology and behavioral assessment, vol. 11, no 1